Nottinghamshire County Council

Adult Social Care and Health Committee

Monday, 02 February 2015 at 10:30

County Hall, **County Hall, West Bridgford, Nottingham, NG2 7QP**

AGENDA

Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Paul Davies (Tel. 0115 977 3299) or a colleague in Democratic Services prior to the meeting.

(4) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

minutes

Meeting	ADULT SOCIAL CARE AND HEALTH COMMITTEE
Date	5 January 2015 (commencing at 10.30 am)

Membership
Persons absent are marked with an 'A'

COUNCILLORS

Yvonne Woodhead (Vice-Chair)(in the Chair)

	Alan Bell	Alan Rhodes
	John Cottee	Andy Sissons
	Jim Creamer	Pam Skelding
A	Dr John Doddy	Stuart Wallace
	Sybil Fielding	Jacky Williams

OFFICERS IN ATTENDANCE

Caroline Baria, Service Director, ASCH&PP
Paul Davies, Advanced Democratic Services Officer, PPCS
Jennie Kennington, Senior Executive Officer, ASCH&PP
Paul McKay, Service Director, ASCH&PP
David Pearson, Corporate Director, ASCH&PP
Kate Revell, Group Manager, Quality and Market Management, ASCH&PP
Jon Wilson, Temporary Deputy Director, ASCH&PP

MINUTES OF THE LAST MEETING

The minutes of the meeting held on 1 December 2014 were confirmed and signed by the Chair.

APOLOGY FOR ABSENCE

An apology for absence was received from Councillor Dr John Doddy (other reason).

MEMBERSHIP

It was reported that Councillors Alan Rhodes and Jim Creamer had been appointed in place of Councillors Muriel Weisz and Michael Payne, for this meeting only.

DECLARATION OF INTEREST

Jon Wilson declared a pecuniary interest in the item on the Interim Leadership Structure of the Adult Social Care, Health and Public Protection Department, and left the meeting during discussion and voting on that item.

CARE ACT 2014 – UPDATE ON LOCAL IMPLEMENTATION

RESOLVED 2015/001

That the update on progress made towards meeting the statutory requirements of the Care Act and the update on financial and resource impact modelling be noted.

CHARGING PROVISIONS OF THE CARE ACT

RESOLVED 2015/002

(1) That consultation be authorised on the introduction of an administration fee and interest charges for the new Universal Deferred Payment Scheme.

(2) That consultation be authorised on the introduction of a flat rate fee for arranging community based support for self-funders.

(3) That the decision on charging for carers' services be delayed for a period of 12 months.

UNIVERSAL DEFERRED PAYMENT SCHEME

RESOLVED 2015/003

That approval be given to consult on the recommendations of the committee paper "Charging Provisions of the Care Act", and on the following recommendations in relation to deferred payments; the consultation should also include the potential option to extend the scheme to service users who receive care and support in their own homes:

- discretion **is** offered where a person has few accessible assets, as the person will be at a high risk of not being able to pay for their care and a Deferred Payment Agreement will reduce the risk of the authority having unsecured debtor as a result

- the Council does not enter into a Deferred Payment Agreement where a person is seeking a top-up, which would increase the amount loaned out unnecessarily and would be a financial risk to the council. Top-ups can continue to be paid by a third party payee, so choice of accommodation is not restricted

- a Deferred Payment Agreement **is** offered to a person with eligible needs who is in supported living accommodation, as this will help them (if they wish) to avoid the need to go into a care home

- discretion **is** offered where a property does not have sufficient value but the land does, as the value of land is unlikely to be more volatile than the value of houses so the risk profile would be similar. A first charge would, of course, be required on the land

- the Council does not seek to delegate its Deferred Payment Scheme, since it already has the skills and experience of running such a scheme over a number of years. However, consideration will be given to hosting the Deferred Payment Scheme for other councils if approached

- the Council does not accept any alternative form of security, other than a first charge on a property or a piece of land, as other assets are seen to bring a higher risk of non-payment

DIRECT PAYMENTS POLICY

RESOLVED 2015/004

That consultation be held on the Direct Payments Policy, with a further report on outcomes to a future meeting of the committee.

PROGRESS REPORT ON WORK OF HEALTH AND WELLBEING BOARD

RESOLVED 2015/005

That the report be noted, and a further summary of the work of the Health and Wellbeing Board be presented in July 2015.

INTEGRATED CARE PIONEERS – WAVE TWO APPLICATIONS

RESOLVED 2015/006

That the Wave Two Integrated Care Pioneer bid be noted.

PROGRESS UPDATE – COMMISSIONING AND EFFICIENCIES PROJECTS

RESOLVED 2015/007

That the update report be noted.

REVIEW OF THE INTERIM SENIOR LEADERSHIP STRUCTURE OF THE ADULT SOCIAL CARE, HEALTH AND PUBLIC PROTECTION DEPARTMENT

RESOLVED 2015/008

(1) That the current interim arrangements be continued for a period of three months from 1 April to 30 June 2015.

(2) That all temporary appointments and cover arrangements be extended to cover this period.

WORK PROGRAMME

RESOLVED 2015/009

That the Work Programme be noted.

The meeting closed at 11.45 am.

CHAIR

Nottinghamshire County Council

Report to the Adult Social Care and Health Committee

02 February 2015

Agenda Item: 4

REPORT OF THE DEPUTY DIRECTOR, ADULT SOCIAL CARE HEALTH AND PUBLIC PROTECTION

BETTER TOGETHER PROGRAMME IN MID-NOTTINGHAMSHIRE

Purpose of the Report

1. The report provides an update on progress in delivering the Better Together programme (BTP) within Mid Nottinghamshire.

2. This report asks members to consider the implications, risks and issues of the development of a capitated budget model of commissioning on the local authority and social care services.

3. Committee are asked to agree further work to be undertaken to determine the future configuration of services in the context of integrated health and social care commissioning and provision.

Information and Advice

4. The Better Together Programme (BTP) aims to deliver a sustainable health and social care system with improved outcomes for local people within the districts of Ashfield, Mansfield and Newark and Sherwood. The BTP forms the basis of the Better Care Fund submission for the Mid Nottinghamshire planning area.

5. The programme is a collaboration between the two Clinical Commissioning Groups, the County Council, all NHS health providers and voluntary sector partners, and which focuses on specific areas of health and social care:

   - urgent and proactive care (including care for people with long term conditions like diabetes, asthma, and frail older people),
   - elective care,
   - maternity and paediatric care.

6. The aim of the programme is to connect services together to ensure that people can better support themselves through self care, get the right advice in the right place, first time when they need it, ensure responsive urgent care services outside of hospital wherever possible and responsive treatment for people with serious or life threatening emergency care needs to maximise chances of survival and a good recovery.

Self Care and Care Planning

7. A Self Care Hub will be developed which will support patients to learn more about their conditions. Patients will benefit from being able to become more involved in making decisions about and planning their own care.

8. The hub will support the delivery of education programmes for people with Long Term Conditions. The hub will work closely with the teams who provide a community based service using a multi-disciplinary team. This is just like a hospital ward, using the same staffing, systems and daily routines, except that the people being cared for stay in their own homes throughout.

9. **Proactive care.** Proactive care known as PRISM is currently being successfully delivered across Mansfield, Ashfield, Newark and Sherwood. These teams focus primarily on people who are at high risk of future admission to hospital and then work with them to put in place care and support which reduces that risk and avoids the need for an unnecessary admission.

10. **Enhanced Intermediate Care.** Intermediate Care can help support people experiencing a period of ill health or difficulty to remain at home rather than having to go into hospital. It can also help people to regain independence following a hospital stay. The new intermediate care model will focus on increasing the number of people receiving care and support at home rather than in a hospital or care home bed. People receiving the most intense level of care can expect to receive up to four visits per day from a joint health and social care team and if needed, have access to night sitting and tele-health services. The proposal is that **Specialist Intermediate Care Teams** (SICT) will provide health and social care and support to bridge the gap between acute and community services. Linking these services together will help avoid unnecessary admissions, reduce delays in discharge and enable more effective patient flows through the system.

11. **Care Navigator** - Often healthcare professionals do not know which services are available for them to offer help to patients and so a new service called the **Care Navigator** will be developed. This will be used specifically for Health and Social Care professionals to contact services when they need to arrange support for their patients who need help. The Care Navigator service will be available seven days a week and will help identify and arrange alternatives to hospital admission or support a discharge from hospital or care home. This means that patients will be signposted to and supported by the most appropriate service in the most appropriate care setting in a timely and co-ordinated way.

12. **Crisis Response Team** - A community based crisis response service will operate 24/7 and provide intense and focused health and social care support (including personal care) to assist people experiencing difficulties and support them to remain living in their own home and maintain independent living skills rather than having to go into hospital. The crisis response staff will be trained staff who will respond to a request for support within 2 hours and will work closely with community teams who will provide clinical support.

13. **Discharge Function** - The new discharge service will ensure that people do not need to stay in hospital any longer than necessary and that they can be discharged with all of the support they need to the most appropriate care setting. The aim will always be to support

patients to return to their own home The team will start this planning process very early on in the hospital stay and they will work closely with their colleagues in the community to ensure that all of the support needed is in place ready for when the patient is medically fit for discharge.

14. The BTP provides a blueprint for action which includes a range of activities required in order to deliver the anticipated outcomes. These activities include the development of a joint commissioning strategy, an estates strategy, IT infrastructure plans, workforce development plans, and performance management framework.

15. The development of a joint commissioning strategy is now being considered through the development of an **outcome based capitated model** of commissioning led by a single lead provider who will co-ordinate all service delivery across the area.

16. Capitated commissioning aims to deliver better outcomes by removing the incentives for providers to maximise income through episodic care within the current NHS commissioning process. Rather than providers being remunerated for each treatment episode (outputs), they are given a capitated budget to cover the whole population with incentives linked to specific outcomes. This model aims to reward providers for delivery of high quality care rather than by quantity of care.

17. The lead provider model takes this one step further by requiring one co-ordinating provider to lead the delivery system, co-ordinating the activity of all other local providers. In this way commissioners can transfer or delegate accountability for delivery to a single accountable provider (SAP) who becomes responsible for establishing an integrated care pathway, procuring services to deliver care and navigating people through the system.

18. Across the three Districts, the health and social care spend amounts to over £300m per annum, of which Nottinghamshire County Council spends in excess of £80m on social care services. A process is underway to map all the expenditure across health and social care within the mid Nottinghamshire area to develop a profile which can then be used to enable the commissioning of a capitated contract across health and social care. A further report will be presented to members to identify the different areas of expenditure across the County.

19. In entering into an agreement to deliver a single capitated budget across health and social care services within mid Nottinghamshire, there are a number of issues and risks which will need to be understood and addressed by the County Council. These can be summarised as having impact in the following areas:

Outcomes

20. The County Council is accountable for the delivery of social care services to the population of Nottinghamshire. The Council may delegate both the commissioning and provision of services to other bodies but retains accountability for the outcomes of any services which individuals receive. The Council is held to account by Government and the regulator and measures delivery through the Adult Social Care Outcomes Framework, sector led improvement processes and other performance management frameworks.

21. Previous experience of integrated provision across health and social care locally has shown that NHS providers have struggled to meet social care outcomes, and national evidence of

integrated provision has largely not demonstrated success in providing value to social care services. It is therefore essential that any future development of integrated commissioning and provision is based upon an agreed outcomes framework which meets the requirements of the Council.

22. Social care is highly personalised, through the provision of personal budgets within which people exercise choice of service delivery. Nottinghamshire County Council is a high performing council with nearly 100% of community based service users having a personal budget and nearly 50% of those having some form of direct payment. Nottinghamshire County Council would wish to see the continued personalisation of social care (and Health) services in line with the duties and requirements of the Care Act 2014.

23. Whilst it is essential that the SAP can procure social care services for the local population, it is as yet unclear how a SAP can deliver personal budgets in line with Council policy without access to the local authority's underpinning systems and processes such as the assessment process, resource allocation system, commissioning processes and direct payments systems.

24. It is not considered feasible or desirable for the SAP to develop its own bespoke processes for the delivery of personal budgets as this would be resource intensive for the provider and could result in differential outcomes for individuals across the county who may be subject to different systems.

25. It is recommended therefore that the County Council maintains a county wide system and process to deliver personal budgets which can be accessed by the SAP on a case by case basis in order to deliver personal social care services to individuals.

26. The allocation and ongoing review of a personal budget is driven by the care management and assessment process which is undertaken by social care staff. In order to deliver an integrated health and social care offer to individuals, the SAP would need to be able to direct both health and social care resources. This will be particularly important where health and social care service interface such as at the point of hospital admission / discharge and where individuals have both health and social care provision for example people with multiple long term conditions.

27. Therefore the SAP will need to be able to both deploy the contracted social care provision and deploy the assessment and care management activity which supports the procurement of services. It is envisaged that should the Council adopt a lead provider model, the SAP will have day to day operational responsibility for the assessment and care management staffing which supports this activity in order to have full control of the overall health and social care resource.

28. The current deployment of assessment and care management services reflects both the point at which people access services and the social care functions of the authority. This entails staff located at hospitals, within locality teams, in integrated teams such as PRISM and IRIS (Information Service for parents and carers of children and young people with disabilities in Nottingham and Nottinghamshire) as well as staff who work in corporate structures such as the Adult Access team and MASH. Whilst it is clear that some of these staff would need to be within the scope of a SAP, others may not, and some of these

functions support wider areas of the Council's social care responsibilities which may remain outside of the SAP contract.

29. One such area of activity which may or may not be a delegated to the SAP is the authority's safeguarding responsibility. The local authority is the lead organisation tasked with safeguarding adults who may be at risk of harm or abuse. These responsibilities are being extended with the introduction of a new legislative framework from April 2015. Currently the Council requires all experienced social work staff to undertake safeguarding assessment duties which involve the investigation of allegations of harm and abuse wherever these occur within the geographical boundary of Nottinghamshire. The Council together with the Safeguarding Adults Board has held the view that individual providers should not investigate allegations (other than in relation to employment issues) concerning their own provision other than in exceptional circumstances. Health services however have developed internal processes for the investigation and governance of safeguarding arrangements within the NHS. Requiring a provider to carry out safeguarding investigations and decision making of itself and others on behalf of the Council raises potential conflicts of interest and would entail a revision of safeguarding policies and procedures which would require the approval of the Safeguarding Adults Board.

30. Members may therefore wish to consider the options of retaining a safeguarding function within the Council or of delegating functions and responsibilities to the SAP. Members may further wish to take advice from the Safeguarding Adults Board in this respect.

31. The promotion of independence, the achievement of value for money and the continued personalisation of services is the agreed strategy for adult social care, which together with the Care Act implementation forms the priority for adult social care commissioning.

32. The Better Together programme also enshrines these principles although it is not yet fully understood how these can be enacted and fulfilled at a system level. It is essential therefore that the County Council is fully engaged in the establishment of an agreed joint outcomes framework which can provide evidence of improvements in social care in line with the local strategy and national policy. A draft joint outcomes framework is being developed and is attached to this report for members' information.

33. One issue which members may wish to consider is the historical difference in how health and social care services approach risk to individuals. Health services have often tended to be more risk averse than social care services. Whilst it is difficult to generalise there are a number of factors which influence appetite for risk such as professional values, ethics, litigation, regulation, choice, individual responsibility, situational responsibility, public expectation, expediency etc. These factors all contribute to the manner in which people receive their care, where and how they receive care and the level of care provided. There are no rights and wrongs in this area it is more a matter of philosophy and ethos, however the degree of difference in approach can be substantial and have consequence on outcomes for individuals. The development of an outcomes framework does not in itself resolve this issue as there may be outcomes which conflict or which may not be mutually supportive, for example keeping people safe versus promoting independence, maximising choice versus being most efficient. Members may therefore wish to specify which outcomes are more of a priority or consider whether a weighting should be applied to ensure approaches to risk reflect the authority's priorities.

34. Advice information and advocacy forms the first requirement for local authorities in their delivery of social care functions. Ensuring people receive the right information at the right time in the right way is intrinsic to the authority's ability to manage demand and therefore manage its resources going forward. Therefore a co-ordinating provider would need to be able to provide relevant information and advice in a timely way to people who are using health and social care services. However the delivery of these functions requires a much broader approach than that envisaged for the SAP and will require the involvement and intervention from many different organisations across the statutory, voluntary and third sector. The Council is currently developing a range of information services which will be available in different formats to the wider population which will be based upon a digital platform to enable the information to be updated as required and accessible to agencies, organisations and individuals.

35. Members may therefore wish to consider the role that the SAP should play in delivering information and advice within the broader framework having thought to the balance to be struck between general advice information and advocacy and that which is required to be given to individuals with specific needs and any potential conflict of interest which could be perceived for a provider who will have a focus on ensuring a value chain of provision and the wider needs of individuals and the population at large.

36. Prevention and early intervention services are key to the delivery of a capitated budget model. The SAP must over time be able to deliver interventions which defer, delay or prevent recourse to further services if the model of a capitated budget is to be able to fulfil the future demand for health and social care. Members may wish to consider whether a distinction could or should be made between areas of primary prevention which may be based at population level, secondary prevention which may be targeted at individuals who are at risk, and tertiary prevention which relates directly to people who are in receipt of health and social care services. As an authority with both social care responsibilities and public health functions, the Council has a duty to arrange prevention services at all levels. However it is within the discretion of the Council to commission these services in whatever manner best meets the needs of the local population. Members may therefore wish to consider which prevention and early intervention services are best placed within the scope of a SAP such as reablement services, intermediate care services and hospital discharge services and those which may be better commissioned at a population level such as advice information, short term prevention and screening services. In addition the Council is also progressing work to develop the capacity of local communities and third sector organisations to help support to people who have additional needs to prevent them from needing to access health and social care services. It is recommended that this work should continue outside the scope of the SAP.

37. The draft outcomes framework is attached as Appendix 1.

Finance and Procurement

38. The Council currently spends over £300m gross (over £200m net) on adult social care. The vast majority (over 70%) of this expenditure is on services procured from over 300 different providers.

