Integrating Community Services for Patients with Multiple Long-term Conditions and the Frail Elderly

Lessons from the Mid Nottinghamshire Transformation Programme

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Director of NHS Strategy and Operations
neoNavitas Limited
About Me

- **Associate Director of Integration and Unplanned Care – Newark and Sherwood CCG**
  - Design and development of PRISM Integrated Care Model as part of the national LTC / QIPP programme

- **Associate Director of Transformation – Mid Nottinghamshire Better+ Together Transformation Programme**
  - Lead for scale up and roll out of enhanced health and social care model across Mid Nottinghamshire

- **Associate Director of Transformation – Nottinghamshire Healthcare Trust (Community Services provider)**
  - Lead for implementation of community services element of the model

- **Director NHS Strategy and Operations – neoNavitas Ltd**
  - Supporting NHS organisations to develop strategic capability for system wide integrated care
Today

• Why we had to change
• PRISM Integrated Care Model
• Scale Up and Roll Out – Transformation across Mid Nottinghamshire
• Challenges and Lessons Learned
• Early Wins?
• Next Steps
Mid Nottinghamshire Health and Social Care Economy

Headlines
- 2 CCGs
- 315,000 pts
- £382 million budget
- 46 GP Practices
- 1 main acute provider across 2 sites (Sherwood Forest NHS Trust)
- 1 main community and mental health services provider (Nottinghamshire Healthcare Trust)
- Adult Social care provided by Notts County Council
This is Albert

- 76 years old
- Ex Miner
- Heart Failure
- Diabetes
- Hypertension
- History of alcohol abuse

He is married to Mary who is 74. She has osteoporosis, diabetes and arthritis. They live in a 3 bed ex council house in a rural area with a dog called Fred and have lost touch with most of their friends. They have 3 children who all live away.
A case for change

Is the Health and Social Care system providing the best possible service for those who need to use it?
The Financial Challenge

Gap between funding and costs of care (£mn)

Total population gap = £70mn
85+ population gap = £120mn

Total population gap = £140mn
85+ population gap = £280mn

Sources: ONS data and sources on previous slides
Our Challenges – What is driving the requirement for whole system change?

• Ageing population – Over 65s will account for 23% of our population by 2020
• Increasing number of people with multiple long Term Conditions
• Non elective admission for people with multiple LTC and age > 75 is increasing year on year and at a higher rate than any other group.
• Sherwood Forest NHS FT has the second highest non-elective length-of-stay (7.8) for Frail and Elderly and Long-term Conditions across the East Midlands and above the national average.
• Between April 12 and March 13, 466 patients were classified as Delayed Transfer of Care (DTOC) and accounted for 18,363 excess bed days
• Acute Trust in financial difficulties largely due to PFI
• Analysis indicates that there will be an additional 22,798 occupied bed days for over 75s in FY13/14: an increase of 21% on FY12/13. This equate to a requirement for 66 additional beds.
• Local Authority funding cuts (30%)
• Patients are receiving services that are delivered by multiple organisations in a fragmented way
• Hospital based care is becoming the default.
Patients and healthcare professionals told us that services were....

- Disease specific – patients often under the care of 3 or more different teams / individuals
- Fragmented, with poor communication between teams
- Isolated – Silo services with health and social care working in isolation
- Confusing – HCPs and patients don’t always know what services are available and how to refer to them
- Frustrating, with lengthy referral times / waits
- Inconsistent, with patients falling through the gaps
- Limited, particularly in relation to out of hours cover – only option for some is 999
- Overloaded, especially primary care and community services
- Reactive – care is based around crisis management
Added Together The System is Unsustainable
Quality of life

Moving Care into the Community

INTEGRATED CARE
- Self-management
- Risk profiling
- Long Term Condition Management incl. Cancer

COMMUNITY CARE
- Consultant-led services
- Specialist teams

SHIFT LEFT

ACUTE CARE
- Specialty Clinic
- Planned procedures
- ICU

Cost of Care per Day

0%

100%
INTEGRATING CARE ACROSS NEWARK AND SHERWOOD
Our Vision

To work collaboratively with our partners across the health economy to:

- Transform the way we deliver care by creating a whole system, fully integrated hospital, community, primary and social care model.
- Improve outcomes for patients with Long Term Conditions and the frail elderly.
- Create access to better, more integrated care outside of hospital
- Reduce unnecessary hospital admissions
- Enable more effective working of healthcare professionals across provider boundaries.
- Address the significant economic challenges ahead
Our Partners

- Sherwood Forest Hospitals Foundation Trust
- Health Partnerships (Community and Mental Health Services Provider)
- Nottinghamshire County Council
- East Midlands Ambulance Service
- GP OOHs provider (CNCS)
- Newark and Sherwood District Council
- Newark and Sherwood CVS and other third sector organisations
- Self Help Nottingham (Self Care)
- Patients
- Carers
Principles of the PRISM 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
- **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**
Risk Stratification
Risk Stratification

- Using risk profiling software – *The Devon Tool* available to all GPs in all practices.
  - Accessed via portal on S1.
- Combined Predictive Model developed and utilised in Torbay ICP.
- Demonstrated 86% accuracy in predicting future admission
- Utilised in 2 ways
  - Service Planning and commissioning
  - Practice Level Patient Identification
Mid Notts Integrated Model of Care for Long Term Conditions

Devon Tool for Systematic Risk Profiling to identify risk

Patients step up and down as risk profile changes

Level

1. 21% - 100%
   Proactive Self Care Support and Management in Primary Care
   Risk score recorded and reviewed annually
   Active Case Finding
   Disease Register
   Accurate diagnosis
   Information Prescriptions
   Care Planning
   Education relevant to patients needs
   Disease prevention and Health promotion

2. 6-20%
   Proactive Disease Management by General Practice supported by specialist community services and teams
   Care Planning and individualised Care plan
   Support to Self Manage
   Education Programmes
   Annual Review
   Specialist Medication reviews
   Anticipatory Care
   Remote monitoring via tele health where appropriate

3. 0.6-5%
   Intensive disease / case management by specialist teams as part of the MDT
   Telehealth / Telecare
   Community Specialist Services and clinics with MDT support
   Care Planning and individual personalised care plan
   Planned Hospital Admission for those who need it and facilitated discharge via intermediate care to reduce LOS
   Disease Specialist Input where required from specialist community teams (COPD, Diabetes)
   Telehealth and Tele Care Psychological Support
   Planned hospital admission, proactive in reach and facilitated discharge where needed

4. Top 0.5%
   Community Matron / Virtual Ward as part of Multidisciplinary Team (Community Geriatrician, GP, Social Care, Therapists, Rehab, Domiciliary)
   Care Planning and individual personalised care plan
   Disease Specialist Input where required from specialist community teams (COPD, Diabetes)
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Public Health
Population wide Prevention
Disease awareness campaigns
Social marketing
Education
Health promotion
Schools

Workforce Development, Training and Education

Smoking Cessation, Health Promotion and Self Care

Low RISK / Complexity

High RISK / Complexity

Co-ordinated Social Care

Personal Care Navigator / Named Lead

Admissions Avoidance

Special Patient Notes / 24/7 Access to specialist support
<table>
<thead>
<tr>
<th>Practice</th>
<th>NHSNumber</th>
<th>Name</th>
<th>Activity</th>
<th>Status</th>
<th>Risk</th>
<th>Change</th>
<th>Caseloads eol/copd hf/comm</th>
<th>Comment</th>
<th>Last updated</th>
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<tbody>
<tr>
<td>C84087</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>95.87</td>
<td></td>
<td></td>
<td>deducted from practice as patient has moved 05.11.2012</td>
<td>08/11/2012 13:16:58</td>
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<tr>
<td>C84087</td>
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<td></td>
<td>Action taken</td>
<td>93.67</td>
<td>95.44</td>
<td></td>
<td></td>
<td>under care of Community Matron, records reviewed today by Dr Bolsher, to consider reducing Bisoprolol to 2.5mgs bd post myocardial perfusion scan</td>
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<td>C84087</td>
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<td>Not reviewed</td>
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<tr>
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<td>Action taken</td>
<td>86.79</td>
<td>90.21</td>
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<td>Referred to CM team</td>
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<td>C84656</td>
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<td>C84087</td>
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<td></td>
<td>84.1</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Notes:**
- **Risk:** The risk level of each patient.
- **Change:** Indicates if the risk has increased or decreased.
- **Caseloads eol/copd hf/comm:** Cases load information related to end of life, chronic obstructive pulmonary disease, heart failure, and community healthcare.

