Our Health & Care Strategy
2015-2020

Norfolk Community Health and Care
NHS Trust

Final September 2015

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1 Executive Summary

1.1 Strategic vision

The vision of Norfolk Community Health and Care Trust (NCH&C) is to improve the quality of people’s lives, in their homes and community, by providing the best in integrated health and social care. This is summed up as “looking after you locally”. This strategy document is to support and enable our clinical staff in delivering the Trust’s vision, by providing patient centered health and care services locally that are clinically and financially sustainable over the next five years.

We have three interconnected and mutually dependent strategic priorities to achieve our vision: Our Quality; Our People; Our Future. Our Health & Care Strategy fits in with these priorities and provides a basis to link supporting strategies into the overall vision.

Our Health & Care Strategy follows on from the previous three year Clinical Strategy, April 2012, which described five service strategies: Older People; Rehabilitation; Children and Young People; Long-Term Conditions and Palliative and End of Life Care. The Clinical Strategy included a total of thirty nine key proposals; the majority of which were delivered over the three years.

Since the Clinical Strategy was put in place CCGs have developed their individual operational plans and Norfolk County Council (NCC) their multi-year strategies. There have also been a number of national and local changes influencing health and care delivery. This document builds on the last strategy, incorporates national and local challenges, and includes the views of staff and stakeholders in the development of the strategy.

1.2 Strategic drivers

Whilst the population of Norfolk is expected to grow in line with the national average, the proportion of older people (aged 65 and over) at 23% is higher than the England value of 17%. It is the oldest age groups that are projected to grow the quickest in the next decade. The increase in patients with Long Term Conditions (LTC) with co-morbidities due to the ageing population, complexities of the care of children and young people in the community, and the increasing patient expectations mean that changes to how, where and by whom care is delivered are required for services that meet patients’ needs and are sustainable.

The NHS England (2014) Five Year Forward View makes it clear that continuing as we are is not an option. Additional national and local reviews conclude that the status quo is not sustainable or effective in delivering patient centred care.

NCH&C, like many NHS organisations, has made and will continue to make cost improvement savings over the next five years (circa £11.4 million savings required over the next two years, 2015 to 2017). At the same time the organisation is challenged with meeting the increasing health and care demands locally. We need to ensure our services are both clinically and financially viable in the long term and to work with local partners to develop seamless patient centred care.

NCH&C, with key stakeholders including patients and carers, requires a step change in mind-set on how care can and will be delivered differently over the next five years, at the same time embracing fast growing advances in technology and health innovation.
1.3 Strategic approach - moving forward

Our Health & Care Strategy sets out NCH&C’s intentions to meet the current and future challenges to deliver quality patient centred care locally. The strategy adopts a Levels of Care model of service delivery which aims to provide a consistent approach to care and underpins how services will be developed and managed by NCH&C. At the heart of the Levels of Care model is the needs of patients and the requirement of coordinated care to improve the patient’s experience of the care delivered.

Patients will have the minimum number of separate visits and consultations that are necessary, with access to specialist advice in appropriate locations within the community. The use of a different skill-mix and the increase in multidisciplinary working, along with maximising the use of technologies such as phone, internet, telehealth/telecare, video-conferencing, apps and email, will improve access and convenience for patients, their families and carers and enhance organisational efficiency. There will be changes over the coming years in how our workforce will deliver care in the community, which will be supported by workforce development and planning and working together with key partners. The Levels of Care model provides the basis to begin this development and planning.

1.4 Levels of Care model

The principle behind the Levels of Care model is that care will be stratified into four levels (see Appendix 3 for descriptions); the workforce will be aligned to the different levels to meet the expected patient demand at each level.

The model allows for part of the care currently delivered by registered staff to be delegated to trained staff that provide more general support following skilled assessment and diagnosis, and development of care plans, thereby releasing capacity. The registered staff will provide essential oversight of the care being delivered through regular reviews and by providing flexible supervision. Further work will be required, together with key partners locally, to align this model to patient centred health and care pathways. This model aligns with our ambitions for empowerment of the patient and their carers, integrated care with NCC and aims to incorporate the significant value that volunteers can bring to health and care services which will improve people’s experience of care, building stronger relationships between services and communities.

Both empowerment of the patient and the role of carers in patient care is vital and more support is required to ensure their needs are met by more proactive management of their health and
wellbeing. Our Health & Care Strategy will encompass and further develop the additional value that both volunteers and carers can bring to deliver patient centred care locally.

The current status of care delivered across the geographical localities is a mixture of different ways of working and variations between the localities. The recent implementation of the operational hub and spoke model for each adult geographical locality has supported the streamlining of processes of how care is delivered locally. The benefits of this will be considered for specialist and children’s services. The Levels of Care model will be used as a tool to guide development of the workforce profile so that it is aligned to needs of patients, their families and carers.

1.5 Engagement and flexibility

Our Health & Care Strategy has been developed by involving over 400 staff and key local stakeholders through an extensive engagement programme during March to July 2015. Engagement included obtaining views from local CCGs, NCC, the voluntary sector, Carers Council for Norfolk, Trust board, governors and from a number of clinical and non-clinical staff meetings. Discussions and views were gathered on the proposed Levels of Care model, which was further developed and refined during the engagement phase to develop the strategy.

The formation of the strategy has included the views of patients, their families and carers, and based on these views, we will set up Our Health & Care Strategy patient and carers focus groups to explore the future in more detail. These will be delivered over the coming months (November 2015 –November 2016) to support the detailed work required in how our services are delivered around the needs of patients, ensuring that value based outcomes that matter the most to patients are achieved when delivering our services over the next five years.

Our Health & Care Strategy links with and is reliant on other supporting Trust strategies. These include strategies for estates, workforce, communication, business development, information management and technology, and finance. Coordination and alignment between these will be critical to the successful implementation of Our Health & Care Strategy.

Whilst Our Health & Care Strategy sets the basis for care for the next five years for NCH&C, it is meant to be flexible and should be regularly reviewed in the light of local and national changes to ensure it adapts to them and remains achievable.

1.6 Opportunity

*NCH&C as the main community provider for Norfolk and working in Suffolk, is in an advantageous position to influence, engage and remodel care within the local community, working with partners to deliver value based health and care services.*

The Levels of Care model has been designed to support this and will influence and support the development of the right workforce, at the right levels and in the right numbers to support the national and local requirements.

The success of Our Health & Care Strategy will depend upon early engagement of everyone concerned within the local economy and having a practical focus on how best to build and implement the five year implementation plan.
1.7 Conclusion

This Strategy sets out a clear role for NCH&C in the provision of services to support adults and children either at home or close to home particularly those who are vulnerable, with complex needs and those suffering with long term conditions.

The success of the strategy will require our commitment to:

- Truly empower our patients and value the contribution of carers, maximising the health and wellbeing of both;
- Build on our ambitions for delivering integrated care;
- Implement a ‘grow your own’ workforce strategy introducing new career structures from bands 1-8;
- Do more in terms of innovation and technology;
- Recruit and empower a Health and Care Council to drive forward the implementation of the strategy;
- Develop more formal relationships with the voluntary sector and the use of community assets; and
- Acknowledge and meet the challenges set out in NHS England (2014) Five Year Forward View for both cost improvement and effectiveness of care.
2 Introduction

2.1 Overview

This document for Our Health & Care Strategy begins with a summary of the key national and local changes taking place within the NHS, strategic priorities for the Trust and what will be achieved in the next five years. The document gives an overview of the Levels of Care model we have developed and sets out how NCH&C will use the Levels of Care model to develop partnership working arrangements with key partners, including the voluntary sector. The methodology used to develop the strategy is described and the document concludes with how to move forward with the strategy together with an outline of the five year implementation plan.

2.2 Local and national context

NCH&C is the main Community Health and Care Provider for Norfolk, delivering quality community services to four commissioning localities: North; South, Norwich and West and in areas in Suffolk. NCH&C delivers community services to other geographical areas as part of securing new business. For example, the Trust has launched a new Early Supported Discharge service (also available in Norfolk) in Suffolk, allowing patients who have had a stroke to return home from acute hospital faster and receive specialist rehabilitation in their own homes. NCH&C also delivers specialist services which are commissioned by NHS England.

The Trust provides a range of services including community hospitals, community dentistry, services for children and families, therapies, community nursing and specialist nursing services. We employ 2,250 full-time equivalent members of staff and 80% of these are healthcare professionals such as doctors, dentists, nurses, and physiotherapists. Appendix 1 provides a summary of the health profile of the areas served by the Trust.

Nationally, the NHS England (2014) Five Year Forward View describes how well the NHS has delivered healthcare services despite the major financial challenge that now exists. It sets out how the next five years will bring about significant challenges for all NHS organisations due to the existing gaps in health and wellbeing, care and quality, and with funding and efficiency gaps. These are partly due to the fast changing needs of patients, more patients with Long Term Conditions (LTC) with co-morbidities due to the ageing population, increasing health inequalities in parts of the country, and increasing patient expectations.