39. The majority of council managed community based services are contracted through framework agreements to preferred suppliers both at an individual service user level and as a capitated contract giving providers more responsibility for delivery of individual outcomes. Contracts for these services could be either novated to a lead provider, or retained by the authority with permission given to the lead co-ordinating provider to purchase from the contract. In this way the lead provider could develop a supply chain within which the health and social care needs of individuals and the wider community could be met, thereby managing supply and demand. However as the scope of the proposed capitated budget is limited both geographically and in respect to need, members will need to ensure that services are available and accessible to service users from across the whole spectrum of need and across the whole of the county. The contracts which are currently procured to deliver these services are commissioned on that basis and any change to this in the near future may present difficulties in respect to access and equity of provision, contract management, and the achievement of best value.

40. Therefore it is not recommended that the Council should transfer its procurement of independent and third sector providers to the SAP. This does not prevent the Council from allowing a lead provider to call off services from a contracted provider through a delegated arrangement. By doing so the Council would need to ensure itself that services were being procured in line with legislateive requirements, statutory guidance and local social care policy. This could be achieved through the delegation of assessment and care management functions to the SAP. Whilst the Council has wide ranging experience of procuring services from third parties to deliver services, the council has never previously transferred responsibility for the commissioning of services at an individual level (sometimes known as micro commissioning). Allowing a third party, contracted provider to carry out assessment and care management functions on behalf of the authority has potential implications for budgetary and financial management, in that the Council is giving responsibility for the commissioning of personal social care to a different organisation outside of the corporate control of the Council. These budgets are to some degree demand led, highly volatile in spend and can be difficult to forecast, manage and control.

41. The capitated budget model requires the provider to deliver services to meet the health and social care needs of the population (within scope) within a defined (capped) budget. Therefore the Council could determine an overall budget within which the provider must operate and expect that the provider will deliver to this bottom line, whilst at the same time providing sufficient flexibility to allow the provider to procure services. The Council would need to ensure there were effective control mechanisms, monitoring systems and risk sharing agreements in place to alert the Council to; and detail arrangements for any over commitment, overspend, under delivery, or underspend. The delegated budget would also need to reflect the agreed (current and future) savings and efficiency targets which are required to balance the authority budget in the medium term, alongside any demand or cost led budget pressures which the authority may agree to meet.

42. Members will need to consider that a desired outcome in developing a SAP model will be that there would be a shift from acute care to community based care and from health care to social care. Whilst this is beneficial in meeting people's individual outcomes and has an overall financial benefit for the health and social care system, in the longer term it will potentially increase the proportion of expenditure on social care at a time when local authority resources are reducing. Members should therefore seek to assure themselves that the SAP is able to meet current demand within a reducing resource base and that the

authority is protected from any longer term financial consequence of increased social care provision should members agree to the delegation of functions and budget to a SAP.

43. Many of the services procured are arranged at an individual level through individual service contracts for residential/nursing care or through individual Personal Budget and/or Direct Payment agreements. The contracting of services on an individual basis is complex and requires the support of both specific adult care financial services and the general financial services and systems of the authority. The specific adult social care financial services are intrinsic to the delivery of these individually contracted services, not least due to the requirement of the authority to collect client contributions and other income to offset the gross cost of services. The assessment for, determination of, and collection of individual contributions is critical to the financial sustainability of the authority. In addition these services provide invoice and payment processing for providers; payments, monitoring and auditing of direct payment accounts; as well as other related client money functions such as deferred payment systems, appointeeships and deputyship services. It is not recommended that these services are delegated or included within the scope of a SAP, and therefore any agreed financial delegation should be at a net budget level rather than a gross budget.

44. All adult social care services are commissioned through the Frameworki information system which records the level of personal budget, the indicative and actual support plan and the agreed service procured to meet the individual needs of each service user. During 2015 the Frameworki system is to be updated to provide a major system upgrade called MOSAIC which will provide additional functionality and ensure the system is Care Act compliant. Alongside this upgrade the County Council is also in the process of considering the outcome of a systems review of all adult social care information and data management systems with a view to rationalising systems and ensuring that the corporate business management system and the Frameworki (MOSAIC) system are fully aligned. Given these large scale changes to the ICT infrastructure, careful consideration should be given to any further changes or disruption that may be caused as a consequence of integrating health and social care service within the next 12 months.

45. The third area of service provision is through the Council's direct services which accounts for around £30m of expenditure across the County and for which the Council is currently considering alternative delivery models. The development of a lead provider model of service could offer opportunities for some or all of these services to operate as integrated health and social care services. For example services could be seconded to the lead provider whilst the Council retained employer status, or services could be transferred to the lead provider utilising TUPE arrangements.

46. Should this type of arrangement be considered, it is likely that the SAP would only wish to take management responsibility for those services which have a direct influence on their existing core business such as Re-ablement services and possibly some bed based provision, leaving other services such as employment, and catering with the authority.

47. A further option would be for the authority to develop an alternative delivery company such as a Local Authority Trading Company or social enterprise which could then be contracted directly by the SAP to deliver services as part of the overall supply chain of provision. Should this option be considered appropriate then all current direct provision could be included in a new business model which could then offer an integrated service to the SAP.

48. Alternatively the Council may decide to retain the services in house, in which case either of the two options discussed above could be adopted with some changes made to existing management and operational structures. Members may wish to consider these options when coming to a determination about the future direction for direct service provision.

Employer Responsibilities

49. There are a range of options open to the authority in respect to the workforce. Employees could be transferred to a partner organisation as part of a service transfer, employees could be formally seconded to a partner organisation or employees could be retained by the authority and aligned to a lead partner who may or may not have day to day management responsibility.

50. The consideration of the Council's on-going employer responsibilities should be determined by the functions under discussion having thought to issues such as future recruitment, retention, staff development, professional support, terms and conditions of employment, and workforce development.

51. A key consideration is learning and development and workforce development in the context of the Care Act implementation with associated changes to policies, procedure, practice and process. The authority needs to be assured that staff are fully conversant with new working systems and methods and able to implement changes to practice and processes at this critical time. Workforce development is not only related to the introduction of new policies and working practices, but is also important in considering the future role of Social Work as a profession and the future delivery, of social care as an intervention to aid people's health and wellbeing. Previous integrated approaches to health and social care have proved less successful over time due in part to an underestimation of the importance of supporting and building and maintaining an ethos and philosophy of social care and the professional development of Social Workers, Occupational Therapists and others. Members should ensure that integrated health and social care arrangements embed a strong focus on the on going workforce and learning and professional development of social care staffing.

52. Leadership is a further area of consideration dependent on the future model of service delivery. Experience has shown that staff that have been seconded or aligned to another organisation can become distant form the Council which continues to be their host employer. This can lead to role ambiguity, loss of organisational and professional accountability and low staff morale. The Council will need to determine how organisational and professional leadership can be delivered to staff who may be working outside the organisation and in different parts of the health and social care system. This could be achieved through ensuring a robust social care based management and leadership function is retained in a structurally integrated care arrangement together with a requirement for the local authority to retain oversight for these areas of practice development. However one of the largest challenges in bringing together staff across health and social care is to bridge the different organisational and professional cultures which exist.

53. It is envisaged that an integrated health and social care system can bring benefit to the local population through the delivery of a holistic care pathway from information advice and self care through to acute medicine and on to long term care. This will require the coming together of various professional disciplines, organisations and agencies each with their own

identities, values, and ways of working; all of which will need to be understood, embedded and cherished if the benefit to users of services is to be achieve.

54. A new operating culture may emerge as new models of practice are developed and new organisational units formed but this is likely to take time and require considerable leadership and workforce development intervention. It is suggested therefore that Members consider a phased approach to integrating services, ensuring professional and organisational leadership is assured and Human Resource capacity is made available to support the alignment and possible future integration of services.

Governance

55. The Council governance process is detailed in the County Council constitution and is enacted through elected members and officers within a scheme of delegation.

56. The accountability members hold for assurance together with their decision making responsibilities and those of committees cannot be delegated to a third party. That is not to say that functions and responsibilities of the Council cannot be delegated, but the accountability for any delegated activity will rest with the Council through the elected members

57. Therefore should the council agree to transfer or delegate functions to a third party, members will need to assure themselves that there is a robust and transparent process of governance in place which provides the authority with oversight of activity and quality, scrutiny of outcomes, workforce and financial assurance. Whilst the provision of services may be delegated or contracted to a different organisation, the strategic and policy direction of social care in the county will remain a responsibility of the local authority to determine and enact.

58. There are some statutory responsibilities and functions which members may determine should not be fulfilled through a SAP, or which the Council or provider may determine should remain within the local authority. Such functions will need to continue to have internal oversight by members and members will need to ensure the continuance of a robust management and performance framework for these. Examples may include services where a provider may have a conflict of interest or where an independent assessment/decision is required such as Mental Health Act assessments, Best Interest Assessments and Deprivation of Liberty assessments. It is suggested that work is undertaken to map local authority functions to determine which areas should remain within the authority and those which may/should be delegated.

59. In addition to the matters noted above in respect to finance, members may wish to also consider the development of a pooled budget arrangement and how the governance of any such pooling of resources may be undertaken.

60. There are discussions already underway in respect to pooled budgets for areas such as the Better Care Fund and transforming care in learning disabilities but a pooling of resources for this programme would be for a different purpose and would require specific governance arrangements

61. Pooling could take place at a commissioning level with the CCGs to deliver a joint capitated budget to the SAP, or could take place at the provider level through separate but related contracts between the CCGs and the Local Authority. Members are recommended to consider the former option as being the most suited to deliver the outcomes sought but may wish to consider alignment of resource at provider level as a first step toward this objective.

62. The outcome of decisions made on the functions which may be delegated and the responsibilities which may need to be retained will help members to determine what form the integration of health and social care may take. There are various options from the alignment of current systems, processes and pathways to a formal integration of commissioning and/or provision. The specific governance requirements of each option will be further developed over the course of the next few months.

Scope

63. The Better Together Programme is aimed at providing an integrated health and social care provision across the areas of Mansfield, Ashfield and Newark and Sherwood for a designated population of older people and people with long term conditions. Therefore people outside of this catchment area and people with different needs such as younger adults or those with learning disabilities fall outside of the remit of this programme.

64. The Council will need to ensure that access to services and provision of services is equitable across the county. This will be potentially more difficult to achieve as services are developed to meet the requirements of the different planning areas and different partner delivery strategies across the county. Access to services is not merely a matter of where and how people access services but more fundamentally who can access services. Currently the Council has agreed a local threshold at which people become eligible for social care, and once eligible a personal budget is calculated to fund services that will meet the person's assessed eligible need. This process will change somewhat as the Care Act is implemented in April 2015 when the eligibility threshold becomes a national determination and the definition of eligibility changes to include the concept of wellbeing. However the overall social care assessment and individual commissioning process remains and the Council is in the process of developing systems and processes to enact the new responsibilities to ensure equitable access cross the county for all residents regardless of nature of need or geographical location.

65. The development of a capitated budget contracted to a SAP is predicated on the provider being able to develop different care models and new care pathways with the aim to reduce people's need for intensive health and social care services. Inevitably this may lead to the delivery of care to people who may not be eligible for local authority funded care if this is seen to prevent longer term use of health and social care services. Whilst access to such preventative services is to be welcomed, it may be that access to similar services will not be available in other parts of the county where different commissioning and provision arrangements exist; and equally that may not be available in the same area to people whose needs fall outside of the SAP contract. Members will need to consider how this potential inequity of access can be resolved.

66. In addition the way in which people access services will change through the development of integrated provision. The Council has for some years been developing a central point of access for all local authority services through the Customer Service Centre, however the integration of health and social care provision will require multiple points of access which will need to reflect local integrated care arrangements. Developing local access points will help to ensure people have a timely access to a range of provisions through a single point of entry (locally) to health and social care resources and reduce the need for hand offs and duplicate assessments. The development of a digitally based referral and assessment process will help to facilitate more flexible access arrangements but Members should assure themselves that there are robust systems to monitor activity and performance and ensure a parity of service user experience.

Support to Carers

67. Alongside the commissioning and provision of services to people who have eligible needs the Council also commissions and provides services to carers. The duties of assessment and provision of services that the Council has toward Carers are due to increase in April 2015 following the implementation of the Care Act. Whilst the capitated budget and SAP contract are designed to cover the totality of needs of the population for secondary health and social care, it does not cover the needs of carers. However, the service which an individual receives is often directly linked to a need identified through a carer assessment, for example respite care. Therefore separation of service user and carer needs is not always possible, and further the assessment of each need is often dependent on the other, for example, in determining a personal budget account will always be taken of the ability of carers to continue to provide care. It is also the case that at present, many carer assessments are carried out by the same Care Management staffing who carry out the service user assessment; indeed the Care Act specifically promotes the use of joint assessments. It is recommended therefore that members consider whether the SAP should also take responsibility for carer assessment and provision or if there needs to be a separately identified and scoped provision to meet the needs of carers outside the scope of the SAP.

Strategic Commissioning

68. Members should also note that there will remain a number of areas of strategic commissioning which will by necessity remain the responsibility of the authority and not form part of any contract with a SAP. The Council will continue to be responsible for a number of areas of commissioned services from third sector and independent sector providers alongside responsibilities for market facilitation, market development and ensuring a high quality of market provision. The responsibilities and duties of the authority and those which will be conferred on the authority from April of this year could be delegated to a third party such as a SAP, but it is not recommended that the Council do so. However members may wish to consider how a more joined up approach to these areas could be developed with NHS commissioning partners through an integrated commissioning arrangement.

69. In addition from April the Care Act brings new roles for local authorities in respect to people who fund their own social care. Over the course of the next 12 months the Council will be developing new information systems, new assessment processes and new financial processes such as deferred payments and individual care accounts to provide for people

who will continue to fund their own care. All of these processes will continue to be undertaken outside of the proposed development of a SAP.

Other Options Considered

70. The Council could continue to deliver social care services outside of a jointly agreed commissioning process with NHS partners. The Better Together programme would continue to be delivered as a health based programme without social care resources and services, however both health and social care partners may then miss the opportunities which working together may bring in terms of system change, financial gain and improved outcomes. This is a watershed moment for the Council. The decisions made in relation to the BTP will begin to determine the authority's position in respect to integration of health and social care.

Implications for Service Users

71. People will receive the right care at the right time in a place closer to home wherever possible. The new model will mean that people will only need to go into hospital when they need specialist help and will be able to remain living in their familiar surroundings at home with the support they need to do so.

72. They will have a named person responsible for co-ordinating their care and all of the people involved in that care will have the information they need about the person and will work closely with each other to ensure that the care being delivered is seamless.

73. People will have more information about their own condition and support to help both themselves and their carers to become more involved in decisions about how their care is planned and delivered.

Reasons for Recommendations

74. The BTP has forecasted a future financial gap of £140m across the health and social care system if organisations do nothing to address rising demands and shrinking resources.

75. This is a system wide model of care which requires all organisations to work closely together, develop new ways of working and break down traditional organisational boundaries.

Statutory and Policy Implications

76. This report has been compiled after consideration of implications in respect of finance, the public sector equality duty, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

77. Financial implications are set out in the report in paragraphs 38 to 48.

RECOMMENDATIONS

It is recommended that the Adult Social Care and Health Committee:

1) consider the issues and implications of establishing a capitated budget and Single Accountable Provider across Ashfield, Mansfield and Newark and Sherwood;

2) agree to further work being undertaken to consider the development of the capitated budget and Single Accountable Provider model in Mid Nottinghamshire;

3) receive a further report on progress in April 2015 on the Better Together programme;

4) receive further reports on the integration of health and social care services in South Nottinghamshire and Bassetlaw respectively;

5) convene a workshop event to further discuss the integration of health and social care services.

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Constitutional Comments (LMc 20/01/15)

78. The Adult Social Care and Health Committee has delegated authority within the Constitution to approve the recommendations in the report.

Financial Comments (to follow)

79.

Background Papers
None

Electoral Division(s) and Member(s) Affected

All

ASCH

Shaping health and care in Mid-Nottinghamshire

Mid-Nottinghamshire
Better Together Programme

DRAFT OUTCOME FRAMEWORK REPORT

December 2014

Introduction

Purpose of Framework and approach

Shaping health and care in Mid-Nottinghamshire

In mid-Nottinghamshire, commissioners are seeking to drive whole system change through a re-commissioning process that aims to realign risk and reward within the system.

The approach focuses on measuring and rewarding outcomes (end results) rather than inputs. This rewards both value for money and the delivery of better outcomes by discouraging unnecessary activity, supporting capitation payments (where inputs are not measured or paid for) and encouraging innovation (as the solution is not predefined). By aligning incentives it will also enable organisations to work together to achieve a common set of goals as well as to redistribute resources across the system as required.

Purpose of the outcome framework

The final contract will contain a single, integrated, outcome framework covering the population and services within scope. Achievement against the framework will be monitored and linked to the payment of providers. This will enable commissioners to incentivise providers to deliver improved patient outcomes as well as safe and effective services.

The Accountable Provider Organisation will be expected to deliver the agreed outcomes in addition to national and local and national quality standards, as well as adhering to the requirement to work with Commissioners to consult on service changes associated with delivering the outcomes.

The outcome design working group

A working group was established to oversee and contribute to the development of the framework. This group brought together a range of stakeholders including representatives from the CCG, Local Authority and Public Health, GPs, secondary care clinicians , HealthWatch and CCG quality leads.

The working group is accountable to the CCG commissioning committee and will ultimately recommend the framework to this group for adoption.

The development of the framework has brought together a range of perspectives including patients, clinicians and technical specialists. An overview of the approach is set out below. Throughout 2015 the framework will continue to be refined in dialogue with provider organisations in line with the formal commissioning process.

Steps to develop the outcome framework

Outcome Design: The outcomes against which providers are measured and rewarded should be grounded in what service users value and how health and care services can help them achieve their ambitions and goals.. To develop this understanding a review of the national literature and local public engagement was completed. From this work a number of outcome statements were developed and refined by the working group.

Indicator collation and selection: There is no single, integrated outcome framework for health and care services in the UK so a number of sources were used. A long-list of indicators were mapped to the outcome statements and were then considered and refined by the group. The indicators selected cover the whole pathway of care, combine existing and new measures and reflect different population groups.

Commercialisation: The next phase of work will focus on commercialising the framework. This involves prioritising and weighting the indicators, confirming baseline performance and considering performance trajectories for the duration of the contract. This process will link to the other work streams of the programme.