**Comment:** Details of the actions taken or comments made about each patient's condition.
Integrated Care
Locality Based Integrated Care Teams

- Locality based Multi-disciplinary teams / Virtual Wards aligned with named GP Practices covering 100% of adult population
- Each team comprising: (all WTE posts)
  - Community Matrons
  - District Nurses
  - Specialist nurses – Resp, Diabetes, CVD, Mental Health
  - Therapists
  - Social Worker (directly commissioned from LA by the CCG)
  - Healthcare Assistants
  - Voluntary / Third Sector Workers – Part of the MDT
  - Ward Coordinator/ Manager
  - Intermediate care / Falls Teams now being integrated
PRISM Integrated Team Model - LOCALITY VIEW

Community Specialist Teams
- Diabetes / COPD / Heart Failure / Cancer
- Level 3 Case Management
- Step Up Step Down between level 3 and level 4 (Virtual Ward)

Linked to

Monthly Risk Stratification

Access to & Support from

Key

- GP Practices / Primary Care
- Locality specific
- Virtual Ward / MDTs x 3
- Cross locality support teams working across all localities and specialist disease management teams
- CCG wide services
- Specialist Community Teams – disease specific. Level 3 case management

Voluntary Services
- Named Community Geriatrician
- Community Support Workers
- Community Matrons
- Social Worker
- Mental Health Professional
- Community Nurses
- Physiotherapist
- Healthcare Assistants

Voluntary Services
- GP

Intermediate Care

Virtual Ward Core Team

Extended Team
- Support across all localities

Crisis Response / Rapid Intervention Service
Mid Notts Integrated Model of Care for Long Term Conditions

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Systematisation of Self Care
Systemisation of Self Care and Care Planning

- Support to increase patient involvement in their own care
  - Education
  - Confidence
  - Access to relevant support networks
- Consultative care planning – we will do “with” and not “to”
- “No decision about me without me”
- Not just about giving information
- Improving and enhancing provision of carer support, information and education
- Inclusion of voluntary sector services to improve patient/carer support
- Year of Care approach – wide scale training for clinical teams and GPs

- Self Care is EVERYONES responsibility during EVERY patient contact
The *evidence* shows that it is the *cumulative effect of each* of these intervention and actions that makes a difference.....

*We have to do them all*
• Health and Social Care leaders across Mid Nottinghamshire agreed that a whole-system strategic service review was required to identify options for a sustainable health economy across Mid-Nottinghamshire.

• It was recognised early on that to create a whole system solution would require **fully integrated hospital, community, primary and social care**

• This requires incremental and transactional service improvement, but also **transformational change**.
Mid-Nottinghamshire
Integrated Care Transformation Programme

Integrated Urgent & Proactive Care
Principles underpinning the design of the proactive and urgent care system

• Radical – No more tinkering around the edges!
• None of the interventions can be considered or developed in isolation – This is a WHOLE SYSTEM model
• Patients and service Users at the centre – Albert!!!!
• Services will be available 7 days a week and, where necessary, 24/7
• Care will be provided in a persons home (or usual place of residence) wherever possible
• Focus on proactive care to reduce risk of crisis and need for admission
• Where admission required – proactive action across the system to ensure timely discharge
• All services will be combined health and social care with multi-disciplinary team working across the system including mental health.
• Patients will receive/have access to the same care/services regardless of where they are domiciled (ie care home vs Own Home)
• Focus on supporting patients to become more involved in their care
• Supporting carers and family
Proactive and Urgent care model

**Self care**
- Maintain independence
- Healthy living & wellbeing

**Proactive care (PRISM)**
- Risk Stratification
- Virtual wards / MDTs

**Intermediate care in the home**
- Low level support
- Enhanced support
- Intensive support

**Care in the patient’s home**

**Crisis notification**

**Care navigation**
- Self Care Hub
  - PRISM plus

**Care Navigator**
- Determine necessary care package and deploy services
- Specialist Intermediate Care Team
- Crisis Response Team
- Discharge coordination

