Report to Norfolk Older Peoples' Strategic Partnership Board

6 March 2013
Item no 3

Activities of Working Groups and Chair / Vice Chair 06.012.12 – 05.03.13

1. Working Groups

1.1 NCC's Trusted Trader Service: consultation on accessibility for older people - Carole Williams and Vice Chair with older people; October 2012

1.2 Strategy concerns: meeting with Norman Lamb, Minister for Social Care - older people and carer representatives; January 2013

1.3 Concerns about funding preventative services for older people: meeting with Shelagh Gurney and Harold Bodmer - older people and carer representatives; January 2013

1.4 NCC's 'Strong and Well' funding: meeting to discuss priorities of older people and their carers - older people and carer representatives; February 2013.

2. Chair & Vice Chair

2.1 ASSD Service Developments/Restructuring

a) NCC Universal Services Board member – Board looking at the development of prevention projects in adult social care - JH
b) NCC Assessment and Care Management Review Board member - JH
c) NCC Integrated Reablement Services Project Board member – AB
d) Visit to NCC's Care Connect service – JH & AB
e) Launch of the Harwood Care Charter – JH & AB
f) Meeting with Catherine Underwood to look at how the partnership can work most effectively with the health and social care commissioners – JH & AB

2.2 Consultations/workshops

a) By NCC on people funding their own care – AB
b) By UEA on 'Care Homes Organisation Implementing Cultures of Excellence' (CHOICE) – JH & AB (also open to chairs of other older people's forums)
c) By NCC on promoting personalisation and personal choice and control ('Making it Real') – JH & AB
d) By Sue Spooner, Assistant to the Lord Lieutenant of Norfolk, as part of the planning for the 'End of Life Care' seminar in March - JH

2.3 Delayed Hospital Discharges/Unplanned Admissions (identified as a priority issue at the awayday conference in December 2012)

a) Meetings with Emma McKay and Chris Cobb, Director of Medicine and Emergency Services, Norfolk and Norwich University Hospital, to look at concerns in more detail – JH

2.4 Relationship with independent agencies (as requested at the awayday conference in December 2012)

a) Meeting with Dennis Bacon, Chair of Norfolk Independent Care to discuss representation of independent agencies on the Partnership Board and common interests – JH

2.5 Shadow Health and Wellbeing Board

b) Member representing voluntary agencies – JH
c) Participation in Workshops planning for unexpected/emergency events - JH

2.6 Joint Health, Social Care and Voluntary Sector Strategic Forum - JH

2.7 Talks/Lectures/Conferences

a) Later Life national conference – JH
b) UEA Seminar on dementia – JH (also open to chairs of other older people's forums)
c) ''How do we empower older people to live independently in East Anglia?' - Red Cross event with presentations from their Managing Director of Operations, Norman Lamb, Simon Wright and JH

2.8 Media

a) Spring 2013 edition of Prime Time, the Local Government's Pensioners magazine that goes out to 15,000 members – double page article by Joyce on the work of the older people's forums and their involvement in strategy.

2.9 Healthwatch Development

a) Involvement in workshops – JH & AB

2.10 Partnership

a) Creative Arts East partnership application for an Arts Council Grant of £50,000 to support activities with older people: letter in support – JH

2.11 Norfolk County Council Committees

a) Cabinet 18th January – attended by JH

2.11 Planning meetings

a) five meetings - JH, AB & Annie Moseley

2.12 Acting as a Forum for information-sharing and joining up (identified as a priority issue at the awayday conference in December 2012)

a) Circulation of information to members, the email 'cc' list and the older people's Board members – JH & Annie Moseley

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Note: Like all the other older people's forum chairs, Joyce and Ann are also very involved in chairing and leading the work in their district forums.

Report to Norfolk Older Peoples' Strategic Partnership Board

6th March 2013
Item no 6

Norfolk Disabled Facilities Grant Project

Update – February 2012

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1. The DFG Project has been running since April 2011, with the aim of streamlining and standardising the processes between Norfolk County Council and the Local Housing Authorities who administer the grant process.
2. The stated objectives of the project are to:
    a. significantly reduce waiting times for clients;
    b. improve client pathways;
    c. develop consistent service delivery across the county;
    d. enhance management of contractors;
    e. reduce operating costs.
3. In October 2011, following a thorough review of the existing service across the county, which produced four options for change, the Chief Executives Group agreed to implement the proposal to develop seven integrated housing adaptation teams, comprising social care and housing staff, to provide a single end-to-end service for people requiring adaptations to their homes.
4. Considerable work has taken place with district and County staff to ensure systems and processes are in place to deliver the new model.
5. The new teams are being phased in over a period of months, so that learning from the initial implementations can be applied to subsequent phases, and to make it easier to make amendments to the processes as they were being used.
6. Social Care staff are continuing to be employed by the County Council, and terms and conditions of employment are not being changed.
7. The first team to be in place was North Norfolk District Council, on 12th November, closely followed by South Norfolk Council on 19th November and Broadland District Council on 26th November.

8. The Borough of Kings Lynn and West Norfolk began taking calls on 21st January 2013, closely followed by Breckland District Council in early February.
9. Great Yarmouth Borough Council have now appointed their team, and should be going live in March, and discussions with Norwich City Council to arrange their start date are in progress.
10. Early indications from the first three authorities are positive, with benefits such as better communication, increased understanding of roles, more creative solutions to meeting people's needs, and faster decision making already being realised. Better relationships with Housing Options teams are also emerging, resulting in people being allocated homes that better meet their needs without extensive adaptations having to be made.
11. There has been a 'soft launch' to the new working arrangements to enable the teams to become established. Arrangements with Social Care and Norfolk Customer Services have been put in place during the transitional period to ensure vulnerable people do not 'fall through the net' or receive a fragmented service. The teams are being asked to complete 'tick-sheets' in the early stages to help monitor workflow, and to make sure that referrals are happening as they should. The results of this are encouraging, as already the largest proportion of calls are direct from the public.
12. Work is also continuing with the social housing providers and district housing allocation teams to make best use of adapted stock. An Adapted Housing Protocol for reallocating adapted social housing stock is being piloted in the New Year between Broadland District Council and South Norfolk Council, and six of the major housing providers in those areas. If successful, other councils and providers will be invited to join.

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Report to Cabinet
28 January 2013
Item No 16

Strong and Well: Strengthening Support for Older People in Norfolk

Report by the Director of Community Services

Summary

The 2011 census outlines that over 20% of all residents in Norfolk are aged over 65 (approximately 185,000 people) and in North Norfolk the proportion aged 65 and over is the third highest of all local authorities in England and Wales. Older People are a great asset for their contribution to the County and many will not experience problems with care needs However, around 25% of the over 65s have a social care need, and so age-driven demand for care services will increase, with an impact in the proportion of the budget spent on older people. It is important to promote prevention and earlier intervention whilst meeting this rising need.

The Council therefore proposes to spend £5m over five years to strengthen support for older and vulnerable people. The intention is to enable communities to help themselves, through a partnership with Norfolk's voluntary, housing, health and business sectors.

The Council will coordinate voluntary Strong and Well visits to targeted older people with emerging social care needs, based on more intelligent information exchange between the community and organisations. We will ask people what they need, and provide a response to help them plan and be independent, and well, for longer. We want communities to use their natural willingness to respect and care for older people, and remove the barriers that prevent this from happening. The programme will only work through an effective and collaborative partnership, with a willingness to have a 'different conversation' based on what people want and not necessarily what is on offer, and a greater tolerance for informal arrangements.

Strong and Well will extend funding to provide services, many of which are already available from voluntary or statutory bodies. As a result of this approach there could be an opportunity to reinstate some funding for prevention services on the basis of a targeted approach.

Recommendations

1. Cabinet is asked to agree the 'Strong and Well' partnership approach and make the offer to citizens, public bodies, and business and community leaders to take part in a five year programme, championed at Cabinet level

2. Strong and Well funding is agreed for vulnerable people aged 75 years and over, with flexible funding of £500,000 revenue each year for five years and £500,000 capital each year for five years, acknowledging that the balance of funding may alter as the programme progresses, as outlined in the Council Plan and 2013-14 Budget report also on the Agenda for this meeting.

3. Strong and Well forms part of the Council's contribution to Health and Well-being Board priorities.

1 Background - meeting future demand

1.1 The current position

1.1.1 The 2011 census recorded over a fifth of all residents in Norfolk as being aged over 65 (185,000 people approximately) and in North Norfolk the proportion aged 65 and over is the third highest of all local authorities in England and Wales. This Norfolk characteristic means that age-driven demand for care services is set to increase, with an impact in the proportion of the budget spent on older people. In 2013-14 the Council faces estimated additional annual costs of £3.5m for social care packages for older people, and this is set to rise each year as levels of need intensify. Meeting these costs allows us to keep pace with demand, but it does not help with prevention.

1.1.2 In Norfolk, over a quarter of all households with a person aged 65 or over have a social care need. Many older people with moderate and low needs will not be able to access social care services because of eligibility criteria, but need some lower levels of support to maintain their independence, and need advice to plan for the future.

1.2 Enabling Communities

1.2.1 Taking action to enable people to maintain their independence for as long as possible will improve individual well-being, encourage communities to help each other, but also prevent people from prematurely entering the social care system and, hence, avoid or delay some of the future demand for social care.

1.2.2 Building capacity in communities is therefore no longer just desirable, but essential to the future of public services. This initiative is an example of where the Council can shift its emphasis from a reactive service provider to a more proactive leader in the Community. The Council is letting people know what action they can take for themselves, and what expectations might be reasonable for communities and community groups to have in order to build resilience. This means enabling other people to take action and then getting out of the way with reduced bureaucracy for example.

1.2.3 People and communities already have many assets and arrangements for helping themselves. However, invest to save funding will make a difference. The Council has already taken similar action through initiatives such as the Living Well in the Community Fund, Winter Warm and Well, the Ageing Well scheme, Norfolk Living Well, the Norfolk Foundation, and the Norfolk Construction Fund. These have produced valuable early results, and they demonstrate that a collaborative and partnership approach can be effective.

1.3 ‘Strong and Well’ Proposal – Strengthening Support for Older People in Norfolk

1.3.1 Strong and Well is a proactive approach which targets vulnerable people with an offer of practical solutions via a person-to-person service. These solutions are geared to maintain older people’s independence and mitigate the risk of social isolation. This proposal is aimed at individual action as well as community action, and will be sustained over five years. It recognises that older people themselves, and their families, are part of the solution as well as the need. It recognises that older people do not always access services and social opportunities which are available to them. Older people in Norfolk are likely to be carers as well as cared

for and this can be isolating.

1.3.2 The proposal is in keeping with the Social Care Bill, *Caring for Our Future*, which outlines a new duty in prevention and the importance of identifying adults in the authority's area with needs for care and support which are not being met (by the authority or otherwise).

1.4 Outcomes for Strong and Well

1.4.1 Over the next five years Strong and Well has the following outcomes:

a. Later take up of formal care services, avoiding social care demand
b. Markedly increased levels of older people with adapted houses and financial plans for later life
c. Vulnerable persons aged 75 and over having a personal contact and a plan to link them with local opportunities
d. A strong partnership with local voluntary and community groups and a strong sense of Norfolk looking after 'its own'
e. A significant increase in volunteering by young people and people not working or with the capacity to take part
f. A new 'habit' of information sharing about vulnerable people, with no new bureaucracy.

1.5 A Major New Partnership

1.5.1 Norfolk Strong and Well will be a partnership between public, voluntary and private sectors that signs everybody up to local coordination in order to share information about who is vulnerable, isolated or at risk. This will link people with practical help that is already there but which people find it difficult to find out about or access. Local coordination will develop responses where there are gaps. A partnership way of working will be flexible and allow participants to work to their strengths, making it more likely that funding and opportunities will go to local groups.

