Borough Council of King's Lynn & West Norfolk

Prevention and Promoting Independence -the District Council Contribution to the Better Care Fund Outcomes in Norfolk

Issue : 5

Martin Sands
10/04/18

Prevention and Promoting Independence
The district council contribution to the Better Care Fund Outcomes
1917/18 update

1. Introduction

This document is intended to show the activities and interventions of the District Councils in Norfolk that help residents to live independently at home, whether supporting them to continue living independently, enabling them to resume living independently after a stay in hospital or care home, or preventing the need for more serious interventions in the first place.

2. Document Overview

The document consists of a number of sections, the first section shows the activities and interventions that are common across all of the seven district councils in Norfolk. Then there are a further seven sections, one for each of the district councils, that show the activities and interventions that are specific to the individual councils. Those activities or interventions provided in the Better Care Fund/ Disabled facilities Grant Locality Plans are shown in *'italicised text'* to distinguish them from other activities or interventions provided.

Each of these sections contains a table that is split into three columns to indicate whether the activity or intervention is intended to help with "living well" (Prevent development of needs), "Maintain Independence" (Early Intervention), "Reablement at Home" (Reablement). Activities or interventions that fit into more than one heading are shown across multiple columns as appropriate.

The seven appendices are the specific BCF/DFG Locality plans produced by each of the seven district councils and integrated commissioners representing their Clinical Commissioning Group and Norfolk County Council. These contain the detailed descriptions of the activities and interventions being undertaken within these plans.

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<table>
<tr><th>Issue/Aim:</th><th>Living Well (Universal Pathway)</th><th>Maintaining Independence</th><th>Reablement at Home</th></tr>
<tr><th>Type of activity:</th><th>Prevention</th><th>Early Intervention</th><th>Reablement</th></tr>
<tr><td rowspan="5">Services/Initiatives Common to all District Councils</td><td colspan="3">Disabled Facilities Grant
Grant funded home adaptations recommended by and Occupational Therapist. Including improving access to bedroom and bathing facilities, cooking and food preparation, improving the safety within the resident’s home.</td></tr>
<tr><td colspan="3">Integrated Housing Adaptation Team – Continuous Improvement Plan
Review and amend existing processes to provide a more efficient and streamlined approach to providing Disabled Facilities adaptations. Agreed target for delivery is an average of 140 calendar days from initial enquiry to completion of the works.</td></tr>
<tr><td colspan="3">IHAT Housing Needs Reports –
Produce housing needs reports to support Housing Options team to identify suitable properties for those people who need an adapted/adaptable property.</td></tr>
<tr><td>Housing standards
Supporting residents to ensure that their homes are healthy and safe environments to live.</td><td></td><td>Housing Options
Enabling moves to more suitable accommodation, where appropriate.</td></tr>
<tr><td></td><td></td><td>Hospital Discharge
Working in partnership with hospitals to provide a common streamlined pathway for referral to ensure residents are able to return home or access suitable alternative accommodation prior to discharge from hospital.</td></tr>
</table>

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Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
Type of activity:	**Prevention**	**Early Intervention**	**Reablement**
Breckland District Council	***Discretionary Reable Grant*** *To broaden the eligibility criteria for the Breckland Discretionary Adaptation grant (Reable) to include a greater proportion of clients who can benefit from the streamlined service.*		
	Breckland Agency Service Establish a Breckland Agency service to extend the support offered to clients in the provision of adaptations.		
	Handyperson Service *Reintroduce a Handyperson Service for Breckland residents.*		
			Fast Track Hospital Discharge Process *Develop process to use the Discretionary Reable grant to fast track Hospital Discharge cases*
			Appointment at Triage *To introduce 'appointment at triage' stage to eliminate the waiting list for assessment.*

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Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
activity:	Prevention	Early Intervention	Reablement
Broadland District Council	**Handyperson Plus -** Provides a small repair and maintenance programme, including the introduction of minor adaptions to help vulnerable residents remain safe in their homes. Assessment and support procedure provides information and guidance. Referral procedure to community services, and advocacy for benefit claims.		
	HIA interventions - Providing support for vulnerable people to stay healthy and independent in their own properties. Assistance with major/minor repairs and adaptations. Ensuring incomes are maximised; assistance with benefit and charity applications referrals to ancillary services and for financial assistance.		
	GP Clusters and MDTs - *Identification of those most at risk of hospital admission at a GP surgery. Co-operation between Integrated Care Co-ordinators and HIA enabling a focused personal intervention with the individuals providing access to the range of housing and benefit related support that the District provides. Referral to other agencies to assist vulnerable people to remain living independently in their own homes.*		
	Energy Advice: - to keep vulnerable residents warm in their own homes.- Provide energy advice on costs, suppliers, insulation and affordable options. Provide access to financial assistance for system repair and replacement where available.		
	Early Help Hub - A multi-agency team located at the Broadland District Council offices working in partnership to advise, support and assist individuals and families. The aim is to work with individuals and families as early as possible to prevent the need for more formal responses. Other council departments link into the hub;		
	Debt and Welfare Advice		
	Community at Heart (inc Community Projects Officer) Takes a whole council approach to getting more closely involved with our communities, building productive relationships and raising awareness of key initiatives between communities and ourselves. Also aims to build more trust and understanding for residents in terms of the role of the council and see first-hand the work of the councillors they voted for. Link to external community roles and groups including those relating to Health and Social Care; for example, NCC Development Workers, Integrated Care Coordinators and Adult Social Care's 3 Conversations Assistant Practitioners Provides Secretariat function to the Broadland Dementia Action Alliance		
	Falls Prevention Slipper Exchanges as part of Local Public Health Offer(LPHO) activity	**Smoking prevention -** LPHO activity-Smoke free parks and sports pitches signs requesting adults refrain from smoking in these areas.	
	LPHO Activity - Excess Winter Death Prevention Activities include: Energy team attending Aylsham Age Wise event, Thorpe St Andrew Heat and Eat Event – direct mailing to recipients of Guaranteed Pension Credit, Slow Cooker workshop (attendees receive free slow cooker), stands from other organisations		
	Community Groups and activities - Set up and/or enabled by BDC such the Marriott's Way 10k race; social physical activity groups; 3 parkruns and council produced cycling & walking leaflets	**Broadly Active -** A programme of physical activity and behaviour change therapy prescribed by a health professional to help manage and reduce the effects of chronic health problems such as coronary heart disease, diabetes, hypertension, anxiety, depression etc. Patients are referred at early stage and as part of a rehabilitation programme after hospital intervention	
	Active Norfolk Activity Pathway The development of outcome focused district level sport and physical activity locality plans co-produced between Active Norfolk, district councils and partner organisations		
	Why Weight A twelve week, tier 2, local weight management plan encouraging individuals to better understand their relationship with food. Education sessions combined with behaviour change therapy encourage lifestyle changes rather than short-term dieting. Suitable for anyone 16+ with a BMI of 25 or more so suitable for early intervention through to complementary treatment for the seriously ill returning home.		

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Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
Type of activity:	**Prevention**	**Early Intervention**	**Reablement**
Great Yarmouth Borough Council	**Social Prescribing** Utilising the Connector roles mentioned below, the local VCS provision and GP surgeries to deliver a comprehensive offer that includes a range of advice and guidance plus personal development, support and navigation and community based self-help.		**Healthy Homes Assistance** Speedily undertakes works to a patient's property to facilitate safe hospital discharge or to prevent admission to hospital.
	Housing related Support Services Sheltered housing accommodation based service and outreach floating support service both keeping older people living at home independently safe & well.		**Assistive Technology – I'm Going Home** 24/7 hospital discharge service using temporary Yare Care community alarms and keysafe.
	Safe at Home HIA Services Providing housing repair and adaptation advice and support service. Includes full design service and support to seek funding. Also provide a Handyperson service.		**Great Yarmouth Community Housing** Comprehensive repair and adaption service for tenants of GY Community Housing.
	Early Help Hub - A multi-agency early intervention and collaboration hub where cases are discussed to avoid crisis interventions		
	Neighbourhoods that Work Building stronger communities and encouraging self-help using Community Connectors, Life Connectors, Skill Connectors and Community Development Workers		
	Yare Care Community Alarms - Utilising assistive technology to support independent living and provide 24/7 access to emergency help.		
	Making Every Adult Matter / Housing First Working collaboratively with a homeless hostel provider to provide housing first then combine it with supportive treatment services, education and employment		
	Sport and Leisure Providing accessible and affordable indoor leisure provision to encourage greater participation and promote healthy living		
	Tenancy Services The council is a stock owning authority providing quality accommodation at affordable rents and provides a comprehensive estate management service that supports & promotes wellbeing.		
	Emergency Repairs & Discretionary Loans Recycling existing loans when repaid to provide funding for emergency repair works for vulnerable households		

