Norfolk Older People's Strategic Partnership Board

Minutes of the meeting at County Hall, Norwich
Wednesday 24th September 2014

Present:	
Kate Money (Chair)	Norwich Older People's Forum
Catherine Underwood	Integrated Commissioning, Health and Social Care
Sue Whitaker	Chair, Adult Social Care Committee, Norfolk County Council
Elizabeth Morgan	Vice Chair, Adult Social Care Committee, Norfolk County Council
Niki Park	Travel and Transport , Norfolk County Council
Paul Jackson	Communications & Engagement, Norfolk County Council
Chris Hardwell	Norfolk & Suffolk Foundation Trust (mental health)
Laura Clear	Norfolk Community Health and Care
Emma Boore	Borough Council of King's Lynn and West Norfolk (housing)
Nigel Andrews	Norwich City Council (housing)
Tony Cooke	South Norfolk District Council (housing)
Amanda Ellis	Norfolk Constabulary
Gaye Clarke	Department for Work and Pensions
Phil Wells	Age UK Norwich
Jon Clemo	Rural Community Council
Andrew Campbell	Voluntary Norfolk
Denise Denis	Norfolk and Suffolk Care Support (residential care)
Lesley Bonshor	Carers Council
Carole Williams	Norfolk Council on Ageing
David Button	Norfolk Council on Ageing
Derek Land	Norfolk Council on Ageing
Marcia Solway-Brown	North Norfolk Older People's Forum
Ann Baker	South Norfolk Older People's Forum
Hazel Fredericks	West Norfolk Older Person's Forum
Pat Wilson	Co-opted Member & Broadland Older People's Partnership

Speakers

Catherine Underwood	Director of Integrated Commissioning
Sue Crossman	Chief Officer, West Norfolk Clinical Commissioning Group
Chris Price	Chair, Norwich Clinical Commissioning Group
Phil Wells	Chief Executive, Age UK Norwich
Laura Clear	Associate Director of Operations, Norfolk Health and Social Care
Tony Cooke	Housing Standards Manager, South Norfolk District Council

In Support:

Annie Moseley	Age UK Norfolk & Norfolk Older People's Strategic Partnership
Nicola LeDain	Democratic Services, Norfolk County Council

Apologies

Harold Bodmer, Joyce Hopwood, Janice Dane, Carol Congreve, Emma MacKay, Linda Rogers, Hilary MacDonald, Jo Ardrey, David Russell, Shirley Matthews, Val Pettit, Emily Millington Smith

1	**Welcome by the Chair** Kate welcomed everyone to the meeting, especially new member Chris Hardwell from the Norfolk and Suffolk Foundation Trust (mental health), and Andrew Campbell from Voluntary Norfolk.
2	**Minutes** a) The minutes of the meeting held on 18 June 2014 were agreed, subject to the change of the venue to Dereham. b) It was noted that the Norfolk Celebrates Age poster had been circulated but would be sent again for information.
Person-centred Care for Older people and their Carers – Integrating services through the Better Care Fund	
3	**What is the Better Care Fund and what should it do – Catherine Underwood, Director of Integrated Commissioning, Norfolk County Council (NCC)** Catherine reported to the Board about the Better Care Fund: a) The Better Care Fund was set by government up to promote the integration of health and care services at a local level so staff from different agencies worked better together. This would reduce duplication and make sure the services provided were right for each person. The focus was on older people and particularly those most at risk, so that sudden unplanned admissions to hospital could be avoided. It was something agencies were required to do. b) The pooled funding – a minimum of £65,000,000 in Norfolk - was drawn from existing Clinical Commissioning Group and County Council budgets – i.e. there was no new or additional funding. c) The Health and Wellbeing Board had overall responsibility for Norfolk's Better Care Fund plan, which tied into one of their key priorities, Promoting Integration. d) Targets included in the plan were to reduce hospital admissions (the key outcome measure), reduce admissions to residential care, monitor where people had remained in hospital when they were ready to leave ('delayed transfers of care'), and improve and develop the reablement service, Norfolk First Support. Additional Norfolk targets were to support people with long term conditions and to make sure people with dementia could have a timely assessment and diagnosis. e) Primary care is at the heart of this work and people will be supported to remain living at home wherever possible and to manage their own care. f) Norfolk's Better Care Fund Plan has now been approved and the fund starts from April 2015. g) It was very important that people had the adaptations and equipment they needed in their home either to help them remain living there or to make sure they could live there safely after being discharged from hospital. District councils which administered Disabled Facilities Grants (DFGs) had a key