1.5.2 The core strength is an 'at your door" service with a visit from a volunteer trained in supporting older people and enabling and encouraging access to services and social opportunities, and promoting digital inclusion. Working with local befriending schemes, village/community agents, the voluntary sector doing street-level working, district and parish councils and businesses, the Strong and Well Volunteer would provide a gateway to local opportunities for the older person and link to schemes such as Homeshield and the Older people's outreach service.

1.5.3 Strong and Well will also link people to community events, social activities and skills sharing, such as intergenerational projects in schools and activities in libraries such as Norfolk Records Office archiving.

1.6 Targeting people aged 75 and over

1.6.1 Strong and Well will target people aged 75 years old and over. According to the 2011 census of 90,000 people, 10% of Norfolk's population is aged over 75. We know that a quarter of all over 65s will have a social care need and that many customers have high care needs at the age of 85. According to the Royal College of Physicians, people aged 75 are at great risk of having a fall and, when they do fall, to need long term care. Over 75s represent a significant group in emergency admissions in Norfolk. 75 year olds are also the target age group in the early diagnosis of dementia in the government's dementia challenge.

1.6.2 Similar initiatives, notably in Thurrock and Coventry, have worked with the

Department of Work and Pensions in identifying hard to reach older people who may need low level support. In Great Yarmouth, Operation Gunpowder has used door-knocking to reach vulnerable people. Strong and Well would use the best practice from these initiatives to target local areas and also work with existing community/village agent schemes to identify older people.

1.6.3 We know that the programme will need to have an effective strategy for supporting carers, as their informal work underpins much of the formal health, care and housing support provided by statutory agencies. The scheme could, for example, extend or promote existing access to respite support services.

1.7 Preventative interventions

1.7.1 Strong and Well provides a checklist and toolkit for the volunteer to enable people to access a range of interventions, and put people in touch. The spectrum on offer is vast and has a diverse range of providers. The following is currently available or could be further developed, but is by no means an exhaustive list:

a. Adaptations to aid daily living
b. Assistive Technology and Equipment,
c. Befrienders,
d. Carers Support,
e. Community Health Services, including falls prevention advice
f. Housing related community support for older people
g. Financial planning and Later Life care Planning
h. Fire Safety Checks and advice
i. Help with Smoke Alarms,
j. Home Improvement Agencies (HIAs),
k. Homeshield,
l. Luncheon Clubs,
m. Minor adaptations to the home
n. Outreach Support Service for Older People
o. Reablement,
p. Short breaks/Respite Care,
q. Specialist Information, Advice and Advocacy,
r. Theatre Royal friendship groups,
s. Timebanking – using credit or vouchers
t. Trusted Trader and Rogue Trader support,
u. Volunteering support
v. Welfare Benefit Advice.

1.7.2 To develop the Strong and Well proposal, some further research activity would address the identification of ‘at risk’ 75s and over and which areas to target for home visits, as well as an establishing an evaluation framework to capture outcomes. Next steps for Strong and Well include the following:

a. Data activity for identifying older people
b. Variation of existing relationships and contracts
c. Brand and marketing campaign
d. Map other funding streams which could contribute
e. Define checklist and toolkit of offers
f. Dealing with the identified new need etc
g. Informing the Health and Wellbeing board
h. Work with Older People Forums

2 Resource Implications

2.1 Finance

2.1.1 Based on initial work with the voluntary sector we estimate a programme of visits at around 7,000 per year costing £500,000. The service will use the existing infrastructure of voluntary and private providers, meaning that every willing organisation can take part and feel part of the initiative.

2.1.2 Funds will be required to coordinate the scheme, to train volunteers, where necessary (where they have not already been trained by local voluntary groups) and to track and measure the outcomes. Should this proposal be successful, a detailed financial plan will be produced.

