Living Longer, Living Well

The 5th Norfolk Older People's Strategy

Promoting Independence and Wellbeing 2019 - 2021

Produced by Norfolk Older People's Strategic Partnership (NOPSP) hereafter referred to as the Partnership

Introduction

Since we launched our last strategy in September 2015 we have seen unprecedented change in the way health and social care is delivered in England. In the introduction to that strategy Joyce Hopwood and I warned that budget cuts and increasing demand for services would mean stress in the system.

How right we were! Since then there have been further cuts to local authority budgets, and the introduction of the Sustainability and Transformation Partnership (STP), which aims at closer integration of health and social care across Norfolk and Waveney. Our partnership has welcomed the ideals behind the STP and engaged whenever possible. But, like others in the voluntary sector, we have warned that such a far-reaching intervention in the lives and welfare of older people can only succeed if we are fully involved i the design and governance of these new or changed services.

We are a strategic partnership, not a delivery organisation. It is our key task to hold to account those seeking to intervene in our lives. These objectives, and the actions needed to support them, are our tools to do that.

This new strategy has been created to ensure that the issues of key importance to Norfolk's growing population of older people are kept to the forefront as the new shape of health and care emerges in our county. The six key objectives in this strategy were selected by older people as those of most importance to them.

I wish the Partnership, and David Button your new Chair, every success as this strategy sets out on its journey.

Prof. Graham Creelman OBE, Chair NOPSP 2015-2018

The next three years will be a critical period of change for all of us. During this time, we may expect to see:

- the integration of Health and Social Care services,
- changes, after some 30 years, to the purchaser/provider split and the internal market, and new accountable care organisations evolving,
- the continuing effect of a decade of austerity,
- a Green Paper, already long delayed, on funding the cost of care and radical change to the financing of local authorities,
- The real impacts of leaving the EU

A major part of these changes will be the expectation that individuals and their communities will themselves become more responsible for their own health and wellbeing. If that is to be achieved, much more effective communication needs to be developed between planners, people who provide services and everyone who needs those services. The Partnership will play its part in watching closely those organisations charged with delivering change. We shall use all our influence to ensure that full, timely, understandable information and explanation is easily available to all of us. We shall reach beyond these priorities included within this latest version of "Living Longer, Living Well" and will examine the availability and quality of all services which impact on the lives of older people.

We know this will be a big ask. The Partnership invites you to share our ambition to improve the lives of older people in Norfolk and to work together with us to achieve this.

David Button
Chair

Who We Are

Norfolk Older People's Strategic Partnership exists to ensure that the county's significant and growing population of older people will live well, and independently, for as long as possible. An important part of this role is to scrutinise the quality and availability of services for older people.

The Partnership is independent and is made up of representatives from the county's seven district older people's forums and from other older people's organisations. There are also representatives from Norfolk County Council Adult Social Services and the NHS, local councils, voluntary organisations and the private care sector. The creation and monitoring of a rolling strategy for older people "Living Longer, Living Well" is a key function of the board and this issue is our fifth.

The Partnership is an independent organisation consisting of representatives from Norfolk County Council, the NHS, district councils, the police, older people's organisations from the voluntary and private sectors, carers and each of Norfolk's Older People's Forums. Unlike many other older people's organisations, we are not involved in the delivery of services or advice. This gives us the freedom to challenge and comment on proposals and decisions which we think are not in the best interests of Norfolk's older people.

The creation and monitoring of a rolling strategy, "Living Longer, Living Well", is a key function of the Partnership and has been created from the key issues identified to us by older people themselves. Similarly, our effectiveness will be measured by older people and we can be instrumental in helping all our partner organisations to work together to meet the needs of those older people and to maximize the huge benefits they contribute to Norfolk's economy and communities.