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<tr><td rowspan="12">Kings Lynn & West Norfolk Borough Council</td><td colspan="3">Handyperson Service - To provide a low level minor adaptations and repairs service focusing on prevention and early interventions</td></tr>
<tr><td colspan="3">Discretionary ADAPT grant- Raise limit from 6K to 12k</td></tr>
<tr><td colspan="3">Provision of Hardship Fund - To assist with client contributions where a client cannot raise the funds required.</td></tr>
<tr><td colspan="3">Provision of loan fund
To assist with cases where total costs exceed the maximum allowable £30K and the client cannot pay the costs above the 30K limit.</td></tr>
<tr><td colspan="2">Early Intervention Initiative –
Target identified cohorts of people with advice, information and low level initiatives such as a prevention home assessment, dementia assessment, home safety assessment, and energy tune up.</td><td>Fast Track Hospital Discharge Pilot:-
Development of Fast Track modular Ramping service and fast track stairlift service</td></tr>
<tr><td colspan="2">Lily
Ask LILY is a service focused on combatting loneliness and reducing isolation to support health and wellbeing. Available online, by telephone, via LILY Advisors at community locations or a home visit, adults can access advice, information and help to engage with social activities..</td><td>Handyman to assist Hospital Discharge:- Use of handyman service to support hospital with minor adaptations for Hospital discharge.</td></tr>
<tr><td colspan="2">Minor adaptation works grant
Introduce non-means tested minor adaptations grant for works under £1000</td><td>Lily:- Link into hospital teams to offer assistance to patients being discharged home.</td></tr>
<tr><td>Assistive Technology – (help people stay safely at home) - develop project to focus on key areas in partnership with Locality Social Care team.</td><td colspan="2">Relocation Grant
To help fund relocation costs in cases where adaptations cannot be made to the current property or moving is a more cost effective solution.</td></tr>
<tr><td>Energy Advice
To assist clients with general advice and funding information about heating problems.</td><td colspan="2">Partnership working with health and community teams
Identifying a streamlined pathway and referral template to enable community therapy teams to send in referrals for minor and major adaptations. To provide training workshops throughout the year to cross-train the multi-disciplinary teams in specialist areas</td></tr>
<tr><td colspan="2">Partnership working with Care Navigators
To work closely with other Organisations that provide support and co-ordinated care for over 75’s in the west. To provide a stream lined process for referrals and to share relevant information about clients that may be accessing these services. To consider a hot desk arrangement within the IHAT</td><td>Non Means tested Hospital discharge Grant
To assist with a fast-track process for delivery of ramps and stair lift adaptations for hospital discharge</td></tr>
<tr><td colspan="2">Prevention Grant
To assist with the provision of minor adaptations for cases that are identified as in health need but have not yet reached care act eligibility</td><td>Amend Safe and Secure and Careline Grants
To provide discretionary assistance for minor repairs and Careline equipment.</td></tr>
<tr><td></td><td>Emergency Repair Grant
To assist with urgent minor repairs -</td><td>Assistive Technology – to assist with safe discharge from hospital - pilot project to focus on AT to help with safe discharge form hospital</td></tr>
</table>

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Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
Type of activity:	**Prevention**	**Early Intervention**	**Reablement**
North Norfolk District Council	**Early Help** Hub collaboration meetings supporting timely interventions and Referral system between hub partners		**Hospital Discharge** Working in partnership with local hospitals to ensure residents are able to return home or access suitable alternative accommodation prior to discharge from hospital.
	Energy Advice Energy advice and signposting. Access to Norfolk Big Switch and Save.		
	Support of local implementation of national campaigns This includes but is not limited to promotions such as Stay Well This Winter, Flu Clinics etc		

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Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
Type of activity:	**Prevention**	**Early Intervention**	**Reablement**
Norwich City Council	**Handyperson Scheme** Carrying out all general repairs, DIY, gardening, painting and decorating. Subsidised rates for older and vulnerable residents including up to two hours free labour on council tax reduction.		
	Discretionary Adaptations Grant *Discretionary grant of up to £5,000, for clients applying for a disabled facilities grant, toward the client contribution required by the means test.*		
	Preventing Admission to Hospital Grants *Non means tested grant of £10,000 and fast track adaptations and improvement service (28 days) to avoid admittance to hospitals.*		
	Domestic abuse outreach service Commissioned domestic abuse outreach service to provide adults, children and young people in Norwich who are currently in an abusive relationship with the necessary advice and support to help them and their children live more safely and independently.		***Hospital Discharge Grants (plus fast track service)*** *Non means tested grant of £10,000 and fast track adaptations service (28 days) to enable timely discharge of inpatients.*
	The Consortium - Commissioned service to deliver a range of social welfare advice, casework and representation services in order to reduce financial and social exclusion and inequalities.		
	Financial Assistance for Home Improvement for vulnerable home owners *Means tested grants and loans of up to £35k to carry out repairs to tackle or prevent hazards prejudicial to health in the home*		
	Social Prescribing - Working through Tuckswood and Gurney GP practices to help people address underlying issues early through linking into services within the community.	**Safe at Home Grants** Grants up to £2,500 to help people living with dementia and vulnerable home owners to maintain suitable and safe homes.	
	Energy Advice - Including loft clearance, insulation and heating grants and help to reduce energy bills.	**Tenancy Sustainment Team** Supporting tenants to remain in their own home	
	Support of local health and well-being initiatives Includes but not limited to Healthy Norwich, digital inclusion, promoting applications for free school meals and Healthy Start amongst new and expectant mothers.	**Norwich Early Help Hub** Working with partners to make sure individuals and families receive the most appropriate and effective support as soon as possible.	***Hospital Discharge Process-*** Working in partnership with NNUH, NCH&C, CCSRS and ASSD to update hospital discharge process to ensure residents are able to return to suitable accommodation (their own home or an alternative).
	Support of local implementation of national campaigns Including but not limited to Stay Well This Winter, Electrical Safety First.	**Money Advice Team** Providing money and debt advice to tenants.	

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Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
Type of activity:	**Prevention**	**Early Intervention**	**Reablement**
South Norfolk Council	**Handyperson Scheme** Carrying out all general repairs, DIY, gardening, painting and decorating. Subsidised rates for our older and vulnerable residents including up to two hours free labour on a means-tested benefit.		
	Social Prescribing Working through South Norfolk's GP practices, Community Connectors help people address underlying issues early rather than continuing to use clinical or medical services unnecessarily through linking into services within the community.	**FIRST Officers** *Financial Independence, Resilience, Support and Training* is a multi-specialism support provision which will be able to provide a holistic package of support to residents of South Norfolk on a variety of issues	**Hospital Discharge (District Direct)** Working in partnership with NNUH to update the processes for Hospital discharge to ensure residents are able to return home or access suitable alternative accommodation prior to discharge from hospital.
	Energy Advice Including insulation and heating grants and help to reduce energy bills		**District Direct Hospital Discharge Grant** The District Direct Hospital Discharge Grant (max £3000) is intended to assist our residents who are able to return home from hospital, but are being prevented from doing so because there are factors at their home (that can be speedily remedied), that prevent them from doing so.
	Support of local implementation of national campaigns This includes but is not limited to promotions such as Stay Well This Winter, Flu Clinics etc.	**Early Help Flexible Fund** Available to support residents with one off small value solutions as part of a wider request for support from the Early Help Hub	
	Triage team Team based within the early help hub who identify and triage those residents on first enquiry about independent living	**Independent living team** Supporting residents to remain in their own home	

Appendix 1 – Breckland Locality Plan

Breckland Council Better Care Fund Locality Plan 2017/18-18/19	
Area covered:	**Breckland Council**
DFG Funding:	BCF Allocation – 2017/18 £1,003,721 2018/19 TBC

Overview:

One of the core purposes of the Council's Housing Team is 'If you want to stay at home, we'll support you to live more independently'

This purpose has been developed to reflect the statutory duty of the Council but also the current and future aspirations of the organisation.

The first objective is to fast track assessments for property adaptations at first contact. The Council has recently developed a Housing Support Hub with the capacity to triage and where appropriate deal with the majority of customer enquiries coming into the housing service, including requests for adaptation assessments. This team has been developed using intelligence which is based on the type and frequency of enquiries historically logged with the Housing Service. It is proposed that following the initial triage, appointments are scheduled at first point of contact based on level of complexity therefore working to a position of no waiting list.

This is particularly useful in terms of hospital discharge where it is proposed that through close engagement with the acute hospitals serviced by the Breckland area, the Housing Support Hub will become a key feature of the respective hospital's discharge process. By developing the multi-disciplined approach of the Hub a decision can be made at first point of what service would be most appropriate to successfully support an expedited discharge.

This way of working can also be exercised when considering elected surgeries and Breckland is committed to where possible preventing an admission but where this is unavoidable and where an adaptation is required will through the above process be in a position to carry out these works to aide a discharge and support the residents recuperation.

In addition, the service is currently considering the intelligence held by the Council to forecast those customers who may require an adaptation in the future and where possible prevent this from occurring. This includes the use of triggers and a collective approach from all Council departments to ensure that the organisation fully understands requests which are being made and what support in addition to what is being asked for is considered and where necessary put in place.

The Council is also reviewing the Reable Grant, Breckland's discretional property adaptations grant in order that this supports the above way of working.

Appendix 1 – Breckland Locality Plan

Delivery for 2017/18-18/19:

Activity in 2017/18 and proposed activity 2018/19

IHAT Continuous Improvement Plan – Breckland is committed to the common objectives of the IHAT continuous improvement plan and the goal to reduce end to end times to 140 days.

2017/18 update - Breckland has reduced the number of people on the waiting list to nil, in addition applicants are triaged and appointments made for initial assessment at first point of contact. The 140 days end to end objective has not been achieved, this is in part due to the clearing of and the associated historic waiting time accrued whilst waiting for the initial assessment.

2018/19 proposal - No Change

Hospital Discharge "Common Referral Pathway" – Work in partnership with hospitals to provide a common streamlined pathway for referral to ensure residents are able to return home or access suitable alternative accommodation prior to discharge from hospital. Breckland is unusual in so far as our catchment covers 3 key hospitals – N&N; Bury and Kings Lynn.

2017/18 update - Breckland has contributed to the successful pilot of District Direct, N&N hospital discharge process. The District has also been supportive and contributed to the proof of concept resulting in the NHS looking to finance the initiative on a permanent basis.

2018/19 proposal - No Change

Hospital Discharge "Fast Track Service" – Develop process to use the Discretionary Reable grant to fast track Hospital Discharge cases. This will require the acceptance of third party assessments of need and agreement of emergency timescales with contractors.

2017/18 update – See below

Discretionary Reable Grant - To broaden the eligibility criteria for the Breckland Discretionary Adaptation grant (Reable) to include a greater proportion of clients who can benefit from the streamline service. Subject to ratification, we will make Reable grants available to £14,000 (currently £7000)

2017/18 update – Reable grant currently at £7000

2018/19 proposal - It is still proposed that the discretional grant (Reable) will be reviewed to take into account the increase in general work costs and to ensure that the District can provide and maintain a fast-tracked adaptations service.

Handyperson Service – as part of the proposed agency service it is intended to reinstate a handyperson service to cover the Breckland area

2017/18 update – Breckland currently outsources its handyperson responsibilities to other neighbouring authorities.

2018/19 proposal - This remains an objective of the proposed new Home Improvement Company.

Appendix 1 – Breckland Locality Plan

Appointment at Triage - To introduce 'appointment at triage' stage to eliminate the waiting list for assessment. A private occupational therapist is currently being used to assist in reducing the current waiting list. Within 3 months (July 17) it is intended that appointments for assessment will be offered at the triage stage.

