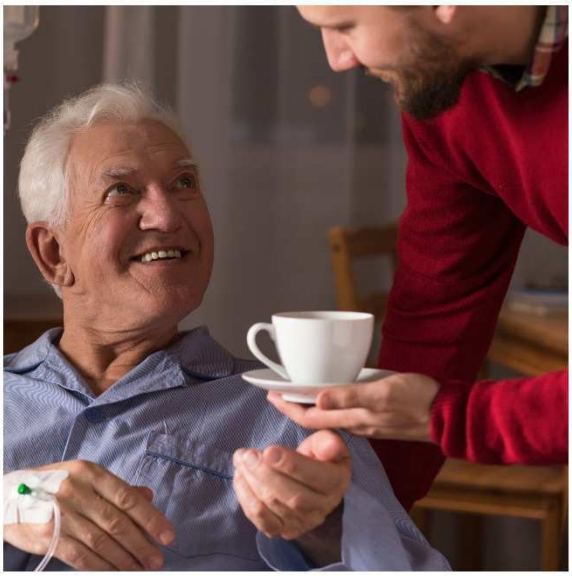
Norfolk County Council

Norfolk Health and Social Care System: high level summary and context for the LGA Peer Review September 18th to September 21st 2018



Norfolk County Council

Norfolk context

Demographics

Norfolk's population is around 892,900 and is expected to **rise to over a million by 2036.**

In the main, **Norfolk has an ageing population**, it is expected that around 26% of the population will be aged 65 and over by 2024.

The 85+ population is projected to grow significantly with a 34% increase by 2024.

Adult Social Care

341 active residential and nursing care homes

- 4 rated outstanding
- 257 rated good
- 68 rated requires improvement
- 12 rated inadequate

118 active domiciliary care agencies

- 1 rated outstanding
- 95 rated good
- 20 rated requires improvement
- 2 rated inadequate

GP practices

88 active locations

- 10 rated outstanding
- 75 rated good
- 3 rated requires improvement

All rating taken during 2015-18

Acute and Community Healthcare

Hospital admissions (elective and non-elective) of people of all ages living in Norfolk were to:

Norfolk and Norwich University Hospital NHS Foundation Trust

- Received 51% of admissions of people living in Norfolk & Waveney Wellbeing service area
- Admissions from Norfolk H&W service area made up 94% of the trust's total admission activity
- Rated inadequate overall (06/2018)

James Paget Hospital NHS Trust

- Received 18% of admissions of people living in Norfolk & Waveney Wellbeing service area
- Admissions from Norfolk H&W service area made up 98% of the trust's total admission activity
- Rated good overall (12/2016)

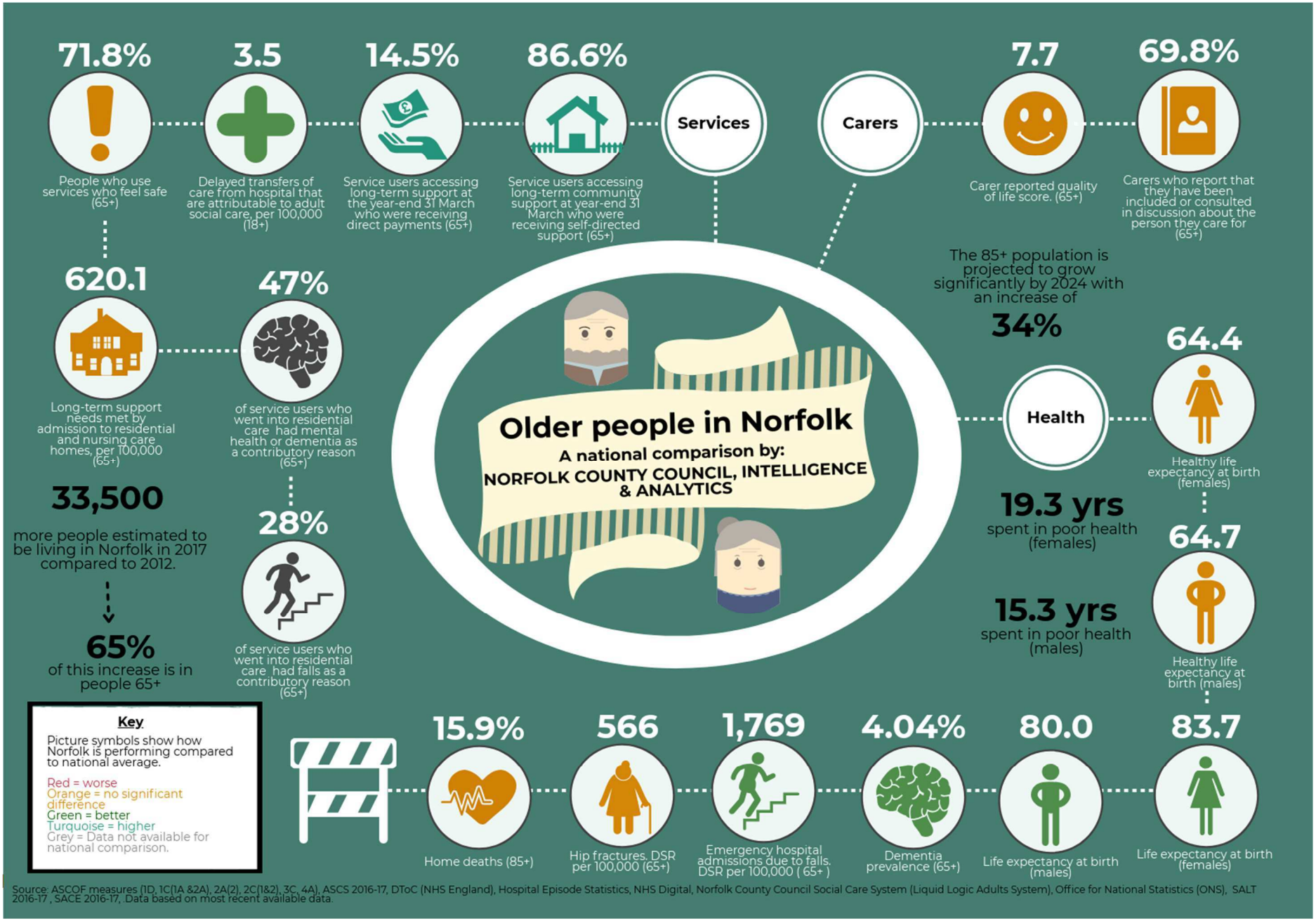
The Queen Elizabeth Hospital NHS Foundation Trust

- Received 24% of admissions of people living in Norfolk & Waveney Wellbeing service area
- Admissions from Norfolk H&W service area made up 71% of the trust's total admission activity
- Rated requires improvement overall (07/2015)

Community services were provided by:

- Norfolk and Suffolk NHS Foundation Trust, rated inadequate overall (10/2017)
- Norfolk Community Health and Care NHS Trust, rated as outstanding overall (06/2018)
- East Coast Community Care, rated as good overall (03/2017)

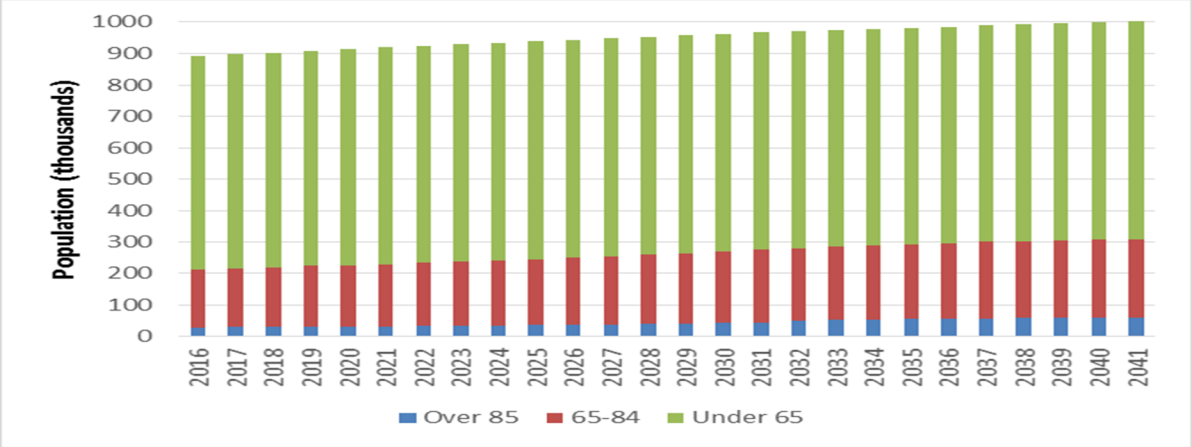
Norfolk County Council



Source: ASCOF measures (1D, 1C(1A &2A), 2A(2), 2C(1&2), 3C, 4A), ASCS 2016-17, DToC (NHS England), Hospital Episode Statistics, NHS Digital, Norfolk County Council Social Care System (Liquid Logic Adults System), Office for National Statistics (ONS), SALT 2016-17 , SACE 2016-17, .Data based on most recent available data.

Demographic Trends for Norfolk

By 2021 the population of people aged over 65 years old will increase by 16,000 in Norfolk and the population of those aged over 85 years old will increase by 2,900. This is a strength because older people are often an asset to our communities, however, older age is often associated with multiple long term health conditions that can adversely impact people's wellbeing, as well as increasing health and social care cost.



Demand

Critically, **the 85+ age group is Norfolk's fastest growing, and it is this age group which has most impact on demand:** between 2015 and 2030 this age group will increase by 77%. People aged 85 and over currently make up about 4% of the population, but account for 16% of all emergency admissions to hospital and over 54% of the admissions to long-term residential and nursing care in Norfolk.

Older people are also more likely to have **dementia**. Over the past five years, Norfolk has experienced increasing levels of people with dementia. Rates of deaths ascribed to dementia have notably increased, accounting for 20% of deaths in women and about 10% of deaths in men in 2016, making this the leading cause of death in women and the second leading cause of death in men, following heart disease.

Falls are the largest cause of emergency hospital admissions for older people and there were almost 1,300 in Norfolk as a result of hip fractures in 2015/16. Common reasons that people are admitted into long term residential care includes falls (28%), and dementia and mental health issues (47%).

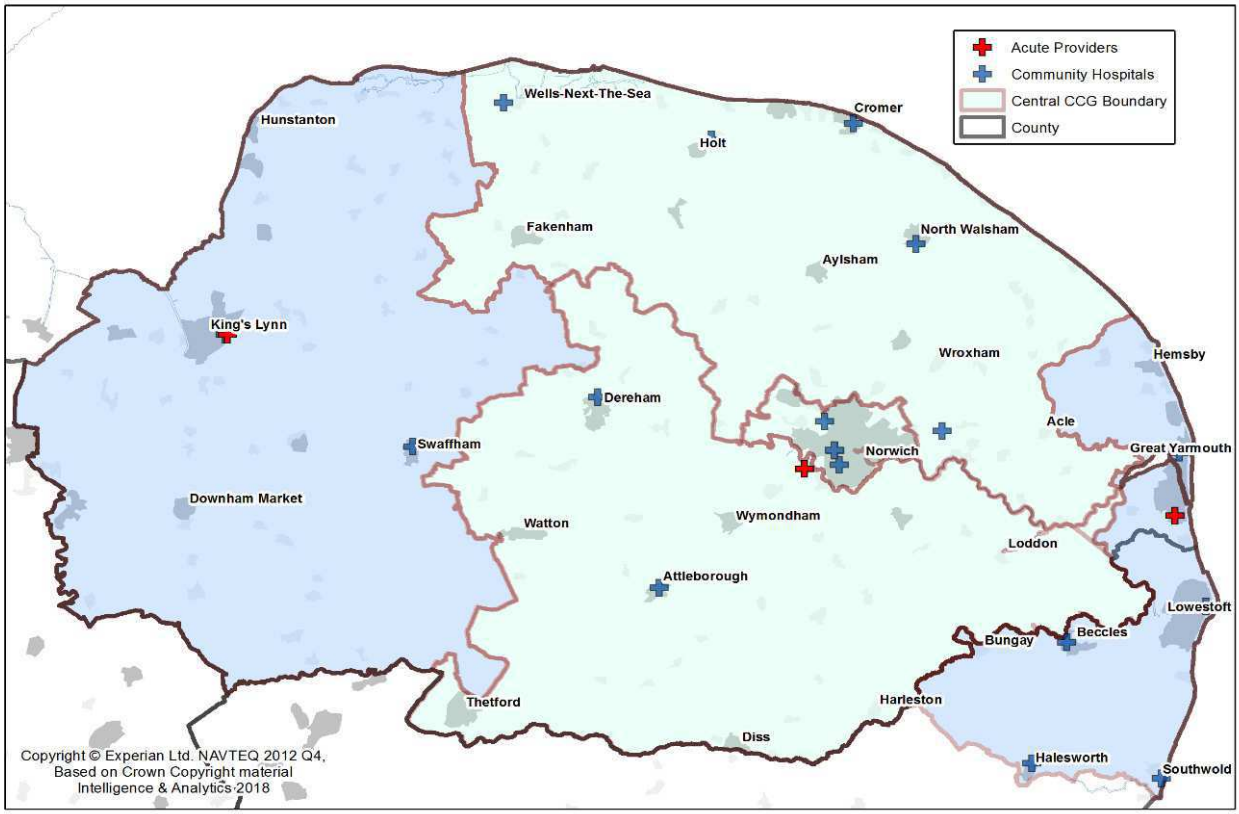
People with **learning disabilities** are living to a much older age. Whereas once relatively few people with a learning disability would live beyond the age of 65, around 12% of people being supported by a learning disability team are now over 65.

Wider social factors are also significant in influencing demand. These include people's general health and wellbeing, their income, particularly given that social care is subject to financial eligibility; and loneliness and isolation – evidence

suggests that people that are at risk of loneliness may be more likely to seek care. Recent analysis suggests that overall there is very low social mobility in five of the seven district areas, which also has a bearing on the future demand for care. People have told us they want to be able to find affordable support easily and in their own communities.

- We spend about **£1 million** a day on adult social care in Norfolk
- On any given day, we will be securing services to around **14,000 people**
- We begin intensive reablement to help **14 people** a day get back on their feet after a crisis
- Every day we receive new calls, new enquiries: equivalent to almost **200 a day**
- Last year **20,205 people** received short term or long term adult social care packages

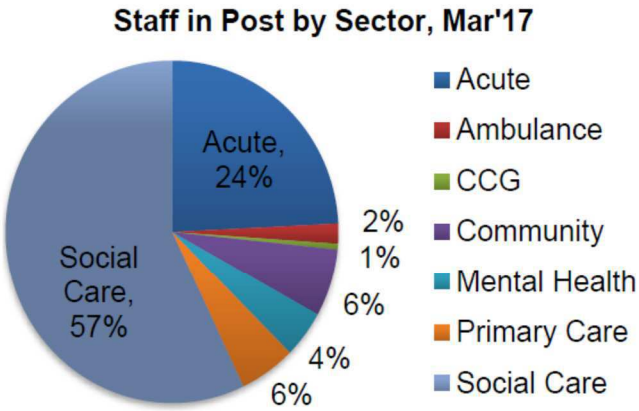
Health care in Norfolk is provided through five CCGs, three acute hospitals and numerous community hospitals. The map below shows Eastern and Western CCGs in blue and the 'central belt' of Norwich, Southern, and North Norfolk CCGs in green. The acute hospitals are: Queen Elizabeth Hospital in King's Lynn, Norfolk and Norwich University Hospital in Norwich, and James Paget University Hospital in Great Yarmouth.