How to Use This Strategy

The Partnership is very much a strategic body. Our resources are slim, and unlike many other older people's organisations, we are not involved in the delivery of services or advice. This gives us great freedom to challenge decisions and proposals which we think are not in the best interests of Norfolk's older people. But this also means that we must rely on our partner organisations to work together to examine and understand, with our help and guidance, the implications of proposals as they might affect them. As a partnership, we can then collate views into a considered response on behalf of our county's older people.

This strategy has been created to give substance to the key issues facing Norfolk's older population. These issues were decided by older people themselves. The strategy is therefore a key guide to organisations seeking to identify what new proposals, or changes to existing services, will mean to them.

Contents

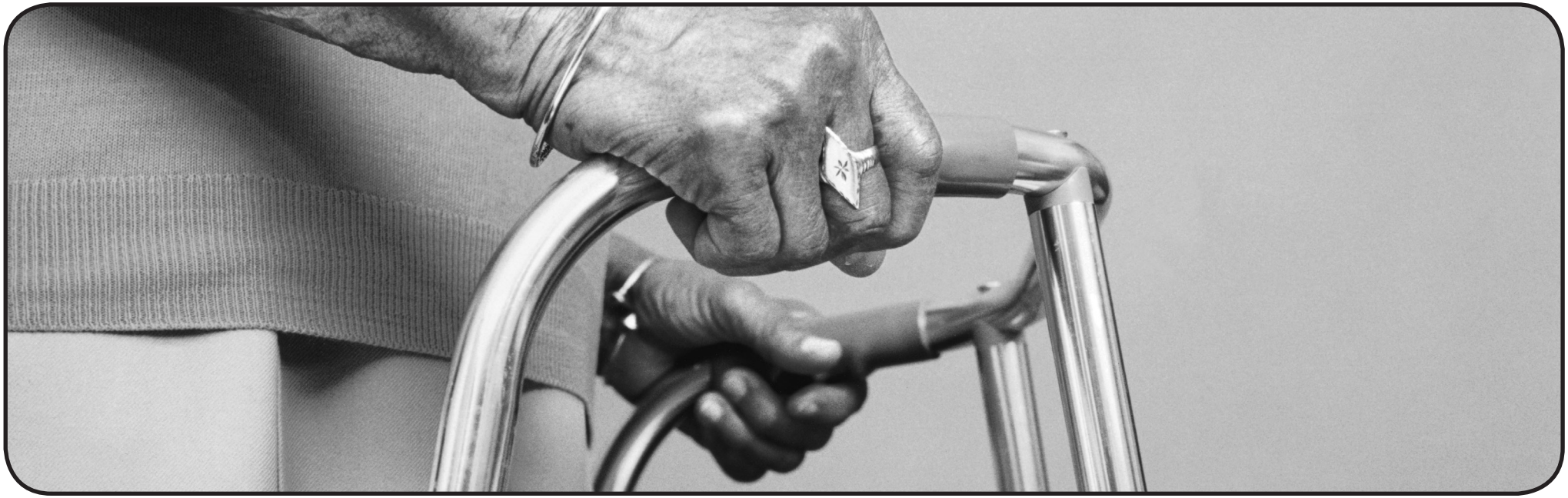
1. Information and Advice

Good and timely information and advice is essential to enable people in later life to make informed decisions, to plan and to access services. Information and advice are the keys that unlock other services.

Older people continue to tell us that information and advice is “crucial to everything”. They want information to be provided in all formats including paper, telephone, digital and face-to-face. Finding clear, relevant information and advice is still one of the biggest problems.

Objective 2019-21	Lead Agency/ies	What Success Looks Like
1.1 Work with the County Council to promote user-friendly, relevant, up-to-date social care web pages, that are both easy to find on their website and to use.	County Council; the Partnership	Older people find the County Council website information easier to access and to use than at present. The relevant web page information should be able to be saved, and/or printed from the website. Instructions to do both should be easy to find and to use. Older people from various fora use case studies to try to find relevant information on the county council web pages.
1.2 Liaise with the County Council and all district & borough Councils to promote inclusion of information on relevant topics for older people in their local area, using newsletters or other local information guides. Liaise with parish councils to promote inclusion of relevant information for older people in their publications. This must include paper media and online.	County Council; district & borough councils; the Partnership	Council and parish newsletters regularly contain useful and relevant information for older people and their carers/families. Older people’s groups can see the inclusion of relevant information in an accessible format i.e. paper and online.

