NHS
Nottingham North and East
Clinical Commissioning Group

NHS
Rushcliffe Clinical Commissioning Group

NHS
Nottingham City
Clinical Commissioning Group

NHS
Nottingham West
Clinical Commissioning Group

Greater Nottingham's vision of integrated care for older people

Nottingham University Hospitals NHS
NHS Trust

Nottingham CityCare Partnership

Nottinghamshire Healthcare NHS
NHS Trust
Positive about integrated healthcare

Nottinghamshire County Council

Nottingham City Council

County Health Partnerships NHS
Providing health services in your community

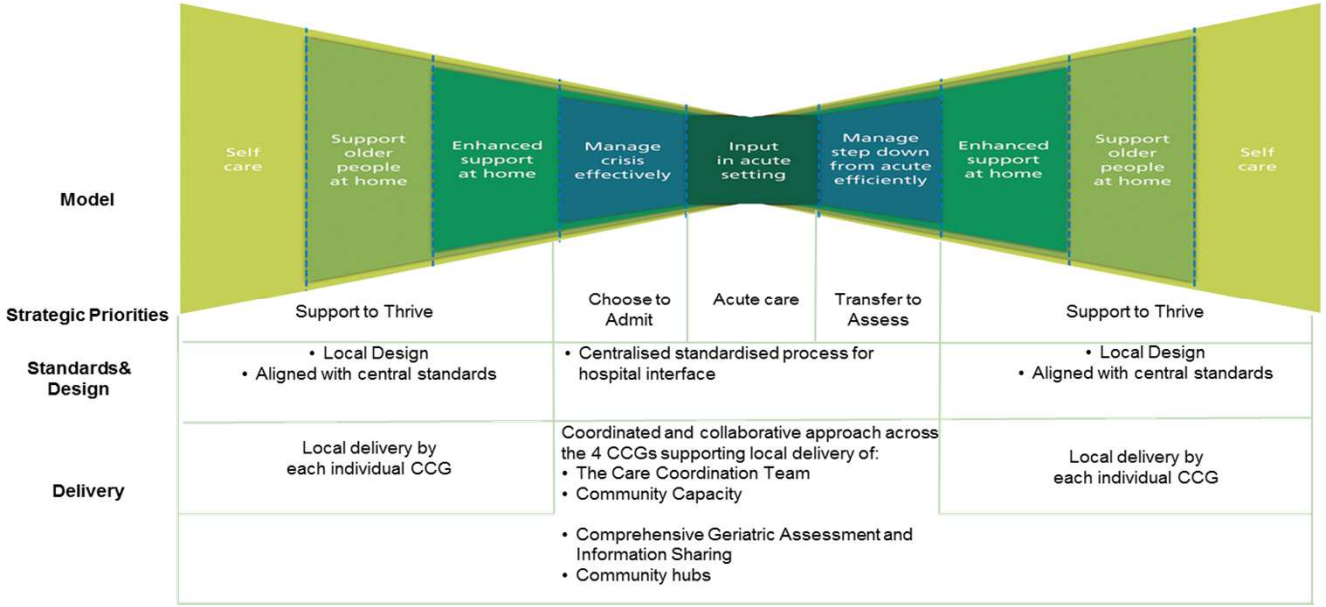
Greater Nottingham – Integrated care for older people

Frail Older People Programme
Greater Nottingham

Contents

Greater Nottingham – Integrated care for older people

The Greater Nottingham health and social care economy (CCGs, local authorities, practices and citizens) has come together to develop a vision for integrated care for its older people. Although integrated care is the aspiration for all citizens, a decision was made to focus on older people because of the growing numbers of older people and an increase in the complexity of their needs. It is anticipated that improving the co-ordination and delivery of services for older people will improve services for other citizens as well.



