

Mid-Nottinghamshire NHS Better Care Fund Case Study

August 2014

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SECTION 1

Introduction

This section explains the purpose of the case study.

Introduction

Purpose of this document

Nottinghamshire Health and Well-Being Board (HWB) is one of the fast-track sites for the BCF planning process.

NHS England has commissioned a case study from each of the fast-track sites to outline the step-by-step methodology used to develop the HWB area's plans.

It is the intention that these case studies will be beneficial for other sites by helping to articulate the approach taken using real-life examples. NHS Newark and Sherwood (N&S) CCG and NHS Mansfield and Ashfield (M&A) CCG work together in the Mid-Nottinghamshire area. This case study details their work on PRISM as an example of exemplar practice in of integrated health and social care planning.

Background for Nottinghamshire

During 2012 and in light of economic and demographic pressures, Health and Social Care leaders agreed that a whole-system strategic service review was required to identify options for a sustainable health economy across Mid-Nottinghamshire.

SECTION 2

Case for change

This section explains the national and local context and describes the rationale for implementing integrated care in Mid Nottinghamshire.

Case for change

The national picture

- Flat health care income.
- Reducing social care income.
- Aging population.
- Cost inflation above RPI.

The local picture

Long Term Conditions (LTC):

- Affect 30% of the population.
- There are more than 35,000 patients in Newark living with one or more long-term conditions.
- Account for 50% of GP consultations and 70% of hospital in patient bed stays.
- Average annual cost of £3000 for patients with 1 LTC and £8000 for patients with 3.
- In 2011/12 N&S CCG spent £4.45 million on unplanned admissions for people with LTCs.
- In 2012/13 N&S CCG has to make savings of £2 million.
- Number of people living with one or more LTC expected to rise by 252% by 2050.
- For Newark and Sherwood this would mean an extra 50,000 patients requiring significant health and social care input.
- The current system is unsustainable.

Disjointed services:

- GPs, social workers and district nurses were not well connected so referrals were time consuming to arrange.

SECTION 3

Using the evidence base to select appropriate interventions for the BCF plan

This section explains the step by step approach taken to create the plan for change and focuses on PRISM (Profiling Risk, Integrated Care and Self Management) as one of the identified interventions. It also covers the approach to risk stratification.

Using the evidence base to select appropriate interventions

National research

The evidence is clear that patients who are empowered, knowledgeable and supported, utilise services less and have better health outcomes. We used these key publications:

1. **“The Proposal for People Powered Health” Nesta and the UK Innovation unit** - estimate that the NHS in England could realise savings of at least £4.4 billion a year if it adopted systematic application of strategies which involve patients, their families and communities more directly in the management of long term health conditions. These savings represent a 7% reduction in spending in terms of reduced A&E attendances, planned and unplanned admissions, and outpatient admissions.
2. **Expert Patient Programme, 2010** showed that patients who took part in effective self-care / self-management programmes went on to use less NHS frontline services, amounting to an average cost saving per patient of around £1500 per year, every year.
3. **Devon and Torbay models for risk stratification** - the ‘Kaiser Triangle’ was used to focus services on patients with the most complex needs. Case management was used with these patients to maximise impact, reduce admissions and deliver savings. See appendix 6.5 for more details.

4. **The Year of Care report (DH, June 2011)** strongly evidenced that putting self management support in place through personalised care planning for people with long term conditions (LTC) provided a sustainable positive impact on reducing avoidable admissions and improving patient experience. The Year of Care model recognises best outcomes requires infrastructure as in the House of Care. The House of Care takes a whole system approach to LTC management. It makes the person central to care. See appendix 6.6.

Local evidence to support the case for change

What patients and Health and Care Professionals (HCPs) told us about Newark and Sherwood services:

- Disease specific – patients often under the care of 3 or more different teams / individuals
- Fragmented care with poor communication between teams
- Siloed services – health and social care working in isolation
- Confusion amongst HCPs and patients re what services are available and how to refer to them
- Lengthy referral times / waits
- Patients are falling through the gaps
- Lack of out of hours cover – only option for some is 999
- Primary Care and community services overloaded
- Reactive service – crisis management, rather than preventative care.

Using the evidence base to select appropriate interventions

The local approach to designing change

- Local Process Care Design Groups were formed and PwC were involved from January to April 2013 to help develop the blueprint model of care and strategic direction.
- In workshops, clinicians discussed examples of good and bad practice from elsewhere, and in the local area, to identify new ways of working.
- One example of good practice was PRISM (Profiling Risk, Integrated Care and Self Management), which Newark and Sherwood (N&S) CCG were already doing (details of the phase 1 PRISM project are given in the next slide).
- It was decided to roll PRISM out to Mansfield and Ashfield CCG, as one of a number of interventions emerging from the initial investigations.
- From August to December 2013 the detailed design work was done for the whole plan to develop the way forward and take the blueprint to a full proposal. This involved working with partners to fully develop the ideas and model the changes that would be required.

The solution?



- Provision of equitable and continuous care for people with LTCs, the frail elderly and people with cancer.
- Aims to transform the way we deliver care across the patch.
- N&S CCG joined the DH LTC QIPP Programme in 2011.
- National pilots (i.e. Torbay) have shown significant results and reductions in avoidable admissions.

Using the evidence base to select appropriate interventions

Developing our evidence base and plan – PRISM phase 1 was already underway:

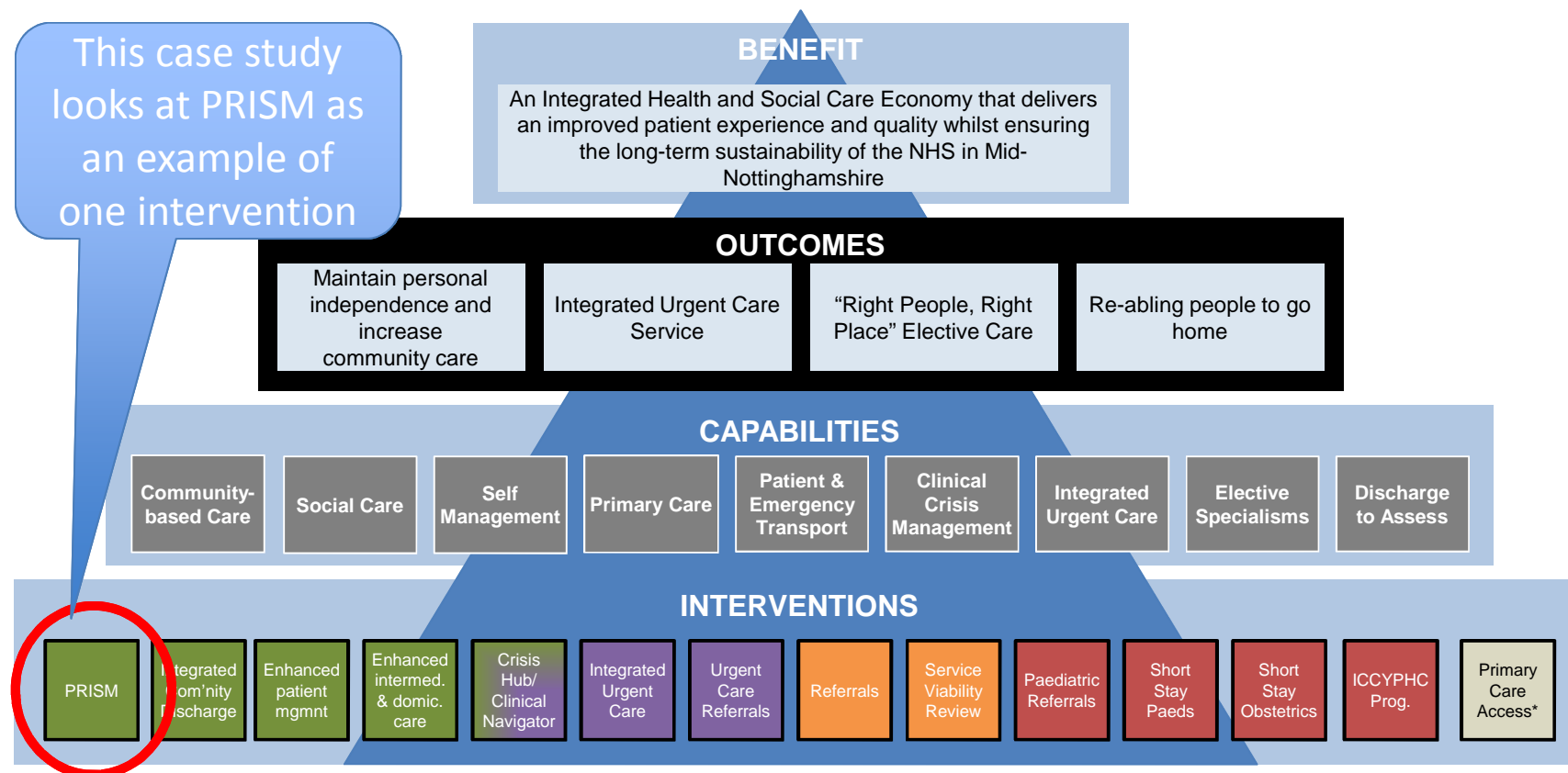
- Health care has historically focussed on treating individual conditions rather than focussing on the bigger picture and looking at the patient as a whole.
- This means that patients may be under the care of two, three or four different services or teams.
- To try and change this, Newark and Sherwood CCG launched PRISM.
- PRISM (Profiling Risk, Integrated Care and Self Management) is a new programme that aims to change the way that patients with long term conditions and the elderly within the district are supported.
- PRISM provides integrated care teams across Newark and Sherwood, incorporating GPs, District Nurses, Social Workers, Mental health nurses and Therapists to ensure that patients receive the right care from the right professional.
- Working with partners including Macmillan Cancer Support, Sherwood Forest Hospitals, County Health Partnerships and Nottinghamshire County Council, PRISM will deliver patient-centred, joined up care for patients in their own homes.
- The first phase of work comprised detailed analysis of current baseline, together with clinical leadership to scope new ways of working that met population health needs and completed in April 2013. This produced a “blueprint” for how services should look in 3 to 5 years. Wider stakeholder engagement is supporting implementation over 1 to 2 years.

Principles of the new approach:

- **Radical** – Completely redesign the system across the entire health economy.
- Work in partnership with all partners organisations.
- A focus on proactive care to anticipate and prevent crisis.
- Primary Care at the heart of the system – A community based model.
- **Systematic profiling and risk stratification** of the whole population and systematic streaming into dedicated services.
- **Integration of care** across the health and social care economy.
- Personalised care designed around the patients’ needs.
- **Care planning and shared decision making** to become systematically embedded into every day practice.
- Increased access to services around the clock and out of hours.
- Recognition of the need to **invest and commitment to do so.**

Using the evidence base to select appropriate interventions

The diagram below provides on one page the golden thread between benefit, outcomes, capabilities and interventions:



*Primary Care Access – this intervention is not within the scope of the ICTP or identified by a care design group, however it is felt this should be included in the scope of the next phase of the ICTP, to ensure that the health and social care economy continues to build the Primary Care capability

PRISM Programme – Phase 1 (Newark and Sherwood CCG)

Working with partners across the health and social care community, Macmillan Cancer Support and other third sector organisations, Newark & Sherwood CCG service improvement team designed and implemented risk stratification, integrated care teams for each of the three localities and tier three case management for patients with a long term condition.

The programme brings together three key elements of care:

1. Risk stratification

- The CCG commissioned a tool to stratify the population accounting to their risk of having an unplanned admission. It pulls on data from a wide range of sources to enable clinicians to accurately predict those patients at the highest risk and enables primary care and community services to proactively identify those patients who may need additional support, and who need either better management of their Long Term Condition from a specialist team, or 'admission' to a virtual ward to provide intensive support.
- The Devon Tool (replacing PARR) is available to all GPs in all practices to categorise patients. All practices trained and now using as part of multi disciplinary team meetings. Currently this tool is hosted in eHealthscope, which is a locally developed data integration and processing tool.

- Rationale - the combined Predictive Model utilised in Torbay ICP was 86% accurate in predicting future admission.

2. Developing integrated care teams and PRISM Plus

- Integrated Care Teams were set up across three localities in Newark and Sherwood, which brought together community nursing, mental health, social care, therapist support and healthcare assistants to work with Primary Care within a 'virtual ward' approach. There are specialist teams supporting the ICTs with long term condition management including diabetes, respiratory disease, heart failure and cancer.
- To support the PRISM programme, Self Help Nottingham and Nottinghamshire devised the innovative volunteer support project, PRISM Plus to connect the statutory sector with the voluntary sector support and advice services. The project is managed by Self Help Nottingham and Nottinghamshire and delivered by a team based at Newark and Sherwood Community and Voluntary Service (CVS). It provides an accessible signposting service to people who have been identified by GPs and other healthcare professionals and works with patients to identify lifestyle and social interventions to support health and well-being.

PRISM Programme – Phase 1 (Newark and Sherwood CCG)

3. Systemisation of Self Care and Care Planning

- Patients and clinicians work together to agree self management strategies to enable patients to live well with their conditions, and provide them with support and information on what actions to take when their condition is worsening. This includes support from self-help groups, voluntary sector providers as well as more traditional health care approaches.
- We are improving and enhancing provision of carer support, information giving and education.
- The inclusion of voluntary sector services improves patient/carer support.

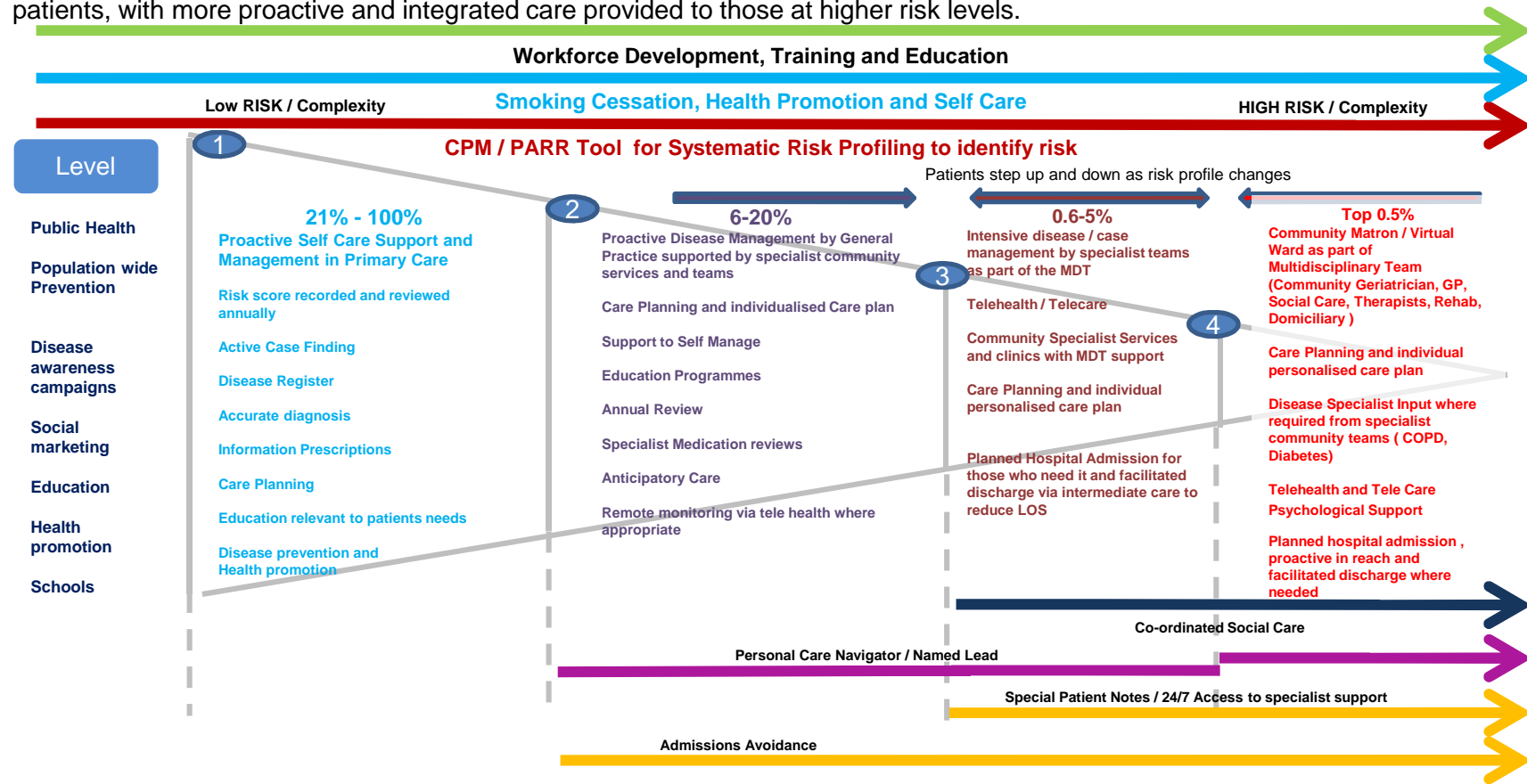
In summary - the evidence showed that it is the cumulative effect of each of these interventions and actions that will make a difference, we had to do them all together to realise the benefits.

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PRISM Programme – Phase 1 (Newark and Sherwood CCG)

PRISM – Newark and Sherwood Integrated Model of Care for Frail and Elderly and Long-term Conditions Patients

The model below sets out the Newark and Sherwood's PRISM model. The model outlines the use of risk profiling to identify patients at high risk of admission/ crisis. The focus is on proactive self care support and management in primary care for the vast majority of patients, with more proactive and integrated care provided to those at higher risk levels.



PRISM Programme – Phase 1 (Newark and Sherwood CCG)

Integrated Care Teams

3 x locality based Multi-disciplinary teams / Virtual Wards:

1. North Ward launched Dec 2012,
2. West Ward in March 2013,
3. Newark Ward April 2013.

Each team comprising:

- 2 x Community Matrons
- District Nurse
- Occupational Therapist
- Physiotherapist
- Mental Health Worker
- Social Worker (directly commissioned from LA by the CCG)
- Healthcare Assistants
- Voluntary / Third Sector Workers
- Ward Coordinator/ Manager

(all WTE posts)

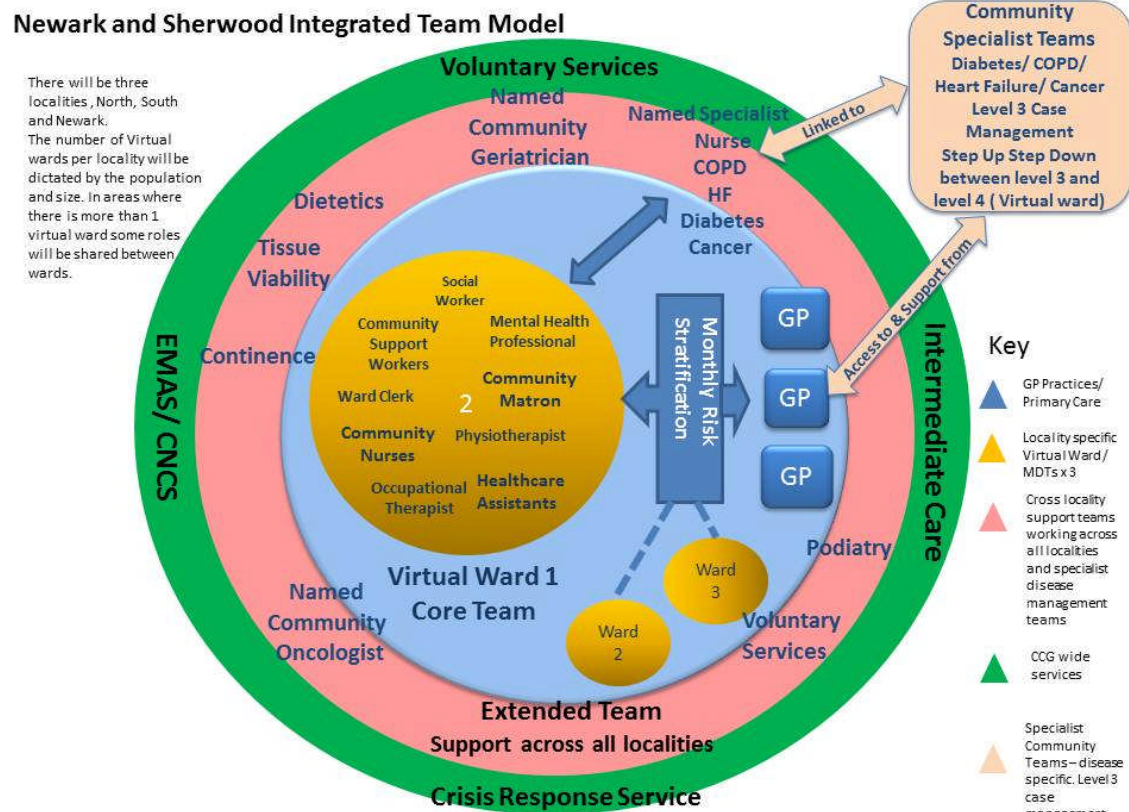
Underpinned by:

- Specialist case management teams (Level 3) for COPD, Heart Failure and Diabetes.
- Community based clinics (CVD, COPD, Diabetes) with commissioned consultant specialist support.
- Community nursing teams and GP practice teams integrated and aligned with each of the 3 ward teams throughout.
- Care Homes integrated into the Virtual wards – people treated as if they were in their own home.
- In the process of commissioning Community Geriatrician support.
- Increased provision of Intermediate care beds (Step up and Step down).
- Procurement of new Crisis Response Service.

PRISM Programme – Phase 1 (Newark and Sherwood CCG)

PRISM – Newark and Sherwood Integrated Model of Care for Frail and Elderly and Long-term Conditions Patients

As part of the more proactive and integrated care provided to those patients at higher risk levels, PRISM puts in place a virtual ward around a specific patient in a community setting. This ward is managed by a community matron and can draw on specialist community teams to prevent the need for patients to receive reactive care in a hospital setting.



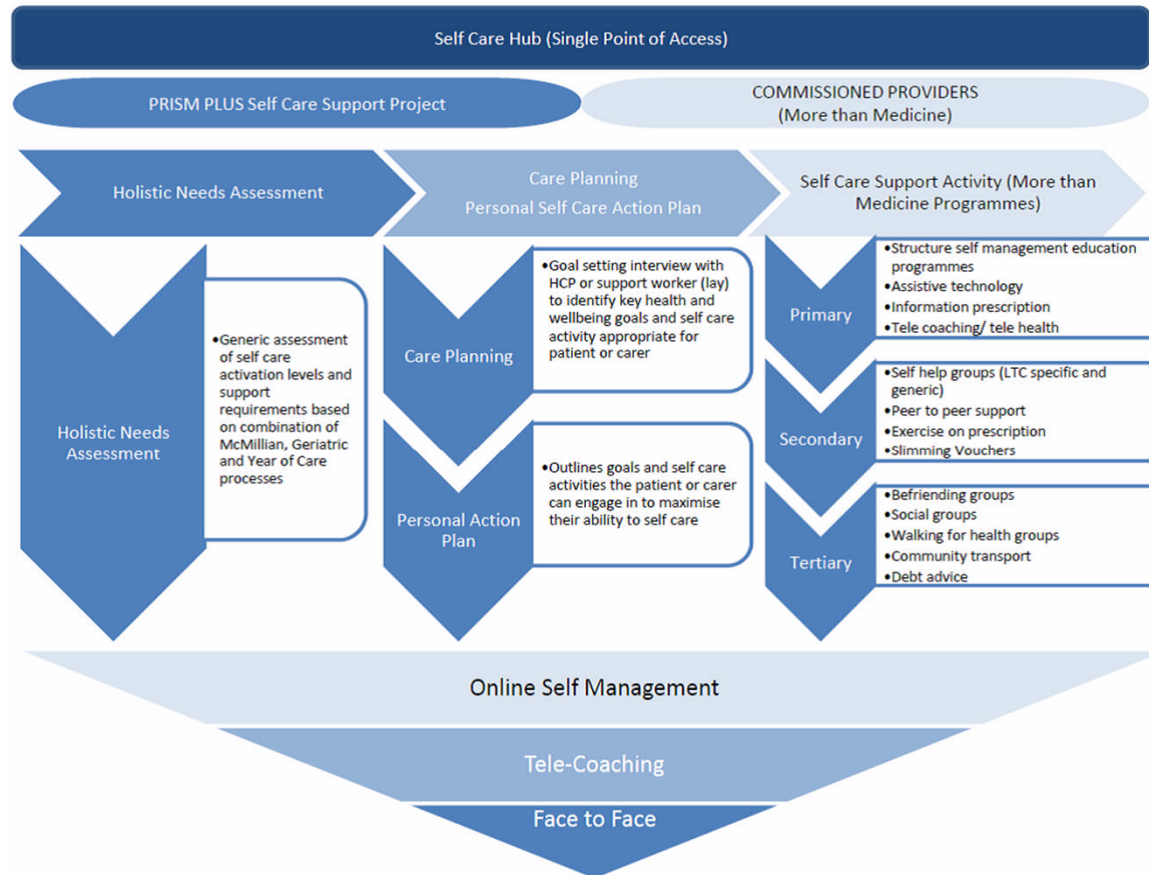
PRISM Programme – Phase 1 (Newark and Sherwood CCG)

Integrated working and PRISM Plus

Figure: Mid-Nottinghamshire Enhanced Patient Management Model – Overview

This diagram shows how care will be driven from the self-care hub supported by the PRISM PLUS self care support model and commissioned providers. Needs assessments will be holistic and the action plans will involve the patients' self-care goals. Support will come from a range of primary, secondary and tertiary sources.

Patients with a Long term Condition will be able to access support from the hub by self-referral or via referral from a healthcare professional or care provider.



PRISM Programme – Phase 1 (Newark and Sherwood CCG)

Self-care Hub

Co-ordination and delivery structured education programmes for Long Term conditions. The hub will work closely with commissioners to identify what type of programmes are required, and develop a rolling programme, which may be delivered by third parties of education. It is recognised that many of the elements of structured education for specific LTC's are common across all LTCs, allowing some economies of scale to be achieved via delivery of generic modules within specialist programmes.

- It will enable patients to access information and support to better manage their long term condition, to be signposted to self-care options, which can help them to make positive life style changes and learn essential skills.
- The hub will work closely with virtual ward teams as patients either in intermediate or proactive care are likely to benefit most from self care.
- A Directory of Services (DOS) will be developed which will detail all self-care support and services available.

PRISM Programme - Phase 2 (whole of Mid-Nottinghamshire)

- The clear rationale underpinning the improvements required in community services to begin the necessary transfer of care from the acute sector meant that in July 2013, it was decided that the programme would be implemented across the whole of Mid Nottinghamshire as part of the Integrated Care Transformation Board and would incorporate the management of a growing number of patient needs in addition to long term conditions.
- Mental health assessment has been integrated with the locality teams.
- Macmillan Cancer Support and Newark and Sherwood CCG have been working in Partnership since July 2012. They aim to integrate Primary and Community cancer care for people from the point of referral for diagnosis, into the CCGs Long Term Conditions PRISM Programme.

Key steps were:

- Agreeing the structure across Mansfield and Ashfield.
- Building the business case to underpin investment.
- Mobilisation:
 - Devon Tool and eHealthscope.
 - Recruitment and induction of additional staff.
 - MDT training and support.
 - Alignment / integration of existing community services into locality structures.
 - Self Care Strategy.
 - Development of pathways to underpin basic model.

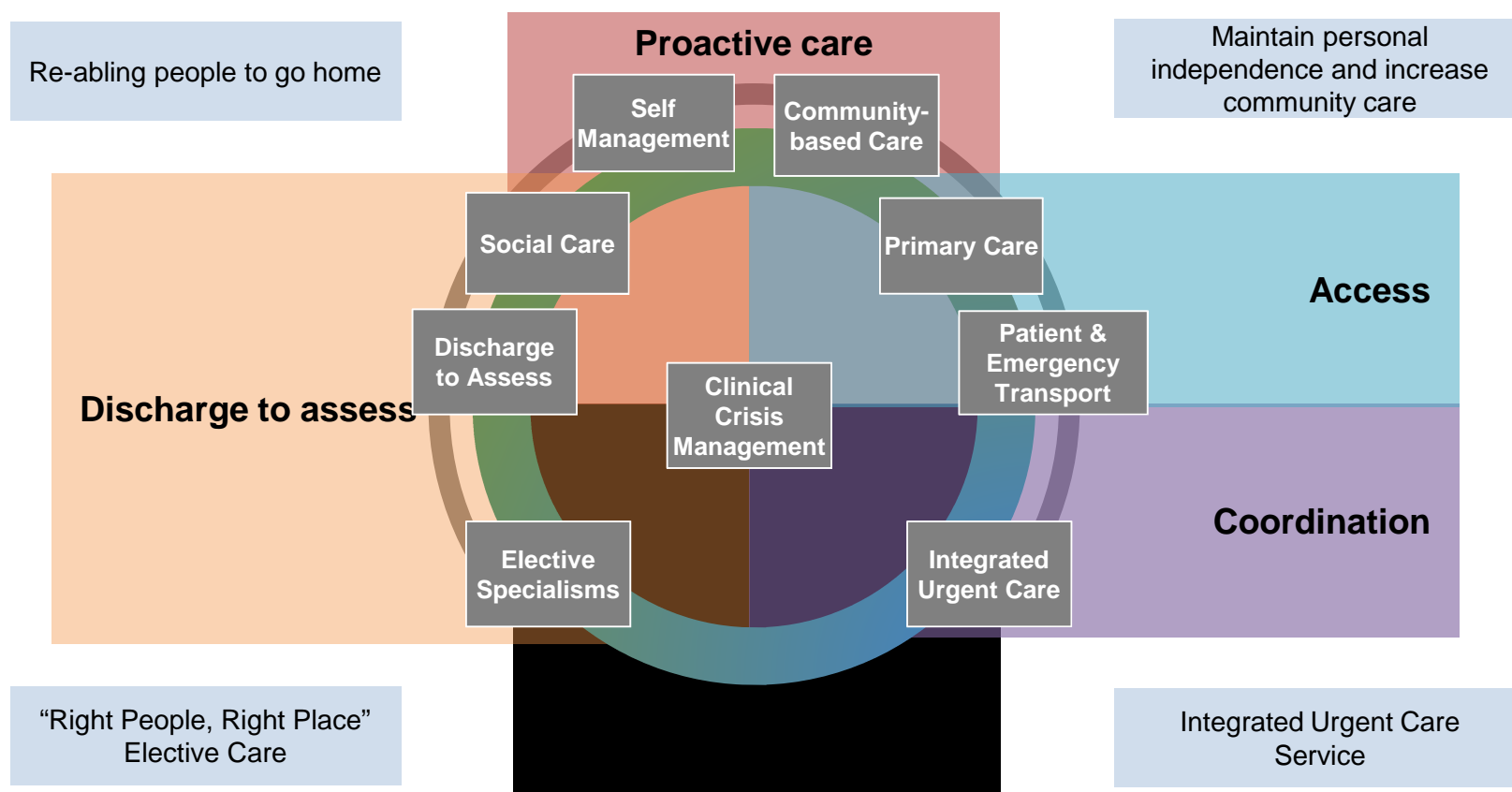
How this fits in with the Better Care Fund (BCF) Plan

- The Nottinghamshire BCF plan is formed from the schemes from each planning area; Mid-Nottinghamshire, South Nottinghamshire and North Nottinghamshire.
- PRISM became a key part of the Mid-Nottinghamshire schemes in Annex 1. There are two schemes that relate to PRISM:
 - Scheme K: Locality Integrated Care Teams, and;
 - Scheme L: Self-Care Management.
- The objective of both schemes is to reduce the time spent avoidably in hospital through integrated care and better community services (development of an integrated proactive and urgent care system).
- Self-care management aims to achieve this by:
 - Empowerment of people through better understanding of the health and social aspects and their ability to act and be supported.
 - Co-creation of wider support services by the third sector in supporting carers, increased volunteering and training of professionals.

Future model of care for health and social care services

The Future Model of Care

The diagram below details, on one page, the proposed future model of care. This model is intended to encompass the full spectrum of physical health and social care services across Mid-Nottinghamshire.



SECTION 4

Modelling the impact of interventions on activity

This section explains the step by step approach taken to model the impact of PRISM.

Modelling the impact of the interventions on activity

Summary of Scheme K: Locality Based Integrated Care Teams

- The Locality Based Integrated Care Teams (LICTs) primarily provide two types of care:
 1. proactive care.
 2. low and enhanced categories of intermediate care.
 3. they also support self-care.
- The proactive services provided by this team build on existing models of care currently in operation through the PRISM programme in Newark and Sherwood. This service is being expanded to Mansfield and Ashfield but will also operate considerably longer working hours (8am to 10 pm).
- Further to this, the same teams will provide low and enhanced intermediate care. This care will be provided 24 hours per day (although the support between 10pm and 8am will be considerably reduced and therapy services will only be provided between 9am and 6pm).
- For modelling purposes each of these two parts was calculated separately then combined to produce the Locality Based Integrated Care Teams.

Summary of Scheme L: Self Care

- The self care workforce figures have been built on a 'bottom up' basis, drawing on the experiences of providing a similar service in another part of the Nottinghamshire system.
- We plan to expand the service across Mid-Nottinghamshire which will require an increase in workforce numbers and ensure that it is accessible at least one evening per week and one day over the weekend.
- The success of this service is dependent upon relationships with the 3rd sector. The vision is that there will be a healthy mix of unpaid, volunteer roles working alongside paid employees and that over time, there will be a healthy talent pipeline between the two strands of the workforce. E.g. health and social care professionals who retire may wish to join a vibrant group of volunteers, providing self-help services, and individuals who volunteer within the service may use this experience to support their entry into paid employment. The workforce model assumes that all staff are paid employees at this point, reflecting a cautious approach, but nevertheless important in terms of getting the service embedded into the community and on a sustainable footing.
- The next stage of the modelling will be to phase in the mixed workforce, showing a mix of volunteers and paid employees. There will need to be some volunteer co-ordinators, responsible for sourcing and working with volunteers, reflecting their differing needs.

Modelling the impact of the interventions on activity

Approach to modelling the impact on costs

1. The modelling work to roll out PRISM across the whole area was led by the Proactive work-stream. They took the strategic thinking for PRISM and firmed up the local ideas and approach.
2. Costing workshops were held to decide what the model would look like e.g. a virtual ward and how it would be staffed, where it would be located etc. Using this information, Mid-Nottinghamshire used external consultants, PwC to cost the staff roles.
3. PwC worked with Community Health Partnerships (CHP) across Nottinghamshire, who were able to give advice on appropriate staff bandings.
4. Using this information and the nationally set salaries a new staff cost model was created.
5. The existing workforce costs were deducted.
6. Estate costs were considered but not included in the modelling because existing premises and patient's home will be used in the new model.
7. Technology costs were calculated at a programme level.

Approach to modelling the impact on benefits

1. Benefits were also modelled bottom up.
2. The approach was to identify the types of patients impacted.
3. Once patients groups were identified we conducted a detailed analysis of the probable impact.
4. We drew on national evidence from other areas e.g. the Liverpool self-care model, for example, the Liverpool Public Health Observatory in 2007 noted: 'Public information campaigns for instance, using social marketing such as "Choose Well" on Merseyside has been shown to facilitate the reduction by 6.4% in A&E attendances during one year. The report included as one of the recommendations from published evidence: Public information campaigns using social marketing may be effective in reducing A&E attendance by advertising alternative action. By investing in self-care hubs in Mid-Nottinghamshire and providing education to enable patients to make better choices, we expect to see a similar reduction in admissions.
5. Other national research which we drew on is mentioned in Section 3, page 8 and in the next section slides 25/26.
6. We also used our past experience from the initial roll out of PRISM in Newark and Sherwood.

SECTION 5

Translating the impact into financial benefit

This section explains the step by step approach taken to calculate the financial costs and impact of PRISM

Translating the impact into financial benefit

The PRISM programme has shown demonstrable reductions in emergency admissions for patients with Long Term Conditions. We have already seen evidence of this from the initial roll out with Newark and Sherwood CCG. Out projected costs and benefits are based on this evidence.

Costs

Figures from Part 2, Tab 3, for schemes relevant to PRISM (i.e. K - Locality Intermediate Care Teams and L - Self-care Service):

Scheme Name	Area of Spend	Commissioner	Provider	Source of Funding	2014/15 (£000)	2015/16 (£000)
K/M - Locality and Specialised Integrated Care Teams	Community Health	CCG	NHS Community Provider	Additional CCG contribution	3,500	1,459
As above	As above	CCG	As above	CCG minimum contribution	-	11,172
As above	As above	CCG	NHS Acute Provider	Additional CCG contribution	-	1,435
L - Self Care Service	Community Health	CCG	NHS Community Provider	CCG minimum contribution	-	160
Totals					3,500	14,226

Explanation of figures:

- £3.5m is made up of £1.4m existing budget based on the costs of NSCCG integrated care team 13/14, plus £2.1m of new spend from 14/15 for expanding the Locality Based Integrated Care Teams (LICTs), again based on experience of prior year costs applied to the growth model.
- £1.459m is the projected cost of specialist intermediate care teams in 2015/16 as mobilisation commences. The full annual costs are budgeted to be £3.8m.
- £11.172m is made up of £1.4m existing budget based on the costs of NSCCG integrated care team 13/14, plus £9m additional investment in 2014/15 and 2015/16 for further expansion of the LICTs. £600k is for new costs for the 'Care Navigator' service. £172k is the projected cost of specialist intermediate care teams.
- £1.435m is the existing budget (based on prior experience) for the DTOC team and EDASS.
- £160k is for new costs of providing the self care service.

Translating the impact into financial benefit

Benefits

Figures in Part 2, Tab 4, for schemes that are relevant to PRISM (i.e. K - Locality Intermediate Care Teams and L - Self-care Service):

Year	Benefit achieved from	Scheme Name	Organisation to Benefit	Change in activity measure	Unit Price (£)	Total (Saving) (£)	How was the saving value calculated?	How will the savings against plan be monitored?
14/15	Reduction in non-elective (general + acute only)	K - Local Intermediate Care Teams	NHS Commissioner	(608)	1,750	(1,064,000)	Based on research (see Annex 1) and performance of the NSCCG LICT during 2013/14 and extrapolated.	Reported avoided admissions by the LICTs.
15/16	As above	As above	As above	(1,484)	1,750	(2,597,000)	As above	As above
15/16	Prescribing Savings	As above	As above	(1)	200,000	(200,000)	Based on research and input from prescribing team	Through prescribing monitoring

Explanation of figures:

We have modelled the potential financial benefits of PRISM based on initial benefits from PRISM in Newark, benefits realised in other similar schemes elsewhere in the UK and Care Design Group input. The anticipated reduction in non-elective (general + acute only) admissions was based on research into the use and impact of integrated care teams:

- The most well-known and successful example of integrated care is that of Kaiser Permanente in the U.S. which focuses on integrating services and removing distinctions between primary and secondary care for people at all stages of the risk pyramid. Multi-disciplinary teams operate out of specialist centres and people with Long Term Conditions are stratified and appropriate interventions delivered dependent on their risk levels.

Translating the impact into financial benefit

Benefits explanation (continued)

- The DH funded a programme of integrated care pilots involving 16 areas in England all trialling various degrees of integration from disease specific integrated care pathways to organisational integration across health and social services. The Torbay ICP which focused on delivering a locality based service, aligned with general practices and comprising integrated health and social care teams, for the care of older people, has demonstrated measurable progress in reducing reliance on acute hospital services and a reduction in emergency bed days used.
- Part 2 sets out the forecast reduction in non-elective admissions and reduced pharmacy costs associated specifically with this intervention. The LICTs are in place and we expect benefits from 2014/15.
- Locally, the PRISM programme in Newark and Sherwood which has been underway since 2012 and has shown demonstrable reductions in emergency admissions for patients with Long Term Conditions. Since PRISM Phase 1 (the first 12 months in N&S), pathway and service changes were preventing more than 50 non-elective admissions a month to secondary care for CCG patients with long term conditions. This totalled just over 600 per year. Based on this we have used a conservative reduction estimate of -608 in 2014/15 increasing to -1484 in 2015/16 once PRISM is fully established across the whole area. This is based on trajectories & QIPP forecast but also reflecting the fixed position in Q2 & Q3 in 14/15. Phased to be more effective in 15/16 but still in line with QIPP plan. For a snapshot showing our past experience of admission reductions see appendix 6.4.
- The unit cost of £1750 is the standard cost used in our management reporting based on the average cost of a shorter stay non-elective admission, age 65+ with ambulatory care sensitive conditions. This was chosen as a good indicator of a potential avoided admission.
- The anticipated reduction in prescribing costs was a Care Design Group assumption based on experience with the respiratory programme.
- Note on dependencies: Locality Integrated Care is one of a number of schemes that need to be developed conterminously in order to have their full impact so it links to the development of improved primary care and specialist Intermediate care. The impact of these interventions is expected to reduce non-elective admissions and deliver savings associated with A&E conveyances, A&E attendances and prescribing. Overall, the full impact of the five-year Better Together programme is expected to deliver the following reductions: A&E attendances -15%, Non-elective admissions -19.5%, Bed days -30%

SECTION 6

Appendices

This section gives links to additional reading and supporting information.

6.1 Further Reading

<http://bit.ly/1tTfeWH> Mid-Nottinghamshire NHS Integrated Care Transformation Programme (ICTP)

<http://www.selfhelp.org.uk/notts-prism/>

<http://www.newarkandsherwood.nhs.uk/innovationzone/prism>

<http://www.chad.co.uk/news/health/prism-integrating-care-in-newark-and-sherwood-1-5003825>

<http://www.nandscvs.org/Community-Engagement/PRISM/Prism-Plus.cfm>

<http://long-term.nottsinfoscript.co.uk/organisation/prism-plus>

<https://www.youtube.com/watch?v=rqAgM-e0gCw>

<http://www.local.gov.uk/documents/10180/12193/Torbay+-+How+%27Mrs+Smith%27%20revolutionised+health+and+social+care/1f28d9aa-2022-498a-99a9-1f9661037b6c>

<http://www.mansfieldandashfieldccg.nhs.uk/index.php/board-papers/september-2023>

Research

www.diabetes.org.uk/upload/.../Year%20of%20Care/YOC_Report.pdf

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/avoiding-hospital-admissions-lessons-from-evidence-experience-ham-imison-jennings-oct10.pdf

<http://www.england.nhs.uk/house-of-care/>

6.2 Testimonials from the PRISM integrated care pilot

- Dr Kate Jack, Clinical Champion for Integrated Care, and local GP said;** “PRISM is an exciting and ambitious programme which will truly place the patient at the heart of services in Newark and Sherwood. Partners are working together to create a sustainable system to ensure that we can deliver first class care in the future. Working as part of the Integrated Care teams will ensure that my patients receive the most appropriate care, from the most appropriate person.”
- Patient experience:** the enthusiasm for this system which is unique to Newark is amazing and it shall work because we believe it is in the interests of patients be treated where they are most comfortable. I have recently had experience with a couple who had a whole series of husband fall, 999 and hospital and this had gone on for years. He also has prostate cancer and lots of other things that are on-gong and long-term conditions and the cycle was getting less it was approximately every three months that he was gong to hospital. Last June he fell again and was admitted to hospital but this time he was transferred to the community ward. Whilst eh was there he was thoroughly assessed and taken to his home in an ambulance so they could see what he needed at home and the team was put in place. The major difference being when someone comes now it’s someone who has his medical history.
- Since he’s been having the home help he’s been able to start walking with a walker again and a fortnight ago for the first time in four years he actually walked with a stick. So for the wife, it’s peace of mind, and not having to worry in the dark moments in the middle of the night whether you ought to call 999 or whether it would be crying wolf, which is what happens if you don’t have a team. It’s about the fact that the anxiety doesn’t build up because she knows there are people there not just for him but for her as well. Since the fall in 2013 he’s not been back to hospital because the care team anticipate what problems may come or discuss those that are starting and they nip them in the bud because they can bring in another member of the team if another skill is required. That is the secret of PRISM and it’s wonderful and it works.

6.3 Workforce modelling – approach and questions

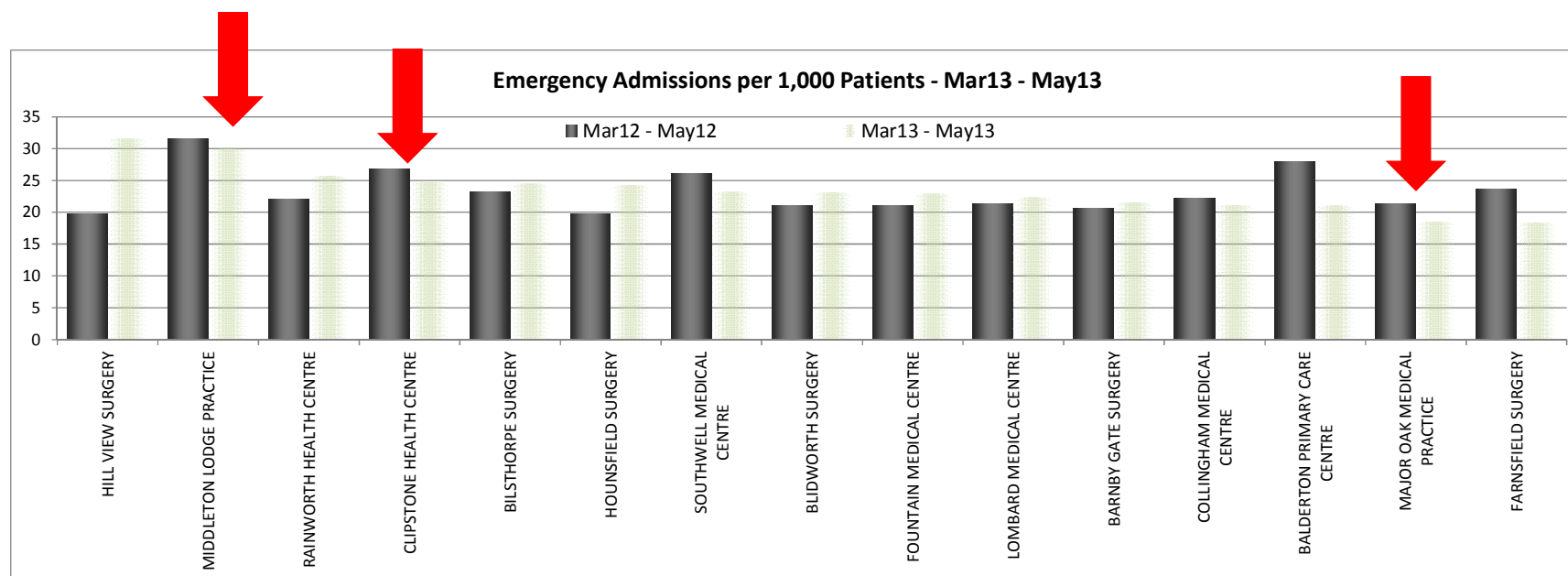
In order to deliver the changes required, these were some of the key considerations:

1. What are the workforce requirements to deliver the change? What roles are required? Where will those roles be based? And what are the potential phasing requirements?
2. What are the potential efficiency / productivity opportunities to be gained, through the workforce from new roles and different ways of working?
3. How will the workforce support the desire to provide truly integrated care across the Mid-Nottinghamshire health and social care community?
4. What is the current supply of the workforce and how will recruitment, retention and training requirements impact on that supply?
5. What considerations need to be given to the technical aspects of the transition?
6. How will the healthcare system manage the transition, maintaining the engagement of a loyal and committed workforce, ensuring that the change is managed in a truly engaging and involving way, providing a foundation for its long-term sustainability?
7. Agree the service hours:
 Locality Based Intermediate Care Teams Planned operating hours:-
 Proactive care services: 7 days per week, 8am-10pm
 Therapy services: 7 days per week, 9am-6pm
 Other intermediate care services: 7 days per week, 24 hours per day (reduced cover 10pm-8am)
 Self care services: To be confirmed but likely to be 6 days per week, 8am-6pm

6.4 Local evidence base

Newark & Sherwood Emergency Admissions March to May 2013 vs March to May 2012. North Locality ICT launched in Jan 2013

After initiating the PRISM programme, 3 Practices in the locality, all showed reduced unplanned admissions vs previous 12 months.



6.5 The Devon Model

The county of Devon have been running integrated care with risk stratification across the county for 3 years. The risk profiling software was 86.5% accurate in predicting unscheduled hospital admission in the top 200 high risk patients.

Accurate placing of patients into the ‘virtual ward’ delivered less emergency admissions and saved money.

The county of Devon was split into three operational localities.

- Locality A bought into the LES and had project management support
- Locality B bought in to the LES but didn't have project management support and local support across the area was patchy
- Locality C didn't buy into the LES and had no project management support and very little local support (and had the largest population)

The evaluation after 3 years showed the following results:

Locality	Average VW occupancy	Average VW occupancy chosen from top 0.5% risk	Average VW occupancy chosen from low risk	Percentage of practices hitting 2011 DPM LES targets	First quarter net admission change 2009 to 2011 for top 0.5% cohort*	Change in actual PbR cost associated with net admission change*
Locality A	107.4%	45.2%	15.5%	65.5%	-22.06%	-£845,310
Locality B	98.8%	37.8%	21.6%	42.9%	-14.24%	-£210,758
Locality C	90.3%	28.7%	26.4%	19.2%	3.91%	£151,742

6.6 NHS England – The House of Care

Enhancing the quality of life for people living with long term conditions (LTC) – The House of Care. The House of Care takes a whole system approach to LTC management. It makes the person central to care. It is about aligning levers, drivers, evidence and assets to enhance the quality of life for people with long term conditions no matter what or how many conditions they have.

