

# Integrated Care Value Case

North West London, England



October 2013

This Value Case has been commissioned by the Local Government Association with support from the national partners on the integrated care and support collaborative

# About this Value Case

- The LGA, with support from the national integrated care partners, has commissioned the development of a toolkit to provide practical support for members of Health and Wellbeing Boards to highlight and promote the evidence of what makes the biggest difference to patient and service user experience as well as making better use of resources across the system.
- There are six key elements to the toolkit:
  1. An overarching 'Value Case' for integrated care
  2. 'Value case' summaries
  3. An evidence review of existing knowledge on outcomes of integrated care
  4. A model for local areas to map the impact of integrated care on outcomes, cost, activity and individual journey through the system
  5. A searchable database of integrated care initiatives throughout the country
  6. A signposting tool which will point to existing useful sources around the planning and implementation of integrated care
- This Value Case is part of a set of value cases which will show how local areas are delivering whole system integrated care, and the resulting impact this has had
- We are inviting all innovative areas who have delivered integrated care to come forward and develop their own Value Case to share with other local areas. For more information or to get involved please visit <http://bit.ly/19ofToY>

## Guiding principles for the value case:

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The overall goal of this work is to develop value cases which are:

- Aimed at Health & Wellbeing Boards

And incorporate:

- Service user stories, capturing changes to the service user's journey.
- Features of the model, including enablers (e.g. technology initiatives to support the mode)
- Costs of the model
- Evidence of benefit, including to activity, spend and outcomes.

We recognise that the information contained in the value case may prompt further questions, in which case we recommend you use the contact details at the end of the value case to follow up with a direct contact.

# About integrated care in North West London

## Context

- North West London (NWL) covers eight boroughs and two million people. Its work is based on genuine partnership between health, social care, third sector and patient and user-led organisations.
- Rising healthcare demand, changing patient expectations and limited resources have led to ambitious plans to move care out of hospital settings to create a high-quality and sustainable health economy. This underpins *Shaping a healthier future*, NWL's programme of service reconfiguration.

## Vision for integrated care in NWL

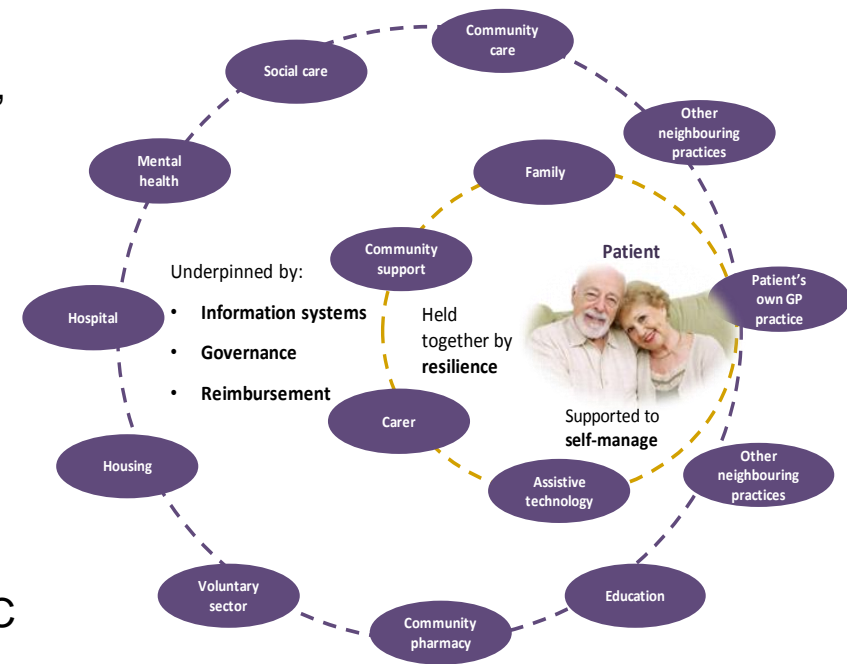
- People and their carers and families will be empowered to exercise choice and control, to manage their own health and wellbeing and to receive the care they need in their own homes or in their local community.
- GPs will be at the centre of organising and coordinating people's care.
- Their systems will enable and not hinder the provision of integrated care.

