Appendix One

Local Government Association

Norfolk County Council **Peer Challenge Report Older People**

September 2018

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Executive Summary

Norfolk County Council (NCC) asked the Local Government Association (LGA) to conduct an Adults' Peer Challenge focussing on the provision of services for older people as part of the East of England ADASS Peer Challenge Programme. The work was commissioned by James Bullion, Executive Director of Adult Social Services. He was seeking an external view to consider how effectively health and social care work together to provide care and support for older people. The Council intends to use the findings of this peer review to strengthen the approach to prevention and strengthen a comprehensive short -term 'offer' to support winter planning. The focus for the Challenge was:

How the health and social care system is functioning across:

- Supporting people's wellbeing in their usual place of residence
- Crisis management
- Step down after crisis, including return to usual place or admission to a new place of residence

The team spoke with representatives from a wide range of organisations and the findings in this report are based on the evidence that was obtained from meetings and documents presented. However, the team did not meet with representatives from two out of the three acute health trusts and the ambulance service. It was clearly demonstrated to the team from those people who participated in the review that there is a strong partnership in place to deliver health and social care in Norfolk. Organisations from across the whole health and social care system have had the opportunity to come together and agree the ambition for an integrated care system. This provides the framework to support those individuals in need. It was also clear that effective partnership working may be inconsistent across all the members of the Partnership, with some playing a more active and engaged role than others. It was recognised that organisations faced different levels of challenge, particularly in acute hospital trusts (both nationally and at a local level) and that the requirement to focus on internal imperatives impacted on the capacity to engage with others and work collaboratively at the same scale and pace to meet the stated ambition.

There was a clearly expressed understanding of the concept and subscription to the idea of systems leadership and there was a recognition that this was necessary to deliver services into the future. At all levels across the Partnership the team found examples of strong, collaborative leadership that was able to take brave decisions to ensure that appropriate services were delivered. However, these are not consistently replicated across the county/ Sustainability and Transformation Partnership (STP) with organisations responding to a range of diverse pressures. There was evidence from staff, partners and service users that they received communication from and had opportunities for engagement with NCC. However, there did not appear to be a consistent level of engagement and understanding across all the elements of the Partnership with some participants stating that they were not always aware of the information they are being given and that it is not in a format and style that they can understand. There did not appear to be a mechanism for checking that information is consistently heard across the whole system. There is also a real opportunity to use the wealth of data collected by organisations across

the partnership, as well as within NCC to inform future planning and underpin commissioning.

The team saw evidence that market development was underway and heard from participants about their experiences of being involved in market development activities. However, participants expressed the view that they did not want the market shaping process to be seen as being determined by NCC and there was an awareness of the potential for the wider Partnership to become more involved in developing the market.

The team noted that there were strong examples of integrated working, which included the piloting of the Norwich Escalation Avoidance Team (NEAT) approach. The team noted that there was strong sign-up to the STP and that this was the vehicle that was leading the move towards further integration. However, there appeared to be an inconsistent approach to integration including; the advice, guidance and information offered to people when they make contact through the 'front door', the understanding of the new model of social work practice being adopted in Norfolk, care pathways and how these were being managed, the parity of esteem between physical and mental health.

There was evidently a 'can do' attitude and approach to addressing issues; both raised at an organisational level and at an individual level. The team heard numerous examples of staff going "above and beyond" what was expected of them to ensure that people were cared for and safe. However, when under pressure staff reported that they defaulted to "tried and tested" practices, relying on what they were familiar with rather than following new models of care.

From the people that the team met it was clear that there is a significant willingness and desire, from across all the sectors, to put mechanisms in place that enable people to come down from crisis. However, given the range of step-down services on offer the team questioned the rate of hospital discharge directly into residential care. Suggestions of options that might provide alternative solutions included; providing adequate and appropriate provision of extra-care housing, the early and consistent use of the universal offer as the "first port of call" and the development of a system wide approach to managing risk so as to move away from the "over prescription" of care packages.

