APPENDIX 2

BETTER CARE FUND CARE ACT ALLOCATION AND IMPROVED BETTER CARE FUND

2017/18 PROGRESS UPDATE (AS AT 5/2/18)

Page

Title	Age Friendly Notts	Scams Prevention	Falls Prevention	Notts Enabling Service
£ Total	237K	107K	85K	1.9M
Description	Support the development of community activities that engage isolated older adults, improving their wellbeing and resilience, reducing their reliance on public services.	Offer help and advice to each of the Nottinghamshire residents on the UK list of vulnerable people at risk of being scammed.	Promoting and organising physical activities for older adults to help maintain their mobility in order to prevent debilitating and costly falls.	Introduce a new role and expend the numbers of another to promote low or no cost alternatives to packages of social care and to develop independence.
Method	3 Neighbourhood Co-ordinators are working in 2 pilot areas (Beeston & Ladybrook) to develop volunteers and activities.	2 Trading Standards Officers are visiting identified residents, assess their risk and helping protect the most vulnerable against scams.	A Falls Officer is promoting activities for older adults, raising falls awareness, and boosting the availability of exercise classes.	Employ 17.5 'Promoting Independence Workers' for YAs and 5.5 'Community Independence Workers' for OAs.
Performance	The team has developed 6 volunteers who have engaged with a further 78 residents in community activities, mostly in sheltered housing sites in Beeston. Feedback has indicated that 19 of these older adults considered themselves to be lonely when first meeting a member of the team; work is now beginning to undertake reviews at 6-months to gauge progress. The team has organised a residents' meeting with Council representatives in Ladybrook to address concerns. It is unlikely that the team will be able to demonstrate achieving the target of £120K cashable benefits.	The team have worked-through all 223 Nottinghamshire residents on the UK list and helped the 29 of these considered to be at high risk to offer support, divert mail and block calls. The profile of the issue has been raised through several events, posters, a website, and the team have a database of 348 'Friends Against Scams' (people that come into contact with older adults that now have a raised awareness of the issue). Unfortunately however, to date the Royal Mail have not allowed awareness sessions in their delivery centres.	The project has developed a range of promotional and information products that have achieved wide exposure (25,000 leaflets and 4,300 web-hits to date). On-line and class based falls awareness training has been organised, along with the development of 14 exercise class trainers. 25 events were held during 'Older Persons' Fortnight', leading 42 attendees to enquire after further classes. The project has secured Public Health funding to extend to March 2020.	Recruitment to the PIW team is taking time and throughput has been below target, which has hampered activity levels. It is taking time to build engagement with operational teams in relation to the CIW role, which has led to activity levels being below target. Estimated cost avoidance is ahead of target, although early case audit work is indicating that this may be optimistic. An initial review report is due in April.

Title	Co-Production Team	Connect	Moving Forward	Brighter Futures
£ Total	606K	600K (17% of the service)	2.4M (55% of the service)	150K (7.5% of the service)
Description	'Co-produce' activities and events with members of the community with mental health needs in order to boost their support networks and wellbeing.	Helping (mostly) OAs to maintain, and sometimes regain, their independence by addressing health management, loneliness, safe and suitable housing, and financial needs.	Provide advice and support, and 42 supported accommodation units, to people with mental health needs experiencing difficulties with housing and/or financial issues.	A service that supports adults with a learning disability or autism spectrum disorder who are at risk of losing their independence to develop the skills and resilience they need to self-manage day-to-day life.
Method	Employ a team of 6 to work with service users to develop activity groups and community events across the county.	Commission a support worker service across the county, taking referrals from the CSC, health, housing, family members, self-refers, and others.	Framework Housing Association is commissioned to provide a Support Worker service, along with 42 low-level support accommodation units.	The existing contract with Framework Housing Association has been expanded to provide for a larger number of younger adults.
Performance	The team co-produced 2 new groups with 8 new members, 7 community events, and had a further 6 new groups under development in quarter 3 of 2017/18. There are 28 other groups or activities across the county that liaise with the team in a 'wellbeing network' – some of which were co-produced, whilst others pre-existed. An initial review report is due in April.	The service has been well-received and there are some good individual case examples of positive impacts. All 3 providers are having difficulties providing outcomes data and what there is in mid-Notts is below target. Utilisation rates in the north and the south have fallen to 57% and 34% respectively, whilst remaining strong in mid-Notts. Discussions are ongoing with providers to improve performance.	The service is continuously meeting or exceeding its activity targets, and meeting the needs of it service users in most outcome areas. There have been difficulties capturing wellbeing information, with fewer than half of services users reporting a higher wellbeing score post-service. Work is continuing to replace less attractive shared accommodation with self-contained units that will improve the performance of the accommodation element of the contract.	The service is ahead of target in the numbers of people receiving help, and is achieving good outcomes in the majority of areas.

Title	ICT Interoperability	Auto Scheduling	Safeguarding Audits	3-Tier Model
£ Total	1M	184K	174K	570K
Description	Enable electronic data sharing between health and social care information systems in order to reduce duplication, delay and errors, and facilitate integrated working practices.	Enabling new or existing service users to schedule their own assessments or reviews, and enabling the Adult Access Service (AAS) to address low level issues rather than passing them on.	The introduction of systematic quality assurance processes in relation to adult safeguarding practice.	AAS to deal with low-level queries immediately (tier 1) or offer time-limited interventions of up to 6-weeks where appropriate (tier 2) as alternatives to referring on for full assessment (tier 3).
Method	Employ project and technical staff within the ICT & ASCH departments, working with health colleagues, to develop and implement data sharing between health and social care.	Employ 2 Community Care Officers within the Adult Access Service to provide the capacity to operate auto scheduling and early query resolution for service users.	A Safeguarding Manager and Officer are employed to ensure that systems of case audits, dissemination of best practice, user feedback and continuous improvement are implemented and maintained.	Provide additional capacity to the Adult Access Service to enable it to implement a 3-tier service model, seeking to intervene at tiers 1 & 2, preventing the need to escalate to full assessment.
Performance	The project has successfully implemented 1-way data sharing to an A&E dept. and a health data warehouse – next steps are to share data in the other direction, and to spread to other hospitals. Business analysis is underway to develop an information portal between NCC and home care providers, and a health & social care information portal will be tested. Public Wi-Fi is being rolled out to facilitate shared working across the estate. NHS numbers are being integrated into the NCC database.	The project is contributing to the global target of 85% assessments to be undertaken within 28 days, which is on track to be met by the end of 2017/18. Activity and qualitative data is not routinely captured or utilised – work is underway to address this.	Implementation will begin in January 2018.	Initial evaluation to be completed in January 2018.

