

Committee: Healthier Communities and Older People Overview and Scrutiny Panel

Date: 10 January 2017

Wards: All

Subject: Impact of savings in adult social care

Lead officer: Simon Williams Director of Community and Housing

Lead member: Councillor Tobin Byers Cabinet Member for Adult Social Care and Health

Contact officer: Simon Williams

Recommendations:

A. That the scrutiny panel note this report

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This report provides an update on the 2016/17 savings plan for Adult Services and the impact on social care outcomes. It should be read in conjunction with the report to this panel in October 2015 which summarised the impact of savings to up to that point. This report is attached as an appendix 1.

2 DETAILS

As part of the whole council's Medium Term Financial Strategy, adult social care has needed to play a full part in finding those savings demanded by the strategy, since adult social care is the single largest controllable budget for the council. Agreed savings come to a cumulative total of nearly £29m between 2011/12 and 2018/19. This is against a net budget of around £48m in 16/17.

2016/17 has been a challenging year for the service, with significant staff changes and a difficult financial landscape. Members will have noted the forecast overspend for the service in the budget monitoring papers. A significant overspend on the placements budget was inherited from 2015/16, which was mitigated by underspends elsewhere in the departmental budget in that year. These mitigating underspends are significantly reduced in 2016/17. In addition to the brought forward pressure, there has been significant provider price pressure, as providers seek to recover their fee income after a number of years of fee restraint, and due to the increase in the national minimum wage. . This has created a difficult backdrop to achieving further savings.

As at the period 8 budget monitoring the service is forecasting that it will achieve £3.5m of the £5m 2016/17 target. The main reason for the shortfall is pressure on the placements budget including home care hours due to increasing frailty of those using

the service. There have also been some slight delays in implementing certain changes, and increased income targets have not been achievable.

Since 2011 the Community and Housing Department has managed its savings programme for adult social care using a framework for the use of resources on a value base. This framework was pioneered by Merton and two other local authorities and is now in more widespread use. A copy of this is attached (Appendix 2). The impact of savings is summarised under these headings.

It should be noted that this report looks at impact on the customer base overall for adult social care. There will of course be specific examples of how customers may be positively or negatively affected by savings: however this is outside the scope of this report.

2.1 Prevention

Generally prevention is being more targeted on interventions which have a clear and more immediate impact in terms of reducing demand for statutory services. This formed the basis of the Ageing Well programme. Some voluntary organisations have seen a decrease in or ending of funding, and the volume of funded programmes has reduced especially taking into account transport. In 2016/17 a savings target of £500k was set against the prevention programme. This was achieved by reducing the value of the Ageing Well programme from £940k to £440k. The reduced continued funding is focused on support for carers, information/advice/solution finding, support for hospital discharge, and in the short to medium term alternatives to the decommissioned meals on wheels service.

The other main source of non statutory funding is in accommodation based support under Supporting People, which goes to a range of vulnerable people including victims of domestic violence, offenders, homeless people, and people with mental disorders. There were no reductions in funding in 2016/17, although there are targets for 2017/18 and 2018/19, which may need to be reviewed if legislation is passed giving authorities greater duties in relation to single homeless people.

2.2 Recovery

Investment in this area is mainly around our re-ablement service (which supports mostly those being discharged from hospital) and equipment. The re-ablement service was downsized in 2014/15 and there were no further reductions in 2016/17.

Regarding equipment, the range of equipment we will supply is in line with other authorities. There has been no reduction in the budget for equipment, but the budget has come under pressure from increased demand. There has been a recent successful bid of £5k to the national Better Care Fund for one off purchase of equipment this year.

2.3 Long term support

Overall volumes of customers has continued its gradual decline. This is in line with national trends, where authorities are concentrating scarce resources on those with the greatest needs. Table 1 below shows the trend since 2010/11.

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Customers receiving long term support	4326	4250	4210	4161	4095	3991

Table 1 Long term care customer

The greatest change continues to be in the use of residential care. Permanent placements have continued to reduce in line with national trends and the strategy of reducing dependency on residential care. The cost of placements, however, is increasing.

SERVICE TYPE	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	Apr-Oct 2016
Permanent Residential Home	546	529	517	485	443	397	322
Permanent Nursing Home	341	344	331	320	307	290	244
Total permanent Residential & nursing	887	873	848	805	750	687	566

Table 2 Residential care placements 2010/11-2015/16

Home care packages, however, have stabilised and have risen slightly as we support more people at home. The savings attributed to reviews of care packages relate to seeking more cost effective care solutions rather than reducing the number of people receiving home care.

