prism
profiling risk
integrated care
self management

NHS
Newark and Sherwood
Clinical Commissioning Group

NHS Newark & Sherwood Clinical Commissioning Group Integrated Care Team Programme

Briefing for Health Scrutiny Committee

22 October 2012

Background

Newark and Sherwood district has a registered population of 127,000 and around 37,000 of these patients are living with one or more long-term condition. Currently, these patients account for around 50% of GP consultations, and 70% of stays in hospital. The average cost of caring for a patient with a long-term condition is estimated to be £3000 per year (compared to £1000 per year for a person with no long term condition), and this rises to £8000 per patient per year with three or more long-term conditions. The Department of Health estimated that the number of people living with one or more long-term condition is set to increase by 253% between now and 2050. For Newark and Sherwood, that will mean an additional 50,000 patients requiring significant health and social care input.

The long-term conditions challenge

The growing challenge of long term conditions and the expected rise in the number of people with multiple and complex needs requires a seismic shift in approach from the current **disease specific and reactive model of care**, whereby a patient may be cared for by 2, 3 or even more different teams, all looking at their own specialty, to one where patients are **proactively managed in a holistic way** by **multidisciplinary and integrated teams who can support all of the patient's needs.**

There is a need to provide more care for more people in their own homes and reduce the reliance on secondary care services so that secondary care can reduce capacity and focus on delivering acute complex care, for patients who appropriately need to be in hospital.

The strategy underpinning the Integrated Care Programme has been developed around the 3 core principles of Long Term Conditions management:

1. Understanding the needs of the population through systematic risk stratification of every patient.

2. Integration of care and services

3. Systematic Self-Management and Shared Decision making

This evidence-based model of care has been shown to significantly reduce the need for unplanned admissions, provide better patient outcomes and satisfaction, and improved quality of care.

Uniquely in Newark and Sherwood, cancer care will be included within the Long Term Conditions model, and Macmillan Cancer Support are a key partner in delivering this programme.

PRISM – the Newark and Sherwood approach

PRISM (Profiling Risk, Integrated care and Self-Management) is Newark and Sherwood's response to the long-term conditions challenge. PRISM aims to develop and implement this model across the area, utilising all three elements.

In order to achieve the necessary transformation from reactive to proactive care in the community setting, it has been vital to ensure that all of our stakeholder organisations are equally committed and engaged in the process. A Partnership Board has been created with commitment and sign up from:

- Sherwood Forest Hospitals Foundation Trust
- Health Partnerships
- Nottinghamshire Healthcare Trust
- Nottinghamshire County Council
- Patient representatives
- GP representatives from across the CCG area
- Macmillan Cancer Support

A total of £1million funding has been secured to support the implementation of the PRISM programme, with a recognition from the CCG that there needs to be significant investment in services in order to achieve the desired outcomes for patients. A dedicated project team from the CCG, Macmillan Cancer Support and Health Partnerships is in place to drive this programme forward.

Overview of the PRISM elements

-Risk stratification

The CCG has commissioned a tool to stratify the population according 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. This will enable 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.

-Integrated Care Teams

There will be Integrated Care Teams across three localities in Newark and Sherwood, which will bring together community nursing, mental health, social care, therapist support and healthcare assistants to work with Primary Care within a 'virtual ward' approach. There will be specialist teams supporting the Integrated Care Teams with long term condition management including diabetes, respiratory disease, heart failure and cancer.

-Self-care

Patients and clinicians will 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 will include support from self=help groups, voluntary sector providers as well as more traditional health care approaches.

Timescales

The first Integrated Care Team will be implemented in the North locality, covering Ollerton, Edwinstowe and Clipstone practice population by December 2012. Funding has been secured to employ a dedicated social worker and mental health worker for the team, as well as existing community staff being mobilised to work within the new structure.

Further teams for the South locality and Newark and Trent locality will be in place by March 2013. The specialist teams needed to support the Integrated Care Teams are currently being developed in conjunction with this stepped timetable, the first – the Community Respiratory team, will be in place by December 2012.