2017/18 update – Achieved – see above

2018/19 proposal – No Change

Breckland Agency Service - Establish a Breckland Agency service to extend the support offered to clients in the provision of adaptations. Options for the appropriate service delivery model are due to be considered by Breckland Councillors summer 2017

2017/18 update – The Council remains committed to provide a high quality works and expedited adaptation and grants service and are currently looking at options in terms of future delivery.

Appendix 2 – Broadland Locality Plan

Area covered:	**Broadland District Council**
DFG Funding:	**BCF Allocation – 2017/18 £766,244** **2018/19 TBC**
Expected demand for DFGs in 2018/19 and planned delivery:	
Expected Demand - 138 recommendations. Planned Delivery - 138	

In the following table, please include your proposal with innovative ideas and practice to support people to live independently at home.

Whilst putting together your proposal(s) please consider:

- the wider contribution of Districts
- how activity can contribute towards reduction in admissions to acute and care homes and support hospital discharge

Proposal 1 – Targeted approaches: Social Prescribing

Describe proposal in this box.

Include:

- The objective of the scheme:

  Further develop a programme where those most at risk of hospital admission and Adult Social Care cases are referred for wider support from the District Council as part of the prevention offer.
- Some background (if relevant) on what has happened before.

  District Councils offer a range of housing and benefit related support to assist vulnerable people to remain living independently in their own homes. This could include adaptations, advice on appropriate benefits, energy efficiency advice, grants/loans for home repairs, a handy person service, community and 3rd sector support and general housing advice. The gateway to this support is through Home Improvement Agency Staff (HIA).
  Currently referrals are through an open process but a targeted approach has been developed at a single GP surgery in the Northern Locality for those most at risk of hospital admission. The scheme has moved the preventative approach forward for this cohort of people.
  The previous three month program has demonstrated considerable success to the satisfaction of the surgery involved and relative partners who operate through the survey. However some refinement of the process is required and further demonstration of the outcomes that are a result of the process. Therefore to move the procedure forward an intervention is proposed at an alternative GP surgery within Broadland District Council's boundary.
- An overview of the scheme and activity that would take place

  The proposal is to develop and refine the provision of the wider support available from District Councils using the HIA as a conduit and establish a cost based approach that demonstrates financial benefits to the surgeries, adult social care and the NHS as a whole achieved by the

multidisciplinary approach taken by HIA officers.
Aimed at those who are at greatest risk of admission and a sample of certain initial demand into Adult Social Care to identify whether this support would aid them / their carer if not already in place.

The new procedure will be influenced by the evaluation of the original Aylsham pilot which is currently being developed in co-operation with the CCG's involved. If the approach evidences that such support further increases the independence of referred patients (if not already receiving such support), reduces admissions and demonstrates financial savings then a business case will be developed detailing the sustainability of the scheme.

Rationale/Evidence base

Detail your rationale/ evidence base here

Developing integrated approaches to ensure services are identifying and wrapping provision around those who are most at risk of hospital admission. The pilot at Aylsham has demonstrated that where the nature of the case allows, there are alternative ways of responding to demand into Adult Social Care rather than a full social care assessment.

Outcomes

Use this space to detail your expected outcomes

- Reduced emergency admissions within targeted cohort of people
- Dedicated prevention offer available to those most at risk
- Reduce reliance on care packages
- Reduced admission to care homes
- Potential for a reduction in carer breakdown
- Increased patient experience
- Potential for reduction in delayed transfers of care

Update

Two successful projects have been delivered involving two surgeries in the Northern locality area. A further intervention has been initiated in the North CCG locality. Evaluation is proceeding. No further intervention is anticipated at present as part of the locality procedure.

Proposal 2 – Targeted approaches: More than 2 adaptations

Describe proposal in this box.

Include:

- The objective of the scheme

Determine whether those who have been referred for more than 2 housing adaptations are known to MDTs – to avoid hospital admission. It is likely that this cohort would be known to

teams but it would be advantageous to be assured as this may highlight those that should be part of an MDT.

- An overview of the scheme and activity that would take place.

  This project would help inform those people who may be in need of an MDT approach, if not already identified. This may be a way of ensuring that those needs which may increase from a health and social care perspective are targeted as a priority, and enabled to maintain their independence via an MDT approach.

Rationale/Evidence base

Detail your rationale/ evidence base here

Developing integrated approaches to ensuring services are identifying and wrapping provision around those who are most at risk of hospital admission.

Outcomes

Use this space to detail your expected outcomes

- Reduced emergency admissions within targeted cohort of people
- Dedicated prevention offer available to those most at risk
- Potential for a reduction in carer breakdown
- Increased patient experience

Update

We shall initiate correspondence with Adult Social Care regarding the continued value of this process.

Proposal 3 – Improving End to End Times for the Adaptation Process

- The objective of the scheme

  To reduce the start to finish time for Disabled Facilities Grant aided adaptations to 140 days.

- Some background (if relevant) on what has happened before

  Previously, Integrated Housing Adaption Teams (IHAT's) consisting of collocated Occupational Therapists and District Council Staff were developed. This resulted in the start to finish times for adaptations to be provided reducing to an average across Norfolk of 243 days.

- An overview of the scheme and activity that would take place

  Demand will be assessed and approaches will be taken to remove waste from the system.

Rationale/Evidence base

Detail your rationale/ evidence base here

- Adaptations provided through DFG's have been proven to delay admission to residential care for an average of 4 years and to reduce the amount of formal and informal domiciliary care required. Therefore, the sooner such adaptations are provided the better in terms of this

preventative effect.

Outcomes

Reduction in the start to finish time for DFG adaptations to 140 days.

Update

Progress has been made and applicants are now generally seen within four weeks of an assessment which should be reflected in reduced start to finish times as this feeds through. We will continue to analyse the process and identify time efficiencies that can be implemented.

Proposal 4 – Provide Low level adaptions through the Handyperson+ Service (BCF funding increase dependant).

Describe proposal in this box.

Include:

- The objective of the scheme

To provide low level adaptions as part of a proactive response to residents who access the handy person scheme.
Broadlands Handy Person plus service currently provides a service for eligible residents to have small works done within their dwellings. The plus element of the service involves a **peas**

- If funding from BCF allows the Handy person will install low level adaptions as result of an initial assessment.

Rationale/Evidence base

Detail your rationale/ evidence base here

- Low level adaptations will be specifically based on accident prevention. They are therefore a preventative tool as opposed to higher level adaption that are preventative but also provide the opportunity for residents to stay in their own homes.

Outcomes

- These low level low cost adaptions are expected to reduce demand on GP surgeries and hospital emissions.

Update

33 low level grants have been approved to date. Subject to Cabinet approval the cap on this grant will be raised to £750

Appendix 2 – Broadland Locality Plan

Proposal 5 – DFG Top up Grants for contributions below £2000 (BCF funding increase dependant)

Describe proposal in this box.

Include:

An overview of the scheme and activity that would take place.

- Discretionary grant of up to £2,000 for clients applying for a disabled facilities grant. This will go towards the client contribution required by the means test.

Rationale/Evidence base

Detail your rationale/ evidence base here

The preventative element of DFG funding has been well documented relating to decreased pressure on care packages and care homes and a reduction in hospital emissions. Providing a top up fund is likely to increase the take up of these grants where a moderate contribution is required.

Outcomes

Widening affordability will increase the number of adaptions which will increase the preventative effect of the service.

Update

This proposal has not been moved forward and will be replaced with further proposals relevant to Better Care Fund.

Proposal 6 – Health Improvement Grants to upgrade inefficient heating systems (Max £4500)

A proposal to provide means tested boiler replacement for defective or non-condensing boilers or storage heaters for residents with health issues. The scheme will continue a current project and will be subject to cabinet approval and accessibility aligned to available funds.

Rationale/Evidence base

Detail your rationale/ evidence base here

Replacing an inefficient boiler enhances the efficiency of heating systems for vulnerable persons and therefore affects the affordability of staying warm with all the health benefits this provides.

Outcomes

Reduce demand for residents and health and care services

Appendix 2 – Broadland Locality Plan

Proposal 7 – Extended Financial Assistance
A new proposal to provide a top up grant or loan additional to £30K DFG. The proposal will be subject to cabinet approval and accessibility aligned to available funds.
Rationale/Evidence base
This proposal will provide further financial assistance where the current cap of £30K will not provide the funds necessary to complete the adaptions at a property.
Outcomes
Reduce demand for residents for health and care services.

Proposal 8 – Architect Grant
A new proposal to provide a means tested architect fee grant for complex cases. The proposal will be subject to cabinet approval and accessibility aligned to available funds.
Rationale/Evidence base
Complex cases are stalled where structural works require pricing prior to approval. The only option for the pricing procedure is for the applicant to finance the architect fee prior to approval hence the stall and sometimes abandonment of the procedure. A grant to cover these costs will help to ensure a smooth process for complex cases where structural works usually in the form of an extension are required.
Outcomes
Fluid procedure and reduced cancelation where complex works are required which will lead to reduced demand for residents for health and care services.

Proposal 9 – Get You Home Grant
A Get You Home Grant of up to £1000 to pay for essential maintenance works at residents' properties identified through the District Direct Service and other hospital referral routes. The proposal will be subject to cabinet approval and accessibility aligned to available funds.
Rationale/Evidence base
The grant would be used for trade services such as plumbing and electrical works and other works beyond the scope of the handy person plus service or one off capital expenses, such as purchasing necessary furniture or appliances or skip hire for decluttering.
Outcomes
Outcome aimed at reducing Hospital ward pressure and to assist resident to return to their homes at the earliest opportunity.

Appendix 3 – Great Yarmouth Locality Plan

Better Care Fund & Disabled Facilities Grant Locality Plan 2017/18 – 18/19 (Update February 2018)	
Area covered:	Great Yarmouth Borough Council
DFG Funding:	BCF Allocation - 2017/18 £1,021,403 2018/19 £TBC

Overview:

This locality plan has been jointly developed by Great Yarmouth Borough Council, Norfolk County Council and Great Yarmouth and Waveney CCG in response to the BCF/DFG allocation for 2017/18 and 2018/19 and in accordance with the BCF guidance which states:

The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives are required to be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

This document provides an overview of delivery up to the end of February 2017 and sets out the proposals and aims for the funding for 2018/19.

