



**Norfolk** County Council



**North Norfolk**

**Clinical Commissioning Group**

# North Norfolk Integrated Care Programme

## Framework Pack



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# Introduction

North Norfolk's approach to Integrated Care has been developed in partnership with :

- North Norfolk Clinical Commissioning Group (NNCCG)
- Norfolk County Council – Community Care (NCC)
- Norfolk Community Care & Health Trust (NCH&C)
- Norfolk and Suffolk Foundation Trust (NSFT)

We aim to deliver fully integrated community health and social care teams, working with General Practice to support people in their homes. This pack illustrates the underpinning framework that we are putting in place to deliver this vision. The emerging vision includes:-

- **Integrated health and social care delivery teams** which fully support the 20 North Norfolk General Practices
- **Risk profiling** to identify cohorts of patients who are at risk
- **Integrated care co-ordinators** to provide a point of contact to a range of health and social care services
- **Identified lead workers** who understand the individual patient's social as well as medical contexts
- An expectation that services will be delivered close to home in **the community**

This pack offers guiding principles for setting up integrated care which will evolve over time. As this is a framework you may choose to modify some of the guidance when shaping how your GP practice will work with the Integrated Care Coordinators (ICCs) to access and refer patients to local services.

# The Risk Profiling Tool

The Integrated Care Programme Board have developed a local risk profiling tool. The tool is designed to identify patients at an earlier stage in their condition/s to enable, preventative, lower level interventions to be accessed in the local community.

The tool is managed by the GP practice and consists of up to 20 pre-defined SystemOne or EMIS filter reports which are exported into an excel spreadsheet. The filters are based on QoF disease registers (the full list of which can be found in **Appendix 1**).

All practices will receive :

- A template with predefined SystemOne / EMIS searches
- A pre formatted Excel template
- Access to a risk profiling training session
- Assistance in tailoring the risk profiling tool to meet practice needs

The initial risk profiling report will identify a large number of patients who may require a review or visit by require health professionals.

The risk profiling tool is only one way of finding people at risk; clinicians may include any patient on their integrated care register whom they think would benefit from wider community help.

Once a patient is identified as a suitable candidate, the GP practice then seeks consent from the patient for their case to be discussed within an integrated care setting.

# Integrated Team Approach

Appendix 2 illustrates the local **integrated team model** which places GP practices, community nursing and social care at the heart of our service, surrounded by a wider network team of community support.

The following infrastructure will support this model:

- **Named linked workers** from the GP Practice, community health, mental health and social care have been identified for each of the 20 GP practices. See **appendix 3** for the role of the social care practitioner and **appendix 4** for the role of the mental health practitioner
- Linked workers are expected to **regularly attend** integrated care meetings and offer professional guidance / support to integrated team meetings
- The **GP practice** reviews the list of patients identified by the risk profiling tool and uses **local clinical knowledge** to identify those patients who would benefit from an integrated care intervention
- Each integrated care patient will be allocated a **lead worker** who could be any member of the integrated care team who is responsible for ensuring that agreed actions and referrals are progressed
- The integrated care team create a **cohort of integrated care patients** which they manage and discuss at integrated care meetings. Patients are removed from the list once no further actions are identified

# Data Sharing & Patient Consent

## Data sharing

There is a Norfolk Information Sharing Protocol in place between all our partners. This allows information to be shared to enable the assessment, planning, provision and review of health, social care and related services for individuals.

## Patient Consent

Patient's consent must always be obtained by the **GP practice** before individuals are discussed in an Integrated care meeting. Whether or not consent has been given should then be recorded on the patient record.

A suggested script for obtaining patient consent can be found in **Appendix 5**.

# Introducing the Integrated Care Coordinators (ICC)

There are 4 Integrated Care Co-ordinators each linked to one of the 4 North Norfolk area hubs. See **Appendix 6** for NN community hub and ICC contact details. The ICCs are as follows :

**NN1 Lesley Rose** based at Meditrina House

**NN2 Alison Campling-Brown** based at Rebecca House

**NN3 tbc**

**NN4 Paula Horner** based at Rebecca House

# The role of the ICC

## What they will do initially:

- Follow up patients identified by risk profiling, and access information across NHS (SystemOne) and Social Care (CareFirst) systems
- Maintain and distribute integrated care patient lists, set up the Integrated care meetings and distribute integrated care meeting notes
- Co-ordinate and track referrals to a wide range of low level health, social care and voluntary sector resources
- Feedback to the practice / GPs / professionals on patient outcomes through email and 'Tasking' on SystemOne
- Reduce duplication of services and information collection

## Areas currently *not* within their remit:

- Deciding who should attend integrated care meetings
- Chairing the Integrated care meetings
- Requesting patient consent
- Making clinical referrals
- Duplicating existing roles
- Making home visits