Structure of the framework

Structure and Domains

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Structure of framework

The Outcomes and Capitated Based contract will contain a single, integrated, outcome framework covering the population and services within scope of the contract. The outcomes and indicators within the framework will give Commissioners and Coordinating Providers a view of performance across pathways and population groups. An outcome framework is a collection of measures that are used to monitor and contract for services.

The framework is made up of three core elements:

Domains	The high-level grouping or classification of outcomes that are measuring similar things – for example, safety or patient experience.
Outcomes	Outcomes are the goals and results of providing health and care services and set out a definition for what Coordinating Providers should be aiming to achieve. Outcomes are grounded in the needs and wants of people who use the services. Many of the outcomes are related and can fit within a number of the domains.
Outcome Indicators	The measures selected to demonstrate the achievement (or not) of the outcome. These will be as outcome focused as possible but where there is a case a process/structure measure can be used as a proxy; for example, many people cite access to timely and responsible services as important. One of the ways to measure this is through process measures/standards. Where possible, existing indicators have been used but there will be a requirement to develop some new indicators.

The aim for the framework is to strike a balance between an appropriate number of measures to reward and recognise performance while not presenting an unnecessary burden on provider organisations or to constrain potential models of care. Through the contracting process these indicators can be refined through negotiation although the outcome statements will be kept the same.

Outcome Domains

There are a number of existing and emerging outcome frameworks. (Appendix 3). We have reviewed these and through the working group identified four 'domains' that are common across them. Outcomes within these domains will represent performance across the system and for different population groups. Indicators will be selected to demonstrate performance against the outcomes.

Outcome Domains

Population Health	The impact of health services on the health of the population such as preventing premature mortality and overall prevalence.
Quality of Life	The overall quality of life that patients and services users are able to have as a result of health and care services. This can include independence and the management of conditions
Quality of Care	The experience people have of health and care, the need to safeguard users and any unintended consequences of care.
Effectiveness of care	The results of or impact of care on services users. This includes immediate and long term recovery.

Structure of the framework

Incorporating outcomes into the contract

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Incorporating outcomes into the contract

The outcome framework will form a relatively small number of measures in the overall contract. Commissioners will get additional assurance from a range of other measures that are routinely collected and reported.

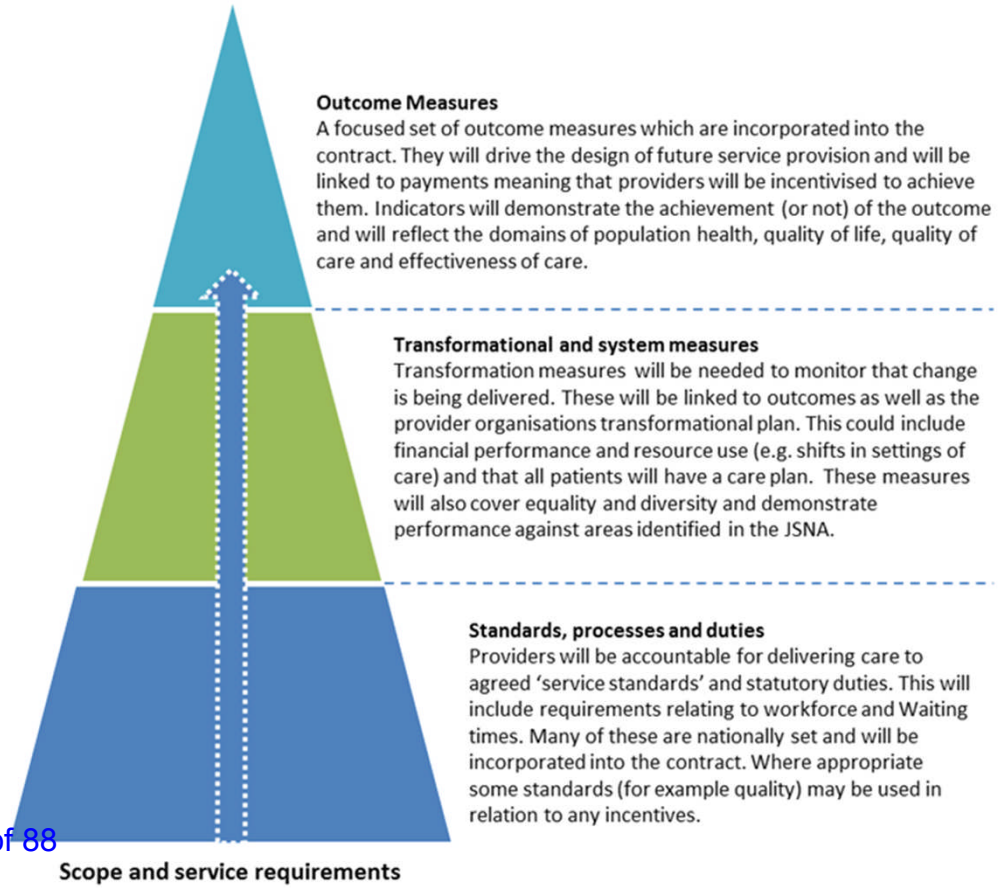
The diagram opposite sets out the different measures that will be measured and monitored. The outcome measures will be set by commissioners, transformational and system measures will be developed jointly with providers and the standards will predominately be set nationally . It is important that these additional measures reinforce the outcomes and do not constrain the potential delivery of new and innovative models of care. However, some standards, such as safeguarding, may be considered significant enough to patients and commissioners that it forms part of the payment mechanism.

The outcome framework also reflects the capitated payment approach. Capitation will incentivise providers to manage the quality and cost of provision meaning that they are more likely to invest in keeping people well and out of hospital.

Aligning services to the scope of the contract

The outcome framework has been developed in the context of the scope . This is because providers can only be held account for outcomes that they have a level of influence and control. Some measures have therefore been discounted where there is a clear distinction. However, the working group agreed to include some measures as they will drive integration and improved services . As the scope is confirmed the framework will continue to be refined. These considerations have been outlined below:

- **Maternity services**: There is currently a place holder for maternity services as this has recently been included in the scope of the contract.
- **Public Health**: While public health is out of scope there are a number of indicators within the Public Health outcome Framework that can be influenced by providers such as injuries from falls for people over 65. It is recognised that some upstream factors ,such as socio-economic, can not be directly influenced.
- **Primary Care:** Core primary care services are outside of the immediate scope of the contract. As such measures set out in QOF (Quality and Outcome Framework) have been discounted. These include some measures related to the management of long term conditions such as monitoring blood pressure.
- **Social Care:** Nottinghamshire Council are currently considering how their services are integrated into the scope. However, the group felt that many measures that traditionally relate to social care are influenced by health providers. The inclusion of these measure reflect the changes the better together programme is aiming to achieve.
- **Mental Health:** Acute Mental Health services are outside the current scope. As such indicators relating to these services have not been included.



Structure of the framework

Personalisation of outcome measures

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Personalisation is an important aspect of integration. The outcomes and indicators selected should therefore incentivise care providers to support service users to achieve their own personal goals and outcomes.

Personalising outcomes means focusing on people's individual goals and the lives they want to lead, rather than just the clinical outputs of their treatment. This means that models of care should be developed and organised around the patient and that service users have a say in what is important for them to achieve on a personal level.

However, at a population level it is not practical or feasible for commissioners to measure the personal outcomes for every patient and/or service user who enters the system. As such, organisations and users within the health and care system have a role to play to practically use to ensure that they personalise their outcome measurements.

- **Commissioners set outcomes and measures that facilitate personalisation:** Commissioners set broad outcomes that they will track that include a set of personalised outcomes. Such as 'people are able to remain independent' or 'service users are able to achieve their personal and social goals'. Other indicators may, for example, include the percentage of service users with a personal budget.
- **Individual care professionals and individuals work together to set personal goals:** Providers work with service users to capture personal goals and aspirations when delivering care.
- **Individuals are supported to track the achievement of personal goals:** Providers regularly check whether people are achieving their personal goals and identify how they can be realised and what, if any, additional support are required.
- **Service users take responsibility:** Service users have a role to play in achieving their own goals and will be expected to take a n appropriate level of personal responsibility.

The case study opposite provides an example of how co-ordinating providers can capture personal outcomes through the development of specific projects. This will, in turn, support the achievement of outcomes relating to independence and quality of life.

Case study: Translating and capturing personal outcomes

Wiltshire Council has established a 'Help to Live at Home Service' for older people and others who require help to remain at home. This approach has focused on the outcomes that the older people wish to gain from social care.

The Council will pay providers on the delivery of person-defined outcomes. These 'payable outcomes' express the goals of a person centred assessment – they must be the product of a person-centred planning process and they are the customer's outcomes.

The Council uses a prescribed set of payable outcome statements to translate individual customer outcomes. The difference from traditional services will be that the council will pay the Provider to help customers achieve outcomes that are defined in Support Plans and not to deliver a prescribed number of units of service – typically hours of domiciliary care – as we do now.

Example outcomes:

- I can manage my personal care (I can wash, dress/undress, shave)
- I can keep myself safe all of the time (Go for short walks, access the local community)
- I can eat, drink and prepare my meals (prepare cold/hot drinks)
- I can make decisions and organize my life (communicate with people independently)

While this service is directly commissioned by the Council it demonstrates how providers and care professionals could translate commissioner outcomes into person-centred delivery.

Source:

- http://ipc.brookes.ac.uk/publications/pdf/Wiltshire_Council_Help_to_Live_at_Home_IPC_Report_April_2012.pdf
- http://www.youtube.com/watch?v=uCretTNaCLg

Outcome Design

Service user and public engagement

Shaping health and care in Mid-Nottinghamshire

The outcomes against which providers are measured and rewarded should be grounded in what service users need and want. Throughout October and November we worked to understand what matters to patients and services users. This work was informed by:

- **Literature review:** There has been extensive research into the needs and wants of patients and services users at a national and local level. As such, existing literature was used as a starting point to develop insight to inform the development of the outcomes. This process reviewed national literature from organisations such as The Kings Fund , a review of national frameworks and, drawing on previous local engagement (a select list of sources is set out in appendix 1).
- **Local engagement:** To supplement and test the literature above we conducted a range of local engagement activities s that were focused on the development of outcomes. This process has involved over 400 people across Mansfield and Ashfield and Newark and Sherwood.

While some needs from health and care will be largely universal across different groups of service users, some will be related specifically to life stage and/or health and social care need; for example, people with a long term condition or the frail elderly. The same applies to the outcomes. For this reason, our work has distinguished between cross-population and population-specific needs, wants, and outcomes. While the final framework has not explicitly separated different population groups this work has informed the selection of indicators. Appendix 2 sets out the emerging themes at a population level.

Service users and the public often focus on their own needs and wants – such as speed and efficiency - rather than outcomes – to remain healthy. In addition there is often overlap between outcomes. This meant that it was necessary to filter and group these statements into a smaller set of measures so that the framework remained concise and the outcomes could be applied at a population level. The needs and wants of individuals will be used to inform some of the other measures that will be monitored.

The following page sets out the themes arising from the literature and local engagement and how they have been translated into outcomes within each of the domains.

Outcome design

Mapping themes and outcomes

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Domain	Themes from engagement an literature	Outcomes in framework
Population Health	• People are prevented from dying early • People are supported to stay well	• People are prevented from dying prematurely • People are able to stay well
Quality of Life	• Supported to live a healthy life and make positive lifestyle choices • Need for care is delayed and reduced • Can maintain their independence for as long as possible • Can stay in their own homes as long as is safe and appropriate • Quality of life is enhanced and not defined by their long-term condition(s) • Confident that their health is proactively managed • Carers maintain a sense of self and control • Have relationships that are important to them • Are able to participate in activities and to not become socially isolated	• People who use health and care services and their carers report a good quality of life • People can remain independent and are able to manage the risks associated with this • People are able to have choice and control over their condition and the services they receive • People can manage their condition and/or frailty to prevent complications • People are able to make a meaningful community and social contribution
Quality of Care	• Treated in a safe and appropriate setting and protected from avoidable harm • Treated with dignity and respect and without discrimination • People are able to access services and information when they need to • Services are joined up and people can access and navigate services with ease • Care is delivered efficiently and service users have the information they need, are listened to, and advised on the options available to them • Service users are supported to manage their own care • Carers' roles are respected	• People are safeguarded against potential harms • People have access to timely and responsive services • People who use services have a good experience of care
Effectiveness of Care	• Care designed for individuals and they have a choice about what treatment they receive and where this is delivered • Early diagnosis in order to stay 'well' and receive the appropriate treatment • Involved in decisions about what care they receive • To receive effective and appropriate care that alleviates their symptoms • Able to recover quickly from care, injury or episodes of ill-health • Avoid unnecessary hospital admissions • Carers are supported to provide high-quality care and support	• Services are effective and reduce the need for readmissions • Service users make their expected and sustained recovery following treatment • Maternity services effective to prepare mothers and babies for the best start in life • Carers are supported to provide high-quality support

Outcome design

Outcome rationale

Shaping health and care in Mid-Nottinghamshire

Domain	Ref	Outcome	Rationale
Population Health	1.1	People are prevented from dying prematurely	This outcome reflects the transition to a population based contract and premature mortality is a core overarching outcome. . All providers have a role is supporting people to live healthier for longer. Combined with other outcomes is it anticipated that this will promote improvements in preventative services.
	1.2	People are able to stay well	To improve population health people need to be supported to stay well and to avoid the onset of preventable conditions. The working group felt that measures of prevalence for key long-term conditions as set out in the JSNA would support 1.1 providing more of an 'upstream' measure.
Quality of Life	2.1	People who use health and care services and their carers report a good quality of life	Health and care services should support people who use those services to have a good quality of life. Service user reported measures are a central means to understand how successful services are at supporting them. Measures relating to this this have therefore been grouped into this outcome.
	2.2	People can remain independent and are able to manage the risks associated with this	Ultimately health and social care input should support people to live independently for as long as they are able to do so. It is identified that there are some risks associated with this and that there is a joint responsibility between providers and service users to manage these.
	2.3	People are able to have choice and control over their condition and the services they receive	Choice and control is a central dignity factor that cuts across all services and settings of care. The Social Care Institute for Excellence describes this as 'Enabling people to make choices about the way they live and the care they receive'. This outcome also relates to peoples choices relating to End of Life care.
	2.4	People can manage their condition and/or frailty to prevent complications	Central to the Better Together programme is the aim to prevent complications and problems before they arise. This outcome therefore reflects the need for services to support people to remain 'healthy' and balances against those which focus on treating people when they have an acute episode.
	2.5	People are able to make a meaningful community and social contribution	Social isolation and wanting to form part of a community was a theme that came through the literature and local engagement. It was recognised that being able to participate and be social has a strong link with both emotional and physical health.
Quality of Care	3.1	People are safeguarded against potential harms	Safeguarding against harms in all settings of care is a core requirement of health and care services. Many of these measures will form the standards of care that providers will be expected to deliver and to meet the statutory duties of commissioners. To reflect this the working group considered a summary indicator that would be linked to the incentives within the contract.
	3.2	People have access to timely and responsive services	Access to care was frequently raised through the local engagement as service users and the public think it is important that services are able to respond when they are needed. As with 3.1 many of these measures will be governed by national standards so a summary indicator for access has been included in the draft framework along with an additional measure aiming to improve the availability with primary care.
	3.3	People who use services have a good experience of care	Quality of care includes quality of caring. However, this can be inconsistent. This is central to improving patient-centred care.
Effectiveness of Care	4.1	Services are effective and reduce the need for readmissions	This is a short-term outcome that reflects the appropriateness of care as well as the ability of health and care services to work together to prevent unnecessary readmissions to hospital
	4.2	Service users make their expected and sustained recovery following treatment	Health and care services should support people to make a sustained recovery that meets the goals agreed before receiving treatment or the service.
	4.3	Maternity services effective to prepare mothers and babies for the best start in life	Maternity is a specific bundle of services within the contract and a range of indicators will be selected to demonstrate the effectiveness of these services.
	4.4	Carers are supported to provide high-quality support	Carers deliver a significant amount of care and can support the system to become more effective. However, they don't always have the support they need to deliver this care effectively.

Outcome design

Collating and selecting indicators

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Outcome Indicators are the measures selected to demonstrate the achievement (or not) of the outcome. The working group considered a range of indicators and selected those that best represent the outcomes in the framework.

Hundreds of measures and indictors exist across health and social care and the aim for this process has been to strike a balance between an appropriate number of measures. To achieve this the working group has attempted to develop a mix of:

- **Outcome focused**: Where possible indicators have been as outcome focused as possible but where there is a case or a need a process/structure measure can be used as a proxy; for example, many people cite access to timely and responsible services as important.

- **Outcomes across pathways**: People will interact with services at different points in time and with different needs. Each interaction will have its own related outcome. It is therefore important that outcomes reflect provision across a whole pathway from maintaining health and wellbeing through to end of life care.

- **Inclusion of both extrinsic and intrinsic indicators**: Extrinsic indicators can be measured consistently using data that is routinely collected and reported such as admissions to care homes. Intrinsic indicators are often reported by service users and capture experience or patient reported quality of live.

- **Indicators for different populations:** This is a single framework for a whole population. However, there are different population groups , such as older people or adults with long term conditions, which will have specific outcomes and indicators. The selection of these has been informed by the literature review and patient and public engagement.

- **Links to strategic plans**: Indicators have been aligned to local strategic plans including the Nottinghamshire Health and Wellbeing Strategy, Better Together Blueprint and Adult Social Care Stratregy. Where possible the aims of the Care Act have also been taken into account.

The majority of indicators that have been identified come from existing sources drawing on national frameworks, emerging frameworks from other parts of the country and local data sources. This has been to reduce duplication and the unnecessary development of new indicators which can be time consuming and costly. A number of placeholders have been included where indicators are being developed nationally.

Throughout the lifetime of the contract commissioners will continue to review and update the framework so that it remains relevant. A contractual mechanism will support this.

The outcome framework and next steps

The following page sets out the initial outcome framework that has been developed through consultation with the outcomes working group.

