Adult Social Care Committee

Item No:

Report title:	**Prevention**
Date of meeting:	**4 March 2019**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

In Norfolk County Council:

a) We spend about £1 million a day on adult social care in Norfolk
b) On any given day, we will be securing services for around 14,000 people
c) Last year 20,205 people received short term and long-term adult social care packages
d) Last year, almost 6,000 had home based reablement services helping them get back on their feet after a crisis

We are fundamentally re-thinking our approach to delivering public services. Many of our services were designed in a very different era and policy framework. Funding regimes now do not account fully for demographic change or socio-economic changes, instead the drive is for local government to become self-sufficient through council tax and increased revenue from locally raised business rates.

At the same time as funding has been reduced, our population continues to grow and the pattern of family life has changed. Medical and technological advances are huge – people live longer and have access to many more medical specialists than in the past. More profoundly disabled young people with increasingly complex needs are coming into adulthood every year. People move around more for jobs than in previous generations, so families cannot always be near to older relatives to help and care.

A growing 'older' population affects Norfolk more than most other places – it has, and will continue to have, a higher proportion of older people compared to the average for the Eastern Region and for Norfolk's 'family group' of similar councils.

Adult Social Services' vision is to support people to be independent, resilient and well. To help achieve the vision, the department has its Promoting Independence strategy which is shaped by the Care Act with its call to action across public services to prevent, reduce and delay the demand for social care.

This paper outlines Adult Social Services approach and contribution to Early Help and Prevention.

Executive summary

In November 2018 the Department of Health and Social Care published the report: "Prevention is better than cure: our vision to help you live well for longer." The document sets out the government's vision for putting prevention at the heart of the nation's health by:

- stopping health problems from arising in the first place
- supporting people to manage their health problems when they do arise

In July 2018 the Health and Wellbeing Board (HWB) agreed its Joint Health & Wellbeing Strategy 2018-2022 with its partners. As part of this they agreed three Strategic Priorities, which included Prioritising Prevention. Through the Strategy, HWB partners have committed to working towards supporting people to be healthy, independent and resilient throughout life as well as offering help early to prevent and reduce demand for specialist services. This strategic priority has direct links

to the work partners are doing through the Sustainability and Transformation Partnership (STP) Prevention workstream.

In their vision for Norfolk, Public Health are prioritising actions which will: promote healthy living and health places; protect communities and individuals from harm; and provide services that meet community needs. This will bring significant benefits to Norfolk people in terms of increased quality of life and better health.

Adult Social Services' vision is to support people to be independent, resilient and well. To help achieve the vision, the department has its Promoting Independence strategy which is shaped by the Care Act with its call to action across public services to prevent, reduce and delay the demand for social care. Adult Social Services approach is to manage demand for services better by ensuring that people remain independent from public services as long as possible and are provided with preventative, community alternatives to council social care where appropriate. The aim is to support as many people as possible to live safely at home.

This report set out Adult Social Services approach to Prevention in line with the three key areas under the Promoting Independence strategy:

a) Looking After Yourself
b) Keeping Well and Recovering Your Health
c) Living with Complex Health Conditions

Recommendations:

Adult Social Care Committee Members are recommended to:

a) Endorse Adult Social Services approach to Early Help and Prevention
b) Consider whether they want further detail or reports on any specific aspect of Early Help and Prevention included in the report or specific prevention approaches

Appendix One – Case Studies (p70)

1 Background

1.1 In November 2018 the Department of Health and Social Care published the report: "Prevention is better than cure: our vision to help you live well for longer." The document sets out the government's vision for putting prevention at the heart of the nation's health by:

a) stopping health problems from arising in the first place
b) supporting people to manage their health problems when they do arise

The aim is to prevent problems from arising in the first place by:

a) targeting and co-ordinating services for groups most at risk
b) making the most of predictive prevention
c) giving children the best start in life
d) supporting healthier food and drink choices
e) getting people more physically active
f) encouraging active travel
g) reducing levels of loneliness and social isolation

The prevention vision for those already living with a health or social care need, and how they can live well for longer is:

a) living well in the community
b) picking up early when people do have health or care needs, and managing these effectively
c) stopping problems from getting worse and supporting recovery

d) supporting Primary care: an expansion of the general practice workforce; retention of experienced GPs; and GPs working more closely together
e) growing community health
f) supporting the whole person, not just treating symptoms

The Government's goal is to improve health life expectancy by at least five extra years, by 2035, and to close the gap between the richest and poorest. The paper includes examples of good practice. The link to the paper is in the Background Papers, section six of the report.