The model (the 'Bow Tie') has been designed to maintain independence where possible and manage crises effectively when necessary. It builds on the three strategic priorities of '*Support to Thrive*', '*Choose to Admit*' and '*Transfer to Assess*'. The model reflects the requirement for integrating provision at a local level whilst acknowledging the demands of a single acute provider shared by multiple commissioners. The primary collaborative work between the CCGs and the acute provider to date has been a focus on the admission and discharge pathways. The key interface between local service provision (*Support to Thrive*) and '*Choose to Admit*' and '*Transfer to Assess'* will be through the development of community hubs and a care co-ordination team. These in turn will be supported by a standardised process for Comprehensive Geriatric Assessment (CGA), which has planned deliverables in March 2014, and additional community capacity that will be delivered from December 2013.

The work is being overseen by the Strategy and Implementation Group for Nottingham South (SIGNS). This is a group of commissioners and providers that was formed in February 2013 to set the strategy for frail older people across CCG boundaries and oversee its implementation.

The drivers for integrated care – The national context

A number of concurrent pressures and challenges have come together necessitating a new approach to health and social care provision if quality is to be maintained and cost controlled. Examples include a shift from acute provision to care closer to home. This in-turn will require a new focus on prevention over intervention and independence over dependence on services. As a result, local health and social care systems are increasingly looking at integrated care as a solution.

"Integrated care and support needs to extend beyond traditional perceptions of 'healthcare' and 'social care' and into areas involving early intervention, prevention, self-care and promoting and supporting independent living."

Integrated Care and Support: Our Shared Commitment – National Collaboration for Integrated Care and Support (May 2013)

The challenges facing health and social care nationally include:

- Rapidly rising demand attributable to a growing population, a greater proportion of frail and elderly people (often with complex multiple health and social care needs and long term conditions), cost inflation and new treatments becoming available that are able to preserve and prolong life;
- Funding for health services not rising in line with demographic demand and significant reductions in social care funding. Cost pressures on the NHS are projected to grow at around four per cent a year up to 2021/22. If NHS funding is held flat in real terms then the NHS in England would experience a funding gap of between £44 and £54 billion in 2021/22, this would be reduced to a shortfall of £28 to £34 billion if QIPP savings are achieved (Nuffield Trust; A decade of Austerity, 2012);
- A desire by clinicians and leaders to deliver safer care, with better clinical and social outcomes for the population – and as such to deliver better value care (net outcomes per pound spent) with the considerable, but finite, resources available;
- Improving the experience of care, greater integration of health and social care is needed to mitigate the impact of fragmented health and care provision on patient experience. Citizens tells us that there are gaps in service provision, poor transitions between care settings and failures in communication. The Health and Social Care Act places a duty on providers to work more closely together to address these issues; and
- £7.6bn (14%) real-terms reduction in funding from 2010/11 to 2014/15, estimated at 2010 spending review (Financial Sustainability of local authorities, National Audit Office, 2013).

The drivers for integrated care – The local context

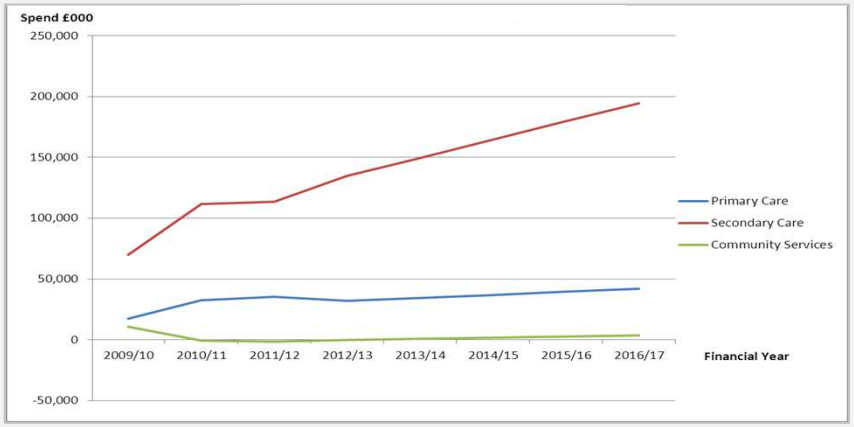
Challenges for Greater Nottingham

The national pressures identified are also being felt locally in Greater Nottingham. A combination of an increasing and ageing population (85,000 over 75's this year rising to over 100,000 by 2025), the shifting expectations amongst citizens around the time and type of care they receive, and a predicted increase in demand, are all placing significant pressure on the health and social care economy.

