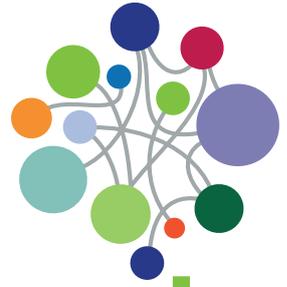


**neighbourhood
integration
project**



Community
NETWORK

Delivering neighbourhood-level integrated care in Norfolk

JULY 2020

Introduction

The COVID-19 pandemic has rapidly accelerated the integration of care in the community. The transformative potential of organisations working together at a neighbourhood level to meet local needs has never been clearer.

Before the crisis hit, the Community Network initiated a project to capture the successes and share the learning from areas where local service integration was already well underway. This case study forms part of a series published as part of this Neighbourhood Integration Project. With funding from NHS England and Improvement, the project focuses on how long-standing local partnerships have resolved the operational challenges that so often hold back the integration agenda.

These case studies were written before the pandemic, with all the change that has brought about, not least the move to digital ways of working. However, as the NHS faces unprecedented pressures not just to recover but reset how services are delivered, we hope they are still a timely way of sharing the practical strategies health and care organisations have already used to deliver more joined-up care.

This Community Network project is supported by NHS Providers, NHS Confederation, the National Association of Primary Care, the Association of Directors of Adult Social Services and the Association of Ambulance Chief Executives.

Key learning

- Effective collaborative working requires good relationships across the board – not just within a joint management structure, but with other services and between patients and clinicians.
- Do not underestimate the differences in culture and working practices between different organisations. It is important to get the management structure right and focus on the role of leadership in enabling culture change.
- Invest in ensuring there is the right technology available for staff to use. This can improve efficiencies and enable more time for delivering patient care.
- Engage with staff in a meaningful way to develop strategies to improve their health and wellbeing as this in turn will lead to improvement in services.
- Invest in pilot projects to test out integrated working between organisations but plan for how they can be maintained long term.

How integrated services are being delivered

Serving a population of around a million people, Norfolk Community Health and Care NHS Trust, which has been rated outstanding by Care Quality Commission, provides more than 70 services across the county as well as some services in Suffolk. This includes 12 inpatient sites that cover intermediate care, respite care and specialist rehabilitation. A range of services are provided, including children and young people's services, rehabilitation, out of hospital care, end of life care, and other specialist services. On a typical day, over 1,500 patients may be seen in their own homes, over 600 patients are seen in clinics, over 1,200 referrals are made and there are over 2,300 face to face interactions between patients and clinical staff.

The geography of the area means services are spread over large distances which include some urban areas and market towns but also a lot of sparse rural areas too. This makes it time consuming for staff to get from one site to another. There are pockets of deprivation across both counties.

Norfolk Community Health and Care's (NCH&C) vision is to improve the quality of people's lives in their homes and community through the best in integrated health and social care. The trust works predominantly with 14 primary care networks (PCNs) across the area served by Norfolk and Waveney Clinical Commissioning Group (CCG), and with the Norfolk and Waveney Health and Care Partnership at system level. This includes collaborating with three acute trusts (James Paget University Hospitals NHS Foundation Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust and The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust), one mental health trust (Norfolk and Suffolk NHS Foundation Trust), Norfolk County Council and the East of England Ambulance Service Trust (EEAST).

A lot of joint work is taking place with the PCNs and general practices with many collaborative projects set up in each of the localities. Examples include advanced nurse practitioners rotating across GP providers and NCH&C, reviewing staffing structures to align community nursing and therapy teams with the PCNs and locating some community health services staff in GP practices.

Examples of collaborative working

Rapid assessment frailty team

A good example of more integrated working within primary care is the rapid assessment frailty team (RAFT). They provide multi-agency assessments to patients within emergency care to support appropriate discharge planning for people who could either be supported at home or 'stepped up' into an intermediate care bed to avoid unnecessary hospital admission. Of the referrals received this year, the team has prevented admission for 67% of patients. For the remaining third, patients have anticipatory assessments undertaken to help reduce length of stay and contribute to the discharge to assess pathway.

Early intervention vehicles

This initiative was launched in 2017 as part of a collaboration between the ambulance service and the community trust. They were facing a high number of 999 calls related to falls by older people which did not require an emergency response or an admission into hospital.

The project involves occupational therapists working with emergency medical technicians (EMT) responding to older people who have had falls to avoid unplanned emergency admissions. As part of the visit, the team carry out a full medical assessment. They also assess the environment to help prevent future falls, order any equipment if required and make any necessary referrals to other services such as to social services for a care package, to the fire services for a safety assessment or to organisations like Age UK and dementia services if required. They may also carry out some treatments like skin tears and will check if the carers' needs are being met.

Initially starting as a three-month pilot, the project has now been operating for three years. The joint visit has helped to promote older people's independence and enabled people to stay in their homes, avoiding future falls and reducing emergency admissions by 75%, as well as providing reassurance to families. It has also improved the knowledge of professionals involved about the variety of options available for service users across health and care.



Give it a go! Accept referrals and see what happens with the power of conversation and bringing frontline skillstogether - see what can we do.

Nick Pryke, assistant director - integrated care, Norfolk County Council
(now operations director, Norfolk County Council)

Norfolk escalation avoidance team

This team acts as a single point of access, providing a referral line for professionals facing urgent unplanned health and care needs. The aim is for professionals in the local area to work together to coordinate an integrated response about how care will be delivered across the county without having responsibility for delivering care themselves.

