

# Integrated Care Value Case

Waltham Forest, East London  
And City (WELC), England



November 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

# 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

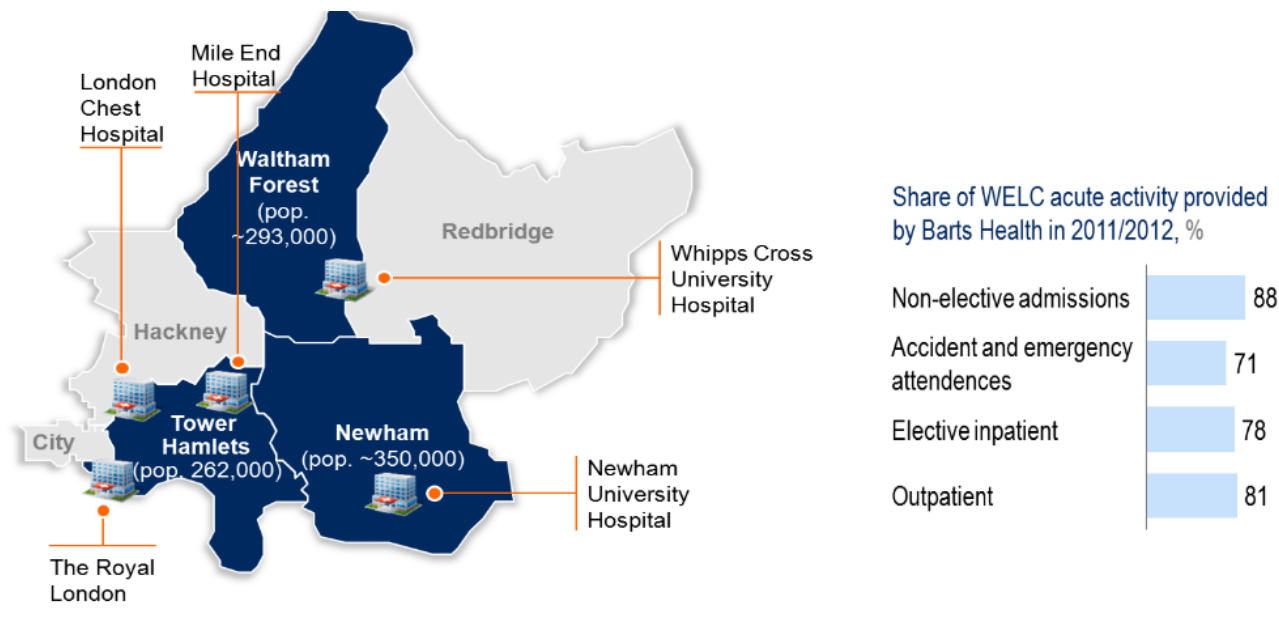
And incorporate:

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

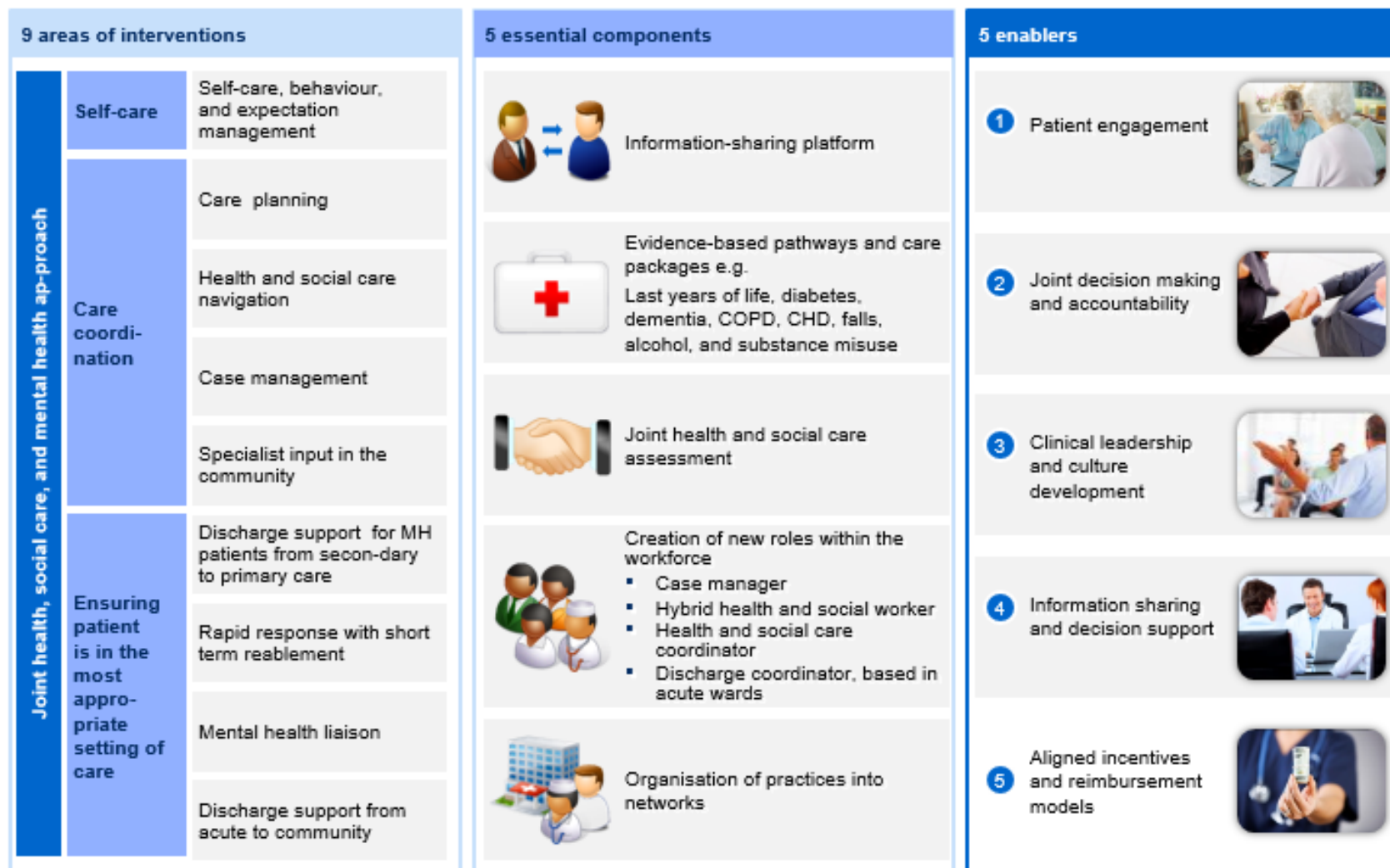
# About WELC Integrated Care Programme

- The Waltham Forest, East London and City (WELC) Integrated Care Programme is focused on revolutionising care for a population of almost one million people in an area facing significant health and social challenges.
- The Boroughs of Newham, Tower Hamlets and Waltham Forest are some of the most deprived in London, with significant health needs and inequalities.
- The Programme was started in Sept 2012 by the WELC Care Collaborative made up of CCGs and Councils from the three Boroughs along with Barts Health NHS Trust, North East London Foundation Trust, East London Foundation Trust and UCL Partners. Barts Health is the main acute provider across WELC.
- Work in 2012/13 focused on establishing governance and whole systems integration.
- Implementation across the three Boroughs has begun in 2013/14, with a five year vision for delivering full integrated care change by 2017/18.



