Ambition 5: Transforming Care in Later Life

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"Our aim is to simplify, improve and integrate health and care for people in later life (including at the end of their life) across Norfolk and Waveney. We want to design our services with and for the people of Norfolk and Waveney, to support them to have the best possible quality of life."

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Chair/ Senior Responsible Officer for Ageing Well Programme Board Chief Executive Officer of East Coast Community Healthcare

Our objectives

a) **To have health, carer and support services that are fit for our ageing population – supporting people as they age, to lead longer, healthier, happier lives**

What would you like to see in our five-year plan for health and care services? What matters to you most?
Recent workshop feedback: "I want more services to understand what matters to me and what I need". "I don't want to get ill if I can avoid it. I need to know what I have to do and how to get the support I need near where I live". "We have to stop people becoming lonely". "If I have to go to hospital I want to be there for as short a time as possible". "Better help for people with dementia". "Older and frailer people kept well at home for as long as possible".

Why we chose these objectives
Our population is older than in most systems, but a lot of our services have not been designed with older people in mind and may not be known to, or easily accessed by the people who need them. Currently the available support from statutory, voluntary, and charitable services is often unknown to the person, confusing or complicated to access. This can mean that people don't always know what they can do to prevent ill health or get the help they need until far too late. So, we want to design and connect services to inform and support people as they age.

With a focus upon prevention and ageing well, we want to make it easy for people as they age to access the right preventative intervention or support as soon as they need it. We want to simplify and join up the different types of services, social assets and amenities near to people, and delivered as close to home and as early as possible.

By making it easy to access support and by removing the barriers between the different types of support available, we will work together to enable people, as they age, to maintain their independence and preserve their quality of life for longer.

Objective 5a: To have health, carer and support services that are fit for our ageing population - supporting people as they age, to lead longer, healthier, happier lives

In our first year, our objective was to develop a shared vision and strategy with older people.

The Ageing Well Strategic Framework has now been published and you can read it here.

The next year will focus on implementation.

What are we going to do?
Our vision is that Norfolk and Waveney will be a place where people in later life and their carers:

- are helped to age well, living happier, healthier lives, living as independently as possible, for as long as possible;
- feel heard and respected, and know they will be treated as individuals;
- experience services that ask, 'what matters most to you' and proactively act upon their answer.

This year, we will work together with our NHS providers, VCSE partners, members of our community, and our Public Health teams in Norfolk and Suffolk to start delivering this framework.

How are we going to do it?
We will set up an Ageing Well Programme board and 4 priority workstreams:

1. Frailty focussed hospital care
2. Improved care and fewer unplanned admissions from care homes and supported accommodation
3. Prevention of frailty and extending healthy older life
4. Improved quality of life for people living with dementia

We will also ask all our providers and places to use the strategic framework to identify where we have gaps or overlaps in our services and work to address those and coordinate our services better.

How are we going to afford to do this?
Simplifying access and focusing on early and local intervention will reduce long term need and costs e.g.by preventing unnecessary ambulance call outs and hospital admissions.

Co-designing services with older people to focus on maintaining independence will reduce costs long term, but we will need to divert funding toward prevention, early intervention and planning for the future, reablement and care at home.

Co-ordinating services using a system-wide perspective will deliver more integrated, high-quality cost-effective care from multiple sectors so reducing waste and duplication so saving cost for our system.

We will also actively seek new external monies / funds to support people in later life where possible.

What are the key dates for delivery?

Year 1 April 2024 - March 2025
Implementation of the strategic Framework:

- Creation of a strong clinical community of practice to lead on frailty focussed hospital care
- Implement a system wide definition of frailty and standardised frailty assessment tool so that we can easily identify people with frailty.
- All providers signed up to the dementia charter

Year 2 April 2025 – March 2026:
Innovation and prevention

- Fully integrated care for people living in residential or supported living environments using technology where appropriate.
- Multi professional triage for older people, so that they can receive support through one stop or combined assessment and, treatment wherever possible, and in the most appropriate setting.
- Planning for older age – supporting people to take control of their health and maintain healthy older life and reduce the period of time spent in frailty.

Year 3 April 2026 – March 2027
Reflect, Review, Replan

- Ongoing use of the framework to address gaps in provision across our system.
- Ongoing use of the framework to identify opportunities for prevention and early intervention.

How will we know we are achieving our objective?

- Reduced unplanned admissions from care homes.
- Better understanding and coding* of our population with frailty, enabling specific support to be put in place.
- All providers signed up to the dementia charter and feedback from people with dementia and those who care for them that this is improving their experience

*clinicians describe a patients complaint, problem or diagnosis and treatment in their notes which is classified into codes for the purposes of activity reporting – this enables us to look at patterns and trends

Case Study

Virtual ward prevents admission to hospital

John is an 84 year old man with long standing issues with his breathing. John was referred to the Virtual Ward by his GP when his breathing became difficult for the third time in 3 months. Both times this had happened before, he had ended up in the hospital emergency department which John found distressing and disorientating, and on one occasion he had been admitted to the hospital for 8 days.

John's GP referred him to the Virtual Ward during an emergency appointment at the surgery. The virtual ward hub accepted the referral and as part of his onboarding, they reviewed his health care records to gain more information about what had happened during his previous admissions and multiple A&E attendances. Remote monitoring equipment was delivered and setup for John at home within two hours of being onboarded. An initial assessment including blood tests were performed in John's own home to confirm the reason for John's deterioration. The virtual ward team developed a management plan and agreed this with John and his family using joint decision making.

John started treatment that day, and remained at home but with daily calls, 24/7 monitoring and two further home visits before he was "discharged" from the virtual ward. Before that happened, the virtual ward team, John and his family also agreed a long term health care plan to try to prevent the need for further A&E attendances and hospital admission.