North West London Pioneer Programme – Profile

1.1 What is your area like?

The area covered by the North West London (NWL) pioneer partnership incorporates eight London boroughs, containing very diverse areas of high deprivation as well as affluence. It therefore has a high level of health inequalities and includes almost every ethnic group represented in Britain. The NWL Whole Systems Integrated Care pioneer programme covers two million people and more than 30 organisations.

1.2 What are you aiming to achieve?

Based on what people in North West London have told us is most important to them, our vision for whole-system integrated care is to: “Improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their communities.”

In working together to achieve this vision, we have made three key commitments.

- 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
- Our systems will enable and not hinder the provision of integrated care

1.3 What have been the highlights of your first year?

- Establishing a model of co-design that involves partner organisations, frontline professionals, people using services and carers to develop a shared approach to tackling common challenges to joined-up, personalised care. This process resulted in the development of the North West London Integrated Care Toolkit, bringing together recommended solutions for population segmentation, outcomes and models of integrated care, governance, contracting and payment models.
- ‘Early Adopter’ projects are now being taken forward within each of our eight boroughs, to implement the framework co-designed and set out in the toolkit with plans to effect real change for patients and service users from April 2015.

1.4 Details of the year

The collaboration between North West London partners has operated at three levels:

- At local level, supporting planning within each borough in accordance with local context and local priorities
- Coordinating across North West London to pool collective experience, expertise and learning
- Beyond North West London, learning from other local places and national partners and contributing to the national pioneer programme

In the first phase of the whole systems programme from September 2013 to February 2014, over 200 professionals and lay partners from across North West London came together to generate common solutions for achieving our shared vision for joined-up, personalised care.

Absolutely central has been our process of co-design with patients and users of services. The term 'lay partners' was created by this group who felt that it signalled a commitment to parity of esteem between commissioners, providers and patients and service users in our programme. See case study: Working in co-design with lay partners.

An important part of our preparatory work was the development of an agreed methodology for segmenting our population into 10 groups based on need to enable new models of care designed for each group matched by a capitated budget. See case study: Profiling the population according to need.

At the beginning of 2014, partner organisations across North West London were invited to work together as 'early adopters' of whole systems integrated care, building on the approach set out in the toolkit and initially focusing on one or more population segment. New models of care would provide for the total needs of that population group, including their social care and wellbeing needs. As we learn by experience and from each other, it is intended that the models of care taken forward by early adopters will be refined and extended to other population groups and geographical localities. See case study: Supporting early adopter projects through an expert panel.

Aligning with and maximising the opportunities presented by other related national and local initiatives has been an essential part of the pioneer programme. This means ensuring that our three to five year vision for whole systems integrated care builds on the Better Care Fund plans agreed by each borough for 2015/16.

At the core of the North West London Whole Systems Integrated Care programme is the principle that GPs should be at the centre of organising and coordinating joined-up, personalised and proactive care – supported by wider networks of health and social care providers. Every practice in North West London is now part of a network for peer review purposes, and some networks are already coming together to deliver services.

Primary care co-commissioning is likely to be a key enabler for delivering the benefits we envisage for our service users and communities. It will also support improvements to primary care estates required for delivery of new and enhanced services.

Progress towards seven-day working will also be an integral part of movement towards integration, as the model is designed to meet people's needs at all times, not just on a 9-to-5, five-days-a-week basis.

Bringing together leaders from across local health and care systems, health and wellbeing boards for each borough will have a crucial role to play as we move to implementation in 2015/16.

1.5 What has been the most exciting aspect?

Working together at scale has provided a unique opportunity to bring together the progress and learning to date derived from a strong history of integrated working across NWL. The whole systems pioneer programme has enabled us to bring together hundreds of people, many of whom had not met before, and to use our people and resources to far greater effect. Early adopters working in each of the boroughs are learning from each other and provide an exciting opportunity to scale up what works so that benefits can be realised as widely and quickly as possible.

The whole systems integrated care programme has marked a fundamental shift in the way we have worked together based on equal partnership and a shared commitment to change. The journey towards co-production has had its challenges and has required trust, honesty and ongoing learning as patients and professionals adapt to working differently. It has led, however, to better solutions and caused us to challenge ourselves to new levels of ambitions for our NWL population.

Going forward, this principle of equal partnership should continue to underpin local implementation, with lay partners continuing to be involved at every stage as guardians and advocates for our person-centred vision.

1.6 What has been the most challenging aspect?

We know we need to work together to address four fundamental challenges to achieving the outcomes intended through whole systems integrated care:

- Enabling the significant cultural shift and changes to frontline ways of working required to take forward new models of integrated care with patients and service users who have been supported to develop their own new ways of relating to services
- Developing a new kind of leadership – one that sponsors joint working and collaboration across the health and care system, other public services and the voluntary and community sector
- Implementing a new integrated care record and data warehouse to make best use of data for direct patient care and planning services

1.7 What are you planning to do next year?

- By March we aim to secure consensus on the capitation model to be used in shadow form across the system in 2015/16. The ability to share health and care data appropriately across the system will be key
- From April next year, early adopters will begin to implement new models of care, with providers agreeing new ways of working together as accountable care partnerships
- NWL partners will work together to agree the person-centred outcomes to be achieved by accountable care partnerships and the metrics by which we can monitor progress in terms of improved outcomes, patient experience and system efficiency
- Some early adopters will begin to look at alignment of incentives across health and social care to start the shift towards an accountable care

approach. This will be critical to the delivery of the NWL person-centred outcomes
- We will continue to ensure effective governance, collaboration and shared learning within and beyond NWL

1.8 What is your advice for areas starting on their own integration journey?

- Co-design integration and new models of care, working with patients and service users so they are actively involved in shaping proposals from the beginning
- It's really valuable to facilitate time and space for people to come together with others across the system to think beyond their busy day jobs and beyond the current system barriers about how care could be delivered differently
- Acquire the ability to understand population need and to design new models of care in response, to track outcomes and support continuous quality improvement – these all rely on availability of accurate, timely data. Ability to share information is key. Population segmentation provides the foundations on which to build whole systems, focusing on need and outcomes, not on individual budgets and services
- The long-term journey towards integration requires resilience and trust between partners and actively nurturing of relationships and commitment to our person-centred vision

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