As a resident of North Norfolk
I am supported to understand and manage:

My Health,

My Care,

My Life,

My Way
North Norfolk: A Health & Social Care Integration ‘Pioneer’

A Partnership Approach to Integration:

The expression of interest for North Norfolk to become a Health and Social Care Integration Pioneer is joint application between North Norfolk Clinical Commissioning Group (NNCCG) and Norfolk County Council – Community Services and has been developed as part of the integrated commissioning arrangements that exist between the two organisations. It is additionally supported through existing integrated operational and commissioning programmes of work delivered by the following internal and external partners who are committed to our approach:

Norfolk County Council – Social Care Team (Northern Locality)
Norfolk Community Care & Health NHS Trust (Northern Locality)
Norfolk & Suffolk NHS Foundation Trust
Norfolk County Council – Children’s Services
Norfolk County Council - Public Health Team
North Norfolk District Council
Broadland District Council

Key challenges emerging from population demography and epidemiology:

North Norfolk has a population of 167,800 and covers 45 miles of coastline, with 20 General Practices covering the boundaries of North Norfolk and Rural Broadland District Councils. Its unique demographic profile provides challenges in enabling the health, wellbeing and independence of its citizens which can be resolved through integrated solutions in health, social care and housing related support services delivered by key public sector partners.

The 3 key challenges which integrated care and support can address in North Norfolk are:

1. Reducing the health inequalities within the population - whilst North Norfolk covers a population which enjoys relatively good health, the district level population data mask variation at lower super output level
2. Supporting a larger than average ageing population and the percentage of older people with one or more long term conditions, such as diabetes, chronic obstructive pulmonary disease (COPD) and dementia
3. Enabling access to treatment and care in a predominantly rural area, with no major conurbation.

A North Norfolk Vision for Integrated Care and Support:

As a resident of North Norfolk I am supported to understand and manage; My Health, My Care, My Life, My Way.

This vision of enabling people in North Norfolk to take control and have choices about how and where they receive effective, value for money, care and support to live healthy, fulfilling and independent lives is at the heart of our vision for integration. All developments see those who require care and support as key partners in shaping, implementing and monitoring the operational and commissioning outcomes across the partnership.

We see the whole population of North Norfolk, but especially older people and those with long term conditions, having access to a fully integrated primary and community health and social care service, with seamless access to community and specialist care and support when required, that is delivered with compassion and dignity. The following are our key ambitions for integration:

- Fully integrated health and social care delivery teams which fully support the 20 General Practices
- Care and Support services being arranged around patients’ GP surgeries with access to a wide range of integrated health, independence and wellbeing related support.
- A single assessment process across health and social care
- Identified key workers who understand individual patient’s social as well as medical contexts
- Greater and seamless local access to services with an emphasis on support and information that enables individual self care & management
- Services which are simple to use and can be “switched on” via a single call and assessment by multiple partners
- A universal expectation that all services delivered at or close to home will be delivered with respect, compassion and a personalised approach to care.

An enabler of this vision is the partnership between Norfolk County Council and ‘Equal Lives’ (a voluntary sector partner), who are signed up to the delivery of Making it Real (MiR) in Norfolk, with North Norfolk Health & Social Care leaders committed to driving this forward locally. A reference group has been brought together which includes people with links to community groups, user led organisations and strategic partnerships that have shaped the MiR outcome priorities by which partners will develop their approaches and be monitored against. These priorities are:
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- People have individual care and support to live their lives as they wish
- People have access to a pool of people who could support them, advice about how to employ them, and the opportunity to get advice from peers
- People have easy to understand information and support they need in order to remain an independent as possible
- People have opportunities to train, study, work or engage in activities that match their interests, skill and abilities

Platforms for Delivering Integrated Care and Support:

To deliver against our vision for integration we have developed some key platforms, with a breath of partners and key stakeholders, which will provide the foundations upon which we will enable a whole system approach to integration in North Norfolk. These approaches are steered through our ‘Integration Board’ and are targeted and evidence based, with a robust infrastructure to monitor the impact against key outcomes.