Objective 2019-21	Lead Agency/ies	What Success Looks Like
1.3 Liaise with local delivery groups across the County that are pioneering social prescribing and social isolation pilots to ensure that information and advice are embedded within the various models developed.	Local delivery groups; the Partnership	Older people feel better informed and supported to maintain independent living at home via their social prescribing 'prescriptions'. Patient Participation Groups evaluate experiences of older people seeking information and advice via their surgery or health hub and report that they are better informed.



2. Transport and getting to services

It is the most basic of things which can decide the success or failure of health and social care initiatives. This is particularly true with transport and the effect it has on getting to services. Our new strategy is being created at a time of significant change in the way health and social care are delivered across Norfolk and Waveney. The thrust of Norfolk's Sustainability and Transformation Partnership (STP) initiative is to seek a much closer integration of health and social care, eventually leading to the creation of an Integrated Care System (ICS). This will in time create one budget for our health and care needs. In many areas this will involve more dispersed community- based services.

As we live longer and strive to remain independent, the ability to reach services becomes ever more critical. Many older people will, inevitably, lose the ability to drive a car or catch a bus. And it is people with the worst health and lowest incomes who then struggle most with travel. The Partnership has been successful in ensuring that transport is considered as a basic requirement in all new health and care proposals. This strategy seeks to ensure that all the mechanisms are in place to get transport provision right for older people across our county. This is not just important for access to services, but also to combat the loneliness and isolation which blights so many older lives.

Objective 2019-21	Lead Agency/ies	What Success Looks Like
2.1 Each new health and social care initiative fully considers transport implications.	STP; the Partnership; County Council; the Norfolk Bus Forum; STP Stakeholder Group	All health and care proposals have a clearly identified transport dimension. Bus companies, County Council transport strategy managers and community transport organisations are included in proposal designs. There is knowledgeable scrutiny of new proposals; there is Partnership representation on relevant boards and groups; the Partnership to maintain active representation on the Norfolk Bus Forum.

Objective 2019-21	Lead Agency/ies	What Success Looks Like
2.2 County Council transport strategy to outline and explain how transport for older people will work with proposed Integrated Care Systems (ICS)	County Council; STP Executive; STP Stakeholder Group; hospital transport managers	A refreshed Norfolk Local Transport Plan reflects changing health and care delivery plans; locality governance structures of ICS services to include transport as a standing item. Constant monitoring of emerging health and care plans; robust scrutiny through the Norfolk Bus Forum; older people's representatives have seats on local ICS governance boards, and not just through generic third sector representation.
2.3 Further co-ordination of community transport services, to include lift share and non-emergency patient transport services; identification of gaps in service provision.	Clinical Commissioning Groups (CCGs); community transport organisations; rail operators; lift share	CCGs include specific integrated transport requirements in ERS* (or other) contracts; a network of community transport operators is created; bus companies and rail operators attempt to integrate services with available community transport. CCGs action on transport contracts; pro-active creation of integrated community transport grid; bus companies and rail operators include community transport availability on their web sites; seek to find solutions to gaps in services.

*ERS = Non-emergency patient transport

3. Housing

Appropriate housing is crucial to staying independent with dignity as we grow older. Poor housing has an adverse effect on health and well-being. While affordable housing is needed for all generations, the future of communities depends on building homes which are fully accessible, fully connected to all services, easily adaptable, as energy efficient as possible and easy to maintain. This applies to both the private and public sector. The costs of incorporating these standards are less at the design and build stage than having to adapt and improve existing property later.