Report
Background

1. Norfolk County Council (NCC) asked the Local Government Association (LGA) to conduct an Adults' Peer Challenge focussing on the provision of services for older people as part of the East of England ADASS Peer Challenge Programme. The work was commissioned by James Bullion, Executive Director of Adult Social Services. He was seeking an external view to consider how effectively health and social care work together to provide care and support for older people. The Council intends to use the findings of this peer review to strengthen the approach to prevention and strengthen a comprehensive short -term 'offer' to support winter planning. The focus for the Challenge was:

   How the health and social care system is functioning across:

- Supporting people's wellbeing in their usual place of residence
- Crisis management
- Step down after crisis, including return to usual place or admission to a new place of residence

2. A peer challenge is designed to help an authority and its partners assess current achievements, areas for development and capacity to change. The peer challenge is not an inspection. Instead it offers a supportive approach, undertaken by friends; albeit 'critical friends'. It aims to help an organisation identify its current strengths, as much as what it needs to improve. But it should also provide it with a basis for further improvement.

3. The benchmark for this peer challenge was the Care Quality Commission's (CQC) (Local Systems Review) framework and this report is based on the following four headings linked to the five CQC framework key questions:

- Partnership – is the system safe?
- System Leadership – is the system well-led?
- Engagement and Communication – is the system person-centred?
- Market Development – is the system effective and responsive?

   The report also responds to the three review focus questions set out above.

4. Although this report can be considered in the context of Norfolk-wide strategies and approaches the team is conscious that given the geography of the county a significant proportion of the evidence gathered was from the Central Norfolk System.

5. The members of the peer challenge team were:

   - **Sharon Houlden –** Director of Adult Services and Housing, Southend-on-Sea Borough Council
   - **Cllr Isobel Seccombe –** Leader, Warwickshire County Council
   - **Sarah Range –** Head of Adult Mental Health, Principal Social Worker, Southend-on-Sea Borough Council
   - **Annie Topping –** Director of Nursing, Quality and Patient Safety, Northumberland Clinical Commissioning Group
   - **Nicki McNaney –** Independent Health and Care Improvement Consultant and Coach
   - **Abby Vella –** Advisor, Care and Health Improvement, LGA
   - **Jonathan Trubshaw –** Peer Review Manager, LGA

6. The team was on-site from Tuesday 18th – Friday 21st September 2018. To identify the strengths and areas for consideration in this report, the peer review team reviewed over 80 documents, held 40 meetings and met and spoke with over 100 people during the four on-site days and collectively spent more than 360 hours to determine their findings. The programme for the on-site phase included activities designed to enable members of the team to meet and talk to a range of internal and external stakeholders. These activities included:

- interviews and discussions with councillors, officers, partners and providers
- focus groups with managers, practitioners, service users, carers and frontline staff
- collecting information from those who access services
- reading a range of documents provided by the Council, including a self-assessment against key questions.

7. The LGA would like to thank James Bullion, Executive Director of Adult Social Services, Debbie Bartlett, Assistant Director Strategy and Transformation and the coordinating team of Louise Cornell, Wendy Simmonds and Tricia Balding for the excellent job they did to make the detailed arrangements for a complex piece of work across key partners with a wide range of members, staff and those who access services. The peer team would like to thank all those involved for their authentic, open and constructive responses during the review process and their obvious desire to improve outcomes; the team members were all made very welcome.

8. Our feedback to the Council on the last day of the review gave an overview of the key messages. This report builds on the initial findings and gives a more detailed account of the review.

Key messages

Partnership – is the system safe?

9. It was clearly demonstrated to the team that there is a partnership in place to deliver health and social care in Norfolk. Through the documents that were made available to the team and in conversations with those participating in the review process there was evidence that organisations come together and provide the framework to support those individuals in need.

