

West Norfolk Alliance Pioneer Programme – Profile

1.1 What is your area like?

West Norfolk is a rural area with one of the most rapidly ageing, dispersed populations in England. The population has high prevalence of long-term conditions and obesity and a culture of lifestyle choices that adversely affect morbidity. West Norfolk faces the pressure of a small district general hospital (DGH) in financial distress, with difficulties in low volume activity, recruitment and retention of staff. A Monitor contingency planning team (CPT) is in place and the clinical commissioning group (CCG) is leading a long-term programme of local health and care system sustainability work which commenced six months before the CPT was appointed.

The main element supporting the implementation of our vision for integrated care has been the development of the West Norfolk Alliance. This is a collaborative partnership involving all the main organisations commissioning and delivering health and social care in West Norfolk. Initially it focused on improving and integrating care across three selected clinical pathways: care of frail and elderly people, maternity care and paediatric acute care. This work has widened as joint work with the CPT has developed.

The CCG is taking a proactive leading role in driving the CPT programme, ensuring it builds both on completed clinical pathway work and on West Norfolk Alliance's achievements to date, thereby building a sustainable model of system-wide integration on a strong foundation of existing cross-sector collaboration. We see this as a valuable opportunity to develop solutions for challenged smaller DGHs that can be transferred to other health systems across England.

1.2 What are you aiming to achieve?

Our vision is for 'sustainable coordinated services with patients in control' enabling:

- Independence, choice and quality
- One assessment and one care plan
- No organisational boundaries and shared information and decision-making

We are committed to the delivery of person-centred, coordinated care (the National Voices definition of integration).

We will know we are successful when:

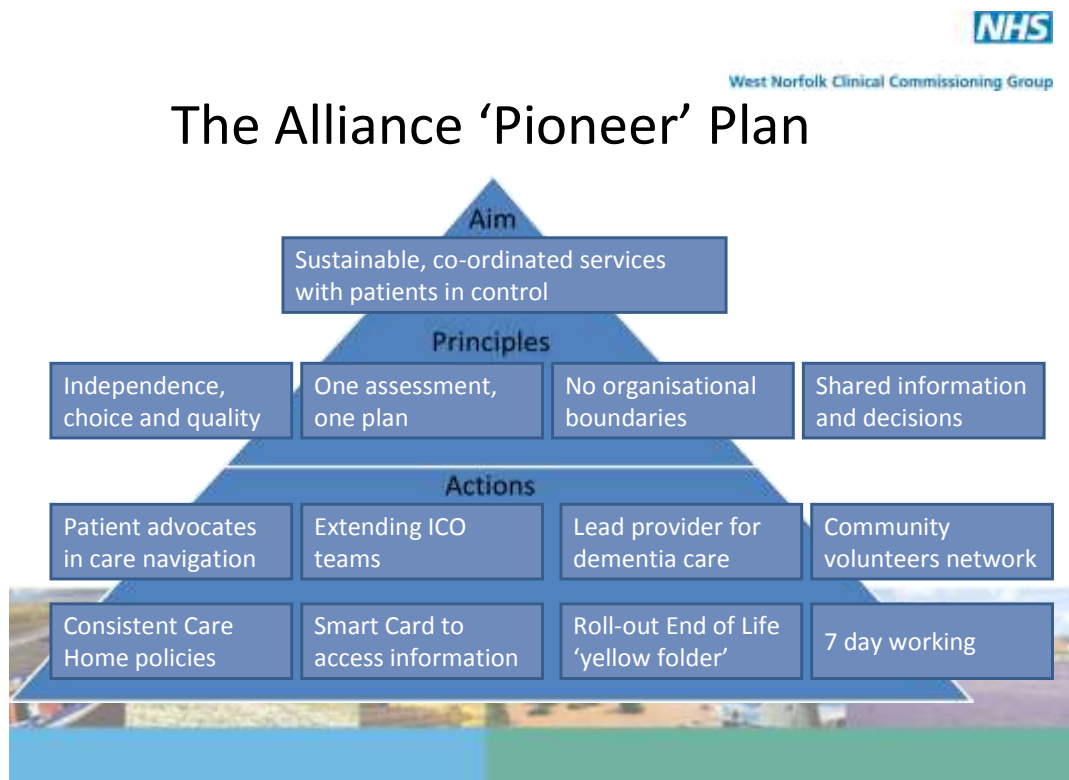
- People are more satisfied with their care
- We have confirmed stakeholder and public support
- Inappropriate admissions to hospital have been reduced (to 2010/11 levels) and to care/nursing homes (by 5% per year)