SERVICE TYPE	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	Apr-Oct 2016
Total planned home care hours	535,658	523,117	495,134	512,905	670,739	742,214	774,556
Home Care unit costs	-	-	-	£18.00	£15.01	£15.70	£15.70*

Table 3 Home Care packages 2010/11-2015/16

* Projected rate

The most impact in Direct Provision has been on day services. The three day centres for people with learning disabilities now offer a reduced range of community activities with the main remit being to provide safe and secure day time respite. Future savings will come from management posts and efficiencies in the residential/supported living service.

There is a savings target of £1.8m from finding more cost effective solutions across all care groups. This is generally achieved by reviewing or re-assessing current support plans and identifying options to reduce the costs. This is done with each individual based on an assessment of their eligible needs and options to meet them. The service is currently forecasting that it will only achieve £550k of this target, due to the difficulties in identifying more cost effective alternatives in the current market and due to the increased dependency levels of customers.

2.4 Process

The new Social Care Information System (MOSAIC) has undergone delays in implementation mainly due to finding the skills needed for the finance aspect, but it is now scheduled for April 2017. Despite this, the service has successfully managed to reduce staffing levels. The service has reduced from 383 fte to 256 fte as a result of the significant restructure exercise carried out in early 2016. Most of these reductions were met from the deletion of vacant posts and voluntary redundancies. Due to a delay in implementation £1,745k of the £1,792k savings target was achieved in year.

Work is continuing to adapt policies and processes to meet the reduced capacity. The implementation of MOSAIC will help improve productivity. In the meantime, customers may have faced some delays in accessing assessments and support, and there has been a temporary backlog in financial assessments which has now been nearly cleared.

2.5 Partnerships

We have long standing partnerships and integrated services in the areas of mental health and learning disabilities. We see this as essential if we are to continue to deliver good outcomes with less funding.

The Better Care Fund is a core element of the relationship with the CCG. The target to increase the transfer of resources through the BCF by £200k was not achieved due to local financial constraints, despite nationally there being a higher level of BCF declared. The level of previous investment in social care was maintained, despite the pressures on the health system. Outcomes from investment in the fund are monitored and reported to NHS England and the local Health and Wellbeing Board. During 2016/17 there has been a reduction in delayed transfers of care (with performance currently top quartile for London), a reduction in care home admissions, and local arrangements for greater integration with community health services have been progressed. However there has not been the hoped for level of reductions in emergency admissions to local acute hospitals.

2.6 Contributions

Customers contribute to the costs of services according to their means. This income from client contributions fell short in 2015/16 by £639k against the budget, and was £1.1m less than the previous year. Income is projected to fall by a further £200k in 2016/17. A review of client income is ongoing to try to ascertain the causes of the reduction in client income. The trend in client income is shown below. It shows that the main reduction has been in residential and nursing care.

Trends in placement income 2011/12 to 2016/17								
	Residential £000	Nursing £000	Homecare £000	Other £000	Actuals £000	% change	Budget £000	Over/Under
11/12	£5,026	£3,494	£2,054	£774	£11,348	-	£10,285	£1,063
12/13	£5,332	£4,682	£1,710	£686	£12,410	9.4%	£10,267	£2,143
13/14	£5,237	£4,317	£1,720	£946	£12,220	-1.5%	£10,968	£1,252
14/15	£4,935	£4,474	£1,920	£1,036	£12,364	1.2%	£11,749	£615
15/16	£4,441	£3,969	£1,827	£999	£11,236	-9.1%	£11,874	£-639
16/17	£4,190	£4,168	£1,818	£944	£11,120	-1.0%	£11,874	£-849
Difference 14/15 - 16/17	£-744	£-306	£-102	£-93	£-1,339			

Table 4 Trends in client income

The 2016 Association of Directors of Adult Social Care (ADASS) budget survey shows that authorities are expecting a fall of c20% in client contributions. However, the 2015 survey reported an expectation of stable income. The sudden drop in forecast income for this year may reflect significant underachievement of income in 2015/16, in line with Merton's experience.