10. It was also clear to the team that effective partnership working is inconsistent across all the members of the Partnership (for the provision of health and social care and covering the Sustainability and Transformation Partnership (STP) footprint), with some playing a more active and engaged role than others. More work would be required to evidence the level of engagement in those acute trusts and the ambulance service, that the team did not meet. The team acknowledged that organisations faced different levels of challenge, particularly in the three acute hospital trusts, the ambulance trust and the mental health trust, and that the requirement to focus on internal imperatives impacted on the capacity to engage with others and work collaboratively.

11. The team noted that there were some examples of good outcomes and improvements that had been achieved through partnership working. This included examples of what appeared to be well established, integrated working in the west, where there were examples of good practice in admission avoidance and early supported discharge, with further improvement work to focus on the frail elderly population.

12. Although the people that the team met with stated that they had good relationships with colleagues in other organisations, both at the frontline and at a strategic leadership level, not all those interviewed could readily provide examples of how these improving relationships had contributed to improvements in outcomes for individuals.

13. From the people whom the team met there was a high degree of awareness of the issues facing the Partnership and the “blockages” that prevent increased benefits, both organisationally and for service users. However, there was also a recognition that as the Partnership they did not always make the hard decisions swiftly enough and act jointly in a robust manner. It was recognised that there may be opportunities to approach this differently through the infrastructure being developed for the STP.

14. The team noted that those participating in the review took the opportunity to reflect on how as partners they came together to consider the issues brought up by the STP in Norfolk and Waveney and how this fitted with the national approach to STPs. Some participants expressed concern that there did not appear to be a parity of esteem between the Health and Social Care partners. There was a perception that this is a Health driven initiative and that Social Care was expected to adopt a health-based ethos. However, a significant number of the people whom the team met described the STP as the vehicle for delivery and it was clearly articulated that there will be an asset-based approach.

System Leadership – is the system well-led?

15. All the partners spoken to by the team clearly expressed an understanding of the concept of systems leadership. The people participating in the review stated that they subscribed to the idea of systems leadership and that they recognised that this was necessary to deliver services into the future.

16. The team recognised the investment of senior leaders, both in NCC and across the Partnership, in the management and leadership of the whole health and social care system. The team noted the open and vocal commitment of partners to the Partnership and how they expressed their belief that developing and deepening the level of partnership working was the best way of delivering the vision for the residents of Norfolk.

17. At all levels across the Partnership the team found examples of strong, collaborative leadership that was able to take brave decisions to ensure that appropriate services were delivered. The team was impressed with the work of the Norfolk Escalation Avoidance Team (NEAT) where specialist from a variety of organisations and disciplines "huddle" together to keep people safe in their own homes for as long as appropriately possible. Other evidence of collaborative leadership was seen in the Executive Director of Adult Social Care leading the STP primary care work stream.

18. The team noted strong exemplars of leadership systems and approaches (see above). However, these are not readily replicated across the county/STP. The Partnership needs to challenge itself to understand the cultural barriers that organisations erect, which prevents the ready take up of effective approaches that are being used elsewhere. The team recognises the diverse pressures that individual partners face; as a whole the Partnership needs to tackle resistance to change and utilising system-wide beneficial practices.

19. The team received a lot of varied feedback about the piloting of initiatives. Many commented on the council's openness and willingness to trial innovation and explore new ways of working. However, it was also perceived that there was a 'culture of piloting' to test out new ideas and approaches to working, which was without robust improvement measures and opportunities to share learning. Funding is gained for short-term periods. However, feedback from staff suggested that the resources came from within the existing staff pool which left others having to back-fill those staff engaged in pilot activities. Other evidence was that pilots went on for long periods of time, that they were stopped to allow for evaluation and conversely that some were not evaluated at all. Lessons learnt from pilots needs to be shared to allow for consistent and system wide adoption of initiates that are proven to be successful so that the culture moves from one of perpetual piloting to a culture of doing and continuous improvement.

Engagement and Communication – is the system person-centred?

20. The team heard evidence from staff, partners and some service users that they were communicated with and had opportunities for engagement with NCC. Representatives from community groups said that they engaged with the council and that they understood the vision for older people. They also said that they understood the direction of travel for the STP.

21. However, there did not appear to be a consistent level of engagement and understanding across all the elements of the Partnership. The team received evidence from some participants, including service users and family carers, that they did not know about or understand the implications of the STP and there was an inconsistent level of understanding within the staff that the team met. They stated that they did not believe that they had heard the messages about the direction of travel. Some service users and family carers told the team that their perception was of poor communication with NCC, with limited opportunities for engagement and that when they put their views forward that these were not listened to. More needs to be done to ensure that residents and service users are aware of the information they are being given and that it is in a format and style that they can understand whilst ensuring the overall message is consistently delivered.

22. There did not appear to be a mechanism for checking that information is consistently heard across the whole system. Senior managers expressed a desire to know how well new models of practice are embedded across the system. It was also unclear how the public is re-engaged with after consultation has taken place. The perception from carers and services users was that they feel like they spend time trying to influence and feedback to the council on proposals but that they rarely get a response on how the council is acting on their in-put. The team recognised that this is an area that NCC wants to become more self-aware about and there is a clear ambition, strategy and engagement programme for both staff and local people. Systems need to be further developed that enable questions to be asked on a regular basis. An overt and transparent approach is likely to encourage further engagement in the process. The team was made aware that a staff survey is soon to be conducted and opportunities such as this could be used to monitor the internal communication of key messages.

23. The team saw evidence of NCC's ambition to drive forward with the use of technology to deliver health and social care preventatively, supporting people in their usual place of residence. One example of how the council is helping to mainstream technology in health and care is through the new Innovation Centre displaying assistive technology within the council to create awareness with staff. It was however, too early at this stage to determine the extent to which this was influencing staff perceptions of technology enabled care. The use of technology to support people's reablement periods was also evident at Benjamin Court. Overall the digital maturity of the STP footprint appeared to be low with work required to improve the interface (and sharing of information) between health and social care.

24. Some staff the team met stated that their perception was that there is currently an under-exploited opportunity to use technology to engage more fully with residents and service users, although there is a clear ambition, strategy and engagement programme for both staff and local people. Staff have considered what may assist for the people they support but need a vehicle to share their ideas with someone who can affect change.

25. The council could do more to provide information through the systems that residents are saying that they want to use, such as the use of social media in a more consistent way and the use of web-based applications.

Market Development – is the system effective and responsive?

26. The team considered that market development was a key theme for the whole Partnership to consider and not just be addressed within the statutory responsibility of the local authority. It was not clear whether the statutory responsibility was being fully exploited. However, participants expressed the view that they did not want the market shaping process to be seen as being determined by NCC with others following on behind. Participants spoke of their awareness for the potential for the wider Partnership to become more involved in developing the market. There was also an awareness that more work needs to be done to ensure that the current willingness is translated into positive engagement and activity. More could be done at an earlier stage to ensure that partners are involved in the shaping process and that their voice is seen to be heard.

27. The team saw evidence that market development was underway and heard from participants about their experiences of being involved in market development activities. This includes workforce development for carers commissioned through Norfolk and Suffolk Care Support. The team heard differing views of how the Local Authority Trading Company (LATC) is involved in shaping the market. Greater clarity could be offered to ensure other providers are not misinformed and to ensure that all work together to supply the care offer that will be required into the future.

28. Participants also spoke of their concern that there may be “blind spots” in the Partnership’s understanding of the market and what is needed to facilitate its development.

29. It was clear to the team that NCC produces and holds a significant amount of data and intelligence on the market. There was evidence that data is used to inform and guide decision making. However, it was less clear how the information resource was used to inform the commissioning process and more could be done to demonstrate how what is known about the market is used in shaping outcomes. The commissioning strategy and intentions could be more clearly expressed so that it is understood by all partners, so that the Partnership can more effectively work together and help ensure that these intentions are achieved.

Supporting people's wellbeing in their usual place of residence

30. The team noted that there were strong examples of integrated working. As well as the NEAT the team saw an initiative bringing together Occupational Therapists from health and social so that they have one list of people they are working with and recording information on one system (System One). The work at Benjamin Court is bringing together social work, occupational therapy, GP visits and soon to be physiotherapy to support people being reabled into the community. The Wymondham Hub was seen as an example of effective integration where people receive multi-disciplinary support from a range of specialist therapies, nursing and social work intervention. It was expressed to the team that staff are becoming more relaxed about the definition of integration and are moving to solve the individual's problem jointly. However, some middle managers said that there was no clear vision or definition of what was meant by integration and therefore no clear approach of how to work together across the Partnership.

31. There was clear evidence of good relationships between organisations and their leaders including between NCC and the district local authorities that the team was made aware of during this review and between NCC and the Clinical Commissioning Groups (CCG).

32. The team noted that there was strong sign-up to the STP and that this was the vehicle that was leading the move towards further integration.

33. There were powerful examples of where integration was working well where GPs were leading and becoming directly involved in partnership working. There has been a perceived shift in enhancing primary care provision and promoting independence. There was also evidence that the ambition to shift the focus from acute to primary care was happening.

34. There was also evidence that in other localities primary care risk stratification and admission avoidance was not well coordinated. There appeared to be a lack of consistency in approach across the STP area.

35. NCC's Integrated Care Coordinators (ICC) act as a single point of contact between health and social care professionals, tracking service users/patients through the system. They work closely with GPs and help enable effective Multi-disciplinary Team (MDT) working.

36. There has been an investment in developing the professional workforce in all organisations through training and development programmes and opportunities to work differently. There has also been and investment in developing the community with a recognition that this approach helps access community assets and as a way of raising awareness of how future demands on the system might best be met.

37. There was evidence of the use of Public Health as an enabler, gathering information and promoting healthy lifestyle messages. The concept of "every contact matters", is being embedded across the workforce.

38. There is a reputable voluntary sector that is well developed and established. The team heard evidence that it is willing to continue delivering services and perhaps more usefully it is willing to engage in designing and creating new ways of doing things. This creates the opportunity to work in an increasingly person-centred way which keeps people in their own homes longer.

39. There is a clear ambition to use technology as a way of supporting people being cared for in the community and in their own homes.

40. The team heard evidence that there needed to be a strengthening in the advice, guidance and information offered to people when they make contact through the 'front door'. A more consistent approach would help manage demand with those responding to people enquiring about services being able to be clearer about what is on offer; informed by a mapping of services, associations and assets in the area where the adult lives.

41. The team did see that some staff had a significant understanding of the new model of social work practice being adopted in Norfolk. However, there were also staff who were confused as to whether models of practice were being piloted or in the process of being rolled out. Managers will need to assure themselves as to how embedded the model of social work practice is and whether this is being applied consistently across the social care workforce.

42. The team noted that there were some inconsistencies in care pathways and how these were being managed. The pathway to support older people with mental health needs was highlighted by different groups of staff from across the partnership as an area that needed further development. This may be due to new ways of working being piloted in some localities and not in others. Progress in pilot areas needs to be clearly and regularly communicated, with opportunities for staff to learn from each other, so that staff know which pathways are to be followed and can make sure that colleagues in other organisations are kept up to date. There also needs to be greater clarity and communication as to when piloting stops, and the way of working becomes business as usual.

43. The team received comments from some participants that they had concerns over the parity of esteem between physical and mental health. References were made to people not having mental health issues post 65 and that they would receive services no matter what the presenting issue. There was concern that beyond a certain age the significance of mental health issues is dissipated, with the individual only being seen as an older person.

44. It was clear to the team that recruitment and retention, across the social care workforce, was recognised as a complex and challenging issue. Some steps have been taken to address specific workforce needs, including the recruitment of an additional 50 social workers and managers. However, there are far reaching workforce needs, including the provision of paid carers for those service users living in remote areas with significant travel-to times, that can only be successfully tackled by a system wide response.

Crisis management

45. From all the interviews with frontline staff it was clear to the team that there was evidently a 'can do' attitude and approach to addressing issues; both raised at an organisational level and at an individual level. This was seen as a significant strength across the whole scope of the review and not just within the approach taken to crisis management. The team heard numerous examples of staff going "above and beyond" what was expected of them to ensure that people were cared for and safe. The team heard of staff who walked through snow when roads were impassable to visit people in their homes. There were also examples of staff 'thinking outside the box' of their roles to come up with solutions to the problems they encountered.

46. There were clear examples of multi-agency working, including the creation of multi-disciplinary teams. This was seen as evidence of a willingness, from across the whole system, to work together to find proactive solutions for people when they were in crisis.

47. The Team also received positive reports of the Swifts service that provides 24/7 support to people who need support after an unplanned event, such as a minor fall.

48. The team considered that the NEAT pilot was a particularly strong example of can-do, collaborative, brave practice and leadership that provides a multi-agency response to supporting people in crisis. The Virtual Ward was seen to be working effectively with NEAT and offered a real alternative to keeping people safe and given the appropriate care whilst remaining in their own homes. The NEAT approach is likely to provide a solution to the challenges facing other areas of the STP wide system.

49. Although there were examples of new practices being implemented the team heard that when under pressure staff defaulted to "tried and tested" practices. When crisis occurred, staff relied on what they were familiar with rather than following new models of care. Staff need to be supported so that they are more resilient and fully conversant with the preferred model of practice so that there is a consistency in approach across the system. Leaders and managers need to reinforce the models of practice to ensure that staff are familiar and comfortable with what is required when in crisis care situations.

50. It was not clear to the team that there was a single understanding across the whole system of how Delayed Transfers of Care (DTOC) was recorded, managed and challenged. This was the case for both the acute sector, as far as the team was able to establish this, and non-acute (Mental Health and Learning Disability) systems. There is an opportunity to develop a clear and agreed approach that is understood by all partners and one where robust challenge is both sort and welcomed.

Step-down after crisis

51. From the people that the team met it was clear that there is a significant willingness and desire, from across all the sectors, to put mechanisms in place that enable people to come down from crisis. Organisations can put forward ideas to create appropriate treatments that are in place to support recovery and help people live as full a life as possible once an individual's episode has ended. There is an aim to ensure that people are encouraged to move into a form of care or supported well-being in the community that is sustainable.

52. The team noted that there was a commitment within mental health services to collaborative working. This was stated publicly, and the team saw evidence (again, within the NEAT) where mental health practitioners worked effectively alongside colleagues from other organisations and disciplines. This provides a strong platform to develop further opportunities to work together to understand and address the mental health needs of older people.

53. The team heard from numerous sources, including service users, partners and staff that the reablement service was well regarded. They were considered to provide a wide range of support and this, together with the way in which they were delivered was highly valued. The team spoke to a soon-to-be-discharged service user at Benjamin Court who was positive about their experience and praised the service and staff.

54. Given the range of step-down services on offer the team questioned the rate of hospital discharge directly into residential care. The Partnership should consider how the system as a whole can more easily recognise and select alternative options to residential care. The team heard that practitioners did not always fully understand the full range of services on offer. Standardising and simplifying the offer, together with improved communications to raise awareness will help. Also, a system wide understanding and approach to managing risk might encourage a greater up-take of alternative destinations. The team noted that NCC was aware of the role that extra-care housing could play in contributing to the long-term planning of step-down provision and encourages the council to consider how this could be achieved. Partners should consider what role they have in ensuring that there is adequate and appropriate provision of extra-care housing.

55. The team saw evidence from frontline staff that the universal offer was often used to provide services in the step-down process. There is an opportunity to embed the understanding of the universal offer across the system, so that it is seen as the "first port of call" when considering how best to meet an individual's needs and thereby potentially lessening the likelihood of escalation to crisis and the subsequent need for step-down support.

56. The team recognised that there was a desire and real effort being made by frontline professionals to facilitate safe discharge from hospital to the right place at the right time. However, the team heard that at times this led to an "over prescription" of care packages, particularly at point of discharge and that there was not always the capacity within the system for robust and

timely review of these packages; losing the opportunity to intervene and appropriately reduce the package of care and take a more rehabilitative approach.

57. The team heard from some service users and staff that there was a perception that where people lived had an impact on the services that were made available to them. There was also acknowledgement that the geographical landscape impacted on the logistical challenges of providing health and social care across the whole county. These need to be clearly and consistently explained so that any perception of 'postcode-bias' is successfully challenged.

Recommendations

The following are the team's recommendations for NCC, together with partners, to consider further and determine what action is required to:

58. Explore what other LATC models are employed elsewhere, in order to consider how these can be best used to deliver maximum value for the whole system and support market development. Existing arrangements in Norfolk can then be tested against other models to ensure the maximum benefit is being extracted from having an LATC. The responsibility for any further development could be shared across the system so that the onus is not solely carried by the local authority.

59. Develop an Organisational Development plan for the system that enables a culture of doing and learning together. Although this would be wider than any one organisation a programme approach for developing the Partnership and leadership across it would be more effective than one-off events delivered by individual partners to consider specific issues or concerns. A more structured and directed approach to developing the Partnership would focus all partners on what was required to deliver the ambition for an integrated care system at scale and pace, agreeing principles to drive consistency whilst working to be responsive to the needs of different localities.

60. Build on the clearly demonstrable passion and enthusiasm of your communities for making a strengths-based practice a reality. The team received strong messages that there is a desire to maximise the community-based assets and there is an opportunity for the local system to harness the energy and engage further in collaboratively developing the offer. There was a recognition that activity is already taking place with community organisations and that the recommendation is to build on this keenness to participate more to further build the ambition and narrative for the whole health and care system.

61. Maintain the current and future role that strong political leadership has in achieving the vision for the whole system. The team acknowledged the interest, knowledge and understanding that elected members had around the impact that an increasing number of older people will have on the system. The implications that this will have on the local authority requires that the issue is maintained as a corporate responsibility and that corporate partners continue to be integral in delivering the Partnership's ambition.

62. Develop a clear narrative around the STP that can be customised dependent on audience i.e. citizens/staff/partners. The team received feedback that it is not yet clear enough to the various elements of the diverse range of organisations and individuals what the STP is and how they can contribute. More work is required to contextualise the information that is available so that a consistent level of understanding is developed.

63. Ensure that the ambition and plans to achieve this are understood by all those involved and affected by the delivery. This will require regular and contextualized information dissemination; even when there may not be new developments. A variety of methods will need to be used and matched to

suit specific sections of the audience; this may include further development of social media, web-based content as well as more traditional methods.

64. Test the level of engagement and buy-in across the system in relation to vision and direction of travel. Feedback mechanisms may need to be enhanced to broaden the impact of people's understanding, gather information and encourage greater engagement. This should be done on a regular basis with information obtained used to stimulate further improvements that are then communicated back to those participating in the information exchange.

65. Test out the degree to which new models of practice are embedded across the staff groups. Feedback systems should also be used to test out that frontline practice is being conducted in line with the direction set by system leaders. This may include tailoring staff surveys, enhancing the approach taken to file audit and encouraging a robust two-way staff briefing system.

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Appendix One