1.2 Prevention is one of the three strategic priorities in the Health and Wellbeing Board (HWB) Joint Health & Wellbeing Strategy 2018-2022, which has been agreed by its partners. (Please see section six for a link to Background papers).

1.3 In their vision for Norfolk, Public Health are prioritising actions which will:

- Promote healthy living and health places
- Protect communities and individuals from harm
- Provide services that meet community needs
- Work in partnership to transform the way they deliver services

This will bring significant benefits to Norfolk people in terms of increased quality of life and better health. It will also support the council's priorities, achieving the best outcomes for children and young people, protecting and supporting vulnerable people and helping Norfolk to be economically prosperous. It provides a further framework for potential joint work between Adults, Childrens and Public Health going forwards.

1.4 The Norfolk and Waveney STP (Sustainability Transformation Plan) Prevention Programme Board has been established to ensure greater focus and commitment from all relevant partners across the STP health and social care system on the prevention of ill health, reduction of the impact of illness, addressing the wider determinants of health and supporting population health management. The Director of Public Health is the Senior Responsible Officer.

1.5 The overall purpose of the Prevention Programme Board is to provide a lead to the development of strategy, setting priorities and delivery of projects in line with national and local priorities relating to prevention and population health management, and to provide assurance to the STP Executive Board of the effective and sustainable implementation of work stream initiatives against plan.

The work programme will be themed to include:

a) Healthy Living
b) Diabetes prevention
c) Promoting healthy lifestyles (diet, physical activity, smoking, alcohol) and Making Every Contact Count (MECC)
d) Smoking cessation and tobacco control
e) Suicide prevention
f) Optimising Healthcare
g) Diabetes care
h) Right Care Elective pathways for respiratory, cardio vascular disease and cancer
i) Population Health Analytics
j) Promoting independence in communities
k) Social Prescribing
l) Promoting self-care and patient education
m) Addressing wider determinants of health and wellbeing.

1.6 Prevention is key to Adult Social Services' vision to support people to be independent, resilient and well. To help achieve the vision, the department has its Promoting Independence strategy which is shaped by the Care Act with its call to action across public services to prevent, reduce and delay the demand for social care.

Norfolk County Council

2 Adult Social Services Early Help and Prevention

2.1 Adult Social Services approach is to manage demand for services better by ensuring that people remain independent from public services as long as possible and are provided with preventative, community alternatives to social care where appropriate. This approach is consistent with the responsibilities relating to wellbeing and prevention in the Care Act. When people do need formal services, our approach is to maximise their independence as far as possible. The aim is to support as many people as possible to live safely at home for as long as they can.

2.2 Adult Social Services approach to Prevention is set out below in line with the three key areas under the Promoting Independence strategy:

a) Looking After Yourself
b) Keeping Well and Recovering Your Health
c) Living with Complex Health Conditions

2.3 Looking After Yourself

2.3.1 Living Well/Three Conversations

Strengths-based social work relies on social care workers having conversations which support people to live as independently as possible, enabling them to overcome crises, and reducing the need for dependence on formal services. Living Well/Three Conversations is a tried and tested operating model which provides the structure and tools to support and strengthen social work teams' capacity to deliver the strengths-based approach to social work.

2.3.2 Development workers

The Development Workers in Adult Social Services mainly work with people who do not meet the eligibility criteria for social care funding in the following ways:

a) Community Development - supporting small independent groups eg creating new groups with a view to supporting people within their own community networks, signposting towards funding training and opportunities, ideas for promoting the group or connecting with other similar groups for mutual support and ideas. The Development Workers seek to develop community capacity through focusing on shared interests and aspirations not just social care 'need'. They work with the District councils and the Voluntary Sector to help achieve this. Examples include Dementia Friendly lunches, Men's Sheds, Norwich History Group, Costessey History Group, Mile Cross History Group; and photography group in Norwich

b) Resource information sharing – they regularly gather information on local resources, opportunities, organisations and venues, and share this information with colleagues or other organisations either electronically through their networks or by attendance at events

c) Individual referrals – take referrals through CSC (Customer Service Centre) or SCCE (Social Care Centre of Expertise) for anyone over the age of 18 who may be described as 'vulnerable' and who would like to explore opportunities for socialising, education, leisure, sport and volunteering in their area. The team look for existing community resources that people can use to connect with their local community to gain informal means of support. Through this the person can improve their health and wellbeing and reduce social isolation, also reducing the need for professional health and social care services