The next steps for the framework are:

- *Commercialisation*: To align the framework with the contract and consider how it will be linked to payments including which measures will be incentivised
- *Performance*: Agree baseline performance and trajectories
- Align with scope: Continue to iterate in line with developments in the scope of the contract
- *Engage providers*: Share the initial framework with providers in line with the formal re-commissioning process. While some indicators may be amended the outcomes should remain the same.
- *Language*: To work with residents to test language of outcomes so that it is meaningful to them
- *Coverage*: Sub-group to test against a current patient journey

Outcome Framework

Summary of domains, outcomes and indicators

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Shaping health and care in Mid-Nottinghamshire

Population Health

People are prevented from dying prematurely
- Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
- Reducing premature mortality from the major causes of death
  - U75 mortality rate from CVD, Respiratory, Liver, Cancer, Heart Failure
- Excess Winter Deaths

People are able to stay well
- Impact on the prevalence of the main long-term conditions identified in the JSNA. These are hypertension, common mental health disorders, CKD, asthma, and diabetes

Quality of Life

People who use health and care services and their carers report a good quality of life
- Social care related quality of life
- Health-related quality of life for Carers, people with long-term conditions and, older people

People can remain independent and are able to manage the risks associated with this
- Permanent admissions to residential and care homes, per 100,000 population (both over 65 and 18-65). A) All admissions, B) Direct from Hospital, C) Other settings over than home (e.g. intermediate care service)
- Proportion of older people (65 and over) who where still at home 91 days after discharge from hospital into reablement/rehabilitation services
- Return to usual place of residence following; Stroke, Fracture Proximal Femur, Dementia and Continence
- Delayed transfers of care from hospital

People are able to have choice and control over their condition and the services they receive
- Proportion of people who use services who have control over their daily life
- Proportion of people using social care who receive self-directed support, and those receiving direct payments
- EOL: % of patients dying in place of preference
- Proportion of patients and service users who feel that they were involved as much as they wanted to be in decisions about their care and support

People can manage their condition and/or frailty to prevent complications
- Proportion of people feeling supported to manage their (long-term) condition
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Examples include Infections, Nutritional, endocrine and metabolic, Diseases of the blood, Mental and behavioural disorders, Neurological disorders, Cardiovascular diseases, Respiratory diseases)
- Diabetes: Complications associated with diabetes including emergency admission for diabetic ketoacidosis and lower limb amputation

People are able to make a meaningful community and social contribution
- Employment of people with long-term conditions
- Proportion of adult social care users who have as much social contact as they would like
- Proportion of adult carers who have as much social contact as they would like

Quality of Care

Users are safeguarded against potential harms
- Providers are expected to comply with all national standards and duties in relation to safety and safeguarding. These will form part of the contract and a selection of measures may be used as a pass/fail for incentivisation.

People have access to timely and responsive services
- Overall satisfaction of people with accessibility and convenience to health and care services
- % reduction in attendances at A&E for primary care conditions including dental, minor injuries and minor eye conditions

People who use services have a good experience of care
- Patients experience of Integrated Care
- Patient experience of hospital care (composite measure of inpatient, outpatient and A&E)
- Overall satisfaction of people who use services with their care and support (Social Care)
- Overall satisfaction of carers with social services
- EOL: Bereaved carers' views on the quality of care in the last three months of life

Effectiveness of Care

Services are effective and reduce the need for readmissions
- Emergency admissions for acute conditions that should not usually require hospital admission
- Emergency readmissions within 30 days of discharge from hospital (fractured proximal femur; hip replacement surgery; hysterectomy; stroke and 'all readmissions')
- Summary Hospital Mortality Indicator (SHMI)

Service users make their expected and sustained recovery following treatment
- Proportion of service users achieving their personal and social goals agreed at the beginning of support or treatment
- Care hours required at the end of reablement and/or rehabilitation services
- Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months
- Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 / 120 days
- Increased health gain as assessed by patients for elective procedures a) hip replacement, b) knee replacement, c) groin hernia, d) varicose veins
- Functional Mobility following stroke
- Cancer: One and five year survival rates for all cancers

Maternity services effective to prepare mothers and babies for an excellent start in life
- Maternity place holder (May need separate framework) - indicators could include (perinatal mortality rates, birth weight, % of babies admitted to Neonatal Intensive Care, experience and choice of maternity care and support, confidence to care for baby, % of women readmitted within 28 days of delivery

Carers are supported to provide high-quality support
- Carers feel they have access to expertise to be effective carers
- Carers reporting that they have had the support they need to stay well and manage their wellbeing

DETAILED FRAMEWORK

Domain 1: Population Health

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Ref	Outcome	Ref	Indicator	Indicator Source
1.1	People are prevented from dying prematurely	1.1.1	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare	NHSOF 1a, CCGOF 1.1
		1.1.2	Reducing premature mortality from the major causes of death - U75 mortality rate from CVD, Respiratory, Liver, Cancer, Heart Failure	PHOF 4.3, NHSOF 1a
		1.1.3	Excess Winter Deaths	PHOF 4.15i
1.2	People are able to stay well	1.2.1	Impact on the prevalence of the main long-term conditions identified in the JSNA. These are hypertension, common mental health disorders, CKD, asthma, and diabetes	Existing data

Domain 2: Quality of Life

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Out Ref	Outcome	In Ref	Indicator	Indicator Source
2.1	People who use health and care services and their carers report a good quality of life	2.1.1	Social care related quality of life	ASCOF 1A
		2.1.2	Health-related quality of life for Carers	CCGOF 2.15
			Health-related quality of life for people with long-term conditions	NHSOF 2
			Health-related quality of life for older people	PHOF 4.13
2.2	People can remain independent and are able to manage the risks associated with this	2.2.1	Permanent admissions to residential and care homes, per 100,000 population (both over 65 and 18-65) A) All admissions B) Direct from Hospital C) Other settings over than home (e.g. intermediate care service)	ASCOF 2A, BCF (just over 65)
		2.2.2	Proportion of older people (65 and over) who where still at home 91 days after discharge from hospital into reablement/rehabilitation services	NHSOF 3.6i, ASCOF 2B
		2.2.3	Return to usual place of residence following; Stroke, Fracture Proximal Femur, Dementia and Continence	HSCIC Compendium, [Blueprint: FELTC2]
		2.2.4	Delayed transfers of care from hospital	ASCOF 2C
2.3	People are able to have choice and control over their condition and the services they receive	2.3.1	Proportion of people who use services who have control over their daily life	ASCOF 1B
		2.3.2	Proportion of people using social care who receive self-directed support, and those receiving direct payments	ASCOF 1C
		2.3.3	EOL: % of patients dying in place of preference	TBC
		2.3.4	Proportion of patients and service users who feel that they were involved as much as they wanted to be in decisions about their care and support	PIRU (app.C)
2.4	People can manage their condition and/or frailty to prevent complications	2.4.1	Proportion of people feeling supported to manage their (long-term) condition	NHSOF 2.1, BCF, CCGOF 2.2
		2.4.2	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Examples include Infections, Nutritional, endocrine and metabolic, Diseases of the blood, Mental and behavioural disorders, Neurological disorders, Cardiovascular diseases, Respiratory diseases)	HES, CCG 2.6, NHSOF 2.3i
		2.4.3	**Complications in relation to a diagnosed long-term condition** - Diabetes: Complications associated with diabetes including emergency admission for diabetic ketoacidosis and lower limb amputation - (See measure 1.1.2 for mortality from heart failure and CVD) - (See 2.3.2 for exacerbations relating to COPD and CVD)	CCG OF 2.8
2.5	People are able to make a meaningful community and social contribution	2.5.1	Employment of people with long-term conditions	NHSOF 2.2, PHOF 1.8, ASCOF 1E
		2.5.2	Proportion of adult social care users who have as much social contact as they would like	PHOF 1.18i
			Proportion of adult carers who have as much social contact as they would like	PHOF 1.18ii

Domain 3: Quality of Care

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Out Ref	Outcome	In Ref	Indicator	Indicator Source
3.1	Users are safeguarded against potential harms	3.1.1	Providers are expected to comply with all national standards and duties in relation to safety and safeguarding. These will form part of the contract and a selection of measures may be used as a pass/fail for incentivisation.	Link to NHSOF 5b
3.2	People have access to timely and responsive services	3.2.1	Overall satisfaction of people with accessibility and convenience to health and care services	IQI PEXIS1
		3.2.2	% reduction in attendances at A&E for primary care conditions including dental, minor injuries and minor eye conditions	NEW
3.3	People who use services have a good experience of care	3.3.1	Patients experience of Integrated Care	NHSOF and ASCOF (TBC) - currently under development
		3.3.2	Patient experience of hospital care (composite measure of inpatient, outpatient and A&E)	NHSOF 4b
		3.3.3	Overall satisfaction of people who use services with their care and support (Social Care)	ASCOF 3A
		3.3.4	Overall satisfaction of carers with social services	ASCOF 3B
		3.3.5	EOL: Bereaved carers' views on the quality of care in the last three months of life	CCG OF

Domain 4: Effectiveness of Care

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Out Ref	Outcome	In Ref	Indicator	Indicator Source
4.1	Services are effective and reduce the need for readmissions	4.1.1	Emergency admissions for acute conditions that should not usually require hospital admission	CCGOF 3.1, NHSOF 3.3a
		4.1.2	Emergency readmissions within 30 days of discharge from hospital (fractured proximal femur; hip replacement surgery; hysterectomy; stroke and 'all readmissions')	CCGOF 3.2
		4.1.3	Summary Hospital Mortality Indicator (SHMI)	HSCIC
4.2	Service users make their expected and sustained recovery following treatment	4.2.1	Proportion of service users achieving their personal and social goals agreed at the beginning of support or treatment	NEW
		4.2.2	Care hours required at the end of reablement and/or rehabilitation services	NEW (SCIE)
		4.2.3	Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months	NHSOF 3.4 (In development)
		4.2.4	Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 / 120 days	NHSOF 3.5
		4.2.5	Increased health gain as assessed by patients for elective procedures a) hip replacement, b) knee replacement, c) groin hernia, d) varicose veins	NHSOF 3.1, CCGOF 3
		4.2.6	Functional Mobility following stroke	TBC
		4.2.7	Cancer: One and five year survival rates for all cancers	NHSOF 1.4 / CCG OF
4.3	Maternity services effective to prepare mothers and babies for an excellent start in life	4.3.1	Maternity place holder (May need separate framework) - indicators could include (perinatal mortality rates, birth weight, % of babies admitted to Neonatal Intensive Care, experience and choice of maternity care and support, confidence to care for baby, % of women readmitted within 28 days of delivery)	TBD
4.4	Carers are supported to provide high-quality support	4.4.1	Carers feel they have access to expertise to be effective carers	NEW
		4.4.2	Carers reporting that they have as much support they need to stay well and manage their wellbeing	ASCOF

APPENDICES

Appendix 1

Select sources for literature review

Shaping health and care in Mid-Nottinghamshire

National evidence base

- 'Measuring what really matters: towards a coherent measurement system to support person-centred care', The Health Foundation (2014)
- 'Outcomes-Based Commissioning for Mental Health services – consultation report', Oxfordshire CCG (2013)
- (https://consult.oxfordshireccg.nhs.uk/consult.ti/OBCMH/consultationHome)
- 'We've got to talk about outcomes – 1', Health and Social Care Alliance Scotland (2013)
- 'We've got to talk about outcomes – 2', Health and Social Care Alliance Scotland (2013)
- 'Improving Children and Young People's Health Outcomes: a system wide response, DH (2013)
- 'Framework for Action, 2013-17', Older People's Commissioner for Wales (2013)
- 'Measuring the social care outcomes of informal carers', Quality and Outcomes of Person-Centred Care Policy Research Unit (2012)
- 'Patient-centredness healthcare indicators review', International Alliance of Patients' Organisations (2012)
- 'Commissioning Maternity Services', NHSE (2012)
- 'What matters to patients?', King's Fund and King's College London (2011)
- 'A Better Life: what older people with high support needs value', Joseph Rowntree Foundation (2011)
- 'My name is not dementia: people with dementia discuss quality of life indicators', Alzheimer's Society (2010)
- 'Supporting carers – early interventions and better outcomes', The Princess Royal Trust for Carers and ADASS (2010)
- 'Commissioning better outcomes for carers – and knowing if you have', The Princess Royal Trust for Carers and ADASS (2010)
- 'Older people's vision for long-term care', Joseph Rowntree Foundation (2009)
- 'Contracting for personalised outcomes : learning from emerging practice ', Department of Health (2009)
- NHS Outcomes Framework (2014-15), Adult Social Care Outcomes Framework (2014-15), Public Health Outcomes Framework (2013-16)

Local evidence base

- 'Quality for all - Improving patient and carer experience at Sherwood Forest Hospitals NHS Foundation Trust' (2014)
- 'Involvement and experience report', Nursing, Quality & Patient Experience Directorate for the Trust Board of Nottingham Healthcare NHS Trust (September 2014)
- 'Patient voice report', Nursing, Quality & Patient Experience Directorate for the Trust Board of Nottingham Healthcare NHS Trust (September 2014)
- 'Report on Communications and Engagement Activity, November - December 2013', Mid Nottinghamshire Integrated Care Transformation Programme (2013)
- 'What you told us. What we did', Mid Nottinghamshire Integrated Care Transformation Programme (2013)

Appendix 2

Population overview

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Shaping health and care in Mid-Nottinghamshire

Population Group	Common themes	Themes specific to patient groups
Older people (over 65)	*Quality of life* • Can receive care that supports them to meet their personal and social goals • Supported to live a healthy life and make positive lifestyle choices • Need for care is delayed and reduced *Quality of care* • Treated with dignity and respect and without discrimination • Can access and navigate services with ease • Services are joined up • Treated in a safe and appropriate setting and protected from avoidable harm • Care is delivered efficiently • Care professionals give service users the information they need, listen to them, and advise them on the options available to them *Effectiveness of care* • Receive care designed for them • Are involved in decisions about what care they receive • Receive care that alleviates their symptoms • Recover quickly from care • Avoid unnecessary hospital admissions	• Maintain their independence for as long as possible • Relationships that are important to them • Can make their desired contribution to their local communities • Can stay in their own homes as long as is safe and appropriate
Adults (18-64) with 1 or more LTC		• Quality of life is enhanced and not defined by their long-term condition(s) • Confident that their health is proactively managed • Supported to manage their own care
Adults with Mental Health Conditions		• Able to recover quickly from discrete episodes of mental ill-health • Avoid unnecessary hospital admissions
Generally healthy adults (18-64)		• Service users recover quickly from injury or episodes of ill-health
Carers		• Carers maintain a sense of self and control • Carers' roles are respected • Carers are supported to provide high-quality care and support
Women and Children		• Supported through pregnancy and to care for themselves and their babies after birth • Care and communication are appropriate to service users' ages • Service users recover quickly from discrete episodes of mental ill-health

Notes:
- Mental Health is currently outside the scope of the contract but was captured during the literature review and outcome design
- Maternity services have been included in scope and a place-holder has been identified
- Children's services are currently out of scope

Appendix 3

Select sources for outcome framework design

Shaping health and care in Mid-Nottinghamshire

Outcome Frameworks and performance measurement

- NHS Outcome Framework (https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015)
- Public Health Outcome Framework (http://www.phoutcomes.info/)
- Adult Social Care Outcome Framework (http://ascof.hscic.gov.uk/)
- HSCIC Indicator Portal (http://www.hscic.gov.uk/indicatorportal)
- Medicaid ACO Quality Measures and Performance Standards(http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html)
- Emerging frameworks: Cambridgeshire and Peterborough (older people), Oxfordshire (Older People), Croydon (Older People)
- Commonwealth Fund (2014): Aiming Higher Scorecard Report (http://www.commonwealthfund.org/publications/fund-reports/2014/apr/2014-state-scorecard)
- Department of Health (2011): Transforming Community Services (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215624/dh_126111.pdf)
- NHS TDA (2013): Delivering High Quality Care for Patients, The Accountability Framework for NHS Trust Boards (http://www.ntda.nhs.uk/wp-content/uploads/2012/04/framework_050413_web.pdf)

Academic and other literature

- Institute for Healthcare Improvement White Paper (2012); A guide to measuring the triple aim; population health, experience of care and per capita cost (http://www.ihi.org/resources/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx)
- Health Affairs (2008): The Triple Aim: Care, Health, And Cost (http://content.healthaffairs.org/content/27/3/759.full.html)
- Michael Porter: The strategy that will fix healthcare (https://hbr.org/2013/10/the-strategy-that-will-fix-health-care)
- *The* NEW ENGLAND JOURNAL *of* MEDICINE (Michael Porter) (2010): What is Value in Healthcare?
- Institute of Public Care (2012) Wiltshire Help to Live at Home (http://ipc.brookes.ac.uk/publications/pdf/Wiltshire_Council_Help_to_Live_at_Home_IPC_Report_April_2012.pdf
- North West London Whole systems integrated care (http://integration.healthiernorthwestlondon.nhs.uk/)
- Commonwealth Fund (2014): Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally (http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror)
- IAPO (2014): Patient Centred Healthcare (http://iapo.org.uk/patient-centred-healthcare)
- The Health Foundation (2013), Measuring patient experience, http://www.health.org.uk/publications/measuring-patient-experience/
- The Health Foundation (2014), Helping Measure Patient Centred Care, http://www.health.org.uk/publications/helping-measure-person-centred-care/
- The Kings Fund (2010), Clinical and service integration. The route to improved outcomes, http://www.kingsfund.org.uk/publications/clinical-and-service-integration
- Monitor (2014), Complying with Monitor's integrated care requirements, https://www.gov.uk/government/publications/integrated-care-how-to-comply-with-monitors-requirements/complying-with-monitors-integrated-care-requirements
- Nuffield Trust (2013), (http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/evaluation_summary_final.pdf)
- Independent Commission on Whole Person Care for the Labour Party (2014), One Person, One Team, One System (http://www.yourbritain.org.uk/uploads/editor/files/One_Person_One_Team_One_System.pdf)
- HM Government (2014): Carers Strategy (https://www.gov.uk/government/publications/carers-strategy-actions-for-2014-to-2016)

Nottinghamshire County Council

Report to the Adult Social Care and Health Committee

2 February 2015

Agenda Item: 5

REPORT OF SERVICE DIRECTOR FOR MID AND NORTH NOTTS

UPDATE ON DEVELOPMENT OF NEW EXTRA CARE SCHEMES FOR NOTTINGHAMSHIRE

Purpose of the Report

1. The purpose of this report is to advise and seek approval from the Adult Social Care and Health Committee on a number of new Extra Care schemes being proposed for development.

