HEALTH AND WELLBEING BOARD - 25th November 2015

Title of paper:	**Integrated care: Supporting older people update**	
Director(s)/ Corporate Director(s):	Maria Principe, Director Primary Care Development and Service Integration, NHS Nottingham City CCG Candida Brudenell, Assistant Chief Executive, NCC	**Wards affected: All**
Report author(s) and contact details:	**Jo Williams,** Assistant Director Health and Social Care Integration, NHS Nottingham City CCG and Nottingham City Council **Joanne.Williams@nottinghamcity.nhs.uk** **Antony Dixon,** Strategic Commissioning Manager, Nottingham City Council Antony.Dixon@nottinghamcity.gov.uk	
Other colleagues who have provided input:		
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	x
Deliver effective, value for money services to our citizens	x
Relevant Health and Wellbeing Strategy Priority:	
Healthy Nottingham: Preventing alcohol misuse	☐
Integrated care: Supporting older people	x
Early Intervention: Improving Mental Health	☐
Changing culture and systems: Priority Families	☐

Summary of issues (including benefits to citizens/service users and contribution to improving health & wellbeing and reducing inequalities):

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.

	How will these recommendations champion mental health and wellbeing in line with the Health and Wellbeing Board aspiration to give equal value to mental health and physical health ('parity of esteem'): The next stage of the Programme includes the integration of mental health services into Care Delivery Groups, this will ensure that both physical and mental health needs are managed comprehensively.

1. REASONS FOR RECOMMENDATIONS

The Integrated Care Programme for adults was established in July 2012 and is one of four priorities within the Health and Wellbeing Strategy with an aim "to 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."
Implementation of the integrated model of care is progressing well; the Board are asked to note progress against the health and wellbeing strategy actions.

2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

The vision for Nottingham is to improve the experience of, and access to, health and social care services for citizens. To deliver this vision an extensive system wide programme of change is underway which aims to reshape local services to deliver joined up care. The emphasis is to be on a more generic model of care across the health and social community rather than single disease specific care pathways. Through this patients should be managed in the community more effectively and efficiently, reducing emergency admissions, re-admissions and supporting the discharge pathway.

The 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 is in development. 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.

Our programme approach has been to deliver the new care model through joint leadership, clinical engagement and patient and carer involvement. Work streams and projects have been established to deliver the model and are supported by robust governance.
The integrated care programme is building up a number of notable successes according to the latest independent evaluation report. The report, commissioned from the Office for Public Management (OPM), highlights the scale, ambition and scope of the programme and picks out the enthusiasm and commitment of partner organisations. It also praises the governance of the programme, implementation of multi-disciplinary meetings (MDTs), co-location of teams, and the impact of the care co-ordinator roles.
This is the second interim report received from OPM, with six months of their programme evaluation still due to run. The external company has drawn on a number of sources to inform the emerging findings, including staff and GP interviews and surveys and patient/citizen interviews and surveys. The report authors are keen to stress that many of the outcomes and impacts of the integrated care programme are likely to take months, if not years, to be fully realised. They have also put forward several recommendations to help the programme as it continues to roll out. These include the need to review the

impacts being made at MDT meetings, consider any issues of capacity and ensure that citizens understand their care plans.

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

Progress: A patient metric 'Proportion of citizens with long term conditions reporting improved experience' has been developed as part of the evaluation of the Programme. An initial set of questionnaires were received from 213 responders between November 2014 and February 2015. A further set of 254 questionnaires were received between June and August 2015, combined figures provide a baseline of 81%. The patient questionnaire covers a range of areas such as quality of life, experience of health and social care services, planning your care and managing your care. The overwhelming majority of respondents receiving services from Nottingham CityCare Partnership and Nottingham City Council remain satisfied with the care they have received. In particular, over 90% of service users believe they are treated with dignity and respect, and over three-quarters believe the people providing their care understand their needs and their condition. This correlates with 83% of all respondents agreeing that they would recommend the service to friends or family.
It was apparent across both surveys that while some of the qualitative comments made by respondents highlight possible areas for improvement or variability in the quality of services, most respondents' comments focused on positive aspects of their service experience.