2.3.3 **Pub is the Hub**

Adult Social Services worked with colleagues in Economic Development and the national 'Pub is the Hub' (PITH) not-for-profit organisation to fund and develop a local scheme in Norfolk. Norfolk County Council has provided small grants and this funding is then matched by the pubs, the local community and businesses. PITH provides information and advice on all aspects, including taking pubs in to community ownership.

The scheme recognises that pubs can be the centre or hub of community life and can provide additional essential services beyond the usual drinks, food or entertainment by broadening the range of things they offer. The projects need to show that they are meeting needs that have been identified by the local community.

Projects in Norfolk range from adding a cafe or community/farm shop, lunch clubs and improved access to the pub.

2.3.4 **Working with District Councils**

This includes the Early Help Hubs/Help Hubs, which are partnerships made up of a wide range of providers from across the voluntary sector and statutory services. Practitioners from different agencies work side by side, giving each other advice, information and practical support to ensure that people receive the most appropriate and effective support at the earliest point, and achieve the most positive outcomes for residents. The Early Help Hubs makes sure people get that help as soon as possible if they begin to experience difficulties. It can offer practical support, advice and guidance to get people back on track.

The approach also works to strengthen wider support for communities, enabling individuals and families to be more resilient, reducing the need for intrusive crisis level interventions.

We also work with the District Councils on community capacity building and enabling communities.

2.3.5 **Information, Advice and Advocacy (IAA) contracts**

There is an IAA partnership lead alongside specialist IAA for people with disabilities (including marginalised adults and a complex benefits casework service), older people, people who are deaf, people with learning difficulties, people with dementia, with mental health problems and for people living with HIV.

2.3.6 **Support to carers**

A new provider, Carers Matters, was awarded the contract to provide the service from October 2017. The service provides a universal service offer in line with a prevention model that promotes independence and a preventative approach.

2.3.7 **Norfolk County Council (NCC) Website and leaflets**

A review of the Adult Social Services section of the NCC website is currently taking place to ensure that the information helps people to find their own solutions to keep them independent as well as what support may be available from the Department if they have eligible social care needs. There is one online directory for the whole of NCC and it should be easier for staff and the public to search for organisations, services and things to do in their local community. Recently an improved Norfolk Community Directory has been implemented corporately, which Adult Social Services are part of, and contribute to. This website is always being worked on and improved.

2.3.8 **Trusted Trader**

The department worked with Trading Standards in Community and Environmental Service a few years ago to set up Trusted Traders for Meals. This enables people to find meals providers in their local area who meet the Trusted Trader criteria. People do not need to be eligible for social services to use Trusted Traders.

2.3.9 **Social Prescribing**

Norfolk is piloting a county-wide offer for Social Prescribing which is funded through Norfolk County Council and Public Health for two years until April 2020. It will be evaluated centrally and consider a range of health and social care outcomes.

Recognising that people's health is determined primarily by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health. In Norfolk, access to the services is through GP practices, Customers Services Centre at NCC and Early Help Hubs at District and Borough Councils.

Social Prescribing schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports. There are many different models for social prescribing, but most involve a link worker, navigator or connector who works with people to access local sources of support.

Emerging evidence suggests that Social Prescribing can lead to a range of positive health and wellbeing outcomes and may also lead to a reduction in the use of NHS services.

2.3.10 **Combatting loneliness and social isolation**

The impact of loneliness and social isolation is significant. To help tackle this problem, Norfolk County Council Adult Social Services has commissioned a range of new services to support people who are struggling with loneliness and isolation. These services, which are being delivered by Community Action Norfolk, the Borough Council of Kings Lynn and West Norfolk, and Voluntary Norfolk, were launched in December

2018 and are now accepting referrals for adults aged 18+ where loneliness is the most immediate issue affecting their wellbeing. In practice people's needs may not be clearly identified. Feelings of loneliness and isolation can be symptoms of other challenges being faced (such as long-term health conditions or debt). Alternatively, feelings of loneliness can cause health and other issues such as depression or self-neglect for example. Therefore, the combatting loneliness and social isolation services and social prescribing services will work together closely to assess the most immediate needs of the individuals referred ensuring the principle that there is no wrong door for local support.