Information and Advice

Introduction

2. Extra Care accommodation for older adults is an extension of traditional sheltered living accommodation. Although there can be many different models of Extra Care, central to any Extra Care scheme is that the accommodation is suitably designed to enable people to live as independently as possible in later life. As well as having their own front door, Extra Care tenants have the support and reassurance of care staff on-site and available 24 hours a day. They also have access to on-site communal facilities, which help to build a sense of community, thus supporting mental and emotional health well-being.

3. In addition to those schemes in Nottinghamshire already in existence, the Council has made a commitment to deliver an additional 160 Extra Care housing places across the county by March 2018, and allocated £12.65 million to deliver those Extra Care housing places in order to improve choice and support for older adults across the county. The Committee has already approved plans to use some of this capital funding to provide additional Extra Care accommodation via new schemes under development for Retford, Mansfield, Gedling, Ashfield and Eastwood.

The role for Extra Care in transforming services for older adults:

4. Extra Care is essential in enabling the Council to transform its support and services for older adults. Extra Care housing is a key element in the reconfiguring and modernising of long-term care provision in Nottinghamshire. Extra Care is also a means of meeting people's needs in the most cost effective way. Even after factoring in the cost of providing the capital investment of £12.65m and also taking in to account any loss of income, it is estimated that Extra Care is £44 per week per person less expensive than a place in a residential care home. This equates to £2,288 per individual each year.

5. Looking to the future, Extra Care has a key role to play in terms of helping the Council to respond to the new and extended duties and responsibilities arising from the Care Act. These responsibilities include promoting and enabling the integration of social care, health and housing functions where it will achieve better outcomes and cost effectiveness for adults with social care needs. Delivery of the County Council's Extra Care Strategy will also help to deliver the requirements of the Better Care Fund, which places a requirement on Nottinghamshire County Council to work more closely with partners in the NHS and in District Councils to deliver better outcomes for people through integrated services.

Update on Mansfield Extra Care, Brownlow Road:

6. The Mansfield Extra Care scheme, being developed on Brownlow Road, Mansfield, is being led by Mansfield District Council (MDC) on land owned by the District. In addition to funding by MDC and NCC, the scheme has also secured a £1.3m grant from the Department of Health. The scheme will provide 64 new homes and communal facilities for older adults (a mix of 1 and 2 bed houses, bungalows and apartments, including 10 bungalows specifically designed for older adults with dementia). MDC has commenced building works on site. Good progress is being made, with completion planned by MDC for November 2015.

7. Reports to the this Committee in September 2013 and February 2014 resulted in approval for officers to work with Mansfield District Council (MDC) to deliver the Brownlow Road scheme and for the release of £4.08 million capital funding, subject to officers bringing a report back to committee when the legal agreements with Mansfield were in an agreed form for sign off by committee. Officers have therefore worked with Legal Services and external legal advisors at Browne Jacobson to develop a draft legal agreement with MDC. The legal documents are now in an agreed form and include the following terms:

   a. All of the 64 new dwellings will be built to the County Council's Extra Care design standard;
   b. The County Council will provide capital funding of £4.08m towards the development of the scheme as a contribution towards the cost of building the dwellings and communal facilities;
   c. MDC will grant the Council nomination rights in respect of 48 of the 64 new dwellings, with the detailed terms set out in the legal agreement;
   d. MDC will make arrangements for Property Management of the completed dwellings and communal areas.

Proposed new Extra Care Scheme at Scarborough Road in Bilsthorpe:

8. Newark and Sherwood District Council, in partnership with Newark and Sherwood Homes (NSH), was successful in its bid to the Homes and Community Agency's (HCA) Care and Support Specialised Housing Fund to deliver an older persons supported housing scheme of 25 two bedroom bungalows at Scarborough Road, Bilsthorpe (on land owned by the District). The total scheme costs amount to £2,186,623, which includes a small contingency. Each two bed bungalow will be built to the 'lifetime home' standard, with features to assist independent living, such as level access showers and a lifeline alarm system. Residents will also have the use of the communal space at the adjacent Burton Court Community Centre. Work commenced on site in April 2014 and completion is expected by the end of February 2015.

9. Discussions with District colleagues have identified the opportunity for the County Council to secure nine of the bungalows at Scarborough Road for use as extra care housing (the remaining 16 units will be designated as supported accommodation for older adults with a lifeline alarm system being provided and managed by NSH). The nine Extra Care bungalows would still be owned by the District Council and managed by NSH, with the County Council directly nominating older adults into the nine units based on an assessment of appropriate social care eligibility and need.

10. Initial feasibility work undertaken by the County Council, District Council and NSH has identified the potential for converting a small area of unused space at Burton Court Community Centre into a small dedicated office as a 'touch down' base for staff from the County Council's designated Care Provider to use when providing Extra Care services to residents in the 9 NCC nomination bungalows. Newark and Sherwood District Council own the Community Centre and have advised that they estimate the cost of creating a touch down base for care staff to be up to. £20,000. The District Council has requested that the cost of creating the office be covered by the County Council as its capital contribution to the Bilsthorpe Extra Care scheme.

Proposed new Extra Care Scheme at Bowbridge Road in Newark:

11. Newark & Sherwood District Council has identified the possibility to create an Extra Care scheme and also a Supported Living scheme for younger adults on land it owns off Bowbridge Road as part of a wider residential development being considered by the District. A new Leisure Centre is being developed by the District on part of the land and the rest of the site could be used to develop an extra care scheme, a Supported Living Scheme and general needs housing.

12. Initial discussions have identified scope for an indicative Extra Care scheme of approximately 65 dwellings for older adults, with dedicated onsite communal facilities. Of the total number of dwellings, approximately 40 units could be used as Extra Care for which the County Council would have nomination rights (with the remaining units being allocated as supported accommodation for older adults). All the units would be retained within the ownership of the District and would be managed by Newark & Sherwood Homes. The County's nominated Core Provider would provide care services and support to the 40 extra care units, in line with the Council's Home Based Support Service Contract.

13. Based on similar size Extra Care schemes, the District estimates that the total scheme costs, including land acquisition, would be in the region of £8m. To finance such a scheme, the District would require a contribution from the Council's £12.65m Extra Care capital. The District would also contribute capital funding, as well as exploring the opportunity to bid for grant funding through the HCA's Affordable Homes Programme 2015-18.

14. Newark and Sherwood District Council submitted a report to its Policy and Finance Committee 4 December 2014 to seek approval to the principle of developing an Extra Care scheme as part of a wider housing scheme proposed for the Bowbridge Road site. In terms of the next steps, the District intends to draft a development brief to soft market test the proposal to use the site to deliver both Extra Care and wider general needs housing through a joint venture initiative with a private sector housing developer. Any market test would be undertaken through the HCA's approved Delivery Partner Panel, of which the

District Council is a member, with a view to gauging opinion from selected private sector developers on the deliverability and viability of any such housing proposal.

Proposed new Extra Care Scheme in Worksop:

15. Bassetlaw District Council is keen to work with the County Council to create a new build Extra Care scheme in the Worksop area of the district. Extra Care accommodation currently exists at Abbey Grove in Worksop, managed by A1 Housing (the local Arms-length Housing Organisation – ALMO). Discussions between Council officers, District officers and A1 Housing colleagues have identified the need for additional extra care accommodation in the area, as well the need for further improvements to Abbey Grove to upgrade accommodation in line with Fire Safety guidance.

16. Initial scoping has identified that there is potential for the footprint of the existing Abbey Grove site to be extended, which would allow for the complete redevelopment of that Extra Care scheme. Further discussions are underway with District Colleagues to determine the potential on the site for a new 50 bed scheme for older adults, of which approximately 36 units could be designated Extra Care accommodation - thereby providing improved, and increased, extra care accommodation for older adults in Worksop and the surrounding areas. If this option were to occur, existing tenants would need to move to an intermediate scheme but upon return would benefit from a high standard of modern accommodation, which would better meet their housing needs and care needs.

17. Initial discussions with officers at Bassetlaw District Council and A1 Housing have indicated that the District might be able to contribute some capital funding towards the cost of redeveloping the Extra Care provision on the Abbey Grove site, as well as applying to the HCA for grant funding towards the cost of the build (HCA has an open bidding round until 2018 for funds towards the cost of creating new build extra care scheme). A1 Housing also has access to the Efficiency East Midlands Framework (EEM), a list preferred developers, which could be used to procure the delivery of an Extra Care scheme (thereby resulting in a swifter, more cost-effective development process).

Proposed new Extra Care Scheme in Arnold, Gedling:

18. Extra Care accommodation in Gedling is currently being developed at St Andrew's House in Mapperley. In addition, Gedling Borough Council is keen to work with the County Council to create a new build Extra Care scheme in the Arnold area of the borough. The County Council may also be interested in possibly creating some Supported Living accommodation in the area.

19. Gedling Borough Council has advised NCC officers that it does not own any sites large enough to be used to create a new build Extra Care scheme - initial discussions have however identified Rolleston Drive, a NCC owned site, as one possible location for an Extra Care scheme, subject to planning permission. Initial discussions have taken place with the Council's Property Department to explore the potential for using up to a quarter of the site for the development of an Extra Care scheme and also some housing for supported living for younger adults.

20. Initial discussions have identified that to finance an Extra Care scheme on Rolleston Drive, the District would require a contribution from the Council's Extra Care capital programme.

Officers at Gedling Borough Council have indicated that the Borough might be able to contribute some capital funding towards the cost of developing Extra Care, as well as assisting with an application to the HCA for grant funding towards the cost of the build. Gedling Borough Council also has a list preferred housing providers, which could be used to procure the delivery of an Extra Care scheme thereby resulting in a swifter, more cost-effective development process. Overall, the exact financial implications are not known at this stage as these need to be determined via more detailed work to establish what kind of Extra Care scheme might be possible on site. It is therefore suggested that financial implications are presented to a future meeting of this Committee as part of detailed plans to be bought to Committee during the course of 2015 for consideration and decision.

Other Options Considered

21. When deciding where to create new Extra Care accommodation, the location of existing schemes, as well as demand/population demographics are all considered by officers when making recommendations to Committee in order to ensure a good geographic spread across Nottinghamshire.

Reasons for Recommendations

22. Experience shows that partnership working is a key factor to the development and successful operation of Extra Care accommodation - the engagement of the District and Borough Councils with the proposals set out in this report bodes well for the successful creation of new Extra Care accommodation in those areas.

Statutory and Policy Implications

23. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

24. The exact financial implications for a new Extra Care Scheme in Newark, Worksop and Arnold are not known at this stage. This is because financial implications can only be determined once more detailed work has been undertaken to establish what kind of Extra Care scheme might be possible on these sites. It is therefore suggested that financial implications are presented to a future meeting of the ASCH committee as part of detailed plans to be bought to Committee during the course of 2015 for consideration and decision.

25. With regard to the Mansfield Extra Care scheme, the NCC contribution of £4.08m can be met from the indicative capital budget for Extra Care.

26. With regard to creating an Extra Care scheme at Bilsthorpe, the cost of up to £20,000 for creating a small dedicated touch down office for care staff can be met from the indicative capital budget for Extra Care.

RECOMMENDATIONS

It is recommended that Committee:

1) give approval for the Council to enter into an agreement with Mansfield District Council regarding the Mansfield Extra Care scheme on Brownlow Road as set out in paragraphs 6 and 7 of this report;

2) give approval for the Council to enter into an agreement with Newark and Sherwood District Council regarding the Bilsthorpe Extra Care scheme as set out in paragraphs 8 - 10 of this report;

3) give approval for up to £20,000 from the Council's Extra Care Capital Programme for the creation of a small 'touch down' office at the Burton Court Community Centre (for use by care staff serving the nine Bilsthorpe Extra Care bungalows) as set out in paragraph 10 – with the detail to be included as part of the Bilsthorpe legal agreement referred to in recommendation 2 above.

4) give approval for officers to work in partnership with Newark & Sherwood District Council to develop a proposal for the creation of an Extra Care scheme on Bowbridge Road in Newark as set out in paragraphs 11 – 14 of this report – with the detailed plans (including financial implications) to be brought to Committee during the course of 2015 for consideration and decision regarding approval to make a financial contribution from the Council's Extra Care capital allocation

5) give approval for officers to work in partnership with Bassetlaw District Council to develop a proposal for a new Extra Care scheme in Worksop as set out in paragraphs 15 - 17 of this report – with the detailed plans (including financial implications) to be brought to Committee during the course of 2015 for consideration and decision regarding approval to make a financial contribution from the Council's Extra Care capital allocation;

6) give approval for officers to work in partnership with Gedling Borough Council to develop a proposal for Extra Care in the Arnold area of the Gedling Borough as set out in paragraphs 18 – 20 of this report – with the detailed plans (including financial implications) to be brought to Committee during the course of 2015 for consideration and decision regarding approval to make a financial contribution from the Council's Extra Care capital allocation.

SUE BATTY
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Constitutional Comments (SLB 14/01/2015)

27. Adult Social Care and Health Committee is the appropriate body to consider the content of this report; any legal agreement is subject to the approval of Legal Services.

Financial Comments (KAS 15/01/15)

28. The financial implications are summarised in paragraphs 24-26 of this report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- Previous Extra Care reports to the Adult Social Care and Health Committee:
  - Update Report 29 October 2012
  - Update Report 7 January 2013
  - Update Report 1 July 2013
  - Update Report 9 September 2013
  - Update Report 3 February 2014
  - Update Report 7 July 2014

Electoral Division(s) and Member(s) Affected

- All.

Nottinghamshire County Council

Report to Adult Social Care Committee

02 February 2015

Agenda Item: 6

REPORT OF DEPUTY DIRECTOR, ADULT SOCIAL CARE, HEALTH AND PUBLIC PROTECTION

APPROVAL TO TENDER FOR EARLY INTERVENTION SUPPORT SERVICES

Purpose of the Report

1. This report now sets out the case for and seeks approval to go to tender for early intervention and prevention support services.

Information and Advice

2. The Adult Social Care Strategy sets out that there will be investment in early intervention and prevention support where this will bring about a reduction in demand for more intense, higher costs services. The Care Act also sets out a requirement for the Authority to 'provide or arrange for services, facilities or resources which would prevent, delay or reduce individuals' needs for care and support, or the needs for support of carers'.

3. Early intervention and prevention support services funded from the former Supporting People budget have been reviewed to consider who is using services, what outcomes are being achieved. Support from the Institute for Public Care (IPC) has been received in respect of evidencing interventions that are effective in delivering prevention outcomes and also identifying risk factors in older people that are most likely to result in escalating need, demand for social care and admission to residential care. Discussions are also on-going with colleagues in Public Health and partners in Clinical Commissioning Groups and District Councils to identify services that both meet the right gap in service and deliver this right approach to achieve preventative outcomes.

4. Three core service demands have been identified as:

   a. **Short term support to self-care** for people at risk of deteriorating health and independence as a result of age, mobility, disability, long term health condition or bereavement. The service will be targeted at people who have lived independently but are now at risk of escalating need and require information, advice, signposting or short term help to work out how they can adapt to their circumstances in order to continue to self-manage. The service, designed to address the identified, need will provide support for up to six weeks and will focus on ensuring that people can manage their health effectively, are living in appropriate homes, have networks of social contact and informal support, are managing financially and can acquire the skills or access the technology to enable them to continue to live without formal support.

b. **Medium term support to promote independence** for people who, as a result of low/moderate learning disability, autistic spectrum disorders, acquired brain injury etc, lack the skills to sustain independence and consequently are identified through safeguarding referrals or become known to local operational teams. These service users can place high demands on staff time and sometimes end up in inappropriate placements that are not likely to result in the best outcomes for them. The service designed to meet this need will provide support over a longer period but still be time limited (up to two years). It will focus on development of skills for independence, access to community based opportunities and resources, and networks of informal support but will also recognise that this target population of service users are likely to return periodically for support or reassurance.

   There are currently around 20 service users with moderate learning disabilities, who do not meet the current eligibility criteria for care services, but who receive commissioned packages of support through the Care, Support and Enablement (CSE) contract, funded from the former Supporting People budget. It proposed that support for these services users would be more appropriately commissioned as an addition to the above service and that budget should be moved accordingly.

   There are currently accommodation services in place that provide valuable resources for vulnerable adults in the county. North Road (Rushcliffe) provides assessment and skills development on a short term basis for up to four people at a time before being moved on to a more permanent accommodation and support arrangement. This is well used by the Asperger's Team and Community Learning Disability Teams and helps to avoid risk averse, over-commissioned solutions. Chatsworth House (Ashfield) provides safe, medium term housing for vulnerable adults, with staff on site for core hours in the day and additional support commissioned from the provider on the basis of individual need. Portland Street (Mansfield) provides self-contained housing with low level support for people with moderate learning disabilities. It is proposed that these services are retained as part of the on-going vulnerable adult provision.

c. **Specialist deaf support**. There is an existing deaf support service that benefits from established links with other deaf specific provision (e.g. with the NHS funded BSL Healthy Minds programme, specialist mental health nurse services for the deaf community and the Deaf Society). The provider utilises specific technology for communication and support planning and monitoring. It is proposed that a specialist service is retained in order that valuable skills and connections are not diluted within a generic service and that staff can be appropriately supported. The service commissioned will be based on a clearer definition of role, a more enabling approach and more effective use of technology to deliver efficiency.

5. In respect of short term support to self-care (identified need 4a.), discussions with the CCG Transformation Programmes are at different stages. In order to recognise and reflect the context of local health and health partnership work, it is proposed that this element of service is tendered in three lots, defined by the transformation area boundaries. Medium term support and specialist deaf service would be tendered as countywide services in two separate lots, therefore creating five lots in total.

6. The budget allocated to the commissioning of the proposed services is set out in Appendix 1.

7. Against the combined services, the targeted service review identified a saving of £200,000 and a target implementation date of September 2015. The savings proposal has been carried forward as a consultation category B proposal. No specific feedback has identified through the NCC Budget Consultation. Previous consultation that has been carried out revealed that whilst a substantial number of people were concerned about the loss of funding of traditional long term support for older people and for community alarms, service users and statutory partners agree with the focus of proposed short term service given the resources that are available. Discussions have also taken place with the current providers of vulnerable adults and deaf support services to help shape these service elements.

