HEALTH AND WELLBEING BOARD
29 October 2014

Title of paper:	**Integrated Care for Adults Update**	
Director(s)/ Corporate Director(s):	Maria Principe, Director Primary Care Development and Service Integration, NHS Nottingham City CCG Candida Brudenell, Director Quality and Commissioning, NCC	**Wards affected:** **All**
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Date of consultation with Portfolio Holder(s) (if relevant)		

Relevant Council Plan Strategic Priority:	
Cutting unemployment by a quarter	☐
Cut crime and anti-social behaviour	☐
Ensure more school leavers get a job, training or further education than any other City	☐
Your neighbourhood as clean as the City Centre	☐
Help keep your energy bills down	☐
Good access to public transport	☐
Nottingham has a good mix of housing	☐
Nottingham is a good place to do business, invest and create jobs	☐
Nottingham offers a wide range of leisure activities, parks and sporting events	☐
Support early intervention activities	☐
Deliver effective, value for money services to our citizens	☐
Relevant Health and Wellbeing Strategy Priority:	
Healthy Nottingham: Preventing alcohol misuse	☐
Integrated care: Supporting older people	√
Early Intervention: Improving Mental Health	☐
Changing culture and systems: Priority Families	☐

Summary of issues (including benefits to citizens/service users):

The report provides an update on the Integrated Care Programme for adults and details progress against the Health and Wellbeing Strategy actions.

Recommendation(s):

1	Note the progress of the Integrated Adult Care Programme.
2	Note the progress against the Health and Wellbeing Strategy actions.

1. REASONS FOR RECOMMENDATIONS

The Integrated Care Programme for adults was established in July 2012 and is supported by Nottingham City CCG and Nottingham City Council. The Programme supports our vision to enable people living in Nottingham to live longer, be healthier and have a better quality of life, especially in the communities with the poorest health. We will achieve this by local people, commissioners and providers working together to transform the health and social care system. Our aim is to remove organisational barriers and ensure that teams from different sectors work together seamlessly. Citizens will receive care in their home or the community; by shifting resources from hospitals to primary and community care we will be able to reduce unnecessary hospital admissions and shorten hospital stays. Services will be high quality, accessible, sustainable and based on the needs of the population.

The Programme is now in phase 2 of implementation. The first phase of the Integrated care Programme has been successful and has achieved a much greater understanding of operational processes and improved information sharing across organisations

The initial evaluation report will be available at the end of October and will make recommendations for future development.

2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

Our integrated care model is a whole system model with the citizen at the centre. It includes simplified access and navigation, equitable access to reablement, an effective response in a crisis situation and Care Delivery Groups offering a proactive / multi-disciplinary approach including primary care and social care. Links to the community and voluntary sector to ensure on-going support for our citizens will be developed. The model also describes a new relationship with secondary care whereby citizens only go into hospital when they have a medical need that cannot be met in the community and their care is transferred back into the community as soon as they are medically stable.

The emphasis of the new model of integrated care will be on a more generic model of care across the health and social community rather than single-disease specific care pathways. In approaching care in this way we are able to ensure patients are managed in the community more effectively and efficiently, reducing emergency admissions, re-admissions and supporting the discharge pathway. As a result of the programme more citizens will report that their quality of life has improved as a result of integrated health and care services.

In scope of the Integrated Care Programme are the following long term conditions: respiratory conditions, cardio vascular conditions, diabetes, neurological conditions, stroke, dementia, cancer, osteoporosis and the frail elderly (who are likely to have one or more of these conditions but may not present with a medical need as the primary reason for intervention).

This programme of work is now in the second phase with the following already in place:

- *8 Care Delivery Groups incorporating groups of GP practices, multi-disciplinary neighbourhood teams, social care link workers and care coordinators are operational across the city.*

- *Intermediate care services, crisis response and Local Authority reablement and emergency home care services have been reconfigured and processes aligned to support the independence pathway (a new model of social care assessment and rehabilitation)*
- *Assistive technology has been expanded to support an early intervention and proactive approach to care.*

To realise the benefits of the whole system model transformation is now focused on the following, with planned implementation throughout 2014/15.