These challenges are alongside the tough financial pressures with health budgets only seeing small increases and social care budgets decreasing in real terms. For example: Nottingham City Council must save £20m during 2013/14, Nottingham University Hospital Trust (NUH) £50m during 2013/14 and Nottinghamshire County Council £154m over a four year period.

As the following chart depicts, current healthcare spend in the region is heavily focused on secondary care (and is projected to continue to do so in the future if recent trends continue) whilst spend on community and primary care has barely changed. As a result, the disparity between community, primary and secondary care spend has been increasing resulting in negligible investment in the community sector and primary care to assist them to innovate and actively promote the reality of integrated care.

Projected Healthcare Spend – Cumulative Movement Year on Year – Nottingham County PCT



(Source: Financial Update from Nottinghamshire Collaborative Commissioning Congress; Sep 2013).
(NB: Notts County PCT has been reorganised into the CCGs of Nottingham West, Nottingham North and East, Rushcliffe, Newark and Sherwood, and Mansfield and Ashfield).

Changes to meet the challenges

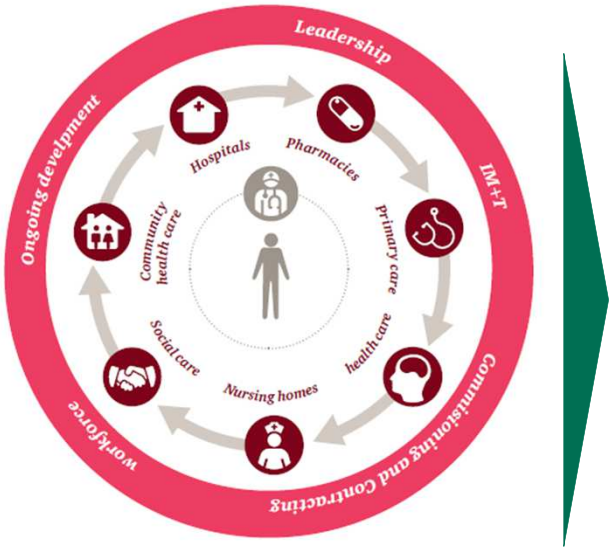
In order to tackle these combined challenges, the organisations involved in the delivery of health and social care in Greater Nottingham recognise that a braver and more radical solution of integrated care is required that will address the following local issues:

- Citizens being admitted into hospital or long term residential care when alternative services could/should have met their needs;
- Citizens remaining in hospital when they no longer need acute services; and
- Citizens who need the care of old age specialists in an appropriate ward in hospital not always receiving it.

The drivers for integrated care for older people – A citizen's perspective

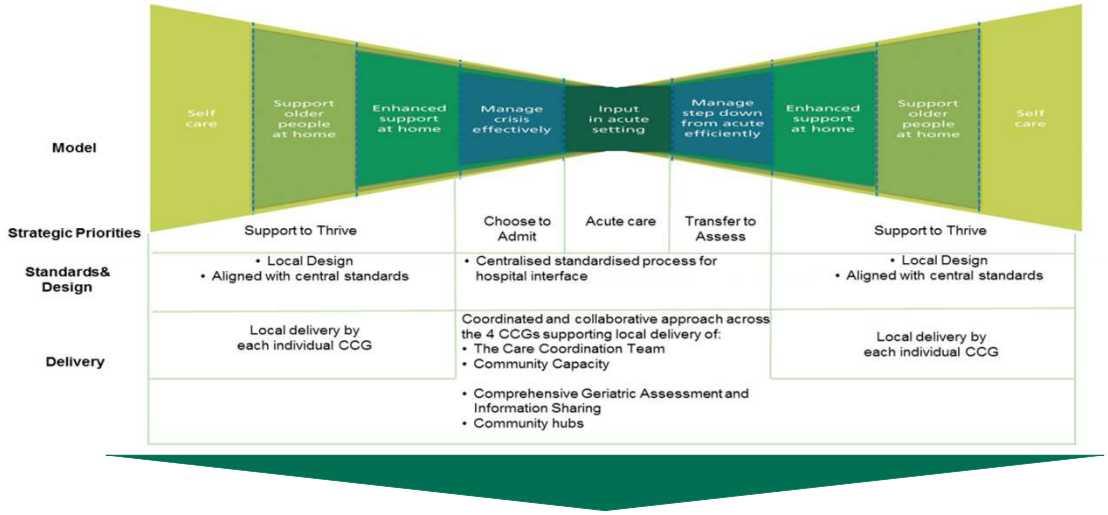
Greater Nottingham's vision of integrated care for older people is important, but it is how outcomes are met and are experienced by the citizen that really matters. The model underpinning integrated care in Greater Nottingham has been designed with the needs of the citizen at its core. Some of the key requirements from a citizen's perspective are summarised below.