ADASS reports that authorities are expecting the fall in income to be predominantly in residential care as more clients are supported at home. We could also conjecture that significant press attention on the issue of paying for care has alerted families to the 'benefits' of strategies to transfer or hide parental assets. There is evidence from elsewhere of financial advisors selling their services for 'wealth protection'. However, it is difficult to assess the impact of this factor.

The charging consultation group continues to meet to provide a forum for the council to discuss its policies and implementation with customers.

2.7 Have savings impacted on performance and customer experience?

Key indicators from the Adult Social Care Outcome Framework are given in appendix 2. They show that generally performance has been maintained against our Comparator Group Average (CGA).

The indicators show that we continue to maintain our performance in avoiding residential admissions (ASCOF 2a(2)) and in keeping people living independently (ASCOF 1G and 1H).

The two areas where performance has dropped is delayed transfers and user satisfaction. Due to significant difficulties in the local care market, delayed transfers of care generally and those attributable to social care both worsened in 2015/16, however only to our comparator average. Performance has since improved in 2016/17, and Merton remains in the top quartile of authorities. Performance indicators ASCOF 2C(1) & (2) have both improved from 8.8 (all delays) and 3.6 (social care delays) to 6.9 and 1.7 respectively.

Customer satisfaction dropped below our comparators in 2015/16, which is not surprising given the changes made in that year. We do not yet have the results for 2016/17.

2.8 Conclusion

Adult social care has continued to need to deliver significant savings. In common with the rest of England, the savings are becoming harder to make and are having a greater impact on customer experience, as comes through from some concerns being expressed by individuals and groups. Objective overall performance as measured by the national outcomes framework has generally been maintained. The need to meet statutory duties under the Care Act and the cost pressures in the market mean that not all savings are being delivered and that the forecast budget out turn reflects a large overspend.

3 ALTERNATIVE OPTIONS

One alternative would be not to find savings in this area; however this would not be feasible if the medium term financial strategy is to be delivered. Another alternative would be to look for other ways of finding savings: examples would be closing in house day centres, using a resource allocation system to reduce all personal budgets across the board, or ceasing all investment in prevention. Whilst these alternatives are at present not deemed appropriate or recommended, all options have to be kept under review.

4 CONSULTATION UNDERTAKEN OR PROPOSED

Adult social care has sought to share its strategic approach to finding savings with for example partners, the voluntary sector and healthwatch. Extensive consultation took place regarding the replacement savings for 2016/17 along with overall savings in the MTFs, the results of which were reported to this panel. Further consultation will take place on any further service changes as required.

5 TIMETABLE

Savings are in line with the medium term financial strategy.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

Adult Services has a savings target of £5m, of which £3.5m is forecast to be achieved. The service is currently forecasting an overspend of £8m as at period 8.

There are no specific property implications

7 LEGAL AND STATUTORY IMPLICATIONS

Adult social care is broadly a statutory service, with council duties enshrined in law especially the Care Act. Customers of adult social care have a statutory right to support if they are eligible according to criteria which are now national. Any savings must be planned and implemented in a way which does not breach these statutory duties.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

Customers of adult social care will inevitably tend to come from protected groups under equalities principles, especially for age and disability. This is why equalities impacts are done for proposed savings.

9 CRIME AND DISORDER IMPLICATIONS

None specific for this report.

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

Adult social care is in the core business of supporting customers and carers to manage risks in their own lives and to use risk criteria to determine the level of urgency and priority for support. Savings have to be planned and implemented in the knowledge that these risks must be managed.

11 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS /REPORT AND FORM PART OF THE REPORT

Appendix 1 – report to HCOP October 2015

Appendix 2 – Use of Resources Framework

Appendix 3 – Adult Social Care Outcome Framework – performance indicators

Subject: Impact of savings in adult social care

Lead officer: Simon Williams Director of Community and Housing

Lead member: Councillor Caroline Cooper-Marbiah

Contact officer: Simon Williams

Recommendations:

B. That the scrutiny panel note this report

12 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This report outlines the approach to finding savings in adult social care, using a framework promoting the best use of resources, and summarises the impact overall.

13 DETAILS

As part of the whole council Medium Term Financial Strategy, adult social care has needed to play a full part in finding those savings demanded by the strategy, since adult social care is the single largest controllable budget for the council. The weighting of the savings target is in line with the July 2011 principles of meeting statutory responsibilities and offering some protection to vulnerable groups. For adult social care the target is 1.0 or exactly proportionate to the size of the budget. For CSF it is 0.75 and for CS and E&R it is 1.25.