2.1.3 The costs are built up by analysing costs within the local voluntary sector for similar schemes including, for example, befriending and volunteering services by Age UK and Red Cross Services. The indicative costs include a per visit amount of around £35, and £500 to train a new volunteer, alongside infrastructure costs – however the service will seek to utilise existing volunteering arrangements.

2.1.4 Costs will be minimised by working with existing partnership arrangements such as Norfolk Warm and Well to bring together public, community and business sector groups, so that Strong and Well will be both universally available but targeted towards priority people.

2.1.5 As part of this initiative, the Council will take into account existing funding and performance arrangements for volunteering, befriending and similar services with a view to ensuring stability and increasing capacity where that is the best value. This will maximise the number of volunteers in Norfolk and enable a new sense of priority for the task.

2.1.6 Further detailed work needs to be undertaken to fully develop the scheme costs. However, the approximate cost breakdown per annum is:

£90,000	infrastructure costs for coordination, recruitment, database targeting, marketing, and overheads
£260,000	additional visits
£150,000	volunteer training and support
£500,000	**Total**

2.1.7 The programme will make flexible use of the capital funding, and this primarily will be through expansion of those existing arrangements highlighted at 1.7.1.

2.2 Staff

2.2.1 Strong and Well will originate in Community Services, but will be a pan-organisation approach bringing staff and volunteers together.

2.2.2 The voluntary sector will be the major partner and could host the operational activity for Strong and Well.

3 Other Implications

3.1 Equality Impact Assessment (EqIA)

3.1.1 The Strong and Well initiative focuses heavily on improved accessibility. The improvements will include inviting partners to add their services to the toolkit to enhance information and knowledge. The potential positive impacts to diverse groups are outlined below:

a. Older people – there would be a positive benefit for older people as Strong and Well is targeting people aged 75 and older

b. People with a disability, impairment or long-term physical or mental health condition – information from the Specialist Information, Advice and Advocacy model (SIAAM) partnership is targeted to these specific groups of people regarding services

c. People from different ethnic or cultural backgrounds, including Gypsies and Travellers – Strong and Well will link up with community development initiatives targeting older people who are harder to reach, such as Bridge Plus

d. People who care for other people – Strong and Well will advise carers as well as the person they care for.

3.2 Communications

3.2.1 To support the launch of the scheme and to inform the public, communications are essential. Input from the media team on press releases and coverage of Strong and Well will be needed.

3.3 Health and Safety Implications

3.3.1 Volunteers such as befrienders and neighbourhood ambassadors currently visit people in their own homes. These volunteers are trained appropriately, which includes spotting adults who might be subject to harm and also how to protect themselves when out in the community. For Strong and Well the current training provided to such volunteers will be assessed and developed appropriately.

3.4 Environmental Implications

3.4.1 The potential positive environmental effects of delivering Strong and Well is that local organisations and partners will be involved in delivering the services and local volunteers will provide the door-to-door service. This should reduce the need for long journeys and reduce mileage to complete tasks. The negative impact could be the number of publications that are delivered to homes as a result of the door-to-door service. However, these publications would be ones that are currently available. To mitigate this risk recipients will be asked to use the internet and libraries to access information.

3.5 Any other implications

3.5.1 Officers have considered all the implications which members should be aware of. Apart from those listed in the report (above), there are no other implications to take into account.

4 Section 17 – Crime and Disorder Act

4.1 Strong and Well has a positive impact within neighbourhood working and will liaise with Operational Partnership Teams within localities.