Individuals referred may gain support from a 'Life Connector' who work directly to provide coaching, practical advice and support to help people make and maintain relationships and strong links within their community. There are around two full time equivalent (fte) Life Connectors in each locality and a volunteer base that is expected to grow as services develop.

These services will also focus on building resilient, robust and connected communities as a means of supporting people who are isolated, lonely and facing risk factors and challenges which if not addressed will mean that they are more likely to need formal care of health services.

2.3.11 **TITAN (Travel Independence Training Across the Nation) Travel Training**

TITAN is a travel training programme, set up by Children's Services, which was devised to assist students over 16 years old who have problems using public transport. It enables students to raise their levels of confidence and self-esteem and gives them the opportunity and entitlement to be proficient in independent travel skills. Travel Training staff train 'in-house' trainers, provide ongoing support to schools/establishments and monitor progress at each establishment. Although this scheme had been used in the past by some Adult Social Services day services and providers, it seemed that Adults could use more of this training to enable people to use public transport rather than having transport provided.

TITAN can demonstrate significant transport savings in Children's Services but was untested in adults. The department is working with TITAN for a fixed term initially so potential savings can be evaluated.

The TITAN team is working with some individual day services for people with Learning Disabilities to free up buses and allow these to be decommissioned. The TITAN team has identified service users at the day services it thinks will benefit from travel training, agreed with people that they will take part and has started working with them in. The training will help build the person's confidence in other aspects of their life such as: future job opportunities; accessing new hobbies; and social skills.

2.3.12 **Strong and Well Grant**

£0.500m of revenue funding and £0.500m of capital monies was made available by NCC to fund Strong and Well. The Strong and Well programme was targeted at people aged 65 years old and over and aimed to maintain older people's independence and mitigate the risk of social isolation. It was aimed at both individual and community action. The Funding for Strong and Well was allocated at a district council level using population and deprivation data. Locality partnerships, including older peoples' forums, the District Councils and CCGs, were asked to submit proposals. Examples of where funding was provided include: The Broadland Handyperson+ Service; and Ask LILY (Living Independently in Later Years) directory in the West.

2.3.13 **Home Based Reablement - Norfolk First Support (NFS)**

This in-house service (part of Norfolk First Response (NFR)) provides intensive support and assessment in peoples' homes for up to six weeks, helping the person to regain as much independence as possible. Approximately 61% of people who go through the reablement service do not need any ongoing care, with 21% needing ongoing support albeit smaller packages of care. Additional investment of £1.1m was made in the service in 2015-16 and onwards by NCC, and NCC and CCG partners agreed to further investment in 2017-18 to increase capacity by 15%. Around 6,000 referrals were taken in 2017-18 and the service should deliver the extra 15% of referrals as well in 2018-19.

2.3.14 **Supported Care Service**

North and South CCGs commissioned an integrated model of community health and care to support people to stay at home rather than be admitted to hospital or attend Accident and Emergency in an emergency. NFS are a key part of this model, providing the reablement element of the support.

2.3.15 **Accommodation based reablement**

Accommodation based reablement complements the home based reablement service and was initiated in 2018. The aim is to maximise the independence of people and reduce the number of people going into residential care, meaning more people could stay in their own homes, as well as helping to expediate discharges from hospital. Accommodation based reablement is offered to people who are medically fit for discharge from an acute bed but are unable to return to their home safely and to people who are at risk of going into hospital or long term residential care. There is external provision in the East and West of the County. NFS (the in-house reablement service) opened an accommodation based reablement unit at Benjamin Court in February 2018 which currently has 18 beds.

2.4 Living with complex needs

2.4.1 **Assistive Technology**

Assistive Technology allows people to safely remain in their own homes. Some of the equipment automatically detects hazards such as fire, floods, falls and carbon monoxide escapes. Other equipment can help people with forgetfulness and memory prompts or feeling secure in their home. There is equipment which can be linked through to community alarm systems, so that people can get help quickly should they need it. Norfolk's Assistive Technology team, which is part of Adult Social Services, currently assesses approximately 2,000 people a year and figures recently received from n-able (the Norse Company that purchases the equipment) show that there is a total of approximately 7,000 people currently receiving assistive technology in Norfolk. Most assessments undertaken by the Assistive Technology team result in the provision of equipment.

