Norfolk County Council

People and Communities Select Committee
Minutes of the Meeting Held on 13 September 2019 at 10am in the Council Chamber, County Hall

Cllr S Gurney (Chairman)
Cllr Fabian Eagle (Vice-Chairman)

Cllr Tim Adams	Cllr Brenda Jones
Cllr David Bills	Cllr Chrissie Rumsby
Cllr Penny Carpenter	Cllr Thomas Smith
Cllr Ed Connolly	Cllr Mike Smith-Clare
Cllr David Harrison	Cllr Sheila Young

Substitute Members Present
Cllr Alison Thomas for Cllr Fran Whymark

Officers Present:

James Bullion	Executive Director of Adult Social Services
Suzanne Meredith	Deputy Director of Public Health (Healthcare Services)
Chris Butwright	Head of Public Health Performance & Delivery
Lorrayne Barrett	STP Lead for Primary & Community Integration
Sarah Jones	Assistant Director Early Help and Prevention
Laura Clear	Interim Director of Community Health & Social Care Operations

1. Apologies for Absence

1.1 Apologies were received from Cllr Fran Whymark (Cllr Alison Thomas substituting)

2. Minutes

2.1 The minutes of the meeting held on the 19 July 2019 were agreed as an accurate record and signed by the Chairman.

3. Declarations of Interest

3.1 The following interests were declared:

- Cllr Ed Connolly declared a non-pecuniary interest as he had been appointed to Norfolk Central Foster Panel
- Cllr Sheila Young declared a non-pecuniary interest as a carer for husband
- Cllr Penny Carpenter declared a non-pecuniary interest as she had been appointed to Norfolk Health Overview and Scrutiny Committee
- Cllr Alison Thomas declared a non-pecuniary interest as she had previously been a Member of the Sustainability and Transformation Partnership

4. Items received as urgent business

4.1 There were no items of urgent business.

5. Public Questions

5.1 No public questions were received

6. Member Questions and Issues

6.1 No Member questions were received

7. Working with the NHS on integrated services in Norfolk and Waveney

7.1.1 The Committee received the report providing an update on progress with developing integrated arrangements including revised joint commissioning, the development of community-based models of social work and support at home, and stronger support within hospitals

7.1.2 The Committee heard a presentation from the Executive Director of Adult Social Services and the Sustainability and Transformation Partnership (STP) Lead for Primary & Community Integration; see Appendix A:

- In March 2019 development of integration policy was reported to Adult Social Care Committee and Policy and Resources Committee and authority was delegated to the Executive Director to refresh integrated arrangements between Norfolk County Council and NHS bodies and formally upgrade agreements
- The Executive Director of Childrens Services was the STP lead for Children's Services and Child and Adolescent Mental Health Services (CAMHS), the Executive Director of Adults Social Services was the lead for primary and community care and the Director of Public Health was the lead for prevention
- There was a move towards a social model of care by investing in prevention, de-escalating risk and working with the social care market
- Work was underway on making best use of the wide range of practitioners and organisations involved in primary care. Where possible staff would be co-located as this was found to be beneficial
- Approaches that were working well would be applied across the whole area unless there was a good reason not to
- Newly created posts had been appointed and local delivery groups were looking at how to support these
- Reshaping social care working with Acute Hospitals would be more focussed on working with people in the community
- The STP workforce workstream was looking at ways of developing leaders

7.2 The following points were discussed and noted:

- A Member pointed out that the report had little planning for dental provision, particularly for children, noting the need to focus on prevention. The Executive Director of Adult Social Services acknowledged this and noted that accessibility of dental services was a core requirement of the NHS improvement programme
- The Deputy Director of Public Health (Healthcare Services) reported that Public Health would work with NHS England, who commissioned dental and oral health promotion services, to ensure the right groups were targeted
- A Member had received positive feedback about the quality of Norfolk's social services staff from the Queen Elizabeth Hospital
- The Interim Director of Community Health and Social Care Operations clarified that restructure of the discharge units at hospitals would involve a greater focus on multidisciplinary working when discharging patients, including use of Home First and Discharge to Assess approaches.