Delivering the same is no longer sustainable...radical changes in how services are and will be delivered are required

As a result of national and local health and care challenges, NCH&C is preparing services currently delivered to remain ‘fit for purpose’ today and for the future. Over the coming years there will be changes to how services are delivered which will involve working differently with stakeholders and patients, their families and carers. All partners including health, care and voluntary sectors will need to work together to implement the changes required to meet increasing patient demand and ensure quality health and care services remain sustainable in the long term.

NCH&C like other NHS organisations will need to develop new ways of working, particularly with the ageing population which have more complex co-morbidities, children and young people with
increased complexity and transitioning to adults. NCH&C acknowledges delivering the same is no longer sustainable and does not always deliver the best value based outcomes that matter most to our patients, their families and carers. Transformational changes are needed at pace in service delivery including embracing digital technology capabilities and aligning services around patients’ needs.

Introducing technology to existing ways of working does not necessarily deliver the desired benefits as anticipated, as some staff do not realise the added value the technology brings to the patient experience and how the technology can support families and carers. Families and carers may have a different understanding and need from technology as live away from patients. Carers can support patients from a distance with the assistance of technology which can support monitoring and management of long term conditions.

When technology has been introduced as an ‘add on’ to existing models of care, experience has shown that some staff revert back to previous ways of working despite the investment secured to support patient care. Technology is most effective when combined with and embedded in the way of working from the beginning. The Trust IM&T Strategy 2014-2019 – Connecting Community Care will enable and support the delivery of Our Health & Care Strategy over the coming years. The strategy has four consolidated work streams of: community working; integrated care, sustainability and a paperless NHS, these are linked to current and future models of care.

2.3 Workforce

It is important to ensure that the workforce now and in the coming years has the appropriate skills, competencies and capabilities to meet the needs of patients, their families and carers. NCH&C together with our partners will review how and where our services are and should be delivered to ensure that they continue to meet the current and future health and care demands. We will actively implement flexible careers by implementing a strategy to ‘grow your own’ workforce creating opportunities to develop our band 1-4 roles and above. Staff at band 1 will be recruited into apprenticeships and develop through to band 2 roles. Staff at bands 3 and 4 will be able to move into a flexible pathway to attain nursing qualifications in the first instance and other professional roles will follow. Band 1-4 roles will be underpinned by a clear education and competency strategy.

We will introduce more exciting career pathways for registered staff from bands 5-8C with new roles such as Nurse/Therapy Consultants and Physicians Associates to underpin the development and support of a new and modern workforce. The workforce across NCH&C and NCC will be closely aligned to ensure consistency in bands 3&4 and to establish clear professional leads who will oversee the pathways for Health and Social Care across Norfolk and across new geographies such as Suffolk.

Our Health & Care Strategy links and supports Trust strategies and will determine workforce planning for the coming years to ensure our staff have greater flexibility, are skilled to deliver more general holistic care in the community, and work together with specialised areas to meet local patient needs.
### 2.4 Strategic priorities

Our vision will be delivered through the achievement of a number of longer term strategic objectives. There are three interconnected and mutually dependent strategic priorities to achieve the Trust’s vision: Our Quality; Our People; Our Future. Our Health & Care Strategy fits in with these as shown below.

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<tr>
<th>Strategic priorities</th>
<th>Quality indicators</th>
<th>Our Health and Care Strategy</th>
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| **1. Improving quality through:** | ▪ Delivering harm free, clinically effective and compassionate care.  
▪ Involving patients and the public and delivering excellent patient experience.  
▪ Integrating delivery with social and primary care and having effective partnerships with other organisations. | ▪ Delivery of quality improvement initiatives and NHS safety thermometer to support harm free care as described in the Quality Improvement Strategy.  
▪ Sustain and increase NHS Friends and Family patient survey.  
▪ Increased partnerships developed with key providers including third sector.  
▪ Seamless patient centred pathways developed and implemented (utilising Levels Of Care model) |
| **2. Enabling our people through:** | ▪ Inspiring staff.  
▪ Empowering staff to speak out and put things right.  
▪ Ensuring the right staff, with the right skills, are available to deliver compassionate care.  
▪ Transforming services.  
▪ Demonstrating effective leadership. | ▪ Consistent and improved staff satisfaction across the organisation.  
▪ Building and growing staff involvement in how care will be delivered by NCH&C e.g. sustainable models of care.  
▪ Continue to deliver the Transformation programme.  
▪ Workforce development including ‘growing your own’ staff and future leaders. |
| **3. Securing our future through:** | ▪ Delivering what commissioners want.  
▪ Delivering a financially sustainable organisation.  
▪ Investing in infrastructure.  
▪ Growth. | ▪ Exceeding commissioners’ expectations.  
▪ Demonstrate superior performance in health and social care delivery.  
▪ Deliver CIP involving staff.  
▪ Our Health & Care Strategy supporting growth opportunities by securing new and sustainable contracts. |

**NCH&C NHS Trust Our Health and Care Strategy 2015-2020**  
**Final 21st September 2015**
3 What will NCH&C achieve in the next five years through the strategy?

NCH&C aims to lead the ‘out-of-hospital community healthcare agenda’ for Norfolk and provide quality out of hospital community services across Norfolk, Suffolk and other locations as new business is secured.

We will develop and refine existing clinical services around the needs of patients, carers and families, working in partnership with key stakeholders in particular GPs and including the voluntary sector, carer support organisations and expert patient programmes. Due to the rapid changes in patient conditions, advances in technology and health innovation, NCH&C aims to develop the current and future workforce to have the appropriate skills, competencies and capabilities to deliver excellent care locally in the community.

We aim to deliver the following over the next five years:

| Leadership in Norfolk                  | Become the lead for ‘out of hospital community healthcare’. Establish an increased uptake of clinical engagement building on the 400 staff and 20 stakeholders engaged in the development of the strategy. Levels of Care model used throughout the localities within Norfolk and Suffolk, increased provisions of generalist services linking with specialists when appropriate. |
| Developed workforce                    | Refresh and refine the current workforce strategy to adopt new approaches to ‘grow your own’ workforce and focusing on retention and successful recruitment. Increase in retention of staff and recruitment of staff. Talent programmes developed and future leaders identified and trained, including consideration of Nurse/Therapy Consultants, Physician associates. Increase in band 1-4 staff across health & Social Care to support Levels of Care model. |
| Clinical & operational excellence      | Working with partners, GPs, staff, patients, families and carers, and communities, develop systems through service redesign including new technology to drive clinical and operational excellence in the community. Working with NCC, to lead strategic approaches to develop voluntary sector involvement in care pathways in the community. |
| Coordinated care                      | Develop new models and pathways for coordinated care to be developed within the community, addressing gaps in services by working closely with the voluntary sector and proactive support to carers. Senior clinicians within the localities to work with Assistant Directors to further develop care pathways linking the Levels of Care model. |
| Partnership working                   | Develop existing and new partnerships and networks in the local health and care economy to meet the increasing patient demands, improve efficiencies, integration and minimise duplication. |
| Robust decision making                | Use existing and new information sources to further build management dashboards to support speedy decisions and clinical reasoning within the Trust and local economy. |
| Issue identification & resolution     | Develop readily available performance dashboards so that all staff from front line to corporate teams are able to identify real time issues and rapidly implement solutions. |
4 The purpose of Our Health & Care Strategy

4.1 Clinical Strategy 2012

Our Health and Care Strategy follows on from the previous three year Clinical Strategy, April 2012, which described five service strategies:

1. Older People
2. Rehabilitation
3. Children and Young People
4. Long-Term Conditions
5. Palliative and End of Life Care

Each of the service strategies set out a number of proposals. There were a total of thirty nine documented key proposals within the clinical strategy. A recent review (December 2014 to March 2015) showed that the majority of the proposals were implemented within the Trust over the last three years.

4.2 Our Health & Care Strategy and integration

With the integration agenda (2012 Health and Social Care Act\textsuperscript{2}), Better Care Fund\textsuperscript{3}, the NHS Five Year Forward View\textsuperscript{1}, and the implementation of the Trust’s integrated management structure with NCC in Dec 2014, NCH&C will through Our Health & Care Strategy ensure services delivered by the Trust are aligned to the Trust’s key goals and objectives during the next five years. It sets the vision of how health and care services will be delivered locally in the community by NCH&C staff working together with key partners.

Our Health & Care Strategy describes the Levels of Care model to support integration and partnership working over the next five years. Supporting strategies will be critical to the successful implementation of Our Health & Care Strategy, as shown below.
The supporting strategies key to Our Health & Care Strategy will be updated and refined to support clinical staff to deliver services using new models/pathways of care. There are and will be additional Trust plans developed to support the implementation of Our Health & Care Strategy for example Volunteering and Carers strategies/plans.