- *Review of specialist services and integration into neighbourhood teams as appropriate.*
- *Choose to admit / transfer to assess – introducing new services and redesigning services to ensure that citizens only go into hospital with a medical need which cannot be met in the community and that their care is transferred back into the community as soon as they are medically stable.*
- *Seven day working – expansion of community services linked to primary care and secondary care operational delivery plans to enable citizens to remain at home wherever possible.*
- *Integration of Nottingham Health and care point (community health and social care access point) to simplify access to services for citizens.*
- *Further expansion of the assistive technology service*
- *Further development of a joint assessment and care planning approach across health and social care.*
- *Implementation of the self care pathway to support early intervention.*
- *Formalising links with the community and voluntary sector to create a 'pull' from health and social care services.*

Progress against Health & Well Being Strategy Actions

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

We will also aim to achieve the following outcomes:

- More elderly citizens will report that their quality of life has improved as a result of integrated health and care services
- The number of older citizens remaining independent after hospital admission will increase

Progress: A patient metric has been developed to support the delivery of the BCF. This metric will allow us to measure the impact of the BCF schemes and integrated care programme on the experience of citizens with long term conditions in receipt of health and social care services. Detailed planning has been carried out across the CCG, Nottingham City Council and CityCare to support this and will be reported in line with the BCF reporting process.

The actions we will take to achieve these ambitions are:

- Develop community health services with social care support linked to groups of GP practices working in geographically proximate areas

Progress: 8 Care Delivery Groups are now operating across the City, further development is underway including a review of specialist services which will make recommendations on areas for further integration.

- Provide better information about services and how to contact them so that citizens know what health and social care choices are available locally and who to contact when they need help

Progress: The "Choose My Support" on-line Service Directory has been live since June 13. To ensure compliance with Care Act requirements a review of current provision is in motion and will identify existing gaps and where appropriate commission new services, to ensure citizens receive information about universal wellbeing and prevention services and signposting services, including independent financial advice

- Develop a process to identify individuals who will benefit from earlier intervention as well as those requiring support from health and social care services, building on risk stratification, risk registers and data held by relevant agencies

Progress: Multi- disciplinary meetings are taking place in GP practices to support earlier intervention.

- Support citizens maintain their independence and manage their own care through the creation of effective networks with community, housing and health support services

Progress – Scoping of self care services and support is now complete. A process to effectively sign post citizens to appropriate self care is currently being developed as part of the planning to simplfy access to and navigation through services.

- Ensure that there is a single person responsible for coordinating the care of citizens with complex needs

Progress – The care coordinator role has been successfully implemented in Care Delivery Groups. This role is being regularly reviewed and developed to support the emerging requirements of the Care delivery Groups.

- Restructure and skill up our workforce so that health and social care services work better together to deliver the right care at the right time

Progress – Restructuring of the workforce is now complete, the focus of workforce development will move on to support the necessary culture change required to deliver integrated care effectively.

- Develop a range of transparent quality measures appropriate to the service being delivered and publish the results so that citizens know what standards of service that they can expect and how this is improving

Progress – KPIs for the reconfigured and aligned services have been agreed. Quality & Commissioning are working to develop a range of standardised outcomes measures that will be applied to all NCC contracted provision

- Increase the number of people signing up to the Nottingham Circle and develop other provision to address social isolation and loneliness

Progress – Nottingham Circle now has some members in all areas of the City and is exceeding the City total target but although developing, all individual hub areas, apart from Bulwell, continue to remain under target. The Self Care pathway of the Integrated Adult Care Programme is concerned with exploring how local communities can be supported to better support vulnerable older people resident within their communities. Five Looking After Each Other pilots to further develop community capacity to support vulnerable adults are being commissioned

3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

Continuation of the current system of commissioning and service delivery for people with long term conditions and older frail people will result in difficulty meeting the needs of this population as well as difficulty managing the increasing demand on current service provision.

4. FINANCIAL IMPLICATIONS (INCLUDING VALUE FOR MONEY/VAT)

An economic evaluation of the impact of the programme is currently underway and will inform future expansion of the approach.

5. RISK MANAGEMENT ISSUES (INCLUDING LEGAL IMPLICATIONS AND CRIME AND DISORDER ACT IMPLICATIONS)

All risks are managed through the Integrated Care Programme Board.

6. EQUALITY IMPACT ASSESSMENT

Has the equality impact been assessed?
Not needed (report does not contain proposals or financial decisions) ☒

No ☐

Yes – Equality Impact Assessment attached ☐

Due regard should be given to the equality implications identified in the EIA.

7. LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING CONFIDENTIAL OR EXEMPT INFORMATION

Health and Wellbeing Board - Integrated Care for Adults Update, October 2013.

8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT