Norfolk & Waveney
COMMUNITY SUPPORT

Norfolk and Waveney Community Support service

9 month evaluation (Oct 2023 - Jun 2024)

Publication Date: September 2024

VOLUNTARY NORFOLK

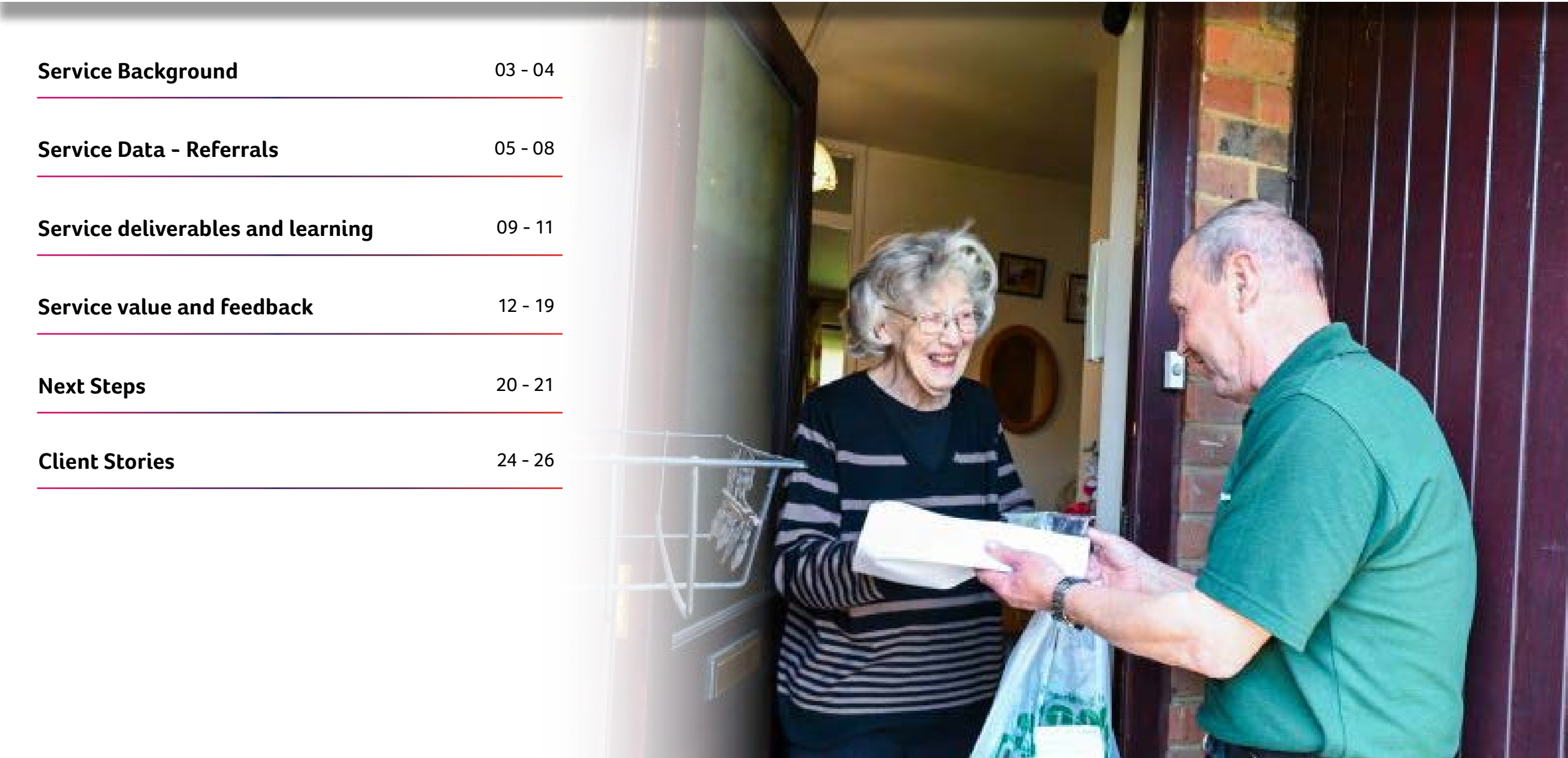
Norwich age UK
Improving the quality of later life

In partnership with

British Red Cross

Contents

Norfolk & Waveney
COMMUNITY SUPPORT



Service Background

Service Background

Norfolk & Waveney COMMUNITY SUPPORT

- **Short-term, practical support for:**
  - patients being discharged from hospital on Pathway 0 to help them return to the community safely
  - people in the community who need help to enable them to stay safe at home
- **A team of staff and volunteers**
- **Support aims to be short-term (2-4 weeks) but can be extended up to 12 weeks where there is a need**
- **Aims to link people into community groups and support networks to support them to remain in the community**
- **Delivered by a partnership of British Red Cross, Voluntary Norfolk and Age UK Norwich**
- **Single point of referral and triage**
- **Referrals are allocated to Voluntary Norfolk, British Red Cross or Age UK Norwich depending on need and capacity. Referrals accepted following triage are:**
  - Allocated to Voluntary Norfolk to match with volunteer support
  - Allocated to British Red Cross or Age UK Norwich for staff support
  - Allocated across providers for a combination of staff and volunteer support
  - Signposted to an appropriate service

Norfolk & Waveney
COMMUNITY SUPPORT

Service Data

Service Data

Norfolk & Waveney COMMUNITY SUPPORT

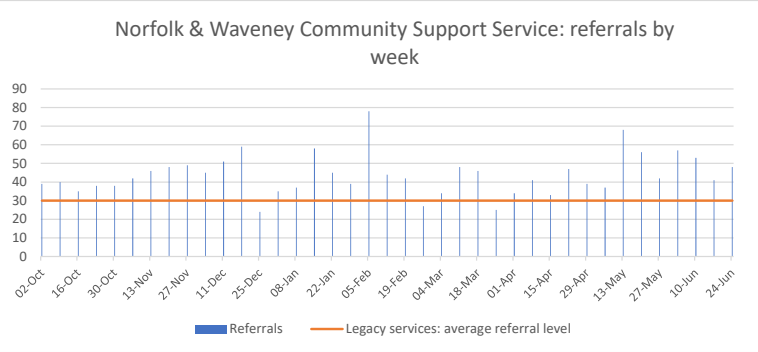
Referrals numbers are strong and from referrers across Norfolk and Waveney in health and social care

Referral Numbers (9 months)

Referrals per week are consistently above the level of the combined legacy services

1716 referrals received and triaged in first 9 months

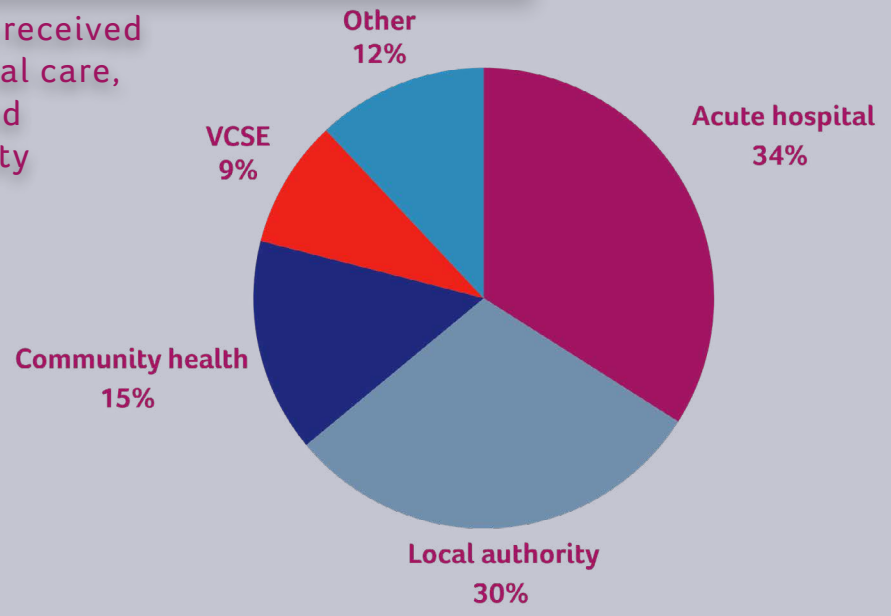
200 per month



Referrals per week are consistently above the level of the combined legacy services

Referrers into the service

Referrals received from social care, health and community



Service Data

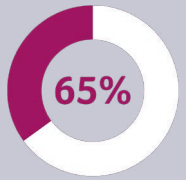
Norfolk & Waveney COMMUNITY SUPPORT

Referrals are weighted towards older ages, people with long-term health conditions and those living alone

Demographics

56% female
44% male

62%
live alone



over 70 years of age

Long-term needs

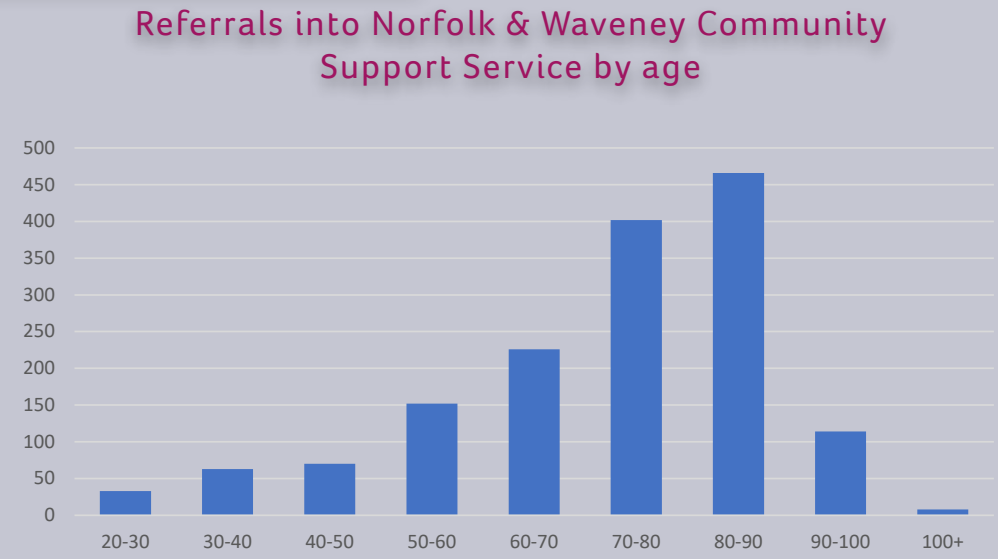
Many clients have long-term health conditions

Long term medical condition
35%

Physical impairment
23%

Long term mental ill health
17%

Referrals by Age



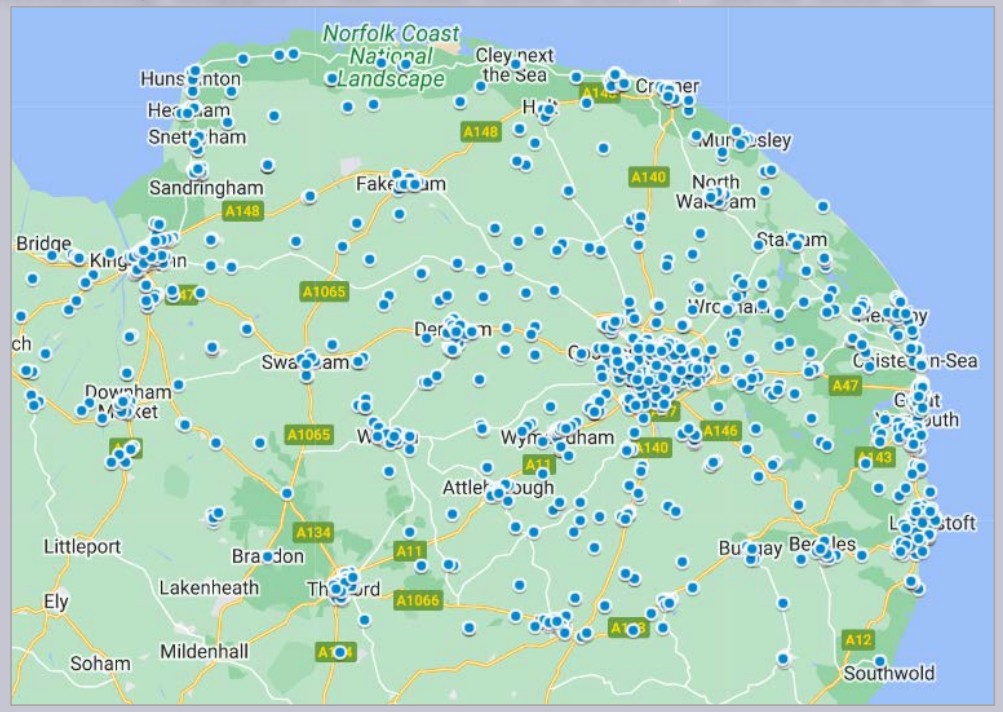
Service Data

Norfolk & Waveney COMMUNITY SUPPORT

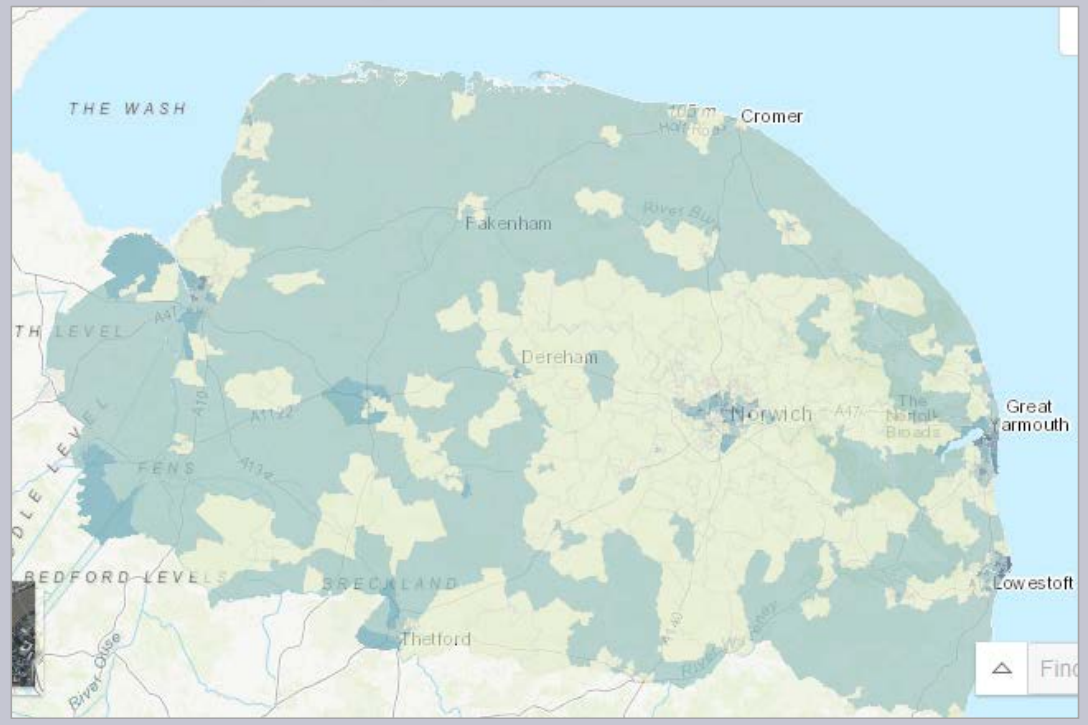
The service is reaching Core20. Referrals are proportionally from more deprived areas and with more health and disability needs

Referrals in the most deprived IMD decile are 81% higher than Norfolk and Waveney's IMD distribution
109% higher for the IMD health and disability domain

Distribution of referrals received into Norfolk & Waveney Community Support service (Oct 2023 – June 2024)



Index of Multiple Deprivation (IMD) Decile - LSOA (2019)



Service deliverables and learning

Service deliverables and learning

Norfolk & Waveney COMMUNITY SUPPORT

The service has achieved all key deliverables and is providing short-term, practical support through a combined volunteer and staff team, as commissioned

Service set-up and referrals

- An integrated service provided by three VCSE organisations
- A single point of referral, triage and allocation
- Referrals from acutes, community health, social care and primary care with data sharing agreements in place
- Referrals allocated according to need of clients allocated post triage:
  - 43% for volunteer support
  - 53% for staff support
  - 4% for combined volunteer and staff support
- Equitable provision across Norfolk and Waveney

Short-term, practical support

- Short term support
  - 40% of clients are in the service for less than 2 weeks
  - 75% of clients are in the service for 6 weeks or less
- Practical support
  - 4745 support activities recorded
  - Top 4 areas of support requested:
    - Support with daily activities 21%
    - Wellbeing / loneliness 19%
    - Pre or post discharge support 14%
    - Assisting to access services 13%

Volunteer provision & growth

- 200 volunteers available
- Streamlined volunteer recruitment and improved training process
- From first quarter to third quarter:
  - Clients supported by volunteers up 37%
  - Volunteer activities up by 88%,
  - Volunteer hours up by 60%

Relationships & integration

- Building stakeholder relationships across referring organisations in the ICS
- Engaging Health and Well-being Partnerships and Place Boards
- Building links to integrate locally and enable referrals to local support and groups
- Links with other related commissioned services (e.g. I&A, social prescribing, District Direct, NEAT and Home Help Hubs)

Service deliverables and learning

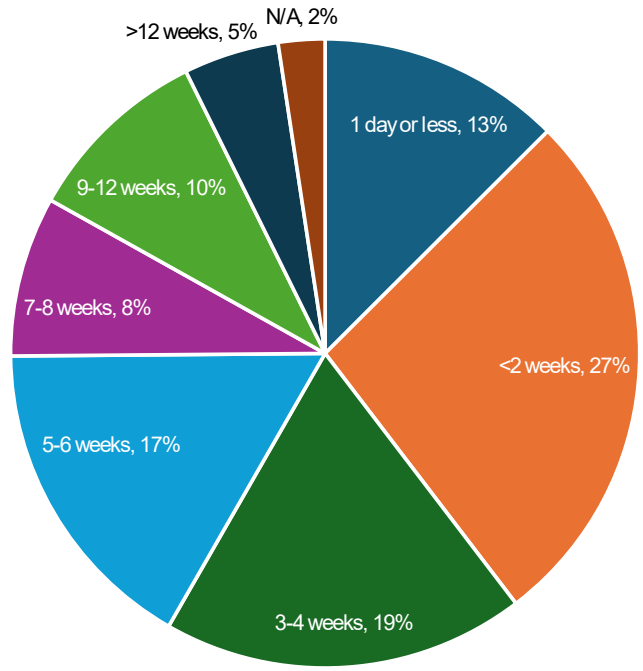
Norfolk & Waveney COMMUNITY SUPPORT

A key learning is that clients have more needs and require more support than the target audience originally profiled

- The majority of referrals are not single or simple support requirements (average needs on referral: 2.4).
- Additional needs / risks are often identified on assessment requiring support and longer time in service
    - This cannot be quantified with data collected to date, but the introduction of a single, shared client management system and introduction of classification of client complexity (low/medium/high) will enable this in future
- Average time in service has increased for staff supported clients
    - 23% of clients in the service for over 6 weeks
    - 39% over 4 weeks
- Unmet needs / difficulties accessing other services can delay exit from the service (e.g. PIP, AA, blue badge applications; social isolation)
- Greater client needs impacts on volunteer requirements. Volunteers support single clients for longer periods. Home risk assessments are also required before volunteers do home visits.

Average needs on referral: 2.4

Time in service (% of clients provided with support)



Service value and feedback

Service value and feedback

Norfolk & Waveney COMMUNITY SUPPORT

Clients receive the practical support they require, and report improved outcomes related to managing independently and their health

Support calls provided by triage

107 (6%) referrals were signposted to the correct support.

248 referrals (14%) received a support call and did not need additional support - generally because family or friends are supporting.

In partnership with BritishRedCross

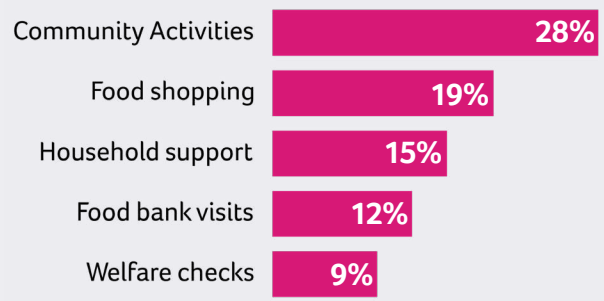
635 clients supported by BRC

- 59 % Feeling more safe and secure
- 31 % Improved ability to manage day-to-day activities
- 30% Improved ability to manage paperwork and finances

VOLUNTARY NORFOLK

656 clients supported by volunteers

Top 5 support areas:



Norwich Age UK Improving the quality of later life

166 clients provided with longer term support by Age UK Norwich

38% improvement in scores in response to the question **'How is your health today?'**

13.5% improvement in scores across all domains of the Functional Measure Tool

Service value and feedback

Norfolk & Waveney COMMUNITY SUPPORT

Referrers are positive about service quality, value key aspects of the model

- VCSE services under one umbrella
- Straightforward referral system
- A support option that sits between providing nothing and a package of care, enabling clients to maintain independence whilst having some support or welfare checks
- The ability to see clients face-to-face. Visiting clients in their home builds a clearer picture of needs and builds relationships, enabling additional support to be sourced more effectively
- That in more complicated situations, the NWCSS Support Workers will coordinate services / support for a client, and keep the referrer updated

- Quick response and provision of service – in contrast to waiting lists for many services
- Ability to refer into a service that can support clients to access services rather than leave vulnerable clients to self-refer (which many don't follow up)
- The range of activities on offer, and that the staff do their best to be flexible and meet client needs

of referrers were very satisfied or satisfied with the Norfolk and Waveney Community Support Service

> "Excellent, speedy outcome and speedy allocation to volunteer. Really helpful when needing a little practical support"
>
> NCC, Assistant Practitioner

> "I find the service very useful and helpful. The referral process is quick and simple and customers are being contacted in a timely manner. I often recommend colleagues to this service. I like that the support workers are in regular contact with the referrer and will keep social care updated on the services they have provided."
>
> SCC, Independence and Wellbeing Practitioner

Service value and feedback

Norfolk & Waveney COMMUNITY SUPPORT

Referrers report positive outcomes for health and social care services

Percentage of relevant referrers saying NWCSS contributes to the following

84%	Reducing the need for health and social care services
85%	Reducing the likelihood of client needs escalating
68%	Reduced delay in discharges
72%	Freeing up staff to focus on clinical/ social care work
46%	Reducing unnecessary hospital admissions
85%	Clients feeling more confident that they can manage themselves

Service value and feedback

Norfolk & Waveney COMMUNITY SUPPORT

NWCSS is supporting Social Care and admissions avoidance services by helping clients to remain independent in the community

Social care related Referrals and Needs

- 25% of referrals from NCC (425 in 9 months, projected to be 600/year)
- Assistant Practitioners are the single largest group of referrers into NWCSS
- Many referrals from agencies supporting admissions avoidance and independent living (e.g. NCHC, ECCH Health Connectors, District Direct, NEAT)
- Clientsare disproportionately older, from more deprived areas, with long-term conditions
- Needs relate to social care and ability to remain independent in the community. Of referrals received:
  - 21% relate to support with daily activities
  - 19% relate to wellbeing or loneliness
  - 17% relate to assistance to access other services

We support clients to access other services to help them live independently:

Financial	Practical	Safety	Transport	Keeping active	Community	Companionship	Health
DIAL, CAB PIP, Attendance Allowance	cleaning services, online and telephone shopping, mobility aids, pet support	fire service, pendant alarms, home security	Bus passes, blue badge, community transport	Active Norfolk, GoodGym, walking groups	Men's Sheds, community groups, day centres	BTN, Lily, Age UK befriending	Mind, Cruse, Silver line, hearing loss

Service value and feedback

Norfolk & Waveney COMMUNITY SUPPORT

Referrers report NWCSS supports social care in 4 main ways (quotes)

Avoiding a package of care

"Used this service to support a patient returning home after hospital discharge rather than sending a referral to social services for a package of care."

"This is a really good service that has helped my patients settle back at home when they have been discharged from hospital. Many of the patients I have referred live alone and were very anxious about returning home. With your support the patients felt confident that they could manage independently which reduced the amount of care package referrals."

Providing an alternative to a package of care

"This support services allows us an additional way to offer help and support to patients who may be reluctant to have a formal package of care. I personally appreciate the ability to help patients reconnect with hobbies and social groups."

Filling a gap in support available

"I find I tend to use your service mostly for light housework, light snack preparation, support with shopping and chaperone to appointments. These are things we do not provide via services such as Norfolk First Support, but are still much needed tasks, to support people to greater independence rather than capping their independence by having commissioned support in place."

Acting preventatively

"Your team supports in all areas that are not always commission-able via Adult Social Services, and it gives people the confidence and much needed support to manage better in these areas, so these issues do not get worse and end up needing commissioned care. It is a great preventative service and your staff have always been helpful and polite."

Service value and feedback

Norfolk & Waveney COMMUNITY SUPPORT

NWCSS supports discharge and reducing re-admissions by ensuring people have support to return home safely and regain independence

Referrals and Needs

- 34% of referrals are from acute hospitals (585 in 9 months, projected to be 800/year)
- Main acute-based roles referring in: discharge coordinators, social prescribers, occupational therapists, physiotherapists.
- Many referrals from agencies supporting successful discharge (e.g. NCHC, ECCH Health Connectors, District Direct)
- Referrals are disproportionately older, from more deprived areas, with long-term conditions
- Of referrals received:
    - 14% relate to pre and post discharge support
    - 9% relate to home and personal safety checks

Support provided and outcomes

- Pre-discharge support to enable discharge includes checking food and heating, arranging welfare checks
- Post-discharge support to enable recovery includes
    - Welfare checks (phone call, home visit if needed,
    - Supporting with food shopping
    - Household support (light cleaning, snack preparation, washing)
    - Support with pets
- Clients are helped to regain independence through:
    - Support to access other services where needed
    - Helping to access safety alarms/key safes
    - Support access community activities and companionship
    - Help to accessing online / phone food shops
    - Help to arrange appointments where needed, and transport to them
    - The safety net of knowing there is someone they can contact to help resolve issues (prevents calls on other community services such as GPs)

Service value and feedback

Norfolk & Waveney COMMUNITY SUPPORT

Referrers report NWCSS supports discharge in 4 main ways (quotes)

Supporting successful discharge, particularly for people

"Particularly when I need to discharge patients who have no support network in the community this service has been absolutely invaluable for the Trust in freeing up the acute bed and for the patient. [...] The funding for this services needs to be permanent if we are to have a flow of discharges. There is a huge elderly population in Norfolk that live alone with no friends/family support"

"I had a patient who wanted to self-discharge and it was reassuring to know that he accepted the service and wasn't readmitted."

Helping avoid re-admission

"Helps reduce discharge delays and re-admission to hospital. Has helped patients regain confidence at home after long hospital stays."

"The service has been very useful for us to use, especially when we know a vulnerable patient is struggling at home and deals some help to adjust back to life at home."

Supporting discharge from A&E

"For patients who want to be discharged from A&E but may need support but don't want full care and remain independent at home it allows them reassurance of a call and advice."

"The service is very helpful when supporting patients who are discharged from A&E. I find the service most useful for patients who are lonely and need help with finding local groups etc. along with well being support for patients and families."

Enabling staff to focus on other discharges

"It allows the team to concentrate on other service users and discharges from the JPH."

Next steps

Next Steps

Norfolk & Waveney COMMUNITY SUPPORT

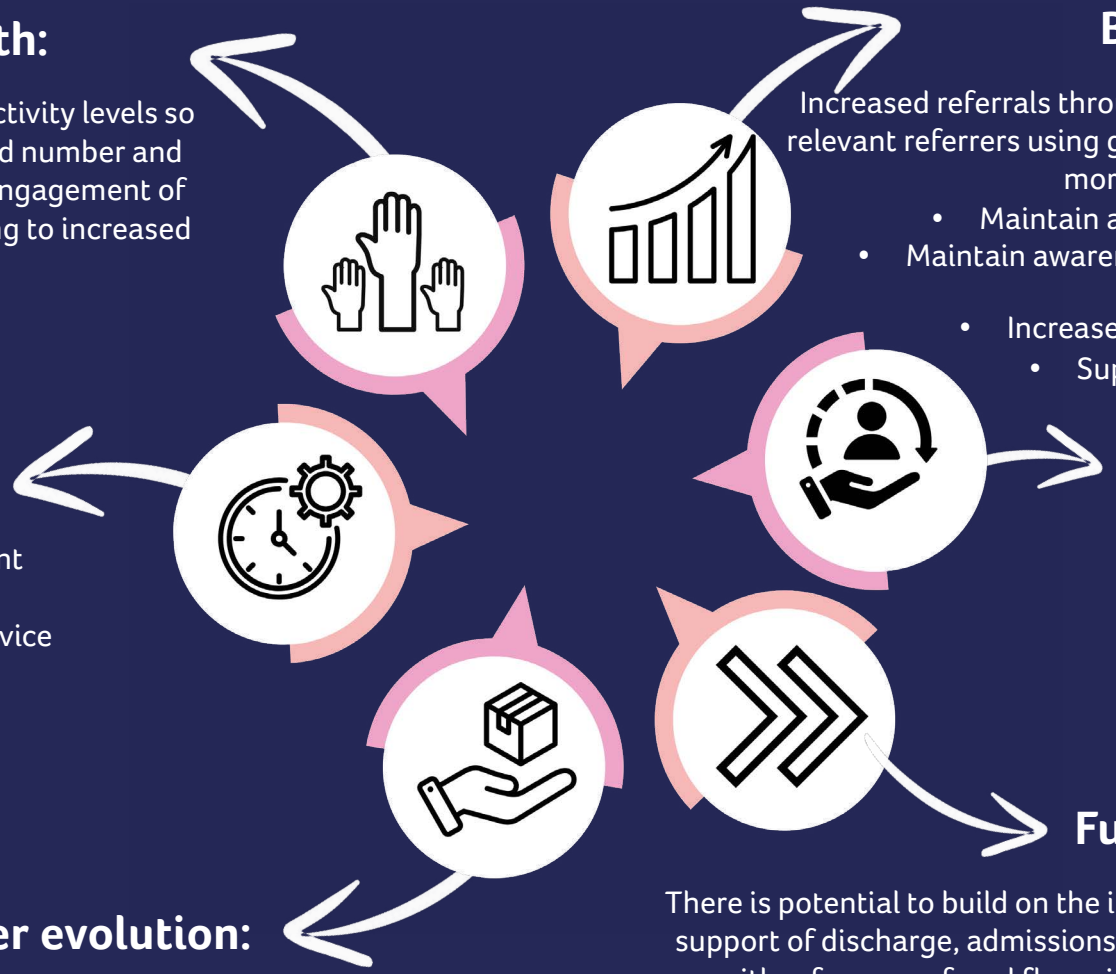
Volunteer growth:

Growth in volunteer numbers and activity levels so volunteers can take on an increased number and greater variety of activities. More engagement of British Red Cross volunteers. Leading to increased capacity.

Building referrals:

Increased referrals through continued promotion of the NWCSS service to relevant referrers using good networks that have been built, including using more varied communication tools:

- Maintain and build awareness in acute hospitals
- Maintain awareness within NCC, build further awareness within SCC
- Increase outreach to PCNs, ICCs, social prescribers
- Support of virtual wards as these establish and grow



Efficiency increases:

Increases in efficiency as partnership and joint team working embeds further, a new client management system is introduced, and the service becomes more established.

Single client management system:

Implementation of a single client management system for the three partners, enabling common data to be captured, and better outcomes measurement for all clients and identification of value added beyond initial referral needs (rollout autumn 2024). Also removing inefficiencies in duplicate data entry.