### 4.3 Meeting current and future demands

Our Health & Care Strategy is designed to support clinical staff to engage with key stakeholders, particularly GPs, and patients, their families and carers, to become more involved in how health and care services will meet current and future demands. Working with key partners the strategy also aims to identify where there are gaps in pathways and how these gaps can be addressed together with others for example, voluntary sector in supporting carers. The support that volunteers bring, whether these are Trust developed volunteers or working with key voluntary sector organisations, can improve the quality of the patient experience. Through the development of the strategy and obtaining views of partners, many local health and care organisations are having dialogues with the same voluntary sectors. There needs to be a strategic approach on how the voluntary sector is utilised effectively by both health and care organisations to ensure that the added value they bring to the patient experience is maximised and not lost.

Our Health & Care Strategy will implement new improved ways in delivery of health and care services which are sustainable. Our Health & Care Strategy does not describe all the details on how the changes in pathways will be implemented as further work and engagement is required to achieve this. Whilst the strategy does not go into the detail or specifics of individual services delivered by the Trust, the Levels of Care model (described within the document) provides a consistent approach that will be taken across the organisation on how services will be delivered by the current and new workforce. Together with local partners within the health and care economy, services will be redesigned, refined and where applicable, new contractual arrangements will be developed and implemented.

The strategy is the start of a journey of local change within the health and care economy. Further work, development of details and engagement will occur during the consultation and implementation stage and through a new delivery group ‘Health & Care Council’, described in the implementation section of the document.

### 4.4 CCG Operational plans

Our Health & Care Strategy together with the Levels of Care model will work with the commissioning intentions as described in the five year operational plans for the individual CCGs. The Levels of Care model provides a consistent approach and underpins how services will be developed and managed by NCH&C.
4.5 Volunteers

Both within the voluntary sector and within public services there are an estimated three million volunteers across England (Kings Fund 2013). Volunteers add significant value to work of paid professionals and enhance the patient experience building strong relationships between services and communities supporting integrated care. Investment in roles, such as a salaried organiser of volunteers as a senior role, may be one option to pursue which is joint funded with local partners. This option would be an essential investment for all care providers in health and care.

The local health and care economy should focus on volunteering as a means of improving quality rather than cutting costs, and should resource volunteer management appropriately. More detailed work will be required and will form part of the implementation plan.

4.6 General Practitioners (GP)

The new GP contract will ensure that all people over 75 with complex, multiple long-term conditions will be cared for by a named GP. The Five Year Forward View describes new models of care that involve increased co-operation between GP practices and providers. Primary care of the future will build on the traditional strengths of ‘expert generalists’, proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Our Health & Care Strategy will enable us to work more closely with our GPs to inform future models of care that will make the most of our partnerships with NCC and the Voluntary Sector and to provide stronger links with nurses, therapists and other community based professionals within NCH&C to deliver care to this targeted group of patients.

We will also use all opportunities in our future relationships with our GPs to share information through the electronic patient record and to offer models of care that make fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.
### Proposed model of care: Levels of Care Model

#### 5.1 Meeting current and future needs

The Levels of Care model has been developed to support the vision of how health and social care services will be managed by NCH&C over the coming years. Working together with local partners, patients, their families and carers to manage the increasing demands for health and care and, ensuring that safe, quality, sustainable services are delivered. The Levels of Care model considers the future and also helps address the challenges that exist today. Some of the current challenges and how they apply to NCH&C are described below.

<table>
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<tr>
<th>National agenda</th>
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<td>The national agenda is pushing for a shift of specialist services into the community to manage the ongoing demand of the acute sector. Specialist services are also being centralised to support economies of scale, build resilience and improve patient outcomes, e.g. centres of excellence.</td>
<td>NCH&amp;C delivers general and specialist services within the community. There are variations across the localities as to how they are commissioned and managed.</td>
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<td>The ageing population results in patients having co-morbidities, and health inequalities mean variations in life expectancies across localities. The delivery of services will need to be tailored to meet these ongoing needs.</td>
<td>NCH&amp;C through integration across services will be able to manage the health and care needs, supporting coordination of care, working closely with GP practices, partners and patients, their families and carers.</td>
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<td>Patients are often seen by a number of specialist services with minimal integration between the specialities within health and care services.</td>
<td>Through workforce development community services will be able to take on more coordination and responsibility to meet the holistic needs of patients, their families and carers supporting both primary and acute care.</td>
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<td>The GP aims to manage the patients’ health issues and has the holistic knowledge of the patients’ needs and how they are being managed. However, due to the increasing demands within primary care, the holistic assessment and management of care can be minimal, resulting in urgent services being used.</td>
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<td>Community services aims to manage the gap between primary and acute care and provide a number of services within the community, ranging from Long Term Conditions care, children services to End of Life care.</td>
<td>NCHC as a key community provider needs to support this transfer of specialist/generalist services allowing for care to be delivered closer to the patient’s home.</td>
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<td>Patients, families and carers want and need seamless care and a joined up approach across the various organisations that deliver health and care services. National reviews such as Raising the Bar – The Shape of Caring Review, Willis, 2015, Shape of Training, Greenaway, 2013, and the more recent Better leadership for tomorrow NHS Leadership Review, Rose, 2015, are indicating the need to review how services, workforce, leadership, general vs specialism services are commissioned and delivered. The ageing population will require broad based specialist training and support so that patients can be cared for in a holistic manner within the community, reducing the number of people and services that are directly involved to minimise duplication, release efficiencies and improve patient outcomes.</td>
<td>Community staff will need to have the additional skills, knowledge and experience to deliver elements of specialist services which are significantly different to how community services have been managed prior to the shift of ‘care closer to home’ agenda. We will need a mix of roles across bands 1-4 in health and social care underpinned by senior clinical leaders at specialist, physician associate and Nurse/Therapy Consultant level.</td>
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Traditionally patients seen by community services tend to have conditions of a lower acuity/complexity than those seen by the acute trusts, with a few notable exceptions such as specialist neurological rehabilitation and palliative care. This trend is changing due to the increasing demand placed on the acute sector and patients with a much greater level of acuity and complexity are now being treated in the community.

NCH&C has seen an increase in the more complex patients being transferred into the community inpatient units and within their own homes in the community. This has been shown in the increase in Rehabilitation Complexity Scale (RCS) levels which is a measure designed to evaluate complexity of rehabilitation needs and intervention required for patients in various health settings. The expectation has been for RCS to be around 8. Patients are being admitted with higher RCS levels and they have been constantly rising (since 2012). Additional Trust performance reports also show an increase in complexity with the patients seen in the community. This change would indicate a change in nursing and therapy requirements which requires investment in training to build on the practice currently in place to develop the additional competencies and capabilities required to manage this profile of patients within the community, for example intravenous therapy as a core skill rather than delivered by a specialist team.

5.2 **Principles of the overall model**

This diagram illustrates the overall Levels of Care model.

The principle is that care is stratified into levels and the workforce aligned to the different levels and expected patient demand (Appendix 3). This allows for part of the care currently delivered by registered staff to be delegated to trained staff that provide more general support following skilled assessment and diagnosis, and development of care plans, releasing capacity. The registered staff will oversee the care being delivered through regular reviews and by providing flexible supervision.

Where there are gaps within the current pathways the voluntary sector will be able to provide some additional services to support patients, their families and carers. This support will improve quality rather than reduce short term costs. Working with the voluntary sector will require a strategic approach within the local health and care economy, minimising duplication, enhancing joint ways of working that is sustainable and provide added value to patients, their families and carers. NHS organisations that have developed these partnerships with the voluntary sectors have developed integrated care programmes to support older people’s health and wellbeing. NHS organisations have invested in different ways to support people who need support the most to promote joined up care. For example: befriending services; supporting patients on discharge from hospital; setting up patients’ prescriptions; shopping and in support of managing isolation or loneliness.
Carers form a larger proportion of people who support patients than the paid workforce or volunteers (see diagram below). More work is required to support them to continue to take a vital role in supporting patient care. Often carers are not identified early enough for example only at the point of crisis situations are the health and care needs identified or missed altogether. More proactive support for carers is key to people being looked after locally.

**Number of health and social care employees, volunteers and carers**

![Diagram showing number of health and social care employees, volunteers and carers](image)

Reference: Volunteering in health and care - Securing a sustainable future, Kings Fund 2013

NCH&C will formalise relationships and partnerships with the local voluntary organisations and carers across the localities. A scoping exercise which was undertaken to support the development of Our Health & Care Strategy captured over 85 voluntary/charity organisations which operate within Norfolk for both Adult and Children and Young people, more scoping will be required to capture organisations that can support patient care in Suffolk. There is also growing on-line support available for patients, their families and carers through patient expert programmes such as [www.patientslikeme.com](http://www.patientslikeme.com). These organisations and support programmes will help address current gaps within patient pathways.