Workforce

The charts below provide an overview of Norfolk's health and social care workforce, over half of the workforce is in social care.

Sector	Staff in Post FTE Mar'17	% Vacancy Mar'17
Acute	11,882	7%
Ambulance	932	under review
CCG	267	n/a
Community	3,154	8%
Mental Health	2,180	13%
Primary Care	2,674	n/a
Social Care	28,000	6% (Sep'15)
Total	**49,090**	**8% (NHS)**



Source: Staff in Post: ESR (Mar'17), General Practice Tool (Mar'16), Skills for Care NMDS (Sep'15); Establishment forecast for Mar'17: NHS Trust Operating Plans (Dec'16), Workforce Plans (Jun'16) (Vacancies = Establishment – Staff in Post)

Norfolk County Council Workforce

Like many authorities, we face a continual challenging in recruiting social care staff. Unlike more central urban areas, people working in Norfolk generally need to commit to living in the county; within the county there are also pockets where it is hard to recruit – for example, North Norfolk and West Norfolk.

The Council agreed to increase social work capacity by 50 fte and in the last year we have developed and enhanced our recruitment and marketing approach to rise to this challenge.

We now have a rolling recruitment campaign, with dedicated support, which has embraced new approaches: These include:

- Promoting Independence Norfolk microsite as a central location for all posts to be advertised.
- Use of search marketing to drive internet traffic to the above site.
- Offer of relocation package for anyone relocating to Norfolk.
- Production of 4 videos promoting life as a particular professional in Norfolk (Exec Director, Social Work TM, Occupational Therapist TM, ASYE Social Worker (NIPE).
- Use of Google analytics to measure the effectiveness of the approaches used and tailor approach accordingly e.g. what method of advertising has been most effective.
- Norfolk Institute Practice Excellence (NIPE) – dedicated team to support newly qualified Social Workers with their ASYE year. Community Care Live – stand at the event, manned by frontline practitioners.

- Targeted local rolling recruitment for Norfolk First Support.

As a result we have recruited 14 (out of 15) team managers and 47 social workers and occupational therapists. Whilst we still have vacancies, these are caused by the usual turn-over.

In the wider care market, there are significant recruitment challenges. In response to this, we are cautiously optimistic of success in an £8m joint bid with Suffolk County Council for European Funding through the ESF to deliver a joint training programme focused on person-centred care and promoting independence within the wider care sector workforce.

There will be a three-year programme which will;

- improve access to higher qualifications among the health and social care workforce.
- map career pathways and qualification routes to enable workers to move into leadership and specialist roles (e.g. dementia, mental health, learning disabilities and autism, end of life).
- deliver direct intervention to support progression, through personalised mentoring
- directly support retention of staff in a vital sector of the economy. Indirectly we expect that the project will improve the attractiveness of the sector, supporting recruitment too in the longer term.

Commissioning strategies have been developed to address the short-fall in workforce and have hinged on the need to increase the status and pay rates for care workers. An example of this is the home care strategy which aims to support and incentivise providers to collaborate on rounds and staffing, in return for a payment premium.

Care market in Norfolk

The care market in Norfolk is wide-ranging and diverse. In total there are around 700 individual providers, ranging from small family run residential homes, to national specialist providers for a range of needs.

There are challenges around the quality of care; across the sector. CQC inspections indicate that 75% of providers have been rated as good, 21% as requires improvement and 3% rated as inadequate. Whilst improvements have been made, we have recognised the need to accelerate improvements and will implement a proactive inspection regime that focuses on the 100 or so providers who are struggling to maintain good quality. The proactive inspections will need to reach the whole market in a three yearly cycle.

We have in place a robust and transparent cost of care annual review to set fee levels across the market; with above inflation rises in recent years to fund the national living wage and a more significant readjustment for older people residential care which has seen an increase by 21% in usual prices over the last three years - a policy decision by Adult Social Care Committee in recognition of the challenging operating context for providers. The Council committed £11.7m from the improved better care fund to support market stability, focused on cost of care and national living wage pressures, as well as specific improvements to the home support price framework and helping providers facing un -planned sleep-in payments.

The current cost of care exercise is considering the outcomes of a number of CQC inspections and is building on the need to increase effective administration – reflecting the importance of accurate record keeping – but also the increased hours of care and support that an increasingly frail population requires.

We have seen a small, but significant increase in the number of homes closing, largely as a result of adverse CQC inspections. We have a highly effective response when providers withdraw from the market, but we recognise the need to do more to prevent unexpected and unforeseen closures. We are confident that changes in our Quality Assurance and markets team will increase capacity and strengthen the market assurance function.

Our main challenge in provision is the need for more enhanced residential and nursing care, to respond to the increasing prevalence of dementia. Providers tell us that recruitment for this field is challenging, particularly nurses. We are currently embarking on an ambitious reset of our residential and dementia care strategy. The approach will be to focus on the need for incentivising increasing capacity of nursing and dementia.

Co-productive cost modelling with providers will ensure that the prices we pay are enough to secure quality services, including a possible workforce premium payment linked to reducing stubbornly high turnover rates in care home and home markets.