- The Chairman asked about progress on referrals coming to Social Care before the weekend; the Interim Director of Community Health & Social Care Operations clarified that progress was being made but when hospitals were under pressure, sometimes referrals came through later in the week; Officers were working with hospital discharge, social work and health teams to overcome this
- A Member noted that Member oversight was not included in the report; the Executive Director of Adult Social Services acknowledged that this should be included, noting the work of the Cabinet Member for Adult Social Care, Public Health and Prevention and Chairman of Health and Wellbeing Board, Councillors on the STP oversight board and accountability meetings.
- A Member discussed concerns about the financial viability of implementing virtual wards. The STP Lead for Primary & Community Integration reported that an STP Officer was leading on workforce, and a joined-up approach was now in place across Norfolk and Waveney looking at recruitment and retention and the GP and nursing shortage, upskilling, new roles, secondment policies, and other innovations to address staffing gaps across the system
- The Executive Director of Adult Social Services reported that GPs recruitment trajectory was not in line with the GP forward view for Norfolk and Waveney and the international recruitment scheme had not been fully successful – this is typical of the pressure our system is under.
- Planning was underway in social care for contingencies around Brexit; there was a 10% vacancy rate in adult social care market jobs at that time, and a 30% turnover rate. Outstanding issues related to funding of social care were noted and had been acknowledged by the Association of Directors of Adult Social Services and NCC.
- The Chairman queried plans to reintroduce bursaries and review the qualification levels required to go into nursing; the Interim Director of Community Health and Social Care Operations clarified that paid apprenticeships were available to lead either to a nurse associate role or a full nursing degree. This had been successful, with 600 applicants for the 40 places in September 2019. Apprenticeship courses for occupational and physiotherapy would also be introduced. Many organisations in Norfolk offered nursing apprenticeships.
- It was hoped that the Advanced Care to Care Homes initiative would improve communications between Acute Hospitals and care homes
- A Member asked Officers what measures were in place to prevent people being discharged too early due to lack of bed space; the Interim Director of Community Health and Social Care Operations reported that community rehabilitation beds and short term social care beds were in place to support people on discharge, but research showed that people recovered better and more quickly in their own homes; the virtual ward had an intensive package of support including overnight support, up to four visits a day and therapy.
- Officers acknowledged that there was a lot to learn related to failed discharges and work was going on with nurses and therapists around this
- There were 20 bed based reablement beds in Benjamin Court in Cromer at that time. A further 10 beds were due to open in Grays Fair Court in Norwich, and Officers were looking into additional reablement services. Bed based reablement had been shown to have a return home rate of 80% and therefore helped reduce permanent admissions to care
- As well as nationally set down measures in the NHS long term plan, measures had been agreed locally around performance as part of the Better Care Fund
- The Deputy Director of Public Health (Healthcare Services) reported in response to a Member query that the STP would develop a dashboard to monitor measures such as healthy life expectancy and issues which impacted on this. The key measures would be chosen as key performance indicators.

- Care organisations were audited to ensure they paid the national living wage and fees paid to care organisations had been increased to facilitate this; further work would be carried out to improve the amount of training offered to care staff using European Union (EU) funding
- Use of Better Care Fund (BCF) funding would be reviewed in agreement with Clinical Commissioning Groups and a report brought to Cabinet and Health and Well-Being Boards in October 2019
- A Member discussed issues raised by a Social Worker at the recent Health Overview and Scrutiny Committee that some nursing homes were unwilling to take people with complex needs, and there was a lack of provision and staffing resource to allow people to die at home if this was their choice. The Executive Director of Adult Social Services acknowledged the social worker speaking out and noted that the fragility in the quality and sustainability of Norfolk's care market; he felt that societal action was required, and the green paper on how social care would be funded was needed before sustainability in the system could be achieved.
- A Member queried the joining up of information technology systems across different agencies; Officers reported there were 2 dominant systems which did not directly communicate, however, a front-end link between them was being worked on. Integrated care co-ordinators ensured notes could be seen across the two systems and a Technology Working Group on the STP, led by the Head of IT at the Norfolk and Norwich University Hospital, was working on making information accessible across the systems. All community hospitals, except for mental health hospitals, were on System One.
- The Executive Director of Adult Social Services clarified that the EU funding for staff retention was from the EU social fund. A written guarantee had been received that the funding would be awarded in full.
- The difference in care available for end of life patients in the West of the County and the rest of Norfolk was noted
- The work of the virtual ward was noted as a positive step
- A Member noted the high-quality care she had witnessed at Lisbon Court