Summary Overview - *Reducing Pressures on the NHS, Including Supporting More People to be Discharged from Hospital*

Title	Home First	Young Adults Project Team	MH Crisis Workers	Trusted Assessor
£ Total	1.5M (44% of the service)	275K	306K	58K
Description	A home care service to provide short term support to service users experiencing a crisis at home, or to provide a bridging or reablement service to facilitate their discharge from hospital.	Coordination and arrangement of packages of care in the community for younger adults with complex LD and MH needs to facilitate their discharge from hospital and secure settings.	Provide support around social issues (mostly debt, benefits and housing) alongside clinical inputs on the mental health pathway, be it in the community or in inpatient facilities.	Pilot a new role at the interface between hospital discharge and care homes, whereby care homes trust the assessment that a patient is suitable for discharge into their care.
Method	The service is commissioned from an external provider.	4 specialist roles are added to the team to 'project manage' the discharge of YAs with complex needs into the community.	7 MH Crisis Workers are commissioned from Framework HA to provide help in a variety of clinical settings, namely MH Crisis Resolution & Home Treatment (CRHT) Teams, GP Surgeries, and acute in-patient wards.	Notts Care Association will employ 2 nurses to liaise between hospital discharge teams and care homes, building trust and discharge/assessment protocols ensuring that patients can be safely discharged without delay.
Performance	The service commenced in late 2017 – the first meaningful performance data will be received at the end of February 2018.	10 of a target of 80 service users have been successfully discharged. There are a further 10 discharges in progress, and 9 service users that cannot be discharged due to a lack of community provision.	Framework HA have previously provided this service within CRHT Teams and have been able to reinstate this quickly, where activity levels are above target. However, the new elements of the service such as expending into primary and inpatient care settings, and using the wellbeing scoring method to measure outcomes have not progressed as envisaged. Alternatives are under consideration.	The pilot is in the planning stage and will begin in early 2018.

Summary Overview - *Reducing Pressures on the NHS, Including Supporting More People to be Discharged from Hospital*

Title	STIS Assessment Beds	START Expansion	SW in Hospital Teams	Intensive Home Support
£ Total	1.2M	2.3M	2.1M	60K
Description	Short term independence services (STIS) are provided in order to help adults regain their independence after a period of hospital care, or where they are having difficulties in the community.	The Short Term Assessment & Reablement Team (START) helps adults in their own home to regain their independence after a hospital stay or where they are having difficulties in the community.	NCC staff are based in hospitals, undertaking assessments and ensuring that support packages are in place to facilitate discharge, and intervening in A&E where the meeting of a social care need can avert admission.	The IHS service is a health service that provides Advanced Nurse Practitioner-led intermediate healthcare at home so as to prevent admission or facilitate timely discharge.
Method	Provide 54 assessment beds with reablement and OT support in supported living schemes and care homes, facilitating discharge from hospital and taking referrals from the community to prevent admission.	Expand the capacity of the existing START service to enable it to keep pace with rising numbers of hospital discharges, and to increase the numbers of younger adult and community referrals that can be accepted.	Employ 18 ASWs, SWs & CCOs based in hospitals across the county to ensure that care packages are in place to facilitate timely discharge and prevent admission from A&E where possible.	Expedite the roll out of the service into Newark & Sherwood 3-months earlier than planned to help ease winter pressures, by funding the CCG to employ ANPs and Support Workers to work alongside NCC STIS teams.
Performance	54 beds are provided, and the combined target (for all service users of all reablement services) of 85% of people living at home 90 days after leaving hospital is being met. The project has yet to report against the rest of its performance indicators.	60% of the new posts in the START service are now recruited to. The % of service users that are either completely or partially reabled has been maintained at 87%. The % of service users that remain at home 90 days after a hospital discharge has been maintained at 85%. The service is estimated to reable 323 extra service users in 2017/18 - 94% of the target. The project has yet to report against the rest of its performance indicators.	The teams are contributing to meeting the national target of sustaining delayed transfers of care (DToCs) attributable to social care at or below 0.7, the latest returns being: September 0.3, October 0.5, November 0.5. Further performance measures are under development.	The extended service has begun in January and monthly reporting will commence in early February.

Title	Optimum Workforce & Leadership	Quality & Market Management Team (QMMT)	Direct Payments
£ Total	232K	371K	375K
Description	Provide workforce learning and development opportunities to care homes and home care providers to help them develop and provide a quality service to their residents and service users.	The QMMT monitors the quality of social care providers across the county, intervenes where quality falls below standard, and reacts where concerns are raised by service users, the public or other agencies.	Pursue 4 DP improvement actions: (i) promote the use of efficient pre-payment cards, (ii) improve audit processes, and extend choice by (iii) developing the micro-provider market and (iv) encouraging more certified PAs to join the market.
Method	Maintain a team of 3 Workforce Planning and Training staff to work with care providers, analysing their development needs and arranging solutions to meet those needs.	Add 4 extra Quality Officer posts to the team, to build capacity to undertake quality monitoring visits with care homes, and enhance levels of coordination with agencies such as CCGs and the CQC.	Add 4 members of staff to the Direct Payments team within Strategic Commissioning to help develop and implement improved Direct Payments processes.
Performance	The team has produced a large number of training and development opportunities, and has won £200K in educational grants for the local care sector. However, the outcomes supported by this work remain unclear, given that providers have the same quality banding profile (as assessed by the QMMT) whether they are full or part members of Optimum, or do not use the service at all. Further analysis is required.	The team is aiming to improve care home bandings, reduce the number of reactive visits, reduce the number of contractual sanctions and reduce the number of safeguarding referrals. Performance will be reported at the end of the financial year.	The project is in the planning and implementation phase, and the full reporting dataset is under development.

PROJECTS ON A PAGE

~ Adult Social Care & Meeting Adult Social Care Needs

~ Reducing Pressures on the NHS, Including Supporting More People to be Discharged from Hospital

~ Stabilising the Social Care Provider Market

Age Friendly Notts (part of the Community Empowerment & Resilience Programme)			Better Care Fund, Care Act Allocation
Description:	Provide an 18-month pilot, testing ways to identify opportunities for, and support the development of, community activities that engage isolated older adults. Thus improving their wellbeing and resilience, reducing and delaying the need for them to call on health and social care services.		
Rationale:	A similar project in Gloucestershire has provided evidence that isolated older adults have higher levels of anxiety and depression, poorer health outcomes and higher call-outs to public services. Actions taken to engage these individuals in community activities were shown to reduce these negative indicators, save public resources and improve quality of life scores.		
Method:	3 Neighbourhood Co-ordinators are working in 2 pilot areas (Beeston & Ladybrook) to develop community activities targeted at lonely and isolated older adults, and to encourage and develop volunteers within the community so that activities and networks become self-generating and self-sustaining.		
Finance:	2016/17	2017/18	2018/19
	£40,701	£144,798	£51,692
Outcome Measures:	1 χ number of isolated individuals identified and attended a community event. 2 Quantifiable feedback from χ% of cohort 1. 3 χ point average improvement in loneliness score among cohort 2. 4 χ number of community volunteers identified and supported to become self-sustaining. 5 £488k whole-system 'cashable benefits' (£120k social services) over 2 years (17/18 & 18/19).		
Performance:	As a new exploratory project, it has taken time to find approaches that have some traction within the communities. The team has now visited the various sheltered housing sites in Beeston, engaging with all of the residents and having some success in stimulating volunteers to organise communal activities. The team has also taken steps to identify and address environmental factors that might undermine older residents' confidence in venturing out; the provision of seating in town centres and a residents action group in Ladybrook are examples. The number of older people engaged with in the wider community remains low however and the project is at risk of not meeting its savings targets. The required outputs (the χs above) remain unquantified; the team is working with Nottingham Trent University on an impact analysis that will report in August 2018.		
Rating:	Amber – the project is at risk of not demonstrating its savings targets. The team is working to clarify and accelerate the activities that will help achieve this.		