### 5.3 Delivering care

Under the Levels of Care model patients will have the minimum number of separate visits and consultations that are necessary, with access to specialist advice in appropriate locations within the community. The use of different skill-mix and the increase in multidisciplinary working, along with maximising the use of technologies such as phone, internet, apps and email, will improve access and convenience for patients, their families and carers and enhance organisational efficiency. The individual levels within the Levels of Care model are described briefly below.

**Level 1** - will require the delivery of the most complex care and acute episodes of care, where patients will have existing co-morbidities; skilled staff will be working with a number of organisations to support the necessary development of joint care plans. Staff will need to have advanced assessment capabilities, diagnostic and clinical skills. This level will require the highest proportion of professional/skilled staff.

**Level 2** – this level will involve a number of specialists within and external to the NCH&C to undertake multi-disciplinary ways of working. As with all the levels, care will be centred on the needs of the patient, their families and carers. The desired outcomes to be achieved for the patient may be

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Staff comments to Levels of Care model:

As long as the framework is clear and resource requirement understood, this might work!
different to the clinical pathways therefore the pathways will need to be flexible and contractual arrangements will have to take this flexibility into account.

Staff will have strong leadership/organisational skills to work in the interests of patients, their families and carers and with various organisations to ensure the right clinical delivery of care is achieved. Patients seen within this level will pose high risks which may be jointly managed with other specialists.

**Level 3** – involves patient empowerment, rehabilitation, re-enablement, patient, family related education/training programmes and joint assessments with various organisations to support the delivery of the joint assessment and care plans. Workforce capabilities will be dependent on the specific service areas.

**Level 4** – the health wellbeing and prevention agenda will be key to this level for both Adults and Children and Young people. There will be a higher proportion of patients supported to self-care within this level. Patients, families and carers seen may be in better health and managing their long term conditions with minimal requirement of skilled specialist staff.

Levels 1, 2 and 3 - require a higher proportion of professional/specialist staff with the relevant competencies and capabilities to treat and manage patients, their families and carers. Level 4 which deals with preventive types of care, requires investment to help manage future demands, the proportion of partners working at this level may be larger in comparison to those in Levels 1, 2 and 3.

Level 1&2, which will require more complex, specialist, and professional, input is expected to be delivered directly by NCH&C. Levels 3 and 4 could involve different partnership arrangements so that not all services are delivered directly by NCH&C, but accountability and responsibility remains with NCH&C with the appropriate support and supervision arrangements in place.

### 5.4 Tailored models

The proposed Levels of Care model was discussed throughout the engagement programme (see comments above). Feedback was received and ideas on how the model could be implemented were discussed and the model revised. The Levels of Care model was presented in staff engagement meetings (see Appendix 2) and the majority of staff understood the principles behind the model and worked together to build and refine the model. Staff commented that it was important to move away from current silos in thinking about and caring for patients and the Levels of Care model provides a framework for this.

Following staff engagement the consensus was to have two tailored versions of the Levels of Care model, one for Adult services and a separate model for Children and Young people.

### 5.5 Adults

The Levels of Care model for Adult services was discussed at various staff groups and with key stakeholders and was revised following feedback. The model developed, set out in Appendix 3a – Levels of Care model – Adults, describes the types of services for each level, the care settings

---

Staff comments to LOC:

Take the building out of the model
- what does the patient need -
remove reference to place then
the model makes sense.
and the clinical and workforce requirements. The model provides further details on the types of patient/service users expected to align to each level.

The descriptions given within the model are high level and each service will use this model to develop a service wide model and decide how care will be managed at each level. The individual services will develop standards which will utilise the service specifications, providing clear direction to staff within the service on what is expected at each banding and Levels of Care.

### 5.6 Children and Young People

Children’s services are commissioned by a wide range of commissioners and are currently aligned to NCC Children's Services’ six localities. There are a number of specialist services for children delivered by NCH&C, for example psychological services for children with learning disability, complex needs and disabilities and other services are delivered by other providers. NCC and the CCGs’ joint commissioning intentions for children target the promotion of health and wellbeing and disease prevention. There are also initiatives tailored to vulnerable young people, including support for safeguarding, and the provision of care to high risk children’s groups. In addition, children with complex conditions are surviving longer, often into adulthood. Although their numbers are small, the level and cost of care provided is significant and is predominantly community-based.

The Levels of Care model for Adult services was discussed at various staff groups and during this engagement it became apparent that the Adult’s model was not suitable for Children and Young people. A tailored Levels of Care model was developed after holding a focus group (3rd June 2015), see appendix 3c.

As for Adults, the Children and Young People Levels of Care model provides high level descriptions within the model. Each service will use this model to develop a service wide model and agree how care will be managed at each level. The individual services will develop standards which will utilise the service specifications, providing clear direction to staff within the service on what is expected at each banding and Levels of Care. The work to develop individual service standards will begin following formal publication of the Our Health and Care strategy and be completed within the first year.

### 5.7 Using the Levels of Care model

The Levels of Care model will be used by the Trust to determine workforce planning over the coming years. Part of the process will be to work with local health and care partners to identify the gaps in current pathways, the skills and capabilities required, and decide the ways in which these gaps can be met that are clinically safe and financially viable.

We will review the services that can only be delivered by staff within the Trust and those services where a different approach to delivery can be explored further. The model will also support the national agenda of the seven day working week which will require a different workforce model. The model will also consider how technology can be used to support families who are caring for patients at a distance e.g. identifying changes to patient’s observation metrics where early intervention can prevent ill health.
5.8 Workforce planning

The Levels of Care model will determine workforce planning over the next five years, especially in relation to training for the new workforce and the ‘grow your own’ agenda.

NCH&C will over the next year have a clearer understanding of the workforce banding requirements for each service, how these will be utilised within the Levels of Care model, and the proportion of generalist to specialists required.

This will over the life of the strategy result in a shift of workforce bands as shown in the graphic.

The shift in workforce banding requirements and proportion of generalists to specialists is being reviewed. NCH&C will use the strategy to determine workforce planning and our response to the NHS England (2014) Five Year Forward View for the next five years.
6 Methodology used to develop Our Health & Care Strategy

An engagement programme was developed by the Executive Team and discussions were held with various staff groups, key stakeholders and the voluntary sector. These all supported and influenced the strategy formation.

Development of Our Health & Care Strategy drew together ideas and feedback from numerous staff group discussions held during March to July 2015.

6.1 Engagement of stakeholders

The engagement activities included:

- High level ‘Our Health & Care Strategy’ document developed by the Executive Team.
- Set of questions developed (see Appendix 2) to ensure consistent feedback was obtained from staff and stakeholders during March to July 2015. There were over 400 staff involved in discussions to support the development of the strategy document.
- Engagement with the Locality Assistant Directors, taking into consideration the CCG operational plans for the individual localities.
- Engagement and sharing of the high level document with NCC who were reviewing their strategies at the same time. NCC shared documents related to their strategy development (expected to be finalised in January 2016) with NCH&C.
- Updates on Our Health & Care Strategy were provided during April and May 2015 within the Trust Weekly news and the high level document shared via the Intranet to obtain further feedback.
- Dedicated (April 2015) inbox for Our Health & Care Strategy, calling staff for ideas and further feedback.
- High level document was shared with the Trust Board, Governors, CCGs and follow up meetings arranged to obtain further feedback and engagement.
- The future development of Our Health & Care Strategy was discussed at the Sustainable Models of Care workshops (6th and 20th January 2015) which included observers from HealthWatch and Commissioning organisations. The high level document for Our Health & Care Strategy, together with set questions, were discussed in detail as part of the follow up Sustainable Models of Care workshop delivered on 28th April 2015.
- Focus groups organised for Children and Young People, Specialist Services and Social Care to discuss Our Health & Care Strategy and the relevance of the Levels of Care model to these specific groups.
- Meetings arranged with the Voluntary sector to discuss the high level document and informal commitment to support the implementation of Our Health & Care Strategy obtained.
- Carers Council for Norfolk – informal meetings are being arranged to support the strategies for both organisations.
Patient Voice – via board reports, compliments and complaints were used to identify key areas to support the development of Our Health & Care Strategy document. Focus patient groups will be organised to obtain further more detailed feedback and insight over the coming months. The delivery group, ‘Health and Care Council’, will work on developing and implementing these groups from November 2015 and will review the continuation of these groups within the first year, November 2016. Key stakeholders will be involved in these patient focus groups to work on the current and future community based patient pathways.

6.2 Stakeholders feedback

All feedback has been consolidated and used to support the development of the strategy document. A summary of the feedback consolidated during the engagement programme has been captured, see Appendix 2.
7  NCH&C achievements so far

We have successfully been rated as Good by the CQC inspection report (December 2014), and are in a secure financial position. However, the Trust needs to make cost improvement savings of circa £11.4 million over the next two years (2015-2017). Staff have been informed and engaged in this through the Sustainable Models of Care workshops (January and April 2015). Clinical staff engagement is crucial to delivering the cost improvement savings in the right areas whilst ensuring that quality or safety in care are not compromised.