# Integrated Care Meetings

The key elements of who does what at an integrated care meeting are summarised below :

## **GP Practice**

- Run the risk profiling tool and identify cohorts of patients
- Seek consent from patients identified as requiring integrated help
- Send integrated care list to ICC

## **Integrated Care Co-ordinator (ICC)**

- ICC checks if patients have health and social care involvement
- Sends updated integrated care list to integrated care team for review prior to the meeting
- Sets up and organises the integrated care meeting

## **Integrated Care meeting**

- The integrated care team consists of a GP, nurse, social care lead, community matron, OT, Physio, MH practitioner and ICC and should be chaired by a representative from the GP practice
- Integrated care team collectively review the integrated care list and suggest appropriate low level referrals and community options
- A named lead worker is allocated for each integrated care patient

## **After the meeting**

- The ICC will distribute the action notes to meeting attendees
- The ICC will update information on CareFirst and SystemOne
- The lead worker will ensure actions are progressed

## **Please note:**

- ICCs only have access to SystemOne so for practices which use other NHS systems an alternative method for recording information on their system will need to be in place. This is something that can be arranged between the ICC and the Practice Manager.

# Wider community options

The integrated team will discuss each integrated care patient to consider if a referral to community or voluntary services would be of benefit . These options will then be discussed with the patient and if appropriate, their carer.

The following are examples of some the service options available :

Northern 'Front Door' Support Services	Self Care & Self Management	Commissioned Community Services
Norfolk First Support - Re-ablement	LTC -Patient / Carer Education Programmes	Volunteering & Befriending Services
Social Care Centre of Expertise & Customer Service Teams	Low level psychological support e.g. coaching	Day Service / Opportunities
Assistive Technology	Medicine & pain management	Community Beds
Home Shield	Specialist nurses	Information Advice & Support Services
Integrated Equipment Store	Healthy Community Programmes	Carers Agency Partnership
Prevention / Development workers	Health Trainers	Village Agents