Scams Prevention			Better Care Fund, Care Act Allocation
Description:	Offer help and advice to each of the Nottinghamshire residents on the UK list of vulnerable people at risk of being scammed.		
Rationale:	Falling prey to scams has negative impacts on health, wellbeing and resilience, and increases the likelihood of increased use of health and social care services.		
Method:	Employ 2 Trading Standards Officers to visit each of the identified residents, assess their risk and work with the most vulnerable to help protect them from being scammed.		
Finance:	2016/17	2017/18	2018/19
	£24,421	£82,383	
Outcome Measures:	1 Offer to visit all of the Nottinghamshire residents on the UK list. 2 Offer help and support to vulnerable residents, preventing any further scams. 3 Raise awareness of the scamming issue through literature, events and networks. 4 Run awareness sessions at all Royal Mail delivery centres.		
Performance:	The team have worked-through all 223 Nottinghamshire residents on the UK list and worked with the 29 of these considered to be at high risk to offer support, divert mail and block calls. It has not been possible to measure the potential financial savings or improvement in wellbeing for these clients, although several case studies do report positive impacts. The profile of the issue has been raised through several events, posters, a website, and the team have a database of 348 'Friends Against Scams' (people that come into contact with older adults that now have a raised awareness of the issue). Unfortunately however, to date the Royal Mail have not allowed awareness sessions in their delivery centres.		
Rating:	Green – activity levels are lower than the previous project in this area, but this has been accompanied by strong promotional activities.		

Falls Prevention			Better Care Fund, Care Act Allocation
Description:	Encouraging, promoting and organising physical activities for older adults to help maintain their mobility and balance in order to prevent debilitating, costly and sometimes life-threatening falls.		
Rationale:	Falls and hip fractures are the commonest cause of death from injury in over 65 year olds, incur significant costs to both the health and social care systems, and have a negative impact on independence and quality of life. Evidence shows that maintaining an active lifestyle into older age improves strength and balance and reduces the likelihood falling; and that coordinated public health interventions can have a positive impact on activity levels in the older population.		
Method:	Employ a Falls Officer to promote activities among older adults, raise falls awareness through training and literature, and boost the number of exercise classes available across the county.		
Finance:	2016/17	2017/18	2018/19
	£14,658	£70,105	
Outcome Measures:	Beyond the lifetime of the BCF-funded project, the objective is to contribute to a reduction the number of falls in the adult population. However, as this will take 3 to 5 years to become evident, a number of process measures have been used to gauge the level of contribution: 1 Distribute 25,000 'Get Up & Go' leaflets and 10,000 supplementary exercise guides. 2 >4,000 hits on the feature-rich Falls Prevention webpage in 2017. 3 240 class-trained front-line staff in the implementation of the falls prevention strategy. 4 200 Falls Awareness on-line trainees by Dec 18. 5 14 Otago (strength and balance) trainee instructors match-funded. 6 42 participants in Older People's Fortnight (that included 21 strength and balance class demonstrations) indicated that they would like to attend exercise classes.		
Performance:	The project has made good progress towards meeting or exceeding all of its initial targets except item 3, class-based training for front-line staff that has achieved 70 trainees to date and is anticipated to achieve 200 by the spring. The project will now be extended for a further 2 years with Public Health funding, so it is anticipated that this target will be met in the summer.		
Rating:	Green – the project is on course to meet or exceed all but one of its targets.		

Notts Enabling Service			Better Care Fund, Care Act Allocation
Description:	To introduce a new worker role (CIW) and combine this with an existing role (PIW) into a new team to promote lower or no cost alternatives to traditional care packages to meet the needs and develop the independence of existing or potential service users.		
Rationale:	In line with Professor John Bolton's recommendations, NCC is aiming to embed promoting independence approaches into its working practices in order to contain the long-term rise in demand for traditional packages of social care.		
Method:	8 'Promoting Independence Workers' (PIWs) work with younger adults (predominantly with a physical or learning disability) to enable them to engage with community activities and to do more for themselves. 5.5 'Community Independence Workers' (CIWs) provide information on community activities to operational workers and service users to help older adults maintain or regain their independence. The CIWs also liaise with the 'Co-Production Service' that helps develop community provision where none exists.		
Finance:	2016/17	2017/18	2018/19
	£13,216	£343,056	£577,214
Outcome Measures:	1 Average of 23 referrals per week processed by the CIWs from 1/10/17. 2 CIWs to signpost alternative arrangements that avoid £387,500 in social care costs PA. 3 Each PIW to work with 39 service users per year. 4 65% of PIW cases to show improved independence. 5 15% reduction in the number of younger adult cases referred for care assessment.		
Performance:	PIW activity is below target due to the delays in recruitment. It is taking time to build engagement with the new CIW role amongst operational teams, consequently referral levels are below target. The CIW team are estimating that levels of cost avoidance are ahead of target – this will be validated by sample review and reported on, along with the impact of the PIW role (indicators 4 and 5), in April 2018.		
Rating:	Amber – activity levels are below target. PIWs to be recruited, CIWs to build operational engagement.		

Extension to the Notts Enabling Service (NES)			Improved Better Care Fund
Description:	An extra 9.5 PIWs and some Social Worker/Occupational Therapy support has been added to the NES, allowing it to grow into 2 bases, one covering the north and one for the south. It is taking time to recruit to the PIW role – a further recruitment drive is being backed by a Committee approved media campaign.		
Finance:	2017/18	2018/19	2019/20
	£130,955	£427,677	£427,677

Co-Production Team			Improved Better Care Fund
Description:	The team 'co-produce' activities and events with members of the community with mental health needs in order to boost their support networks and wellbeing.		
Rationale:	Empowered individuals within supportive networks are more resilient, have improved outcomes and are less likely to call on health and social care providers.		
Method:	Employ a team of 4 development workers to stimulate and facilitate members of the community with mental health needs to organise community activities, events and self-sustaining groups.		
Finance:	2017/18	2018/19	2019/20
	£193,894	£206,000	£206,000
Outcome Measures:	The team is in the process of ordering its activity and outcomes (wellbeing scores) data.		
Performance:	The team co-produced 2 new groups with 8 new members, 7 community events, and had a further 6 new groups under development in quarter 3 of 2017/18. There was only one wellbeing score returned in quarter 3 (which showed a marked improvement). There are 28 other groups or activities across the county that liaise with the team in a 'wellbeing network' – some of which were co-produced, whilst others pre-existed. An initial review report is due in April.		
Rating:	The full reporting dataset is being compiled.		

<table>
<tr><td>CONNECT</td><td colspan="3">Improved Better Care Fund</td></tr>
<tr><td>Description:</td><td colspan="3">‘Connect’ is a service aimed at older adults and people with long term conditions, helping them to maintain, and sometimes regain, their independence by addressing needs relating to health management, loneliness, safe and suitable housing, and economic well-being.</td></tr>
<tr><td>Rationale:</td><td colspan="3">In line with Professor John Bolton’s recommendations, Nottinghamshire County Council is aiming to embed early intervention and promoting independence approaches into its service offer in order to support the health and wellbeing of its residents and contain the long-term rise in demand for traditional packages of social care.</td></tr>
<tr><td>Method:</td><td colspan="3">3 service providers have been commissioned to provide a Support Worker service across the county, taking referrals with 2 or more risk factors (chronic disease, bereavement, elderly carer, etc.) from the Contact Support Centre, health and social care, housing and voluntary sector organisations, family members, self-refers, emergency services, councils and the police.</td></tr>
<tr><td>Finance:</td><td>2017/18</td><td>2018/19</td><td>2019/20 *This iBCF contribution represents c.17% of the total value of the 3 contracts</td></tr>
<tr><td></td><td>£200,000*</td><td>£200,000*</td><td>£200,000*</td></tr>
<tr><td>Outcome Measures:</td><td colspan="3">
<table>
<tr><td colspan="2">2016/17 Objectives</td><td>South Metro</td><td>Mid Age UK</td><td>North NCHA</td></tr>
<tr><td colspan="2">95% utilization</td><td>96%</td><td>149%</td><td>93%</td></tr>
<tr><td colspan="2">Number of brief interventions (1 or 2 interactions)</td><td>1,740</td><td>1,707</td><td>573</td></tr>
<tr><td colspan="2">Estimated cost per brief intervention</td><td>£85</td><td>£133</td><td>£54</td></tr>
<tr><td colspan="2">Number of short term support (STS) episodes of up to 12-weeks</td><td>241</td><td>422</td><td>112</td></tr>
<tr><td colspan="2">Estimated cost per STS episode</td><td>£2,508</td><td>£1,063</td><td>£1,720</td></tr>
<tr><td>Target</td><td>Service user output measures:</td><td></td><td></td><td></td></tr>
<tr><td>%</td><td></td><td colspan="3">% Achieved</td></tr>
<tr><td>100</td><td>Access to health services needed</td><td>92%</td><td>86%</td><td>100%</td></tr>
<tr><td>80</td><td>Better management of physical health</td><td>100%</td><td>58%</td><td>92%</td></tr>
<tr><td>80</td><td>Better management of mental health and emotional wellbeing</td><td>88%</td><td>80%</td><td>88%</td></tr>
<tr><td>90</td><td>Access falls to prevention activity and services</td><td>100%</td><td>61%</td><td>67%</td></tr>
<tr><td>75</td><td>Better management of drug/alcohol misuse</td><td>0%</td><td>50%</td><td>50%</td></tr>
<tr><td>80</td><td>Reduced self-harm and self-neglect</td><td>100%</td><td>88%</td><td>100%</td></tr>
<tr><td>80</td><td>Healthier lifestyle</td><td>100%</td><td>75%</td><td>100%</td></tr>
<tr><td>75</td><td>Improved feeling of safety/security in own home and in the community</td><td>100%</td><td>86%</td><td>92%</td></tr>
<tr><td>90</td><td>Skills developed or regained to achieve and maintain independent living</td><td>97%</td><td>83%</td><td>100%</td></tr>
<tr><td>95</td><td>Community-based solutions found or signposted to support maintenance of independence</td><td>100%</td><td>60%</td><td>100%</td></tr>
<tr><td>90</td><td>Increase engagement with local community</td><td>82%</td><td>69%</td><td>100%</td></tr>
<tr><td>85</td><td>Building stronger networks of family and friends</td><td>92%</td><td>92%</td><td>100%</td></tr>
<tr><td>90</td><td>Improved maintenance and upkeep of the home</td><td>100%</td><td>76%</td><td>100%</td></tr>
<tr><td>100</td><td>Consideration of housing options</td><td>100%</td><td>85%</td><td>95%</td></tr>
<tr><td>70</td><td>Finding more appropriate accommodation.</td><td>84%</td><td>81%</td><td>100%</td></tr>
<tr><td>100</td><td>Moving to different accommodation.</td><td>100%</td><td>89%</td><td>75%</td></tr>
<tr><td>95</td><td>Access to assistive technology, equipment, aids and adaptations</td><td>100%</td><td>89%</td><td>100%</td></tr>
<tr><td>95</td><td>Maximising income</td><td>89%</td><td>85%</td><td>100%</td></tr>
<tr><td>85</td><td>Reducing and better managing debt (including rent/service charge/mortgage arrears)</td><td>81%</td><td>85%</td><td>100%</td></tr>
<tr><td>85</td><td>Better management of personal, financial affairs</td><td>100%</td><td>85%</td><td>100%</td></tr>
</table>
</td></tr>
<tr><td>Performance:</td><td colspan="3">The service has been well-received and there are some good individual case examples of positive impacts. All 3 providers are experiencing some technical issues regarding the collection and collation of outcomes data in 2017/18 (and all 3 have action plans to address this), and utilisation rates in the north and the south have fallen to 57% and 34% respectively. Contract discussions regarding the use of capacity, including proposals to tackle social isolation and to support hospital discharge are ongoing.</td></tr>
<tr><td>Rating:</td><td colspan="3">Amber – issues of underutilisation and partial reporting are to be addressed with the providers.</td></tr>
</table>

'Moving Forward'				Improved Better Care Fund
Description:	The Moving Forward service provides advice and support to people with mental health needs experiencing difficulties with housing and/or debt and/or benefits issues, as well as 42 supported accommodation units for people living with mental health needs.			
Rationale:	Housing and money problems can be a cause of, or exacerbate mental health issues, leading to severe stress and risk of homelessness. Helping to resolve these issues will have a positive benefit on health outcomes and wellbeing, as well as maintaining accommodation. 'Supported accommodation' units are a more cost-effective solution for people that do not require the 24-hour support provided in the alternative 'Supported Living' option.			
Method:	Framework Housing Association is commissioned to provide a countywide Support Worker service with the capacity to help 245 service users at any one time with housing, welfare and money issues, along with 42 low-level support accommodation units.			
Finance:	2017/18	2018/19	2019/20	*This iBCF contribution represents c.55% of the total value
	£800,000*	£800,000*	£800,000*	

Outcome Measures:

Maintain capacity to support 245 service users in the core service		Green	266
Meaningful (min 3-point) improvement in service users' wellbeing score post-service		Amber	46%
N°	%	*Core service outcome measures (outcomes recorded on 321 of 742 service users):*	
227	90	Income Maximisation	Green
102	85	Managing Debt	Green
5	71	Did the client need help to obtain paid work?	Amber
3	27	Participation in Training/Education	Amber
9	38	Participation in Work-Like Activities	Amber
134	95	Accessing Community/Community Services	Green
47	96	Managing Physical Health	Green
207	96	Managing Mental Health	Green
19	76	Managing Substance Misuse Issues	Amber
13	100	Managing Independence Through Assistive Technology	Green
89	93	Maintaining Accommodation	Green
8	100	Compliance with Statutory Requirements in Relation to Offending Behaviour	Green
12	86	Managing Self- Harm	Green
3	100	Managing Harm to Others	Green
15	94	Managing Harm from Others	Green
173	96	Developing Confidence, Involvement & Control	Green

Performance:	The service is continuously meeting and exceeding its capacity targets. It meets the needs of it service users in many areas, with some exceptions around the difficult areas of work or education placements. There have been difficulties capturing wellbeing information, with fewer than half of services users reporting a higher wellbeing score post-service. Work is continuing to replace less attractive shared accommodation with self-contained units that will improve the performance of the accommodation element of the contract.
Rating:	Amber – large numbers of people are being helped, however there are some gaps to be addressed through the contracting process with the provider.

'Brighter Futures'				Improved Better Care Fund
Description:	A commissioned countywide service that supports adults assessed as vulnerable who are at risk of losing their independence to develop the skills and resilience they need to self-manage day to day life.			
Rationale:	The evidence base shows that adults with a learning disability or autism spectrum disorder that develop the skills to be able to live with a higher degree of independence have improved outcomes and wellbeing, and reduced packages of care.			
Method:	Add 8% extra capacity to the existing Framework Housing Association service to increase the number of younger adults that can benefit.			
Finance:	2017/18	2018/19	2019/20	*This iBCF contribution represents c.7.5% of the total value
	£50,000*	£50,000*	£50,000*	

Outcome Measures:

Increase the caseload by 8% from 150 to 162		198% Utilisation
Target %	*Service user output measures:*	
100%	Reducing or better managing debt	85%
80%	Better management of personal financial affairs	89%
80%	Support to maintain tenancy and avoid eviction	87%
100%	Consideration of housing options	96%
75%	Support to find and move to appropriate accommodation	100%
75%	Improved feeling of safety/security in own home and in the community	91%
90%	Reduced self harm and self neglect	78%
90%	Access to mental health services	66%
90%	Access to drug and alcohol prevention services	48%
95%	Healthier lifestyle	70%
75%	Less social exclusion, isolation and loneliness	88%
90%	Increase engagement with the local community	78%
85%	Building stronger networks of family and friends	80%
90%	Access to further education and employment opportunities	10%

Performance:	The service is ahead of target in the numbers of people receiving help, and is achieving good outcomes in the majority of areas.
Rating:	Green – there are a handful of outcome areas than can be improved; to be addressed through the contracting process.

Information & Communications Technology (ICT) Interoperability			Improved Better Care Fund
Description:	Enable electronic data sharing between health and social care information systems in order to reduce duplication, delay, errors and blockages, and facilitate integrated working practices and better decision making.		
Rationale:	Incomplete information, collecting the same information several times, and silo working all introduce delay, waste and opportunities for error into the patient/service user journey through the health and social care system. Building an integrated information flow that informs all parts of the system in real time will help reduce these problems.		
Method:	Employ project management and technical staff within the ICT & ASCH departments, working with health colleagues, to help develop and implement data sharing and service redesign projects at the interface between health and social care.		
Finance:	2017/18	2018/19	2019/20
	£345,000	£345,000	£345,000
Outcome Measures:	Successful development and implementation of: 1 2-way NCC data sharing with KMH, NHCT & NUH that enables more integrated working. 2 2-way information sharing between NCC and the GPRCC that informs planning and enables targeted early interventions. 3 Development of an information system that shares data between integrated discharge teams and home care providers. 4 Implementing automatic NHS number updates with Mosaic. 5 Supporting secure Wi-Fi access where this aids integrated working practices.		
Performance:	1&2 – The project has successfully implemented 1-way data sharing from NCC to King's Mill Hospital and to the GPRCC, and is now developing the processes to enable reciprocal data sharing into Mosaic. The business analysis, technical and information sharing agreement (ISA) developments required to support outcome 1 are running in parallel to an options appraisal of an 'off-the-shelf' data sharing portal. There have been preliminary discussions in Bassetlaw of how to embed interoperability opportunities. 3 – Business analysis work is underway to support the development of this solution. 4 – An interim solution is in place, awaiting an update to Mosaic for full implementation. 5 – A public Wi-Fi solution is live and in the process of being rolled out.		
Rating:	An annual appraisal can be given in September 2018.		

Auto Scheduling & Resolution of Queries within the Adult Access Service			Improved Better Care Fund
Description:	Enabling new or existing service users to schedule their own assessments or reviews, and enabling the Adult Access Service to deal with queries from service users rather than passing them on to district teams.		
Rationale:	Allowing service users to choose a suitable time for their appointment prevents bookings being made at inappropriate times that subsequently require rebooking – reducing delay and waste and improving user satisfaction. Similarly, where service user queries can be dealt with quickly by the Adult Access Service, this reduces delays, costs and improves satisfaction.		
Method:	Employ 2 Community Care Officers within the Adult Access Service to provide the capacity to operate auto scheduling and early query resolution for service users.		
Finance:	2017/18	2018/19	2019/20
	£21,165	£81,200	£81,200
Outcome Measures:	1 χ number of assessment slots scheduled by the AAS. 2 85% of CASAs undertaken within 28 days. 3 χ% of service queries (update messages) resolved with χ days. 4 95% service user approval rating.		
Performance:	The % of CASAs completed within 28 days has risen from 61% in April 2017 to 83% in December 2017, so is on track to meet the 85% target by March 2018. The other performance data mentioned here is not routinely captured and utilised so further work is required to develop this.		
Rating:	Amber – management information needs to be developed.		

Safeguarding Audits			Improved Better Care Fund
Description:	The introduction of systematic quality assurance processes in relation to adult safeguarding practice.		
Rationale:	Robust QA processes are required to give confidence to NCC, service users, carers and other stakeholders that safeguarding practice is sound, in line with legislative frameworks, and in keeping with the principles of Making Safeguarding Personal.		
Method:	Employ a Safeguarding Manager and Support Officer to ensure that systems of case audits, dissemination of learning and best practice, user feedback and continuous improvement are implemented and maintained.		
Finance:	2017/18	2018/19	2019/20
	£13,177	£80,466	£80,466
Outcome Measures:	1 χ number of case reviews. 2 χ number of subject interviews. 3 χ number of themed learning events. + *number of participants* + *feedback score from participants* 4 Year-on-year improvement in audit quality scoring. 5 Quarterly reports to the ASCH Governance Group, and the Quality Assurance Sub-Group of the Notts Safeguarding Adults Board (NSAB).		
Performance:	Implementation will begin in January 2018.		