1.3 What have been the highlights of your first year?

- Establishment of the West Norfolk Alliance

- Development of a multi-agency prevention strategy and delivery of a local web-based system providing information on support
- Six-week reablement services extended to include 'premises reablement' (with plans also to include 'social network' reablement) as well as individual reablement
- A network of senior community matrons with prescribing powers and integrated care coordinator posts.
- A pilot to share summary records across primary and secondary care
- Social work added to multi-disciplinary teams and integrated operational management of community health and social care
- Plan for an integrated hub to provide a single point of access
- A virtual ward model delivered by an integrated team
- Extensive public consultation and stakeholder involvement
- A shared approach between NHS and both tiers of local government to voluntary sector support
- Improved sharing of relevant information
- Reduced duplication of assessments
- Increased uptake of personal health budgets for social and health care

1.4 Details of the year



The alliance is redesigning services across health and social care to achieve greater integration and whole-system sustainability. This is likely to involve substantial innovation and reconfiguration. This year, we have made progress on the following:

The development of a multi-agency prevention strategy and the delivery of LILY (Living Independently in later Years); this is a local web-based information system (with call centre back-up) that provides information on support available locally to enable people to remain independent and connected to their communities. See case study: [LILY \(Living Independently in Later Years\)](#).

Highly performing Norfolk County Council six week reablement services are in place. A more holistic approach is being implemented. In addition to reabling the individual, a partnership with the borough council home improvement team allows 'premises reablement' to be included where necessary. The third aspect of reablement is the social network. Research on this area is currently taking place with the support of a local social enterprise.

We have a network of senior community matrons with prescribing powers who manage a stratified caseload of people with complex needs. They work closely with a multi-disciplinary, primary-care focused team using an integrated care coordinator to enable information-gathering and communication across systems and connect with services.

Our 'Eclipse Live' information sharing project has been refreshed and given new impetus through the formation of a new cross-functional project team and a focus on overcoming the human and operational challenges of adopting new technology as part of clinical practice. See case study: [Eclipse Live information sharing project](#). We are designing a technological solution to securely sharing records – a smartcard using primary care data that can be accessed by approved partners with patients' consent, to treat them appropriately in situ, connecting with community resources and avoiding unnecessary journeys to hospital. A pilot is under way to share summary care records with nursing homes and emergency services to establish the principle of data sharing across primary and secondary care.

Social work input has been added into multi-disciplinary teams – a rapid assessment team based in A&E and the virtual ward team. Integrated operational management brings together community health and social care with some co-location. We plan further co-location across community health, social care and community mental health.

Plans are being developed to expand an existing integrated hub to provide a single point of access for a more comprehensive rapid, coordinated response. This will include representatives from community health, mental health, social care and a link to the voluntary sector.

Capacity for seven-day working is being built – a social worker is now present in the acute hospital over the weekend to carry out assessments and coordinate services in order to facilitate discharge.

A review of the long-established integrated care organisation (ICO) model has been completed. This will result in the establishment of a West Norfolk 'best practice' model which will be progressively implemented across all 23 GP practices. This will bring greater process consistency to the multi-disciplinary risk stratification and working, key worker model and the support it receives through the integrated care

co-ordinator posts. It will also add a care navigator role (commissioned from the voluntary sector) to mirror with high-risk patients the integrated care co-ordinator role in respect to professionals.

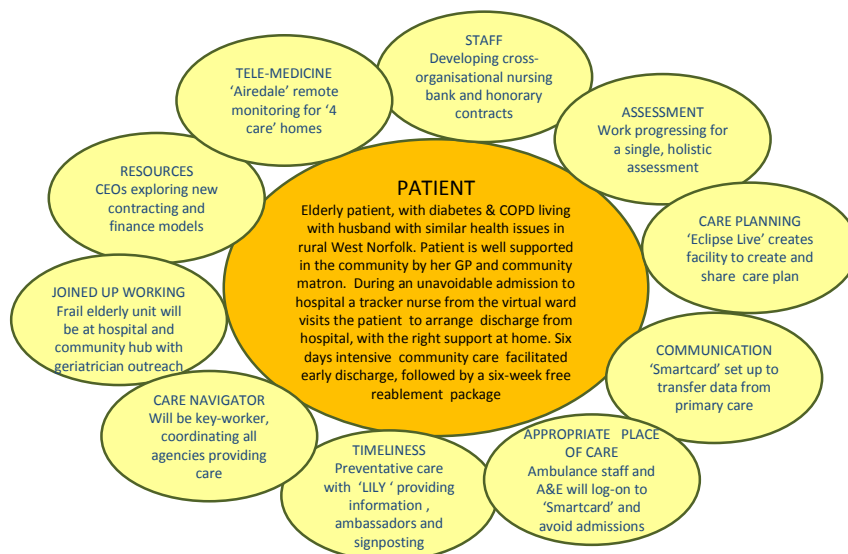
We have enhanced our admission avoidance/early discharge capability through the establishment of a Hospital at Home (virtual ward) model where more intensive clinical support can be delivered in the patient’s own home. This service is delivered by an integrated team that includes occupational therapy and social work staff as well as intensive community nursing. See case study: [Hospital at Home \(virtual ward\)](#).