**Acute care**
- A&E/ MAU/ WARD
  - Single Front Door
  - Back door

**Intermediate care in the home**
- Low level support
- Enhanced support
- Intensive support

**Bedded Intermediate Care**
- Low level support
- Enhanced support
- Intensive support

**A more responsive primary care service**

**Communicating effectively with the public**

**Key:**
- Self Care
- Proactive care
- Urgent Care
- SICT

**Flow:**
- Away from the community
- Towards community
Proactive and Urgent care model

Care in the patient’s home
- Self care
  - Maintain independence
  - Healthy living & wellbeing
- Proactive care (PRISM)
  - Risk Stratification
  - Virtual wards / MDTs

Crisis notification
- Self Care Hub
  - PRISM plus

Care navigation
- Care Navigator
  - Determine necessary care package and deploy services
  - Specialist Intermediate Care Team
  - Crisis Response Team
  - Discharge coordination

Acute care
- Acute Medical Emergency
- A&E/MAU/WARD
- Bedded Intermediate Care
  - Low level support
  - Enhanced support
  - Intensive support

Key:
- Self Care
- Proactive care
- Urgent Care
- SICT

A more responsive primary care service

Communicating effectively with the public
Scaling Up PRISM and joining up the system

• Front Door Team
• Transfer To Assess
• Integrated Community Discharge working across organisational boundaries
• Enhanced and Integrated Intermediate Care model
• Clinical Navigator
Care Navigator

Self care
- Maintain independence
- Healthy living & wellbeing

Proactive care
- Risk Stratification
- Virtual wards / MDTs

Interim care in the home
- Low level support
- Enhanced support
- Intensive support

Crisis
- Crisis Response Team

Care navigation
- Self Care Hub
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Acute care
- A&E/ MAU/ WARD
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Bedded Intermediate Care
- Low level support
- Enhanced support
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Communicating effectively with the public

Key:
- Self Care
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Proactive and Urgent care model
Bring Forward Schemes 14/15
Early Successes
Newark & Sherwood Emergency Admissions per 1,000 patients by Practice
May 13 to July 13

Emergency Admissions per 1,000 Patients - May13 - Jul13

- **N&S North Locality**
- **N&S West Locality**
- **Newark and Trent Locality**
Progress with Roll Out?

• Transfer To Assess
  • PRISM teams working at front door and on wards ("pull")
  • Daily board rounds on key wards/ EAU
  • Increased discharges of Frail Older people by an average 25 per week
  • Either from wards/ EAU or via Turnaround at Front Door
  • Spot Purchase of care homes beds in community to accommodate
  • Discharged into care of PRISM Intermediate Care teams who manage the beds with staged step down to domiciliary care
  • Non Weight Bearing pts an issue due to LOS required
  • 30-90 day Readmission rates?
Progress with Roll Out?

• **Intermediate Care**
  - Slowly changing perception that IC is a separate “service”
  - PRISM teams delivering IC as part of integrated community service
    - Domiciliary – default place of care unless clinically unsafe / inappropriate to do so
  - Care Homes
  - Community Hospital

• **MDT’s**
  - Monthly MDT meetings taking place in every single practice (proactive / admissions avoidance / complex care planning)
  - GPs becoming more involved and taking ownership
  - GP cover for domiciliary Intermediate care

• **Clinical Navigator**
  - In process of being designed and commissioned
  - Engine room and navigation across the system inc OOHs
## Nottinghamshire County PRISM Dashboard - YTD

### Change to view latest 3mths data

### Secondary Care Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Apr-Dec 2013</th>
<th>GP Prac</th>
<th>FCG/locality</th>
<th>CCG</th>
<th>Mid/South Notts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients aged 18-79 yr</td>
<td>5340</td>
<td>6192</td>
<td>32334</td>
<td>55252</td>
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<tr>
<td>Patients aged 80 yr and above</td>
<td>845</td>
<td>875</td>
<td>5212</td>
<td>8895</td>
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<td>All A&amp;E attendances</td>
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<td>37546</td>
<td>81417</td>
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<td>Rate per 1,000 weighted Pop</td>
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<td>173.0</td>
<td>181.5</td>
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<td>Patients aged 18-79 yr</td>
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<td>1684</td>
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<td>Patients aged 80 yr and above</td>
<td>556</td>
<td>535</td>
<td>3170</td>
<td>5387</td>
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<tr>
<td>Patients with LTC</td>
<td>441</td>
<td>411</td>
<td>2379</td>
<td>3860</td>
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<tr>
<td>All Emergency admissions</td>
<td>2304</td>
<td>2219</td>
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<td>21347</td>
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<td>Rate per 1,000 weighted Pop</td>
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<td>63.3</td>
<td>64.2</td>
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<td>Median LOS for stays 2-28</td>
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### CHP reported activity

