NHS
North Norfolk
Clinical Commissioning Group

North Norfolk

Patient Partnership Conference

29th April 2014

Aylsham Care Trust Centre, Aylsham

Integrated Care

Working together for excellent healthcare in North Norfolk and Broadland

Introduction

NHS North Norfolk (NNCCG) hosted the 12th Patient Partnership Conference on 29th April 2014, at the Aylsham Care Trust Centre. The conference was chaired by Tony Belham, Practice Manager for Birchwood Surgery, and member of NNCCG's Executive Team, who opened proceedings by setting the scene for the day and providing an overview of the following topics to be discussed:

- Activities and points to note since the last Patient Participation Conference in October 2013;
- Integrated Care in North Norfolk – progress made to date and our vision for the next 5 years; and
- How can we make sure Integrated Care continues to develop in North Norfolk?

The conference was well attended with representation from GP practices, social care, members of local patient participation groups, patients, carers and family members with a special interest in integrated care.

Tony Belham advised the attendees that photographs would be taken throughout the day, which will be used within this report. No objections were raised.

This report captures the presentations, feedback and priorities identified during the event, which will inform the CCG's objectives for the future development of integrated care.

Format and Agenda

The following agenda was tabled for the event, which incorporated presentations from Dr Linda Hunter, Vice Chair for the NNCCG Council of Members and GP in Hoveton / Medical Practice, and operational and clinical leads across health and social care, followed by an opportunity for participants to engage in discussion groups:

9.30	**Arrive and Refreshments**	
10.00	**Welcome from the Chair** • Aims of the day	**Tony Belham** Manager Birchwood Surgery & Executive Group member
10.10	**Update including:** • Previous conference: ○ Integrated Community Services • 111 and Ambulance response times • Pathway redesign • Volunteering Contract Award **Q&A**	**Dr Linda Hunter**, Vice Chair NN CCG & GP Hoveton and Wroxham Surgery

10.40	**Integrated Care in North Norfolk**
	• Setting the scene – how do the 4 integrated care hubs work in North Norfolk?
	• Norfolk's Better Care Fund
	• What areas need further development? E.g.:
	  ○ Out of Hours/111
	  ○ Embedding the use of voluntary and community resources
	  ○ Continuing to link services together
	Q&A
		James Gair,
		GP Birchwood Surgery & Executive Group member;
		Jo Cook,
		Head of Social Care (North);
		John Everson,
		Head of Integrated Care (North)

11.00	**Break for Refreshments & Networking**	
11.30	**Discussion Groups** • Setting the scene	**Tony Belham**
11.35 **12.15**	**Discussion Questions** • How can North Norfolk have an effective and affordable out of hours service? • What wider support do patients need from their integrated care? • What do we want integrated care in North Norfolk to look like in 2019? • Group Feedback	Facilitators
12.30	**Next Steps** **Day, date and venue for next conference** **Close**	**Tony Belham**

Update

Dr Linda Hunter gave a presentation (available on request) updating those present on the following activities of the NNCCG, since the last conference:

- Dr Hunter reflected on the NNCCG's activity since the last patient conference in October 2013, and how the CCG had acted upon the following key points raised:
    - Using integrated teams, supported by Integrated Care Coordinators, to improve communication and ensuring that community staff have more allocated time within GP practices;
    - Future services designed around locality hubs, to ensure GPs are at the centre of pathway development;
    - Engaging in a joint project with Norfolk County Council to improve patient transport, reflecting the needs of a rural location; and
    - Improving access and availability of community beds by developing a North Norfolk pilot with dedicated beds for enhanced services.
- Dr Hunter also highlighted the key commissioning activity for 2014/15, such as:
    - Re-commissioning of the Wellbeing Service, which is currently being led by NNCCG as coordinating commissioner for Mental Health Services in Norfolk and Waveney;
    - On-going performance review of the 111 and emergency services, to ensure response times are being met and all steps are being taken to mitigate against patient harm;
    - Initiatives to reduce the burden on the unplanned care systems, particularly to address winter pressures, such as the introduction of a Care Home Access Direct telephone line. This will provide Care Homes with direct access to a GP out of hours and availability of anticipatory medication;
    - Proposal to utilise the additional £5 per capita, allocated to GP practices with a view to reducing avoidable admissions;
    - Pathway redesign for Gastroenterology, Orthopaedics and Dementia care; and
    - Norfolk-wide review of voluntary sector contracts to ensure that the re-procurement process reflects our local vision for voluntary services.

The presentation was followed by a "question and answer" session, reflecting on the activity over the last 12 months and future commissioning intentions:

Q) Is it true that the East of England Ambulance Service Trust (EEAST) will be removing the first responder role in the local area (Rapid Response Vehicle - RRV)?