## Progress to date

- NWL has a significant track record as early leaders of integrated care, taking forward ambitious and innovative integration programmes.
- Two **integrated care pilots** (ICPs) already manage the care of the highest risk, most vulnerable patients.
- The Tri-borough (Westminster, Kensington & Chelsea and Hammersmith & Fulham) was as one of the first wave **Community Budget Pilot** sites, working in partnership with central government to improve the experience for the service user and reduce cost through closer integration of health and social care.

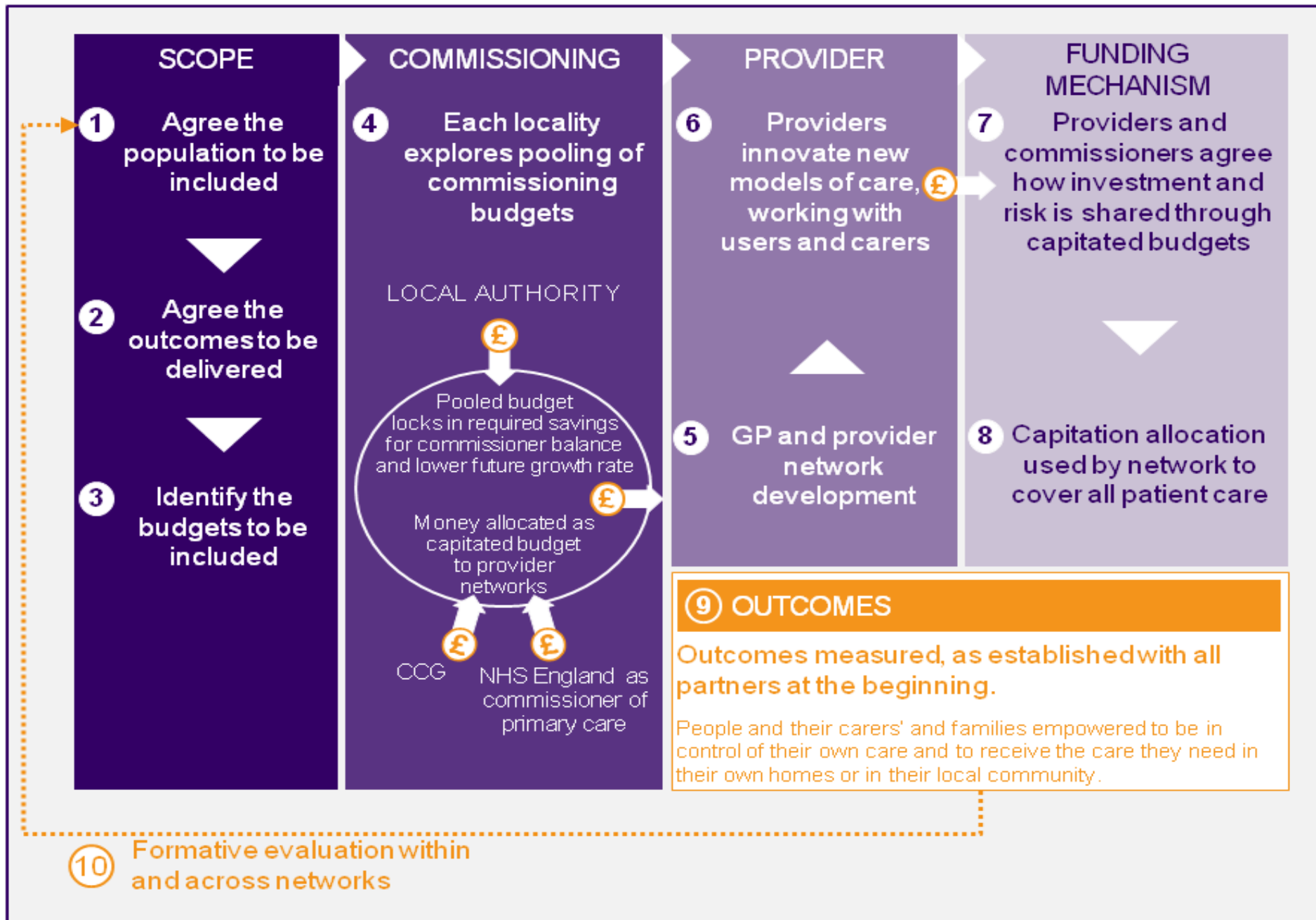
## Next steps

- Building on the success and lessons of the two ICPs, NWL are now developing towards whole systems integrated care (WSIC). The WSIC programme involved all eight CCGs, local authorities and partner providers, and will work with service users to co-design a new model of care.