The citizen is at the centre of Greater Nottingham's vision



Strategic priorities of Integrated Care	Citizen's requirement of care
Support to Thrive	• My health and social needs are identified as early as possible. • I am supported to manage my own condition at home. • I know where to go and who to contact when I need care.
Choose to Admit	• Community services are there for me if I need support at home or overnight. • When I am unwell I am assessed using Comprehensive Geriatric Assessment. • I will be directed to the right place in the first instance. • Hospital is there for me if I need specialist clinicians to manage my medical conditions until I am stabilised or I need an operation.
Transfer to Assess	• I leave hospital as soon as it is medically safe to do so. • I will only be transferred to long term care or a nursing home if that is the best place to meet my needs.

The model and strategic priorities of Greater Nottingham's vision of integrated care for older people



The care of frail older people is one of the main strategic priority areas identified by the Greater Nottingham care economy and this is reflected in Greater Nottingham's vision for older people:

'Right Care, Right Place, First Time'

Delivery of the vision is through a co-ordinated and collaborative approach, which has been adopted across all of the CCGs and City and County Councils following three strategic priorities:

1. ***'Support to Thrive'*** – Enabling citizens to remain independent in their own homes for as long as possible. Delivered through multiple proactive initiatives, health and social care needs will be identified at the earliest possible opportunity and support will be provided to the individual to enable self-care at home;

2. ***'Choose to Admit'*** – The coordination and delivery of services in the community and at the front door hospital interface to prevent unnecessary admissions into hospital. Coordinated through community hubs (a single point of access) and delivered by multidisciplinary teams; and

3. ***'Transfer to Assess'*** – The coordination and delivery of services in the community and at the back door hospital interface to facilitate early transfer as soon as the citizen is medically safe for transfer. Coordinated through community hubs (a single point of access) and delivered by multidisciplinary teams.

The strategic priorities of Greater Nottingham's vision of integrated care for older people

'Support to Thrive'

This strategic priority is currently being implemented at a local level with CCG, Council and third Sector support. Due to local circumstances, progress has advanced at different rates for each CCG area but as of November 2013, the focus of SIGNS will start to move towards the 'Support to Thrive' elements of the model and will support the design of local services complementing and effectively interfacing with 'Choose to Admit' and 'Transfer to Assess'.

'Choose to Admit' and 'Transfer to Assess'

The delivery of the two strategic priorities that deal with the interface to NUH is being coordinated via four projects that are due to be implemented on a phased basis between October 2013 and March 2014, consistently across the four CCGs.