- Mark Taylor, Chief Officer of NNCCG explained that the Trust has no plans to remove RRVs, commonly known as first responders. EEAST are rebalancing the types of transportable resources distributed across the region, between Double Staffed Ambulances (DSA) and RRVs to ensure that the right vehicle can be deployed, subject to the nature of the emergency call.

Q) If you make a self-referral to Norfolk and Suffolk Foundation Trust's (NSFT) Wellbeing Service how quickly can you get an appointment? Is there a risk of people who are self-referring not accessing the right service?

- Dr Hunter explained that when someone makes a self-referral they will be contacted by a member of the Access and Assessment Team, who will carry out an initial assessment to determine if the Wellbeing Service can deliver the appropriate care for the individual and assign a referral to treatment time (RTT). Patients will be signposted to another service or given appropriate advice if the referral is not accepted. However, it should be noted that if a referral originates from a GP, the decision on whether the patient should be seen within 4 hours, 7 hours or 28 days is made by the GP at the point of referral, subject to the severity of the condition.

Q) Patients feel a negative connotation towards the way in which the word "pathway" is used to describe how they will be treated. Can GPs and commissioners accept that there needs to be better terminology which gives the patients more reassurance?

- CCG colleagues agreed that the term 'pathway' is commonly used amongst commissioners and clinical colleagues to describe the way in which treatment will be delivered, by whom and in what order. However it is acknowledged that this

may not suit the general public's understanding. The CCG welcomed any suggestions for alternative wording.

Integrated Care in North Norfolk

Dr James Gair, member of NNCCG's Executive Team, Governing Body and GP Birchwood Surgery; Jo Cook, Head of Social Care for North Norfolk (NCC); and John Everson, Head of Integrated Care (NNCCG and NCC), delivered a joint presentation highlighting the following points:

- How the four Integrated Care Hubs currently work in North Norfolk;
- What is Norfolk's Better Care Fund; and
- Which areas in the Integrated Care Programme need further development?

What is Integrated Care?

The purpose of integrated care is to bring together a range of health and social care professionals to deliver seamless joined up care for the individual. This is achieved by:

- Centring care around the person and their carers;
- Delivering early interventions to avoid an individual and/or their families/carers reaching crisis point;
- Sharing information across systems to facilitate seamless care;
- Having a single point of contact responsible for coordinating and managing all the different aspects of a person's care; and
- Linking care to local services in the community, through a partnership approach with the following organisations:
    - North Norfolk CCG (NNCCG);
    - Norfolk County Council – Community Services (NCC);
    - Norfolk Community Health and Care Trust (NCHC);
    - Norfolk and Suffolk Foundation Trust (NSFT);
    - Voluntary Sector Organisations; and
    - Patients, their families and their carers

Our Key Ambitions

The concept of integrated care is in its infancy, however NNCCG have learnt valuable lessons from early implementation and have identified the following key ambitions which need to be delivered going forward:

- Services should be arranged around the patient's GP surgery, to ensure ease of access;
- Joint timely assessments across health and social care;
- Lead workers who understand a patient's medical and social care needs;
- Seamless and timely access to services with advice to help patients self-manage their care;
- Services "switched on" with a single call; and
- Services delivered as close to home as possible, with respect, compassion and around a person centred approach.

Dr Gair explained that, whilst patients should receive a seamless service, there are many organisations which need to work in a coordinated way to facilitate this. The core Integrated Team consists of GPs, community nurses and therapists, social care assessment and management teams and home based/ reablement care teams. However these are supported by a wider cohort of organisations such as the acute sector; specialist palliative care; voluntary and third sector organisations; 111 and out of hours services; carer support; specialist mental health; pharmaceutical support; social care provision; and public services such as housing.

This demonstrates the scale of the challenge faced by CCGs and how important it is to have effective methods of communication in place.

How does it Work?

Jo Cook explained how the model of integrated care has been designed to meet the needs of the people in North Norfolk and rural Broadland. The concept of locality hubs, which bases an assigned Integrated Care Coordinator within one of four hubs grouped around GP practices, was demonstrated.

GP practices use risk profiling tools to electronically identify those patients who would benefit from the delivery of integrated care. A further in-depth review is conducted with input from link workers from a variety of multi-disciplinary teams assigned to each practice to develop a care plan, which is then managed by a lead worker assigned to the patient. The process is further coordinated by an Integrated Care Coordinator.

Again, it was reiterated that this work is conducted behind the scenes, with minimum impact noticed by the patient.

NNCG have recently produced a short film, highlighting the experience of a local patient and her husband who received integrated care in North Norfolk, which was shown to the audience. It was noted that the film did not convey the patient's initial difficulties and delays in accessing health and social care, and resultant negative impact. However it was acknowledged that considerable improvements have been made, since implementation of the Integrated Care Pathway and involvement of the Integrated Care Coordinators.