The overarching programme that provides the platforms for our integrated vision is our Integrated Long Term Conditions Programme. The evidence base for which is the QIPP Long Term Conditions programme, a national initiative sponsored by Sir John Oldham. Its aim to deliver a national support and improvement programme enabling local geographic areas to implement evidence based systems for supporting people with LTCs.

We have developed this in North Norfolk to enable coordinated and seamless service provision across Community Health, Mental Health and Social Care. We want people with Long Term Conditions to have effective, timely and high quality integrated care and support interventions which will enable them to be appropriately supported in their own homes and reduce unnecessary hospital admissions.

The programme aim, in its year of implementation (2013/14) is a 6% reduction in emergency admissions for patients with a long term condition against the 12/13 baseline in line with the primary overarching expectation to:

- Reduce Emergency admission for patients with a LTC
- Improve patient experience through self care & self-management
- Embed the principle for people using services of - “No decision about me without me”

This programme of work is intended to directly contribute to Outcome 2 in the NHS Everyone Counts Outcomes Framework:

- Enhancing quality of life for people with long term conditions
- Health-related quality of life for people with long-term conditions
- Proportion of people feeling supported to manage their condition
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
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The Five Key Platforms to Integration:

The key platforms that will deliver this programme of work and those that will provide the foundation upon which we will build our infrastructure for enabling whole system health and social care integration are:

1. **Integrated Risk Stratification:**

   **Current Position: Predictive Risk Stratification**
   In consultation with health, social care and mental health professionals we have developed a local Predictive Risk Tool. The tool is designed to identify those patients at an earlier stage in their condition/s to enable preventative, lower cost self-care/self-management interventions to be accessed. The key risk indicators used to identify these people are derived from health (primary care, acute & mental health) and social care data thereby highlighting people who, as a system, we can support to enhance their health, independence and wellbeing, whilst preventing the deterioration of their condition and reducing duplication of professional input.

   **Planned Next Steps: Complex Case Management Risk Stratification**
   The technical platform for predicatively identifying people also provides us with information on those people who have the most complex needs who are likely to need some level of acute intervention. We are currently looking at this cohort of people as they often have input from multiple health, mental health and social care services. The expectation is that we take a case management approach (already developed) that targets and coordinates support, reduces length of stay in hospital and supports people to live independently for longer, once back at home.

**Integration Pioneer Ambition: Holistic & System Wide Risk Stratification**
Having a clear and targeted approach to supporting different cohorts of people, at the right time, with the most appropriate support within North Norfolk is central to our vision. Therefore ensuring that the information that generates this picture comes from across the whole ‘system’ of support networks is paramount. To enable this we will look to work further with our other partners within the District Councils, NCC Children’s service and our Voluntary Sector Providers, to develop a wider, multi agency, risk profiling approach to holistically identify those people who, with lower level, light touch interventions can maintain their own health, independence and wellbeing.
2. **Integrated Care Teams:**

**Current Position: Piloting the Approach**

We have developed our local Integrated Care Team model with Clinical, Community Nursing, Social Care, and Mental Health leads in North Norfolk who will utilise the stratification data generated by the predictive risk tool. 5 of our 20 practices are currently piloting this approach:

The key principles are:

- Each surgery has a named professional from all partners, as part of a MDT approach (see Fig 1), which reviews cohorts of patients identified through the Predictive Risk Tool, or from other key ‘risk’ groups, such as those on the Gold Standard Framework, to direct and support into the most appropriate service.

- Integrated Care Coordinators are employed to smooth the path to integrated working by enabling the coordination across the partners, accessing records across the system, facilitating the MDT meeting and progressing any resulting actions or referrals.

- The Integrated Teams operate within 4 integrated hubs across North Norfolk providing flexibility and focus within designated geographic areas (See Figure 2).

**Next Steps: Full Implementation & Programme Developments**

- Full implementation is planned across the 20 practices in September 2013.

- All Practice, Community Health, Social Care and Mental Health leads have signed up to take part in the health coaching programme to facilitate joint professional development and align ‘enabling’ approaches to care and support across the system.