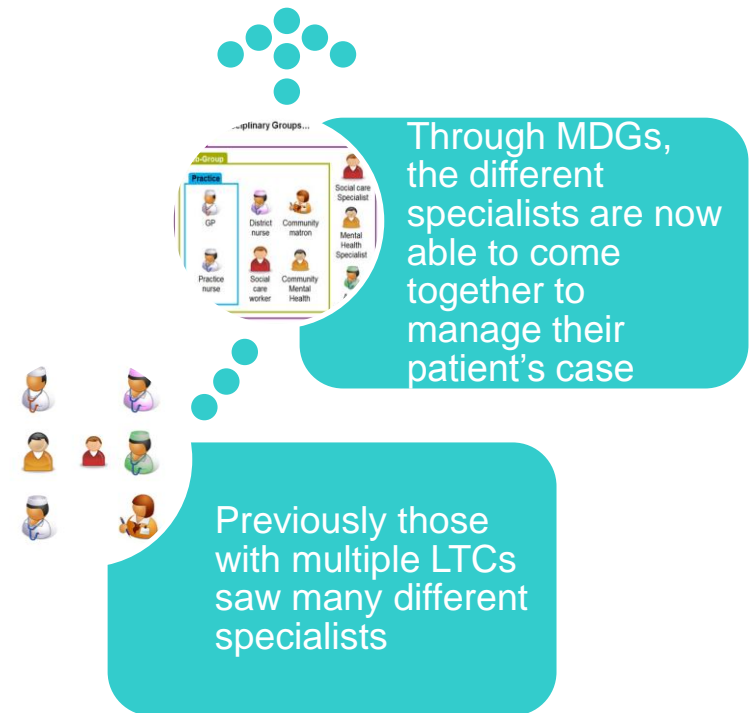
North West London's vision for whole systems integrated care

