

Integrating health and social care in Nottingham City

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Nottingham City Vanguard Programme

Improving care for
older people

Care Homes Team

Delivering quality
nursing support

Case Study

West Norfolk – Living
Independently in Later
Years programme



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At the Vanguard

of improving care for older people

The Vanguard programme in Nottingham City is set to move more older people's care from hospital to the community, introduce greater use of healthcare assistive technology and IT in care homes (such as video consultations), improve medicines management, and build partnerships of support across professions and organisations in improving patient/citizen care. Feedback mechanisms will be put in place so lessons can be learnt and services continually adapted and improved.

The programme is being overseen by a steering group which includes GPs, nurses, pharmacists and community geriatricians. Organisations and networks involved in the Nottingham City CCG-led programme include Nottingham City Council, Nottingham CityCare Partnership, Nottingham University Hospitals, Nottinghamshire Healthcare, Age UK, University of Nottingham and the Care Home Managers Forum.

The Vanguard work with care homes fits into our Integrated Care programme, bringing together health and social care services to provide joined-up, 'holistic' care for citizens / patients.

To find out more, please email:
joanne.williams@nottinghamcity.nhs.uk

Objectives of the Nottingham City Vanguard programme:

- 1 Strengthen the culture of partnership, support, and engagement with the care home sector, local community services and voluntary sector (from its existing strong basis), working together to improve the experience of care home residents
- 2 Review and redesign services commissioned to support care homes in order to improve outcomes for residents and deliver efficiencies through better use of resources
- 3 Support the roll-out of new technologies and telemedicine to provide fast and effective access to clinical and specialist input
- 4 Increase the provision of community beds to support people to return to independent living with appropriate support from community services
- 5 Ensure care home residents have agreed goals of care based on proactive, resident-centred multi-disciplinary review involving families
- 6 Develop an effective hospital discharge pathway and processes that support residents to return to care homes as early as possible, seven days-a-week
- 7 Develop and implement an effective urgent care pathway for care homes
- 8 Develop and implement an effective end-of-life pathway for care homes.

Care homes team is stepping up support



The Care Homes Nursing Team in Nottingham City is now seeing on average 90 patients every day and is keen to integrate care with colleagues at an earlier stage in the residents' care.

The team of district nurses, run by Nottingham CityCare Partnership, helps care home residents with a range of nursing tasks including wound care, administration of injections, ulcer prevention and care, palliative care, as well as providing educational support for carers.

The service is made up of two district nursing teams, based at New Brook House in Hyson Green and the Meadows Health Centre, as well as a team of specialist nurse practitioners, also based at Meadows Health Centre.

Following the establishment of the team two years ago, nursing support is now provided to 58 residential homes across the City in all areas except Strelley, Wollaton and Clifton. It is hoped that the service will be extended to these three areas in due course.

The team also works with reablement services providing nursing care at Connect House near the City Hospital and Acorn House in Carrington. The Specialist Nurse Practitioner team work with both residential and nursing homes across the City,

supporting new admissions with the transition into their new home for up to six weeks.

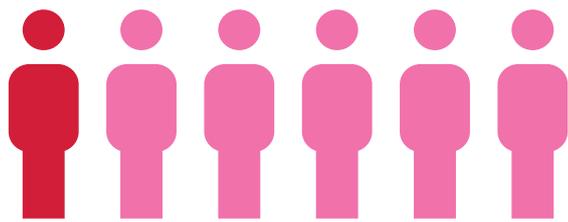
Helen Woodiwiss, Care Homes Nursing Team Manager, said: *"There is an increasing focus nationally and locally on health care of the elderly. People are living longer, becoming more dependent with higher care needs, and we must ensure that those needs are met. By providing the appropriate support, we can help keep people cared for in the care homes rather than being admitted to hospital. Certainly if care homes feel supported in managing the care of their residents, they are more likely to call for the support of our nurses and less likely to call 999.*

"We have seen the number of referrals increase as our relationships have improved with the care homes and they have become more open and transparent about the needs of their residents. They appreciate the consistency of the same nurses going in to see them and knowing the first name of the nurse, it sounds a small thing but it's really important. Sometimes there are challenges to be faced in the homes such as safeguarding but we work with them to provide support on these issues and we have positive working relationships.

