Newark and Sherwood Clinical Commissioning Group | Mansfield and Ashfield | Nottinghamshire Healthcare NHS Trust | Sherwood Forest Hospitals NHS Foundation Trust | Nottinghamshire County Council

Mid-Nottinghamshire NHS Integrated Care Transformation Programme (ICTP)

Presentation to the Nottinghamshire County Council Health and Wellbeing Board

June 5th 2013

Transformation Partnership – leadership vision

- 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.
- Both Commissioners and Providers of services to the locality have agreed that the work must focus on meeting population health needs, and that whilst organisational impacts will be differential, they must not take precedence over reaching a system-wide solution.
- 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**.
- Patients, not organisations, must be at the centre of the transformation; and able to manage their own care where possible and easily access the right services at the right time.
- The first phase of work comprising detailed analysis of current baseline, together with clinical leadership to scope new ways of working that meet population health needs completed in April. This has produced a **"blueprint" for how services should look in 3 to 5** years. This now needs wider stakeholder engagement to support implementation over 1 to 2 years.

What do we mean by integrated care ?

Definition

Integrated care refers to a way of organising services whereby the patient's journey through the system of care is made as simple as possible. It is:

"*Care, which imposes the patient's perspective as the organising principle of service delivery and makes redundant old supply-driven models of care provision. Integrated care enables health and social care provision that is flexible, personalised, and seamless." (Lloyd and Wait (2005)*

Five principles

- Integrated care must focus on those patients for whom current care provision is disjointed and fragmented, mainly complex patients with co-morbidities.
- Effective clinical leadership must exist, to promote changes in clinical behaviour.
- The interaction between generalist and specialist clinicians must promote real clinical integration.
- There must be integrated information systems that allow the patient's journey to be mapped across a care pathway at any moment in time.
- Financial and non-financial incentives must be aligned to provide the conditions to ensure that care delivery is of high quality and cost-effective.

What do we know about our local services ?

Through discussions with care professionals, patients and their representatives and carers the following were established as key challenges to how care is delivered to the public:

•Poor communication across organisations and a lack of integration of services;

•A lack of understanding of the services available and how to access these services;