	role to play here. Discussion: • When they can't manage to live independently at home, most people go into residential care. Less than 10% move into housing with care which is less expensive. • Staff were being consulted about how services could be better integrated. • According to patients, the GP practice was the place where most people feel they would contact services, so local services should be centred around them, and community services around them should be supported. • It was often difficult to get appointments in some GP practices – there was sometimes several days wait. And when a GP appointment was urgent, it was often difficult to get community transport as this had to be pre-booked in advance, so people without access to transport had to get very expensive taxis. • It was important to work with care homes to make sure they didn't refer people to hospital inappropriately. The contact for queries about the Better Care Fund Plan is Jo Clapham, Commissioning Project Officer, Integrated Commissioning: jo.clapham@nhs.net or tel: 01603 224061
4	**Commissioning Integrated Care in The West Norfolk: 'Pioneer progress one year on'** **– Sue Crossman, Chief Executive, West Norfolk Clinical Commissioning Group (WNCCG)** The Board received a presentation from Sue about the challenges that the West Norfolk CCG were facing: a) West Norfolk had an ageing population with high health and social care needs. Their local acute hospital, the Queen Elizabeth, had a £15 million deficit and had been placed in special measures. Service users had told the Clinical Commissioning Group (CCG) they were often experiencing fragmented care, with delays and confusion about what each health and care professional's role was, and people's needs were assessed by different agencies at different times so they had to repeat their story. b) The West Norfolk Alliance, the partnership of organisations involved in providing health and social care, therefore drew up a plan to provide sustainable coordinated services with patients in control - a huge aim which will mean, with the person's permission, greater information sharing between organisations, and that staff have to work in new ways. c) They have set up hospital care at home with a 'virtual' ward of up to 24 people who can have 3 visits a day from staff – with usually 4-6 days of intense intervention then a more reablement-type service. 'Tracker' nurses go into hospital to assess needs and identify where patients can move back to their home and into the virtual ward, and this is speeding up discharges. Feedback shows that patients are happy that they can get home sooner and are reassured they will still have enough appropriate care. d) They are developing a pooled staff bank with 'honorary contracts' - new more flexible roles so that different professionals can undertake the same assessment. Staff can work in the community across agencies, and in and out of the virtual ward when needed. Staff 'have permission' to work

	differently, and joint staff workshops have been crucial to changing understandings about what they can and can't do. e) Health information can be shared using Eclipse Live software and, if permission is given by the person involved, their information will be shared between agencies and different levels of staff – e.g. ambulance staff can look at the person's advanced care plan and medications etc f) They have worked with the Borough Council of King's Lynn and West Norfolk to set up a website called Lily (**L**iving **I**ndependently in **L**ater **Y**ears) of resources available to help people live independently in the community. http://asklily.org.uk/kb5/westnorfolk/cd/home.page People can search the website or phone the Lily number 01553 616200 and Borough Council staff will respond. 'Care Navigators' will advise people and advocate for them. g) They are setting up a hospital Frailty' Unit for older people, with a community out-reach physician who can treat the range of medical conditions that frail older people often have. h) They are developing tele-monitoring in the home so that people can monitor vital signs such as blood pressure and report the results, and are promoting assistive technology which can help people remain living at home
5	**Commissioning Integrated Care: the Norwich Experience** **- Chris Price, Chair, Norwich Clinical Commissioning Group** **- Phil Wells, Chief Executive, Age UK, Norwich** The Board received a presentation from Chris and Phil on developments towards integrating care in Norwich: a) Following on from the presentation from the West Norfolk CCG, it appeared that the initiatives being implemented there were similar across the county, but had been adapted for a rural or urban community. Norwich was an urban environment and had some high areas of deprivation and low male life expectancy. They needed to support GPs who were decreasing in numbers while the demand on them was rising. The Better Care Fund would be used to build on existing new developments which were evidenced to be effective. b) They had a new website listing services provided by voluntary agencies. c) There were services in place in case an emergency happened at the weekend to prevent the patient from going into hospital wherever possible. d) GPs could see around 30 patients in the 2 hours, but this was the time it might take to carry out a home visit. They were therefore considering setting up a visiting service which could possibly be undertaken by another health professional e.g. where there was a risk of someone falling. e) They were encouraging each GP practice to link to a particular residential home as this could help reduce unplanned admissions to hospital f) They used small grants to support community organisations and initiatives which were really important to support people to remain living in their own homes. g) They were developing care plans which, where patients were happy to give consent to some of their information being shared with other professionals, could be accessed through an agreed internet system. h) They would use tele-medicine so people could monitor their own health.. i) From 1st October Age UK Norwich would be working with the group of older