What is the future of Integrated Care?

John Everson provided an overview of the Better Care Fund (BCF), which has been introduced to enable health and social care organisations to facilitate integrated care across the whole system, delivering a positive impact on patients, their families and carers. The BCF should lead to:

- Improved identification of individuals most at risk that require support within their own homes;
- A reduction in avoidable emergency admissions to hospital and admissions to residential and nursing homes;
- Better community support pooling resources available locally;
- Better facilities to support individuals after a fall and/or falls prevention;
- Improved support for people diagnosed with dementia and their families and carers;
- Better pathways into and out of hospital, to avoid readmissions; and
- Better integrated and functional mental health pathway.

John Everson explained that the CCG will be able to measure the success of the BCF by seeing:

- A reduction in permanent admissions of older people to residential and nursing care;
- An increased proportion of older people still at home 91 days after discharge into reablement / rehabilitation;
- A reduction in delayed transfer of care from hospital;
- A reduction in avoidable emergency admissions;
- An improved rate of diagnosis for dementia; and
- An improved patient/service user experience of care.

The presentation was followed by a “question and answer” session, in relation to integrated care:

Q) Please explain what “health coaching training” is.

John Everson explained that it is about getting people to engage in what is happening and empowering people to have the life they want to have.

Q) Is there a plan to have an integrated commissioning process?

Yes, we have an Integrated Commissioning Team that commissions health and social care. Currently John Everson’s role provides a link between NNCCG and NCC. This role provides an opportunity to identify where services should be commissioned jointly, to avoid duplication and provide better clarity and improved patient experience. The aim is to deliver better, smarter services. We’re really clear that we do not want people to tell their story more than once.

Q) Changes are frequent. How do ordinary people keep up with them?

Jo Cook explained that the speed of change is incredible; however there is a strong desire to improve services. It is important to receive a seamless service through the integrated care coordinators. The main priority is for patients to get a seamless service that provides the right service at the right time. Feedback indicates that receiving the right service is more important to patients than understanding changes.

Q) Patients commented on data protection leading to patients repeating their stories unnecessarily.

John Everson explained that Commissioners are currently trying to find solutions to this through the integrated teams. Patients should see an improvement once all background work is complete.

Feedback following questions for discussion

Attendees were invited to discuss the following questions posed. Feedback was captured by a facilitator assigned to each group.

Q. How can North Norfolk have an effective and affordable Out of Hours service?

- Promotion and education needs to take place so that people understand when and who to ring during out of hours. Data on who is using 111 to access out of hours services would be helpful in order to help determine who should be the target audience for improved education.
- A single central out of hours base was proposed, potentially situated in Cromer that consists of a team of clinicians, supported by a volunteer patient transport scheme. The scheme would be used to transport patients in the local area to the out of hours base, if needed. Upon further consideration by the entire forum, it was suggested that four smaller out of hours hubs, would be able to provide a more robust service.
- In support of the above, one group suggested aligning the out of hours hubs with each of the 4 clusters.
- Effective out of hours triage processes which identify the correct treatment at the outset and provide quality services are imperative. Patients have reported making repeated phone calls to 111 and receiving mixed messages.
- Information sharing protocols need to be improved; out of hours problems with clinicians accessing data needs resolving.
- It was suggested that patients should have their own medical record card, which contains basic demographic and medical history, such as the Summary Care Record, which they can take ownership of sharing with the clinician. This removes the reliance on electronic records and addresses some issues of consent.
- People have expressed frustration when waiting for a return call from a clinician, after contacting the out of hours service. There needs to be a guaranteed minimum standard for return phone calls, to avoid individuals reaching tipping point and contacting 999.
- Patient transport solutions, such as a volunteer driver scheme, was suggested as a way of helping people to access out of hours services, instead of calling 999.

- If people are using the 111 service to access out of hours health services they should also be able to access integrated social care via the same number.

Q. What wider support do patients need from their integrated care?

- Strong support from the voluntary sector, for example befriending service, meals on wheels, carer support.
- Good information flow to enable people to be knowledgeable about the range of services available. One up-to-date directory of services.
- Really good out of hours service with proactive help.
- A simple, reliable and failsafe system that works.
- Single assessments that include joined up health and social care support. For example, creation of a Reablement Plan at the start of all acute admissions, to ensure that the patient can be safely discharged to their home, with the appropriate health and social care support network in place which can be switched on with a single call. This should reduce potential for readmission.
- People cannot reconcile the language of "integration" with how their health and social care needs are being met. The challenge is to describe 'joined up care' in such a way that enable patients to understand how Social Care (community services, local authorities) and Healthcare (GPs, hospitals) need to work together and communicate to deliver seamless support for the individual.
- Patients need to tell their story only once – if services are truly integrated, patients should only need to tell their story to a single provider, who has been given the authorisation to share the information. Professionals are seeing the Data Protection Act as an obstacle to sharing information, however if the appropriate consent is obtained at the outset, patients would have no objection to information being shared.