Key considerations

It is important to note the following which has been part of the conversation to develop this joint plan;

- Capital contribution by Great Yarmouth Borough Council: Should the Council require further financing to meet its statutory DFG function then approval to borrow would be sought. The Borough also provides discretionary loans as and when funds are available as a result of existing loans being repaid.
- The current funding of the Home Improvement Agency Service (Safe at Home) via the Clinical Commissioning Group: This helps to fund the caseworker role which not only supports vulnerable applicant through the DFG process but also provides Information and Advice to people who contact the HIA. It is recognised that if this was withdrawn, it would significantly impact on the capacity of the HIA to support the delivery of the outcomes associated with BCF/ DFG.
- As agreed the £36,251 underspend from 2016/17 has been rolled forward into 2017/18, helping to deliver the outcomes of this locality plan.
- Additional officers (1.86 fulltime equivalent) have been employed by Great Yarmouth Borough Council to deliver the projects set out in the plan and to help deliver similar project outcomes in Waveney for 2018/19. Capitalising revenue through the charging of fees for each job has generated insufficient income to maintain the additional officer posts and these rolls are now being supported by additional funding from Norfolk County Council, Suffolk County Council and Waveney District Council.

Expected demand and planned delivery for 2017/18:

Disabled Facilities Grant

The table below sets out the delivery associated with disabled facilities grants for 2014 to 2017

Year	Completions	Total Spend	Average Cost
2014/2015	118	£606,497	£5,139
2015/2016	118	£687,974	£5,830

Appendix 3 – Great Yarmouth Locality Plan

2016/2017	115	£898,967	£7,817

Activity 2017/18

Type of work	No. applications received	No. applications approved	Value of approvals (£)	Value of payments made (£)	Completions	Outstanding commitment
Disabled Facilities Grant	101	100	£843,679	£888,194	117	£317,961

The 2016/17 Locality Plan set out parameters for utilising any underspend on DFG because there was a recognition that while there is significant demand for DFG it isn't always possible to covert that in a timely fashion into actual jobs.

Healthy Homes Assistance and **I'm Going Home** are two projects that have evolved out of the 2016/17 plan. These projects have used surplus BCF / DFG funding to enable people to return and / or remain at home. The projects have targeted delayed hospital discharge cases and admission prevention through A&E.

DFG Locality Plan for Great Yarmouth

Proposal 1:

Health Homes Assistance

The objective of this scheme is to ensure that any BCF surplus funding is used and targeted at specific people to either enable timely hospital discharge or provide a proactive prevention service that prevents hospital admission. This is done using grants for works up to £10,000

This surplus funding is to be used to target cohorts of people where improvements made to their home will deliver a clear benefit to their health and wellbeing and subsequently a reduction in demand for services.
The cohorts currently identified are;

- Hospital discharge cases
- Measures' to prevent hospital admission e.g. falls prevention

Works under £1,000 (Grant, not means tested)

Eligibility - Anyone identified as being in the target groups listed. Assistance restricted to three separate applications in any twelve month period.

Applicants must be referred by a health care professional using the Healthy Homes Referral Form. Social Work Duty, Out of Hospital Team, GPs, etc. – Key is that there is a health outcome.

Works over £1,000 (Grant, means tested, for works up to £10,000)

Eligibility - Anyone identified as being in the target groups listed. Assistance for works costing more than £1,000 is restricted to a single application in any twelve month period with a maximum of £10,000 in any 5 year period. However works under £1,000 can still be applied for separately. Where Healthy Homes Assistance is used in conjunction a Disabled Facilities Grant (DFG) application the maximum combined total grant available is £30,000 (less any means tested contribution).
Applicants must be referred by a health care professional using the Healthy Homes Referral Form. Social Work Duty, Out

of Hospital Team, GPs, etc. – Key is that there is a health outcome.

2017/18 Results

Progress and Delivery

A full-time technical officer and a part-time support officer were appointed at the end of November 2016 to develop and implement the locality plan. The Healthy Homes Assistance scheme was developed in conjunction with key partners in health and social care, the aims of the scheme and measures were agreed.

The officers took time to shadow key frontline staff from other organisations to learn about the issues they faced and how the Healthy Homes Assistance scheme could support their work. This informed the referral process which was developed to be quick and easy to use.

Officers attended promotional events to raise awareness of the Healthy Homes Assistance scheme and to network with other organisations, which has developed the knowledge of the officers and avoided duplication of work.

The Healthy Homes Assistance was ready to commence taking referrals on 3rd January 2017

The table below sets out the activity to date from 1st April 2017.

Type of work	No. applications received	No. applications approved	Value of approvals	Value of payments made (£)	Completions	Outstanding commitment
Healthy Homes Assistance	144	133	£134,327	£111,073	121	£26,198

Outcomes

Healthy Homes Assistance key outcome has been hospital admission prevention. To date 92% of completed cases in 2017/18 have featured work to prevent hospital admission.

Referrals for works under £1,000 are typically taking on average 21 days. The ***quickest turnaround to date has been 1 day*** and the longest 66 days. The 66 day case required the fabrication of a set of made to measure galvanised handrails.

The CCG report cost savings of £112,106 to the local NHS trusts as a direct result of the works undertaken by the project since 1st April 2017. Savings calculations for social care and the wider society are yet to be undertaken.

Client Feedback

- Mrs E no longer has painful shoulders as a result of struggling to managing her husband wheelchair over internal thresholds in the home and Mr E now feels comfortable asking his wife to help him get around the house as she is no longer in pain.
- Mrs B tells us she feels like her old self again as she feels clean because she can now bath herself safely again
- Mr M can sleep in his own bed again and is no longer at risk of falling when going upstairs

Practioner feedback

- Impressed with the speed at which the works can be delivered.

Appendix 3 – Great Yarmouth Locality Plan

Aims and objectives for 2018/19

So far Healthy Homes Assistance has made significant impact both in terms of savings through timely appropriate intervention and to the lives of people receiving the service.

The aims and objectives for 2018/19 will be around continuing the service with a view to making it both sustainable and integral to the overall wellbeing offer in Great Yarmouth

The service has attracted a lot of interest and there is a desire to expand the scheme. One of the aims is to explore linking up with GP surgeries around admission prevention and linking into the social prescribing service that is starting to be delivered in the borough.

A further aim will be to explore how this service aligns with other services and commissioning priorities locally. If the scheme is seen as being of value exploring how the money the system has to invest through the CCG and Adult Social Care can support and enhance what is being delivered.

Proposal 2:

I'm Going Home

For a very short period of time the patient is supported by a range of services working closely to ensure the patient reaches a point where they can remain at home without the further need for care and support or with a care and support package that is then charged for.
The package could comprise of:

- Yare Care Community Alarm
- Key safe
- Physical works to the patients home that facilitates hospital discharge and improved health
- Access to 24/7 monitoring for up to 6 weeks
- Wellbeing calls from the control centre
- Support from the Out of Hospital Team / swifts
- Potential to add in assistive technology

Benefit to Patients

- Patients feel more confident about leaving hospital knowing They are discharged with the knowledge that they have access to 24/7 emergency support and reassurance
- They have access to the out of hospital & swift team
- They have a health, care and support package that will enable them to get well at home.
- There's a coordinated & holistic approach to discharge, which takes into account medical need plus social needs and wellbeing.

Benefit to Organisations

- Timely and safe hospital discharge.
- Increased patient confidence on leaving hospital meaning they are less likely to be readmitted
- Cost benefits of enabling someone to return home more quickly.
- Coordinated approach to discharge – every organisation contributing to the package has full knowledge & understanding of patient requirements plus there is a shared responsibility and commitment to managing patient expectations.
- Encourages integrated working beyond health & social care

I'm Going Home started taking referrals on 1st February 2017

Appendix 3 – Great Yarmouth Locality Plan

2017/18 Results

Progress & Delivery

- 15 alarm units with roaming sim facility and temporary key safes are held by health and social care teams in a number of key locations ready for use.
- Training was provided to teams at the James Paget University Hospital and East of England Ambulance Service.
- A 24/7 referral process is in operation.

The table below sets out the activity to date from 1st April 2017.

Scheme	No. Referrals	No. Installations	Capital investment	No. calls received by the alarm centre	*No. of physical responses deployed	No. of clients taking on the paid service
I'm Going Home	68	68	£0	364	83	13

*Physical responses deployed include the out of hospital team, the swift response team and the ambulance service.

Outcomes

- ***158*** hospital bed days saved
- Equalling ***£32,655***** savings

**The savings have been calculated using local data sets agreed with the CCG.

Both client and practioner feedback has been very positive and the scheme is attracting a lot of local attention. Clients and their families have reported feeling safer leaving hospital with a temporary alarm, one daughter said ***'I would not have felt safe having dad home without the I'm Going Home package'***. Practioners involved in issuing the alarms have said '***the service is invaluable'*** and ***'it's brilliant it's made hospital discharge instantaneous'***

Aims and objectives for 2017/18 – 18/19

I'm Going Home has in 8 weeks of operation made significant impact both in terms of savings by facilitating hospital discharge and to the lives of people receiving the service.

The aims and objectives for 2017/18 and 18/19 will be around continuing the service with a view to making it sustainable and a service which is seen as integral to the overall wellbeing offer in Great Yarmouth

The service has attracted a lot of interest and there is a desire to expand the scheme. Discussions are due to take place with GP surgeries and with the voluntary sector to see how services can link more closely to improve the package of support on offer at the point of discharge and to prevent further hospital admissions.

There will be future evaluation of the scheme which will review progress and consider options for future delivery. This will be reported to partners in order to help inform the discussions on future funding beyond March 2019.

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

Better Care Fund & Disabled Facilities Grant Locality Plan 2018/19	
Area covered:	**West Norfolk Borough**
DFG Funding:	**BCF Allocation - 2017/18 £1,352,170** **2018/19 £TBC**

Overview:

2016/17 allows for a budget of £1,748,225
2017/18 allows for a budget of £2,147,470
2018/19 allows for a budget of **£TBC**

This Plan shows the work that has taken place in 2017/18 and what the aims and proposals are for the next year.