Housing development should consider the growing number of older people within a multi-generational population who will need ready access to a range of health, social, commercial and cultural resources without the need for a private car. If we get this right for older people, the housing needs of all generations will be met more easily.

Objective 2019-21	Lead Agency/ies	What Success Looks Like
3.1 Promote and encourage more integration, in mixed developments, of housing and infrastructure that better meet the needs of older people.	County Council; district & borough councils; parish councils; housing associations	Greater availability of accessible dwellings within reach of supportive facilities including transport, healthcare, shopping and spiritual and social resources. To minimise isolation and offer inclusion to people with physical and mental frailties their needs should be reflected within strategic and local plans. Planning decisions evidence that these issues have been fully considered.
3.2 Promote and encourage schemes to improve accessibility of existing housing stock and particularly to offer adequate insulation and affordable warmth.	District & borough councils; social landlords; property owners	Improved quality of life, fewer excess winter deaths, more people able to receive care at home

Objective 2019-21	Lead Agency/ies	What Success Looks Like
3.3 Promote and encourage the development of a range of new residential property to meet at least Category 2 [Lifetime Housing] Standard.	County Council; district & borough councils	Support and care is provided in people's own homes more easily, more safely and with less expense. Planning permissions indicate how evidence of need has been considered.
3.4 Encourage and support opportunities for "rightsizing".	District & borough councils; social housing providers; Public Health; financial services; voluntary organisations	People are helped, by unprejudiced advice and with practical assistance, to move into properties that enable them to remain independent in their own home long-term. Publicity is available to inform and demonstrate how this is achievable. More family homes are available.
3.5 As traditional telephone systems are phased out, promote the availability and affordability of digital connectivity to all properties to enable the most appropriate technological support.	County Council; district & borough councils; parish councils; broadband providers	Older people can benefit from assistive technology to minimise loneliness and isolation, to manage their home and to reduce the need for assistance. Professionals can apply more cost-effective solutions.

4. Loneliness and Isolation

Loneliness affects people of all ages and backgrounds. Loneliness is described by the Jo Cox Commission as being 'a subjective, unwelcome feeling of lack or loss of companionship'. A carer can have a very busy life but may still be cut off from social relationships. Parents can be lonely surrounded by children. People with disabilities find it difficult to join in social events. Just feeling "down" can make it difficult to have the confidence to leave the house. Loneliness can be as harmful to health as 15 cigarettes a day. It puts people at higher risk of high blood pressure and cognitive decline. Recent research by the Heart Foundation charity found that older people living alone are 50% more likely to go to their GP or A&E department than those living with someone. Mental health issues such as anxiety and depression also increase due to isolation.

Norfolk's ***In Good Company campaign*** has moved from strategy to action. The County Council linked several calls to social services as being related to loneliness. Norfolk has taken a partnership approach, recognising that loneliness is about the individual, the family, the neighbours and the communities we live in. This is in addition to professionals from statutory and voluntary agencies and organisations identifying loneliness as needing preventative interventions. Recent pilot initiatives have been launched in Norfolk to help, such as social prescribing and combating social isolation. These need to be monitored and encouraged. What is certain is that, without such interventions, loneliness and isolation will continue to increase as the county's population of older people grows.

Objective 2019-21	Lead Agency/ies	What Success Looks Like
4.1 Encourage and recognise opportunities for social contacts that challenge loneliness.	Statutory and voluntary organisations	Transport, dementia, carers, housing and health and social care challenge loneliness in their strategies and actions.
4.2 Support Norfolk's ***In Good Company campaign***. Encourage others to gain the Norfolk Kite Mark. Support Norfolk's ***No Lonely Day*** promises.	The Partnership; Norfolk organisations; local community groups	More organisations achieving the Norfolk Kite Mark and Norfolk's ***No Lonely Day*** promises with monitoring of results.
4.3 Organisations are challenged to recognise their responsibilities and act to tackle loneliness in communities.	The Partnership; County Council; district, borough and parish councils	Identification of local responses to tackling loneliness.