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<th>Activity</th>
<th>Apr-Dec 2013</th>
<th>GP Prac</th>
<th>FCG/locality</th>
<th>CCG</th>
<th>Mid/South Notts</th>
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<tbody>
<tr>
<td>Reduced risk of admissions</td>
<td>828</td>
<td>1259</td>
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<td>Rate of reduced risk of admissions</td>
<td>8.2</td>
<td>6.1</td>
<td>7.6</td>
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<tr>
<td>No of pts referred to Prism Team (PT)</td>
<td>1372</td>
<td>7865</td>
<td>15491</td>
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<tr>
<td>Rate of pts referred to the PT</td>
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<td>38.0</td>
<td>45.8</td>
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<tr>
<td>% of pts using assistive technology</td>
<td>3%</td>
<td>2%</td>
<td>3%</td>
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<tr>
<td>% of pts with a named key contact</td>
<td>72%</td>
<td>81%</td>
<td>70%</td>
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### Partnership working

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<th>FCG/locality</th>
<th>CCG</th>
<th>Mid/South Notts</th>
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<tbody>
<tr>
<td>% of practices undertaking a PRISM MDT meeting in the previous month</td>
<td>3%</td>
<td>2%</td>
<td>3%</td>
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<tr>
<td>% of patients recorded as having Social Services intervention</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>% of patients recorded as having Mental Health team intervention</td>
<td></td>
<td></td>
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<tr>
<td>% of patients on EOL pathway who died in their preferred place of death</td>
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</table>

### Patient Outcome

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<th>Apr-Dec 2013</th>
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</tr>
</thead>
<tbody>
<tr>
<td>% pos feedback from pts survey</td>
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<td></td>
<td></td>
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<tr>
<td>% pos feedback from carers survey</td>
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<tr>
<td>30 day readmissions for pts with LTC</td>
<td>353</td>
<td>350</td>
<td>2117</td>
<td>3494</td>
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<td>90 day readmissions for pts with LTC</td>
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<td>572</td>
<td>3403</td>
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<tr>
<td>% of pts who have discussed and agreed their care plan</td>
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<tr>
<td>% of pts at high end of crisis pyramid</td>
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</tr>
<tr>
<td>% of pts at lower end of crisis pyramid</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Trends

Trends are calculated using the previous 12 mths data shown as % of difference.

- **2 stars**: up by more than 5%
- **1 star**: up by up to 5%
- **No star**: No change from previous 12mth period
- **Green arrow**: down by up to 5%
- **Red arrow**: down by more than 5%

Please note all rates are calculated using the Practice/FCG/Local/NHS England. These populations are calculated as a rate per 1,000 weighted population to allow comparisons.
# Nottinghamshire County PRISM Dashboard - YTD

## Change to view latest 3mths data

### Secondary Care Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Apr-Dec 2013</th>
<th>GP Prac</th>
<th>FCG/locality</th>
<th>CCG</th>
<th>Mid/South Notts</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients aged 18-79 yr</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-2.8%</td>
</tr>
<tr>
<td>Patients aged 80 yr and above</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.6%</td>
</tr>
<tr>
<td>All A&amp;E attendances</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate per 1,000 weighted Pop</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-1.9%</td>
</tr>
<tr>
<td>Patients aged 18-79 yr</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-3.7%</td>
</tr>
<tr>
<td>Patients aged 80 yr and above</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients with LTC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-3.8%</td>
</tr>
<tr>
<td>All Emergency admissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-6.8%</td>
</tr>
<tr>
<td>Rate per 1,000 weighted Pop</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-3.7%</td>
</tr>
<tr>
<td>Median LOS for stays 2-28 days</td>
<td>5.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.0%</td>
</tr>
</tbody>
</table>

### CHP reported activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Apr-Dec 2014</th>
<th>GP Prac</th>
<th>FCG/locality</th>
<th>CCG</th>
<th>Mid/South Notts</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced risk of admissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of reduced risk of admissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of pts referred to Prism Team (PT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of pts referred to the PT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of pts referred from Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of pts using assistive technology</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of pts with a named key contact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Partnership working

<table>
<thead>
<tr>
<th>Partnership working</th>
<th>Apr-Dec 2013</th>
<th>GP Prac</th>
<th>FCG/locality</th>
<th>CCG</th>
<th>Mid/South Notts</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of practices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patients on EOL path who died</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Patient Outcome

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Apr-Dec 2013</th>
<th>GP Prac</th>
<th>FCG/locality</th>
<th>CCG</th>
<th>Mid/South Notts</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>% pos feedback from pts survey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% pos feedback from carers survey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 day re-admissions for pts with LTC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-0.8%</td>
</tr>
<tr>
<td>90 day re-admissions for pts with LTC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-8.8%</td>
</tr>
</tbody>
</table>

### Trends

- **Up by more than 5%**
- **Up by up to 5%**
- **No change from previous 12mth period**
- **Down by up to 5%**
- **Down by more than 5%**

---

Please note all rates are calculated using the Practice/FCG/Locality/CCG/Mid Notts Weighted populations supplied by NHS England. These populations are calculated as a rate per 1,000 weighted population to allow comparisons.
<table>
<thead>
<tr>
<th>Secondary Care Activity</th>
<th>Apr - Dec 2013</th>
<th>GP Prac</th>
<th>FCG/locality</th>
<th>CCG</th>
<th>Mid/South Notts</th>
<th>Trend</th>
<th>CHP reported activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients aged 18-79 yr</td>
<td>5340</td>
<td>6492</td>
<td>33334</td>
<td>55252</td>
<td>-2.8%</td>
<td></td>
<td>Reduced risk of admissions</td>
</tr>
<tr>
<td>Patients aged 80 yr and above</td>
<td>','845</td>
<td>875</td>
<td>5212</td>
<td>8895</td>
<td>3.6%</td>
<td></td>
<td>Rate of reduced risk of admissions</td>
</tr>
<tr>
<td>All A&amp;E attendances</td>
<td>6185</td>
<td>6067</td>
<td>37546</td>
<td>81447</td>
<td>-1.1%</td>
<td></td>
<td>No of pts referred to Prism Team (PT)</td>
</tr>
<tr>
<td>Rate per 1,000 weighted Pop</td>
<td>176.3</td>
<td>173.0</td>
<td>181.5</td>
<td>189.5</td>
<td>-1.9%</td>
<td></td>
<td>Rate of pts referred to the PT</td>
</tr>
<tr>
<td>Patients aged 18-79 yr</td>
<td>1748</td>
<td>1684</td>
<td>10106</td>
<td>15960</td>
<td>-3.7%</td>
<td></td>
<td>% of pts referred to PT from Hospital</td>
</tr>
<tr>
<td>Patients aged 80 yr and above</td>
<td>565</td>
<td>535</td>
<td>2170</td>
<td>5387</td>
<td>-3.8%</td>
<td></td>
<td>% of pts using assistive technology</td>
</tr>
<tr>
<td>Patients with LTC</td>
<td>441</td>
<td>411</td>
<td>2379</td>
<td>3860</td>
<td>-8.8%</td>
<td></td>
<td>% of pts with a named key contact</td>
</tr>
<tr>
<td>All Emergency admissions</td>
<td>2304</td>
<td>2219</td>
<td>13276</td>
<td>21347</td>
<td>-3.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate per 1,000 weighted Pop</td>
<td>65.7</td>
<td>63.3</td>
<td>64.2</td>
<td>63.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median LoS for stays 2-28 days</td>
<td>5.00</td>
<td>5.00</td>
<td>5.00</td>
<td>5.00</td>
<td>0.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Partnership working**

<table>
<thead>
<tr>
<th>% of practices undertaking a PRISM MDT meeting in the previous month</th>
<th>GP Prac</th>
<th>FCG/locality</th>
<th>CCG</th>
<th>Mid/South Notts</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients recorded as having Social Services Intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patients recorded as having Mental Health team Intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patients on EOL pathway who died in their preferred place of death</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Trends**

- **Red arrow**: up by more than 5%
- **Yellow arrow**: up by up to 5%
- **No change**: no change from previous 12mth period
- **Green arrow**: down by up to 5%
- **Blue arrow**: down by more than 5%

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Please note all rates are calculated using the Practice/FCG/Locality/CCG/Mid Notts Weighted populations supplied by NHS England. These populations are calculated as a rate per 1,000 weighted population to allow comparisons.
Challenges

• Aligning transformation programme interventions with existing QIPP and service reviews

• Balance between business as usual for CCGs and delivery of transformation programme

• Problems of incremental development which cannot deliver the benefits articulated for whole system design

• Measuring success – i.e what is an avoidable admission and how do you record that?