A detailed report on Assistive Technology was presented to this Committee in September 2018, and the link is in the Background Papers section of this report.

2.4.2 **Swifts and Nightowls**

This is a 24-hour free service that provides help, support and reassurance if someone has an urgent, unplanned need at home but doesn't need the emergency services e.g. if the person's partner or carer is suddenly admitted to hospital, or if someone has a fall but is not seriously injured.

In 2016-17 the service took 13,899 referrals and prevented:

a) 6,699 calls to the emergency services
b) 3,121 hospital admissions

c) 4,662 calls to community health

The service is part of Norfolk First Response (NFR), the Adult Social Services in-house provider.

3 Financial Implications

3.1 There is strong evidence that, by investing in Prevention, Adult Social Services, NCC and the wider social care and health system saves money.

3.2 Savings have been calculated for home based reablement, the Swifts and Nightowls service and accommodation based reablement.

3.3 At present there is a lack of a sound evidence base, both locally and nationally, on which to model the savings achieved using assistive technology (AT). In the absence of a strong evidence base, Adult Social Services has produced an initial benefits model which will be tested and refined as steps are put in place to capture and track the financial benefits arising from AT provision. This will be done using several sources, including evaluation of pilots/new activity, data captured from the recent changes to the LAS (Liquidlogic Adults System) AT assessment and review forms and a new LAS Performance dashboard.

3.4 Whilst noting the savings attributable to Prevention, the converse must be recognised: if the spend on Prevention was to be reduced, there will be a disproportionately greater increase in Adult Social Services spend on packages of care for people.

3.5 It is calculated that for each £1 invested in **home based reablement (NFS)**, Adult Social Services save £4.06 (gross). 61% of people who have been through reablement do not need a package of care at the end of it. Of the other people who go through reablement, 21% have a home care package at the end and the average reduction in the packages of home care for these people is 24.36%. The savings show as less home care expenditure, which is part of the Adult Social Services Purchase of Care budget.

3.6 This assumes that we only make savings through home based reablement by preventing, reducing or delaying for 12 months, i.e. reablement prevents the need for home care or a larger home care package for 12 months. It is believed that this is understated, but prudent, as there will be people who don't need home care because they have been reabled for a longer period than 12 months.

3.7 It is important to note that the CCGs fund almost half of the home based reablement service: they recognise the importance of the service in helping people to stay at home and in facilitating discharges from hospital.

3.8 Our estimate of the monetary returns on the annual investment of £1.5m in the **Swifts and Nightowls**, is approximately £3.8m pa, i.e. for every £1 we invest, the health and social care system saves at least £3.51 gross or £2.51 net.

3.9 When the Swifts and Nightowls visit people, they ask them what they would have done if the Swifts hadn't been able to attend. This is used this as our basis for the estimation. Of the people visited in 2016-17: 3,121 people said they would have gone to A&E; 6,699 would have phoned the emergency services; and 4,662 would have contacted community health. We have taken these Swifts annual statistics (which are shared with the CCGs) about what we have avoided, Regional or National statistics about outcomes if for example an ambulance is called out and then used Regional or National unit costs to calculate the savings.

3.10 The estimation does not include any costs of discharges/assessments by Adult Social Services if a person goes in to hospital nor an estimate of the cost of the proportion of

people that would then probably go on to have a long-term package/other services if they were admitted, e.g. residential care, accommodation based reablement etc. It is therefore a prudent estimate of the savings to the system as a whole.

3.11 Based on the first few weeks of results from **Benjamin Court, the accommodation based reablement unit run by NFS**, it was estimated that for each £1 invested in Benjamin Court we saved £3.12 (gross). The savings show as less residential care and home care expenditure, which are part of the Adult Social Services Purchase of Care budget.

3.12 As for home based reablement the savings estimate assumed that Adult Social Services only make savings by preventing, reducing or delaying for 12 months.