# The lessons the ICPs taught us have informed the development of WSIC

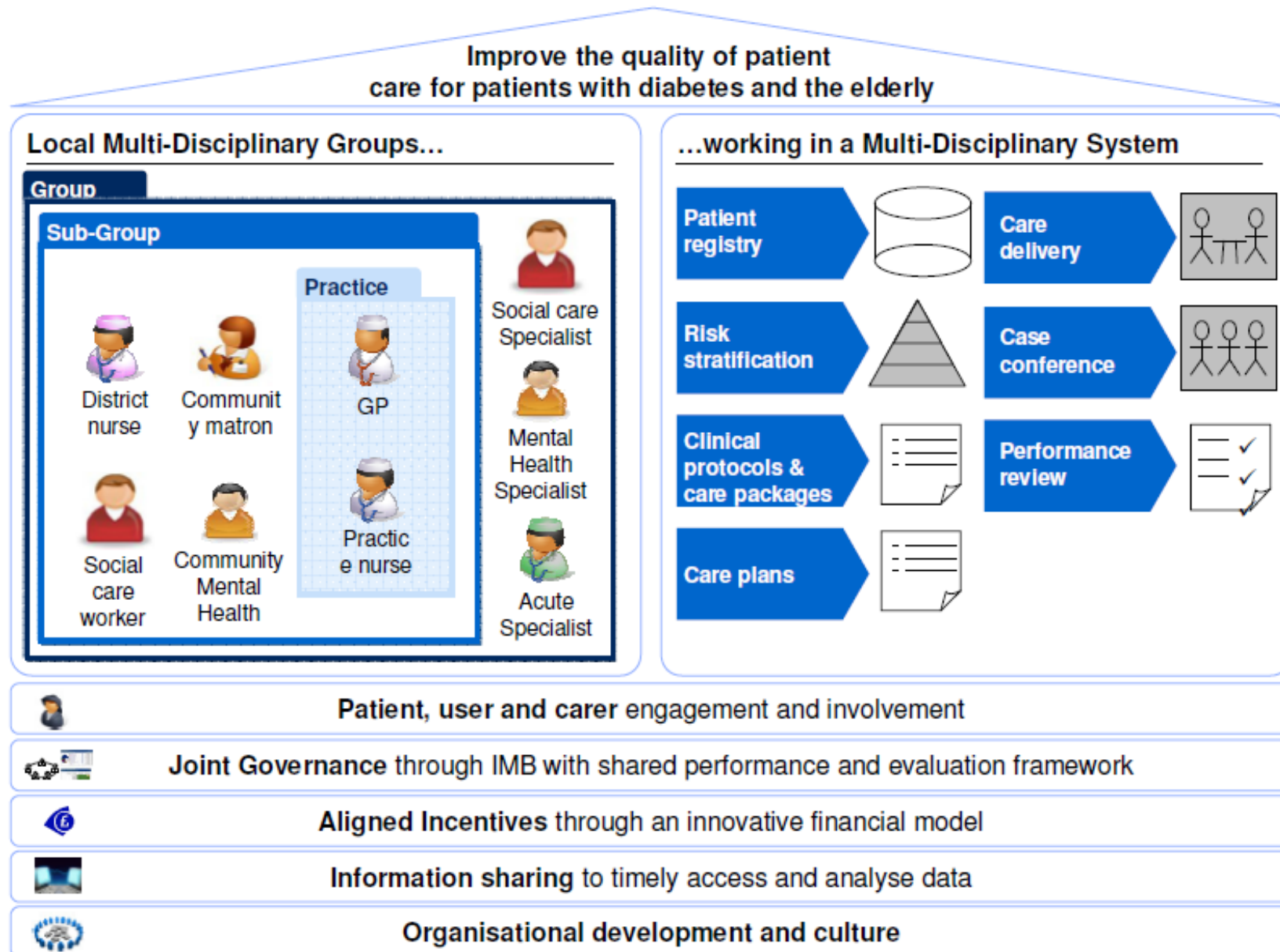


# About the North West London integrated care pilots

- The integrated care pilots (ICPs) are a provider-led initiatives serving NWL's entire population of 2 million.
- There are two ICPs in NWL: Inner (covering the boroughs of Westminster, Kensington & Chelsea, Hammersmith & Fulham and Hounslow) established in July 2011 and Outer (covering the boroughs of Brent, Ealing, Harrow and Hillingdon) mobilised from summer 2012.
- The aim of the ICPs is to improve outcomes for patients, create access to better, more integrated care outside hospital, reduce unnecessary hospital admissions and enable effective working of professionals across provider boundaries.
- At the core of the ICPs is having multi-disciplinary groups (MDG) involving professionals from community health, mental health, primary care, secondary care, social care, community pharmacy and specialist nursing coming together with patients and carers to realise a shared vision of high quality services.
- Multi-disciplinary groups (MDGs) meet monthly as case conferences with the aim of improving the care of these individuals.
- To date, the combined ICPs have produced over 36,731 care plans and are currently holding 42 MDGs each month.
- It is this successful track record that is being developed in WSIC.



# Visual model for NWL ICP





**Patient, user and carer engagement and involvement**



**Joint Governance through IMB with shared performance and evaluation framework**



**Aligned Incentives through an innovative financial model**



**Information sharing to timely access and analyse data**



**Organisational development and culture**

# Outcomes evidenced by NWL ICP: What difference does it make?

## User experience

- 88% of users reported improved access to NHS services
- 98% of users with ICP care plans felt more involved in the decision making
- 80% of users with ICP care plans had a better relationship with their GP and other care providers
- 96% of patients think that having the care planning discussion has helped improve how they manage their health problem

## Frontline staff experience

- 90% of staff involved either agreed or strongly agreed that the case conferences were a very good learning experience
- Over 60% reported that the advice they offered or received at the case conference would enable them to reduce at least 1 emergency admission

## Health & wellbeing outcomes

- **Consistent screening for common problems.** In the elderly patient cohort, 77% of patients were screened for their risk of falls and 69% were screened for cognitive decline.
- **Detection and management of previously unknown clinical or social problems.** For example, 20% of patients were diagnosed with a new clinical condition and 12% initiated a significant change to their social situation
- **Proactive discussion about how to manage health in the future.** 88% of patients discussed their health related goals for the future and developed an action plan to reach these goals and 38% of patients began anticipatory care planning.

## Impact on institutional care

- 15% reduction of non-elective admissions in >75s in 2011–2012.
- Emergency activity for the targeted patient groups has seen a decrease of 14% in Inner NWL alone

## Productivity

- 81% of users reported reduction in time to book appointments
- 80% users reported that less time was spent of revisiting past medical history on GP appointments as a result of ICP care plans, leaving more time for discussing presenting complaint



*“The meetings are very useful and they allow me the opportunity to contribute and add value to the discussions around patient care.”*

*“The patient discussion led to a change in medications to decrease risk of dementia progressing”*



# How we did it: key enablers

## Governance

- Joint governance through an integrated management board made up of representatives of all providers with a shared performance and evaluation framework.