In the latest NHS Friends and Family patient survey (July 2015), 99% of patients said they would recommend the care they receive from NCH&C.

We are pursuing NHS Foundation Trust status which will have a number of benefits to the organisation, staff and patients we serve, these include: improving outcomes; improving quality; strengthen the business of the organisation; attracting and retaining talented staff; supporting service integration; and promoting system sustainability and quality. NCH&C as a strong independent provider will support commissioners in stimulating collaboration and competition within the local health and care economy.

NCH&C has successfully delivered an ambitious programme of internal transformation. This has resulted in large-scale clinical and systems redesign, improved care for patients through innovation, and secured investment in technology, staff training and improved efficiency through utilising estates more effectively.

Further information of the results achieved through the transformation programme and quality initiatives are detailed in our Quality Account:

Examples of the results achieved include:

- Efficiencies savings of £1.9m through the transformation of the Community Nursing and Therapy service; increasing face to face clinical care by reducing the non-clinical activities.
- Development of Care Plans enhancing communication and feedback on current and future care plans for patient, reducing duplication of care and process.
- Increase in teams utilising eRostering to manage capacity, reducing non-clinical time spent managing capacity and ensuring key capabilities are available at the right times.
- Increase in engagement sessions with clinical staff to support innovation and areas of improvement and gather ideas to further develop/redesign clinical services.
- Increase in investment and use of technology, e.g. eBooks utilised by Community Nursing and Therapy service, increasing clinical face to face time with patients from 36% to 62% and increasing.
- Creation of four locality hubs supporting consistency of how services are delivered (through standardisations of processes) and managed across the localities.
- 99% of our patients in community nursing & therapy post transformation would recommend NCH&C to their family (Dec 2014)
- Clinical service developments, e.g. Urgent Care Centre, Hospital care at home service (Virtual Ward) in Norwich; and new medical model.
- Piloting Collaborative Learning in Practice (CLiP) – the training and development of student nurses benefits the local economy in growing the future workforce. NCH&C supporting the programme allows for the future workforce to have crucial experience of working within the community to support future demands of health and care services and understand the need for joined up care across organisation boundaries especially in the community.
- Successful Trust wide implementation of the Behavioural Framework and leadership programmes such as REAL programme to front line staff.
- The Trust Medical Director is one of 17 healthcare pioneers from the UK and abroad identified to receive national support to roll out relevant technologies, processes and models of care to patients, hospitals and GP practices throughout England. This will support NCH&C with improving quality and adopting innovative practices across the organisation.
8  In Summary - Moving forward

Our Health & Care Strategy has been developed together with partners and staff. We will continue to inform and engage with staff, patients, their families and carers of where the Trust is now and where we need to get to in terms of delivering the vision set out in this strategy.

The majority of services delivered by NCH&C will work within the Levels of Care model. Referrals received will be managed initially by senior staff, detailed assessments will be undertaken, care will be coordinated, care plans will be developed and care delegated to a new workforce of bands 1-4 staff with appropriate supervision frameworks in place. Patients will have the minimum number of separate visits and consultations that are necessary, with access to specialist advice in appropriate locations within the community. The use of different skill-mix and the increase in multidisciplinary working, along with maximising the use of technologies will improve access and convenience for patients, their families and carers and enhance organisational efficiency. We will support and empower people and their carers to remain at the centre and in control of their health & care and we will also develop formal partnerships with the voluntary sector to deliver the vision.

As with national agenda, NCH&C will be implementing health promotion initiatives, working closely with GPs and working towards a seven day working week which will require further changes to how services will be delivered. Developing the right workforce, at the right levels and in the right numbers is critical to achieving the national and local requirements.

There will be significant work for local partners in health and care to undertake so that true alignment of our services achieves the desired patient outcomes and ensures that services are both clinically and financial viable in the long term. Continuing as we are is not option and a significant shift in both mind set and capabilities is required for the local health and care economy to benefit patients, their families and carers and manage the increasing demand.

The success of Our Health & Care Strategy will depend upon early engagement of everyone concerned within the local economy and having a practical focus on how best to build and implement the five year implementation plan. The delivery group, ‘Health & Care Council’, will help support this early engagement. This will require a combination of clinical expertise, the voices of patients, carers and service users and the commercial acumen from our corporate teams.

The Five Year Forward View sets out the need to move away from the short-term answers into longer term more radical solutions. NCH&C envisions that Our Health & Care Strategy will support the step changes required to allow for patients to be looked after locally.
# Outline of 5 year implementation plan

High level descriptions of the key activities that will be undertaken once the final strategy is approved are listed below. Detailed plans and timescales will be developed working together with partners, staff and patient groups.

<table>
<thead>
<tr>
<th>Key activity</th>
<th>Outcomes to be achieved</th>
</tr>
</thead>
</table>
| Develop patient/family and carer focus groups linked to the Levels Of Care Model | Present the Levels of Care model for service specific conditions and patient pathways  
- Focus groups to inform the patients’ needs at each level and desired workforce skill mix to help build the Levels of Care model for each service.  
- Build on existing groups e.g. Carers for Norfolk locality |
| Consultation with staff, partners on the membership of the Health and Care Council | Formation of NCH&C delivery group – ‘Health & Care Council’ to coordinate and oversee changes required to support implementation of Our Health and Care Strategy.  
- Agreed terms of reference for the Health & Care Council delivery group.  
- Agreed membership for the Health & Care Council, representing clinical services, localities, key partners, patients, families and carers.  
- Agreed outcomes to be achieved via the delivery group and communicated to corporate and front line staff plus partners. |
| Refresh the existing Workforce strategy 2012-2017 – incorporating workforce planning over the next 5 years | Workforce strategy is refreshed and refined which links with Health Education East of England (HEE): Grow your own agenda  
- Grow your own – developing staff within band 1-4 and above for NCH&C providing guidance on clinical and managerial career pathways with support of the local health and care economy.  
- Talent management programme developed together with the local health and care economy to support growing your own future leaders. Utilising the recommendation from the June 2015 Rose review.  
- Titles, positions and roles become more streamlined across the Trust to support understanding of functions, roles and responsibilities.  
- Retention and recruitment plans developed for general staff required to meet the increasing demands.  
- Focus staff surveys used to support implementation of the strategy, supporting innovation and engagement. |
| Formal arrangements in working with Carer Council for Norfolk | Structured programmes of activities developed to engage utilising existing Carers forums to obtain feedback and insight to refine existing services and redesign future patient pathways.  
- Build on existing carers assessments programmes to support health and wellbeing agenda. Linking with voluntary and charities within localities. |
| Develop and implement new working arrangements with voluntary organisations that are aligned to services and Trust values | Build on scoping of local voluntary organisations for Norfolk and incorporate organisations that can support Suffolk services delivered by NCH&C.  
- Formalised engagement with voluntary organisations which can support NCH&C community services.  
- Development of formal contractual agreements on how the organisations can support each other with the increasing patient demand and address current gaps in pathways of care and improve patient experience.  
- Establish ways to measure the value of volunteering to the various levels within the patient pathway.  
- Robust online directory of voluntary and charity organisations for Norfolk, Suffolk and other locations where NCH&C delivers community services. |
<table>
<thead>
<tr>
<th>Key activity</th>
<th>Outcomes to be achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Development of Trust Voluntary strategy working with key partners. Clear structure developed for how volunteers are working within localities for both Adult and Children and Young People services.</strong></td>
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</tr>
<tr>
<td><strong>Develop on-going staff engagement using existing meeting forums. Learning from the engagement programme for Our Health &amp; Care Strategy. Continue with inbox to capture on-going feedback to support implementation phases.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Our Health &amp; Care Strategy discussed on a regular basis utilising existing team/departmental meeting forums</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Feedback captured via existing mechanisms and taken forward to Care Council delivery group.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Our Health &amp; Care Strategy a regular feature in weekly news, plan of activities developed for 6 month periods and robust feedback mechanisms developed.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>System leadership with partners in local health and care economy</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Clear consistent operational plans for ‘Out of hospital care’ developed, building on existing operational plans for each of the CCGs with close working with GPs, social care and voluntary sector.</strong></td>
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</tr>
<tr>
<td><strong>Clear plans to address ‘bottlenecks’ to children services such as community paediatrics where voluntary partnership can help address the gaps in the current pathways e.g. parenting programmes.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Over time reduction of caseload held by complex services due to existing gaps in patient pathways identified and improved with additional services commissioned.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Increase in proportion of new patients seen to follow-ups over time.</strong></td>
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</tr>
<tr>
<td><strong>Standardisation of processes achieved for key services delivered across the localities to support improvements in quality of care, building resilience especially for specialist services.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Coordination roles further developed across the localities to support complex care management.</strong></td>
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<tr>
<td><strong>Optimising existing digital technologies to support the implementation of Our Health &amp; Care Strategy</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Refresh Information Management and Technology strategy to support implementation of Our Health &amp; Care Strategy.</strong></td>
<td></td>
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<tr>
<td><strong>Refine management dashboards developed and implemented to support alignment of Trust goals and objectives with front line services.</strong></td>
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</tr>
<tr>
<td><strong>Development of a Health Informatics Service (funded together with local partners) to develop digital solutions e.g. self-care web tools, real time service directory to support the urgent care agenda.</strong></td>
<td></td>
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<tr>
<td><strong>Digital tools to support delivery of care e.g. Skype, Face time and texting messaging.</strong></td>
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<tr>
<td><strong>One single point of entry to services ‘one stop shop’ with navigation tools to support robust signposting.</strong></td>
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<tr>
<td><strong>Simplified commercial support for front line staff</strong></td>
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<tr>
<td><strong>All staff have a clear understanding of service specification e.g. service specification on one page.</strong></td>
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<tr>
<td><strong>Meaningful performance metrics both internal and external understood by front line staff.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Less task related workforce and more innovative flexible engagement achieved.</strong></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 1: Health profile summary