1. **Community Hubs** will be based in each CCG and serve as a single point of access for community team referrals following a crisis (i.e. managing referral to the acute) and for the Care Coordination team to contact when ready to discharge. From March 2014, community hubs will take responsibility for coordinating a response to meet the on-going needs of citizens and manage and allocate local health, social care and third sector capacity;

2. The **Care Coordination Team** is based in the acute hospital and will work as one team to coordinate and case manage all supported transfers of care out of NUH;

3. The **Community Capacity** project will assess Greater Nottingham's need for increased community capacity. Initial capacity analysis has shown that there are 32 older citizens who remain in hospital each day when their needs could be met in a community setting if the services were available. This translates into a requirement for additional beds and home based services. By December 2013, an additional 21 community beds will be commissioned that are staffed to meet the needs of the most complex patients as part of an integrated community service. A more strategic review of the on-going needs for community services beyond March will be carried out before then; and

4. **Comprehensive Geriatric Assessment (CGA) and Information Sharing** are the underpinning priorities that support the process changes across the interface with NUH and community hubs. Under the new model the Care Coordination Team at NUH will pass information on patient needs to the community hubs via an electronic referral on SystmOne. The needs of patients will be assessed based on the 5 domains of CGA. By March 2014 there will be an implementation plan on how to record and share CGA across primary care, social care, NUH and community services.

Frail Older People Programme
Greater Nottingham

The principles of Greater Nottingham's vision of integrated care for older people

The four Greater Nottingham CCGs are working with both the City and County Councils and their community providers: CityCare Partnership and County Health Partnerships, to deliver an integrated service through collaborative and co-ordinated approaches.

Collectively a set of shared principles have been developed that align to the SIGNS strategy and address all elements of the bow tie model through a service redesign that is centred on the citizen. These principles are locally owned and implemented within each CCG.

Shared principles supporting the Greater Nottingham vision for Integrated Care for Older People

• An integrated and sustainable Health and Social care service through collaboration with local authority, district council and voluntary sector	• Simplified citizen journey through the implementation of a single integrated adult care pathway	• Virtual Ward model of care: risk stratification tool; MDT's held at each practice; integrated care teams; extended working with mental health services and social care	• Older people enabled to take care of themselves and live independently in their own homes for longer with less reliance on intensive care packages
• 48 hour follow up for frail older patients following an unplanned admission	• Enhanced support for care home residents	• Enhanced support for patients leaving Lings Bar Hospital	• Coordinated response to end of life care
• Crisis response service to support avoidable admissions to hospital	• Clear navigation across health care with key decision making points: community hubs and care coordination team	• Systematic support for long term condition management, for example, implementation of Assistive Technology	• Citizen and carer support, including self-care management, as part of *'support to thrive'.*

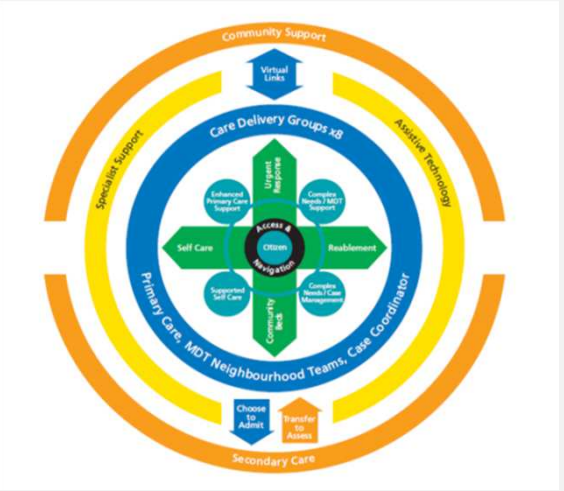
The two examples that follow show how the model for integrated care for older people and its key principles are being planned to be implemented at CCG level (or are currently in place) and apply to the wider adult (over 18) population by Nottingham City CCG and by the County CCGs.

How Nottingham City CCG is planning to implement the vision of integrated care for older people

Nottingham City CCG – Adult Integrated Care

Nottingham City CCG, Nottingham City Council and CityCare Partnership are working together to integrate care as part of the Adult Integrated Care Programme. Collectively they have developed a model that aligns to the SIGNS strategy by addressing all the elements of the 'Bow Tie' model through a service redesign that is centred on the citizen. The overall aim is to:

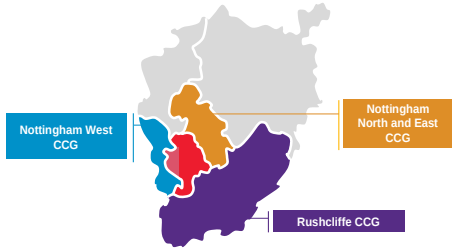
- Simplify the citizen journey;
- Enable older people to take care of themselves and live independently in their own homes for longer with less reliance on intensive care packages; and
- Develop an integrated and sustainable Health and Social care service.