8. It is now therefore proposed that the County Council goes to tender to seek providers for five lots of service as outlined.

Other Options Considered

9. The option of rolling the medium term promoting independence support and deaf services up with the support to self-care was considered as there is a shared goal to support people to independence. However the service demands are based on a very different service user history and starting point: the short term support self-care assumes that the service user has lived independently but faces risks to on-going self-management as a result of ill health, reduced mobility, bereavement etc whereas the medium term support service will support people who may never have had the skills to manage independently. It is for this reason that Mid Nottinghamshire CCG does not see a connection between their self-care programme and this need.

10. The option of integrating the deaf service with either of the other two service types was also considered. Whilst there are good links with the short term support to self-care, there is clear rationale not to separate this specialist provision into three lots.

Reasons for Recommendations

11. It is now recommended that the County Council proceeds to tender for the outlined services in order that:

    - Appropriate early intervention support is put in place for older people and people with long term conditions. There is currently a gap in provision in this area and the proposed service would support the Council to discharge it's duties under the Care Act 2014;

    - Existing support provided through a vulnerable adults floating support service and a deaf floating support service are focussed in accordance with the revised Adult Social Care Strategy;

Statutory and Policy Implications

12. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are

material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

13. The budget for this tender is established core budget linked to historic services which will be replaced through this process. The majority of this budget is already available and uncommitted since the cessation of contracts for older people's service in November 2014. The commissioning of these services is not a requirement for the delivery of further savings.

Human Resources Implications

14. Current and future service are commissioned from external providers. Existing service contracts for support to older people ended on 30th November 2014 but many providers have continued to deliver a reduced service on a self-funded basis. The commissioning of the short term element of the proposed service will create new jobs where the previous few years have seen significant reductions.

Public Sector Equality Duty implications

15. Commissioning these services should have a positive impact in terms of addressing the needs of older and vulnerable adults at greatest risk of developing the need for more formal social care interventions.

Safeguarding of Children and Vulnerable Adults Implications

16. All services tendered will seek to address safeguarding risks to service users. The medium term support service will take safeguarding risks into account in prioritisation and service allocation.

Implications for Service Users

17. The short term support to self-care represents a new service development and therefore has no existing service users. Service users of the existing Vulnerable Adults service and Deaf Support service may see changes to both their service provider and the service delivered. In particular, deaf service users are likely to experience increased expectations around self-management and a reduction in one-to-one support, home visits and accompanied appointments.

RECOMMENDATIONS

That:

1) the following early intervention and prevention services are approved to proceed to tender at an annual cost of £1.713M:

- Short term support to self-care
- Medium term support to promote independence
- Specialist deaf support

2) this budget is supplemented by an additional budget of approximately £85k that is linked to specific individuals currently supported through the Care, Support & Enablement contract

JOHN WILSON
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Constitutional Comments (LM 20/01/15)

18. The Adult Social Care and Health Committee has delegated authority within the Constitution to approve the recommendations in the report.

Financial Comments (to follow)

19.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- None

Electoral Division(s) and Member(s) Affected

- All

	Total Available		Lot 1 – Bassetlaw Short term support to self-care	Lot 2 – Mid Notts short term support to self-care	Lot 3 – Broxtowe/ Rushcliffe/ Gedling short term support to self care	Lot 4- Countywide Medium term promoting independence support	Lot 5 – Countywide Deaf Support
Short term support to self-care	£ 937,168 £ 212,076 £ 1,149,244	ASC PH*	£ 206,864	£ 471,190	£ 471,190	£ -	£ -
Medium Term Promoting Independence Support	£ 125,462 £ 589,187 £ 714,649	Accommodation General support **	£ -	£ -	£ -	£ 714,649	£ -
Specialist Deaf Support	£ 61,500					£ -	£ 61,500
Total	**£ 1,713,317**						

***** Funds currently linked to Community Outreach Advisors whose role with be incorporated within the service.

** Plus an amount linked to non-statutory service users currently support through the Care Support and Enablement contract who transfer to this service. Approximately £85,000 p.a. to be added to Lot 4.

Nottinghamshire County Council

Report to the Adult Social Care and Health Committee

02 February 2015

Agenda Item: 7

REPORT OF THE DEPUTY DIRECTOR FOR ADULT SOCIAL CARE, HEALTH AND PUBLIC PROTECTION

ORGANISATIONAL REDESIGN & RESOURCES REQUIRED FOR CARE ACT IMPLEMENTATION

Purpose of the Report

1. This report:

- Outlines the level of staff reductions still required in Assessment and Care Management in ASCH to achieve existing saving proposals published in November 2013.
- Gives a summary of the work undertaken to assess the staffing impacts of the Care Act and provides the detail of these findings.
- Requests consideration of a different approach to implementing Organisational Redesign that accounts for the increase in staffing required for delivery of the Care Act.
- Identifies the anticipated impact of the Care Act on three other key areas of service: Customer Service Centre, Adult Access Service and Adult Care Financial Services.
- Requests approval for the establishment of new temporary posts, the extension of existing temporary posts, and amendments to existing temporary posts, to support delivery of the implementation of the Care Act and undertake the necessary transformation to manage the increased demand for assessment and service provision through the transformation of how services are delivered.
- Details other key areas of demand impacting on service delivery and suggests ways these could be met.
- Summarises the financial implications of all of the above points.

Information and Advice

2. The staffing reductions required to deliver the savings for Assessment and Care Management in Younger and Older Adults and the Reduction of Social Care staff in Hospital settings, were outlined in the section 188 notice published in November 2013 and the details of the reductions have been shared with Trade Unions and staff. A summary of the savings required are below:

- Assessment & Care Management, Older Adults (B01) £ 659,000
- Reduction of Social Care Staff in Hospitals (B03) £ 196,000
- Younger Adults Assessment & Care Management (B07) £1,000,000

3. The proposals for the above Outline Business Cases are to achieve the savings by staff reductions. The number of reductions required includes a number of vacancies, which lowers the number of physical staff reductions required. There are approximately 30 FTE vacancies that correspond with planned reductions. These vacancies have been held specifically, in order to achieve the required savings for 2014/15. The combined savings required for the business cases in Assessment & Care Management for 2015/16 is £264,000, pending final confirmation from Finance.

4. In a scheduled progress report to the Adult Social Care and Health Committee on Organisational Redesign on 8 September 2014, it was highlighted that before further reductions could be implemented to achieve 2015/2016 savings, there was a need to consider additional and new demands and other challenges placed on the department. Primarily this refers to the Care Act but also includes increases in existing demand that cannot currently be met, as well as work undertaken by teams that have been established on a temporary basis such as the Central Reviewing Teams and the Data Inputting Team (DIT).

5. Work to quantify the impacts outlined above has been in progress over the last few months and a workforce capacity model has been designed that calculates the additional levels of staff required to meet new responsibilities arising from the Care Act. The model takes into account any planned changes to the way the service will work in the future, such as mobilisation of the Adult Social Care workforce over the next year and other changes to ways of working in line with the Adult Social Care Strategy, such as offering various methods of assessments to service users, including on-line assessments, and telephone assessments and reviews.

6. The model has been developed by the Transformation Team, in conjunction with the Care Act Programme Team and Finance. The model is evidence based, using establishment information and statutory return data (RAP) to understand productivity per worker. This is multiplied by the anticipated increase in demand as a result of the Care Act to calculate additional FTE required. Once this initial figure is reached, further work is done with the service to apply some reasonable assumptions on how the additional work will be completed to mitigate and lower the initial figures. This includes changes to ways of working and efficiency savings expected from mobilisation of the social care workforce which are accounted for in the model.

7. The model has focussed primarily on Assessment and Care Management in the first instance but work has also been undertaken on the impact in the Adult Access Service, Adult Care Financial Service and the Customer Service Centre

Care Act Staffing Requirements

Assessment and Care Management

8. The modelling work to date shows that to meet the increase in demand as a result of the Care Act in 2015/16 an additional 43.2 FTE posts will be required in Assessment and Care Management. This includes an increase in a variety of assessment posts as detailed in the table below at a combined cost of £1,676,867.

Post	Care Act Requirements 2015/16 (FTE)
Advanced Social Work Practitioner	1.1
Social Worker	22.2
Community Care Officer	16.5
Occupational Therapist	3.4
Promoting Independence Worker	0.0
Team Leader	0.0
Total	**43.2**

9. The below table shows a comparison of FTE reductions required to achieve the Organisational Redesign savings (OBCs B01, B03, B07) against the increase in FTE posts required for the Care Act from April 2015.

Post	Org Redesign Reductions (FTE)	Care Act Requirements 2015/16 (FTE)	Difference (FTE)
Advanced Social Work Practitioner	1.7	1.1	-0.6
Social Worker	11.2	22.2	+11.0
Community Care Officer	13.9	16.5	+2.6
Occupational Therapist	0	3.4	+3.4
Promoting Independence Worker	5.3	0.0	-5.3
Team Leader	2.0	0.0	-2.0
Total	**34.1**	**43.2**	**9.1**

10. The above table shows that for the majority of posts the requirement of the Care Act exceeds the number of proposed reductions. Given this, it is proposed that the staff reductions planned for April 2015 are not implemented. This will mean that there will be no need for compulsory redundancies or to grant any voluntary redundancies across the Assessment and Care Management service and the skills and experience of the existing workforce will be retained to help the service manage significant increases anticipated as a result of the new Care Act legislation.

11. Details of exactly how the Care Act work will be undertaken is still being considered and the Care Act Programme Manager is currently preparing an options paper on the configuration of the workforce for consideration.

12. This approach will require some employees to move from their roles in existing teams to undertake the same or similar role in another team within the service. For example it is anticipated that there will be an increased need for assessment staff in Older Adults and there is a planned reduction in assessment staff in Younger Adults, these alternatives will be offered where the post is deemed a reasonable alternative for the individual in terms of skills required and levels of responsibility. This will be conducted in accordance with the Council's HR policy.

13. In order to achieve this movement across the department it is intended that the service would continue implementing the enabling process in line with Organisational Redesign enabling principles agreed with the Trade Unions. This includes operating on the grounds of least disruption to the service. Employees will be offered the opportunity to self-select moves to other available posts. Only where this is not possible will competitive interviews be undertaken and those displaced will be offered suitable alternative posts in the service.

14. It is intended that the original savings required from these OBCs will be removed from the permanent staffing budget, with the additional cost for the retained and increased staff being met by various sources of Care Act funding, some of which will be temporary.

Other areas impacted by the Care Act

15. In addition to calculating the impact of the Care Act on required staffing levels in Assessment and Care Management, the workforce model has mapped the impact on three other keys areas; the Customer Service Centre; Adult Access Service and Adult Care Financial Services, Strategic Commissioning, Safeguarding and Debt Recovery. Again there is still work to be done to understand exactly how the additional work will be completed and how the future workforce might be configured, however figures show that the below additional FTE posts will be required in 2015/2016.

Service Area	Additional FTE Required	Cost
Adult Access Service	2.3	£71,565
Adult Care Financial Services	6.5	£188,350
Customer Service Centre	4	£110,758
Safeguarding	1	£57,129
Strategic Commissioning	1	£49,172
Statutory Debt Recovery	1	£26,061
Total	**15.8**	**£503,035**

16. As a result of the increased resources required in these areas it is proposed, that some or all of the proposed reductions do not go ahead as planned.

17. This would affect the following Outline Business Cases:

- Customer Services Centre (A28 proposed November 2014) a reduction of 8fte, 5fte at the level required for the Care Act.

- Adult Care Financial Services (A36 approved February 2014) a further reduction of 4fte to be implemented for April 2015)

18. As with the additional requirements in Assessment and Care Management it is envisaged that the cost of these additional posts should be met from funding for implementation of the Care Act but reductions from the permanent staffing budget can still be made to achieve the savings.

19. The Committee has previously approved changes to Home-based Services and the Multi Agency Safeguarding Hub, which need to be funded through the Care Act budget from 2014/15.

Reconfiguration of the MASH	£85,600
Re grading of post in Home-based Services	£ 5,129
Total Cost	**£90,729**

Care Act Programme resources

20. In May 2014 the Adult Social Care and Health Committee agreed funding for the Care Act Programme in 2014/15 of £328,956 until March 2015. Part one of the new duties and responsibilities under the Care Act need to be implemented with effect from April 2015. Over the last nine months, the programme has focused on ensuring the Council will be legally compliant with the new duties and responsibilities, and developing new ways of working to manage the demands from 2015 onwards. The second phase of the programme during 2015/16 will progress implementation of the new ways of working, such as alternative ways of delivering assessments and work with partners in the development of information and advice to the citizens of Nottinghamshire. The workforce will be reconfigured and new assessment activity planned in order to spread the load of the work during 2015/16. This will ensure new requests from self-funders can be managed within resources agreed. In addition, the major financial reforms will be implemented in April 2016 and new systems and processes will need to be designed, developed, tested and implemented. There are also critical financial and resource implications for the Council arising from these financial reforms which need to be fully modelled.

21. The composition of the programme team is based on the requirements to deliver key areas of work in 2015/16. It will continue to draw upon a range of expertise and knowledge to deliver key elements of the Care Act. For example, staff from Adult Care Financial Services will need to make a strong contribution to new work-streams – both Charging for Support and Paying for Support.

22. Approval is also sought for the continuation of posts in the Care Act Implementation Programme Team. The posts are included in the table on page 7 of this report.

Current unmet demand

23. In addition to the requirements of the Care Act, it has become apparent through analysing performance data that there is a proportion of existing demand that presents to the department that is not currently being met within the existing staffing capacity.

24. This unmet demand falls largely in Occupational Therapy Assessments across both Older and Younger Adults' service areas. Waiting lists in this area are substantial and without additional resources to address these issues it is anticipated that these waiting lists will grow as demand for services increases.

25. Following work to understand the additional Occupational Therapy requirements in Young Adults' services it has been identified that an additional 1FTE post per locality would relieve the pressure on the service while work to streamline processes and change the operating model are undertaken, given the similar levels of pressure in the Older Adults' service the same rationale has been applied and a total of 7FTE Occupational Therapists are required at an annual cost of £302,946 p.a.

Existing Temporary Staffing Requirements

26. As well as posts required from April 2015 to implement the Care Act there are a number of other existing temporary post or teams within the structure that the modelling work assumes will continue and are required to meet the needs of the Care Act. These teams/posts are:

- The Data Inputting Team £213,000p.a
- 1fte Team Manager- Adult Access Service £ 52,000p.a
- 1fte Senior Practitioner Adult Care Financial Services £ 49,172p.a

27. The table on page 7 summaries all the additional posts required to meet new responsibilities arising from the Care Act that are proposed within the body of this report. The 86.7 FTE posts identified as additional resource required is not the number of staff that would need to be recruited. In the majority of cases there are already the staff numbers required. The 86.7 FTE represents the number of posts that funding is required for.

Post Details				
Area of Demand	**Service Area /Team**	**Posts/Area**	**FTE Required**	**Cost 15/16**
Care Act	Assessment & Care Management	Eligibility	10.0	£396,361
		Self Funder Assessments	24.4	£916,108
		Carers Assessments	2.8	£104,150
		Safeguarding	4.0	£173,690
		Prisons and Approved Premises	1.0	£43,278
		Transition Services	1.0	£43,278
	Adult Access Service	Adult Access Service	2.3	£71,565
	Adult Care Financial Services	Adult Care Financial Services Financial Assessments 5.5FTE DPA's 1FTE	6.5	£188,350
	Customer Service Centre	Level 2 Service Advisors and Management Support	4.0	£110,758
	Safeguarding Team	Designated Adult Safeguarding Manager (DASM)	1.0	£57,129
	Strategic Commissioning	Commissioning Officer	1.0	£49,172
	Statutory Debt Recovery	Statutory Debt Recovery Officer	1.0	£26,061
	MASH	Reconfiguration	0.0	£85,600
	Market Development	Regarding of HBS TM	0.0	£5,129
	Sub Total		**59.0**	**£2,270,628**
Care Act Implementation	Care Act Team	Programme Manager	1.0	£69,038
	Care Act Team	Project Manager	1.0	£52,000
	Care Act Team	Finance Business Partner	1.0	£49,172
	Care Act Team	Commissioning Officer	2.5	£122,930
	Care Act Team	Programme Officer	1.0	£43,278
	Care Act Team	Digital Officer	0.5	£18,474
	Care Act Team	Business Support Officer	0.5	£11,071
	Care Act Team	Direct Payments Commissioning Officer	0.7	£9,834
	Care Act Team	Direct Payments Community Care Officer	0.5	£0
	Care Act Team	Additional Non Staffing Costs	0.0	£10,000
	Sub Total		**8.7**	**£385,797**
Current Unmet Demand	Assessment & Care Management	Occupational Therapist	7.0	£302,946
	Sub Total		**7.0**	**£302,946**
Existing Temporary Demand or unfunded posts	Assessment & Care Management	DIT Team	10.0	£213,000
	Adult Access Service	1fte Team Manager	1.0	£52,000
	Adult Care Financial Services	1FTE Senior Practitioner	1.0	£49,172
	Sub Total		**12.0**	**£314,172**
Totals			**86.7**	**£3,273,543**

28. Nottinghamshire County Council's funding allocation for implementation of the Care Act is expected to be £6.7m for 2015/16, of which £1.9m is to be allocated from the Better Care Fund.

29. The Department of Health has recommend allocations for the £6.7 million is set aside for certain elements of the Care Act. Early reports show that suggestions will be to allocate £1.8million for Early Assessments of Self Funders and £0.47million for Capacity building and Information from the overall total allocation of £6.7 million.

30. The Department of Health funding will also be expected to cover other costs of the Care Act, such as the cost of additional care packages for example for carers and arising from the new national eligibility criteria, and will not solely be for staffing resources.

31. It is also important to note that there is no guarantee of funding beyond 2015/16 for the Care Act. It is inconceivable that there would not be anything made available, but it is not known at what quantum, or on what basis, this would come. It is not expected that anything more will become clear until after the Comprehensive Spending Review following the 2015 General Election.

Other Options Considered

32. Given the significant increase to workloads that the new responsibilities arising from the Care Act will result in, the ability to achieve this without additional resources is not considered an option.

Reason for Recommendations

33 These recommendations are made to ensure that the Adult Social Care & Health Department have sufficient staffing resources to comply with Care Act legislation from April 2015 whilst still achieving the savings required for existing business cases.