3.13 These savings/returns appear to have reduced, although remains a net saving, as we have had more people going through Benjamin Court, we have taken people with more complex needs, the outcomes overall have altered a bit and we can see the longer-term effect of the interventions. Plus, there have been a small number of people who have stayed significantly longer than anticipated.

4 Conclusion

4.1 In November 2018 the Department of Health and Social Care published the report: "Prevention is better than cure: our vision to help you live well for longer." The document sets out the government's vision for putting prevention at the heart of the nation's health by:

- stopping health problems from arising in the first place
- supporting people to manage their health problems when they do arise

4.2 In July 2018 the Health and Wellbeing Board (HWB) agreed its Joint Health & Wellbeing Strategy 2018-2022 with its partners. As part of this they agreed three Strategic Priorities, which included Prioritising Prevention. Through the Strategy, HWB partners have committed to working towards supporting people to be healthy, independent and resilient throughout life as well as offering help early to prevent and reduce demand for specialist services. This strategic priority has direct links to the work partners are doing through the Sustainability & Transformation Partnership (STP) Prevention workstream.

4.3 In their vision for Norfolk, Public Health are prioritising actions which will: promote healthy living and health places; protect communities and individuals from harm; and provide services that meet community needs. This will bring significant benefits to Norfolk people in terms of increased quality of life and better health.

4.3 Adult Social Services' vision is to support people to be independent, resilient and well. To help achieve the vision, the department has its Promoting Independence strategy which is shaped by the Care Act with its call to action across public services to prevent, reduce and delay the demand for social care. Adult Social Services approach is to manage demand for services better by ensuring that people remain independent from public services as long as possible and are provided with preventative, community alternatives to council social care where appropriate. The aim is to support as many people as possible to live safely at home.

4.4 This report set out Adult Social Services approach to Prevention in line with the three key areas under the Promoting Independence strategy:

a) Looking After Yourself
b) Keeping Well and Recovering Your Health
c) Living with Complex Health Conditions

5. Recommendations:

5.1 **Adult Social Care Committee Members are recommended to:**

a) **Endorse Adult Social Services approach to Early Help and Prevention**
b) **Consider whether they want further detail or reports on any specific aspect of Early Help and Prevention included in the report or specific prevention approaches**

6. Background Papers

6.1 **"Prevention is better than cure: our vision to help you live well for longer"**

Assistive Technology, report to Adult Social Care Committee on 3 September 2018, page 72

Health and Wellbeing Board reports, 31 October 2018, "Our Joint Health and Wellbeing Strategy 2018 -22", page 19 and Norfolk & Waveney Sustainability and Transformation Partnership (STP), page 24 onwards

Officer Contact

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IN TRAN communication for all

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Appendix One: Case Studies

Case Study 1 – Accommodation Based Reablement, Benjamin Court

Brian*

Age 89 years

Referred for reablement by Occupational Therapist from Norfolk and Norwich University Hospital due to mobility problems.

Lives in rural village, alone in his own home which has a small living room, kitchen and downstairs toilet and upstairs bedrooms.

When Brian first arrived at the unit, he appeared frail, with signs of self-neglect and wasn't very communicative. He was very low in morale and seemed reluctant to self-care or engage in his initial assessment.

His neighbours informed the unit that they were concerned about him not managing independently and had tried to help by arranging agency services to assist with cleaning his house, which Brian would then always cancel. They were concerned that he was not managing his home, highlighting issues that he had no hot water, a broken sink, an old bed, no washing machine and a very old boiler. Brian was more than happy for his neighbours to purchase items on his behalf, but his neighbours were concerned that there were no formal arrangements to use his finances. The unit's Social Worker discussed this with Brian and with his agreement, a referral was made to Money Matters to help Brian with his finances and to advise on guidelines for his neighbours to make purchases for him, thus reassuring everyone.

Following an OT's home assessment and a subsequent discussion with Brian, it was found that Brian was concerned about managing his steep stairs especially at night time when he wanted to use the downstairs toilet. Brian agreed to the suggestion of having his bed moved downstairs into the living room so that he could safely use the toilet downstairs at night. As the bed would be close to an open fire (coal) and this was the only source of heating, a referral was made to Fire Safety for an assessment. An Assistive Technology Practitioner from the unit also advised for a Heat Sensor and a Community Pendent Alarm be installed in his home which Brian agreed to. His neighbours arranged for his new bed to be placed downstairs.