We are currently poised to refresh and re-launch meaningful engagement at a strategic level with providers, establishing a formal Care Association which will provide oversight and support to providers and the care workforce. This work goes hand in hand with the European Social Fund bid (see above) and work with the Local Enterprise Partnership, which seeks to combine workforce improvements and built environment improvement into once coherent growth strategy.

NorseCare

In 2011 Norfolk County Council created NorseCare, a company wholly owned by the County Council, operating within the Norse Group. The company was created to operate all NCC care homes and provide care into previously NCC run housing with care schemes. NorseCare operates under a contractual relationship with NCC

Much has been achieved through Norsecare. The company is the largest single provider of residential and housing with care services in Norfolk. Norfolk County Council (NCC) spends nearly £290 million a year in the care market, of which just over £34 million is with NorseCare; this represents 13% of NCC's total investment in residential care and 98% of NCC's investment in Housing with care.

As a strategic partner, we are able to work with Norsecare to shape and plan for the strategic direction of care. An early improvement was the re-organisation of homes in Norwich and Great Yarmouth and the development of flagship care for people with dementia and housing with care. Quality is high throughout the company, and we are able to benefit from the scale and capacity of the company to support market failure. Recently this saw the short-term placement of a Norsecare manager into a home to avoid crisis and ensure the smooth transfer of people to new placements.

NorseCare plays an important role in delivering Adult Social Services' strategy for change, Promoting Independence. Since the contract was started, the operating context for the Council, and the wider care market has significantly changed. As a result, we have refreshed the original contract to ensure NorseCare provision is fit for the future and closely aligned to support the strategy.

Financial context

Like all local authorities, Norfolk Adult Social Services faces significant financial challenges.

The County Council has prioritised protection of adult social care, taking the full social care precept since 2017/18. In that year, Members effectively re-based the adults budget to ensure a sustainable position from which to accelerate substantial transformation. This saw the re-profiling of previously agreed savings, and additional monies into the base budget to address increasing costs.

The Council's investment in adult social care in 2017/18 meant that the improved Better Care Fund grant announced in Spring 2017 could be used proactively to support the health and social care system. Plans agreed with health partners recognised the need for funds to protect social care and help the market for future years, but were also able to support new invest to save initiatives. The Council has set up an IBCF reserve to enable schemes to be implemented and evaluated over two to three years. Examples include accommodation based reablement, enhanced home support service, trusted assessors, targeted support for mental health discharge, social prescribing and increasing capacity of social work teams to implement a new approach to social work.

There is political backing for the approach to transformation, and robust financial management and oversight. Our strategy for achieving balance is driven by demand management, supported by maximising income, relentless focus on efficiency and judicious use of invest to save.

The Council has taken every opportunity to make the case for more investment specifically for Adult Social Services, as well as the broader case for fair funding for Norfolk as a whole. There was unanimous agreement from Full Council to lobby the Government on funding for Adult Social Care, and a clear, detailed response from Adult Committee on the Call for Evidence from Health and Communities and Local Government committees for their joint inquiry into long term sustainable funding of social care. Local MPs have been kept briefed about Council's position.

Most recently the chairman of Adult Social Services Committee has welcomed the reports from the LGA and County Councils Network and urged the Government to come forward with a long-term sustainable financial solution.

At the same time, Adults has needed to achieve the lion's share of a whole-council savings programme. Since 2011, we have made £96m net savings. We have firm plans for a further £54m, and we are currently working up plans for an additional £39m.

In 2017/18 we had an underspend of £3.696m, which equates to a 1.37% variance on the budget. As part of the outturn, we were able to set aside £4.5m into a business risk reserve in order to support invest to save, or smooth the profiling of other challenging savings.

In 2018/19, we have savings of £27m which is highly challenging. £22m of those savings are on track, but we have identified £5m (mainly around Learning Disability) as high risk of non-delivery. Our current budget forecast is for an overspend of £1.99m.

The strong business case for prevention has seen the Council not only protect existing prevention spend, but increase spending where there is a clear benefit in line with Promoting Independence. Our unique non-statutory Swifts services has been sustained; we are continuing to expand home based and accommodation based reablement, some of which is now funded by CCGs. We are increasing

investment in assistive technology to extend the reach and offer; wider council services (beyond adult social services) are targeting their information, guidance, prevention so that it supports our prevention agenda.

Overall vision and strategy

In response to the challenges we face in Norfolk, we have clear vision for adult social services:

To support people to be independent, resilient and well

To achieve our vision, we have a strategy – **Promoting Independence** – which is shaped by the Care Act with its call to action across public services to prevent, reduce and delay the demand for social care. It is also a positive response towards managing what is a difficult financial climate for public services. It does not see a retreat to a statutory minimum but ensures that we manage demand and have a sustainable model for the future, at the core of which is quality social work which builds on the strengths of individuals. There are three main elements:

Prevention and early help – empowering and enabling people to live independently for as long as possible through giving people good quality information and advice which supports their wellbeing and stops people becoming isolated and lonely. We will help people stay connected with others in their communities, tapping into help and support already around them – from friends, families, local voluntary and community groups. For our younger adults with disabilities, we want them to have access to work, housing and social activities which contribute to a good quality of life and wellbeing.

Staying independent for longer – for people who are most likely to develop particular needs, we will try and intervene earlier. Certain events, such as bereavement or the early stages of an illness like dementia can be a trigger for a rapid decline in someone's wellbeing, but with some early support we can stop things getting worse and avoid people losing their independence and becoming reliant on formal services

Living with complex needs – for some people, there will be a need for longer term support. This might mean the security of knowing help is on tap for people with conditions like dementia, and that carers can have support. We will look at how we can minimise the effect of disability so people can retain independence and control after say a stroke or period of mental illness. For some people, moving into residential care or to housing where there are staff close by will be the right choice at the right time, but such decisions should be made with good information and not in a crisis.

Our priorities for change and transformation are

- **Building capacity and living well**, the Living Well - 3 conversations approach and the recruitment and project activity that will provide the capacity to delivery this model and remove the backlogs
- **Learning disabilities** the range of projects focused on promoting independence and delivering savings for individuals with learning disabilities
- **Integrated short-term support**, the establishment of schemes to deliver against the Better Care Fund and High Impact Change Model alongside other projects that are targeting reductions in Delayed Transfers of Care and improvements to the interface between Health and Social Care
- **Technology enabled services**, the development of the Technology Enabled Care Strategy including the future role of assistive technology will ensure that decisions to commit future savings targets to these areas are based on robust evidence
- **Housing** – 10 year Programme to stimulate the development of 2800 Extra Care units, investing NCC land and capital where appropriate, to meet future forecast need and support older people to stay independent in their local communities. This is in partnership with district councils, social landlords, developers and providers

We are committed to a **new model of social work** which will require radical changes to teams and processes. Living Well; Three Conversations has been developed by Partners for Change who have helped us the model to a series of innovations sites. We have tested it, refined it and developed our own workable model which stays true to the philosophy and delivers the right outcomes in our context.

The model is backed up by **investment in 50 additional social work and occupation therapy staff**, to both address the unacceptably high volume of backlogs and to recognise the need for more face to face time for the Living Well model. We analysed patterns of social work and associated activity across the county to understand better current workloads, practices, challenges and barriers, and set a target for bringing down the backlog over two years. This is having an impact – backlogs are down from a peak of around 3000 to around 1800.

Key performance and benchmarking

For over 65s, our data shows that in comparison with our statistical family, we have:

- Lower than average contacts
- Higher than average number of people using short-term support
- High than average reablement from hospital
- Lower than average numbers in long-term support
- High than average permanent admissions – although this has significantly reduced.

Norfolk County Council

	Key Performance Indicators (adapted from ASCOF with additional local and integration KPIs)				
2					
3	Indicator	Current Result	2017/18 Result	2016/17 Result	Latest Family Group Average
4	**Enhancing quality of life for people with care and support needs**				
5	% of people who use services who have control over their daily life	-	76.3%	79.30%	79.40%
6	Adults (18+) receiving self-directed support	-	82.9%	90.9%	86.9%
7	Carers receiving self-direct support	-	89.5%	85.9%	82.9%
8	Adults (18+) receiving direct payments	-	28.8%	30.5%	33.0%
9	Carers receiving direct payments	-	88.6%	85.2%	73.6%
10	% of people who use services who reported that they had as much social contact as they would	-	41.0%	49.3%	46.4%
11	% of carers who reported that they had as much social contact as they would like	-	-	32.0%	34.6%
12	**Delaying and reducing the need for care and support**				
13	% of adult social care cases that go on to assessment	34.1%	36.3%	-	-
14	% of those in settled accommodation 91 days after completing reablement	95.9%	90.5%	93.5%	83.8%
15	% of people who require no ongoing formal service after completing reablement	70.5%	74.4%	-	-
16	% of short term services within an outcome of "no ongoing support" or "low-level support"	-	81.5%	84.3%	79.8%
17	65+ Admissions to permanent residential/nursing care per 100,000 population	607.9	644.6	633.4	598.5
18	Number of days delay in transfers of care per 100,000 population (attributable to social care)	3.9	3.7	3.2	8.3
19	Emergency admissions to hospital (65+) per 100,000 population (65+)	-	22,336	-	23,403
20	**Ensuring that people have a positive experience of care and support**				
21	No. unallocated cases awaiting assessment (holding list)	1,836	2,565	2,710	-
22	% of people who use services who are satisfied with their care and support	-	63.8%	64.8%	67.1%
23	% of people who use services who find it easy to find information about services	-	72.2%	73.2%	74.3%
24	% of people who use services who stated that people involved in their care and support worked well together (additional question to statutory survey)	-	86.0%	-	-
25	**Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm**				
26	The proportion of people who use services who feel safe	-	66.8%	70.3%	70.6%
27	The proportion of people who use services who say that those services have made them feel safe and secure	-	79.0%	83.3%	87.5%

To monitor the effectiveness and impact of our Promoting Independence strategy, we track 7 high level indicators which align with the key intervention points of the strategy. Stretching targets have been set against these:

Cases that lead to assessments - Leading practice in social care suggests that a quarter of contacts to social care should translate into a formal care act assessment, and more people are supported with advice, information and prevention. Our target is 25% and currently performance is 34.75%.