Our whole-system sustainability initiative has been built on public consultation with discussion sessions at many existing local forums (such as the local older persons forum and the local voluntary sector provider forum) and discrete CCG-held public consultation sessions. The area of co-production is also being featured with the active engagement of a wide range of stakeholders in redesigning the local health system to ensure the future financial viability of the local acute hospital. A further example of co-production has been the design of “LILY plus”, where a stakeholder group attended a series of six independently facilitated design workshops.

Through the close partnership between commissioners (the district (borough) council, the county council and the CCG), the main providers and the local voluntary sector, the alliance has a shared approach to supporting a sustainable community-based voluntary sector. An example is the piloting of the ‘care navigator’ model: three temporary posts are being managed by two local voluntary organisations and a local social enterprise where the potential for utilising community assets is at its strongest.

The ‘Alliance Sunflower’ diagram below shows how we see the different parts of the integration programme working together to provide a holistic person-centred service for an individual.

A case study of care of an individual ... progress so far ...



The whole-system sustainability project is very much a work in progress, but early indications from some of the projects that have established closer integrated working are of increased patient satisfaction.

1.5 What has been the most exciting aspect?

The formation of the West Norfolk Alliance, which has provided the integrated leadership to make the whole project possible. The group of chief executives led by the CCG which make up the alliance have committed their support via a formal memorandum of understanding to tackle the obstacles to implementing more ambitious integration. Despite some senior departures and new arrivals, the resolve of the alliance remains undiminished and is pushing forward the pursuit of greater integration with the commissioning of multi-agency work in the following areas:

- Alignment of IT systems
- Co-location of staff
- Recruitment and retention
- Sharing back office services
- Empowering staff

1.6 What has been the most challenging aspect?

Bringing about change across the total alliance workforce. The alliance is committed to the delivery of person-centred, coordinated care across the whole local health and social care system. This requires a move from silo working and the merging of professional cultures and the adopting of a new 'alliance ethos'. The biggest challenge is to achieve this level of changed thinking – to get to the position where every manager owns, promotes and models integrated working and where every frontline worker is empowered to carry it out.

1.7 What are you planning to do next year?

- Planning the implementation recommendations from the system sustainability programme, which at this stage are embryonic, but could involve a radical new 'health campus' approach to integrated care, based on one of the models in the Five Year Forward View
- Developing the existing limited 'hub' model by the community health provider that provides a central point for referrals and the co-location of 24/7 immediate response services (including one small social care service). There are plans in the next year to relocate the hub to enable significant expansion of co-located immediate response services from across community health, social care and community mental health
- Implementing the recommendations from our estates strategy that is currently mapping the estates holdings of each of the members of the alliance with a view to maximising both value for money and the potential for co-location of key functions and staff groups

1.8 What is your advice for areas starting on their own integration journey?

A helpful starting point has been the agreement at an alliance board level to the development of a shared ethos across the workforce – a common way of thinking and behaviour that is recognisable to service recipients as ‘the alliance way of working’. This is being developed through our workforce strategy that includes such initiatives as the engagement of staff, a shared recruitment portal, a shared staff bank, and a common induction element. We have a progressive workforce development programme under way to challenge frontline staff, managers and organisational leads to implement an agreed set of actions to promote positive assumptions and overcome obstacle to integrated care.

Public engagement has been extremely helpful in establishing a baseline in local public expectations. This was our starting point and has remained the reference point for the evaluation of progress.

Of course we did not welcome the fact that our local DGH is in special measures with Monitor. A beneficial consequence, however, is that we have all been forced to recognise that the issues affecting the acute hospital are part of the whole system. They must therefore be addressed in a holistic way by changes across the whole system, with collective responsibility across the system for ensuring that those changes are implemented to improve outcomes for patients and service users.

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