	people who had been identified as the most vulnerable in 2 or 3 pilot GP surgeries in each of two different localities. For the first year, Age UK Norwich and Norwich CCG were each funding a 'Promoting Independence Coordinator' to visit people in their own homes. They would ask the person about the support they had from family, friends and from statutory and voluntary agencies, what they would like to do, and what sort of support they might need to achieve this. The Coordinators would then link them with volunteers who would help them access the activities they were interested in. This would be a very personal service which could help reduce their isolation, loneliness and depression, their visits to their GP and, a key outcome, reduce unplanned hospital admissions. If the pilot showed evidence of effectiveness, it was intended that the CCG would fund and expand the service in following year.
6	**Delivering Integrated Care: a community health perspective on the challenges and opportunities** **- Laura Clear, Associate Director of Operations, Norfolk Community Health and Care (NCHC)** Laura updated the Board on the work of NCHC: a) Since 2009, there had been a very successful integrated care pilot of social care and community health services in west Norfolk, and this integrated service was now being rolled out across the county. There would now be one organisation under a single Director who would manage community health and social care staff, with new integrated care locality managers. The applicants for the senior posts would be staff currently in either organisation, and they hoped all would be appointed by the end of November. By 2018, all health and social care providers would have to be integrated. b) A Section 75 agreement had been agreed so that managers from either organisation could manage staff from the other organisation, and staff could undertake some tasks that had been traditionally done by the other agency, such as simple care packages and monitoring. c) During the consultation process, it was revealed that the most common priorities for service users were; o Better coordination of services around each individual o The GP practice being the natural focus of care o One person to know the whole story and a single assessment o To be treated with courtesy and respect d) The second phase of the integration would review the teams and team leader functions. Staff would be based together (co-location), there would be multi-disciplinary teams meetings in GP surgeries with Integrated Care Coordinators (ICCs) to make sure all agencies communicated with each other, shared protocols across both organisations, a single assessment process, and agreed ways of information sharing where the person had given permission, despite there being two very different computer systems. e) Services were also being integrated successfully in North Norfolk, where patients were being identified quickly if they were in a high risk group, integrated teams were co-located with four ICCs in each locality (16 in total) to identify people at risk and tracking them if they had been admitted to hospital to ensure all relevant agencies were aware and working together.

	The free 24/7 Swift Response service was successfully working alongside nurses at night. f) In South Norfolk staff would be moving to a central location in Wymondham by the end of December, alongside the manager of the Norfolk First Support reablement service. g) When consulted about how these changes were working out in practice, staff were very positive. It was aN exciting time with huge opportunities for improving people's experience of the service, improving staff satisfaction and avoiding duplication.
7	**Delivering Integrated Care: a housing perspective on the challenges and opportunities** **- Tony Cooke, Housing Standards Manager, South Norfolk District Council (SNDC)** Tony spoke from a housing perspective: a) The SNDC Housing Adaptation Team administer Disabled Facilities Grants (DFGs), which also involve assessments by Adult Social Care Occupational Therapists. In the past, the time from application to completion had taken many months as, despite both groups of staff doing their best with their part of the work, two different agency systems and processes were involved. So they decided to simplify the process – staff from both agencies worked in the same office (co-location), shared the same outcomes and even though they had different computer systems which didn't link up worked round this and talked to each other when there was a problem. They had integrated their processes and procedures, and the time from initial contact to completion had reduced substantially to around10 weeks. Now officers are making suggestions for improvements. b) Staff in different agencies need to look at people's needs holistically and be more flexible about how a need is met, rather than just saying that their agency can't provide or do that. c) Greater effort generally should be made to integrate health and social care with housing. This includes all general needs housing - social housing, owner occupied housing and privately rented housing, as well as housing for people with special needs and sheltered and residential. Discussion: • There was a need to balance the communities in housing with care scheme, so there was a range of people needing low, medium and high support. Housing with care should be a home for life, rather than people having to move later on to a residential care home. • Good housing was crucial to people's health and wellbeing and just small amounts of money could ensure a house was properly adapted and warm and dry, so people could remain living in their own home as they wanted. • More easily adaptable housing would be available in the future. There was national guidance for housing with care, and this should become the model. • In Norwich, some sheltered housing units had been remodelled, and the older people who would be living in them had given their views at different stages of the planning and building work, so that they were really what people wanted and would meet their needs. • Some new housing wasn't fit for purpose – e.g. the ceilings aren't strong