## Organisation and Culture Development

- Each multi-disciplinary group (MDG) is clinically led.
- Multi-disciplinary teams (MDTs) include a GP, nurse, social worker, acute physician, mental health team, district nurse co-ordinated by an MDG manager.
- The ICP provides teaching and training in accordance with the CCG Clinical Learning Set programme.

## User and Carer Co-design

- Patient, user and carer are engaged and involved through established reference groups, workshops, surveys.

## Aligned Incentives and Performance Evaluation

- We align incentives through case conferences, enhanced care plans and innovation funding.
- We track and evaluate the performance of GP's surgeries and MDGs to drive competition and share best practice.
- Each MDT is reviewed based on patient experience, clinical outcomes, financial performance and team effectiveness.

## Information Sharing – ICP web portal

- Information sharing across multiple organisations is made possible by a single platform.
- This is an IT tool which links and shares provider information, allowing health and social care professionals to see key integrated data sets for patients that had consented to share their personal information.



*“There is a really welcome attitude to the patients and carers user group and to involving us in the design of the pilot so it really works. You can always tell when people are really listening.”*

# What we did: integrated care design

## Understanding Population

- Created a patient registry that covered the population and used associated data from all settings of care.
- Initially diabetic and elderly care pathways were rolled out at inception of the pilot; COPD, and cardiac pathways were then developed.
- Currently the ICP focuses on segmenting individual patients by risk, enabling the planning of proactive care.
- The Outer ICP covers a potential population base of 1.2m registered patients, covering 223 GP practices; approximately 140,000 fall within the current criteria for receiving integrated care.

## Clinical Protocols and Care Packages

- Clinical protocols and care packages (including activity and resource requirements) were developed for each group, ensuring standardisation of best practice.

## Care Plans

- Care plans are developed in one-to-one meetings between clinicians and patients allowing for better doctor-patient relationship, and greater patient involvement in decision making.
- These care plans are delivered by multi-professional groups through an integrated approach.
- The patient has one contact point in the delivery of their care plan.
- Across NWL, over 33,000 patients now have a care plan.

## Case Conferences

- The most complex cases are discussed at a case conference in an MDT session.
- At these conferences, root cause analysis of NEL admissions is presented for shared learning
- Across NWL, 220 case conferences have been held, and over 1,600 patients discussed.



*“It’s now so easy to work with other colleagues – why couldn’t it always be like this? I know what has happened to my patients, what I need to do to help them and quickly get them additional care when necessary. I’m back on the front-foot!”*

# Who we did it for and why

## Users and carers

- Quality of care lagged behind national indicators in some areas, with clinicians describing care as 'reactive and uncoordinated'.
- Service user satisfaction was variable.

## Commissioners

- Commissioners in NWL are facing a combined £1bn funding gap in 2014/15, at the same time as healthcare demand is increasing by 4% a year.
- A siloed approach to the provision of complex services and the differential entitlement to receiving them – free at the point of delivery for health and means tested social care – had created perverse and costly incentives for providers, therefore needing an integrated approach.

## Workforce

- Siloed working meant that there was limited awareness of all services that were provided, and poor professional working relationships. The ICP model served as a platform for bringing all these professionals together to achieve a shared outcome.
- Central to this was a shift from a reactive to a pro-active culture.

## Providers

- NWL had misaligned organisational boundaries preventing coordinated decision making, and creating slow and incomplete information exchange between providers.



*"I'm blessed to have such caring and supportive doctors, nurses and health care professionals involved with our family's care - we could not ask for anything more, thank you for all your support"*