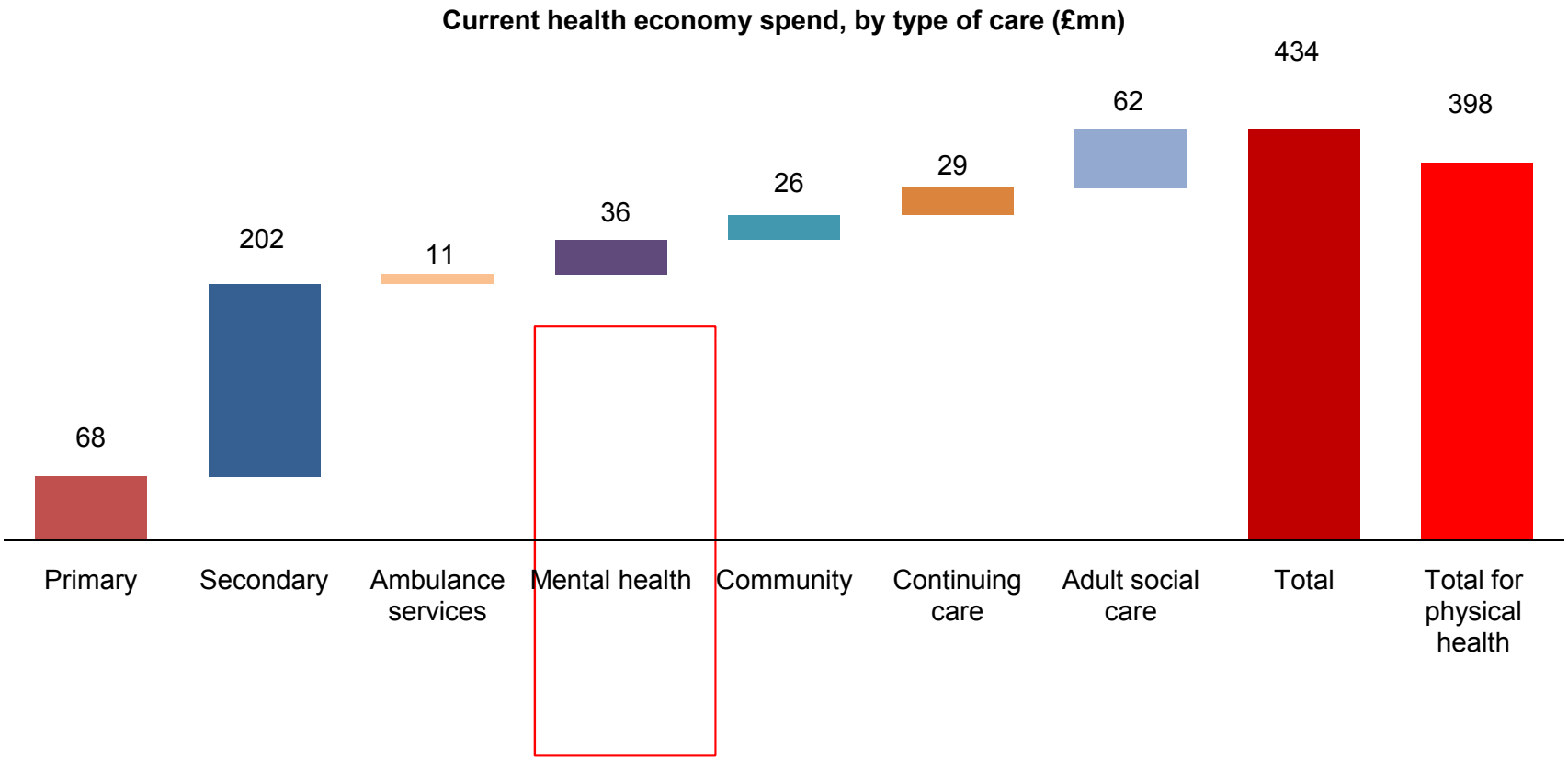
•A lack of focus on prevention and treatment of patients in an out of hospital community setting

•A significant increase in the number of frail and elderly people in the population who require higher levels of care

•A significant increase in the number of births, putting an increased demand on services

•The relatively low proportion of local people accessing the local acute hospitals for elective services

How much do we currently spend on local services ?



Sources: Newark and Sherwood CCG Integrated Plan, Community data, CCGs' 'Plan on a page' documents, Audit Commission Value-for-money profiles

Why do this work now ?

The population of over 75s in Nottinghamshire is set to increase by 25% by 2020. For Mid Nottinghamshire alone, the impact of the projected population growth in 2013/14 amounts to;

- Circa **4,000 additional A and E attendances**
- Circa **2,200 additional non-elective admissions**
- Circa 23,000 additional occupied bed days = **66 additional beds**

Whilst the current overall spend across this health economy is £434m, by the end of FY12/13, there will be a financial gap of **£19m.** Population growth and costs of provision are due to increase far ahead of funding, meaning that:

- Long term conditions currently account for 50% of GP consultations and 70% of hospital in-patient bed stays. The number of people with long term conditions is expected to rise by over 250% by 2050
- In 5 years, the **£19m** gap will have grown to **£70m, i**n 10 years, the gap will be **£140m**

The current health and social care system of provision is unsustainable

Blueprint proposals– Maternity and children's care

Initiative	Quality benefit	Measure
Short stay paediatric assessment unit – offers assessment as opposed to admission	Consultant led, but with community nurse support, providing better decision-making. Less stressful for patients as fewer and shorter hospital stays	Reduce short stay admissions by up to 70%
Short stay ante-natal assessment unit – 24 hours	Less time in hospital, enhanced delivery outcomes, and additional support to complex social care needs	Reduce short stay admissions by up to 50%
Paediatric referral optimisation	Increased clinical input to reduce inappropriate referrals and un-necessary emergency admissions. Less stressful for patients and improved support for GPs.	Reduce emergency admissions by 20%. Make better use of out-patients clinics
Integrated Children and Young Peoples Health Care Programme	Providing co-ordinated support to enable children and young people with complex needs to lead normal lives, improve safeguarding outcomes and the social, health and economic prospects of carers	Reduced emergency admissions and in-patient lengths of stay

Implementing these initiatives could give rise to financial savings of £4m p.a.

Blueprint proposals– Elective services

Initiative	Quality benefit	Measure
Review and improve referral processes	Reduction in inappropriate referrals frees up clinic time for better use. May result in more patients being able to access local services where they are viable and high quality	Where referral rates exceed national average, they will be normalised
Service viability review	**Ensure that services are commissioned on basis of best outcomes, and that patients can receive the right highest quality secondary services in their locality with appropriate tertiary support/referrals as required**	**More high quality secondary care services provided from local hospital facilities**

A work in progress, but ……

Implementing these initiatives could give rise to financial savings of £7m p.a.

Blueprint proposals – Urgent Care; responding to crises for the whole population

Initiative	Quality benefit	Measure
Crisis Hub/clinical navigator	Improves patient experience, removing their problems navigating around providers, and keeps them at home where possible Avoid un-necessary A and E attendances	Reduce A&E attendance by 12% and admissions by 10%
Integrated urgent care service at Newark and Mansfield – "single front door" – primary, social, community and A&E/MIU and assessment/ clinical decision units	More clarity for staff/patients on appropriate care pathway when in crisis, and better experience from reaching right destination quickly Less variation in service and more capacity through joint working with secondary and primary care	Productivity improvement across A&E and GP out of hours of 20% Reduction in NEL length of stay =3,500 bed days
GP Provision – same in the early evening as early morning	Fewer sub-acute patients will present early evening where the demand profile is significantly greater than the regional average	Reduction in A&E attendances and resultant admissions
Streamlining urgent care referrals – enhanced role for ambulance service	Ambulance service and other providers working together to improve decision-making before making transfers to urgent care settings should result in more patients being treated at home/in the community, rather than being conveyed to hospital	Increased availability of ambulances Reduce A&E attendances and admissions

Implementing these initiatives could give rise to financial savings of £10m p.a., but will require re-investment in community and other services

Blueprint proposals…. Integrated pro-active care for frail elderly and those with long term conditions

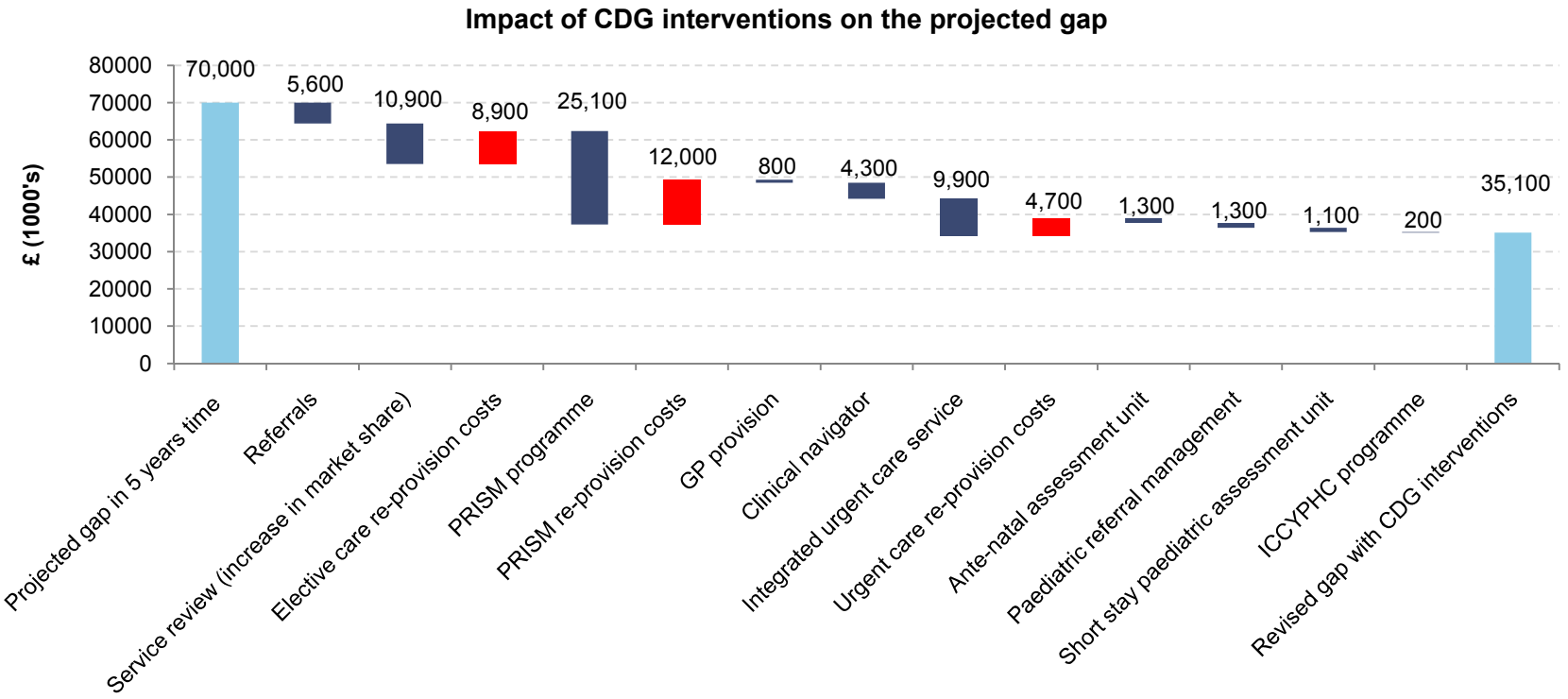
Initiative	Quality benefit	Measure
Enhance domiciliary and intermediate care	Patients able to live more independently, stay at home longer, and have emotional, physical and social care needs assessed together	Reduce hospital admissions and re-admissions and length of stay Reduce nursing/care home use
PRISM – Profiling Risk Integrated Care Self Management	By identifying and case-managing at risk citizens within the community, emergency admissions will be reduced and the outcomes for the frail elderly and those with long-term conditions (including cancer) will be improved Patients and carers will be more involved in managing their own care and will feel less isolated	Reduce admissions by up to 30% and re-admissions by 10% Reduce length of stay by 30% Reduce prescribing costs by £1m Reduce residential care demand by 25%
Extend the integrated community discharge service	Better patient and carer experience Reduction of hospital acquired complications Prompt and pro-active identification of end of life care Patients discharged for assessment where possible – reducing burden of S2 and S5 assessments	Increased discharges to home and reduced time from discharge to home Reduced patients in long term care Reduced average length of stay
Enhanced management of patients in care homes	Improved care for patients in care homes by offering more intensive health treatment should reduce hospital acquired complications, maintain function level of patients and improve end of life care	Reduce number of admissions from care homes, and length of stay for care home admissions

Implementing these initiatives could give rise to net financial savings of £13m p.a., but will require circa £12m re-investment in community and other services

Summary financial impact of blueprint proposals

Financial Savings

The graph below provides a breakdown, by intervention, of the estimated savings (against current model / cost of provision) to be made through the delivery of the future model of care. In summary, the interventions identified will reduce the potential 5 year financial gap of **£70m** to **£35.1m**.



Source: PwC analysis – This analysis is based on the PRISM programme achieving a 30% reduction in admissions

What does integrated care look like in practice?

Already piloted in Newark and Sherwood, the locality based "virtual ward" or multi-disciplinary team (MDT) comprising:

- Community matrons
- District nurse
- Occupational therapist
- Physiotherapist
- Mental health worker
- Social worker
- Health care assistants
- Voluntary/third sector workers
- Ward co-ordinator/manager

Underpinned by …..

- Increased provision of intermediate care beds (Step up and Step down)
- Community based clinics (e.g. cardiovascular disease, COPD, diabetes) with secondary consultant specialist support
- Rapid Assessment and Intervention Service
- Care homes integrated into the “virtual wards”, so patients treated as if they were in their own home
- Specialist case managers for COPD, heart failure, diabetes and care homes
- GP practice teams integrated and aligned with “virtual ward teams”
- Improving provision of carer support, information and education
- Engagement of voluntary sector services to improve patient/carer support

How does integrated care make a real difference ? A case study ….