Predicted spend is **- £2,050,508**

Expected demand and planned delivery for 2018/19:

Year	Completions	Total Spend	Average Cost
2015/2016 –			
Adaptation Works	162	£927,666	£4,614
2016/2017 –			
Adaptation Works	280	£1,391,701	£4,970
Prevention Works	895	£77,073.03	£86.11
2017/2018 –			
Adaptation Works	367	£1,966,506	£5358
Prevention Works	472	£52,259	£112
2018/19 –			
Adaptation Works	TBC		
Handy Person Works	TBC		

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

Activity in 2017/18;

- The hospital discharge pilot continues to see referrals into Care & Repair from the QEH, the Handy Person Service assisting with discharge, Lily Advisor service in the QEH on a regular basis and continued partnership working with the community and health teams.
- The number of those trained, marketing events and referrals continue to grow for Lily.
- Finalisation of the new Housing Assistance Policy is being implemented amending some grants and creating some new ones.
- Efficient and effective implementation for electronic triage, calls flow to CIC, a framework contract and further competency training during the last year. The new Assessment process is still being worked on.
- New Assistive Technology kit has been ordered and paperwork is being drawn up, there are 17 '3rings' kits available.

Proposals for 2018/19;

Hospital Discharge Pilot continuing to focus on;

- Fast track hospital discharge pilot
- Non means tested hospital discharge grant
- Handyperson to assist hospital discharge
- Ask LILY will further develop to support all adults to reduce social isolation and support health and wellbeing.
- Ask LILY will work with Community Action Norfolk to deliver social prescribing project.
- Partnership working with health and community teams

Early Intervention Initiative continuing to look at;

- Ask LILY
- Identifying cohorts of potential clients

Development of the Borough Councils Private Sector Housing Investment Policy;

- Finalisation of the new Private Sector Housing Investment Policy ready for approval and sign off
- Amending some existing grants, including;
  Discretionary ADAPT grant, provision of hardship fund, provision of loan fund, minor adaptation works grant, relocation grant and prevention grant

Progress the IHAT Continuous Improvement Plan;

- Continuing to look at productive and efficient ways to improve the service

Development of the new Assistive Technology proposal;

- 2 main areas focusing on helping people stay at home and assisting with safe discharge from hospital

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

DFG Locality Plan for West Norfolk

Proposal 1:

Hospital Discharge Pilot

This objective is to establish a formalised approach with staff across Housing, Health and Social Care to join up provision of services and reach more people at an earlier point in the process of discharge from hospital or care.

Fast Track Hospital Discharge Pilot

The IHAT has worked with the local Queen Elizabeth Hospital to develop a fast track service for those clients in need of modular ramps or stair lift. This sees the development of a new referral system for this to happen through the Hospital Discharge teams sending referrals through to Care & Repair. For example when elective surgery is planned for amputees there is an automatic referral for the provision of modular ramps and / or stair lift.

Non means tested Hospital discharge grant

This has been written into the new Private Sector Housing Investment Policy to assist with a fast-track process for delivery of ramps and stair lift adaptations for hospital discharge.

Handyperson to assist Hospital discharge

This has seen one of the Borough Council's Handy Persons being able to assist the Queen Elizabeth Hospitals 'man in a van'. This has seen the Handy Person covering leave and completing environmental surveys, providing / dropping off equipment and fitting grab rails.

LILY Advisor Service

Link into hospital teams to offer assistance to patients being discharged home, offering advice and information. This has seen LILY being promoted throughout the Hospital and with relevant teams.

Partnership working with health and community teams

Identifying a streamlined pathway and referral template to enable community therapy teams to send in referrals for minor and major adaptations. To provide training workshops throughout the year to cross-train the multi-disciplinary teams in specialist areas.

2017/18 Results

Fast Track Hospital Discharge Pilot

- 22 hospital cases referred from the QEH in 2017/18 into IHAT, these are being monitored and

discussed with Lead QEH OT at regular meetings to look at the pathway and outcomes of these cases. They are a mix of bariatric, end of life, amputee and other type cases which is enabling us to look at amending the locality plan for 2018/19.

- Non means tested hospital discharge grant – this has been included within the new Housing Assistance policy going through panel and cabinet sign off currently.

Handyperson to assist hospital discharge

- This has continued throughout 2017/18 and we are monitoring the jobs specified to the HPS as a learning tool and discussing this feedback with the Lead QEH OT in regular meetings.

Ask LILY Advisor Service

- LILY Advisors in the Hospital 9 am – 5 pm, Monday to Friday
- No longer funded from February 2018 (funding now agreed)
- Awaiting outcome of Social Isolation funding bid (funding now agreed)
- Infopoint now installed at the QEH direct line to CIC LILY queue
- Marketing Assistant promoting council services once a month at the hospital

Partnership working with health and community teams

- 59 health referrals received since project initiation (7 in 2016/17 and 52 in 2017/18).
- Continued training workshops on the assessment template and process and manager meetings (health, IHAT & social care) throughout 2017/18 to discuss progress and outcomes of cases.
- The IHAT Team have tracked and evidenced the savings in time on various cases to show the benefits of this integrated process, this has been a very successful piece of work for the West in 2017/18.

All of the above will continue in 2018/19, an additional part of this proposal is the current plan to place a Housing specialist role based at the QEH (Monday to Friday) initially for a 12 month period. The role will be split between IHAT and Housing team funded by the district. This role will build on the existing work and relationships already in place but will include developing relationships within the Social Care / Social Worker team at the QEH to assist with the referral pathway and building knowledge / understanding between the two organisations.

Aims and objectives for 2018/19

- Housing specialist role based at the QEH (Monday to Friday) initially for a 12 month period.
- Continue closer working with the Community Health teams – making sure all colleagues have been trained in the IHAT process and providing on-going training. A third workshop / training session is planned for April 2018 – this will see another group of community therapists attending. Identifying other teams and organisations that this training may be relevant for and organising this in due course to make sure as many colleagues are using this referral route as possible.
- Continue to develop the work established between the Handy Person and the QEH.

- Continue the work around fast-track modular ramps and stair lift cases – make sure all colleagues are using this referral route.
- Continue the Ask LILY Advisors to be available in the hospital Monday to Friday 9 am – 5 pm to assist with advice and information.
- On-going hospital training planned for; Rapid Assessment Team, Rehab Team, West Newton Team, also considering hosting a stand and advertising LILY on the West Wing entrance.

Proposal 2:

Early Intervention Initiative

Target identified cohorts of people with advice, information and low level initiatives such as a prevention home assessment, dementia assessment, home safety assessment.

Ask LILY

Preventative service bringing together services, organisations and social activities adults. Accessed online, by telephone and via LILY Advisors at community locations or a home visit.

Identifying Cohorts

Handyperson Service – to provide a low level minor adaptations and repairs service focusing on prevention and early interventions.

Frequent callers – working with the call handling centre for the Careline alarms and local CCG to determine whether there are small cohorts of frequent callers who may need assistance from local services that may include other Assistive Technology and Care & Repair.

Care Navigators – plans are being established to develop the working relationship between the IHAT with the Care Navigators. A meeting has taken place to introduce the two teams and identify joint working between the two services.

Referral protocol – Care Navigators work in West Norfolk with patients who are high need. These are likely to be clients who need the services of IHAT / Careline / Handy Person Service. So working with this client base means we have an opportunity to speed up the IHAT process and get to people in need sooner.

Other areas of work with the Care Navigators is for them to access to health information databases used by IHAT, understanding the Care Navigators holistic assessments and training for the Care Navigators on DFG's / IHAT.

2017/18 Results

Identifying Cohorts of potential clients

The Handyperson Service has continued throughout 2017/18 to focus on providing a low level, minor adaptations / equipment prevention service. The service has delivered approximately 472

minor adaptation jobs. The new Housing Assistance policy has included a small menu of low level grants covering minor adaptations, dementia works and an emergency repair grants. We are piloting using contractors off the framework to complete minor jobs to see if this is value for money and to provide cover for sickness.

Frequent Callers

Contacting clients who have activated their alarm frequently due to anxiety, to date 114 clients have been contacted and referred to the following services:
12 x information
27 x LILY
23 x Handy Person Service
9 x Care & Repair

Future of LILY

Update on activities / work to date:
40 LILY Advisors
1902 entries on Ask LILY website plus 208 activities
676 staff and volunteers trained
50 Marketing and publicity events
417 organisations contacted
1102 community events attended
1078 onward referrals made
Additional BC funding allocated to support delivery until 31.03.2018

Aims and objectives for 2018/19

The Handy Person Service will continue in 2018/19, providing low level minor adaptations and repairs service focusing on prevention and early interventions.

To work with Community Action Norfolk to develop social prescribing.

To continue Ask LILY, expanding to 18 years.

Partnership working with Care Navigators to work closely with other organisations that provide support and co-ordinated care for over 75's in the West. To provide a stream lined process for referrals and to share relevant information about clients that may be accessing these services. To consider a hot desk arrangement within the IHAT.

LILY to increase activity in all areas, develop the service for the local area by using LILY Advisors and members of the public to shape the service into the future. Ask Lily has secured funding for the next 3 years from Norfolk County Council Combating Loneliness and Reducing Social Isolation (Western CCG area)

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

Proposal 3:

PSHP (Private Sector Housing Investment Policy)

Within the IHAT team the aim is to develop and edit the current Private Sector Housing Investment Policy to make this work better and be much more accessible for the customer. Current considerations include;

Discretionary ADAPT grant

Raise limit from £6,000 to £12,000

Provision of Hardship Fund

To assist with client contributions where a client cannot raise the funds required

Provision of loan fund

To assist with cases where total costs exceed the maximum allowable £30,000 and the client cannot pay the costs above the £30,000 limit

Minor adaptation works grant

Introduce non-means tested minor adaptations grant for works under £1000

Relocation Grant

To help fund relocation costs in cases where adaptations cannot be made to the current property or moving is a more cost effective solution

Prevention Grant

To assist with the provision of minor adaptations for cases that are identified as in health need but have not yet reached care act eligibility

2017/18 Results

- Finalisation of the new 'Housing Assistance Policy' ready for approval and sign off
- Amending some existing grants, but also including; a Housing Review Panel as part of the process for complex cases, provision of a loan fund for top ups, minor adaptation works grant for works under £1000, relocation grant, prevention grant and Careline & an AT initiative.
- Policy was approved by Corporate Performance Panel 19th of February to progress to Cabinet in April.