- Referral pathways to self-care & self-management support options will be finalised and will include, housing, voluntary sector and other health and social care services. It will also bring together other integrated support systems already developed such as local Integrated Housing and Adaptation Teams (with the District Councils) & our Reablement Team.
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- We will employ an integrated care coordinator within the Norfolk & Norwich University Hospital, within the Community Liaison Team. They will enable a more responsive join up between the Acute system and our local Integrated Care Teams, facilitating an improved community offer to the individual, thorough intensive case management & reablement thus reducing any delays in discharge and preventing inappropriate hospital re-admission.

- We will develop and implement a programme of work to deliver improved diagnosis of dementia across our Integrated Teams in North Norfolk. This will be achieved by improving access to memory assessments, diagnosis education programmes, targeted screening, assessments and referrals and integrated community support developments.

Integration Pioneer Ambition: Integrating Expert Providers
The ‘Help to Live at Home’ programme of work Norfolk County Council is developing will radically rethink the role of the voluntary & independent sector in providing interventions that help people to remain independent. Our ambition is to redesign services to enable these provider partners, (such as Domiciliary Care providers) to be a part of our local integrated teams with the ability to provide responsive, assessment and service interventions, independently from our community health and social care teams, which will enable people to stay at home.

3. Integrated Self-Care & Self-Management:

Current Position: Developing Alternative Pathways:
The ability to proactively and pre-emptively identify patients with long term conditions (before their condition deteriorates to a point that requires intensive and high cost interventions), requires clear alternative and appropriate lower level provision to be identified.
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We are working with partners, committed to our vision for integration, to scope the existing provision that we are currently providing across North Norfolk. We are looking to identify what support options there are, where the gaps are and where the opportunities are for aligning and integrating our approaches to provide seamless and accessible services.

The North Norfolk and Rural Broadland Strategic Partnership Board, is the mechanism by which will be managing this approach to local integrated service development and delivery, whilst delivering our local health and well-being priorities. The board’s membership and strategic aims can be seen below:

Next Steps: Creating a Comprehensive Self-Care & Self Management Offer
We have carried out a stakeholder event that has helped us to identify 3 key areas to align and develop service offers that are reflective of the support either directly provided or commissioned within our Strategic Partnership: The following table highlights these areas and some examples of the associated care and support options.

<table>
<thead>
<tr>
<th>1. Education and Support Services</th>
<th>2. Telecare and coaching</th>
<th>3. Patient Activation – (Patients empowered to manage their care)</th>
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<tbody>
<tr>
<td>• patient and carer education programmes</td>
<td>• use of telecare and telehealth to aid remote self-monitoring</td>
<td>• systematic training for health and social care professionals in consultation skills that help engage patients.</td>
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<tr>
<td>• medicines management advice and support</td>
<td>• psychological interventions (e.g., coaching)</td>
<td>• pain management</td>
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<tr>
<td>• advice, advocacy &amp; support services e.g. about diet and exercise</td>
<td>• telephone-based health coaching</td>
<td>• people with full access &amp; ownership to their patient/care plan/support plan record</td>
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To develop this further we are:

- Holding focus groups with key stakeholders and experts to help understand what current practice and evidence based support should be considered within this programme of work.
- Working in our Strategic Partnership to develop and align longer term plans, commissioning decisions and funding arrangements to meet the health and wellbeing requirements in North Norfolk.

Integration Pioneer Ambition: A Whole System Approach to Integrated Commissioning

The need to create efficiencies and reduce duplication of service provision and create a framework of integrated service offers across the health and care system is a fundamental driver. To facilitate this in North Norfolk we aim to develop a holistic integrated commissioning, procurement and funding framework and strategy, between the North Norfolk & Rural Broadland Strategic Partnership, that expressly facilitates our integrated commissioning ambitions.

4. Integrated Approaches to Coproduction and Engagement

Current Position: A Strong Local Commitment and Infrastructure:

Enabling the residents of North Norfolk to understand and manage ‘My Health, My Care, My Life, My Way’ is a key ambition. This reflects our commitment to ensure that people who use services and their carers are at the centre of, and have a key role in shaping the services that are available to them. In addition facilitating choice and control about what, how, when and where people access support is also a fundamental.

Our commitment in North Norfolk to delivering Making it Real priorities, the development and support of local engagement groups for people who use services and their carers, and the coproduction and performance monitoring of services are all approaches that keep people at the centre of our developments.

Next Steps: Developing and Aligning our Approaches:

We will be developing a reference group of people with Long Term Conditions and their Carers to become part of a reference group who can inform developments particularly with regards to self care and self management approaches.

At a broader level the North Norfolk & Rural Broadland Strategic Partnership will also scope the existing groups and mechanisms by which we engage with the public to clarity approaches and develop a consistency of approach.

Integration Pioneer Ambition: A Whole System Coproduction and Engagement Framework:

The proliferation of user and carer engagement groups across all of the partners provides excellent opportunities for engagement and coproduction, however they are often specific to the service or client area and can perpetuate a fragmented view of the services available to meet people’s needs. It can also lead to consultation fatigue when multiple partners are engaging with groups on multiple topics at the same time. To help shape an integrated vision
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and engage and coproduce across the system we aim to use the expertise within existing groups, HealthWatch and the Making it Real Reference Group to help shape a North Norfolk Engagement & Coproduction Board who can inform all of our joint decision making and developments.

5. Integrated Monitoring and Performance Framework:

Current Position: A Framework in Development:
The current monitoring and performance framework for our integrated approach to managing Long Term Conditions (LTC) uses the number of Emergency Admissions, for people with a LTC, as the key quantitative indicator of the impact of the approach. The qualitative indicator uses a validated patient questionnaire (LTC6) that identifies whether care planning and supported self-care have been operational and effective. The measures indicate changes in knowledge, beliefs and perceptions which are necessary to sustain change over time.

The framework is also in place to monitor the impact of our work to support those who have the most complex needs, particularly when facilitating timely discharges from an acute setting and preventing re-admittance through intensive case management and reablement.

Next Steps: Expanding the Framework:
It is anticipated that the integrated team and self-care/self-management approach will have additional positive implications for the integrated team partners. We are therefore investigating key indicators that could be built into the monitoring and performance framework that will demonstrate the impact on teams and services provided by Community Health providers, Mental Health and Social Care (e.g. the level of residential care admissions).

Integration Pioneer Ambition: A Whole System Monitoring & Performance Dashboard:
Having a robust understanding of the impact, for all stakeholders, of integrated approaches to the commissioning and delivery of care and support will be an important evidence based upon which to develop and base future decisions. We would therefore aim to develop a system wide performance and monitoring dashboard, for those preventative developments that would have impact for multiple partners. This would not only include health, social care, mental health, housing, health and wellbeing outcome indicators, but also reflect any real term financial benefits to the health and social care system to this preventative approach.

North Norfolk – A Health & Social Care Integration Pioneer:

As a Health & Social Care Integration Pioneer, North Norfolk will be provided with the opportunity to develop and share our learning of integration, that has, and will continue to be, grounded on a strong foundation of evidence based good practice. This has been achieved, at scale and pace, through our experience of delivering, for example, the QIPP LTC Programme, Integrated Care Organisations pilot, Making it Real and our Integrated Health & Social Care Commissioning Team.
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North Norfolk’s 5 Integration Pioneer Ambitions outlined in the paper will be the focus upon which we would seek support from national partners and provide learning to the wider system, as summarised below:

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We have a vision and a programme of work that is and will be developed and delivered by committed partners across the North Norfolk health and care system. We also have demographic challenges, in terms of having one highest ageing populations & prevalence of people with one or more long term conditions, with a high level of rurality, which provides us with a unique opportunity to demonstrate the positive impact of an integrated approach.

As a health and social care system in North Norfolk, there is a need for us to achieve efficiencies in our approaches, deliver value for money and quality services in innovative and radical new ways. This is not an option but a challenge we can meet as an integrated system.

In North Norfolk we have a commitment to keeping people who use services, families and their carers at the centre of and part of all of our developments ensuring we never lose sight of the primary purpose of all of our work and drive for integration, namely;

As a resident of North Norfolk I am supported to understand and manage;

My Health, My Care, My Life, My Way.

Lead Contact Details:
John Everson
Head of Integrated Commissioning - North Norfolk Community Health and Social Care
North Norfolk CCG & NCC Community Services
1 Mill Close | Cawston Road| Alysham| Norfolk| NR116LZ
Mob: 07825055494
Email Address: j.everson@nhs.net