Waltham Forest, East London and City (WELC) Pioneer Programme – Profile

1.1 What is your area like?

The Waltham Forest, East London and City (WELC) Integrated Care Programme focuses on revolutionising care for almost one million people in an area facing significant health and social challenges:

- Deprivation is twice the national average
- Hospital stays for alcohol and substance misuse are up to 50% higher than average
- Newham and Tower Hamlets have the second and third-highest levels of admissions for psychosis in London
- 22% of patients account for 80% of hospital costs
- The number of people over 65 is projected to increase by 7% by 2016

There is a compelling case for changing the health and social care system across this part of London, which covers the boroughs of Newham, Tower Hamlets and Waltham Forest.

The programme was started in September 2012 by the WELC Care Collaborative, made up of clinical commissioning groups CCGs) and councils from the three boroughs, with Barts' Health NHS Trust (the main acute provider), North East London Foundation Trust, East London Foundation Trust and UCL Partners.

1.2 What are you aiming to achieve?

- To enable as many people as possible to live independently
- To personalise and co-ordinate care around the patient
- To deliver care in the most appropriate setting
- Eventually, to provide targeted services for 20% of people most at risk of hospital admission
- By 2017/18 to have built a holistic model of care for people most at risk

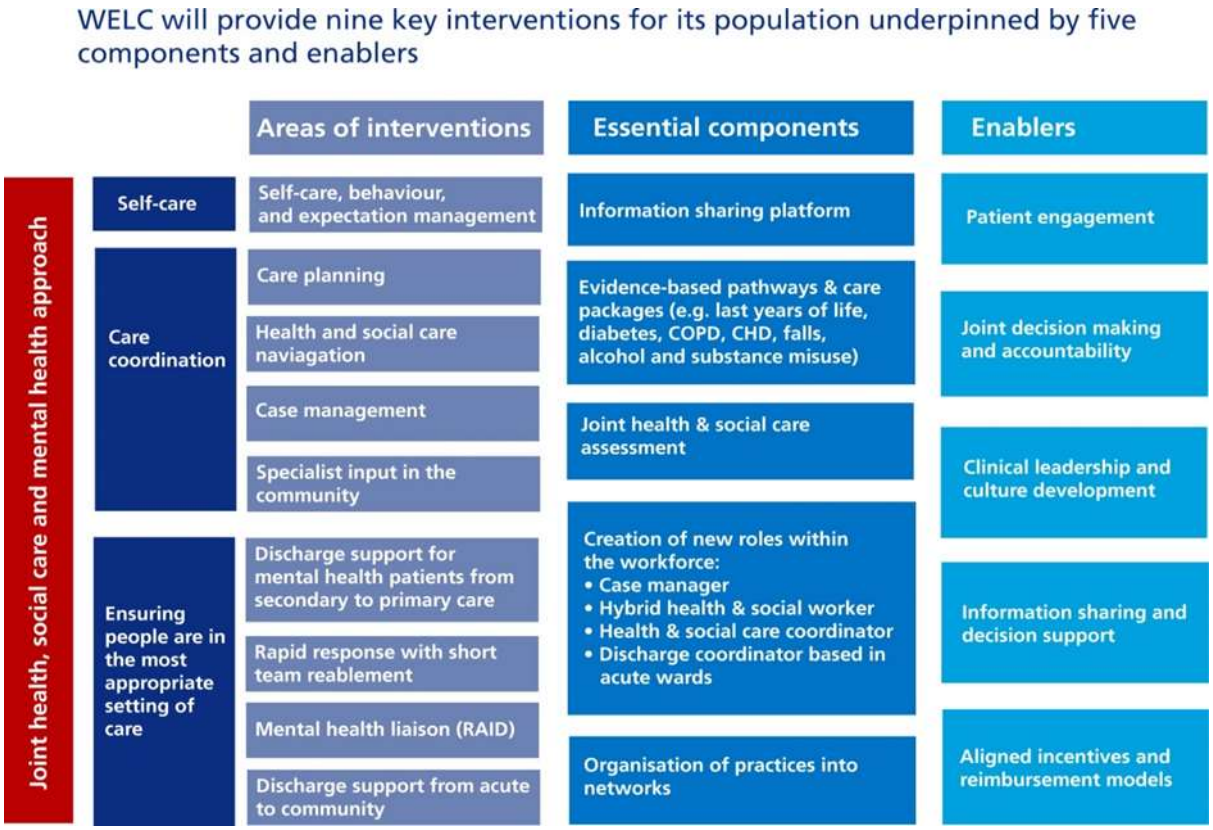
We recognise that we cannot change by doing things the way they have been done.

We want providers of care to work together to:

- Focus on outcomes, not inputs and outputs
- Put user involvement and experience at the heart of what they do
- Co-ordinate services around individuals' needs
- Use one budget for a population so they are collectively responsible for risks and rewards

To achieve our aims we wanted providers and commissioners to plan better together. We wanted to move away from activity-based payments to encourage prevention activity. We wanted to encourage joint decision-making and shared responsibility for gaps that occur in the health and social care system.