Assessments which go onto services - Our new model of social work which looks at the strengths of an individual, should lead to fewer full Care Act assessments taking place, as we work to support people earlier. However, where assessments do take place, good practice suggests that a greater proportion are likely to require formal services, since other sources of support will have been already sought. Our target is 85.32%and current performance is 51.91%.

Effectiveness of reablement - Reablement continues to be a major factor in promoting people's independence and preventing people from needing intensive on-going formal care. Recent analysis suggests that approximately only 20% of people who have received reablement services from Norfolk First Support need ongoing local authority funded long term services. Furthermore, for those that do require services, we typically see a 24% reduction in the service requirement. Our target is 69% and current performance is 67.28%.

Reviews that lead to reduced services - We are currently carrying a backlog of work, much of which is made up of reviews. We have two targets associated with this measure reflecting two key groups of people – people aged 18-64, and older people (65+). For people aged 18-64 our target is 43.21% and our current performance is 11.81%, for older people our target is 20.98% and our current performance is 15.07%.

Rate of permanent admissions - Our target for this represents a significant improvement from being around the median to being one of the lowest 'placing' Councils in Norfolk's family group. For people aged 18-64 our target is 15.6 per 100,000 of the population and our current performance is 22.92. For older people our target is 594.3 per 100,000 of the population and our current performance is 607.93.

Holding lists - We have modelled a reduction in this which sees the most significant reduction in 2018/19 and 2019/20 through a combination of change. Current performance is 1,836 against a target of 618 by the end of 2018/19.

Delayed discharges of care - New targets have been allocated by the Department of Health and Local Government Association with an expectation of achievement by the end of September and beyond. For Adult Social care this is equivalent to about 729 total delays attributable to adult social care in a month. In June the figure was 930 delayed days.

Norfolk County Council

How well do health and social care services work together to support older people in Norfolk

Our detailed self assessment addresses the specific Key Lines of Enquiry and includes links to evidence. What follows here is a high level summary against the three main questions which form the scope of this Peer Review:

- Keeping people's wellbeing in their usual place of residence
- Crisis management
- Step down after crises, including reablement
- Return to usual place of residence or admission to a new place of residence

Keeping people's wellbeing in their usual place of residence

Norfolk has increased investment in prevention at the interface between health and social care at a time of significant budget pressures. Over the period 2016-19 our gross spend on prevention has increased by 33% from £15m to £20m during a challenging financial climate in which the department has had to make recurrent savings of £49.4m.

Many initiatives are jointly commissioned and funded and there is a strong practice of joint working across primary and community care.

There is a deliberate shift underway at the health and social care interface to proactively engage with people to support their wellbeing, prevent isolation, loneliness and connect people to support. The range of resources and services includes:

- The **Norfolk Directory** is a live and dynamic resource of all services across health and care for individuals, support workers and organisations.

- **Specialist advice and advocacy** - supports individuals to make decisions about their care. Harnessing the capacity and skills of other community-based advice services, such as Age UK, Mind and Carers Matters, using the **Norfolk Community Advice Network Referral System** which links to around 35 local agencies.

- **A growing network of development workers and local connectors** who have great knowledge of local resources support people to stay connected and involved in their community. This network encompasses our own social care development workers, community based staff funded through joint health and social care social prescribing funding, and local connectors who will support individuals to combat isolation and access community based services.

- We work proactively with Norfolk's seven District Councils to deliver an **Integrated Housing Adaptations Service** for residents. This shared service brings together skilled professionals to design and deliver housing adaptations

that support people to live independently in their own homes. This complements other district led initiatives including handy persons schemes.

Our integrated working and collaboration supports prevention and helps maintain independence for people we work with.

Joint management arrangements between NCC and Norfolk's main community provider, Norfolk Community Health and Care, enables resources to flex quickly across organisational boundaries. District nursing, therapists and social care workers are structured around GP clusters with link workers for most practices. Multi-Disciplinary Team Meetings are effective at reviewing support for the top 2% most at risk patients and occur monthly in many GP surgeries. These are overseen by **Integrated Care Coordinators** who undertake risk stratification, facilitate information sharing and links with community based resources.

There is a **joint assessment culture in the community**, with professionals at the interface undertaking joint visits or sharing judgements via a joint preventative assessment. In Norwich Locality a **single Therapy Service** has developed which brings together OTs and Physios from community health and social care. This enables a quick response and removes duplication. A single recording system pilot is currently underway for the service which allows joint triage and allocation of work across the team.

These efforts are reinforced by changes in social work practice. NCC is moving towards a **three conversations model of social work**, with conversation one focusing on connecting people with the things that help them get on with their lives independently, based on their community assets and strengths. We are exploiting the strong alignment between this and **health coaching** to create a model of early intervention for community based services.

Norfolk's health and social care partners are ambitious about tailoring care needs to the individuals in their local areas. **Local Delivery Groups** are focusing on the development of new models of care which will further integrate primary, community, social care, voluntary sector and district council provision.