The team, based in the 111 headquarters, consists of nurses including mental health nurses, social workers, therapists, paramedics, GPs, integrated care coordinators and business support. The team have multidisciplinary 'huddles' where they discuss cases, focusing on how to support people to stay at home or within the community safely, using preventative approaches, promoting independence and identifying any other additional needs. Each huddle will finish with a call to the referrer to provide an update on what has been discussed.

The response to this way of working has been incredibly positive. Staff report that having more face to face communication has helped to build relationships across teams. Staff have also commented on the power of collective thinking and making connections with other professionals, checking to see who has the capacity to take on cases as a proactive way of working. The statistics speak for themselves. After seven days, 83% of admission avoidance cases were still at home, 90% of people discharged from one of the acute trusts were not re-admitted to hospital and 93% of people discharged from community inpatient beds had not been re-admitted.

High intensity user service

Another example of a pilot which was then rolled out to become a permanent feature was the high intensity user service by NCH&C and Central Norfolk CCGs, following an example of a pilot in Blackpool. Data collected in emergency services identified that the main reason why some people were frequently attending A&E was 'no abnormality detected', meaning that there was no acute reason for their attendance. Eight new 'health improvement practitioners' were recruited across the county. Their role was to work with this cohort of patients to understand the underlying reasons for their A&E attendance. They provide peer support for these service users as well as supporting them to attend appointments. These practitioners have developed a knowledge of local provision which then helps to signpost people to other services. They work with service users for a time limited period – around six months – to ensure the focus is on supporting people to get back to their own networks.

Enabling factors

Collaborative working

The journey of integrating health and social care started in 2014. Since then, there has been a joint management structure between the community trust and the local authority to facilitate collaborative working, with senior leaders having responsibility for delivery teams across both health and social care services, governed by a section 75 agreement. Working in this way has helped to reduce unnecessary duplication in practice and services. A good example of this is the streamlining of referral processes for occupational therapists across health and care services.

With the benefit of six years of experience under their belts, the relationships between the two leadership teams have evolved, with the focus now on how to support system working rather than the priorities of two separate organisations.

Factors that have helped this effective collaborative working included ensuring there was buy-in at board level, with board members and council leaders taking responsibility to work towards a common vision, including changing leadership behaviours to drive wider cultural change across the organisations. Leaders also feel it has been important to find the right balance between being locally responsive while keeping an eye on evolving national policy on system working.



Sometimes when making changes, it is often said that it is about asking forgiveness rather than permission to try something different. We need to be brave when making decisions and ambitious for the difference we can make for patients and staff.

Paul Cracknell, deputy chief executive, Norfolk Community Health and Care NHS Trust

Investing in technology

Significant investment in technology and digital provision has been key in facilitating joint working. A digital strategy was developed which had buy-in from the board. This included reconfiguring the service desk to become a one-stop shop for services like ordering digital equipment to support more responsive service delivery.

Making a considerable investment to improve technology required leaders to make difficult decisions, including delaying investing in other priorities like improving the estate. The leadership team had to be clear that investing in digital was the right choice to enable them to serve the needs of a geographically dispersed community in an efficient way.

Another key part of the digital strategy was enabling all professionals, whatever service they work in, to access patient records. This in turn meant they were able to have a holistic view of the patient's care and support, leading to more informed decision making, better discharge planning, improved patient pathways and patient flow.

The significant focus on digital services has paid off: staff have the right information at the right time all in one place, as well as the ability to record new patient information in real time.

Benefits for local people and staff

The benefits from these initiatives to promote collaborative working has been immense. Outcomes for patients and service users have been improved, with initiatives like EIV and NEAT enabling patients to stay at home rather than go to hospital. Having services co-located together in the same building has meant more effective knowledge sharing between professionals, resulting in more holistic care for service users. The strengthened relationships between different stakeholders has led to a more flexible and resilient workforce with higher staff motivation reported as a result. The cost of care packages has also reduced.

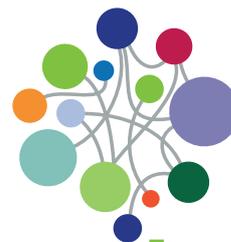
This joint working has also helped address the pressures within the social care workforce. This has included a new programme to develop social care staff, with new recruitment drives, training programmes and apprenticeships to build a more resilient and flexible workforce.

Advice for others

- Be brave and make bold decisions. There needs to be a willingness to be proactive and try new things to see what works.
- There needs to be a shift in mindset to always consider what is best for the patient rather than what is easiest for the service.
- Although many of the projects initiated started as a pilot, it helps to lock in funding to enable these projects to run for longer.
- A great way to know whether integration is working is when the patient is not aware which team or service the professionals are working for.

Other useful information

- [Norfolk Community Health and Care NHS Trust](#)
- [Early Intervention Unit](#)
- [Norwich Escalation Avoidance Team](#)
- [High Intensity User Service](#)



Community NETWORK

The **Community Network** is the national voice of NHS community providers, hosted by the NHS Confederation and NHS Providers. We support trusts and not-for-profit organisations providing NHS community health services to deliver high-quality care by influencing national policy development, sharing good practice, and promoting a vision of integrated care in the community.

neighbourhood integration project

The **Neighbourhood Integration Project** is a collaboration between NHS Providers, the NHS Confederation, the National Association of Primary Care, the Association of Directors of Adult Social Services and the Association of Ambulance Chief Executives. It has been funded by NHS England and NHS Improvement.

For further information and to get in touch:

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