

HEALTH SCRUTINY PANEL
29 MAY 2013
ADULT INTEGRATED CARE PROGRAMME
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

- 1.1 To hear about work taking place to integrate health and social care services in Nottingham through the Adult Integrated Care Programme.

2. Action required

- 2.1 The Panel is asked to use the information provided at the meeting to inform questioning and discussion about the Adult Integrated Care Programme.

3. Background information

- 3.1 There are strong national and local drivers for increasing integration of health and social care. Commentators argue that fragmented services fail to meet the needs of the population and that greater integration can improve the patient experience and health and social care outcomes, and increase efficiency in care provision. There are increasing pressures from an ageing population and increases in numbers of people with multiple long-term conditions.
- 3.2 On 14 May 2013 the Care and Support Minister launched a commitment to co-ordinating health and care. Plans, to be delivered by national and local partners include:
- a) An ambition to make joined up and co-ordinated health and care the norm by 2018 – with projects in every part of the country by 2015;
 - b) An agreed definition of what people say good integrated care and support looks and feels like (see paragraph 3.3);
 - c) ‘Pioneer’ areas around the country appointed by September 2013; and
 - d) New measures of people’s experience of joined up care and support by the end of this year.
- 3.3 Commissioned by NHS England, National Voices (national coalition of health and social care charities) has developed a definition and narrative for integrated care. This is attached at Appendix 1.
- 3.4 The Adult Integrated Care Programme was established in July 2012 to change the way health and social care is commissioned and provided for older people and those with long term conditions. It is supported by

Nottingham City Clinical Commissioning Group and the City Council. In a report to the Health and Wellbeing Board in December 2012 it was stated that the vision was that “through integrated strategies, within 3-5 years, citizens will see a transformed health and social care system where there is:

- a) Early identification and intervention of on-going health and social care needs.
- b) Support to ensure that citizens are empowered to manage their own condition/s.
- c) A proactive approach to identify citizens at risk of needing an increased level of care to ensure appropriate support is in place before a crisis situation occurs.
- d) The right care delivered at the right time through primary care, community services and social care working together in localities; accessing secondary care appropriately.
- e) Coordinated care through services being delivered by multi-disciplinary teams holding regular MDT meetings.
- f) Personalised care planning with access to appropriate specialist support in the community.
- g) Improved transition of care between community and hospital setting.”

3.5 The Programme comprises four projects:

- a) Co-ordinate care – a new model changing how primary care, community health services and social care services are commissioned and delivered, emphasising joined-up care and proactive support.
- b) Independence pathway – a new model of assessment and rehabilitation, enabling people to remain as independent as possible.
- c) Single front door – building on existing work in Nottingham CityCare to deliver a joint, single point of access to health and social care services.
- d) Assistive technology – supporting the early intervention and prevention approach will be integrated assistive technology, harnessing products and services designed to enable independent living.

3.6 The Programme Manager for Adult Integrated Care will be attending the meeting to provide information on the aims and directions of the Programme and how it will be supporting priorities contained within the Joint Health and Wellbeing Strategy, an overview of the work streams and the intended outcomes for citizens.

4. List of attached information

4.1 The following information can be found in the appendices to this report:

Appendix 1 – National Voices ‘A Narrative for Person Centred Co-ordinated Care

5. **Background papers, other than published works or those disclosing exempt or confidential information**

None

6. **Published documents referred to in compiling this report**

Report to Health and Wellbeing Board meeting held on 19 December 2012

'Connecting Care' Newsletter January 17 2013

7. **Wards affected**

All

8. **Contact information**

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National Voices

People shaping health
and social care

A Narrative for Person-Centred Coordinated Care

www.nationalvoices.org.uk

www.thinklocalactpersonal.org.uk

@NVTweeting

@TLAP1

About this Narrative

- Commissioned by NHS England on behalf of the National Collaboration for Integrated Care and Support
- Co-developed with the health and care system by National Voices, a grouping of 130 health and social care charities
- Draft based on: research on what matters most to patients and service users; on survey questions that were fully tested with patients; and on consultations with National Voices members
- Refined at a workshop in September 2012, with service users, charity representatives and NHS and social care leaders
- Second draft published for two months feedback in January 2013
- Feedback from commissioners and providers of care, service user organisations and others was analysed and discussed at a workshop in March 2013, and a final version produced
- This final version aligns with TLAP's 'Making it Real' initiative

Summary

Overarching summary – service user perspective

Care planning

My goals/outcomes

Person centred coordinated care

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

Information

Transitions

Communication

Decision making

Subject

(‘Integrated care’ means...)

person centred
coordinated care

**Definition - service user
perspective**

**I can plan my care
with people who work together
to understand me and my carer(s),
allow me control,
and bring together services
to achieve the outcomes important to me.**

**Generic 'I'
statements**

My goals/outcomes

All my needs as a person are assessed.

My carer/family have their needs recognised and are given support to care for me.

I am supported to understand my choices and to set and achieve my goals.

Taken together, my care and support help me live the life I want to the best of my ability.

**Generic 'I'
statements**

Care planning

I work with my team to agree a care and support plan.

I know what is in my care and support plan. I know what to do if things change or go wrong.

I have as much control of planning my care and support as I want.

I can decide the kind of support I need and how to receive it.

My care plan is clearly entered on my record.

I have regular reviews of my care and treatment, and of my care and support plan.

I have regular, comprehensive reviews of my medicines.

When something is planned, it happens.

I can plan ahead and stay in control in emergencies.

I have systems in place to get help at an early stage to avoid a crisis.

**Generic 'I'
statements**

Communication

I tell my story once.

I am listened to about what works for me, in my life.

I am always kept informed about what the next steps will be.

The professionals involved with my care talk to each other. We all work as a team.

I always know who is coordinating my care.

I have one first point of contact. They understand both me and my condition(s). I can go to them with questions at any time.

Generic 'I' statements

Information

I have the information, and support to use it, that I need to make decisions and choices about my care and support.

I have information, and support to use it, that helps me manage my condition(s).

I can see my health and care records at any time. I can decide who to share them with. I can correct any mistakes in the information.

Information is given to me at the right times. It is appropriate to my condition and circumstances. It is provided in a way that I can understand.

I am told about the other services that are available to someone in my circumstances, including support organisations.

I am not left alone to make sense of information. I can meet/phone/email a professional when I need to ask more questions or discuss the options.

Generic 'I' statements

Decision making including budgets

I am as involved in discussions and decisions about my care, support and treatment as I want to be.

My family or carer is also involved in these decisions as much as I want them to be.

I have help to make informed choices if I need and want it.

I know the amount of money available to me for care and support needs, and I can determine how this is used (whether it's my own money, direct payment, or a 'personal budget' from the council or NHS).

I am able to get skilled advice to understand costs and make the best use of my budget.

I can get access to the money quickly without over-complicated procedures.

Generic 'I' statements

Transitions

When I use a new service, my care plan is known in advance and respected.

When I move between services or settings, there is a plan in place for what happens next.

I know in advance where I am going, what I will be provided with, and who will be my main point of professional contact.

I am given information about any medicines I take with me – their purpose, how to take them, potential side effects.

If I still need contact with previous services/professionals, this is made possible.

If I move across geographical boundaries I do not lose me entitlements to care and support.



People shaping health
and social care

A Narrative for Person-Centred Coordinated Care