"We take referrals via the Nottingham Health and Care Point and would encourage GPs to inform our team as soon as possible when

Continued on page 5

Factfile: Care homes in Nottingham



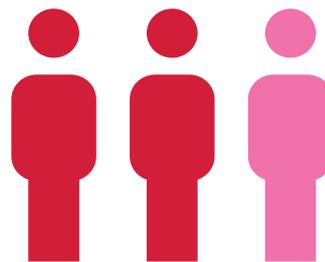
One in six people aged 85 or over are living permanently in a care home

2300

Approximate number of care home residents in Nottingham City

8354

care homes in the city & providers



Approximately two out of every three people in Nottingham City's care homes are funded by the local authority, and one in three are self-funded



There are approximately **50 to 60** new permanent admissions to care homes every month and the overall numbers are slightly increasing year on year

The average care home resident has



On average, care homes residents have....



Nottingham City is a NHS England Vanguard site for achieving better quality care in care homes

- The Vanguard work will improve joint working between care homes, community care and secondary care in order to achieve better quality of care within care homes and improve outcomes for citizens, increase trust and ultimately better planned end-of-life care
- NHS Nottingham City CCG and partners have an ambitious vision - to commission a 'beacon' best practice care home model which is fit for the future
- The vision is to enable residents living in a care home to be healthier, have a better quality of life and be treated with dignity and respect, focusing on residents' capabilities rather than their dependencies
- The Vanguard work aims to remove organisational barriers and ensure that care home staff have support from specialist health services to identify, understand, manage and respond to the everyday impact of providing essential care
- Residents will receive co-ordinated input from generalists and specialists of multiple disciplines in partnership with social care professionals and care home staff

Continued from page 3

liaising with care homes about their patients' care as we can provide the dedicated support they need."

The team currently has about 420 patients on their caseload and there are 17 members of staff on the team.

Helen, who is based at New Brook House, added: *"We would particularly like to be updated with information about residents who are approaching end-of-life and have been put on the end-of-life care pathway. We'd like to be made aware of this as soon as possible so we can provide the right support and make sure that the person's care needs will be met."*

The changes that have been made to the Care Homes Nursing Team have been carried out in parallel to the development of the Integrated Care programme in the City. The team is currently working with the Care Co-ordinators to help raise awareness of their service and to become more integrated in the joined-up health and social care of citizens. The team will also be essential to the success of the Integrated Care Vanguard programme that is being set up in the City to promote best practice in people's care in care homes.

Helen said: *"We have made a lot of progress so far, we have provided a lot more support for people in care homes and training for care home staff. We have definitely improved the patient experience, the next steps now are to improve integration and to improve the patient experience even more."*



Pictured here and on page 3 are some representatives of the Care Homes Nursing Team

Tech tour of Yorkshire for AT team



The Assistive Technology (AT) team at Nottingham City CCG has been out and about recently on a fact-finding mission to discover best practice elsewhere in the country.

Dave Miles, Assistive Technology Project Manager, and Chris Summerlin, Assistive Technology Project Assistant, visited Airedale NHS Foundation Trust in May to find out more about the unique range of digital healthcare solutions provided by this acute care trust. Airedale is an exemplar in remote monitoring and is one of the six Vanguard care home sites. The Trust, based in Keighley, West Yorkshire, has developed a range of digital healthcare and telemedicine services over the past decade.

The team's visit to Airedale follows an earlier tour of the Leeds Assisted Living Centre which formally opened in February 2015. The Assisted Living Centre is an assistive technology hub which encompasses the community equipment store, telecare service, alarm monitoring and response service, blue badge assessment centre and training and demonstration facilities.

Dave said: *"We've recently had a visit ourselves from the NHS England team looking at use of assistive technology and they were very pleased with what they saw taking place in Nottingham. While we know we're ahead of most places in this area, we also know we can still learn from others and these visits to Yorkshire have provided more information and insights on how we can best take forward our plans locally."*

New reference guide launched at CDG meetings

Colleagues from across the City have been meeting to discuss how integrated care is making a difference to their working lives and to the lives of citizens.

The second set of quarterly Care Delivery Group (CDG) meetings were launched in June and have been well attended, with members of staff being updated on a range of topics including the self-care pilot in Bulwell and the development of an integrated CDG directory guide.

Pictured here discussing the latest developments are members of a local CDG meeting at the Family Medical Centre in Carlton Road, Nottingham.



Bulwell hosts pilot of new self-care scheme

As part of the Integrated Care programme in Nottingham City, a major self-care initiative is being piloted in Bulwell. Self-care is all about empowering people with the confidence and information to look after themselves when they can, and visit health and care professionals when they need to.

This gives people greater control of their own health and encourages healthy behaviours that help prevent ill health in the long-term.



Self-care training with Self Help UK

In Nottingham City one in three of the registered population is living with a recorded long-term condition (LTC). The strain of these LTCs is massive, both on the individual and on healthcare services, but it does not have to be.

Self Help UK is delivering self-care training to healthcare professionals to give you the best tools and information to enable your patients to self-care and pick up some

Set of joined-up initiatives to help people to access support they need – “Bulwell pilot”



approaches to aid your own health and wellbeing.

We want Nottingham to be at the forefront of self-care developments so that our citizens can maintain their independence and our healthcare staff can support them to do so. By understanding how and why

self-care can be dually beneficial, you will be helping your patients to keep control of their lives and access health services appropriately.

Training sessions will take place every month until the end of February 2016. Upcoming dates are shown on page 8.

Self Help UK Training Dates

Date	Venue	Time	Booking Link
CDG 3			
Thursday 10 September 2015	Southglade Leisure Centre	9.30am – 12.00pm	http://bit.ly/selfcaretraining10Sepam
Thursday 10 September 2015	Southglade Leisure Centre	2.00pm – 4.30pm	http://bit.ly/selfcaretraining10Seppm
Tuesday 15 September 2015	Southglade Leisure Centre	2.00pm – 4.30pm	http://bit.ly/selfcaretraining15Sep
Wednesday 16 September 2015	Southglade Leisure Centre	9.30am – 12.00pm	http://bit.ly/selfcaretraining16Sep
CDG 3			
Thursday 24 September 2015	Bells Lane Community Centre	1.00pm - 4.00pm	http://bit.ly/selfcaretraining24Sep1pm
Friday 25 September 2015	Bells Lane Community Centre	9.00am -12.00pm	http://bit.ly/selfcaretraining25Sep
Tuesday 29 September 2015	Bells Lane Community Centre	9.00am -12.00pm	http://bit.ly/selfcaretraining29Sep
Wednesday 30 September 2015	Bells Lane Community Centre	1.00pm - 4.00pm	http://bit.ly/selfcaretraining30Sep
CDG 4			
Friday 2 October 2015	New Brook House	9.00am -12.00pm	http://bit.ly/selfcaretraining2Oct
Tuesday 6 October 2015	New Brook House	1.00pm - 4.00pm	http://bit.ly/selfcaretraining6Oct
Wednesday 7 October 2015	New Brook House	1.00pm - 4.00pm	http://bit.ly/selfcaretraining7Oct
Thursday 15 October 2015	New Brook House	1.00pm - 4.00pm	http://bit.ly/selfcaretraining15Oct
CDG 5			
Tuesday 1 December 2015	The Place Activity Centre	2.00pm – 4.30pm	http://bit.ly/selfcaretraining1Dec
Thursday 3 December 2015	St John's Carrington	2.00pm – 4.30pm	http://bit.ly/selfcaretraining3Dec
Tuesday 8 December 2015	The Place Activity Centre	1.30pm – 4.00pm	http://bit.ly/selfcaretraining8Dec
Thursday 10 December 2015	St John's Carrington	2.00pm – 4.30pm	http://bit.ly/selfcaretraining10Dec
Tuesday 15 December 2015	The Place Activity Centre	1.30pm – 4.00pm	http://bit.ly/selfcaretraining15Dec
Thursday 17 December 2015	St John's Carrington	2.00pm – 4.30pm	http://bit.ly/selfcaretraining17Dec
CDG 6			
Thursday 5 November 2015	MCO Centre	2.00pm – 4.30pm	http://bit.ly/selfcaretraining5Nov
Thursday 12 November 2015	MCO Centre	2.00pm – 4.30pm	http://bit.ly/selfcaretraining12Nov
Thursday 19 November 2015	MCO Centre	2.00pm – 4.30pm	http://bit.ly/selfcaretraining19Nov
CDG 7			
Monday 21 September 2015	St Leonard's Community Centre	2.00pm – 4.30pm	http://bit.ly/selfcaretraining21Sep
Thursday 8 October 2015	St Leonard's Community Centre	2.00pm – 4.30pm	http://bit.ly/selfcaretraining8Oct
Thursday 29 October 2015	St Leonard's Community Centre	2.00pm – 4.30pm	http://bit.ly/selfcaretraining29Oct
CDG 8			
Wednesday 13 January 2016	Meadow's Library	2.00pm – 4.30pm	http://bit.ly/selfcaretraining13Jan
Thursday 14 January 2016	Clifton Library	2.00pm – 4.30pm	http://bit.ly/selfcaretraining14Jan
Wednesday 20 January 2016	Meadow's Library	2.00pm – 4.30pm	http://bit.ly/selfcaretraining20Jan
Thursday 21 January 2016	Clifton Library	2.00pm – 4.30pm	http://bit.ly/selfcaretraining21Jan
Thursday 28 January 2016	Clifton Library	2.00pm – 4.30pm	http://bit.ly/selfcaretraining28Jan
Wednesday 10 February 2016	Meadow's Library	2.00pm – 4.30pm	http://bit.ly/selfcaretraining10Feb

Implementation of the self-care pilot commenced in July in Care Delivery Group (CDG) one (Bulwell) for 18 months. The aim is to explore how the different elements of self-care support can work together to improve citizen experience and encourage self-management. Depending upon an evaluation of the pilot scheme in Bulwell, it is hoped that the approach will be rolled out across Nottingham City.

The pilot includes:

- Staff training
- Further development of the care co-ordinators' role in the neighbourhood teams, to support them to become experts in self-care
- Launch of an integrated health and social care website directory providing up-to-date information about a range of health and social care services including self-care
- Self-care hubs located in a range of venues to enable people without use of home IT to access information and advice about health and social care services
- Community clinics, run by Nottingham City Council's Enablement Gateway, offering assessment for low level equipment, support around social inclusion and potentially opportunities to try out assistive technologies
- Community navigators – a volunteer-based service which will help citizens find appropriate voluntary sector and community support
- Access and navigation – a new model for how people access and navigate health and social care services in the City
- A social prescribing model to help embed self-care into practice.



A series of questions and answers for staff about self-care were produced in the recent Connecting Care 'special edition'.



New service supports long-term recovery from cancer

A new service for men and women living with cancer, run by Notts County FC Football in the Community, is inviting referrals from clinicians.

The football club's community programme has teamed up with Macmillan Cancer Support to establish a project that uses physical activity to help patients during their recovery from cancer. The CARE (Cancer and Rehabilitation Exercise) project will test the concept and benefits of providing an exercise referral programme for patients at the end of their cancer treatment.

The project, funded by Macmillan for the next two years, provides a 12-week guided exercise programme, followed by ongoing support for 12 months to ensure participants continue to benefit from their new strength and fitness.

In Nottingham City and the south of the county there were 17,700 people living with and beyond a cancer diagnosis and this is set to rise to 34,400 over the next 16 years.

The project provides participants and their families with a social environment to share stories, build strength and increase their confidence and self-esteem during a difficult period in their lives. It is based at the Portland Centre in the Meadows



If you have any questions about self-care training, please contact Michele Banton, Self-Help UK, on **0115 911 1662** or Annabel Taylor at Annabel.Taylor@nottinghamcitycare.nhs.uk

Survey reveals progress in integrated working

Staff are now much more confident about sharing information and multi-disciplinary team (MDT) meetings are helping to improve team-working – these are two key recent findings from the ongoing independent evaluation of Nottingham City's Integrated Care programme.

This second survey of staff and GPs, carried out this year, saw the number of respondents double compared to the initial baseline survey in spring 2014 and generally the feedback has been very positive.

The report from the Office for Public Management (OPM) states: *"Respondents were more confident than last year about the types of information that can be shared with practitioners from other agencies. In particular, all team manager, practice manager and intermediate care practitioner respondents reported being confident about this."*

"A greater proportion of respondents to the 2015 survey reported having enough information about other services to carry out their role effectively, and that they know how to contact others who can also provide support. Respondents were more likely to report receiving sufficient support to enable them to carry out their roles,

and the vast majority of respondents continue to agree that they make a difference to the lives of the people they care for."

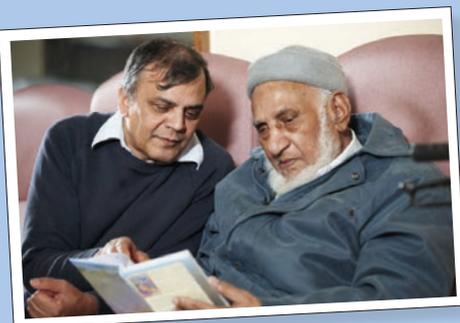
OPM's report states that the care co-ordinator role was frequently mentioned as working well. In particular, respondents highlighted their ability to make referrals to other services and to provide information. Respondents also indicated that having co-located teams and mobile working supported shared working between health and social care colleagues.

Respondents continued to feel their teams work well together. A number of respondents emphasised improved communication across teams. The MDT meetings and monthly meetings were highlighted as helping to build relationships. In particular, a number of respondents from health services commented on the success of more joined-up working and improved communications with social care, leading to improvements in citizen care.

Areas that still remained as challenges according to the report were some referral processes, duplication in some of the assessments undertaken, and the need for improved communication between teams, particularly around the discharge process.

OPM's review of the Integrated Care programme is due to run until March 2016 when a final report will be published.

Citizen experience of care boosted



The citizen experience is improving thanks to the integration of health and social care in Nottingham City – that's the view of staff and GP respondents in the latest survey of the Integrated Care programme.

In the independent survey, carried out by the Office for Public Management (OPM), respondents reported improved citizen experience compared to 12 months ago. Almost three-quarters of respondents agreed or strongly agreed that *'we take a holistic view of each patient/service user's needs'* - an increased rate of agreement compared to the 2014 survey.



In addition, the majority of respondents (70%) agreed with the statement that *'we fully consider carer needs'* and the statement *'patients/service users and carers are generally satisfied with the care they receive'* scored equally highly. This marks a shift in perceptions from the first survey last year, when only 53% of respondents agreed with the statement.

However, although responses to the 2015 survey were generally more positive than to the 2014 survey, there are still reports that citizens have to repeat themselves when coming into contact with different services.

The Integrated Care and Better Care Fund Programme Board Members

Chair: Jo Williams

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Maria Principe

Director of Primary Care Development and Service Integration

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Director for Adult Social Care

Phyllis Brackenbury

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Hazel Wigginton

Assistant Director of Community Services and Integration

Charu Tangri

GP

Steve Upton

Assistant Director of Urgent Care and Transformation

Antony Dixon

Strategic Commissioning Manager

Executive Leads

The Executive sponsors for the Adult Integrated Care Programme are Ian Curryer, Chief Executive of Nottingham City Council, and Dawn Smith, Chief Officer at Nottingham City CCG.

Maria Principe is the Director of Primary Care Development and Service Integration at Nottingham City CCG. Candida Brudenell is Director of Quality and Commissioning at Nottingham City Council.

Key contacts within the Adult Integrated Care Programme

Representing NHS Nottingham City Clinical Commissioning Group (CCG)

Dr Manik Arora

Dr Arora is a GP at the Rivergreen Medical Centre in Clifton. He leads on long-term conditions for the CCG. Email: manik.arora@nhs.net

Hazel Wigginton

Hazel is Assistant Director of Community Services and Integration at the CCG. She is responsible for overseeing the work of the Independence Pathway Implementation group and the Care Delivery Implementation group as part of the Integrated Care Programme. Email: hazel.wigginton@nottinghamcity.nhs.uk

Representing NHS Nottingham City Clinical Commissioning Group (CCG) and Nottingham City Council

Jo Williams

Jo is Assistant Director of Health and Social Care Integration and Chair of the Integrated Care Programme Board. She has previously led on the redesign of intermediate care and the development of the Crisis Response and integrated Community Neurology services. Email: joanne.williams@nottinghamcity.nhs.uk

Representing Nottingham City Council

Colin Monckton

Colin is Director of Commissioning Policy and Insight at Nottingham City Council. His previous experience in the private sector was in strategic planning and all aspects of customer insight. Email: colin.monckton@nottinghamcity.gov.uk

Antony Dixon

Antony Dixon is Strategic Commissioning Manager within the Children and Families Department at Nottingham City Council. Antony has responsibility for commissioning of adults provision and leads on the implementation of the Better Care Fund programme on behalf of the Council. Email: antony.dixon@nottinghamcity.gov.uk

Gemma Poulter

Gemma Poulter is Interim Health Integration Manager at Nottingham City Council and leads on Adult Social Care for the Integrated Care programme. Gemma is responsible for a number of the social care services which are key to the development of Integrated Care. Email: gemma.poulter@nottinghamcity.gov.uk

Representing Nottingham CityCare Partnership (CityCare)

Steve Upton

Steve Upton is Assistant Director of Urgent Care and Transformation and leads on the Independence Pathway for the Integrated Care programme. Email: steve.upton@nottinghamcitycare.nhs.uk

Tracy Keane

Tracy Keane is Assistant Director of Integrated Care and Transformation and leads on CDG and neighbourhood team development for the Integrated Care programme. Email: tracy.keane@nottinghamcitycare.nhs.uk



And finally...

A reminder of how to keep up to date with the Integrated Care Programme:

- Visit www.nottinghamcity.nhs.uk for updates
- Email: connectingcare@nottinghamcity.nhs.uk
- Contact any of the Programme Board members on the back page
- Look out for future issues of Connecting Care
- Talk to your line manager if you have any specific queries you would like raising.