Pat's story;

- 60 year old lady, endocrines disease, recurrent pneumonia (due to complex lung and heart disease), anxiety and previous history of alcohol abuse
- Risk score of 98% risk of admission – admitted every winter for the last 4 years with recurrent chest symptoms
- Discussed at MDT and admitted to "virtual ward" – input from respiratory physio, OT, mental health worker and community matron
- Learnt new breathing techniques, knows when to use rescue antibiotics and has a number to call when she feels she needs assessment/advice
- Biggest change to her ability to cope with her illness at home has been work done to reduce her anxiety. Mental health worker has worked with her and her family to help them deal with panic symptoms
- Risk of admission dropped to 73%; she has not been admitted to hospital for over 4 months now, even though she has had 2 chest infections

Some testimonials from the PRISM integrated care pilot……

Community Matron;

- *" One of my patients had been regularly calling 999 and being admitted to hospital. He is in his 80s and his needs are really social rather than medical. We discussed how we could best give this gentleman the care he really needs. Within 60 minutes our Ward Social Worker had arranged a respite bed. Instead of hours spent on the phone trying to refer, things happened immediately".*

Social Worker;

- *It's just fantastic how quickly I can get services in place for my patients – from hours spent previously via phone and e mail trying to refer PRISM integrated care allows it to happen immediately".*

Nurse;

- *Sitting in the MDT meeting today, listening to all these people involved in caring for your patients, was such a humbling experience. I feel so proud to be part of this project – I think it's probably the most important thing I've ever been involved in as a nurse".*

Patient;

- *(Before) I only had my GP and Community Matron. I didn't want to bother people. I felt I would never get better. (Now) I have had less hospital visits, I understand my body better, am determined to carry on, feel more confident and supported.*

Integrated care – the headlines

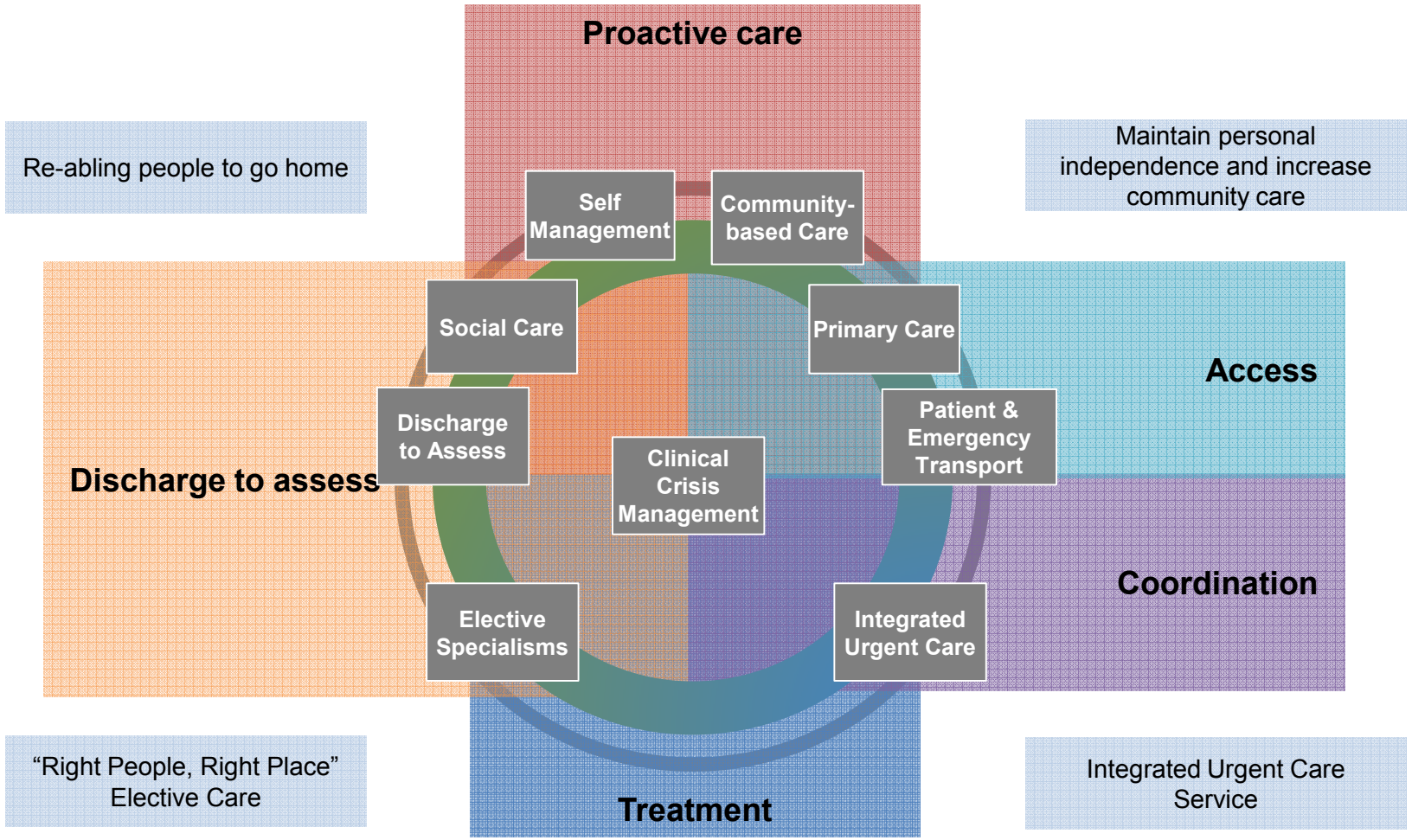
Before	The future
Different people looking after various conditions for a single patient	Integrate care across the whole system and embed care planning and shared decision making in to everyday practice
Hospital often the only option for a patient when their condition worsens	Incorporate a population wide approach to care and not just a reactive response
Services only available within office hours with little or no joined up arrangements out of hours	Deliver services where patients need them and make access available seven days a week