5 Risk Implications

5.1 The following risks have been considered and assessed;

Risk	Likelihood	Impact	Mitigation
Current Situation:			
M0207: Failure to meet the needs of older people	Possible	Older people, especially those with moderate needs will not get the information and advice they need.	Strong and Well scheme which is targeted at people aged 75 years old and over.
Meeting the *Caring for Our Future* mandate: asserts a new duty in prevention and the importance of identifying adults in the authority's area with needs for care and support which are not being met (by the authority or otherwise).	Likely	Adults who are in need are not proactively identified and their care needs are not met	Strong and Well scheme identifies adults and proactively tackles their needs on an individual basis.
Strong and Well Proposal:			
Risk	**Likelihood**	**Impact**	**Mitigation**
Adults are not safeguarded from harm	Rare	Major	Strong and Well potentially presents an opportunity to identify adults who may be suffering from abuse and to alert authorities
Lack of Voluntary Sector capacity	Possible	Major	Strong and Well will work with partners to understand and work with current levels of capacity, with a view to boosting this where needed

Volunteers are inadequately trained and supported	Unlikely	Major – Strong and Well relies on a volunteer workforce	Strong and Well will support partners to train and support volunteers, learning from initiatives such as Age UK Noriwch's befriender scheme
The scheme is not seen as local enough	Unlikely	Major – the essence of the scheme is local area coordination	The Strong and Well partnership will be devolved from the outset with
The scheme is not seen as equitable across the county	Possible	Major	The Strong and Well partnership will seek information from district partners about communities who are in most need, but the scheme will also be mindful of account health inequalities and rural isolation.

6 Overview & Scrutiny Panel Comments

6.1 Community Services Overview and Scrutiny Panel, held on 8 January 2013, discussed the initiative. Members discussed the importance of targeting this money in order to make the most of it, and whilst accepting the need to support those aged 75 and above, suggested some flexibility. Members discussed the prospects for spending any additional one-off funding on alleviating the affects of reduction in spending on preventative services that arose from the Big Conservation programme, especially where those services are working well. The meeting endorsed the Cabinet Member for Adult Social Services in a bid to Cabinet in respect of investing more in prevention services for vulnerable older people who are aged 75 or over.

7 Alternative Options

7.1 There are no other options which proactively meet the needs of people who are 75 years old and over.

8 Reason for Decision

8.1 Community Services recognises the major challenge of the need to work efficiently whilst responding to the rising number of older people in Norfolk with care needs and sees an opportunity to work in partnership with others to support older people in their communities to build stronger community connections, prevent social isolation and take preventative action over a sustained period of time. By targeting people 75 years old and over, we will also mitigate the risk RM0207 Failure to meet the needs of older people, which is stated in the Community Services Service Plan.

9 Recommendation

9.1

1. Cabinet is asked to agree the 'Strong and Well' partnership approach and make the offer to citizens, public bodies, and business and community leaders to take part in a five year programme, championed at Cabinet level.

2. Strong and Well funding is agreed for vulnerable people aged 75 years and over, with flexible funding of £500,000 revenue each year for five years and £500,000 capital each year for five years, acknowledging that the balance of funding may alter as the programme progresses, as outlined in the Council Plan and 2013-14 Budget report also on the Agenda for this meeting.

3. Strong and Well forms part of the Council's contribution to Health and Wellbeing Board priorities.

Background Papers

None

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

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If you need this Agenda in large print, audio, Braille, alternative format or in a different language please contact Jill Blake on 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Minimum Deliveries of Domestic Heating Oil

On enquiries to Trading Standards, it was discovered that the meter measuring systems on road tankers are certified to legal requirements that mean the customer has an accurate minimum measure delivered. If that tanker is asked to deliver a different minimum amount then the percentage error could prejudice either the trader or the purchaser.

The legal minimum delivery varies depending on the equipment each supplier uses on its tankers, usually around 300-500litres, with the older ones set at 500 litres. Only newer electronic meters can go lower. Oil companies are correct to say that they must deliver at least the minimum their type approval certificate states.

Therefore it is worth shopping around to find someone who can deliver under 500 litres if that is what you need.

There is a good leaflet produced by Trading Standards on the NCC website "Your guide to Buying Heating Oil" http://www.norfolk.gov.uk/view/NCC110248 or by telephone 01603 222619.

Ann Baker
Vice Chair
Norfolk Older People's Strategic Partnership
01.02.13