Service and offer evolution:

Using evaluation data to review service offer and allocation of resource where needed

Future potential:

There is potential to build on the infrastructure in place to enable increased VCSE sector support of discharge, admissions avoidance and community support (e.g. relationships with referrers, referral flow, single referral and triage system, contracting and IG arrangements)

Client Stories

Client Stories

Norfolk & Waveney COMMUNITY SUPPORT

Reducing likelihood of admission / escalation

- Client referred via NCC, had contact with both BRC and AUKN.
- The client was getting down due to poor mobility, and has a dog who is older and diabetic. Client has had falls and was discussed that she would benefit from physical activity.
- Information provided for Extra Hands and Bluebell Support Service, and client has subsequently increased the hours for her cleaner and dog walker to help out.
- She has taken on health coaching with AUKN and is a few sessions in.
- Client is a bit more independent and can cook more meals by herself (although her cleaner still helps) and is trying to maintain exercises given to her by the health coach.
- Next step is another welfare call to check in and also make sure social services have completed a financial assessment

- Client starting to experience different wellbeing related challenges, impacting his daily life. On initial visit, could see issues with hoarding, client raised issues of potential harassment, wanted help with getting over the passing of his brother, TV not working. Discussed issues, security cameras and lights, and provided contacts for aerial firms.
- By next visit, client had brought security items. Looking into more socialising and had started driving again to become more independent. An aerial firm had sorted his TV.
- Client has been signposted to Ataloss to go to Cruse, and Lofty Heights to help with his home.
- Due to the anti social behaviour and hoarding (level 8), safeguarding was raised.
- Social workers visited who said his home was at risk of fire and the fire service may be in contact, and due to anti social behaviour, will look at better locks for his doors.
- Next steps are welfare calls to check in, but seems like a lot of positive steps forward.

- Client referred as she had a stroke and required assistance.
- First intervention Ms S informed me that her hearing aid was broken. I contacted the company on her behalf to get this repaired.
- I was in contact with Adult Social Care regarding getting attendance allowance so we could source an assistant to help with things like organising her post, making appointments and other general support required.
- Ms Smith also told me how much she loved her garden but couldn't do it anymore from fear of falling. We discussed hiring a gardener, which lead to me sourcing a gardener for her and meeting him at her home so she could tell him exactly what she wanted.
- A Support Worker from Sensing Change was supporting Ms Smith in getting a better phone that she could see, use, and understand better than the phone she currently had. Bungay Hub is doing Ms Smith's shopping every week with the set-up supported via Voluntary Norfolk.

Supporting discharge/ post-discharge

- Referral received stating that R would be discharged from hospital later today and needed support with food. Client daughter is usual support, however she is away tonight.
- R had no cash for shopping. NWCSS advised that we could get a food parcel to R within 24 hours. NNUH said that they would ensure he has a hot meal before discharge this evening. We were advised that R requires a soft food diet only.
- Doorstep delivery made with various foods to span over 48 hours (breakfast, lunch and dinner).
- On arrival, daughter was in fact there. However NWCSS confirmation of support meant client was able to be discharged within hospital timeframes because they knew support was in place until his daughter returned.
- Daughter confirmed that she will support her father from here on.

- SU 87 years old, admitted for a fall. SU being discharged without care and is unsteady on her feet.
- SU lives with granddaughter but granddaughter works 2 days a week and she is concerned for her grandmother's welfare in her absence.
- We were asked to do welfare calls and visits, for 2 weeks, whilst the SU settles in, on the days that the granddaughter works, and to assist with obtaining a falls alarm and key safe.
- We made 4 calls and 4 visits to the SU during this 2 week period.
- We contacted the hospital District Direct Officer to get a 'Going Home Box' (which contains a falls alarm and key safe which is loaned to the SU for a couple of weeks).
- We organised collection of the 'Going Home Box' and delivered it to the SU and set it up. The granddaughter will put a hook in the wall to attach the key safe.

- Patient is very anxious following hospital discharge. P has been diagnosed with Ovarian cancer, for which she is now undergoing chemotherapy and would benefit from support with accessing the community safely and getting shopping in.
- Assessment completed. P will need a food parcel and a grocery shop. Assigned volunteer to collect / deliver a food parcel.
- Further support needed following with food shopping. Following week staff visited P and carried out food shopping for her. Client had food to enable her to stay healthy following discharge.
- Volunteer contact for the following week provided emotional support until she was ready for independence.

Client Stories

Norfolk & Waveney
COMMUNITY SUPPORT

Norfolk & Waveney
COMMUNITY SUPPORT

For further details, please contact:

www.communitysupportnw.org.uk

Online referral form

01603 972 374

referral@communitysupportnw.org.uk

VOLUNTARY NORFOLK

Norwich age UK
Improving the quality of later life

In partnership with

British Red Cross