Systematically implement;

Risk profiling, integrated services, care planning and self-management

Fewer unplanned admissions, better patient outcomes and satisfaction, improved quality of care

Future Model of Care for Health and Social Care Services



Conclusions

Truly integrated health and social care in Mid Nottinghamshire should;

- Enable care to be at home or close to home wherever possible, thus optimising patient and carer independence
- Improve the experience of patients in crisis – offering a “single front door” approach where all of the services come together; acute, community, mental health, primary and social care
- Significantly reduce acute hospital admissions, freeing up in excess of 100 acute beds
- Provide opportunities to use our best quality local hospital facilities to increase sub-acute and intermediate care capacity
- Bridge at least 50% of the projected financial gap based on current population health projections
- Create a more highly skilled workforce, with time to innovate

Next steps - learning from other systems

Positive precursors for success of the Transformation Partnership

- Foundation of joint working between health and social care exists
- Shared understanding of integration
- Joint desire to deliver vision regardless of organisational challenges
- Strategy fits with JSNA

Possible challenges

- Cultural differences between professional groups
- Different workforce terms and conditions
- Technology solutions for data/information sharing
- Differential financial pressures

Ensuring success ….learning from other systems

- 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 teams to design services and don't miss simple and inexpensive innovations that can have a major impact
- 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

And …..

- Health and Wellbeing Board actively engaged to ensure that transformation is evidence based and responds to local community's needs through joined-up provision

Next steps - timescales

A detailed delivery "roadmap" is being prepared, but key steps include;

Immediately

- Individual organisations continue to work through the impacts of the new integrated care models e.g. financial, workforce, estate
- Care professionals and stakeholder/citizens representatives to take forward detailed design of new services and pathways

Summer 2013

- Engagement exercises to run alongside development of new models of care
- CCG and Local Authority commissioning forum to be established to develop appropriate commissioning/contracting models
- On-going evidence-based analysis of outcomes of new care model
- System-wide estate and ICT strategy to be developed

2014 onwards

- Changes to be implemented from years 2015/15, with whole system changed embedded within 5 years