5. Integration of Health and Social care

Integrating health and social care is high on the government's agenda, but progress is slow. The government's response to the recommendations of the Parliamentary Health and Social Care Committee's inquiry into 'Integrated care: organisations, partnerships and systems' in September 2018 stated: "There has not been a sufficiently clear and compelling explanation of the direction of travel and the benefits of integration to patients and the public... The language of integrated care is like acronym soup: full of jargon, unintelligible acronyms and poorly explained."

In Norfolk integration means that health organisations and local councils will work together to ensure that services wrap around the whole person, meeting all their needs. In this way people can live healthier lives, get the care and treatment they need in the right place at the right time, and stay living in their own home for as long as possible.

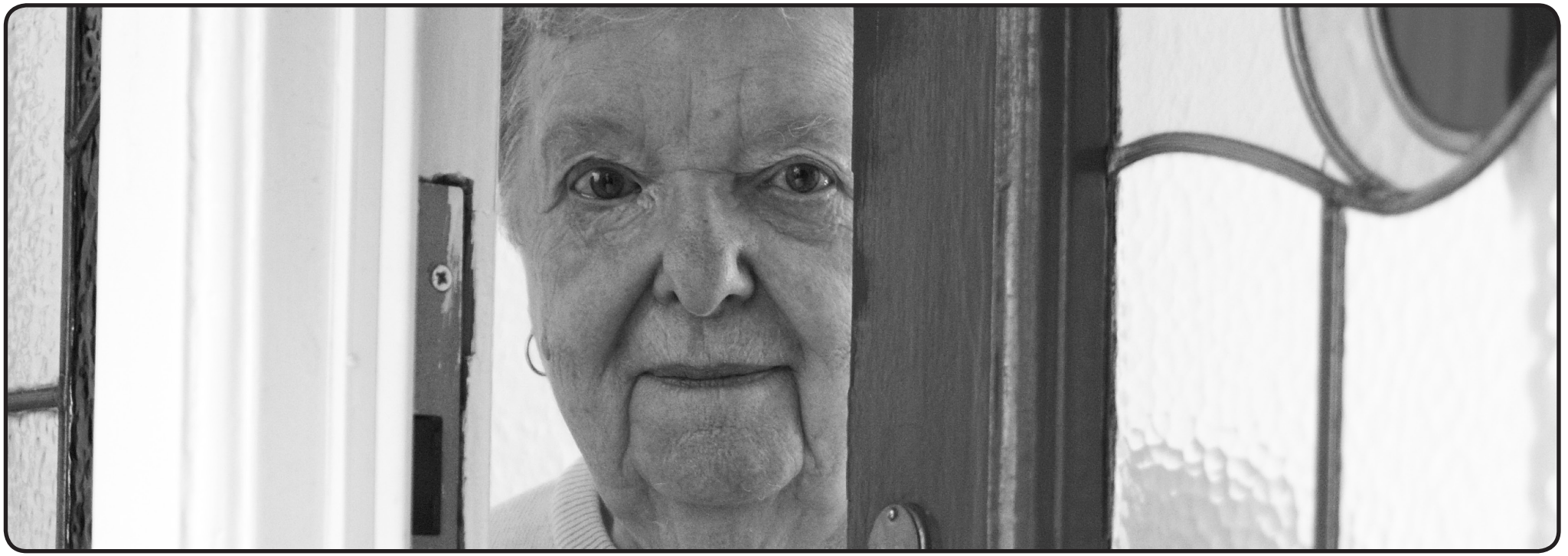
Integration is happening in several ways. The County Council and the CCGs have appointed integrated commissioners who are responsible for a theme; such as older people or housing, as well as a geographical area. At the same time the STP and the CCGs are developing new ways of delivering services, where health and social care staff work together in teams to provide services in the community.