Norfolk County

The recent (June 2015) Joint Strategic Needs Assessment\textsuperscript{10} confirmed Norfolk’s population to be estimated at 877,700 in mid-2014 – an increase of around 6,700 on the previous year.

Population changes and predictions from this assessment included the following:

- **Norfolk’s population** has increased by 7.6\% over the last decade (2004), compared with an increase of 9.3\% in the East of England region and 8.2\% in England.
- For 2037, there is projected growth of 140,400 people in Norfolk – this is an increase of 16.2\% which is similar to the national figure but below the East of England region’s projected increase of 20.1\%. The largest increase in numbers is projected to be in **South Norfolk**.
- Numbers of **children and young people** in the county (aged 0-17) rose marginally.
- Numbers of working age adults (aged 18-64) increased by around 19,100.
- Numbers of **older people** (aged 65 and over) increased by around 39,200 (23.6\%).
- The estimates for mid-2014 confirm that Norfolk’s population has a much older age profile than England as a whole, with 23.4\% of Norfolk’s population aged 65 and over, compared with 17.6\% in England.
- Norfolk’s **oldest age groups** are projected to grow the quickest in the next decade – with the 75-84 year olds projected to increase by 32.9\% and the 85 and overs projected to increase by 39.7\%.

Norfolk Districts & Suffolk

NCH&C delivers community services to four main districts in Norfolk which are North, South, Norwich and West. It also delivers services in Suffolk. The health summaries of each are described below.

<table>
<thead>
<tr>
<th>District health profile</th>
<th>Health Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>Population: 102,000.</td>
</tr>
<tr>
<td></td>
<td>Health of people in North Norfolk is varied compared with the England average.</td>
</tr>
<tr>
<td></td>
<td>Deprivation is lower than average, however about 14.9% (2,100) children live in poverty.</td>
</tr>
<tr>
<td></td>
<td>Life expectancy for both men and women is higher than the England average.</td>
</tr>
<tr>
<td>South</td>
<td>Population: 128,000.</td>
</tr>
<tr>
<td></td>
<td>Health of people in South Norfolk is generally better than the England average.</td>
</tr>
<tr>
<td></td>
<td>Deprivation is lower than average, however about 10.9% (2,300) children live in poverty.</td>
</tr>
<tr>
<td></td>
<td>Life expectancy for both men and women is higher than the England average.</td>
</tr>
<tr>
<td>Norwich</td>
<td>Population: 136,000.</td>
</tr>
<tr>
<td></td>
<td>Health of people in Norwich is varied compared with the England average.</td>
</tr>
<tr>
<td></td>
<td>Deprivation is higher than average and about 27.1% (6,100) children live in poverty.</td>
</tr>
<tr>
<td></td>
<td>Life expectancy for both men and women is similar to the England average.</td>
</tr>
<tr>
<td>King’s Lynn &amp; West Norfolk</td>
<td>Population: 149,000.</td>
</tr>
<tr>
<td></td>
<td>The health of people in King’s Lynn and West Norfolk is varied compared with the England average.</td>
</tr>
<tr>
<td></td>
<td>Deprivation is lower than average, however about 17.4% (4,300) children live in poverty.</td>
</tr>
<tr>
<td></td>
<td>Life expectancy for women is higher than the England average.</td>
</tr>
<tr>
<td>Suffolk County</td>
<td>Population: 736,000.</td>
</tr>
<tr>
<td></td>
<td>The health of people in Suffolk is generally better than the England average.</td>
</tr>
<tr>
<td></td>
<td>Deprivation is lower than average, however about 15.1% (18,900) children live in poverty.</td>
</tr>
<tr>
<td></td>
<td>Life expectancy for both men and women is higher than the England average.</td>
</tr>
</tbody>
</table>

*Information sources from [www.healthprofiles.info](http://www.healthprofiles.info)
### CCG population and adult social care information Norfolk

Table below describes the demographics of the local population and key social care information for each of the four CCGs across Norfolk. NCH&C delivers community services across each of the four CCGs and has a joint integrated management structure for adult services.

<table>
<thead>
<tr>
<th>CCG</th>
<th>Population in Norfolk</th>
<th>Key information on adult care for each CCG</th>
</tr>
</thead>
</table>
| North     | 93,636 42,933         | - A smaller proportion of people aged 65+ accessing services for physical disabilities - likely to be because of fewer people being eligible for care in relatively affluent areas, rather than because of an absence of overall need  
- Significantly higher proportion of people with learning disabilities receiving services  
- A higher proportion of people receiving residential care. Likely to be because of a higher proportion of people in the very oldest age groups, and in some rural areas because of a lack of community-based alternatives to residential care (so less home care etc.). |
| Norwich   | 134,672 33,071        | - Higher proportion of older people receiving services. This is likely to be because of a relatively high proportion of older people in the wider Norwich CCG area, and because of a high number of eligible older people in some deprived areas.  
- Expected higher proportion of people with mental health problems, reflecting Norwich's large urban area.  
- A lower than average take-up of all main service groups. |
| South     | 134,281 48,359        | - Lower proportions of service users compared to the county average for all service user types - which is likely to be because of lower overall levels of eligibility in areas that are generally more affluent  
- A lower than average take-up of all main service groups - also likely to be because of lower levels of eligibility for services |
| West      | 94,395 39,656         | - Dispersed distribution of social care service users, with relatively high numbers in some rural areas, as well as parts of King’s Lynn, Swaffham and Downham Market  
- Relatively low proportion of older people in each service user types compared to the county rate, despite overall high numbers of older people in the population. This is partly because the county rate reflects particularly high levels of older service users in the Norwich and Health East CCG Areas.  
- Broadly similar breakdown of service types to the rest of the county |
| Total     | 456,984 164,019       |                                                                                                            |

**Note:** Information collated for all 4 CCG (2012 data) via [http://www.norfolkinsight.org.uk/jsna/ccg](http://www.norfolkinsight.org.uk/jsna/ccg)
### Appendix 2 - Summary of feedback consolidated following staff engagement (March – June 2014)

#### 1. Does the proposed Levels Of Care Model make sense to everyone?

<table>
<thead>
<tr>
<th>Examples where further details/information was required or the proposed model was not clearly understood</th>
<th>Examples where the information presented appeared to be understood</th>
</tr>
</thead>
</table>
| ▪ Not clear where non-clinical or support services fits within the model e.g. estates.  
▪ No transition from children to adults services.  
▪ No - not to patients and may not drive behaviours and changes we want. Always want to be promoting independence, so want a model which is flexible. Could be a useful model for looking at finances. | ▪ As long as the framework is clear and resource requirement understood, this might work.  
▪ Build in learning from patient experience.  
▪ Model is sensible but need to be aware of unstructured process.  
▪ Take the building out of the model - what does the patient need - remove reference to place then the model makes sense.  
▪ Model does reflect national shift towards self-management.  
▪ Yes understand fully but not enough resources to deliver under current commissioned models. |
| ▪ Do NCHC or service users decide which level a patient sits at?  
▪ Will one person/service provide L1 to L4 or will there be one person/service delivering care for each level?  
▪ Not clear, more clarity/discussion into what goes into the each level.  
▪ Where do the patients go that are in-between the levels? | ▪ Voluntary services have a part to play at every level.  
▪ Be more emergent instead of trying to plan what we can't plan.  
▪ Needs to be fully integrated with Acute/Social Services /Voluntary sectors/CCGs.  
▪ Yes. Useful tool for commissioning/staff /holistic care planning.  
▪ General consensus is that care model does make sense but the wording could be streamlined and simplified to make the meaning clearer. |
| ▪ Yes, if well defined then should tell us what skills we need.  
▪ Health coaching, decision making, Governance e.g. understanding boundaries.  
▪ Not explicitly. Needs to depict the need for skills with each level, to cascade learning/skills to lower levels.  
▪ Training/support for other providers/agencies.  
▪ All staff at all levels need to be highly skilled in advanced communication/mentoring to support/develop self-enablement plan. | ▪ We need to understand where we expect to have the greatest input into the care model.  
▪ Our staff model will depend upon where our core business sits.  
▪ All staff will need to understand case management (this needs structure), need better access to diagnostics, near patient testing etc.  
▪ More money & resources into preventative, educational and use of more voluntary services.  
▪ Model supports workforce planning, not actual clinical skills.  
▪ All disciplines so different and individual. |