3 Tier Model			Improved Better Care Fund
Description:	Empowering the Adult Access Service to deal with low-level queries immediately (tier 1) or offer time-limited interventions of up to 6-weeks where appropriate (tier 2) as alternatives to referring on for full assessment (tier 3).		
Rationale:	Signposting and early interventions with an emphasis on reablement and/or promoting independence can provide more timely and cost effective solutions than the traditional approach of providing a full assessment, often leading to continuing packages of support.		
Method:	Provide additional capacity to the Adult Access Team to enable it to implement a 3-tier service model, seeking to intervene at tiers 1 & 2, preventing the need to escalate to full assessment.		
Finance:	2017/18	2018/19	2019/20
	£38,024	£265,930	£265,930
Outcome Measures:	1 15% reduction in CASAs. 2 £991,000 saving against the community care budget over 3 years. 3 Length of time to completion of Tier 1 episodes. 4 Length of time to completion of Tier 2 episodes. 5 95% customer approval rating (sample telephone questionnaire 2-weeks post service).		
Performance:	Initial evaluation to be completed in January 2018.		

Enhanced Capacity to Meet Rising Demand	Improved Better Care Fund
Enhanced Capacity to Meet Rising Demand	Enhanced capacity to support Team Managers to meet new statutory obligations, staff to undertake complex care assessments, and provide temporary capacity to undertake a review of the assessment and care management structure - £384,000 (pro rata, full year effect £768,000) for Team Manager and frontline staffing capacity, £40,000 (pro rata, full year effect £80,000) for review of the structure over 2 years. ~ An additional 4 peripatetic FTE Team Managers across the County will create the capacity to support managers with rising numbers of Deprivation of Liberty authorisations, safeguarding audit work and the new competency framework. ~ Enhanced social worker capacity is required to meet statutory duties relating to four key areas of work, where there is increasing demand and pressures on current staffing due to the complexity of the work involved. These are Community Deprivation of Liberty Safeguards, Care and Treatment Reviews, increased safeguarding referrals and investigations and Advanced Mental Health Practitioner (AMHP) assessments. The funding will cover the cost of 9.3 FTE Social Workers, 2 FTE AMHPs and 2 x 0.5 FTE Team Manager posts. ~ Temporary funding for one year will also enable a review of resources, capacity, pressures and activity to inform a future structure for the whole of assessment and care management staffing. The associated posts required are 1 FTE Project Manager and 0.5 FTE Programme Officer.
DoLS Reviews	£600,000 to complete 1,050 extra Deprivation of Liberty Safeguarding (DoLS) Reviews using external agencies.
Meeting Demand in Younger Adults' Services	£3.368m (full year effect). ~ Pressure on the adult social care budget resulting from an increased demographic demand for care and support services for younger adults with learning disabilities, mental health needs and Autism Spectrum Disorders. Many of these adults have complex health and social care needs, are living longer and are reliant on ageing carers. ~ The national policy under the Transforming Care Programme to move people with complex needs relating to LDs and autism out of long stay hospitals into community provision has also meant more people require bespoke packages to meet their needs. Changes to national policy in relation to housing benefit has affected the development of supported living facilities and the level of demand for appropriate residential care has made it more difficult to manage costs in the care market. The funding will be used to secure the appropriate care and support services in the community.
Transport – Day Services Element	Pressures on the service user transport budget - £478,000 (full year effect). ~ An appropriate budget for service user transport is required to allow people to access services that help them to remain at home and in their communities, e.g. day services, respite care. Historically there has not been sufficient funding to meet identified needs in this area. The proposal focuses on the day services element of the overall adult social care transport budget.
	Better Care Fund, Care Act Allocation
Carers' Allocation	£500,000 per annum. Supporting the delivery of respite care and short breaks to service users, enabling their unpaid carers to take a break from caring. This helps carers to maintain their own health and wellbeing, and to continue in the caring role. The service is provided to the cared for person, usually as residential care or home-based care, but it benefits the carer as well as the cared for. The Care Act creates a duty to support both the cared for and the carer, this creates additional demand for respite provision. Respite care is provided following a Care and Support Assessment for the cared for and a Carer's Assessment of the carer's needs – both need to be eligible for support in order for respite care to be provided.

Home First			Better Care Fund, Care Act Allocation
Description:	Commission a home care service to provide short term support to service users experiencing a crisis at home, or to provide a bridging or reablement service to facilitate their discharge from hospital.		
Rationale:	Delays to discharge are both costly to the health service, and detrimental to health and social care outcomes – this service will provide a rapid response short term package of care in the home so that discharges are not delayed whilst an ongoing package of care is arranged. The short term package will have an emphasis on reablement, so that independence is increased and the ongoing package is reduced. The service will also provide rapid response short term support for people living in the community who would otherwise be at risk of admission to hospital or residential care.		
Method:	Commission this service as described from an external provider.		
Finance:	2016/17	2017/18	2018/19 *The BCF contribution is c.44% of the contract value
		£725,417*	£764,823*
Outcome Measures:	1 Contribution to a reduction in the number of non-elective admissions. 2 Contribution to a reduction in Delayed Transfers of Care (DToC). 3 Reduction in size of commissioned home care packages. 4 Reduce the number of people being admitted in to urgent short term care. 5 Commence 100% of packages within 24 hours. 6 80% positive service user feedback.		
Performance:	The first performance data will be received in January 2018.		

Younger Adults Project Team (YAPT)			Better Care Fund, Care Act Allocation
Description:	The YAPT coordinates and arranges packages of care in the community for younger adults with complex LD and MH needs to facilitate their discharge from hospital and secure settings.		
Rationale:	Community care enhances the quality of life of service users and provides better long term outcomes; NCC is fully committed to meeting its obligations under the Transforming Care agenda.		
Method:	Employ a dedicated team to 'project manage' the discharge process and community provision for younger adults moving out of hospital and secure settings.		
Finance:	2016/17	2017/18	2018/19
		£88,201	£187,127
Outcome Measures:	Over the lifetime of the project approximately 80 patients/service users that require a project managed discharge from hospital/secure settings into the community.		
Performance:	12 service users have been moved into the community to date – 2 of which have required readmission.		
Rating:	The project is in the process of developing outcome measures.		