Aims and objectives for 2018/19

- The new Housing Assistance Policy to go to Cabinet to be approved on 29th May 2018.
- Review the new Housing Assistance Policy and track a cohort of cases

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

Proposal 4:

IHAT Continuous Improvement Plan

The overall goal of the Improvement Plan is to transform from a reactive to a more proactive service. In order to do this the IHAT service needs to be efficient and able to handle the demand in a timely fashion.

2017/18 Results

Continuing to look at productive and efficient ways to working to improve the service:-

- Electronic triage process has been implemented and streamlines the initial contact and triage of the enquiry / person.
- Calls transfer to CIC for both C & R and Careline – implemented and has created a smooth pathway for new enquiries allowing access to all services – LILY, Careline and IHAT / HPS.
- A Framework contract has been in place since April 2017, 20 contractors in total and a Schedule of Rates. We have included a technical survey within the SOR to utilise contractor skills / time instead of a Technical Officer – this helps manage demand and free the TO's up for more complex feasibilities.
- Competency training has covered stair lift assessments within the Client Officer and AP team and is including some access / ramp cases with guidance from the IHAT OT. A peer group meeting takes place each week with the IHAT OT for CO's / AP to have cases signed off. Handypersons also present cases to the Assessment team.
- The waiting list in West remains above 100 due to demand as the team itself has been constant but demand continues to rise. There has been a private OT join the team for a number of months in 2017/18 to help reduce the waiting list.
- Data / case reports for all client officers, AP and TO's have been created to allow for closer case management, The IHAT Co-ordinator will be building in the 7 stages targets into the reports to allow for early identification of a stage going over target and for officers to respond.
- New Assessment Process (using the district systems only and minimal input into Liquid Logic) – this is currently being worked on in some areas and will be implemented fully into 2018/19 once signed off by County managers. There will be an IHAT Peer group workshop across the County to implement the process.

Aims and objectives for 2018/19

- Implement New Assessment Process
- Continue seeking improvements with the goal being to reduce the average time taken to provide an adaptation (enquiry to completion of works) from 240 calendar days to 140 calendar days.
- Continued aim to reduce the waiting list to 56.

- Further developing competency training – ramps.
- Continued competency training including access – ramps and modular ramps.
- Look at the opportunities of mobile working for both the Client Officers and Technical Officers.

Proposal 5:
Assistive Technology (new proposal)

2017/18 –

- Working with NCC
- Joint recruitment explored, but not progressed.
- Last meeting with AT service manager on 09.01.2018, advised a further review of the AT team taking place.
- Offered "a desk" at Kings Court, still looking into training to reduce the number of visits required, but NCC not able to progress at the moment.
- Limited AT training available, awaiting the launch of the Telecare Service Association training portal.

Hospital –

- £100,000 allocated by BC.
- 1 x Additional Careline Officer recruited.
- A number of equipment demonstrations have taken place.
- Have met with Lead OT and RAT team twice and agreed that '3rings' and 'Pebbell' equipment will support HD.
- Ordered equipment, currently drawing up paperwork. 17 full '3rings' kits available, grant funded for 12 weeks.
- Starting with RAT team – likely to install 5 initially.
- '3rings' monitored by the clients relatives.
- Working on Pebbell / PNC compatibility so hope to monitor via Herefordshire Housing call centre.

Assistive Technology – (help people stay safely at home) – develop project to focus on key areas in partnership with Locality Social Care team.
Careline Community Service are working with the Norfolk County Council Assistive Technology team to look at;

- Training and development opportunities for Careline Officers.
- Completing straightforward AT installations (if possible, considering N-able in West Norfolk).
- AT assessors to carry community alarms for installation in West Norfolk / North Norfolk when required by a client.
- AT assessors to work from Kings Court with the Careline Community Service team.
- To work with NCC / CCG colleagues to identify cohorts of clients to enable AT to form part of early prevention initiatives to improve home safety.
- Research new technologies and develop a proposal around assistive technology which can support clients with long term medical conditions, reducing the requirement for GP / Hospital visits.

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

Assistive Technology – to assist with safe discharge from hospital – pilot project to focus on AT to help with safe discharge form hospital.

- To identify cohorts of patients who would benefit from a community alarm / assistive technology at the point of discharge and imbed in the discharge process, enabled by amendments to the PSHP.
- To consider whether hospital volunteers can be trained in the installation of community alarms.
- Research new technologies and develop a proposal around the piloting of new technologies including telehealth and telecare, aiming to reduce the number of re-admissions within 90 days.

Aims and objectives for 2018/19

- AT Hospital Pilot.
- Complete TSA training to help develop joint working with NCC.
- As Above - Continue to develop the project and track progress

Appendix 5 – North Norfolk Locality Plan

Area covered:	**North Norfolk District Council**
DFG Funding:	**BCF Allocation - 2017/18 £1,030,087** **2018/19 £TBC**
Expected demand for DFGs in 2018/19 and planned delivery:	
Circa 150 grants at an average of £7,000	

In the following table, please include your proposal with innovative ideas and practice to support people to live independently at home.

Whilst putting together your proposal(s) please consider:

- the wider contribution of Districts
- how activity can contribute towards reduction in admissions to acute and care homes and support hospital discharge

Proposal 1 – Delivery of Disabled Facilities Grant

Describe proposal in this box.

Include:

- The objective of the scheme:

  To deliver adaptations as per the Council's statutory duty, employing best practice and innovation wherever possible.
- Some background (if relevant) on what has happened before

  The delivery of adaptations has been evolving since the implementation of the North Norfolk IHAT in November 2012 and will continue to evolve in line with the proposals made by the IHAT Managers Group and IHAT Strategy Group
- An overview of the scheme and activity that would take place

  It is expected that following the changes made within the North Norfolk IHAT (implementation of the Preventative Assessment, roll out of training for Community OTs to make direct recommendations, charging for technical and professional support, capitalisation of maintenance/extended warranties for equipment and closer working with the Early Help Hub and referral from the new social prescribing and loneliness and isolation services) will result in the full budget being spent. The Council continues to look at how it can reduce the length of time taken to deliver adaptations in line with the Government's request and will be working towards delivering adaptations in 140 days in line with the achievement of authorities in Warwickshire which employ a similar model to the IHAT.

Rationale/Evidence base

Detail your rationale/ evidence base here

Appendix 5 – North Norfolk Locality Plan

The Council has a statutory duty to deliver adaptations through Disabled Facilities Grant and the Government has requested that local housing authorities do everything they can to reduce the length of time taken to deliver adaptations and has increased the DFG allocation to enable this to happen.

Outcomes

Use this space to detail your expected outcomes

- Reduced emergency admissions in particular resulting from falls (steps and stairs, getting in and out of the bath)
- prevention offer
- Potential for a reduction in carer breakdown
- Improved customer journey/satisfaction.
- Potential for reduction in delayed transfers of care
- Improved health and wellbeing
- Increased independence and ability to access community facilities

Proposal 2 – Targeted approaches: GP Clusters and MDTs

Describe proposal in this box.

Include:

- The objective of the scheme:

  Determine whether those most at risk of hospital admission have been assessed for a housing adaptation as part of the prevention offer.
- Some background (if relevant) on what has happened before.

  Currently a referral for housing adaptations is an open process and is dependent on a request for an assessment for an adaptation being made. This approach ensures that a targeted response is considered to those most at risk of hospital admission thus furthering the preventative approach taken to this cohort of people.
- An overview of the scheme and activity that would take place

  Multi-Disciplinary Team working is in place for the top 2% of people identified most at risk of hospital admission. The proposal is to pilot within 2 GP practices (one in the East and one in the West of the district) a desk top review of this cohort interrogating IT systems (CareFirst/LAS and M3) to identify which have and which have not had an adaptation intervention and to consider whether an adaptation intervention or further assessment/review of the adaptation would assist in helping to manage health conditions to increase independence and reduce/delay potential hospital admission/residential care placement.

  Next steps are dependent on the output from the pilot(s). If this approach evidences that looking at a population group in this way further increases their independence (if not already had a housing adaptation assessment) then be rolled out across all GP surgeries and form part

of the MDT process.

Rationale/Evidence base

Detail your rationale/ evidence base here

Developing integrated approaches to ensuring services are identifying and wrapping provision around those who are most at risk of hospital admission.

Outcomes

Use this space to detail your expected outcomes

- Reduced emergency admissions within targeted cohort of people
- Dedicated prevention offer available to those most at risk.
- Potential for a reduction in carer breakdown
- Increased patient experience.
- Potential for reduction in delayed transfers of care

Proposal 3 – Targeted approaches: More than 2 adaptations

Describe proposal in this box.

Include:

- The objective of the scheme

Determine whether those who have been referred for 2 housing adaptation or more are known to MDTs – to avoid hospital admission. It is likely that this cohort would be known to teams but it would be advantageous to be assured as this might indicate those that should be part of an MDT.

- An overview of the scheme and activity that would take place.

This project would help inform those people who may be in need of an MDT approach, if not already identified. This may be a way of ensuring those needs who may increase from a health and social care perspective are targeted as a priority and enabled to maintain their independence via an MDT approach

Rationale/Evidence base

Detail your rationale/ evidence base here

Developing integrated approaches to ensuring services are identifying and wrapping provision around those who are most at risk of hospital admission

Outcomes

Use this space to detail your expected outcomes

- Reduced emergency admissions within targeted cohort of people
- Dedicated prevention offer available to those most at risk.

- Potential for a reduction in carer breakdown
- Increased patient experience.

Proposal 4 – Implement proposals that have already been tested with good outcomes

Describe proposal in this box.

Include:

- The objective of the scheme

Implement the roll out of use of the preventative assessment by trusted assessors. This is a county-wide initiative.
Some background (if relevant) on what has happened

- Before referrals for assessment would be received from Health OTs and the assessment undertaken by a Social Services OT/AP. This initiative negates the needs for a further assessment and uses the information gathered by Health OTs as trusted assessors thus speeding up the process, improving the customer journey and increasing capacity in the system An overview of the scheme and activity that would take place

It is estimated that this initiative will assist in moving closer to the 140 day target for provision of adaptations through DFG

Rationale/Evidence base

Detail your rationale/ evidence base here

The assessment process is impacting on the ability to progress with adaptations at pace.

