Integrated Care for Adults

•The Integrated Care Programme for adults was established in July 2012 and is supported by Nottingham City CCG and Nottingham City Council.

•There is a strong national driver to improve services through better integration. Integrated care is seen as being essential to meet the needs of the ageing population, transform the way that care is provided for people with long term conditions and enable people with complex needs to live healthy, fulfilling, independent lives.

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Integrated Care for Adults

- Priority 2 of The Health and Wellbeing strategy states:

  We will improve the experience of and access to health and social care services for citizens who are elderly or who have who have long term conditions.

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For Ada's sake its time for us to
work together better.

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Key themes from the analysis phase

- The current health and social care system is very complex; it is difficult for citizens and clinicians to access appropriate support in a timely way.
- From the stakeholder engagement events it is clear that we do have a strong shared ambition for the future which includes the following characteristics
  - Simplifying the system
  - Taking an holistic approach
  - Citizen centred / Ada centred / seamless
  - Shared information
  - Services integrated across health and social care
  - Single point of access
  - Joint outcomes

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Integrated Care Model

- Our proposal is to reshape services locally so that they are patient focused, Primary Care led and deliver joined up care. The emphasis will be on a more holistic model of care rather than single-disease specific care pathways.
- Implementation will involve a different approach to commissioning, reconfiguration of community health services and social care assessment and delivery as well as strengthening the links to community and voluntary sector resources.

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Integrated Care Model

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Key characteristics of the model

- **Care Delivery Groups** (CDGs)will be made up groups of GP practices and neighbourhood teams comprising health and social care staff.
- 8 CDGs will operate across the City. There is an opportunity to tailor resources to the CDG according to the health inequalities/health needs profile in each area.

Key characteristics of the model

- Care Delivery Groups will be supported by a **care coordinator**. The aim of a care coordinator is to complete administration tasks to release clinicians to focus on direct patient contact and support.

- **Access to and navigation** around services needs to be simplified. A navigator role or service will need to be developed.

Key characteristics of the model

- Core **neighbourhood teams** will be multi – disciplinary and will include the following in phase one:
  - Community Matrons - Community Nurses
  - Occupational therapists - Physiotherapists
  - Social workers - Support staff CCOs, APs and RSWs

- Neighbourhood teams will be more proactive in their approach to care, with processes in place for risk stratification, care planning, transfer of care, specialist support etc.

Key characteristics of the model

- New approach to assessment and re ablement – the independence pathway
- Integrated assistive technology service
- Opportunities for primary care to deliver care in different ways

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Benefits of this model for citizens

- Holistic approach to care
- Improved continuity of care.
- Citizens will be better informed and feel empowered to manage their own health and care needs.

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Benefits of this model for citizens

- Citizens will only go into hospital when they need to due to improved management in the community.

- Reduced likelihood of clinical management errors / misunderstanding.