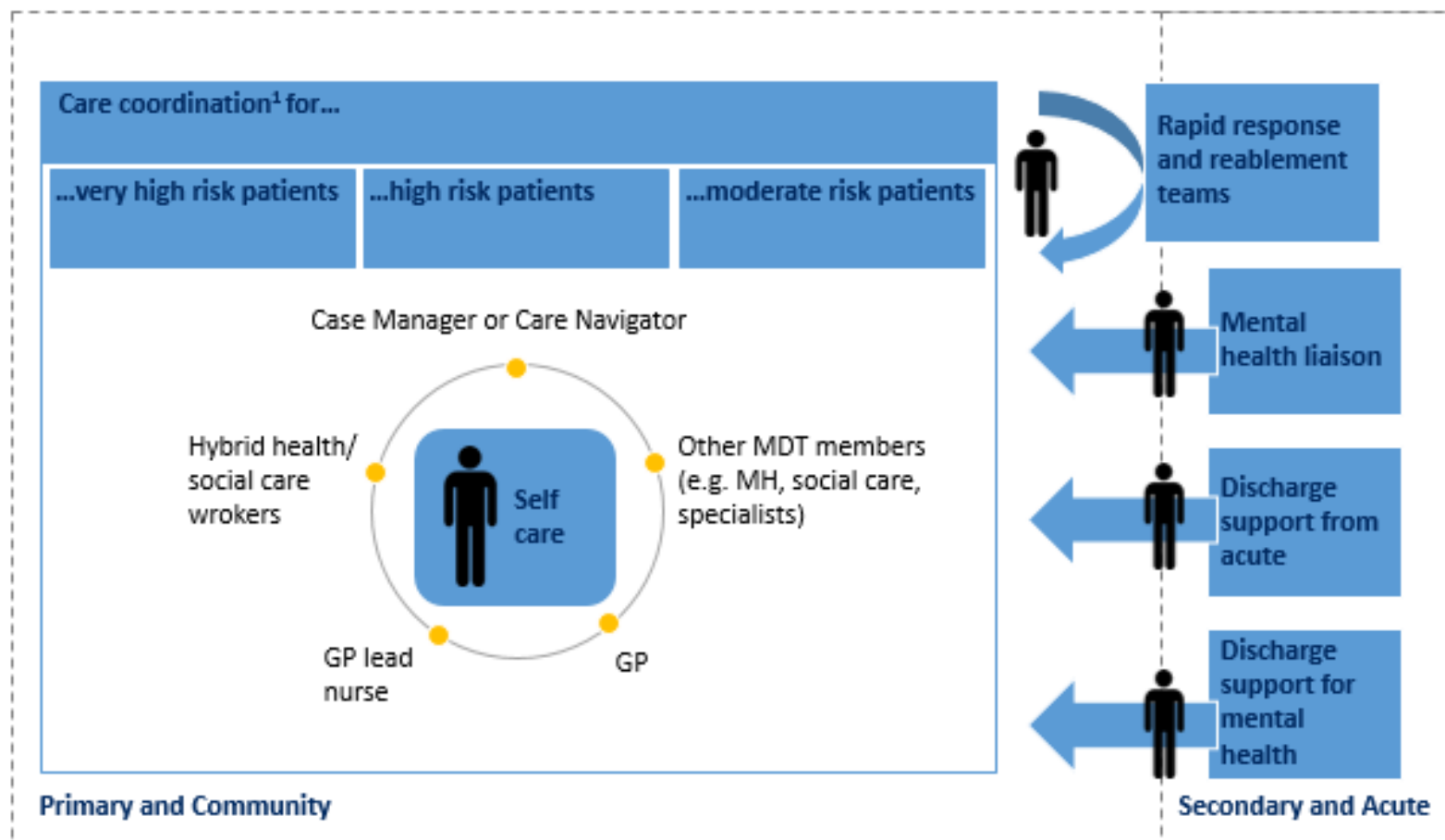
# WELC Integrated Care visual model: approach

WELC will provide 9 key interventions for its population, underpinned by 5 components and 5 enablers



# WELC Integrated Care visual model

WELC aims to co-ordinate care around the patient and deliver care in the most appropriate setting. It will target very high risk, high risk and moderate risk patients – those with long-term conditions, the elderly and people with mental health problems – and build a model of care that looks at the whole person by 2017/18:



<sup>1</sup> Care planning, health/social care navigation, case management, specialist input into the community

# Outcomes evidenced by WELC: What difference does it make?

WELC outcomes to date will be evaluated at the end of 2013/14. However, positive impact has already been seen from implementing integrated care at Borough level so far:

## User experience

- Case for change identified that patients / carers want clarity about who they speak to and when, to avoid repeatedly providing details and expect all the professionals they come into contact with to act as a team
- We will evaluate how well this happens as process and patient experience

## Frontline staff experience

- Frontline staff were involved in the case for change and identified many things they could do differently with the right enablers in place.
- The program aims to evaluate the impact implementing enablers makes to staff working lives

## Health & wellbeing outcomes

- Using best practice care packages, Tower Hamlets has seen 30% increase in immunisations in 4 years, and diabetes patients with BP <145/80 -5% and cholesterol levels <5-3% are above London levels
- WELC Integrated Care expects to reduce emergency admissions by 40% and patients residing in care homes by 38% by 2017/18