Mental Health Crisis Workers			Better Care Fund, Care Act Allocation
Description:	Provide support around social issues (mainly linked to debt, benefits and housing) alongside clinical inputs on the mental health pathway, be it in the community (admission avoidance) or as an inpatient (preventing delayed discharge). Staff are based within the Crisis Resolution and Home Treatment teams to enable effective joint working.		
Rationale:	Housing and financial difficulties are often identified as co-existing/contributory factors in mental health crises that are not tackled within clinical pathways, resulting in a more prolonged impact on health and wellbeing. By providing support with these issues it is envisaged that crises can be reduced or avoided, and blocks to discharge can be removed.		
Method:	7 countywide Mental Health Crisis Workers are commissioned from Framework Housing Association (FHA) to provide help with housing and financial issues in a variety of clinical settings, namely MH Crisis Resolution & Home Treatment (CRHT) Teams, GP Surgeries, and acute in-patient wards.		
Finance:	2016/17	2017/18	2018/19
	£70,500	£35,794	£200,000
Outcome Measures:	1 Establish relationships with 5 large primary care centres, generating 25 early interventions. 2 275 people helped within the CRHT environment. 3 Help 150 people with discharge from in-patient care. 4 Contribution towards prevention of 597 acute bed days. 5 Establish 'I Plan' resilience plans with service users. 6 Average 4-point improvement in service user wellbeing score following interaction.		
Performance:	FHA have previously provided this service alongside CRHT Teams and have been able to reinstate this quickly, having helped 209 service users in the first 6 months (above target). However, the service has not been extended into primary care as envisaged, and the health Trust have recruited a housing specialist to their team instead of integrating FHA workers*. In place of this, work is now underway to adapt the service to work with the Psychiatry Liaison Service at Bassetlaw, and Emergency Departments with the aim of avoiding unnecessary admissions. The service has not fully implemented resilience planning or the measurement of wellbeing** scoring as yet. **Therefore a contribution to reduced bed days cannot be shown. **In the 24 cases where wellbeing has been measured there is a marked average improvement of 22 points.*		
Rating:	Amber – activity levels are high and outcomes are good, but not in all of the areas originally envisaged. Scoring and planning tools are not being utilised fully. To be addressed through the contracting process with the provider.		

Trusted Assessor			Better Care Fund, Care Act Allocation
Description:	To pilot a new role at the interface between hospital discharge and care homes, whereby care homes trust the assessment that a patient is suitable for discharge into their care.		
Rationale:	Where a mismatch occurs between a hospital's assessment of suitability for discharge and a care home's capacity to provide the level of support required, patients can be readmitted, and care homes can insist on carrying out their own assessment before accepting a discharge in future, introducing delay into the process.		
Method:	Employ 2 clinical staff to liaise between hospital discharge teams and care homes, building trust and discharge/assessment protocols ensuring that patients can be safely discharged without delay.		
Finance:	2016/17	2017/18	2018/19
		£10,000	£48,000
Outcome Measures:	1 50% reduction in A2B DToC (awaiting care home assessment) numbers at King's Mill and QMC. 2 χ number of care home accepting 'trusted assessments'. 3 χ% reduction in D1B & D2B DToC (awaiting residential placement) numbers at King's Mill and QMC. 4 χ% reduction in readmissions from participating care homes.		
Performance:	The project is in the planning phase.		

Short Term Independence Service (STIS) Assessment Beds			Better Care Fund, Care Act Allocation
Description:	Short term independence services are provided in order to help adults (mostly older) regain their independence after a period of hospital care, or where they are having difficulties within the community.		
Rationale:	A short term period of reablement support, be it in the service user's own home or in a community assessment bed (as in this instance), can help older adults regain or maintain their independence within the community, preventing or delaying the need for admission into residential care, and reducing the need for and size of ongoing packages of care.		
Method:	Provide 54 assessment beds with reablement and OT support staff within supported living schemes and residential care homes, facilitating discharge from hospital and taking referrals from the community where short term support might prevent admission to hospital or residential care. This service caters for more complex cases that require more support than can be provided for in the service user's own home.		
Finance:	2016/17	2017/18	2018/19
		£581,913	£621,769
Outcome Measures:	1 Provide 54 assessment beds 2 85% of people living at home 90 days after leaving hospital and receiving a STIS assessment 3 95% customer approval rating 4 Maximum 21-days average length of stay 5 Minimum 85% occupancy 6 Maximum χ% discharged to hospital or residential care home		
Performance:	52 beds are provided, and the combined target (for all service users of all reablement services) of 85% of people living at home 90 days after leaving hospital is being met. The project has yet to report against the rest of its performance indicators.		
Rating:	The full reporting dataset is under development.		

Short Term Assessment and Reablement Team (START)			Improved Better Care Fund
Description:	Short term independence services are provided in order to help adults regain their independence after a period of hospital care, or where they are having difficulties within the community.		
Rationale:	A short term period of reablement support can help adults regain or maintain their independence within the community, preventing or delaying the need for admission into residential care, and reducing the need for and size of ongoing packages of care.		
Method:	Expand the capacity of the existing START service to enable it to keep pace with rising numbers of hospital discharges, and increase the numbers of younger adult and community referrals that can be accepted. The team has previously had to prioritise provision for older adults being discharged from hospital.		
Finance:	2017/18	2018/19	2019/20
	£382,351	£955,842	£955,842
Outcome Measures:	1 85% of people living at home 90 days after leaving hospital and receiving START support 2 95% customer approval rating 3 χ number of service users completing a package of care 4 Average length of stay maintained below χ 5 ? Measure of number/frequency of OT-led/overseen reviews 6 χ% of service users achieve their predicted date of discharge 7 Waiting time for CASA maintained below χ 8 χ% of service users are 'reabled' (no or reduced need for continuing care) 9 Minimum contact time: χ% for peripatetic workers χ% for reablement workers 10 % of service users that do not complete their package maintained below χ% 11 χ% increase in capacity		
Performance:	60% of the new posts in the START service are now recruited to. The % of service users that are either completely or partially reabled has been maintained at 87%. The % of service users that remain at home 90 days after a hospital discharge has been maintained at 85%. The service is estimated to reable 323 extra service users in 2017/18 - 94% of the target. The project has yet to report against the rest of its performance indicators.		
Rating:	The full reporting dataset is under development.		

Social Workers Based in Hospital Discharge Teams			Improved Better Care Fund
Description:	NCC social care assessment staff are based in hospitals, undertaking assessments and ensuring that support packages are in place to ensure smooth and timely discharge. NCC staff also intervene in A&E where the meeting of a social care need can avert admission.		
Rationale:	Accommodating medically fit service users in hospital is expensive and wasteful to the health and social care system. It can undermine the service user's independence and likelihood of rehabilitation.		
Method:	Employ 18 ASWs, SWs & CCOs based in hospitals across the county to ensure that care packages are in place to facilitate timely discharge and prevent admission from A&E where possible.		
Finance:	2017/18	2018/19	2019/20
	£579,728	£798,099	£859,705
Outcome Measures:	1 100% of hospital-based assessments completed within 48 hours of receipt. 2 96.5% of appropriate patients discharged within 1 day of assessment. 3 Sustain DToCs attributable to social care at or below 0.7. 3 ? Measure of admissions avoidance.		
Performance:	The teams are contributing to meeting the national target of sustaining delayed transfers of care (DToCs) attributable to social care at or below 0.7, the latest returns being: September 0.3, October 0.5, November 0.5. The full reporting dataset is under development.		