Three key projects will help to deliver this model of care in City CCG:

- The **Coordinated Care** project has created 8 new Care Delivery Groups (CDGs) that will be established from January 2014. These groups of key health and social care professionals will be aligned to a specific geographical area that will enable them to work together around the citizen's needs, share information and combine experience to continuously improve the care they provide. The CDGs will comprise of multi-disciplinary neighbourhood teams linked to GP practices and supported by a care coordinator. This new model will change how health and social care services are commissioned and delivered at a local level. Access to services will be simplified to ensure that citizens receive appropriate support and that navigation around health and social care services is simplified.
- The **Independence Pathway** project involves the planned transformation of the reablement and rehabilitation pathways to allow citizens to remain as independent as possible. Four pathways are being developed that reflect the complexity of the citizen's conditions and needs; Self Care, Reablement, Community Beds and Urgent Response. They will be easily accessible to the citizen through a single front door after a referral from a health or social care professional.
- The **Assistive Technology** project is distinct to the programme but it is recognised that the project needs to support the new model of Coordinated Care. A joint health and social care strategy has been developed to support an early intervention and prevention approach. Commissioning of the service will be done jointly to ensure that assistive technology is embedded into the pathways that enable the citizen to remain independent.

The three South of County CCGs and their work on integrated care for older people



Integrated Care and the South of County CCGs – examples of current services

Across the three South of County CCGs there are a range of local services being delivered to support the strategic priority of '*Support to Thrive'* and integrated care.

There is also an exploration of a proposed service delivery model for acute community care for the County CCGs working in collaboration with the County Council (this work is called 'Blurring the Boundaries'. It is currently being considered and it is anticipated that a decision will be made on whether to implement it in the coming months.

Example of work being considered

Blurring the Boundaries – *acute community care*

The South of County CCGs and the County Council have commissioned the development of a service specification that could deliver the local components of '*Choose to Admit'* and '*Transfer to Assess*' as well as components of the South's intermediate care service (e.g. intermediate care beds). The specification is in an early stage of development and is being considered for approval. This service is referred to as 'acute community care' and has the following definition:

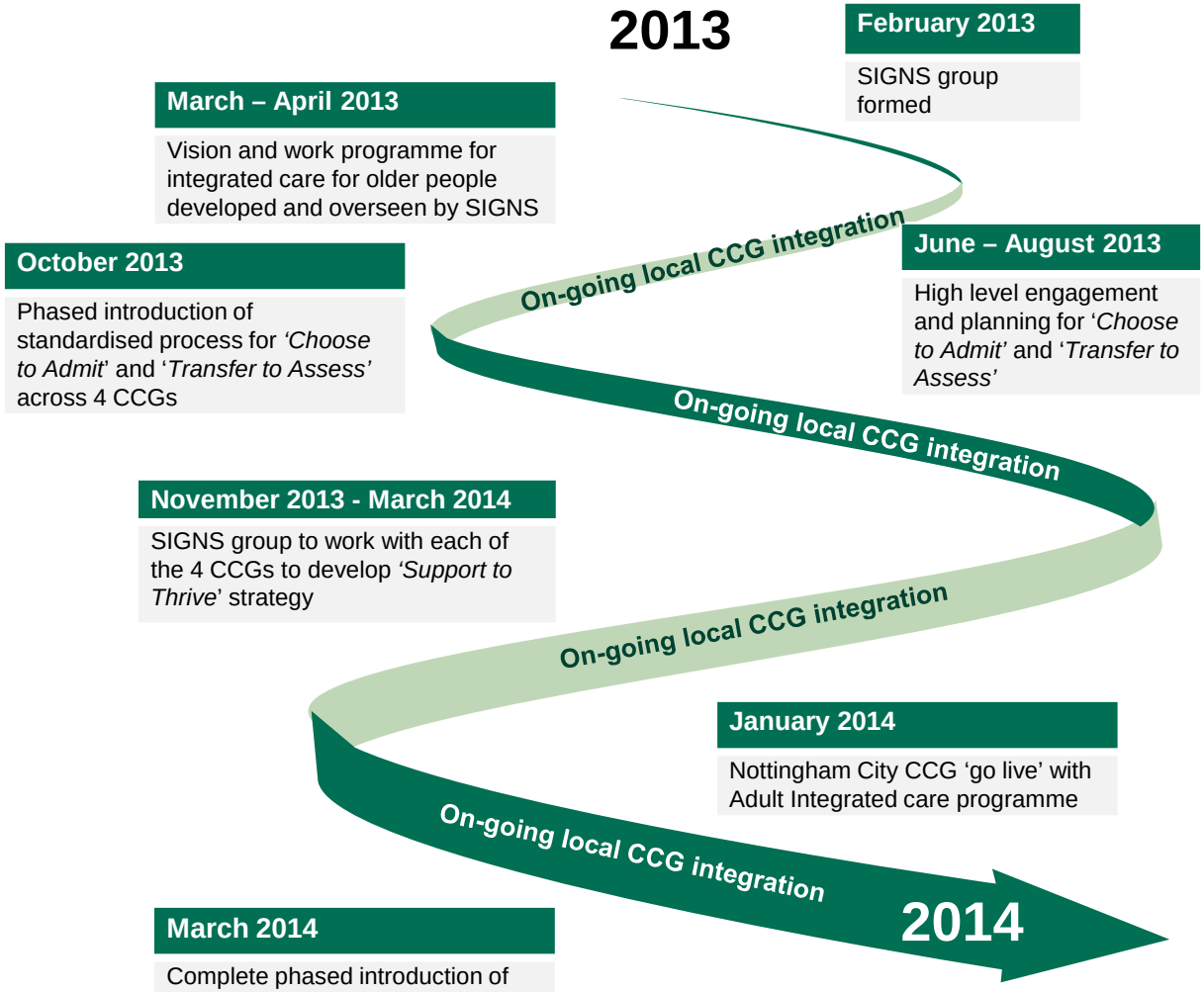
"A range of integrated services to promote faster recovery from illness, prevent unnecessary Acute Hospital admission and premature admission to long term residential care, that supports timely discharge from hospital and maximise independent living."

There are currently a range of different services provided in the South of County that deliver intermediate care and reablement. The main drive for Blurring the Boundaries is to consolidate these services and providers into a single contractual form incentivising them to work together and working to an agreed pain share/gain share mechanism against a range of service specific outcome measures.

Examples of key aspects of the proposed service model include the following:

- The acute community care service would be time limited (up to 6 weeks) with the potential for citizens to be discharged earlier;
- The service would deliver an episode of assessment, treatment and rehabilitation for citizens;
- It would be delivered by a range of health and social care practitioners including access to 24-hour care delivered either at home, in a registered nursing home or in a community hospital setting;
- The balance of home/bed based support would be determined by the lead provider for Acute Community Care services who should consider the balance/range and cost of available 24 hour beds within the locality; and
- The use of bed based services is likely to be for those people who initially need a level of observation, and support and continuous care at all times not available through a home based package.

Greater Nottingham's timeline for integrated care for older people and next steps



Progress has been made across Greater Nottingham on integrated care but translating the vision into a reality for all citizens requires on-going collaborative working and commitment.

The next stage of work is crucial and needs to include:

- A system wide approach around financial implications, risks and benefits;
- A focus on leading the cultural shift required;
- Assuring the quality of care;
- Identifying and agreeing commissioning and contracting models;
- Approaches to sharing patient information; and
- Workforce support and development.