We have agreed this core service model:



We have partnered with UCL Partners to support the evaluation of the impact of our programme, embedding a researcher in residence within our team. We will know we have succeeded when we see a measurable impact in the following areas:

- User experience – we are involved in the national integrated care PROM pilot and exploring the use of PAM (patient activation measures) all partners are undertaking more qualitative work with individuals and groups of patients, to explore the impact of joining up services
- Frontline staff experience – the involvement of frontline identified many things they could do differently; we will evaluate the impact of change on working lives
- Health and wellbeing outcomes – WELC Integrated Care expects to reduce emergency admissions by 20-40% (dependent on variable baseline rates)
- Impact on cost – impact on cost is being remodelled each year of the programme. The focus now is less on cash savings for commissioners and more about long-term sustainability of the local health economy and associated provider landscape

We are tracking a core set of metrics by linking GP and acute data as part of the acute provider CQUIN in 2014/15. These are reported monthly for the top 5% of the population at risk of admission:

- Emergency admissions per 1,000 population

- Avoidable emergency admissions per 1,000 population (using the Better Care Fund (BCF) definition)
- Readmissions at 30 days per 1,000 population
- Total bed days per 1,000 population

For 2015/16 we are considering adding BCF outcomes to this list to look at use of residential and nursing care across the system, creating shared responsibility for these outcomes by adding them to all CQUINs (for community health services and mental health) in a stepped approach towards payment on outcomes.

1.3 What have been the highlights of your first year?

- Development of provider collaboratives
- Implementing our service model
- Exploring approaches to self-management See case study: Supporting self-management
- Information sharing
- Creation of new roles within the workforce
- Progress towards commissioning for outcomes and capitated budgets

1.4 Details of the year

Implementation of our service model is almost completed in all three boroughs for the very high risk and by the end of the first quarter of 2015/16 for the high risk group too (the top 5 % at risk of a hospital admission). We are now in a position to measure results across the three boroughs.

We are now able to join up data across acute and GP care for all three boroughs and are using this to track progress. We brought together analysts, clinicians and commissioners in September 2014 to explore this outcomes data and refine approaches to evaluation. We are progressing real-time data sharing in different ways across the three boroughs, working together with providers and local authorities to do this consistently across the patch.

We have created new roles to reinforce relationships between providers, improve patient experience and reduce inefficiencies. The creation of senior case manager posts (for the very high risk group) and care navigator posts (for high and moderate risk groups) is helping to ensure that patients' care needs are better met.

GP practices are starting to work together as federated provider networks. This is important for aligning community services, social care and mental health and helps ensure efficient use of resources and information sharing. We created a specification for an integration function and completed a two-stage assurance process with providers in one borough this year, asking providers to account collectively for how they would work together around outcomes, finances, workforce, information sharing and clinical governance. GPs have reported being better able to identify trends for patient needs at network level, and have been able to 'look up' and see beyond their individual practices.

They key enablers so far have been:

- Patient engagement, using National Voices principles, involving patients in evaluation and having patient representation on our integrated care boards
- Joint decision-making and accountability with a joint steering group bringing together commissioners and providers
- Clinical leadership and culture development – bringing providers into single meetings thereby encouraging collaboration; and facilitating network meetings between GPs, allowing broader consideration of patient trends and risks
- WELC's programme management office facilitates information sharing between partners and disseminates best practice across the boroughs. It also supports the 'do once and share' aspects of the programme, such as developing approaches to contracting and reimbursement, metrics and evaluation and workforce and organisation development

Changing existing pathways of care to implement the WELC service model has been our priority in the first year of the programme. We are now developing with commissioners and providers an approach to capitated budgets and payment for outcomes which will incentivise integrated care for particular population groups with the aim of stimulating further integration. See case study: Developing capitated budgets.

1.5 What has been the most exciting aspect?

We have put much effort into provider development. See case study: Developing the provider landscape. Based on learning from how the GP provider networks developed in one of the boroughs, we have used a similar process of identifying joint tasks to stimulate collaborative working. The two-stage assurance process has stimulated the development of a provider partnership which is now actively working on joining up their services. The providers are working collaboratively on eight workstreams.

1.6 What has been the most challenging aspect?

This is a massive programme to implement across three geographical areas, with hundreds of people involved. The real challenge is not so much managing the programme, but building trust between individuals and organisations and between professional staff and patients. We have had support from the King's Fund Four Communities programme to facilitate local conversations about how to create and maintain collective and distributed leadership across the patch.

1.7 What are you planning to do next year?

The main challenges for 2015/16 will be:

- Fully implementing all aspects of the service model for the top 5% at risk in all three boroughs and then planning which aspects of the model are implemented for the remaining 15%
- Agreeing baseline data for the remaining metrics and identifying a core set of metrics for payment on outcomes

- Creating a model for exploring suitable groups for capitation and working with providers to explore risk and gain share, improving data quality, and system readiness for shadow capitation in 2016/17
- Consolidating the federated GP model in all three boroughs to create a base for extended provider networking
- Realigning incentives and payment to ensure providers take ownership of system-wide outcomes. A new payment model will contract providers as a group to be responsible for key performance indicators
- Adapting the integration function and 'assurance process' in the remaining two process and completion of the process to bring together provider collaboratives

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

Don't strive for perfection in the system. Our mantra has become "you have to start somewhere and just do something". Instead of being paralysed by fear at not being able to reach the perfect holistic health and care system, we think about steps we can take tomorrow and the next day to take us further along the road. Chipping away at small tasks can add up to real achievements.

To get people to work together you need to give them 'something to do' collectively. Our providers were meeting frequently together but were unsure what for, until we gave them a specification and a process to go through to focus their discussions. We have to progress this by moving towards payment on outcomes and capitation, to help us commission collectively. It is very important that both providers and commissioners invest time and resources in provider development.

Information governance was a stumbling block for many areas but we have found ways to join up data by working with our commissioning support unit using data processing contracts.

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