Outcomes

- Reduced emergency admissions within targeted cohort of people
- Dedicated prevention offer available to those most at risk.
- Potential for a reduction in carer breakdown
- Increased service user experience.

Appendix 5 – North Norfolk Locality Plan

Proposal 5 – Options for use of any underspend

Describe proposal in this box.

Include:

- An overview of the scheme and activity that would take place

The DFG budget for North Norfolk was underspent in 2016/17 and there is potential for the budget to be underspent in 2018/19 if the number of recommendations is not generated to deliver the estimated number of completed DFGs. The Council would like to work with partners to utilise any potential underspend on capital schemes that will reduce the need for adaptations and support residents to live independently in the community and would like consideration to be given to the following;

- Improving dementia provision at Housing with Care schemes
- Subsidising the cost of new supported housing schemes (where required)
- Subsidising the cost of new build wheelchair accessible properties
- Funding the adaptation of properties within the current social housing stock that lend themselves to adaptation and which are not currently tenanted in order to meet the needs of those whose current property cannot be adapted (mainly households with children)
- Purchasing properties on the open market to meet the needs of households who needs are not currently being met and form whom there are no other solutions to meeting their needs

Rationale/Evidence base

Detail your rationale/ evidence base here

Utilisation of all available capital funds to meet shared strategic priorities

Outcomes

Use this space to detail your expected outcomes

- Dedicated prevention offer available to those most at risk.
- Increased service experience
- Reduction in delayed transfers of care
- Specific support available within the local community

Appendix 6 – Norwich Locality Plan

Better Care Fund & Disabled Facilities Grant Locality Plan 2018/19	
Area covered:	**Norwich City Council**
DFG Funding:	**BCF Allocation - 2017/18 £969,369** **2018/19 £TBC**

Overview

1. Within Norwich, the HIA/District Authority has is delivering the 2017/18 BCF DFG plan with a budget £969,369. This plan shows what the aims and proposals are for the next year.

Planned activity for 2018/19

2. Through the BCF, our Home Improvement Team will continue to deliver DFGs, discretionary DFG top up grants, and financial assistance for home improvement to vulnerable home owners on the following basis:
    a. DFGs of up to £30,000 for appropriate and necessary adaptations which are reasonable and practicable
    b. DFG discretionary top up of up to £35,000 for cases where major adaptations or relocations are required, and it is not possible to provide a cost-effective solution in the existing home of the client with a mandatory disabled facility grant
    c. Financial assistance of up to £35,000 for vulnerable people who own their own home outright or who have a mortgage, but cannot afford to pay for essential repairs. This is means tested, and is linked financial ability to pay for works, and the amount of equity in the home.
    d. Safe at home grants of up to £2,500 to provide dementia specific adaptations, emergency repairs or investigative works where disabled facilities grants are not suitable.

3. We will also deliver the following three proposals; two continue to be developed and one is a new proposal:
    a. Hospital discharge scheme – continued activity
    b. Adaptations assistance project – continued activity
    c. Preventing admission to hospitals – new activity

4. All the work of the Home improvement team supports people to live independently at home and provide health and wellbeing in the community. They provide a client-centred approach ranging from prevention and promotion of health and wellbeing to specific targeted interventions for people, for example, those living with dementia. It is expected that the proposals will maximise the potential for the physical environment to support vulnerable and disabled people, through access to adaptations and a range of housing options as well as ancillary services. The proposals will also contribute to the metrics of the better care fund:
    a. Non-elective admissions
    b. Admissions to residential care homes
    c. Effectiveness of reablement
    d. Delayed transfers of care

5. Compared to the total annual NHS budget, the cost savings to health and social care provided by the individual locality proposals are marginal. However, when considered in conjunction with our wider activities and interventions in regard to prevention and promoting independence (see Appendix 1), much can be achieved, particularly in terms of prevention and cost savings, from the cumulative effect of marginal gains.

Appendix 6 – Norwich Locality Plan

Proposal 1: Hospital discharge scheme & grant

6. Our hospital discharge scheme formed part of our previous set of plans and has been well received to date. In October 2016, we introduced a hospital discharge grant (non-means tested) of up to £10,000 to enable inpatients to access support and funding to tackle disrepair and adaptations in a timely manner. For straightforward adaptations and repairs, we aim to respond to the hospital discharge team by 3pm on the day of referral. Where more complex works are required, one of our case workers will visit the client in hospital to arrange access to the property and for works to be completed. We aim to complete these works in around 28 calendar days, compared with 144 calendar days for non-inpatient home improvement team referrals.

7. We carry out a follow up with clients three months after works are completed. This includes a customer satisfaction questionnaire and a follow up call, providing us with the ability to measure the value of the work carried out in terms of the client's health and well-being. Where key safes are fitted, a follow up call will be made a week after the works are complete to identify whether there are any other needs or services that we can help with, for example, income maximisation, handyperson service, living in fuel poverty, and onward referrals to other support agencies.

8. Over the course of these set of plans, evidence will be gathered to demonstrate a reduction in delayed transfer of care cases linked to housing related issues, and the cost savings to health and social care as a result of our interventions.

Aims and objectives for 2018/19

9. Further work is required to ensure that clinicians are aware of what activities local authorities' can provide to aid a timely discharge and that they are utilised in all cases where appropriate. In addition, it has been recognised that as local authorities, we need to work collaboratively to offer a single point of referral for health professionals to refer to for all local authority housing and home improvement related services.

10. A small task and finish group has been formed, made up of staff from districts across the county and the Norfolk and Norwich University Hospital (NNUH), to review the hospital discharge process, including the existing hospital discharge and homelessness prevention protocol[1]. The process will include discharge from all the hospitals in Norwich (NNUH, NCH&C , CCSRS and Hellesdon). There are a number of actions that will be carried out as part of this process which will enable a lean and efficient service to be delivered.

11. The first task is to produce a short list of simple questions that a patient can answer on admission that will highlight the need for any housing issues and wider needs to be addressed outside of the clinical setting. Draft questions will be based on the following:
    a. Where do you live when you're not in hospital?
    b. Do you own your home, or who do you pay your rent to?
    c. Do you find it difficult getting into and around your house, in/out of the bath, or up and down the stairs?
    d. Do you find it hard to carry out small repairs and odd jobs around the home and garden?
    e. Do you have contact with one or more people on a frequent basis?
    f. Do you often feel cold in your own home?

[1] Following the death of a homeless patient on the streets of Norwich some three years ago, the uncoordinated hospital discharge practice was highlighted by the Coroner's Office which led to the development of the NNUH hospital discharge and homeless prevention protocol.

g. Do you feel unable to pay your gas and electricity bill?

12. Unsafe housing can often be the reason why people are admitted into hospital in the first place, particularly through cold and trip hazards. These dangers have been estimated to cost the NHS over £600m every year in England[2]. By carrying out this '60 second' home health check, we can identify people to help and target BCF to make adaptations and improvements to their properties.

13. Further areas to focus on as part of the hospital discharge scheme include work with:
    a. the hospital discharge team to pilot a housing representative to be co-located in the discharge hub at the NNUH to support the ward co-ordinators in identifying at the earliest opportunity patients who will require district services to enable a timely discharge
    b. the network used for hospital discharge services in the community (including the Red Cross and Settle In service) to ensure that they are aware of the support and interventions available through the local housing authorities
    c. the hospital discharge team and public health to review the discharge data and identify pinch points on the process
    d. the homeless/housing outreach project based out of City Reach
    e. the East Anglian Ambulance Service to ensure that they are aware of the support and interventions available through the local housing authorities and identify the need for works to the property
    f. the pre-elective admissions team to produce a pathway where housing need can be identified before a patient is admitted creating a streamlined patient pathway.
    g. the wider partners including adult social care, CCGs and the community and voluntary sector to explore avenues of engagement (this links with our Community Pharmacy/Safe at Home proposal detailed further on in the plans).

Proposal 2: Adaptations assistance project

14. Applicants for disabled facilities grants are required to undertake a statutory means-test which determines what their contribution towards the works should be. This calculates a nominal loan value that the applicant could afford to support. The reality, however, is that many clients with small contributions have insufficient savings or the spare income to support a loan and this is reflected in a drop-out rate from applicants in that category which is has grown to around 25% (or approximately 40 cases a year at current demand levels).

15. The current mandatory means test is complex and tends to penalise those with housing costs that are higher than the standard amount specified or where the standard allowances for overall living costs are too low. It therefore works against the government's intentions to increase preventative spending on disabled adaptations. This means that a significant number of disabled residents in Norwich are not receiving appropriate and necessary adaptations which will enable them to live safely and independently in their homes despite government funding being made available for this purpose.

16. In order to ensure that applicants do not withdraw and that full use is made of the better care fund, we have recently introduced an adaptations assistance grant of up to £5,000 toward the contribution required by the means-test. The council can limit the risk of overspending the better care fund allocation by making the offer of the top-up grant dependent on available funds. If demand increases to a point where there is insufficient available capital to offer a top-up then the client would be offered a choice of proceeding with a disabled facilities grant only (including any contribution) or waiting for funding to become available. The council would not, therefore, be in breach of its statutory duty to approve a disabled facility grant to an eligible applicant. The offer of adaptations assistance grants would be suspended at the point at which the predicted year-end

[2] *https://www.hsj.co.uk/*

expenditure reached 90% of the available capital budget.

17. Applications for disabled facility grants cannot be placed on a waiting list due to the requirement to determine them within a six month period. However, there is the ability under the governing legislation to delay payment for up to six months to enable budgets to be managed across financial years. That mechanism, combined with the proposed suspension point should enable the capital funding to be kept within budget.

18. National research[3] has shown that people, who have an adaptation in their home and later move into care, do so some four years later than those who have not had adaptions carried out. With a residential care plan costing around £27,000 per year compared to the average disabled facilities grant costing less than £6,000, adaptations can have a major impact for social care budgets.

19. Since the introduction of the grant towards the end of January 2017 we have been able to process 12 additional referrals, subsequently helping those people who would ordinarily not have received the necessary adaptations to enable them to live safely and independently in their homes.