## Impact on institutional care

- Newham has seen a 20% reduction in emergency admissions and 14% reduction in elective admissions by using telecare monitoring
- Dementia services in East London have been reconfigured into integrated community teams, with a shared ward serving 3 boroughs

## Impact on cost

- Waltham Forest Integrated Case Management expects to see savings of £1m from reduced, unplanned admissions in FY 12/13
- Each WELC Borough expects to generate net savings of between £8m and £17m by 2017/18

## Productivity

- WELC plans to evaluate productivity outcomes in next 6 months, following an independent evaluation conducted by UCL Partners



*“Patients get an opportunity to discuss their care as a whole, not just their medical care, but the social aspects, the psychological aspects, and also what the carers feel they need”*

# How we did it: key enablers

## Patient engagement

- National Voices principles have been used to embed patient-centred care
- Patients will be involved in the initial evaluation of the WELC at the end of the financial year 2013/14
- Tower Hamlets planning pilot of 'Patient Activation Measure' to track patient perceptions of their engagement
- Patient representation at Integrated Care Boards is positively impacting on how patient needs are considered

## Joint decision-making and accountability

- Joint WELC Steering Group has now brought together commissioners and providers across three Boroughs
- Individual Integrated Care Boards of commissioners and providers have been replicated at Borough level
- Joint structure has had a positive impact on making providers feel more engaged and involved in discussions

## Clinical leadership and culture development

- WELC PMO has brought together different providers (GPs, hospitals, district nurses) into single meetings
- Meetings have had positive impact on how providers perceive they can collaborate together in the future
- WELC has facilitated Network meetings between GPs to allow broader considerations of patient trends / risk

## Information sharing and decision support

- WELC PMO is facilitating information sharing across three Boroughs, and disseminating best practice
- PMO is a useful mechanism for encouraging change that three Boards can then take forward in Boroughs
- Three Boroughs are progressing work at different rates, but PMO allows sharing of best practice across them all

## Aligned incentives and reimbursement models

- WELC is realigning incentives and payment to ensure providers take ownership for system-wide outcomes
- A new payments model will contract providers as a group to be responsible individually and collectively for KPIs
- Model incentivises providers to work together to ensure patient outcomes are achieved



*“Aim to get services using their primary record electronically”*



# What we did: integrated care design

## Information sharing

- An information sharing platform was introduced to allow co-ordination and co-operation between providers and transparency into a patient's case and the care he / she is receiving.
- This ensures clinicians have sight of a patient regardless of organisational boundaries and that information is shared between practitioners.

## Evidence based pathways and care packages

- Evidence-based pathways and care packages are being implemented to ensure appropriate care is provided, e.g., falls management, dementia, diabetes, COPD, CHD, alcohol and substance misuse.
- This is allowing joint rather than single pathways provision of more holistic packages of care. For example, a coordinated care package incorporates existing pathways to ensure the patient's needs across the physical health, social care and mental health spectrum can be met.

## Joint health and social care assessment

- To ensure holistic assessment of patient and effective use of resources, staff will be appropriately trained and the current assessment forms redesigned to ensure they are lean.
- This is currently being implemented.

## Creation of new roles within the workforce

- New roles have been created within workforce to reinforce strong relationships between providers, improve patient experience and reduce inefficiencies.
- The creation of Senior Case Manager (for very high risk cohort) and Care Navigator (for high and moderate risk groups) roles will ensure the patient's care needs are met.

## Organisation of practices and networks

- Organisation of practices into networks with alignment from community services, social care and mental health is helping to ensure efficient use of resources and information sharing on cases.
- GPs within the programme have already reported being better able to identify trends for patient needs at Network level, and have been able to "look up" beyond their individual practices.



*“Look for examples where there is already a multi-disciplinary response, to build on this”*



# Who we did it for and why

## Users and carers

- To enable patients and service users to live independently and remain socially active
- To establish education and self-care programmes for patients
- To personalise care to patients and service user's needs and preferences
- To help avoid patients having to retell their stories
- To reduce non-elective admissions for patients by providing proactive care interventions

## Commissioners and clinicians

- To bring together providers and commissioners who may not ordinarily speak with one another
- To encourage providers and commissioners together to meet more often and plan together
- To move away from activity-based payments to encourage more prevention activity
- To avoid misaligning clinician incentives
- To help improve performance and reduce costs across the whole system