	enough to take hoists • Reablement has a key role to play in supporting people to remain living at home, and Norfolk County Council's First Support Service which provides up to 6 weeks of free support will be further developed. • Key to integration is the development of very good working relationships between staff of different agencies, so that trust can develop and staff can find new ways of working together so they can focus on the person and their carer. • The Better Care Fund should be used to promote prevention - small grants can really help community groups provide support and activities to reduce loneliness, and improve diet and exercise. • The police often have the first contact with a vulnerable older person. For example, someone with dementia may fear they have been burgled and call the police. They often hadn't had a diagnosis or support, and might be isolated and lonely. Police and health, social care and housing agencies need to work together in localities.
8	**General Discussion with the Panel** The points raised in the general discussion included: a) Support was being given to staff who were being asked more of. Frontline teams were being consulted on the improvements which they felt could be made. b) The money involved in the Better Care Fund plan was not new money; it was a different way of resourcing. Preventative work was being invested in, to help make the most of the existing funds. c) There were many factors that contributed towards a hospital admission, and therefore measuring the Better Care Fund plan targets against reducing hospital admissions could be unrealistic.
9	**Any Other Business** a) Carole Williams reported that the small group of Board members which responded to requests for their views on improving older people's access to information had given feedback to Norfolk County Council's Trading Standards on their Trusted Trader website and handbook. The group had given similar feedback in 2013 and had been very pleased to see that their comments had been acted on. **Action:** Annie Moseley to circulate the report with the minutes. . b) Paul Jackson, Consultation and Community Relations Manager for Norfolk County Council (NCC), reported that the council was consulting on the budget for 2015/16, as there was a £17.5 million funding gap. The initial proposals had been to find the gap through efficiencies. Proposals for other ways of making the remaining savings needed had been discussed by the Adult Social Care and other committees. The Policy and Resources Committee would then review the proposals and consider the impact of them, and the proposals would then go out for public consultation from 29th October to 19th December 2014. **Action:** All to look at the NCC website link to the consultation which is live from 29th October –

https://norfolk.citizenspace.com/consultation/budgetandservices

You can either click on the link about and either:

- fill in the online consultation form by going to the pale blue box: 'Read our consultation and have your say' and click on 'Online feedback form'
- or print a paper version by clicking on: 'Consultation document – word' or 'Easy read consultation document - word'
- or ask for a consultation form to be posted to you, by ringing the county council on 0344 800 8020
- or give your views verbally by phone by ringing 0344 800 8020

[**30.10.14 Update from Paul Jackson**:
Since 24th September, £11.9 million has been found by the County Council in further efficiency savings, but the government has announced that NCC will receive less funding than expected from the Better Care Fund. The revised funding gap is therefore now a little bigger - £12.9million for 2015-16. The key Adult Social Care group of people receiving services are those who receive funding in their personal budget for transport. People who currently receive this will not receive if from next year if a) they receive a mobility allowance (including those who use this to have a motability car); b) they wish to use a service which isn't local where a local service exists; c) there is community transport available which they can access; and d) there is a local group of people needing a similar service in which case efforts will be made to provide the service in that locality. For those who do not meet these criteria, funding for travel may be provided in their personal budget so they can access services.

NB The projected funding gap for 2016-18 is now £209 million – very considerably larger.]

The next meeting of the Norfolk Older People's Strategic Partnership is the Awayday on

Wednesday 3rd December at Breckland District Council Offices in Dereham, from 10.0 am – 3.0pm

- this meeting is for Board members only, and includes an opportunity to develop a workplan for 2015.