Q. What do we want integrated care in North Norfolk to look like in 2019?

- The main comment was continuity; patients want to see the services that are developing in 2014 go from strength to strength and still exist in 2019, instead of being reorganised and replaced by new schemes.

Conclusion

The overall perception of the day was captured in the following feedback questionnaire, circulated to all attendees.

Questions	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I found the event useful	11/28	17/28			
I found the content easy to understand	10/28	17/28	1/28		
I understand more about care in Norfolk than I did beforehand	10/28	14/28	4/28		
I found the subject relevant and interesting	11/28	17/28			
I felt able to take part in the discussion	10/28	17/28	1/28		
More information in advance would have helped me	3/28	8/28	9/28	6/28	2/28
The venue was appropriate for this event	12/28	12/28	4/28		
I enjoyed the catering and refreshments	11/28	12/28	5/28		
The event was of the right length	9/28	18/28	1/28		
I have made new contacts in North Norfolk	5/28	8/28	12/28	3/28	

Comments received regarding 111 and Out of Hours will be used to inform the design of the new service. Particular attention will be given to promotion, education and patient held records.

Suggestions made regarding the wider support within Integrated Care and the need for continuity will be taken to the Programme Board for inclusion in the programme.

Date of the Next Patient Conference

Date: To be confirmed
Time: 09:30 to 12:30 – to be confirmed
Venue: To be confirmed

List of Participants

	NAME	ORGANISATION	PPG Member?
1.	Dr Alasdair Lennox	Cromer Group Practice and NNCCG	N
2.	Chrissy Jackson	North Norfolk CCG	N
3.	Francis Bailey	Stalham Staithe PPG	Y
4.	Norma Leake	Aldborough	N
5.	Hilary Beynon	Stalham Green PPG	Y
6.	Ursula Jackson	Stalham Green PPG	Y
7.	Jim Spiller	Aldborough PPG	Y
8.	Bob Brownjohn	Wells PPG	Y
9.	Nina Chapman	Aldborough Surgery	N
10.	Delia Fox	Wells PPG	Y
11.	Jessica Bane	Ludham Surgery	N
12.	Lal Wright	Holt PPG	Y
13.	Maggie Prior	Holt PPG	Y
14.	Robin Simmonds	Mundesley PPG	Y
15.	Lesley Rose	Fakenham ICC	N
16.	Melanie Smith	Cromer Group Practice	N
17.	Paula Horn	North Walsham ICC	N
18.	Ali Campling-Brown	North Walsham ICC	
19.	Amanda Widdows	Fakenham ICC	N
20.	Clare Ruff	NCHC	N
21.	Tony Belham	Birchwood Practice and NNCCG	N
22.	Pauline Craske	Sheringham Medical Practice	N
23.	Janet Eastwood	Sheringham Medical Practice	Y
24.	Sally Ross-Benham	Stalham Staithe Surgery and NNCCG	N
25.	Roy Lond	Stalham Staithe Surgery	Y
26.	Richard Seaman	Aldborough	N
27.	Sandra Edgell	Hoveton and Wroxham Medical Centre	N
28.	Lynda Sowter	Drayton and St Faiths Medical Practice	N
29.	Janet Edgar	Drayton and St Faiths PPG	YY
30.	Linda Edwards	Aylsham and Reepham PPG	Y

	NAME	ORGANISATION	PPG Member?
31.	Judi Agnew	Aylsham and Reepham PPG	Y
32.	Liz Hewett	Cromer PPG	Y
33.	Andrew Wilkinson	Holt Medical Practice	N
34.	Joyce Groves	Acle PPG	Y
35.	Rachel Arkieson	Drayton and St Faiths Medical Practice and NNCG	N
36.	Jeff Wilson	Reepham PPG	Y
37.	John Everson	NNCCG	N
38.	Fiona Craig	NNCCG	N
39.	Neil Belant	Market Surgery	N
40.	Michelle Ducker	NNCCG	N
41.	Mark Taylor	NNCCG	N
42.	Dr Linda Hunter	Hoveton and Wroxham Medical Centre and NNCCG	N
43.	Margaret Winter	Paston Surgery	
44.	Ray Winter	Paston Surgery	
45.	Christine Mawson	NEL CSU	N
46.	Marion Slack	Ludham Surgery	Y
47.	Marion Saunders	Cromer Group Practice PPG	Y
48.	Nikki Crawford	Coltishall Surgery	N
49.	Margaret Blyth	Coltishall Surgery PPG	Y
50.	Michele Nash	Cromer Group Practice PPG	Y