7.3 The Committee

a) **CONSIDERED** and **SUPPORTED** the progress on integrated commissioning and community-based models and policies for integrated social work services, and to comment on the risks and opportunities

b) **SUPPORTED** further updates to Select Committee as required, and further action by the Executive Director of Adult Social Services, in consultation with the Cabinet Member for Adult Social Care, Prevention and Public Health, on revised agreements with the NHS to achieve improved outcomes

c) **AGREED** that the Chairman would refer comments from the meeting to the Cabinet Member for Adult Social Care, Public Health and Prevention, particularly around:

- the child dentistry programme
- education in schools related to dental hygiene
- concerns over workforce issues and Delayed Transfers of Care
- inclusion of a written statement in the report related to elected members and scrutiny

8. Winter planning

8.1.1 The Committee received the report reviewing the impact of resilience planning for 2018/19 and highlighting the outline approach for the coming winter, 2019-20

8.1.2 The Committee heard a presentation by the Interim Director of Community Health and Social Care Operations; see Appendix B:

- Winter pressures tended to peak in January and continue until after Easter
- Ninety care homes in Norfolk were signed up for trusted assessors to assess patients on their behalf, speeding up assessment
- The assistive technology offer would be rolled out to allow people to be referred to the service while still in hospital
- Discharge to Assess and Home First models were being promoted
- Information on Home First would be promoted via the internet, a social media campaign, posters and leaflets given to people when they went into hospital
- The Winter Pressure Grant would be used for, among other things, supporting the market and investing in market capacity, managing transfers of care, improving flow of processes, staff training, Enhanced support in Care Homes, recruitment, assistive technology, incentivising homes to provide higher levels of care packages, additional cover in the duty team and expanding and extending Swifts to provide support out of hours.

8.2 The following points were discussed and noted:

- It was queried what improvements to support delayed transfers of care were expected over winter; the Interim Director of Community Health and Social Care Operations reported that there would be a focus on the Home First approach supporting people at home for example the funding to expand Swifts.
- Officers confirmed that all front-line staff were encouraged to have flu vaccinations, and these could be provided if needed
- A Member pointed out that safeguarding was not mentioned in the report; the Interim Director of Community Health and Social Care Operations noted that this was always an area of focus and was not something peculiar to winter, but acknowledged that this could be included
- The issue related to care homes not taking people back after a hospital admission was raised; the Interim Director of Community Health and Social Care Operations reported that there needed to be an acknowledgement that care homes were people's homes and community support could be provided there; trusted assessors could help identify support that could be put in place in care homes to allow people to safely return after a hospital admission
- It was discussed that Great Yarmouth had one of the lowest life expectancy rates in Norfolk, impacted by poverty and that some people returned home from hospital to inappropriate home environments. The Executive Director of Adult Social Services acknowledged that more frail people were seen in the Yarmouth area at a younger age. It would be important to address this through prevention services funded through BCF and Adult Social Care funding
- Public Health had been working with District Councils to look at supporting residents with improvements to their homes to address fuel poverty, promoting flu vaccines and other preventative approaches.
- A Member felt that with the increase in Councillor allowances, it was important to support residents in need. The Chairman noted that many Councillors used their allowance to support community projects.
- Fuel poverty was discussed; it was noted as an issue in deprived urban areas, rural areas without access to gas mains and in deprived rural areas
- Cllr Thomas raised the Norfolk and Norwich "Settle in Service" to support patients when they returned home from hospital; she had not been informed about this service as local Councillor and therefore not able to promote it with residents; Cllr Thomas **agreed** to circulate the poster to other Councillors. The Chairman **asked** Officers to circulate details of any other similar services to Members.
- A discussion was held about Councillors being a link for their community; the