## Workforce and organisations

- To stop separate organisations from making decisions in silos
- To encourage joint responsibility for any 'gaps' that can occur in the health and social care system
- To better ensure that members of the workforce have the right information at the right time, underpinned by appropriate levels of shared information and IT systems



*“[As a patient] you want someone to make a phone call and know that someone will be coming with a rapid response that you need to hopefully keep you out of hospital”*

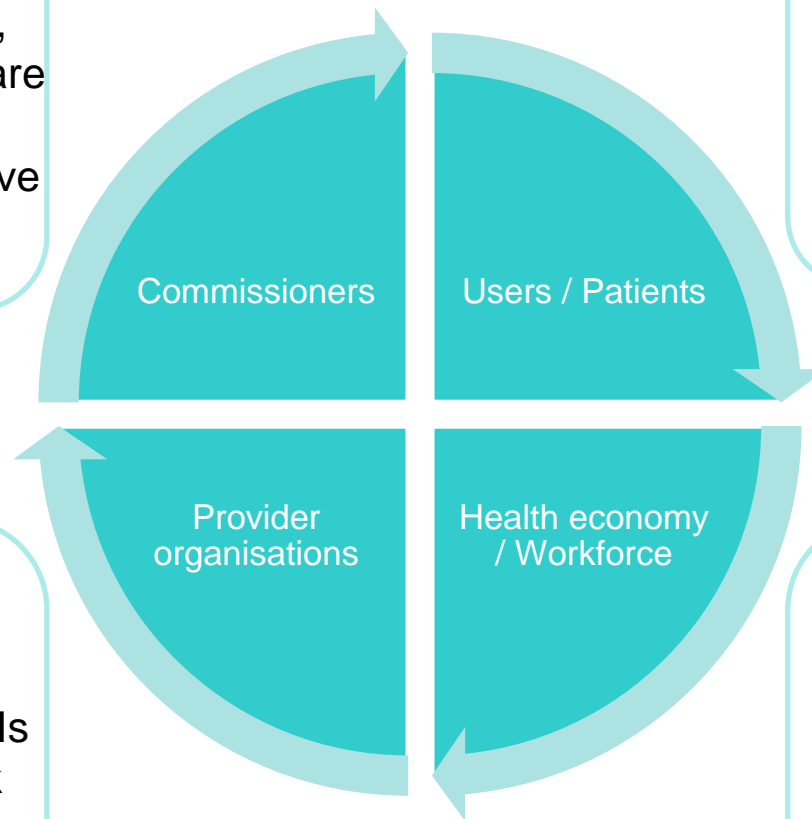
# Anticipated benefits

## Benefits

- Collaborating with providers
- Offering more responsive, co-ordinated, proactive care
- Outcome based commissioning, irrespective of commissioner

## Benefits

- Able to better manage care
- Not having to retell stories
- Staying active and independent
- Able to personalise their care



## Benefits

- Collaborating with commissioners
- More responsible for KPIs
- Better incentives to work towards
- Feeling more involved in decisions
- Integrated provider landscape

## Benefits

- Able to deliver more for patients
- Maximising patient outcomes
- Able to examine and track wider patient trends (e.g. GP Networks)
- A future health economy centred around patients

# Lessons learned

WELC is planning an evaluation of its impact to date at the end of the financial year 2013/14, which will include patients and be delivered externally by UCL Partners. Emerging lessons from WELC to date have been:

## Design services around the patient, not organisation needs

- For WELC, service design has used the principles of National Voices to design patient-focused interventions, regardless of organisational boundaries.
- Patients and patient representatives continue to be closely involved in the WELC development.

## Encourage collaborative working

- WELC is ensuring that the right incentives and enablers have been used to maximise collaborative working across different groups.
- For example, encouraging collaboration between providers and commissioners.

## Measure and provide access to outcomes

- WELC is ensuring that reliable, timely data is easy to access for all; is linked back to individual patients where possible, and presented in a way that influences changes in behaviour, for example through integrated care dashboards.

## Encourage organisational development through better accountability

- WELC has focused effort and resource on developing provider organisations' ability and confidence to work together as a collaborative, and increasingly hold each other to account for delivery of programme outcomes.



*“Get agencies to agree to share information and agree how to share data, 24/7”*

*“Have a single point of contact – try to direct people to one single place. Have one contact but a range of people who can then be contacted from there”*

# Contact details

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