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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Our objectives

a) To develop a shared vision and strategy with older people that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people.

What would you like to see in our five-year plan for health and care services? What matters to you most?
Recent JFP consultation feedback: "Support for social care for older people to reduce acute admissions". "Access to the right care pathway and improved social care for dementia and Alzheimer's." "Tackling dementia care". "Older/frail people kept well at home"

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. Current services are often confusing or complicated to access meaning that people don't always get the help they need until far too late. So, we want to design our services with our older residents.

We want to make it easy for older people to access support as soon as they need it, whether that support is for social, care or health needs. We want to simplify and join up all of our different services, so they are wrapped around our residents, 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 support older people to maintain their independence and preserve their quality of life.

Objective 5a: To develop a shared vision and strategy with older people

What are we going to do?
Develop a shared vision and strategy with older people, that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people. We will then work together to deliver that strategy, to improve people's health, wellbeing, clinical outcomes and experiences of using and being supported by our services in their later lives. This will be known as our Ageing Well Strategy.

How are we going to do it?
Bring together members of our older population with colleagues from health, local government, the care sector and voluntary and community services to agree what the ideal service would look like for older people.

Work backwards from that to identify what needs to be in place to achieve that vision, using population health data and evidence based best practice to identify where and how this should be delivered. Map our current services to identify gaps and overlaps between the current and desired future state. Identify what new services or projects we need, and which current services need to change, expand or stop to best achieve this.

Establish an Ageing Well Programme Board to develop and then oversee the delivery of this strategy over the next 3 - 5 years.

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 divert funding toward reablement and care at home, reducing costs associated with long term complex care packages and residential care. Co-ordinating services using a system-wide perspective to deliver more integrated, high-quality cost-effective care from multiple sectors so reducing waste and duplication so saving cost for our system.

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

What are the key dates for delivery?

April - Sept 2023:
- Identify partners from across the ICS; including people in later life, to engage and co-produce the vision.
- Map the 'as is' position of existing services and support. Identify gaps, overlaps and opportunities.
- Agree a system wide definition and assessment tool for frailty to be used across all providers
- Begin to develop a strategy and 3-year plan to achieve the vision. Test this with a wide range of people in later life, carers, VCSE and other health and care professionals

Oct 2023 – March 2024:
- Develop a detailed road map to identify changes to services, commissioning, and communication of the future state.
- Continued coalition building; gaining commitment of individual organisations to work together to achieve the new ways of supporting people as they age to live well.
- Set up working groups to lead on the workplan, set and monitor metrics to measure impact.

April 24 – March 2025: Maintaining the momentum and effort
- Resetting goals and metrics to measure effectiveness of programme, changing the plan to ensure it is delivering as needed
- Recognising success and reflecting on lessons learned.
- Continued checking back with people in later life and carers that the transformed services are meeting their needs.

How will we know we are achieving our objective?
Publication of an Ageing Well strategy by December 2023, and a detailed road map for implementation plans by March 2024.

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.