Vice-Chairman suggested that a good neighbour scheme was looked into, which the Committee agreed that Committee Members should take the lead on. The Chairman **asked** Officers to look further into what Councillors could do as community links, with appropriate safeguards in place for them

- The Executive Director of Adult Social Services reported that in order to address preventable falls, the Swifts service would be expanded, and the A&E Deliverability Board were looking at falls prevention; it was key for GPs and social workers to work together and provide prevention for people at risk of falls
- the Interim Director of Community Health and Social Care Operations confirmed that the social media films promoting Home First were made in house, and videos would be produced showing a range of people from the population
- The local resilience forum was reviewing the resilience strategy as a whole system of organisation and this included the Council's role; sixty of the parishes in Norfolk had resilience plans and these would be updated to take into account community resilience
- Cllr Harrison left the meeting at 12.13
- A Member pointed out that there was was a lack of planning related to supporting people with mental health
- A Member noted there were many small charitable trusts who could give funds to people in need that were lesser well known and encouraged Councillors to utilise them.
- The Deputy Director of Public Health (Healthcare Services) reported that flu vaccination was one of the most effective prevention measures that could be taken during winter for vulnerable people and frontline staff; information in the news had discussed the increased incidents of measles in the population and it was important to support Public Health England in their work to encourage parents to feel safe in getting their children vaccinated
- A Member queried whether the impact of Brexit on health services over winter had been considered. The Executive Director of Adult Social Services reported that the broad implications of Brexit had been considered and that contingency plans were in place; it had been identified that it may impact on capacity over winter therefore winter funding would be used to incentivise staff to take on more hours or organisations to take on more staff during this time of pressure
- A Member suggested that Members visit Benjamin Court and Grays Fair Court

8.3 The Committee:

a) **DISCUSSED** and **COMMENTED** on the high-level content of the Winter Plan (shown at Appendix A of the report)

b) **SUPPORTED** the utilisation of 19/20 Winter Pressures Grant under the headings set out detailed in section 4 of this report

c) **AGREED** that the Chairman would refer comments from the meeting to the Cabinet Member for Adult Social Care, Public Health and Prevention, particularly around:

- the welfare of frontline staff, including the flu jab programme for staff
- supporting the promotion of the HomeFirst video, leaflet and other promotional material
- encouraging care homes to take back people after an admission to hospital
- the impact of poverty on admissions to care and hospital, and on winter planning, particularly in areas with higher social deprivation
- looking at Councillor involvement in welfare checks and discharge from hospital
- input on the Norfolk Resilience Strategy for Councillors to be involved in supporting communities, whilst also ensuring appropriate measures are in place to support councillor safety

- ensuring the impact of Brexit is taken into account in winter planning
- ensuring that people with mental health issues are included in the winter planning

The Meeting Closed at 12.28

Cllr S Gurney, Chairman,

People and Communities Select Committee

Adult Social Services

in good health
The Norfolk and Waveney Health and Care Partnership

Working with the NHS on integrated services in Norfolk and Waveney

Lorrayne Barrett, STP Lead for Community Integration

(supporting James Bullion as Senior Responsible Officer for Primary and Community Care)

NCC Vision Statement

in good health
The Norfolk and Waveney Health and Care Partnership

"Here at Norfolk County Council, we have a clear ambition: for our County to be a place where we put people first, where everyone works together to create a better place to live. A place of opportunity: where we can fulfil our potential and lead productive, healthy and independent lives. A place where we all have the chance to contribute to and benefit from economic growth and regeneration, as well as protecting our unique environment. It will be a place where any of us can access the education we want, develop the skills we need, and gain the employment we seek."