Statutory and Policy Implications

34. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

35. The Financial Implications are contained within the body of the report.

Safeguarding of Children and Vulnerable Adults Implications

36. The request for additional resources contained within this report includes the resources required to meet the new and extended Safeguarding Responsibilities placed on the Council arising from the Care Act

Implications for Service Users

37. The additional resources requested within this report are required to ensure that the Authority is Care Act compliant and ensures the relevant service provision for Service Users requiring a service from the Adult Social Care and Health and Public Protection Department.

Ways of Working Implications

38. The report and the work undertaken to compile the report accounts for the new ways of working being rolled out across the Department.

RECOMMENDATIONS

That Committee:

1) approve the proposals for the establishment of 86.7 FTE additional post and extension of existing posts for 2015/16, as summarised in the table on page 7, to ensure that the Council meets the legal requirements of the Care Act from 1st April 2015;

2) approve the proposal to achieve existing savings proposals by reducing the permanent staffing budgets and agree that the Council's Care Act Funding Grants can be utilised to fund the additional posts required to implement the Care Act for 2015/16;

3) note the contents of this report for information relating to the Care Act.

JON WILSON
Deputy Director for Adult Social Care, Health and Public Protection

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Constitutional Comments (LM 20/01/15)

39. The Adult Social Care and Health Committee has delegated authority within the Constitution to approve the recommendations in the report.

Financial Comments (to follow)

40.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- Resource requirements for the Care Act Programme Team

Electoral Division(s) and Member(s) Affected

- All

Nottinghamshire County Council

Report to SLT

7th January 2014

Resource requirements for the Care Act Programme Team

Purpose of the Report

1. This report:
   - Outlines the resource requirements for the Care Act Programme Team, including the Direct Payments in Residential Care project. This includes a re-organisation of the programme team to reflect the requirements for 2015/16 with an overall reduction of 0.5 Commissioning Officer Post.
   - Provides details on roles.
   - Provides an overview of the work plan for 2015/16.

Background

2. The implementation of the Care Act brings about the biggest legislative change to service delivery in 70 years and presents the biggest challenge to face the local authority over the next two years. The changes in the Care Act become active in a number two phases. The first part of the new duties and responsibilities under the Care Act need to be implemented with effect from April 2015 with the second phase enacted in April 2016.

3. In May 2014 the Adult Social Care and Health Committee agreed funding for the Care Act Programme in 2014/15 of £328,956 until March 2015. In the committee report it was recognised there would be a need to resource a programme in the second year, but this was subject to funding from the Department of Health (DH).

Overview of work programme

4. In the first nine months, the programme has focused on ensuring the Council will be legally compliant with the new duties and responsibilities, and designing and developing new ways of working to manage the demands from 2015 onwards.

5. Although some areas are becoming law from April 2015, there is an acceptance by the DH that, for a variety of factors (lateness of guidance, broad nature of changes and new areas of policy), some of the changes local authorities introduce will be “good enough” – good enough to initially meet the requirements of the Care Act, but not what would be acceptable after a period of time or will require further fine tuning. In the first part of 2015/16, the work of the Care Act team will implement the supporting changes required from phase one.

6. With these changes introduced, there remains a need for ongoing monitoring and evaluating of the new processes, staff guidance, levels of staff engagement and compliance. Past experience shows that there is a high level of work of an iterative nature around the development of new ways of working – the real change only begins once implementation dates are reached.

7. The Programme Team will also be responsible for identifying the changes required for 2016/17, then designing and developing these changes for implementation.

8. In summary, the programme team will cover:

- complete implementation to meet new requirements of these areas of work from the April 2015 reforms
- embed the cultural change required through guidance/procedures, practice and training/awareness
- complete the redesign of systems and processes to meet the requirements of the Care Act and manage demands
- plan, design and implement the changes required for April 2016 reforms
- support workforce configuration and plan early assessments for self-funders
- communicate, raise awareness and support the training
- provide programme management and governance to the programme

Posts proposed: summary

9. Approval for the following posts is requested within The Care Act Programme Team. (This includes a re-organisation of the team and a reduction in a Commissioning Officer post by 0.5)

Post	Nos.	Grade	Cost	Length	Funding source	Comments
Programme Manager	1.0 FTE	F	£69,038	12 months	Care Act	Funding already agreed until January 2016 (ASC committee 2013/081)
Project Manager	1.0 FTE	D	£52,000	12 months	Care Act	Funding agreed in ASC Committee report May 2014 and extension subject to funding
Care Act Commissioning Officers	2.5 FTE	C	£122,930	12 months	Care Act	Funding agreed in ASC Committee report May 2014 and extension subject to funding
Programme Officer	1.0 FTE	B	£43,278	12 months	Care Act	Funding agreed in ASC Committee report May 2014 and extension subject to funding
Business support officer	0.5 FTE	3	£11,179	12 months	Care Act	Funding already agreed until January 2016 (ASC committee 2013/081)
Finance business officer	1.0 FTE	C	£49,172	12 months	Care Act	Funding agreed in ASC Committee report May 2014 until March 2015

Post	Nos.	Grade	Cost	Length	Funding source	Comments
Digital officer	0.5 FTE	A	£18,474	12 months	Care Act	New post
Care Act Commissioning Officer, DPiRC	0.7 FTE	C	£36,074	12 months	Split: DPiRC Grant £24,601 Care Act Grant £9,834	Existing post
Care Act Community Care Officer, DPiRC	0.5 FTE	5	£3,717	3 months	DPiRC Grant	New post
Travel, phone and ICT			£10,000			
Total			**£414,100**			
Total funding required			**£385, 797**			

10. Below provides a brief summary of each role within the Care Act programme

Programme Manager: 1.0 FTE, F Grade
Funding agreed Nov 2013 *In Post*

The Programme Manager's responsibility is to ensure the successful delivery and the efficient functioning of the programme and realisation of the benefits defined by its objectives. To ensure the delivery of programme objectives to the appropriate levels of quality, time, budget and performance in accordance with the programme plan. The Programme Manager will have line management responsibilities for the Programme Team.

Project Manager: 1.0 FTE, D Grade

The Project Manager will have day to day responsibility for the Programme Team and for the delivery of the work-streams within the Care Bill programme. They will be responsible for ensuring that effective project management practices are adhered to and that risks, issues and interdependencies are identified and managed effectively. The Project Manager will oversee pilots and developments. This role will lead on communications and co-production. The Project Manager will have line management responsibilities and deputise for the Programme Manager.

Commissioning Officers: 2.5 FTE, C Grade

The Commissioning Officers will be allocated specific work streams to lead on within the Care Act programme of work to ensure clear ownership and accountability required to deliver the objectives of the programme. See next section for further detail.

Programme Officer: 1.0 FTE, B Grade

This role will link to the Transformation Team; it will support the Programme Manager and Project Manager in ensuring the Care Act programme of work is set up, monitored and delivered to the required standard and within the constraints of time, cost and legal requirements. They will also be required to work in conjunction with the team's Finance

Business Partner to ensure that finance systems are aligned with business developments and workflows.

Business Support Officer: 0.5 FTE, Grade 3
Funding agreed Nov 2013

The purpose of this role is to ensure that effective programme office processes and mechanisms are in place to support the programme team and their activities. This post has been reduced to a 0.5 post to meet the overall costs of project within the funding available.

11. In addition to the programme team, it is recognised that specialist posts are required to support key areas. These include as follows:

Finance Business Partner: 1.0 FTE, C Grade

The extension of the Finance Business Partner post will lead on the Finance Modelling work stream and monitor activity and costs following the first phase of the 2015 reforms. The post will contribute to work on Paying for Support and Charging for Support work-streams which include; the Resource Allocation System, the financial cap, care account and charging framework.

Digital Officer: 0.5 FTE, A Grade

The Digital Officer will lead on developments to promote the use of a range of on line solutions, which will help manage demand at the first point of contact and assessment.

Commissioning Officer, Care Act, Direct Payments in Residential Care: 1.0 FTE, C Grade

The extension of this post will project manage the Department of Health pilot of Direct Payments in Residential Care and support wider Care Act work.

Community Care Officer, Care Act, Direct Payments in Residential Care: 0.5FTE, Grade 5 (3 months)

The Community Care office is a trial post and will assist operational staff with assessments and reviews of people opting to have a direct payment, and developing links with care homes. This post has released the Commissioning Officer to complete wider Care Act work.

Areas of work

12. This section provides further detail on the areas of work and the roles of the team. (The digital work is supported by the Digital Officer.)

13. **Programme management and assurance**

- Programme plan for 2016/17 in place that is monitored and updated
- Risk and issue management in place
- Work-stream plans in place and monitored

- Highlight reports
- Equality impact assessments
- Regular stocktakes and self-assessments
- Agree how changes will be monitored and reviewed
- Evaluate impact and next steps
- Gradual closure of the work-streams and programme

Role: Programme Officer and Programme Manager

14. **First contact**, **assessment and eligibility**

- Complete outstanding requirements from April 2015
- Review of tools and processes from front end through to review – identify and implement improvements
- Build upon work to develop alternative ways to deliver assessments, including digital solutions – review and improve
- Review application of eligibility criteria
- Monitor and review resource allocation
- Review ordinary residence and continuity of care arrangements
- Deliver new requirements to process for 2016/17 reforms

Role: Commissioning Officer and Project Manager

15. **Advice and information**

- Support the development of a fit for purpose universal information and advice service including online provision
- Develop and maintain wider partnership across health and housing to ensure offer is responsive and co-ordinated
- Develop wider workforce with partners, 3rd sector and providers to provide advice and information
- Tendering for a new platform across the partnership
- Development of the financial information and advice provision (dependent on timescales around tendering process for service)

Role: Commissioning Officer and Project Manager

16. **ICT**

- Ongoing joint work between a number of suppliers and internal providers, around both Systems Review type recommendations, Mosaic upgrade and the new digital/self-serve offer
- Establish interim solution for handling self-funders
- Define system and process changes required for 2016/7 changes

Role: Project Manager

17. **Integration, co-operation and partnerships**

- Position on delegation of local authority functions determined and implemented

Role: Commissioning Officer

18. **Communications**

- Implement the communications plan, both internally and externally through 2015-16 to respond to the changes

Role: Commissioning Officer

19. **Appeals**

- Implement new appeals process

Role: Commissioning Officer

20. **Early assessments of self-funders**
- Implement plan on early assessments of self-funders

Role: Commissioning Officer

21. **Prepare for 16/17 reforms**

- Respond to consultation on 16/17 reforms
- Scope work required to respond to changes

Role: Programme Officer and Programme Manager

22. **Implement new reforms**

- Charging and paying for care changes associated with the introduction of the care account and cap
- Implement new systems and processes including integration with existing digital processes

23. **Paying for the reforms**

- Model total cost of reforms
- Monitor 2015/16 costs

Role: Finance Business Partner

24. **Direct payments in residential care**

- Manage the Department of Health pilot of Direct Payments in Residential Care and support wider Care Act work.

Role: Commissioning Officer and Community Care Officer

Recommendation

25. To approve the posts identified in this report to successfully implement the Care Act.

Nottinghamshire County Council

Report to Adult Social Care & Health Committee

02 February 2015

Agenda Item: 8

REPORT OF THE SERVICE DIRECTOR For ACCESS AND PUBLIC PROTECTION

VULNERABLE PERSON PANELS (VPPs)

Purpose of the Report

1. To inform Members about the work of the Vulnerable Person Panels operating in each district area and which is overseen by the Community Safety Committee.

2. To provide Members with an opportunity to comment on the development work that is currently taking place in relation to these Panels.

Information and Advice

3. For some years now each district has had in place, under the umbrella of the Community Safety Partnership, multi-agency panel based arrangements for dealing with vulnerable people. These are known as Vulnerable Person Panels (VPPs) in all areas except Newark and Sherwood and Bassetlaw where the panel is known as a Local Multi Agency Problem Solving Group (LMAP). For the purposes of this report however the term VPP will be used to refer to the work taking place in all districts.

4. The VPPs consider individual cases involving people identified as vulnerable to, for example, antisocial behaviour, hate crime or domestic violence, as determined by each VPP. The purpose of these meetings is to share relevant information about a case and then to ensure that appropriate interventions and problem solving plans are in place and being delivered.

5. Since their inception the operating models in each area have been developed to address issues in relation to a number of local factors for example, membership, volume of the cases presented and the resources available to address these. Whilst each VPP should reflect local circumstances, these should not impinge on a minimum standard of service offered. Although there are many similarities between the models operating in each area there are some differences such as themes addressed, membership and local awareness. These have a direct impact on the 'buy-in' from key organisations operating in each district. This creates a situation whereby countywide services are represented in some VPPs and not others reflecting the outcome of local negotiations. It is intended that by recommending and adopting a minimum set of standards there will be more consistency across the County on key matters and a clear route to raise concerns where these minimum standards are not being met.

6. In April 2014 a VPP conference was held at which VPP members stressed the need to ensure the continued effectiveness of the VPP arrangements operating in each district, to

offer a consistent level of service across the County and to enable VPPs to react to the changing environment within which they operate. Following this conference, to further explore the issues raised, a review was undertaken led by Nottinghamshire Police and conducted by members of the County Council Community Safety Team.

7. This review, which was undertaken with the full participation of members/chairs of the VPPs, led to the development of a set of minimum standards and improved accountability together with a consistent structure and operating procedures for the panels, to address the issues raised at the conference. These minimum standards were agreed at the Safer Nottinghamshire Board (SNB) in September 2014. At this meeting it was also agreed that the vulnerable people agenda should be identified as one of the priority themes for SNB and a Champion appointed to lead this area of business in line with the Champion approach adopted with the other SNB priorities. Paul McKay, in his role as Service Director for Access and Public Protection, was identified as ideally placed to undertake this role.

8. The minimum standards cover the following areas:

    - awareness of VPPs – shared terms of reference
    - membership – formalising partner engagement in the VPP process to ensure that all districts have equal access to service providers who can support work with vulnerable people
    - themes addressed at VPPs – agreement of the core themes that can be referred to panels
    - operating model – adopting the operating model highlighted as good practice through the work of the Antisocial Behaviour Transition Group that oversaw the recent introduction of the Antisocial Behaviour Crime and Policing Act 2014
    - information sharing – ensuring the appropriate protocols are in place to aid information disclosure in the VPPs
    - case management – developing a consistent case management system approach across the County and an outline process for performance managing the VPP work
    - responses – The development of a tactical menu of responses to include local, regional and national good practice, services details within the County, contact points and relevant powers and tools available to VPPs
    - management of meetings – Monthly meetings with a consistent chair who attends the Executive Group of the relevant Community Safety Partnership
    - strategic overview – Introduction of a Champion for Vulnerable Persons to oversee the introduction of the minimum standards, promote a preventative approach and inform and update SNB on priorities and emerging issues across VPPs.

9. One of the key areas where development is required is in relation to how VPPs work with the Multi Agency Safeguarding Hub (MASH) and Adult Social Care. The “No Secrets” definition of a vulnerable adult will be superseded by the Care Act 2014 so the concept of “significant harm” no longer features. This could mean different thresholds for Adult Social Care, and therefore the VPPs, which should operate at a level below this threshold. Conversations have started between those involved in the Care Act Programme Team, which is funded by the Adult Social Care and Health Committee, and those involved in the VPP development work to look at the implications of the Care Act 2014.

10. Another key area of the VPP development work relates to the perceived lack of services for cases referred to the panels involving people who have possible mental health issues that do

not meet the Adult Social Care threshold. In exploring and addressing this area of concern links are being made with Public Health due to their lead role in the 'No Health without Mental Health, Nottinghamshire's Mental Health Strategy 2014/17' which has been signed off by the Health and Wellbeing Board. One of the priorities of this strategy, and the subsequent Framework for Action, is 'Identifying problems early and supporting effective interventions'.

Other Options Considered

11. Each district VPP could be left to address its own issues within the structure of their Community Safety Partnership. However by joining the development activity into one programme of work this ensures the strategic buy-in from SNB to resolving the key issues facing these important panels that are providing support to some of our more vulnerable residents who may not meet the thresholds for access to other support mechanisms or services.

Reason/s for Recommendation/s

12. It is recommended that Members note the contents of this report as the subject matter involves the delivery of support to vulnerable residents which is a key priority in our Redefining Your Council strategy.

Statutory and Policy Implications

13. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Crime and Disorder Implications

14. The work outlined in this report is intended to have positive implications on crime and disorder by working with local people identified to the district community safety partnerships as vulnerable to, for example, antisocial behaviour and hate crime.

RECOMMENDATION/S

1) It is recommended that Committee note the contents of this report particularly the Vulnerable Person Panel development work.

PAUL MCKAY
Service Director Access and Public Protection

For any enquiries about this report please contact:
Vicky Cropley, Community Safety Officer, Community Safety Team x 72040

Constitutional Comments

15. As this report is for noting only, no constitutional comments are required.

Financial Comments (to follow)

16.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- Report to the Safer Nottinghamshire Board, 'Developing the Vulnerable Persons Panels in Nottinghamshire' prepared by Superintendent Richard Fretwell, Nottinghamshire Police.

Electoral Division(s) and Member(s) Affected

- All.

Nottinghamshire County Council

Report to Adult Social Care and Health Committee

02 February 2015

Agenda Item: 9

REPORT OF CHAIRMAN OF THE ADULT SOCIAL CARE AND HEALTH COMMITTEE

NATIONAL CHILDREN'S AND ADULTS' SERVICES CONFERENCE OCTOBER 2014

Purpose of the Report

1. This report gives an overview of the conference which was held in Manchester from 29 - 31 October 2014, with a focus on adult services. The conference also covered key issues in relation to children's services, which was included in a separate report to the Children and Young People's Committee in December 2014.

Information and Advice

2. Councillor Muriel Weisz, the Chairman of the Adult Social Care and Health Committee, and Jon Wilson, Deputy Director for Adult Social Care, Health and Public Protection attended the conference representing adult services on behalf of the authority. David Pearson opened the conference with a speech entitled 'Unleashing Greatness' and was involved in a number of workshops and panels in his role as President of the Association of Directors of Adult Social Services (ADASS).

3. Councillor Kate Foale, Deputy Chairman of the Children and Young People's Committee and Anthony May, Corporate Director of Children, Families and Cultural Services also attended on behalf of the authority, to represent children's services.