### 2. Does the refined model support the Trust to understand what skills staff will need in the coming years?

<table>
<thead>
<tr>
<th>Examples where further details/information was required or the proposed model was not clearly understood</th>
<th>Examples where the information presented appeared to be understood</th>
</tr>
</thead>
</table>
| ▪ Not enough definition or explanation of descriptions /levels.  
▪ Needs more detail - Trust needs to commit and fund plus plan time to release staff off to obtain the relevant training.  
▪ It is a start - a place to begin the more detailed work.  
▪ The model needs to clearly define the skills in each level for specialist services. | ▪ As long as the framework is clear and resource requirement understood, this might work.  
▪ Build in learning from patient experience.  
▪ Model is sensible but need to be aware of unstructured process.  
▪ Take the building out of the model - what does the patient need - remove reference to place then the model makes sense.  
▪ Model does reflect national shift towards self-management.  
▪ Yes understand fully but not enough resources to deliver under current commissioned models. |
| ▪ Yes, if well defined then should tell us what skills we need.  
▪ Health coaching, decision making, Governance e.g. understanding boundaries.  
▪ Not explicitly. Needs to depict the need for skills with each level, to cascade learning/skills to lower levels.  
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NCH&C NHS Trust Our Health and Care Strategy 2015-2020  
Final 21st September 2015
3. Where should the Trust focus our attention in the coming years?

- What we are good at (skill set)?
- What brings in the most income?
- What the CCGs want to commission/need?
- We shouldn’t spread ourselves too thin.
- What is the forecast of the need?
- Need to focus in areas of less competition or in the areas we are most effective.
- Why don’t we have apps and social networking.
- More educational & professional online services for clients re: medical conditions - self improvement.
- Focus group for patients regarding this document, their views, what do they want, need.
- Improved engagement with CCG so services may move forward more rapidly and integrated working (e.g. Social Services, acute trust).

As a Health and Social Trust we should put more focus on L4 but utilise partner agencies where possible. Third sector/charity/voluntary etc. and our skill mix will then grow using bands 3s, 4s in L4.
- First three levels are core business.
- Need to be involved in level 4 but not necessarily have to deliver it all.
- Workforce changes to smaller proportion of highly skilled and higher proportion of generic highly trained staff moving up and down the levels of care model.
- Signposting of services.
- Competency of staff, patient safety & workforce appropriately skilled.

Integrating more with social care.
- Level 4 - demand is greatest here, more work is needed, lower banded workforce, self help - seen as a potential weakness at the moment.
- Need to reduce the inconsistencies.
- Perhaps co-ordinator roles to keep an eye on third party support, clubs and groups in the area.
- Identifying partners, focus on complex assessments/review delegate and hand over care.

Up skilling the generalist workforce and investing in them.
- Better use of Band 3s in nursing.
- Develop a core skill set.
- Sort the specifications, simplify for clinical staff to understand and deliver to them.
- System wide collaboration.
- Joint assessment (common system) - health/social voluntary - to support patients / carers, stay at home.
- Reassessment at the right time.
- Use of IT/social media etc. to reach wider population.
- Managing expectations of service users/stakeholders.
- Clear career pathways required.

4. What must the Trust do to have a clear view on what we absolutely must do in terms of services we directly deliver?

- Review profile of localities.
- What clinical skills are required, what we are commissioned to do, organisations that can deliver for less, commence partnership working arrangements.

SLAs/specs -service spec which explains what is expected vs delivering, posters already started and need to finish these.
- Control and review mechanisms to ensure we are sticking to this, with flexibility and tolerance of a certain amount of clinical judgement for exceptions - factor into model once understood.
- Training for managers & staff to ensure understanding & confidence.
- All specs, KPIs visible.

Clear service specifications - spec on a page.
- Commissioners & CCGs, working better with them, understanding what they can have.
- Clearly aligned support service strategies.
- Trust each other, accept an initial assessment ‘patient telling their story once’.
- Empower the patient and carers.
- Clarify our core business.

We need everybody to understand the strategy.
- Joined up working (across services) is vital in sub-acute phase.
- Seven day a week service - across all relevant services, inc. GPs.
- Developing clear service standards for each service, adopting team models which incorporate levels of standards/care.
- Competencies developed, linking skills, training to support current and new workforce.
5. What are the types of services we can deliver with partners?

- Everything potentially, need to know who partners are, how they are related to pathway of cares and at what stage.
- Wellbeing services – therapy.
- Referring to exercise referral scheme e.g. local gyms etc.
- Education providers e.g. Heart UK.
- What do the patients want / need.
- All services need partnerships.
- Robust assessment tools.
- End of Life - hospice / symptom management.
- Patchy across Norfolk need more information.
- Experience of staff to date not encouraging in relation to partnership working.

- L1 NCH&C only.
- L2 partnerships for diagnostics, linking with volunteers.
- L3 partnerships for diagnostics, exercise via websites.
- L4 partnerships for diagnostics, exercise, self management, telemedicine, in-house education, adult education.

- Pharmacy around medication management.
- Level 4 health promotion, supportive care.
- All levels 1-4 involve varying degrees of partnership working.
- Level 3 - volunteers/social services assisting with exercises / supportive care.
- Level 1 & 4 – support education/empowerment.

- Identify people in level 4 to support patients, empower carers.
- Need a good directory of services, clear volunteer structure/strategy.
- Health Promotion, support carers
- Information brokers – experts in signposting.

6. What services should the Trust no longer deliver?

- What doesn't fit with the Trust strategy.
- Should we grow by focussing on what we do well and speedily and leaving behind what we don’t do.
- Service specifications - not known by all.
- Stop services that do not add value.
- This makes some roles feel vulnerable.
- Everyone in group struggled to answer this question.

- Services which don’t make any money, services which could easily be provided by other organisations/voluntary sectors.

- Anything that is not cost effective or where someone can do better for same or far less.
- Specialists e.g. new interventions/working practices from other trusts, we should be paid for these services.

- Financially unsustainable services, any service not paid for or modelled within capacity planning.
- Time limited projects requested with CCGs with no exit plan or contract.
### 7. Where are the opportunities locally and nationally to support NCH&C to deliver the levels care model, meet the growing demand and continue to be successful as an organisation?

- Development of frailty as a condition and develop an assessment tool to inform practice.
- Provides measured outcomes.
- 5 year forward plan/community first, integration, frail & elderly - virtual wards.
- Links with Health Education
- Seven day working by therapy, medical staff and social care staff,
- Continuing care- childrens and adults - Norfolk and Suffolk.
- Use of Better Care Fund.
- Integrated working linking with voluntary sector, need more information on demographics.
- Research NNUH/UEA new areas of care to see what does/doesn't work & pilots.
- Simple referral process will improve efficiency.

### 8. Can the Trust via this engagement with staff and stakeholders start to create integrated care pathways?

- Yes but we need greater classification of the model.
- What are the benefits to us?
- Cost/Volume model. Making sure we are well represented need to be at the table of right groups.
- Yes- but need good, working understanding of our own services provided first.
- Reduce duplication e.g. Assessments, etc.
- Yes.
- Patient / carer focus groups, partnerships with stakeholders.
- Expert patient (Level 4).

### 9. Can the Trust start to develop a list of basic services which are purchased from other providers?

- Get ‘own house in order’ and then look at partnerships working.
- Look at removing divide between specialists/childrens.
- Small specialist services (unless resilience built into service).
- Pooling resource with integration pathways.
- Disease specific associations.
- Voluntary sector.
- Leisure industry / centres.
- Public Health.
- Yes. The discussion on the care strategy needs to be take place at team meetings so staff are engaged and involved in the development and implementation of the strategy.
- Focus groups for adults and childrens need to take place linking with social care.
- Workforce planning/development should start to take place together with this strategy as they are linked.
- Apprenticeships.
- Review complaints and complements to review what is working well for the Trust. This will support which services should be kept or purchased elsewhere.
Appendix 3 – Levels of Care model

The high level document developed as part of the engagement programme included a proposed Levels of Care model for all services; this was discussed and updated following feedback for Adult services.

During the engagement programme it became apparent that the model as described was not suitable for Children and Young People and a new model developed. There are now two agreed versions of the Levels of Care models which are described below.

Appendix 3a: Adults

Appendix 3c: Children and Young People
Appendix 3a – Levels of Care model – Adults

Levels of care for NCH&C Trust for Adult Services

**Level 1 (a & b)**
- L1a - Specialist units e.g. Regional Specialist Rehabilitation Services.
- L1b - Community hospital/virtual ward (approx. one third) used for this purpose, flexible agreed criteria to accept patients/service user from acute, community, and care homes, who require intensive medical and nursing rehabilitation.
- Access to 24/7 medical support available.
- Workforce – skilled with assessment capabilities, prescribing, diagnostics and advanced clinical skills.

**Level 2**
- Specialist services provide support to patients/service user with complex conditions who require support from specialists outpatient services e.g. community paediatrics, community dental services, older people medicine and specialist intensive nursing /case management including high users of GP/Acute services.
- Serving a small proportion of the local population with complex health and social care needs that can be predominately met in the community environment.
- Multi-disciplinary teams working across primary, secondary, tertiary and community boundaries.

**Level 3**
- Community hospital/virtual ward (approx. two thirds) used for this purpose, strict agreed criteria to accept patients/service user from acute.
- Nurse led service with joint management arrangements with therapy and social care.
- Workforce – skilled with assessment capability including social care, prescribing, access to regular monitoring, access to medical support, advanced discharge planning processes adopted, with use of care home beds available as required.

**Level 4**
- Community services delivering generic health and social care service across the four localities for adults and children.
- Working with organisations to help deliver the level of care required, empower and re-enable patients/service user, support carers and families.
- Formalise opportunities for sub-contracting, partnership working with voluntary and independent sectors to support patients/service user, carers and families.
- A less specialised Workforce and more generic in the level of support delivered (supported by training from specialists in Levels of Care 1-3).
- Signpost and work with levels 3 & 2 services and specialist hubs.

Involving voluntary sector & supporting carers
Appendix 3b – Detailed care settings and patient/service user types – Adult Services

**Level 1 (a & b) – Sub-acute**
- Community hospital/virtual ward (one third) used for this purpose, flexible agreed criteria to accept patients/service user from acute, community and care homes.

**Level 2 – Case/Care Management**
- Complex specialist services that can be delivered in the community settings as an outpatient function e.g. community paediatrics, community dental services, older people medicine and specialist nursing/case management.
- Multi-disciplinary teams working across primary, secondary, tertiary and community boundaries.

**Level 3 – Rehabilitation/Re-enablement**
- Community hospital/virtual ward (two thirds) used for this purpose, strict agreed criteria to accept patients/service user from acute and community.
- Nurse led service with joint management arrangements with therapy and social care.

**Level 4 – Wellbeing & Prevention**
- Community services delivering generic health and social care service across the four localities.
- Peer support/expert patient programmes.

**Overall aim by 2020**
- Demonstrate an increase in patients/service user treated and managed locally (community) in Norfolk for both health and social care needs
- Increased percentage of highly skilled staff who are engaged with the Trust goals and objectives
- Demonstrate superior performance in health and social care delivery

**Level 1 (a & b)**
- **Care settings**: seen in community hospitals, patients/service user own homes, care homes
- **Patient/service user types**:
  - Patients/service user who are suffering from sub-acute illness with unstable and unpredictable needs
  - Referred from GP or A&E

**Level 2**
- **Care settings**: Community clinics, specialist inpatient units, patients own homes, care homes utilising technology facilities to support MDT approach
- **Patient/service user types**:
  - Complex patients/service user with multiple health and social care needs
  - Patients/service user with learning disabilities and neurological conditions
  - Patients/service user who were seen in outpatient facilities in the Acute that can now be seen in the community settings
  - Patients/service user with joint care arrangements
  - Specialist Palliative Care

**Level 3**
- **Care settings**: seen in Community Hospitals/patients own homes/care homes
- **Patient/service user types**:
  - Patients/service user from Acute who are medically fit but require nursing input and intensive monitoring.
  - Patients/service user referred via the GPs that need nursing input and monitoring.
  - Patients/service user requiring therapy led rehabilitation
  - End Of Life
  - Supporting other providers with respite care

**Level 4**
- **Care settings**: partner organisations facilities and other settings e.g. care homes, disabilities centres, GP centres, children centres, day hospitals
- **Patient/service user types**:
  - Well managed Long Term Conditions
  - Children 0–19, universal pathway
  - Re-enablement
  - Wellbeing clinics – walk in patients
  - Patients/service user who benefit from education, training and self-monitoring advice
Appendix 3c – Levels of Care model – Children and Young People

Levels of care for NCHC Trust – Children and Young People

Level 1
- Complex community health assessment and intervention – for children with complex health and/or complex neurodevelopmental needs – e.g. children who require a multi disciplinary range of specialist community assessments and interventions that work together around the child.
- Referrals via SPOR (Single Point of Referral) but will mostly be referrals from Level 2 up to Level 1 (within NCH&C referrals).
- Hours - majority are 9-5 with some variation (e.g. Community Nursing).
- Community children’s services including Consultant Community Paediatricians, Psychology, Nursing, OT etc.
- Working in partnership with other key agencies (e.g. County Council).

Level 2
- Specialist community assessments and interventions for children and young people with complex health and/or developmental needs.
- Including referral for a uni-professional or targeted assessment and intervention.
- Interventions delivered in the community and may be delivered by ‘unqualified staff’ under supervision of qualified clinicians.

Level 3
- Empowering others (parents, other partners and agencies) to provide support and intervention for children with complex health and/or neurodevelopmental needs in the community.
- Targeted workshops (delivered by Staff from levels 2 and 3).
- Specialists from Levels 2 and 3 enabling others to deliver intervention, e.g. SLT designing interventions delivered by schools.
- Training and consultation to key partners.

Level 4
- Community services delivering generic health and social care service across the four localities for children and young people.
- Formalise opportunities for sub-contracting, partnership working with voluntary and independent sectors to support children and young people, parents / carers and families.
- Signpost and work with levels 3 & 2 services.
Appendix 3d – Detailed care settings and patient/service user types – Children and Young People

Level 1 – Complex Assessment and Intervention for children with complex health and/or developmental needs.
- Complex specialist services delivered in the community settings as an outpatient function e.g. community paediatrics, Learning Disability CAMHS, Psychology, Community Nursing etc.
- Multi-disciplinary teams working across agencies.

Level 2 – Specialist Assessment and Intervention
- Specialist Assessment and intervention for children with complex health and/or neurodevelopmental needs.
- Delivered in the community.

Level 3 – Empowerment and Engagement
- Empower others and enhance skills of others to meet the needs of children with Complex health and neuro disability, including parents, and other agencies and partners.
- Consultation and training consistent with criteria developed.

Level 4 – Wellbeing & Prevention
- Community services delivering generic health and social care service across the localities.
- Peer support/expert programmes.

Level 1
- Care settings: Community clinics, ‘in-reach’ to inpatient settings, CYP own homes, respite provision, care providers, schools, education provision etc.
- CYP user types:
  - Complex CYP with multiple health and social care needs
  - CYP with learning disabilities and neurological conditions and complex and challenging behaviour
  - CYP who were seen in outpatient facilities in the Acute that can now be seen in the community settings

Overall aim by 2020
- Demonstrate an increase in patients/service user treated and managed locally (community) in Norfolk for both health and social care needs
- Increased percentage of highly skilled staff who are engaged with the Trust goals and objectives
- Demonstrate superior performance in health and social care delivery

Level 2
- Care settings: seen in clinics, CYP own homes, respite and care providers, education settings
- CYP types:
  - Children who require specialist assessment of their complex health and/or neuro developmental needs (and associated behaviour) specific to the professionals skills and expertise
  - Referral via SPOR

Level 3
- Care settings: seen in Community Hospitals/patients own homes/care homes/children’s centres/schools etc.
- CYP user types:
  - CYP where there are concerns about complex health and/or neuro-disability and behaviour
  - CYP where the needs are mild and emerging and/or can be supported by empowerment and skill building in others (supported by specialists within NCH&C)
  - Specialists (NCH&C) provide consultation, training and advice to deliver this

Level 4
- Care settings: partner organisations facilities and other settings e.g. care homes, GP centres, children centres, day hospitals, education settings
- CYP user types:
  - Well managed Long Term Conditions
  - Children 0 – 19, universal pathway
  - CYP and families who benefit from education, training and self-monitoring advice
## Appendix 4 – Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOC</td>
<td>Levels of Care</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group Norfolk</td>
</tr>
<tr>
<td>NCHC</td>
<td>Norfolk Community Health and Care</td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Conditions</td>
</tr>
<tr>
<td>NCC</td>
<td>Norfolk County Council</td>
</tr>
<tr>
<td>HEE</td>
<td>Health Education England</td>
</tr>
</tbody>
</table>
Appendix 5 – References


3. Improving quality of life for people with long term conditions, Department of Health 2012


15. KPMG Creating value with patients, carers and communities 2014.