ASSD Vision Statement

in good health
The Norfolk and Waveney Health and Care Partnership

"Supporting people to be independent, resilient, and well."

STP PCC Vision Statement

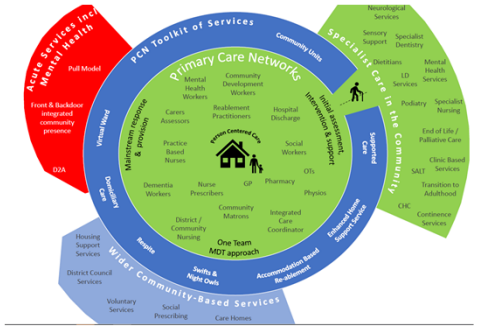
in good health
The Norfolk and Waveney Health and Care Partnership

As a system we have set out a series of vision statements to help shape our health and care services for our population. We aim to communicate and adapt this vision further over the coming months.

- Together we will build **healthier communities** in Norfolk and Waveney
- We will provide **high quality and responsive** health and care services for Norfolk & Waveney. We will be there for our people when they are vulnerable, regardless of age or ailment
- We will make it easier for people to **access our services** to enable people to lead happy and healthier lives
- Working in partnership we will provide **sustainable services** through an empowered workforce

in good health
The Norfolk and Waveney Health and Care Partnership

The Core Common Approach



in good health
The Norfolk and Waveney Health and Care Partnership

Overarching Principles

- Co-production with Primary Care, operational staff and citizens
- Local Delivery Groups will play a fundamental role in local application and implementation
- Population Health Data will inform model and allocation of resource
- Focus on prevention, wellbeing and choice
- Emphasis on local requirements and nuance but with consistent outcomes
- Sharing of good practice and innovation that has been evaluated. If positive, roll out unless valid reason not to do so
- Cornerstone is a core, effective multi-disciplinary team. Each practice/team will know who their named colleagues are and how to access them/their services
- Joint prioritisation and allocation of work to most appropriate team member/service. Notes well defined
- Co-location of staff wherever possible and proactive offer of hot-desking, common space in all sites (underpinned by robust data sharing protocols)
- Work must dovetail with other STP workstreams
- Need to be flexible as new guidance or circumstances emerge
- Makes most efficient and effective use of staff skills and knowledge
- Optimise opportunities as we go – including any quick wins
- Primary Care Home approach

in good health
The Norfolk and Waveney Health and Care Partnership

Examples of Key areas of work

- Relationships - ensuring influence at the Local Delivery Groups
- Review of Section 75s to support developments
- Defining Multi-Disciplinary Team Meetings - what good looks like?
- Mapping 2 hour rapid response
- Re-shaping teams in the acute hospitals that plan discharge
- Single point of access and out of hours responses
- Social Prescribing
- Enhanced Care to Care Homes
- Embedding prevention
- Joint initiatives – e.g. NEAT, Joint Occupational Therapy, Joint Duty teams, etc.
- Local Information packs
- Work overseen by reformed/reshaped integrated commissioning team working with integrated operational managers

in good health
The Norfolk and Waveney Health and Care Partnership

Some Potential Barriers

- Different culture/ethos/priorities
- Financial Challenges
- Changes

in good health

The Norfolk and Waveney Health and Care Partnership

Risks

Risk	Likelihood	Severity	Mitigation
Loss of democratic accountability	Low	High	• Ensure that governance through democratic structures remains clear • Section 75 in place to govern and monitor structural relationships with NHS partners • Ongoing review of Section 75 will provide further scrutiny the effectiveness of this. • Member involvement with STP/ICS development and of the Health & Wellbeing Board
Failure to deliver NCC statutory requirements	Medium	High	• Clarity around NCC priorities and responsibilities • Establish clear performance indicators and ensure robust monitoring • Clear guidance and support provided to NCC officers involved in developing integrated ways of working locally
Potential funding shortfall for Adult Social Care due to integration of capital and revenue budgets between the Council and NHS. NB on ASC risk register.	3	5	• Section 75 agreements in place to manage forward planning and joint arrangements • Partnership Boards in place • Introduction of Improved Better Care Fund • Regular monitoring and liaison with health partners on outstanding debt
Dominance of NHS culture and medicalised models of delivery	High	Medium	• Senior leadership creates greater visibility of local authority culture and approaches • Challenge at senior level • Organisational development to support culture change