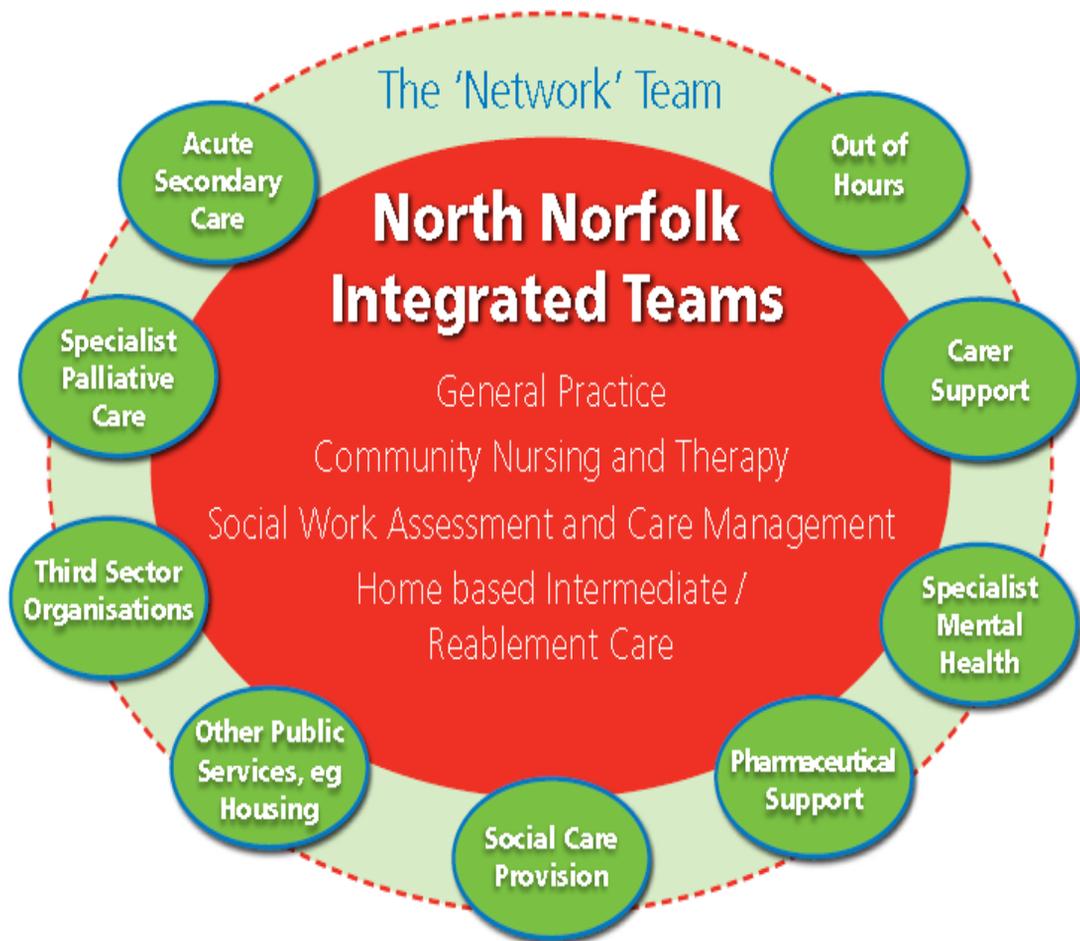
# Appendix 1

## Risk Profiling Data Fields

<b>DATA FIELDS SELECTED</b>
QoF "REGISTERS"
Respiratory
Dementia
Fall or Fracture in last 6 months
Osteoporosis
Stroke 2 (TIA))
AF
Diabetic Neuropathy
CKD
IHD / CHD
Heart Failure
High HbA1c
Parkinsons
<b>OTHER</b>
Multiple Medications (10+)
Social Care Input Level
Dr's Appt in last 3 months (6+)
Home Visits in last month (3+)
A&E Attendance in last 3 months (3+)
Emerg Admit in last 3 months (2+)
Out of Hours in last month (3+)
Housebound
<b>PATIENTS EXCLUDED FROM OUTPUTS</b>
Those who declined consent to share data
If multidisciplinary assessment taken place

# Appendix 2

## Integrated Team Model



# Appendix 3 - Role of Social Care

There may be patients on the patient list who do not meet the criteria for social services involvement. Where this is the case the ICC can assist in signposting to other organisations that may be able to help.

The following outlines what to expect from social care:

- The role of the Linked Social Care practitioner is to advise and consider social care and occupational therapy interventions when discussing individual patients. They can also provide wider and more general advice in these areas to other professionals participating in the meeting
- *Whilst any individual requesting help with a social care need is eligible for a Community Care Assessment, please be mindful that Social Services work within an eligibility criteria. Assistance and services are given to those people who have a critical or substantial need*
- In most cases the worker attending the integrated care meeting, will not be the allocated worker to the individual discussed. However the Integrated Care Coordinator (ICC) will always endeavour to either liaise or feedback any pertinent information as discussed during the meeting should an allocated worker already exist

***It is not possible due to the number of referrals that the Integrated Care Meeting (ICM) will establish an alternative front door or routine referral route into Health or Social Care services***

***The role of the Integrated Care co-ordinator will be to smooth and track the pathway of referrals that are made to the central point of referral for Health or Social Care. However If it is established at the ICM that a case is complex, requiring a face to face visit from a Social Care Professional, the ICC can take the details and make a referral direct into the Locality Duty Team***

## **Referral pathway for those not on the ICM pathway;**

- To refer a patient to social care who is not discussed at the ICM please ring the usual Customer Service Centre on **0344 800 8020**
- The referral will be dealt with either :
  - By the Social Care Centre of Expertise based there; this will be a telephone based assessment for those less complex assessmentsor
  - It will be passed to the locality teams if the referral requires a face to face assessment and/or the situation is complex with mental capacity issues/safeguarding /complex family dynamics etc

# Appendix 4 - Role of Mental Health

There may be patients on the patient list who already have involvement from the Mental Health Trust (NSFT). Prior to the meetings the mental health representative will be aware of the patients scheduled for discussion, and will bring any relevant updates to the meetings.

- **The role of the mental health representative will be to feedback information on patients under the Trust's care and to offer advice and signposting for other patients discussed.**

In most cases the worker attending the integrated care meeting will not be the allocated worker to the individual discussed. If a case is discussed that does not have any mental health input from the Trust (and the meeting members are in agreement that this would be of benefit) then the mental health representative will signpost a referral through the Trust's Assessment and Triage Team for action. Please note the mental health representative may not be the individual who offers this intervention.

## **Mental Health Team eligibility criteria**

**People suffering from a dementia or mental health complexity in later life where:**

- There is a need for memory assessment and potential treatment with Cholinesterase medication
- They suffer severe symptoms such as hallucinations or delusions which are causing significant distress
- They manifest serious challenging behaviour as a result of their illness which places the individual at significant risk of harm
- They manifest serious challenging behaviour as a result of their illness which places others at significant risk of harm or impact, including family carers
- Their condition consistently interferes with normal daily living either through self neglect or disruptive behaviours
- They are at substantial or critical risk without assistance with vital activities of daily life, but refuse it because of their mental condition
- Their situation is particularly complex e.g. interplay of various factors - range of symptoms, environment, relationships with others; timely specialist intervention may prevent admission to hospital or a care home

**or fulfil two or more of the above and**

- their diagnosis is unclear, including unexplained sudden onset

# Appendix 5 – Patient Consent

## Suggested script for GP practice staff when obtaining consent from patients to share their records at integrated care meetings

Hello *patients name* its *name of caller and job title* from *name of GP practice, GP name* would like to discuss you and your potential health and care needs at a team meeting. Members of this meeting include professionals from:

- NHS community provider (Norfolk Community Health & Care NHS Trust)
- NCC Adult social care community team
- NHS adult mental health provider (Norfolk and Suffolk NHS Foundation Trust)
- And representation from the GP practice
- Or anyone who could contribute towards you health and care needs

The purpose of these meetings is to ensure that all the professionals are working together and doing all they can to assist you with any health and care needs that you currently have or may have in the future. The information that we need to share is :

Name, address, telephone number, date of birth, NHS number and why *GP name* wants to discuss them (this may be their long term condition i.e. diabetes)

Are you happy we discuss you and share the information that we have about you with the other professionals?

If they say **NO** : Thank them for their time, ensure this is documented on the patient record and ensure that the relevant GP is informed. This patient is **not included** on the integrated care list.

If they say **YES** (with no questions) :

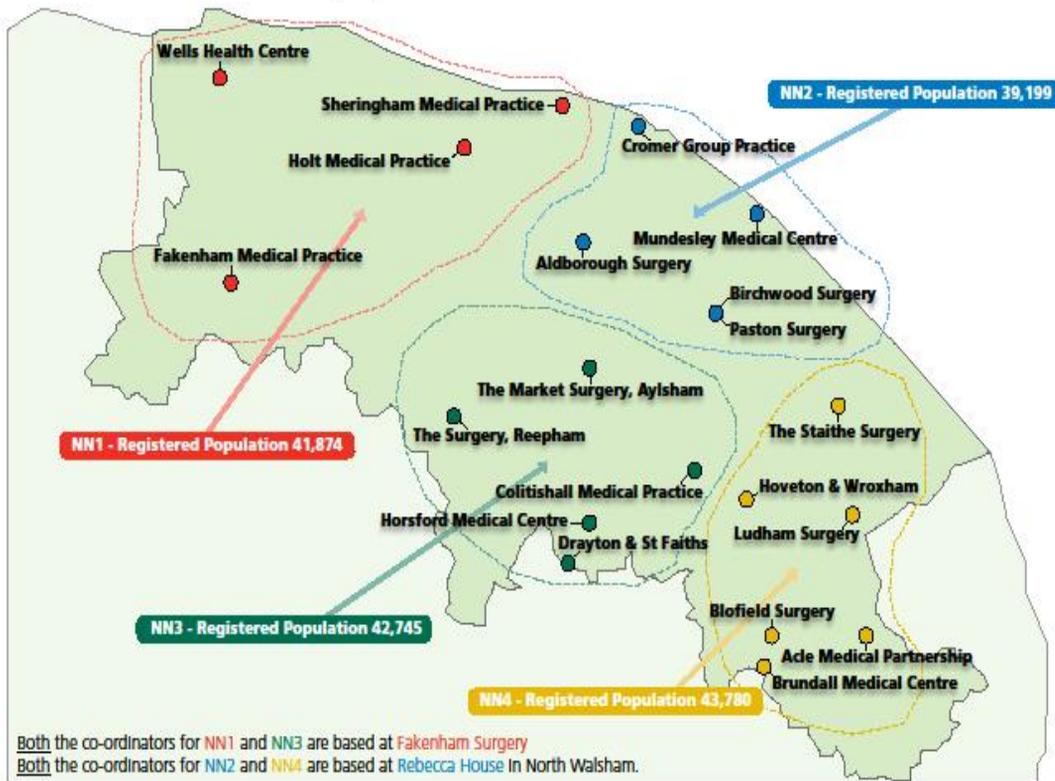
Record their consent then thank them for their time and say that they will be informed if any further actions are identified. This patient is **included** on the integrated care list.

If they do have questions: Ask them if they would like someone to call them? Then arrange a follow up call.

**Consent / non-consent by the patient must be recorded on the patient record . The above script may be tailored to suit individual patient needs**

# Appendix 6 – North Norfolk Community Hubs

North Norfolk CCG Practice Groupings



Name	Area	Telephone	Email
<b>Lesley Rose</b>	<b>NN1</b>	<b>07795 590920</b>	<a href="mailto:Lesley.rose@norfolk.gov.uk">Lesley.rose@norfolk.gov.uk</a>
<b>Alison Campling-Brown</b>	<b>NN2</b>	<b>07825 896001</b>	<a href="mailto:Alison.campling-brown@nchc.nhs.uk">Alison.campling-brown@nchc.nhs.uk</a>
<b>tbc</b>	<b>NN3</b>		
<b>Paula Horner</b>	<b>NN4</b>	<b>078677654420</b>	<a href="mailto:Paula.horner@norfolk.gov.uk">Paula.horner@norfolk.gov.uk</a>