We play a strong **leadership role** in the STP so that we are able to influence a whole-system approach to early intervention and shift to spending on primary and community services. The Executive Director leads the primary and community workstream, and the Director of Public Health leads the primary sub group

Challenges

- Embedding a common countywide approach to risk profiling patients, tightening up on MDT practice to reinforce relationships with link nurses and social workers and include wider representation from the voluntary sector and housing.
- Continuing to address and bring down the backlog of work across Norfolk. Living Well innovation sites have demonstrated that this way of working can

drastically reduce holding lists. We need to implement Three Conversations in a way which achieves this at scale across the county

Crisis management

Norfolk has a good approach to crisis management, through a combination of universal county-wide services, and locally tailored responses developed with CCGs.

Norfolk Swift Response is a 24-hour service which provides help, support and reassurance if a person has an urgent, unplanned need at home but doesn't need the emergency services. It operates countywide and supports 14,000 people a year with referrals made by professionals and individuals. Whilst it is funded by Adult Social Services, its impact is across the health and social care system, saving money for the health service, complementing the work of the ambulance trust.

Multi-agency escalation avoidance teams – each CCG area has in place a dedicated service designed to avoid admission to hospital and address crisis. This is most advanced in Norwich where the Norwich Escalation Avoidance Team (NEAT) acts as a multi-agency coordination centre that responds to all urgent and unplanned health, social care and wellbeing events. Analysis demonstrates a **saving of £335 per referral** based on time savings, admission avoidance and prevention benefits. NEAT optimises system efficiency by streamlining pathways and eliminating duplication.

The main elements of this approach have been picked up across all CCGS; in north and south there is a supported care model; in the West there is a virtual ward approach, and in the East there is out of hospital This model is now being delivered across other locality areas.

A range of innovative services are commissioned at the interface to support people in crisis and keep them at home. The **Central Norfolk Early Intervention Vehicle** is a combination of ambulance practitioners, OTs and Physios. It supports falls patients to remain at home and ensures onward referral to appropriate care pathways. Analysis indicates that 20% reduction in transfer rates for those individuals treated by CNEIV when compared to normally staffed ambulances, translating to a saving of £232 per patient.

Health and social care organisations **work effectively together at the interface to manage provider failure** and help safeguard patients. In such situations joint visits and reviews as well as oversight from senior professionals through regular meetings ensures that concerns are managed effectively and adequate plans are executed to deal with issues.

The Norfolk System is engaged with the **Enhanced Health in Care Homes** framework as a basis for reducing admissions from care homes to hospital and is collaborating to support improvement in the quality of care offered. A care homes dashboard has been developed to show admissions to hospital, which has subsequently been adopted by NHS England. It highlights a reduction in avoidable

hospital admissions from care homes for 2017/18 compared to 2016/17 - 8.3% in North Norfolk, 35.3% in Norwich, 14.6% in South Norfolk and 15.8% in West.

Challenges

- Striking the right balance between locally tailored schemes and ways of working, and ensuring a consistent set of standards for Adult Social Care users across the county, regardless of where they live

Step down after crisis and return to usual place of residence

Over the last 18 months we have invested significantly in services which support people after a crisis.

The cornerstone of this is reablement. Alongside our CCG partners, we invest £7.4m a year on an effective Norfolk wide reablement service. **Norfolk First Support** provides free intensive assessment and reablement in a person's own home for up to six weeks. The service works with people to regain as much independence as possible following a crisis, and assists those affected by carer breakdown. Each additional £1 invested in home-based reablement saves £4.06, and outcomes for people going through the service are consistently good.

Homeward and virtual wards in Norwich and West Norfolk provide step-up and step-down care for people following crisis. Virtual ward in the west supports patients with early discharge from hospital and admission avoidance for those who could stay at home with the right support. The team of community-based nurses, social worker and therapists provide up to six days of support at a person's home.

Norfolk's **Enhanced Home Support Service** helps individuals to regain their independence, confidence and resilience following a crisis. The service is available for up to 7 days to support with over-night confidence, meal preparation, accessing community resources, assistive technology, medication monitoring and shopping.

For those who are unable to go home following a hospital stay, **Accommodation based reablement** – primary focus of the service is to reduce admission into long term residential care homes. The service works with people to ensure they regain their independence in a safe environment. People return to their usual place of residence or appropriate placement having completed a reablement programme. Includes GP input, OTs and physios. Every £1 invested in accommodation based reablement at Benjamin Court saves £3.12. Again, outcomes for people are good.

District Direct – a partnership between district councils, CCGs and the Norfolk and Norwich University Foundation Trust, works to fast-track adaptations to people's homes so they are return home safely and swiftly.

Despite this, Norfolk's DTOC figures remain high in comparison to other areas. A recent **Multi-Agency Discharge Event** created urgency around creating:

- A joint operations centre to monitor performance and activity, coordinate and manage escalation and liaise across system providers
- Improved communication at all levels around discharge, including with care home providers
- Greater awareness of services available to support individuals at home
- A stronger home first ethos among all staff

To tackle this, system change is underway through the implementation of **Discharge to Assess (D2A) pathways**. Cross organisational integrated pathways have been developed, with a focus on delivering culture change. Key principles agreed include no duplication of assessment, open sharing of data and sharing of care plans. D2A is being fully implemented at NNUH and all NCHC inpatient units.

Challenges

- Our Delayed Discharges of Care numbers are too high and despite short periods of relatively lower numbers, the underlying trend has remained high
- Admissions to permanent residential and nursing care for older people have plateaued, where we expected and modelled further reductions. We need to understand more about why this is.