in good health

The Norfolk and Waveney Health and Care Partnership

Risks continued

Risk	Likelihood	Severity	Mitigation
Reputational damage arising from NHS problems with a number of Trusts in special measures and financial insecurity.	Low	Low	• Being alert to upcoming issues • Joint communication and press activity through the STP
Potential for integration to impact on reputation through pressure on integrated staff/ joint teams regarding capacity and focus on departmental priorities impacting on reputation / ability to deliver. NB on ASC risk register.	Low	Medium	• Pressure closely monitored by ADs and escalated to Director Integrated Services. • SMT monitor and consider the implications and costs across both organisations. • Issues can be escalated to S75 Monitoring Board for resolution. • Budget and performance metrics and holding to account sessions are kept separate and focussed.
Loss of efficiencies by moving towards a localised approach to delivery at Primary Care Network level, rather than delivery on a countywide basis	Medium	Medium	• Evidence-led business approach to determining localised solutions and understanding implications of moving away from countywide delivery mechanisms.
Delayed Transfers of Care (DTOC): A significant increase in DTOC might jeopardise additional integrated funding (iBCF) and have adverse consequences as well as for the quality of care This would further increase financial pressures on the health and social care system. NB on ASC risk register.	High	High	• DTOC Improvement Plan in place • Improved Better Care Fund is targetted, in part, on reducing DTOC • Winter plan in place to support co-ordination between health and social care and improved management of surges in demand

NCC ASSD Winter Planning 2019/2020

Laura Clear – Interim Director of Community Health & Social Care Operations

Promoting Independence

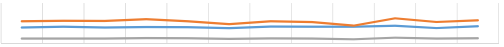
Why Winter Brings Pressure for Health and Social Care

Year on year increased demand due to:

- **Ageing population, with a significantly higher % of 85+ people** (frailty and risk of emergency admission increase with age).
- **Increasing numbers of people with long-term health condition** - 38,000 people currently with 4 or more long-term conditions, increasing to 48,000 by 2026.

Winter, primarily due to the impact on breathing illnesses, flu and norovirus strike, adds extra pressure, demand typically peaking in January.

Monthly trends in key indicators of demand in health and care services



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Total Non elective admissions to hospital (all reasons, aged 18+)	7,767	8,195	7,761	8,016	7,954	7,471	8,237	8,127	8,128	8,627	7,459	8,397
Adult Social Care contacts	10,885	11,154	11,054	11,894	10,886	9,469	10,893	10,476	8,689	12,337	10,494	11,397
Adult Social Care referrals	2,236	2,272	2,216	2,494	2,374	2,048	2,363	2,264	1,889	2,689	2,259	2,428

System Challenges

- Rurality of the County – impact of limiting **access to healthcare services**.
- Issues of **available workforce** to deliver care across all settings.
- Increased numbers of people living with **chronic illness**, linked to our ageing society plus issues of obesity (recent data is of 2 in 3 adults in Norfolk are overweight).
- Challenges due to the **high prevalence of Dementia** (reflecting the older demographic in certain areas) thereby increasing demand for services and packages of care. An NCC report in 2018, detailed **47% of Long Term Care Home** admissions relate to issue of mental health/dementia.
- A Care Market which has **increased demand from complexity** whilst also attempting to **maintain Quality**. At any point in Norfolk, around 80 homes, circa 23%, will require improvement.
- Provision of **extra care housing** in Norfolk is currently low.

In Winter 18/19, despite favourable weather and no flu, the system operated close to, or over capacity with the impact of:

- **None of the acute hospitals met their 4hr A&E target.**
- **NHS and Social Care delayed transfers of care (DToCs) increased. For NCC ASSD this represented the third year of increase.**

NCC ASSD Winter 18/19 Response

- Alongside NCH&C, engaged with the development of a System Winter Room.
- Actively re-directed resources and implemented policies, that addressed delays.
- For Social Care, introduced a new`Opel' escalation process.
- Jointly developed with NHS colleagues an improved data set.
- Admission avoidance work including the development of NEATs and a frailty `toolkit'
- Actively engaged with the provider market, including developing a `bed tracker'
- Increased capacity to crisis-focused social care services (reablement and short term services) by increased investment including iBCF and Winter Pressures Grant (WPG).
- Partnership work with Districts on a number of initiatives, including District Direct which provides support to people who have a housing need adversely impacting on hospital discharge.
- Within the High Impact Change Model, achieved established status for our Trusted Assessment Facilitators and Enhanced Health in Care Homes work streams.
- An increased focus on support for Carers.

NCC ASD Winter 18/19 Data

Adult Social Care Provision (% variance from annual average rates over time)

System Approach - Demand Management

STP Vision

- Together, we will build healthier communities in Norfolk and Waveney.
- We will provide high quality and responsive health and care services.
- We will be there for our people when they are vulnerable, regardless of age or ailment.
- We will make it easy for people to access our services to enable people to lead happy and healthy lives.
- Working in partnership we will provide sustainable services through an empowered workforce.

This **vision is underpinned by clear priorities**, all of which aim to **increase personal and community resilience** and **reduce reliance on acute care**.

System Approach - Resilience & Prevention

NHS

- An increased focus on developing interventions based on Population Health Data & Risk Stratification. A move to proactive rather than reactive health care.
- Partnership working on various schemes, to improve health but also reduce reliance on acute care.

Public Health

- Established programme of health interventions.
- Review of the 2015 Community Resilience Strategy which involves working with 60 Parish Councils through the Norfolk Resilience Forum to refresh and review the Strategy, extending its reach away from crisis response to more generally building resilient communities, also factoring in climate change.

For NCC ASSD, our Promoting Independence Strategy

NCC ASSD – Promoting Independence Strategy

Independent

- New model of strength based Social Work – a focus on a persons strength, personal networks and connections.
- Reablement – ongoing development of and investment in Norfolk First Support (including Swifts).
- Improved Assistive Technology Offer.

Resilient

Wide programme of work to promote resilience and wellbeing including:

- Development of the Norfolk Directory
- Social Prescribing/Social Isolation
- Working in partnership on a range of Activity based/Health improvement programmes.

Well

- An increasing focus on admission avoidance, including the development of NEATs.
- Improved multi disciplinary team working to identify people at risk of admission.
- A focus on the role of Carers.

NCC ASSD Winter Planning 2019/20

- Utilise Winter Pressures Grant (WPG) (later slide).
- Joint Planning with NCH&C.
- Delivery Plans to ensure wider NCC support for Social Work Operations during periods of escalation. The development of ODP's factoring in also workforce resilience (flu vaccination etc.).
- Build further on the effective interventions from last year, including increased investment in Reablement (home and bed based) & Enhanced Home Support.
- Continue with our plans to improve Dementia and Carer support plus our work with Care Homes, the implementation of ebrokerage and new discharge standards and contract terms.
- Implement the new model of Social Work with the NNUH and QE Hospital Social Work teams with aligned process changes to simplify process.
- Work across the System to develop to `established' status within the High Impact Change Model with a specific focus on `Home First'

Leaflet....Communication.....Training....

Animation at : https://youtu.be/kosX_zXCKwI

homefirst

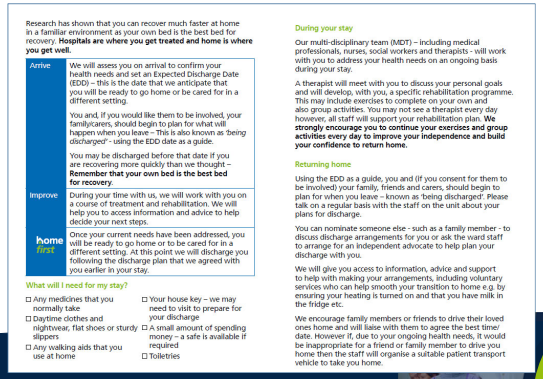
Media Release

Web Copy

Social Media

Banners/Posters

Direct Comms



Research has shown that you can recover much faster at home in a familiar environment as your own bed is the best bed for recovery. **Hospitals are where you get treated and home is where you get well.**

Arrive

We will assess you on arrival to confirm your health needs and set an Expected Discharge Date (EDD) – this is the date that we anticipate that you will be ready to go home or be cared for in a different setting.

You and, if you would like them to be involved, your family/carers, should begin to plan for what will happen when you leave – This is also known as 'being discharged' - using the EDD date as a guide.

You may be discharged before that date if you are recovering more quickly than we thought – **Remember that your own bed is the best bed for recovery.**

Improve

During your time with us, we will work with you on a course of treatment and rehabilitation. We will help you to access information and advice to help decide your next steps.

home first

Once your current needs have been addressed, you will be ready to go home or to be cared for in a different setting. At this point we will discharge you following the discharge plan that we agreed with you earlier in your stay.

What will I need for my stay?

- ☐ Any medicines that you normally take
- ☐ Daytime clothes and nightwear, flat shoes or sturdy slippers
- ☐ Any walking aids that you use at home
- ☐ Your house key – we may need to visit to prepare for your discharge
- ☐ A small amount of spending money – a safe is available if required
- ☐ Toiletries

During your stay

Our multi-disciplinary team (MDT) – including medical professionals, nurses, social workers and therapists - will work with you to address your health needs on an ongoing basis during your stay.

A therapist will meet with you to discuss your personal goals and will develop, with you, a specific rehabilitation programme. This may include exercises to complete on your own and also group activities. You may not see a therapist every day however, all staff will support your rehabilitation plan. **We strongly encourage you to continue your exercises and group activities every day to improve your independence and build your confidence to return home.**

Returning home

Using the EDD as a guide, you and (if you consent for them to be involved) your family, friends and carers, should begin to plan for when you leave – known as 'being discharged'. Please talk on a regular basis with the staff on the unit about your plans for discharge.

You can nominate someone else - such as a family member - to discuss discharge arrangements for you or ask the ward staff to arrange for an independent advocate to help plan your discharge with you.

We will give you access to information, advice and support to help with making your arrangements, including voluntary services who can help smooth your transition to home e.g. by ensuring your heating is turned on and that you have milk in the fridge etc.

We encourage family members or friends to drive their loved ones home and will liaise with them to agree the best time/ date. However if, due to your ongoing health needs, it would be inappropriate for a friend or family member to drive you home then the staff will organise a suitable patient transport vehicle to take you home.

Norfolk County Council

NCC ASSD Supporting the System in Winter 2019/20

*NCC Funding & BCF/iBCF Funding for initiatives is not included within this detail.

Key Area	Description	2019/20 Provision Grant Allocation
Supporting price increases, provider failure and purchasing	Support to meet higher purchase of care pressures than planned. Invest in Market Capacity to Support Care Sector in the event of market failure.	2.422
Managing Transfers of Care	Projects/Resources to improve flow and process, including additional staff, staff training and communications (primarily Home First but including Enhanced Health in Care Homes). Additional resources to support recruitment. Extend Assistive Technology offer to Hospital Teams. Increased/improved bed provision. Individual packages of support to incentivise providers. Support for District Direct Service. Enhance capacity of EHSS to operate more directly in a preventative role.	1.666
Out of Hours Emergency Support	Additional AMHP cover in EDT. Expand/Extend Swifts Offer.	0.090
	19/20 Winter Pressures Grant Value	**4.179**

Any Questions?