There are places where integration is already working, for example in the Norwich Escalation Avoidance Team (NEAT) but there is still some way to go. Some local changes are happening very rapidly, but information to the public is not necessarily keeping up, and opportunities for public involvement or co-production in new services can be limited.

Objective 2019-21	Lead Agency/ies	What Success Looks Like
5.1 People understand what health and social care integration means to them.	STP; local delivery groups; Adult Social Services	People are told about changes to how services that affect them are delivered as soon as they are introduced. These may be new services or changes to existing services. There is a consistent system across health and social care for providing this information. Information is provided in a range of formats appropriate to the people who need it.

Objective 2019-21	Lead Agency/ies	What Success Looks Like
5.2 Local services fit around patients regardless of who provides the service.	STP; local delivery groups; Adult Social Services	Staff work in multi-disciplinary teams which include health, social care and the voluntary, community and social enterprise sector (VCSE). Patients may be looked after by staff from any of the organisations that employ people with the appropriate skills and contribute to the service they are receiving. All staff wear name badges. Service providers can share patient records so that patients only need to tell their story once and everyone has the most up-to-date information. Health and care services work seamlessly and are designed in such a way that they lead into each other where necessary.
5.3 Services are planned jointly by health and social care commissioners and providers and older people have a direct input into the planning and design.	STP; local delivery groups: Adult Social Services; VCSE	Service planning and design structures demonstrate the involvement of both health and social care organisations on an appropriate basis. Health and care organisations involve older people, their carers and VCSE organisations at an early stage in planning and designing or redesigning services. Older people, their carers and VCSE organisations are proactive in identifying plans for new services or changes to existing ones and ask to be involved.

Objective 2019-21	Lead Agency/ies	What Success Looks Like
5.4 Older people and their carers have an on-going role in monitoring, reviewing and evaluating services.	CCGs; Adult Social Services; Carers Matter Norfolk; Carers Voice	Older people and their carers are invited to comment when services they use are being monitored in the course of contracts. Older people and their carers are involved when newly developed services are being evaluated. Older people and their carers are involved when services are being reviewed before contracts are renewed or a new tendering process is planned.



6. End of Life Care

Older people want not only to live a 'good life'; they want to have a 'good death'. People living with a palliative diagnosis and those nearing the end of their lives, have a right to appropriate care, compassionately delivered by health and social care workers and informal carers. Present End of Life care, across Norfolk & Waveney is not cohesive. The level of care given is a postcode lottery with differing levels of health, social care and support at the end of life.

This has resulted in an overarching STP collaborative group working on a new model of palliative and end of life care for Norfolk & Waveney (2017 -2020). This model aims to provide co-ordinated care in all settings: hospitals, care homes, hospices and at home.

This model aspires to the Six National Ambitions: 1) Each person is seen as an individual. 2) Each person gets fair access to care. 3) Maximisation of comfort and wellbeing. 4) Care is co-ordinated. 5) All staff are prepared to care. 6) Each community is prepared to help (National Palliative & End of Life Care Partnership; A National Framework for Local Action 2015 - 2020)

All organisations and individuals should be able to refer into the system and receive the necessary education and training for End of Life care. As this work is already underway the strategy for the Partnership should align itself with the Six National Ambitions and the Norfolk & Waveney STP. The Partnership should have a watching brief on the following objectives of the End of Life strategy as they relate to older people.