- The number of older citizens remaining independent after hospital admission will increase

Reablement and urgent care services are being redesigned to ensure equitable access for all citizens who could benefit from a period of reablement or rehabilitation; this will result in more citizens remaining independent at home. Plans to fully integrate reablement and urgent care services through a Joint Venture have been approved.
The Joint Venture will also support an integrated access point based on citizen's needs. This will simplify navigation through services and means that citizens will no longer need to differentiate between health and social care. The community triage hub is operational and acts the triage point for independence pathway services.

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: Eight care delivery groups are operational across the city; operational processes are being further developed to support this new way of working and a shift to more proactive care. For example the social care link worker role is being developed to offer community based clinics in an attempt to see citizens as early as possible and offer preventative interventions.

Following a review of all specialist services in the community the integration of the falls and bone health service and end of life service into neighbourhood teams is complete. The planning to integrate mental health services into CDGs has been initiated and is supported by the Nottinghamshire Healthcare Trusts review of community services.

- 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 City Council, in partnership with the CCG has undertaken a review of current information and advice provision to ensure that it is Care Act compliant and meeting the requirements of Nottingham's citizens. This review is being informed by the development of the CDG Self Care pilot (see below). Proposals for the commissioning of a new model of information and advice provision to fulfil this objective will be taken to the Health and Well Being Board Commissioning Executive Group in December.

- 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 team meetings using risk stratification are established across CDGs. Planning is underway to support CDGs to target the most complex patients and highest users of services utilising 'right care' data which shows that in the last 6 months 259 patients have had 4 or more emergency admissions. Care coordinators are auditing the top 49 patients who make up 15% of these admissions; an action plan will then be agreed through MDT meetings.

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

Progress –
A self-care pilot is currently underway in CDG 1(Bulwell) Services include:-

- ***Social prescribing – GPs / nurses identifying a citizen's broader needs and completing a social prescription for a Care Coordinator to action;***
- ***Community Navigators – volunteers to help citizens access support services they need;***
- ***Click Nottingham – community pioneers who help connect citizens to social support;***
- ***Rally Round – an app which coordinates who is doing what to help someone;***
- ***Web-based directory of services – providing advice and information;***
- ***Self-care hubs – housing the directory of services and placed in key locations for those who do not have access to their own IT.***
- ***Further development of the care co-ordinator role in the neighbourhood teams, to support them to become experts in self-care, help to identify people with self-care needs to support them to: Become experts in self-care; Help identify people with self-care needs; Support the clinical team in accessing self-care services.***

All staff directly involved in the pilot and the broader self-care developments across the City will be offered training in self-care support from Self-Help Nottingham, incorporating principles of the Care Act.
The pilot has been developed in conjunction with the voluntary sector, it also supports elements of the Nottingham City Council Looking After Each Other (LAEO) programme.
Two housing / health coordinator posts have been funded for 12 months to provide housing support to integrated care teams in CDGs 6 and 8 initially.

- 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. The role is under further development and will support patients and carers directly; the service will also operate over 7 days to ensure consistency of care wherever possible.

- 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 –JSNA chapters for each care delivery group have been produced and support the on-going analysis of workforce capacity to ensure that it is aligned to health prevalence. External support on leadership and culture change is being progressed through the Integrated Care pioneer support package.
Many services are reviewing their provision and considering how 7 day working can be introduced as they are re-commissioned. There will therefore be a gradual migration towards 7 day working rather than having achieved this by a fixed date. A report was presented to Health and Well-being Board Commissioning Sub-committee in September covering some initial proposals including piloting Community Matron 7 day working in 2 CDG areas, consideration of the need for a 24 hour urgent care service (already operating 7 days) and scoping the potential for 7 day working within social care hospital discharge and rapid response.

- 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 has been rebranded to Click Nottingham and is now funded through the Integrated Adult Care Programme Budget as part of the Self Care Pilot. The Better Connecting Need and Support strand of the Looking After Each Other Programme continues to investigate ways of addressing social isolation. Current activity is focused on Bulwell (linking in with the Self Care Pilot) and an interim evaluation is due in February which will inform consideration of scaling up the approach to other localities

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. FINANCE COMMENTS (INCLUDING IMPLICATIONS AND 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. LEGAL AND PROCUREMENT COMMENTS (INCLUDING RISK MANAGEMENT ISSUES, AND LEGAL CRIME AND DISORDER ACT AND PROCUREMENT 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)	x
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