Brian was asked how he managed his shopping. Previously he received support from Aylsham Care Trust to pick him up and take him to a local supermarket twice a week. However, he was concerned that now he was not as mobile, they would not be able to take him. The reablement team supported Brian with exercises to gain strength for him to use a walking stick rather than a frame which he preferred as he didn't like his walking frame. He received assurances that ACT would still be able to support him with his shopping. Brian was given information on other local shopping services that would deliver as well as meals on wheels services should the need arise in future.

Brian's neighbours supported him to purchase a new sink, installation of a washing machine and a new boiler which Brian had asked for. Brian was given information on laundry services for occasions he could not manage his washing, but he felt confident that he would be able to. Brian had the facilities to cook his own meals, so OT provided a perching stool and cantilever table, so Brian could cook and eat his meals in the living room in front of his new television!

Grab rails, bed loops and a perching stool were placed in his home to make him more independent with self-care.

During his time on the unit, Brian began to take care with his appearance with decreasing support required for personal care. His social well-being evidently improved through the unit's activities and he was engaging with others. He was very much looking forward to going to lunch clubs

when he got home. A package of care was arranged for Norfolk First Response to provide daily visits to help him settle in.

On the day of discharge, Brain looked smart, his hair was combed, his skin was glowing, he was walking with little aid and he was smiling.

Case Study Two – Assistive Technology

CM telephoned to say that the family are extremely pleased with the equipment. Only a few days after the equipment was installed, the heat sensor alerted after his mother left a pan of baked beans on the hob. CM says that the pan was of a heavy quality and was extremely badly mangled. He believes the equipment potentially prevented a serious fire. When the fire department arrived Mrs M was oblivious to the situation, despite the alarms sounding.

CM lives in Yorkshire, his mother lives in Norfolk and the Assistive Technology provides him with reassurance as a carer for his mother.

Case Study Three – Development Workers

The Development Workers look for existing community resources that people can use to connect with their local community to gain informal means of support. Through this they can improve their health and wellbeing and reduce social isolation, also reducing the need for professional health and social care services.

The Development Worker listened to customers with family members living with dementia and heard that the opportunity to go out together for a meal and to socialise as they had in the past was something they missed. Due to the often confusing and frustrating nature of dementia many people had lost touch with this important aspect of their lives. Acknowledging that Day Centres and Dementia Cafes offer an excellent service, the Development Worker began to research local pubs with a view to promoting the idea of Dementia Friendly pub lunches.

Many rural villages have a pub at the heart of the community and pubs are keen to diversify to attract new regular customers. Initially, one pub emerged as a good place to run a ‘pilot’ lunch for people with dementia and their families. It has been a great success, attracting about 20 people. Already there are plans to increase the regular planned number of lunches offered and other pubs have shown interest.

The lunches are ‘Dementia Friendly’ because people can have confidence that the pubs involved will be welcoming and the environment accommodating to those affected by dementia and their families.

The Development Worker connects the pub to Dementia Friends trainers to improve staff, provides contact details for Age UK or other relevant organisations and assists on the first launch day. Any further bookings are then managed by the pub with no further involvement from Adult Social Services or NCC required.

As well as providing new social opportunities for people which improve their health and wellbeing and reduce social isolation, this approach also helps to support pubs in local communities to diversify and remain viable, becoming a hub for their local community.

Since 2016 Dementia Friendly Lunches elsewhere in Norfolk have been facilitated by other Development Workers, including in Garden Centres and other venues.

Case Study Four – Home Based Reablement (NFS)

Mrs T was discharged from hospital with four visits a day. She had a history of falling and had been in hospital for several weeks prior to our service commencing following yet another fall. Mrs T lives with her two granddaughters, but they have little input in her care routine. She had lost confidence but was very determined to stay as independent as possible.

Our staff worked together with the reablement OT to increase Mrs T's confidence when walking. They reminded her not to walk too fast with her frame and not to cross her feet over each other (a legacy of a previous stroke).

At first the staff were assisting with personal care, then they observed Mrs T doing this for herself and finally they would wait in another room whilst she did this independently. They also encouraged her to make a sandwich for her lunch. Once again they initially had to assist quite a bit, but eventually she could do this for herself.

At the end of six weeks Mrs T was discharged from the scheme with no ongoing care.