4. The National Children and Adult Services Conference is the major annual national conference for adult and children's services. It is designed to provide an opportunity to understand further and get up to date information on proposals to deal with current issues in adult and children's services.

5. The key themes of the conference were:

- preparation for and implementation of the Care Act
- integration of health and social care and how the Better Care Fund can support this
- effective use of resources
- improving commissioning and focusing on innovation in practice.

6. There were a series of sub-plenary, innovation and policy sessions across the 3 days of the conference covering a wide range of topics. This report will present a summary of the content and themes of a selection of the sessions over the course of the conference. In addition to this there were plenary sessions where the conference heard from Tristram Hunt (Shadow Secretary of State for Education) and Andy Burnham (Shadow Secretary of State for Health), Jeremy Hunt (Secretary of State for Health) and Eric Pickles (Secretary of State for Communities and Local Government), Nicky Morgan (Secretary of State for Education), Edward Timpson (Parliamentary Under Secretary of State for Children and Families) and finally Norman Lamb (Minister for Care and Support).

7. In the session on getting ready for the implementation of the Care Act 2015/16 Clara Swinson, Direct of Social Care Policy at the Department of Health, talked about the £470m that the Government has provided to fund local authorities to implement the Care Act in 2015/16. She acknowledged that the overall funding position for social care is very tight and said the Government will monitor data from the Better Care fund (BCF) plans on the national condition to protect social care services, and local authorities' access to money in the BCF for Care Act implementation. She highlighted revisions made to the Department of Health's impact assessment to reflect changed assumptions on costs meaning there will be greater costs allocated for carers in 2015/16 and beyond, and reduced costs for Deferred Payment Agreements (DPAs) and early assessment of self-funders. There will also be delayed implementation of the new right of self-funders in residential care to request that a local authority arrange care on their behalf.

8. David Pearson, President of the Association of Directors of Adult Services (ADASS), said that local authorities are generally in a good place in relation to preparing for implementation and there is evidence of good collaboration. The national stocktakes have shown that 97% of councils say that they are very or fairly confident that they will be able to deliver the reforms from April 2015, but there is still concern about costs. He highlighted the financial challenges for social care which has faced a £3.5 billion reduction already with a £4.5 billion pressure anticipated by 2020. Kathy Roberts from the Care Provider Alliance provided a summary of the main changes, challenges and opportunities of the Care Act for care providers.

9. One of the Innovation sessions on Wednesday focused on how the integration of health and social care can work in practice and how new models of service delivery are already beginning to emerge. As co-leaders of the session, the College of Social Work (TCSW) and the Royal College of General Practitioners (RCGP) showed how social workers and GPs can collaborate to remodel services and how investment in social work reduces costs across health and social care. NHS England, supported by RCGP and TCSW, has endorsed the "House of Care" model of long term conditions management. The model can be delivered through 'cluster' teams of GPs, social workers and community health and social care practitioners, overseen by Health and Wellbeing Boards. The session leaders said that evidence shows such approaches reduce both hospital admissions and delayed discharges; save money and provide a sustainable vision of high quality care in austere times.

10. In Wednesday's afternoon plenary session Andy Burnham talked to the conference about refocusing the health and care system in the country to move towards full integration with Health and Wellbeing Boards at the top of the system. He also talked about maintaining and extending personalisation within health and social care. Tristram Hunt focused on

the importance of the family unit, whatever form that may take, in contributing to a solid foundation for children and ensuring improved life chances. He said Labour should not be afraid of promoting and valuing the family, even though this is not generally seen as a strong part of their political perspective.

10. On Thursday morning there was a policy session on The Barker Commission's report on the future of health and social care which has called for a new settlement based on a single ring-fenced budget and local integrated commissioning. Its recommendations include a simpler pathway of care and support and the introduction of free personal care for people with high needs. The session summarised the Commission's proposals, and invited discussion about the implications for people with care and support needs, local authorities, the NHS and Health and Wellbeing Boards. A key theme of the session was the future funding of care and influencing policy thinking in the run up to the 2015 election and the priorities of the incoming government

11. Following this there was a sub-plenary session with the launch of the Commissioning for Better Outcomes framework which has been developed by the University of Birmingham in conjunction with ADASS, the Local Government Association, the Department of Health and the Think Local Act Personal partnership. The framework is based on a route map for better outcomes and co-produced standards on what matters most to service users. There are 12 standards which are grouped into 4 domains – person-centred and outcomes focused, inclusive, well-led and sustainable and diverse market. It was suggested that local authorities use the framework, with their partners, as part of their self-assessment and peer challenge process to rate performance and progress against the standards.

12. One of Thursday's Innovation sessions concerned the opportunity to use complaints more effectively to support service improvement, system change and local accountability. The audience was told that out of 20,000 complaints received across local government in the last year the Local Government Ombudsman (LGO) looked at 12,000. The Ombudsman has considered complaints about council run and funded adult social care services since 1974. From 2009 their role was extended to include all privately funded social care to create a single ombudsman service for all adult social care.

13. Social care is the fastest growing area, with a 130% increase in complaints since 2009. However, there is still a low level of complaints received from private providers. The audience was told that a higher number of complaints can reflect organisations with an open mature approach to customer feedback and concerns; so the relatively low numbers of complaints from private providers means that the sector should challenge itself on this. The LGO annual review of adult social care complaints showed that 46% of complaints were upheld and 40% of the complaints received came from 25 Councils. The audience were told that the Local Government Office, Healthwatch and the NHS are working together to develop standards and expectations.

14. In Thursday afternoon's plenary sessions the conference heard from Jeremy Hunt and Eric Pickles. Jeremy Hunt said that change would be locally led and there would be no further structural change at a national level. He talked about 4 pillars of the system: funding which would be created by economic growth, a single approach to the commissioning and delivery of all community care including GP care and Public Health; innovation and efficiency, with IT and digital developments linking health & social care,

and the importance of culture and a move away from targets to outcomes and peer review. Eric Pickles spoke about then importance of respect for vulnerable people and the need to create a care system based on dignity and humanity. He cited the Better Care Fund as a platform for building a better system with 7 day social care services, single named professionals for service users and information shared across professionals through joint assessments.

15. One of the final policy sessions of the day focused on the next steps for personalisation further to publication by Think Local Act Personal of a new partnership agreement earlier this year. David Pearson talked about moving on from numbers of people on personal budgets to quality issues, including extending personalisation to people who have extensive needs including more people with dementia. He said there is work to be done to follow up the variations shown in the ADASS personalisation survey in the application of personalisation and compliance with the Care Act. There is also a need to involve more users and carers in service design and quality assurance and to invest in social capital and mapping assets. Alex Fox, Chief Executive of Shared Lives, developed this theme by talking about the importance of developing community capacity and the framework produced in October for Health and Wellbeing Boards called 'Developing the Power of Strong, Inclusive Communities'. Alex suggested that the relationship between services and communities needs to change and we need to work with all community resources considering integration and leadership across communities not just services. Alex also asked if the focus now needed to be on assets not just needs – is it time to think about a Joint Strategic Needs *and Assets* Assessment?

16. Zoe Porter, Personal Health Budgets Delivery Team with NHS England, explained that integrated personal commissioning will provide an integrated, 'year of care' budget that will be managed by people themselves or on their behalf by councils, the NHS or a voluntary organisation. She explained that 10 demonstrator sites, which can show they are rooted in co-production, will be identified to implement and evaluate the integrated personal commissioning model over the next 3 years. A wider programme to create learning networks, and disseminate helpful learning is also under development at NHS England.

17. On the final day there were sessions on implementing the Dilnot reforms to adult social care funding and the Care Quality Commission's (CQC) new approach to the regulation and inspection of adult social care. With regard to adult social care funding, the audience was told that the current system can force people with average and lower wealth to spend up to 80% of their assets on care and support. The Department of Health is working on the assumption that catastrophic costs mean the loss of more than half of an individual's asset, and the cap and the extension to the means test deliver protection for these people. The consultation on the final regulations and guidance for the cap on care costs will close in March 2015. They will be published in October 2015 for implementation in April 2016.

18. The session provided more detail on how the Department of Health is building the cap on care costs system by working through the issues in the key areas of extending means-tested support, setting how people meter towards the level of the cap (£72,000), recording progress through care accounts and local authority duties once a person has reached the cap. There will be a different approach in relation to working age adults and two priorities have been identified to test approaches against for this group:

- those born with an eligible care and support need should have a “zero cap”
- the income working age people are left with after charges should be the same as pensioners.

19. The CQC session gave an overview of the findings of The State of Care report 2013-14. This is the first report produced under the CQC’s new approach to regulation and inspection and although it provides evidence of a lot of good practice it highlights a wide variation in the quality and safety of care across the country, which Andrea Sutcliffe, Chief Inspector of Adult Social Care, described as ‘unacceptable’. The main areas of concern identified were: safety and safeguarding, recruitment and training of staff and the absence of registered managers in settings, which generally leads to a lower standard of care.

20. The session also covered a report produced on dementia care called ‘Cracks in the Pathway’. This highlighted the variable quality of services and that the transitions between hospital and care homes were poor and needed improvement. The session ended with Andrea Sutcliffe’s reflections that the CQC has changed significantly with new staff, a new strategy and new methodologies, including a ratings system. She stressed the importance of co-production in the work they are doing and the power of the ‘Mum Test’.

21. The conference ended with a speech by Norman Lamb. He spoke very warmly about the way in which local authorities have responded to recent government initiatives and changes. He saw the reframing of Deprivation of Liberty responsibilities as being a positive protection for vulnerable people, whilst recognising the financial challenges for the local authorities. In relation to the Better Care Fund, he praised the distinctive contribution that the social care perspective brings to this joint working, especially in early prevention services. He was pleased to see that some partnerships had agreed to pool more than the minimum required. Expectations of what the Fund can achieve are pitched high, for good reason, but there should be no illusion about the scale of the challenges. So far as the Care Act was concerned, he recognised both the broad nature of the changes, the new areas of policy as well as the lateness of guidance, which was being responded to so positively by local authorities.

Other Options Considered

22. Not applicable.

Reasons for Recommendations

23. The report is for noting only.

Statutory and Policy Implications

24. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications

are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION

That:

1) Committee notes the overview in relation to adult services given in this report of the 2014 National Children and Adult Services Conference.

Councillor Muriel Weisz
Chairman of the Adult Social Care and Health Committee

For any enquiries about this report please contact:

Jennie Kennington
Senior Executive Officer
T: 0115 9774141
E: jennie.kennington@nottscc.gov.uk

Constitutional Comments

25. Because this report is for noting only, there are no constitutional comments.

Financial Comments (to follow)

26.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- Presentations from the NCAS conference 2014 - ADASS website.

Electoral Division(s) and Member(s) Affected

- All.

Nottinghamshire County Council

Report to Adult Social Care and Health Committee

2 February 2015

Agenda Item: 10

REPORT OF CORPORATE DIRECTOR, POLICY, PLANNING AND CORPORATE SERVICES

WORK PROGRAMME

Purpose of the Report

1. To consider the Committee's work programme for 2015.

Information and Advice

2. The County Council requires each committee to maintain a work programme. The work programme will assist the management of the committee's agenda, the scheduling of the committee's business and forward planning. The work programme will be updated and reviewed at each pre-agenda meeting and committee meeting. Any member of the committee is able to suggest items for possible inclusion.

3. The attached work programme has been drafted in consultation with the Chair and Vice-Chair, and includes items which can be anticipated at the present time. Other items will be added to the programme as they are identified.

4. As part of the transparency introduced by the revised committee arrangements in 2012, committees are expected to review day to day operational decisions made by officers using their delegated powers. It is anticipated that the committee will wish to commission periodic reports on such decisions. The committee is therefore requested to identify activities on which it would like to receive reports for inclusion in the work programme.

Other Options Considered

5. None.

Reason/s for Recommendation/s

6. To assist the committee in preparing its work programme.

Statutory and Policy Implications

7. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such

implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

1) That the committee's work programme be noted, and consideration be given to any changes which the committee wishes to make.

Jayne Francis-Ward
Corporate Director, Policy, Planning and Corporate Services

For any enquiries about this report please contact: Paul Davies, x 73299

Constitutional Comments (HD)

1. The Committee has authority to consider the matters set out in this report by virtue of its terms of reference.

Financial Comments (NS)

2. There are no direct financial implications arising from the contents of this report. Any future reports to Committee on operational activities and officer working groups, will contain relevant financial information and comments.

Background Papers

None.

Electoral Divisions and Members Affected

All.

ADULT SOCIAL CARE & HEALTH COMMITTEE - WORK PROGRAMME

Report Title	Brief summary of agenda item	Lead Officer	Report Author
2nd February 2015			
Tender for Older Person/Vulnerable Adult Services	Report seeking approval for the department to go to tender for Older Person/Vulnerable Adult Services	Deputy Director, Adult Social Care, Health and Public Protection.	Lyn Farrow
Update on Development of New Extra Care Schemes for Nottinghamshire	To advise and update the Adult Social Care and Health Committee about a number of new Extra Care schemes being proposed for development	Service Director, Mid and North Nottinghamshire	Cherry Dunk
Care Act and Resource Requirements		Deputy Director, Adult Social Care, Health and Public Protection.	Jane North
Health and Social Care integration in mid-Nottinghamshire		Deputy Director, Adult Social Care, Health and Public Protection.	Sue Batty
Vulnerable Persons Panel	Report on the work of the multi-agency panels that discuss community issues regarding people who are seen as vulnerable to others within their neighbourhoods.	Service Director Access and Public Protection	Sarah Houlton
National Children and Adults Conference	Report on the conference in October 2014 (deferred from January Committee)	Deputy Director, Adult Social Care, Health and Public Protection	Cllr Weisz, Jon Wilson, Jennie Kennington
2nd March 2015			
Care Act – New Policy		Service Director, South Nottinghamshire	Jane North
Members' visits to Council and Independent Sector Care Services	Report to review the current system and make recommendations for changes which will include visits to independent sector care providers.	Service Director Access and Public Protection	Jennie Kennington/Rosamunde Willis-Read
Transforming Care – response to	6 monthly progress report.	Deputy Director for Adult Social Care, Health and Public	Cath Cameron-Jones

Report Title	Brief summary of agenda item	Lead Officer	Report Author
Winterbourne View Report		Protection	
Direct Payment Support Service	Update after 12 months of the changes to Direct Payment Support Services	Deputy Director for Adult Social Care, Health and Public Protection	Gill Vasilevkis
Performance Update for Adult Social Care and Health	Quarterly update report on the performance of Adult Social Care, including update on latest CQC inspections.	Deputy Director for Adult Social Care, Health and Public Protection	Anne Morgan
Nottinghamshire Safeguarding Adults Board Annual Update Report	Summary on work and progress of Board over last 12 months.	Service Director Access and Public Protection	Allan Breeton
Transformation Resource Requirements	Update on resource requirements to support delivery of transformation within the ASCH&PP Department.	Deputy Director for Adult Social Care, Health and Public Protection	Ellie Davies
Organisational redesign update report	Progress report on Organisational Redesign within Assessment and Care Management	Deputy Director for Adult Social Care, Health and Public Protection	Stacey Roe
Young Carers and Disabled Parents	12 month update on the work regarding Young Carers and Disabled Parents	Service Director, South Nottinghamshire	Wendy Adcock
30th March 2015			
Carers Information, Advice and Engagement Hub	Recommendation report regarding Carers Hub Tender.	Service Director for South Nottinghamshire/Service Director, Mid and North Nottinghamshire	Penny Spice
Action Plan from Peer Challenge	Update on the action plan to address areas for development arising from the peer challenge	Deputy Director, Adult Social Care, Health and Public Protection	Jennie Kennington
Update on Adult Social Care Strategy	Progress report to Committee on implementation of the Strategy and communications related to the Strategy.	Deputy Director, Adult Social Care, Health and Public Protection	Jennie Kennington
Work of the Customer	Progress report regarding the work of the	Service Director Access and	Helen Scaman/Steve

Report Title	Brief summary of agenda item	Lead Officer	Report Author
Service Centre	Customer Services Centre in relation to care packages	Public Protection	Jennings-Hough
Development of employment and skills training hub	Report on the proposal to transform the County Horticulture service into a focused, time-limited employment and skills training hub to support people to develop skills in the fields of horticulture, retail and administration work.	Deputy Director, Adult Social Care, Health and Public Protection.	Jane McKay
27th April 2015			
Overview of departmental savings and efficiencies programme	Progress summary on all departmental savings proposals.	Deputy Director for Adult Social Care, Health and Public Protection	Ellie Davies
Care provider contract suspensions update report	Overview of live suspensions of care provider contracts in Nottinghamshire.	Service Director Access and Public Protection	Kate Revell
1st June 2015			
Progress report on the emergency beds at Helmsley Road Short Break Service	Progress report following the re-designation of the four emergency beds at Helmsley Road Short Break Service	Deputy Director for Adult Social Care, Health and Public Protection	Ian Masson
Independent Living Fund update	Progress report on transfer of funding and fund users to the Council.	Service Director for South Nottinghamshire	Paul Johnson
29th June 2015			
Update on progress with personal budgets for people with dementia	Progress report to review situation one year on from project with Alzheimer's Society to increase no. of people with dementia who have personal budgets and direct payments.	Service Director, Mid and North Nottinghamshire	Jane Cashmore
Performance Update for Adult Social Care and Health	Quarterly update report on the performance of Adult Social Care, including update on latest CQC inspections.	Deputy Director for Adult Social Care, Health and Public Protection	Anne Morgan
Update on progress for the ICELS tender and	Progress report regarding the ICELS review team work on improving returns.	Service Director, Mid and North Nottinghamshire	Jessica Chapman

Report Title	Brief summary of agenda item	Lead Officer	Report Author
review team			
July (date TBC)			
Update on work of Health and Wellbeing Board	Summary report on work of HWB over last 6 months.	Deputy Director for Adult Social Care, Health and Public Protection	Jennie Kennington
August (date TBC)			
September (date TBC)			
Services to Carers	Progress report regarding work commissioned by the department for carers	Deputy Director for Adult Social Care, Health and Public Protection	Penny Spice
Just Checking pilot project		Deputy Director, Adult Social Care, Health and Public Protection.	Mark Douglas

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