Agreed savings come to a cumulative total of nearly £29 m between 2011/12 and 2018/19. This is against a net budget of around £55m in 15/16. However so far every year about £1m in growth has been put back into the budget in recognition of pressures from demography, and a smaller amount of funding has been put in for inflation. We are about half way through this savings programme, both in terms of time and the profile of savings taken (£13.8m still to deliver from 2014/15 to 2018/19). On top of this there will be some further savings coming forward in the 15/16 budget round for 16/17 and subsequent years, totalling around £2.9m, as the contribution to the remaining savings still to be found up to 2018/19. See Appendix 5 for details of savings over the years.

Since 2011 the Community and Housing Department has managed its savings programme for adult social care using a framework for the use of resources on a value base. This framework was pioneered by Merton and two other local authorities and is now in more widespread use. A copy of this is attached (Appendix 1). The impact of savings is summarised under these headings.

It should be noted that this report looks at impact on the customer base overall for adult social care. There will of course be specific examples of how customers may be

positively or negatively affected by savings: however this is outside the scope of this report

2.1 Prevention

Generally any prevention is being more targeted on interventions which have a clear impact in terms of reducing demand for statutory services, and as such is being targeted on those in higher levels of need. The attached “triangle of intervention” (Appendix 2) was agreed with the voluntary sector in 2010, at that point we signalled an end to investment in Level 4 services and said there would be a focus on outcomes at Level 3. This formed the basis of the Ageing Well programme from 2012-15. Some voluntary organisations have seen a decrease in or ending of funding, and the volume of funded programmes has reduced especially taking into account transport. In the next round of investment (2015-8) the amount of available funding will be halved and we are signalling that it will be targeted still further up the “triangle” going into Level 2.

The other main source of non statutory funding is in accommodation based support under Supporting People, which goes to a range of vulnerable people including victims of domestic violence, offenders, homeless people, and people with mental disorders. The overall level of such support has reduced as part of reductions in this fund, although support has not dropped as much as funding because of tightened contract monitoring. Looking ahead there will be further significant reductions in support offered.

2.2 Recovery

Investment in this area is mainly around our re-ablement service (which supports mostly those being discharged from hospital) and equipment.

We have significantly downsized the in-house re-ablement service in 14/15 but our aim remains to give the opportunity to all those who can benefit from re-ablement to use the service and regain maximum independence. Since 2011/12 Merton has performed well in terms of facilitating timely discharge from hospital (measured through Delayed Transfers of Care due to social care reasons), and usually been among the very best in London. For the first few months of 15/16 however this has been more challenging due to market conditions described below.

Regarding equipment, the range of equipment we will supply is in line with other authorities. The waiting list and waiting times for assessment has not increased. We have achieved better value for money through procurement from a store managed by Croydon. We have tried, and will continue to try, ways of enabling people to access the more common types of equipment without needing assessments at home, for example having an assessment centre where people can come in and trial certain equipment, and offering guided support on our web site.

2.3 Long term support

Overall volumes of support offered have decreased in real terms. The total number of customers receiving services fell from 4326 in 2010/11 to 4095 in 2014/15, despite greater demand due to demography. The decrease has been more marked in numbers in care homes (1133 down to 966) but also is evidence for those receiving home care

(1645 to 1549). We are achieving this through an explicit promoting independence approach, whose key principles are also attached (Appendix 3), and including a programme of reviews to see if people still need so much support once we have helped them through the original issue which brought them our way. Looking ahead, between 2015 and 2019 we estimate that a further overall reduction of 15% in terms of volume will be needed to achieve the required savings. This carries a high delivery risk given that all those affected are statutorily eligible for services, but given that the majority of social care spend is in this area (funding the private and voluntary sector to provide support), there is nowhere else to look to achieve the savings target. It is important to state that, whilst we believe that overall it is both possible and necessary to make further savings in this area, each customer has a review based on his/her own needs without a prior determination of the outcome.