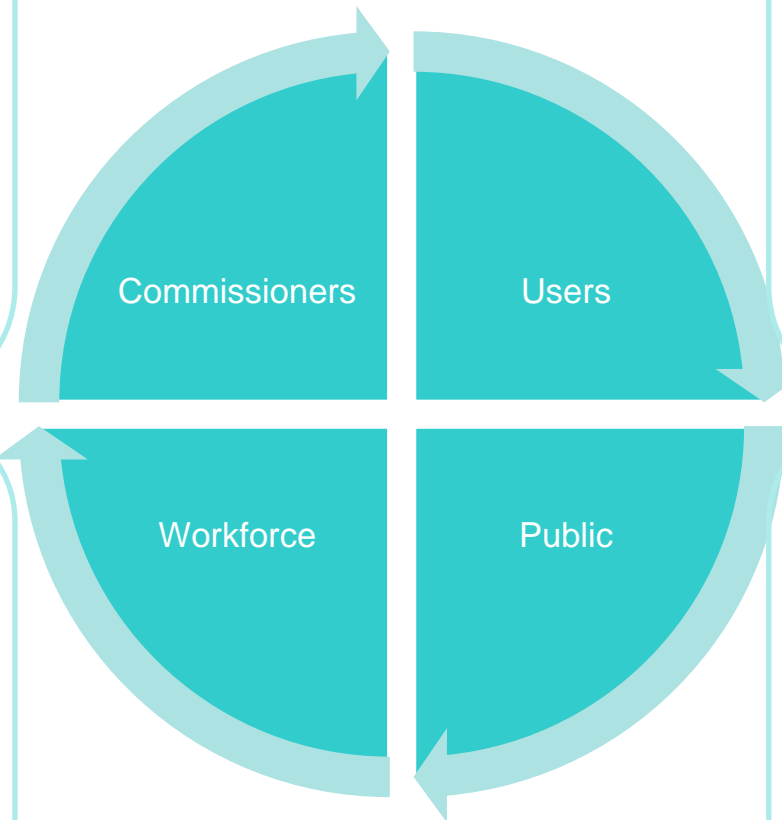
# Anticipated benefits

## Benefits

- Reduction in emergency admissions by up to 15%
- Reduction in A&E attendances by up to 30%
- Reduction in emergency inpatient days
- Reduction in poly-pharmacy and prescribing costs (evidence to show this could be as much as £400 per patient)
- Increased coordination and collaboration between health and social care, only forum where health and social care specialists meet regularly to discuss coordinated health and well-being actions

## Benefits

- Improved quality of patient care
- More structured and streamlined patient journey
- Individualised care plan
- Increased involvement in care planning and decision making: 91% said they received a good amount of information around managing their own health.
- Opportunity to discuss finance (10%), housing (15%) and nutrition and diet (58%) with professionals



## Benefits

- Create a richer professional experience (90% feel that MDG provides a good learning experience)
- Better relationships between multi-disciplinary groups (95% of staff felt that the MDG's improved inter-professional relationships)
- Increased awareness of the scope of other professionals' roles and abilities, e.g. role of community matrons
- Shared learning about a variety of conditions, drugs and services

## Benefits

- Efficient use of NHS funds
- Better value for money
- Improved awareness of available local services e.g. Falls service, dementia cafes, diabetes support groups
- Improved diagnosis and identification of illness, therefore earlier treatments and service interventions
- Improved levels of trust, respect and compassion between staff and for patients and service users

# Lessons learned

## Outcomes

- Be realistic about targets and dependencies:
  - E.g. reduction in NEL admissions: Analysis suggests that up to 50% of ICP benefits are dependent on the availability of effective out-of-hospital services
  - E.g. Wanted to reduce the 3620m annual cost of services for diabetic and older service users by 24%: Initial evaluations of programme success showed negligible improvements in outcomes and service user/costs – however international evidence suggests a minimum of three to five years before there is an impact on activity, patient experience and outcomes

## IT System

- IT system for care planning was slower and more complicated than first anticipated – IT system implementation timelines must accommodate considerable leeway for refinement and unexpected complexity

## Workforce

- There will always be late-adopters to any change programme, but continuous and consistent engagement, together with proven benefits will change their views
- Volunteers in the pilot experienced higher workloads – dedicated and co-located support staff may improve this.

## Ways of Working

The ICP developed leaders that successfully engaged with the workforce and enabled them to work together towards achieving positive programme outcomes. The learning from the successes of this programme will form the building blocks in the move towards the ambitious next stage of whole systems integrated care :

- **Strong clinical leadership**, in particular that of the GP, played a central part in ensuring effective participation and engagement of other clinicians with the ICP programme..
- Significant investment in **senior management leadership** and **dedicated programme support** has also played a major role in driving the ICP's success , along with the active involvement of patients including large-scale simulation events run by patients for professionals



*“The ICP has begun to give us the tools to deliver – it is the cement that will help us build integrated care”*

# Contact details

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