Intensive Home Support (IHS)			Improved Better Care Fund
Description:	The IHS service is a health service that provides intermediate healthcare at home so as to prevent admission or facilitate timely discharge. The service is aligned with the NCC Short Term Independence Service (STIS – outlined on pages 20 & 21 of this report), so that vulnerable service users' health and social care needs can be met at home.		
Rationale:	Where health and care needs can be met in the home this helps service users maintain their independence, improves outcomes, and saves health and social care system resources.		
Method:	Expedite the roll out of the IHS service into the Newark & Sherwood District 3-months earlier than planned to help ease winter pressures, by funding the CCG to employ Advanced Nurse Practitioners and Health Support Workers to work alongside NCC STIS teams.		
Finance:	2017/18	2018/19	2019/20
	£60,000		
Outcome Measures:	1 To provide 56 step up places with an average LOS of 14 days, 1/1/18 > 31/3/18. 2 To provide 25 step down places an average LOS of 28 days, 1/1/18 > 31/3/18. 3 To see a total of 81 patients, 1/1/18 > 31/3/18. 4 To prevent 38 ED attendances and potential non elective admissions, 1/1/18 > 31/3/18. 5 Support achievement of 85% of all CHC assessments occurring outside of the hospital environment. 6 Support achievement of the target of 3.5% DTOCs. 7 Achieve £74,250 health system savings.		
Performance:	The extended service has begun in January and monthly reporting will commence in early February.		

'Optimum' Workforce Leadership			Better Care Fund, Care Act Allocation
Description:	Provide workforce learning and development opportunities to care homes and home care providers to help them develop and provide a quality service to their residents and service users.		
Rationale:	Helping to develop the skills of care provider staff throughout the county will support them in meeting their regulatory requirements and enhance the quality of care and service that they provide for their residents.		
Method:	Maintain a team of 3 Workforce Planning and Training staff to work with the care providers, analysing their development needs and arranging solutions to meet those needs. Care homes can choose to become paying members of the service, with 2 levels of support on offer.		
Finance:	2016/17	2017/18	2018/19
		£107,150	£124,537
Outcome Measures:	The team existed prior to the advent of BCF and has traditionally been monitored on output measures such as *how many development toolkits have been developed and taken up* or *how many Trainee Nursing Associates are we supporting?* These measures show large numbers of a wide range of developmental activities, however it has been harder to evidence the outcomes of these activities, i.e. are care homes offering a demonstrably better service as a result of this work? One possible way to develop this is the care home bandings used by the Quality & Market Management Team to assess overall quality of service. This data is available for 115 non-members, 36 lower level members, and 12 higher level members; with the proviso of a small sample size, the data does not show any correlation between quality banding and membership type – non-members and members are alike in their quality profile.		
Performance:	The team has been energetic in producing a broad range of training opportunities, developmental toolkits, workshops and events, and has seen a little growth in its membership. However, some further work is required to understand how non-members appear to be maintaining the same level of quality as members.		
Rating:	Amber – further work is required on understanding the impact on outcomes.		

Enhancing the Quality & Market Management Team (QMMT)			Improved Better Care Fund
Description:	The QMMT monitors the quality of social care providers across the county, including residential and nursing care homes, homecare providers, extra-care housing schemes, day services and others. The team intervenes where quality falls below standard, and reacts where concerns are raised by service users, the public or other agencies.		
Rationale:	With increasing expectations and focus on quality across society, the work-intensive reactive elements of the Team's function has been increasing, leading to a requirement to build the capacity of the team to be able to undertake the proactive, quality improving aspects of the work.		
Method:	Add 4 extra Quality Monitoring Officer posts to the team, to build the capacity to undertake quality monitoring and improvement visits with care homes, and enhanced levels of coordination with external agencies such as CCGs and the CQC.		
Finance:	2017/18	2018/19	2019/20
	£47,215	£161,669	£161,669
Outcome Measures:	1 Improvement in care home bandings. 2 Reduction in reactive visits. 3 Reduced number of contractual sanctions. 4 Reduction in safeguarding referrals.		
Performance:	The team will report at financial year end.		

Increased capacity in the DIRECT PAYMENTS team			Improved Better Care Fund
Description:	Pursue development actions in 4 areas relating to the administration of Direct Payments; (i) promote the use of administratively efficient pre-payment cards, (ii) improve audit processes, and extend choice by (iii) developing the micro-provider market and (iv) encouraging more certified Personal Assistants to join the market.		
Rationale:	Direct Payments are a key component of the *personalisation* of services to individual service users, facilitating an approach that tailors care to an individual's needs, empowering them to make choices for themselves, improving their wellbeing and independence. Ensuring efficiency and accuracy in administration of payments generates time and cost benefits to both service users and NCC; developing diversity in the market improves choice and cost effectiveness.		
Method:	Add 4 members of staff to the Direct Payments team within Strategic Commissioning to help develop and implement improved Direct Payments processes.		
Finance:	2017/18	2018/19	2019/20
	£50,947	£161,863	£161,863
Outcome Measures:	1 Increase in the % of DPs used for PAs 2 Increased proportion of DPs via pre-payment cards 3 Reduction in DP administrative costs 4 Reduction in the average value of recoups 5 New systems to ensure that 100% of ACFS alerts are investigated 6 Increase in the number of micro-provider start-ups		
Performance:	The project is in the planning and implementation phase.		
Rating:	The full reporting dataset is under development.		

National Living Wage & Fair Price for Care	Improved Better Care Fund
£5.645m (full year effect). ~ This is a known budget pressure, relating to ensuring sustainability and stability of the social care market. It has arisen as a result of legislative changes which came into effect from April 2016 with the introduction of the National Living Wage. In addition there are pressures in relation to inflationary increases applied to older adults' care homes in accordance with the Fair Price for Care. The financial impact of the NLW increase and the Fair Price for Care index linked inflationary increase for 2017/18 is £5.645m. ~ The Council contracts with a large number of external providers for adult social care services. In order to ensure that the Council can continue to commission the services to meet its statutory duties in relation to the provision of adult social care services, the Council needs to pay increased fees to meet the increased costs that the care providers are now incurring arising from the implementation of the National Living Wage. Concerns remain about the sustainability of the adult social care market and providers continue to report considerable difficulties in recruiting and retaining care staff including nursing staff. There is a risk that some providers may not be able to sustain delivery of care services that are financially viable as a result of increased costs relating to staff pay and on-costs including National Insurance and pensions contributions. Evidence in other parts of the country is that providers are handing back contracts where their cost pressures are not being reflected in the fees paid by local authorities.	