The cost of support reduced in real terms up to 14/15 through not offering inflationary uplifts to providers and through quite intensive negotiations where required, using models which calculated how much it was reasonable to pay for a given set of support needs. These procurement savings have formed a major part of the savings achieved to date. However, it is common knowledge that providers now have very limited if any room for further cashable efficiencies based on current models. This is due to a range of national factors such as a legal clarification of what constitutes the national minimum wage, European legislation over matters like sleeping in and paid time to a first call, shortage of people to work in this sector, and providers using greater leverage to increase prices. Because Merton has in recent years paid comparatively less overall to its providers than neighbouring boroughs, we are now finding it increasingly difficult to find providers to take our customers unless we pay more. This is having an impact this year, both in an increase in delayed discharges from hospital as providers do not want to take the more complex part of the work, and in terms of our having to pay higher prices overall which is a cost pressure of around £500k for this year.

Our long term support for people with learning disabilities is based on good support for people in their own homes, good respite for carers, and good day services. We are one of the very few boroughs who still offer specialist residential care respite, although carers would say that this has had to be rationed more and certainly carers experience a marked drop in nights available as they move from children's to adult services. For day services, again we have retained in house day centres because carers and service users say that they want them and because in our view there are a cost effective way of offering reliable support. We have had to cut both staffing levels and transport, with the impact that we offer less door to door transport and we offer fewer tailored programmes to individuals or small groups outside day centres. We are seeking to mitigate the latter impact through recruiting more volunteers. We still offer door to door transport for these who are assessed as needing it under our assisted travel policy.

2.4 Process

We have reduced numbers of staff who are not direct care givers from 265 FTE in 2012/13 to 168 in 2015/16. There are further significant staffing savings to find in this area amounting to about 30-35 staff. We seek to minimise adverse impact on customers through looking first to non- front line staff wherever possible, and through finding more efficient ways of doing things. Examples of changes are letting Merton Vision manage the whole process for newly visually impaired people rather than insisting on assessing them ourselves, and most recently the closure of one "access

team” who did initial screening and responses to referrals in favour of looking more to the voluntary sector to do this. We are four months into this change and to date are not experiencing a negative impact. Due to the disproportionate numbers of non front line posts cut (for example in management and commissioning) it is becoming more challenging to deliver on the full range of management, administrative and commissioning tasks expected of us. As we look for further ways to achieve savings, it is likely that we will be looking to reduce duplication with NHS or voluntary sector processes, and where possible move more processes to be controlled by customers. We are also looking for ways to support our care management staff to spend a higher percentage of their time in contact with customers through a new information system being brought in at the start of 2016, and through using the principles of flexible working.

2.5 Partnerships

Despite the financial pressures described above our partnership with the voluntary sector has remained strong, and adult social care has played a leading role in some of the Compact awards won by Merton. We continue to greatly value the ability to discuss with the sector, frankly and where needed confidentially, how together we can find ways to meet customer needs with less money.

Regarding the NHS, we have long standing partnerships and integrated services in the areas of mental health and learning disabilities. We see this as essential if we to continue to deliver good outcomes with less funding. In early 2013 we agreed with the Clinical Commissioning Group and other NHS partners to extend this integration into the area of older people and people with long term conditions, with three locality teams now having been formed including social care, primary care and community services health staff. We see this as offering a better customer experience and helping us to achieve our staffing efficiency savings through reducing duplication.

2.6 Contributions

Customers contribute to the costs of services according to their means. This income increased from £8.3m in 2011/12 to £9m in 2014/15. There comes a point where there is little point in putting fees and charges up further because very few customers would pay the higher rates when the means test is taken into account. Merton is already among the councils who levy higher charges compared with other similar councils. This is why there are no proposals for future years to make savings by increasing income in this area.

The council gets a contribution from the NHS for the costs of nursing care in nursing homes: given usage of nursing homes has declined it would be difficult to plan for greater income in this area. Finally the council also gets a contribution in 2015/16 from the CCG through the Better Care Fund for keeping social care at a level which is sufficiently responsive for the NHS.

2.7 Have savings impacted on performance and customer experience?

Up to 14/15 performance levels have generally held up well. There are not long waiting times for assessment, safeguarding incidents are handled in a timely way, we have facilitated discharge from hospital effectively, we support more people into employment

compared with other London councils. We are average on customer satisfaction levels. We have a quality board to ensure that a focus on customer experience and quality is retained. Appendix 4 shows how some key areas of performance have changed over recent years.