• Balance of developing new community based service model against backcloth of L.A cuts

• Availability of workforce to staff the new models – small pond to fish in

• Technology solutions for data/information sharing

• Differential financial pressures

• Keeping going when the going gets tough – need passionate advocates who will not be swayed

• Cultural differences between professional groups and organisations

• Resourcing Delivery - Needs capability and capacity
What Did We Learn?

- Stakeholder engagement is key and must not be underestimated – invest in the time up front
  - Primary care buy in critical
  - Organisational sign up and commitment at senior level across all stakeholders
- Investment in community services
  - Historic underinvestment meant we started from a low baseline
  - Staff training and skills development
  - Cultural as much as clinical
- Dedicated project management and PMO approach
- Integrated Care on its own will not achieve the desired outcome
- Whole system redesign is required to underpin the model
- IT systems and ability to share records are critical
- Recognition that the outcomes won't necessarily be achieved immediately
Ensuring success ....Lessons Learned

• Organisational sign up at highest level

• Establish joint governance and accountability early on

• Have a high tolerance of risk to achieve the vision – don’t be scared to press on even if every detail isn’t worked through

• Use front-line clinical teams to design services and don’t miss simple and inexpensive innovations that can have a major impact ( i.e self care )

• Invest in organisational development and change management to overcome cultural and organisational differences, financial and other risks

• Base the strategy on benefits to patients ... then specify, communicate, monitor delivery, and iterate

• Comprehensive and system wide staff engagement critical – take them with you
**Next Steps**

- Commissioning of and contracting for the new system model
- How do you commission for a whole system model?
- The current system design, service configuration and array of misaligned incentives in the system drive perverse behaviours and therefore has to change.

**Need to move away from a multiple provider, activity based contracting model towards a model that:**
- incentivises outcomes
- rewards the right behaviours
- aligns risk with control and influence
- gives providers more flexibility to target resources and investment to better meet the needs of patients.

This is **outcome based commissioning**
## Outcomes Based Commissioning Model for Mid Nottinghamshire

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accountable Provider Organisation</strong></td>
<td>The contract will be let to an “Accountable Provider Organisation” which will be responsible for providing all the care (which will be defined by the scope of services and outcome framework) for our population over the contract term. The Accountable Provider Organisation could be a single organisation or multiple organisations that have come together as the contractual counterparty.</td>
</tr>
<tr>
<td><strong>Outcome based</strong></td>
<td>Payment to the Provider(s) will, in part, be based on meeting a set of patient centric outcomes. The objective is to shift service planning and delivery away from traditional activity based, provider orientated intervention models towards patient centred, outcome focused preventative models of care.</td>
</tr>
<tr>
<td><strong>Capitated</strong></td>
<td>Commissioners will move away from payment by results towards a capitated budget for the population. This, combined with the outcome based contract, will incentivise providers to invest proactively in maintaining the health and well-being of the population.</td>
</tr>
<tr>
<td><strong>Contract length</strong></td>
<td>To allow the Accountable Provider Organisation to demonstrate improvement in patient outcomes the contract duration likely to be longer than traditional contracts and potentially between 5-10 years.</td>
</tr>
</tbody>
</table>
Process

• **Coordinating Providers**
  • 7 existing providers
  • Sherwood Forest Hospitals Trust
  • United Lincoln NHS Trust
  • Nottinghamshire Healthcare Trust
  • Nottingham University Hospitals NHS Trust
  • CNCS (OOH’s provider)
  • Circle
• Working together but not necessarily playing the same role (lead provider?)
• Primary Care
• Nottinghamshire County Council
The consequences of being ambitious are less scary than not being ambitious enough....
Thank You

Jan Balmer
janbalmer@neonavitas.co.uk
Tel: 07734 296846