Aims and objectives for 2018/19

20. Although a formal evaluation will not be done until the end of year, initial evaluation of this scheme suggests that it is a success.

21. At the time of writing this report 35 families had accessed the assistance. It has not had a significant effect on the allocated budget but has resulted in adaptations going ahead when otherwise they may not have.

Proposal 3: Preventing Admission to Hospital Grant

22. Our hospital discharge scheme is limited to being reactive work dealing with issues as and when they arise. Using the extra £100k allocated to the city council from central government in January 2018, the city council implemented a preventing admission to hospital grant.

23. This grant is in effect a mirror of the Hospital Discharge Grant but with the purpose of avoiding unnecessary admittance to hospital caused by unsafe or unsuitable housing related issues.

24. The grant is a £10k non means tested grant with the only qualifying criteria being a referral from either the Norwich Escalation Avoidance team (NEAT) or the councils own environmental strategy team, through their cosy city initiative(who have been working to identify vulnerable people whose health is at risk due to poor heating and insulation).

Aims and objectives for 2018/19

25. It is our intention to continue to offer this type of financial assistance for the duration of this set of plans to enable us to make full use of the better care funding. An evaluation of the project will take place towards the end of 2018/19 to assess its success and the value of offering such assistance.

26. Further work is needed to build on our relationship with NEAT, which will be achieved by attending their weekly multi-disciplinary team meetings where prevention cases will be discussed and solutions identified.

[3] Linking Disabled Facilities Grants to Social Care Data, Foundations 2015

Appendix 6 – Norwich Locality Plan

27. The home improvement team will carry out a follow up with clients three months after works are completed. This will include a customer satisfaction questionnaire and if necessary a follow up call, providing us with the ability to measure the value of the work carried out in terms of the client's health and well-being.

Appendix 7 – South Norfolk Locality Plan

South Norfolk CCG Better Care Fund Locality Plan 2018/19 South Norfolk Council	
Area covered:	**The South Norfolk Council administrative area of the South Norfolk CCG**
DFG Funding:	**BCF Allocation - 2017/18 £780,666** **2018/19 £TBC**

Overview:

South Norfolk Council believe that a housing authority has much to offer health and social care. To us, housing is simple. A suitable, stable and secure home in the community supports people in being healthier and happier – which is the most important thing to everyone. But also, by embedding housing in the integration agenda we can be instrumental in helping health and social care reduce their costs.

The right home environment can protect and improve health and wellbeing and prevent physical and mental ill-health; it can enable people to manage their health and care needs, including long-term conditions, and ensure positive care experiences by integrating services in the home; it can allow people to remain in their own home for if they choose.

The right home environment is proven to delay and reduce the need for primary care and social care interventions, including admission to long-term care settings; prevent hospital admissions; enable timely discharge from hospital and prevent re-admissions to hospital and enable rapid recovery from periods of ill-health or planned admissions

Our approach to the home environment has been prepared in consultation with Norfolk Public Health, the South Norfolk Clinical Commissioning Group and the Norfolk Health and Wellbeing Board and is set out in the South Norfolk "Prevention and Promoting Independence" document. The activities described below comprise our main contributions to the Norfolk Better Care Fund Plan for 18/19 and 19/20.

Progress and performance will be reported to the South Norfolk Early Help Strategic Board.

Delivery for 2018/19

Proposed Activity in 2018/19

1. **Living Independently at home** – our aim is to reduce the average time taken from enquiry to completion to the Norfolk agreed target of 140 days. We will implement the improvements identified in our review of the system to ensure an effective delivery chain.

2. **Hospital Discharge (District Direct)** – in partnership with the Norfolk and Norwich University Hospital we will develop and embed the District Direct model to ensure barriers to discharge are identified at the earliest opportunity and a housing pathway agreed that ensures patients can return home at an appropriate time and are not put at risk by being discharged inappropriately.

3. **Care & Repair Service (Home Improvement Agency)** – we will continue to commission a home improvement agency to support vulnerable people to remain in their homes.

4. **District Direct Grants** – administered by the Care & Repair Service to support hospital discharge

5. **Handyperson Scheme** – we will continue to commission a Handyperson to support vulnerable people to remain in their homes.

6. **Social Prescribing** – we will pilot Social Prescribing services in GP practices to provide social and community based alternative for people presenting at the surgeries with non-medical issues

Activity 1 – Living Independently at Home (18/19)

Housing Adaptations – South Norfolk is committed to the Norfolk objective of reducing the average time for completion of non-priority case adaptations from 243 days to140 days and 55 days for priority cases.

Health Occupational Therapists (OT's) based in Community teams will undertake Disabled Facility Grant assessments, removing the need for two assessments.

Assistant Practitioners (AP's) and Home Improvement Agency Case Officers accredited to undertake stair lift assessments, releasing more time for OT's to deal with complex cases

Minor adaptations, repairs and home safety checks will be delivered through a Council managed Handyperson Service. Grants and discounts will be available to eligible residents.

Private sector housing residents will be assisted through the adaptation process

Poor housing, unsuitable housing and precarious housing circumstances affect our physical and mental health. The health of older people, children, disabled people and people with long-term illnesses is at greater risk from poor housing conditions. The home is a driver of health inequalities, and those living in poverty are more likely to live in poorer housing, precarious housing circumstances or lack accommodation altogether.

Activity 2 - Hospital Discharge

District Direct supports patients and hospital staff to identify and overcome barriers to discharge via a dedicated district resource within the integrated hospital discharge hub. The aim is to support residents to return home in a timely manner from hospital to an environment that meets their needs with the necessary support in place.
District Direct pilot includes:
• A dedicated District Direct officer based within the integrated hospital discharge hub
• Support to DISCOs to identify at an early stage patient vulnerable to delayed discharge,

developing and promoting the referral process and gaining patient consent
• Assessment and action plan to remove the barriers preventing patients from returning home
• Patient follow up to support sustainable independent living at home
We have raised concerns over the current allocation of places in Housing with Care schemes where high void levels have result in lost rent to landlords and underutilised care provision. Whilst a review of the schemes is being undertaken we are exploring interim alternative use of the accommodation including use as discharge beds.

Focus will be placed on identifying housing need at the earliest stage of the patient pathway including working through GP Practices to support patients assessed as needing elective medical interventions.

The protocol will be applicable to all the hospitals in Norwich (NNUH, NCH&C and CCSRS).

Future development

2.0/3.0 FTE employed by South Norfolk Council to be based within the NNUH Integrated Discharge Hub
Development of District Direct referral routes from A&E department
Support the hospital campaign to transfer people from being bed-based to day room facilities
Share best practice within mental health and community hospitals
Roll out to James Paget and Queen Elizabeth hospital

Activity 3 – South Norfolk Care & Repair Service (18/19 budget £tbc**)**

South Norfolk Care and Repair assists older, disabled and vulnerable people to live a good life for longer, offering reliable information and advice and supporting them to make modifications to their homes as their health and needs change, especially through later years. This model of providing low level early support has been consistently recommended by the DCLG and more recently in the Better Care Fund guidance from the DoH.

South Norfolk Council recognises the value of this service and despite Adult Social Care withdrawing support will continue to provide the service, prioritising vulnerable people in the private housing sector.

Activity 4 – District Direct Grants (18/19 £tbc)

The District Direct Hospital Discharge Grant (Appendix One) is intended to assist our residents who are able to return home from hospital, but are being prevented from doing so because there are factors at their home (that can be speedily remedied), that prevent them from doing so. Enabling that speedy discharge enables the hospitals to make better use of their resources, freeing up expensive bed space and increasing health service capacity and resilience. More importantly for some of our

residents, the speedy move back to their own homes improves their chances of recovery and lessens the likelihood of readmission and loss of life expectancy.
This grant is intended to compliment and not replace other support and assistance that may be available, either from the Council or other agencies.
It differs from the Disabled Facility Grant as it is addressing the immediate need which may be short term/temporary in nature, for example a resident returning home to recuperate. However, it could also be used to compliment a DFG by enabling a person with longer term needs to be able to return home with a support/care package whilst their longer-term needs could be addressed with a DFG, are fully assessed and understood.
We have set the maximum grant at £3000 to enable us to fund items that have been suggested by other agencies, however the experience from other parts of the country where such assistance is being provided indicates the average grant to be less than £500. With the most common works being installation of key-safes to allow carer access, and temporary ramping to doors to enable wheelchair access. This type of work could normally be undertaken by our Handyperson Service.
The type of work that could be funded has been included for example purposes not intended to be a definitive list. We have focussed on the intended outcome of the grant and the grant parameters in order to enable flexible responses and solutions to what will be invariably individual circumstances.

Activity 5 - Handyperson Scheme (18/19 £tbc)

South Norfolk has delivered a handyperson service since 2004. The scheme is designed to deliver small repairs and 'odd jobs' around the home to people who may find it difficult to carry out these jobs for themselves.

The scheme addresses property maintenance, minor adaptations, home-security, home safety and falls prevention all at the same time, as well as engaging with older people who are not currently in receipt of services, or who are suffering isolation. This is in line with the government's vision for efficient, holistic handyperson services. Unsafe housing can often be the reason why people are admitted into hospital in the first place, particularly through cold and trip hazards.

Referrals are received from partner agencies to for fitting key safes, grab rails etc to enable provision of care.

Activity 6 - Social Prescribing (18/19 £tbc)

Social prescribing aims to help people address underlying issues early - rather than using clinical or medical services unnecessarily. Social prescribing and building community capacity forms a central part of the Norfolk NHS Sustainability and Transformation Plan (STP) to address demand on health services.

South Norfolk Council employed Community Connectors are being embedded in South Norfolk's 13 GP practices (covering 18 sites) utilising district council, community and partners'

infrastructure and resources. Relationships are in place with practices to enable fast mobilisation. Early estimates indicate that the district wide provision could deliver £950k of savings to the health sector over 2 years.
Activity 7 – Triage team (18/19 £tbc)
Dedicated triage team within the early help hub to triage all independent living enquiries – identifying those residents who would benefit from smaller adaptations delivered through the handyperson or community support; completing ASC triage assessment for residents identified as benefiting from a Disabled Facilities Grant.