2.8 Conclusion

In general for the years 2011/12 to 2013/14 it has been broadly possible to make efficiency savings with surprisingly low impact on customer experience. However much of this was through squeezing provider prices through procurement, and finding other reasonably palatable ways of saving money. The use of resources framework has given us a systematic and value based way of looking at the totality of our investment and not just the savings, and of discussing plans and options with stakeholders.

2014/15 began to see a change, in that it proved far more difficult to realise the savings in support packages, and we began to see the tailing off of reductions in fees paid to providers.

Looking ahead from 2015/16, savings will be less palatable, especially as there are in reality virtually no further price savings to be found from providers and instead there will be upward pressure on prices, and as we make further staffing reductions from an already reduced base. It will be necessary to monitor very closely the impact and feasibility of savings every year.

14 ALTERNATIVE OPTIONS

One alternative would be not to find savings in this area; however this would not be feasible if the medium term financial strategy is to be delivered. Another alternative would be to look for other ways of finding savings: examples would be closing in house day centres, using a resource allocation system to reduce all personal budgets across the board, or ceasing all investment in prevention. Whilst these alternatives are at present not deemed appropriate or recommended, all options have to be kept under review

15 CONSULTATION UNDERTAKEN OR PROPOSED

Adult social care has sought to share its strategic approach to finding savings with for example the voluntary sector and healthwatch. Whilst the medium term financial strategy has not been formally consulted on because it is a medium term plan subject to change, adult social care consulted on replacement savings for 15/16 and intends to consult on all savings for 16/17.

Appendix 2 – Use of Resources Framework

<p>Prevention</p> <p>I am not forced into using health and social care earlier than I need to. I am enabled to live an active life as a citizen for as long as possible and I am supported to manage risks</p>	<p>Recovery</p> <p>When I initially need health or social care, I am enabled to achieve as full a recovery as possible and any crises are managed in a way which maximises my chances of staying at home</p>	<p>Long Term Support</p> <p>If I still need continued support, I am able to choose how this is done. I can choose from a range of services which offer value for money. The resources made available to me are kept under review</p>
<p>Process</p> <p>The processes to deliver these three outcomes are designed to minimise waste, which is defined as anything that does not add value to what I need</p>	<p>Partnership</p> <p>The organisations that support me work together to achieve these outcomes. These organisations include health and social care, other functions in statutory bodies such as councils or government, and the independent sector</p>	<p>Contributions</p> <p>I and others who support me are expected and enabled to make a fair contribution to this support. These contributions may be financial according to my means, informal care and support from those close to me or from volunteers, or from me playing my own part in achieving these outcomes</p>

Appendix 3

Adult Services Care Outcome Framework – national performance data

ASCOF ref:	Indicator	2012/13		2013/14		2014/15		2015/16		Oct 16
		Merton	CGA	Merton	CGA	Merton	CGA	Merton	CGA	Merton
2A(2)	Permanent admissions of older people (65+) to residential & nursing care homes per 100,000 pop	420.8	432.8	507.7	414.9	336.9	444.3	417.1	495.5	-
2C(1)	Delayed transfers of care from hospital per 100,000 pop	2.5	6.1	2.7	6.7	4.4	7.2	8.5	8.8	6.9
2C(2)	Delayed transfers of care from hospital attributable to social care, per 100,000 pop	0.7	1.9	0.0	2.0	0.7	2.3	3.6	3.6	1.7
1G	Proportion of adults with learning disabilities who live in their own home or with their family (%)	73.4	69.8	70.4	71.6	74.5	67.5	76.6	71.3	78.9
1H	Proportion of adults in contact with secondary mental health services who live independently, with or without support (user survey)	76.9	79.7	82.1	78.9	86.9	79.7	85.7	73.2	91.6
3A	Overall satisfaction of people who use services with their care and support (User survey)	57.4	59.6	63.3	60.7	63.3	60.1	58	60.1	-
3D(1)	Proportion of people who use services who find it easy to find information about support (user survey)	71.8	68.7	78.6	73.1	75.1	73.4	74.5	72.2	-
4A	Proportion of people who use services who feel safe (user survey)	57.4	62.3	68.9	62.7	67.1	65.0	69.8	67.2	-
4B	Proportion of people who use services who say that those services have made them feel safe & secure (user survey)	60.4	72.7	86.3	78.4	78.8	81.8	76.5	82.0	-

CGA = Comparator Group Average;