Objective 2019-21	Lead Agency/ies	What Success Looks Like
6.1 All older people should have easy access to a 'Yellow Folder'*, which is completed as early as possible, to give their wishes about their treatment and care at end of life. (These are being reviewed & will include the ReSPECT** documentation on Advance Care Planning)	CCGs; GPs; libraries; care homes & domiciliary agencies; Adult Social Services; voluntary sector	Folders are readily available throughout the community. Publicity about the folders should be national and countywide. All professional health & care providers should ask for them when providing care as a matter of course Help to complete it should be available when needed. Signposting to other 'advance directive' material should be available where required.
6.2 All older people should be encouraged to make a will and complete LPAs*** for Health and Welfare and/or Finance and Property.	Voluntary organisations; solicitors; family & friends; care homes; libraries; domiciliary care; funeral directors	More widespread and understandable publicity about will making and LPAs. Encourage health, social care, voluntary agencies & families to recommend to older clients to make wills and LPAs sooner rather than later.

Objective 2019-21	Lead Agency/ies	What Success Looks Like
6.3 The existing 24/7 advice line for professional to professional and 24/7 Palliative Carers Advice line for patients, carers, voluntary services & the bereaved needs to expand to countywide. Bereavement Cafes have started in Suffolk and could be started in Norfolk to help give support.	CCGs: Adult Social Services; hospitals; communities	Shared records and shared data agreements enable everyone involved to always be aware of the situation and as early as possible. The advice lines have expanded to cover the whole of Norfolk and Waveney. Information and signposting service for psychological/ bereavement support and care. Bereavement Cafes have been set up in Norfolk to help give the support needed.
6.4 The Hospice at Home service for both day and night care should be rolled out throughout Norfolk and Waveney.	CCGS; Adult Social Services; hospitals; voluntary organisations; communities	There is no post code lottery to the care offered, equally received in remote rural areas. There is an integrated approach to the care given, which ensures all sectors are working together to the same standards. Care of the dying person is personalised and all those caring for them are able to receive the appropriate training.
6.5 Develop groups and individuals within communities who are willing to help when people are at the end of their life, e.g. sitting services, shopping, support to carers or the bereaved.	Voluntary organisations; community groups; neighbourhood schemes	An up to date list of local people/groups which can be called upon when those who are at the end of their life and/or their carers or the bereaved, need extra support over and above that offered by the statutory services.

* **A Yellow Folder** is a booklet which is filled out by each individual and provides details about their health and care needs. It gives their next of kin (NOK), their medications and importantly what type of care they wish to receive and where they wish to receive it should they become ill, including what their wishes are if they are dying. It should be kept in an accessible place at their home or wherever they live and be available to all those providing health and social care for them, including the Ambulance Service

** **ReSPECT** = Recommended Summary Plan for Emergency Care & Treatment
ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning. For more information go to: (https://www.respectprocess.org.uk)

*** **LPA** = Lasting Power of Attorne

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communication for all

For more information about Norfolk Older People's Strategic Partnership contact:

David Button - Chair
Erica Betts - Vice Chair
Mary Ledgard - Vice Chair
Carole Williams - Vice Chair

Email **nopspb@aol.co.uk** or leave a message on our answerphone service **07963 304015**

For more copies of the strategy:

Age UK on **0300 500 1217**
Or click on **www.norfolkolderpeoplespartnership.co.uk/strategy2019-2021.pdf**

For information about support for older people and their carers ring:

Norfolk County Council Adult Social Services on **0344 800 8020**
or email **information@norfolk.gov.uk**

Age UK Norfolk on **0300 500 1217** or email **info@ageuknorfolk.org.uk**

Age UK Norwich on **01603 496333** or email **enquiries@ageuknorwich.org.uk**

Carers Matter Norfolk on **0800 083 1148** or email **info@carersmatternorfolk.org.uk**

Produced by:

Strategic Partnership with older people's forums in Norfolk, Norfolk County Council, Norfolk Health, district councils, Norfolk Constabulary, registered social landlords, Healthwatch Norfolk, voluntary and statutory agencies, private agencies and politicians concerned with the well-being of older people.
With thanks to all the older people, their carers and partner agencies across Norfolk who contributed their time and experience to tell us what needs to be done.

Date produced: December 2018

Designed by TEN Creative

Printed on recycled paper by Interprint, using vegetable based inks.

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