Whole System Integrated Care
London workshop

Background

The Local Government Association supported by Integrating Care hosted a half day engagement workshop on 17th July 2013 at Coin Street Community Builders' Centre, attended by over 80 individuals working on integrated care initiatives. The event was used as a platform to engage with these individuals, drawing on their experiences of implementing integrated care to explore how they could be best supported in their endeavours. The discussion also gave attendees the opportunity to share learning around different ways that they had managed to overcome barriers to integrated care.

Attendees were divided into 8 groups where focussed discussions took place responding to a series of questions to help inform and feed into the LGA Integrated Care Toolkit and Support programme and beyond.

Thoughts on survey findings / where are we now
- **Do you agree / disagree?**
- **What kind of support could help us address some of the issues?**

Groups were asked to consider the early results from a diagnostic survey that attendees had completed in advance of the workshop. In general, the groups identified with the results, although there was some dispute that so many felt there was a clear process in place for engaging with people in the co-design of integrated care. Each group went on to discuss some of the barriers and challenges to integrated care, and what kind of support might be needed to address these issues.

Requirements of toolkit / value cases
- Some groups questioned the need for another toolkit and felt it would be preferable to have an output which draws together all the existing work / resources rather reinventing the wheel.
- It would be good to see evidence of where integration has failed before to apply lessons from this.
- It would be helpful to have something which guides people as to which area in the 'whole system' is best to focus on to guide prioritisation. Where will have the most impact, e.g. working with frontline staff?
- Value cases / toolkits might help with:
    - Simple rules within the complex system
    - Creative ways of jointly managing budgets / shared resources
    - Risk stratification
    - Examples
    - Model for plan to be shared between all organisations
    - Model for cost of care
    - International models and comparators

Financial barriers
- The primary concerns in the room were around finances and governance.
    - One group suggested that we need a "third space" for money, a trusted pool that can be shared for the right outcomes and user experience.

- There are issues with funding flows in the current system which are detrimental to progressing integrated care; particularly there is no incentive for acutes to change.
- We need to be able to evidence cost reduction or savings from integration.
  - One group felt that we should be more realistic and focus on integration as a way to contain demand, avoid costs and absorb demographic pressures rather than producing new savings?
- Need transparency around finances (would pooled money achieve this?) and the cost of integration.
- Issue with balancing the decreasing budget of social care against increasing demand in mental health – we need different financial incentives to solve this, targeting integrated interventions.
- One group felt that the language of savings is not helpful – we should focus on "more for less" and the patient / user experience.
- The NHS tariffs often work against integration and there is a backdrop of expected savings, e.g. QIPP.
- We need something in place to align incentives and commissioning flow.

Being patient-centric
- There was a challenge that public / local engagement is really happening effectively: one group felt that there is little evidence of how to do this properly yet.
- The groups all agreed that integrated care is a person-centred discussion and that we should stress the "client-centred" nature of this work.
- We need evidence of patient / user outcomes which capture their experience and in order to start commissioning for outcomes, we need to understand what the "customers" need and co-design how this might look with patients / users.
- There was also some discussion around the target cohort of people for integrated care – should this be population based or restricted to the frail and elderly?

Case for change
- Making the case for change is imperative: there has to be a clear case for all sides involved and an agreement on the common goal.
  - This is an opportunity to commission for more alignment for all services.
- Need to define what we mean by integrated care – is there a single model? Also need to define what we mean by values, using evidence to support this.
  - How do we brand something which is quite open to interpretation?
- To tie organisations together we should focus on the needs of those involved and not on the needs of the organisation.
- We need to think about what hasn't already been solved in integrated care work so far, e.g. we are currently lacking robust clinical evidence around learning disabilities and mental health.
- To construct a compelling case for change we need more information on measuring outcomes.
- While clinicians buy into integrated care, it can take years to get the benefits coming through.
  - We need to move at scale and pace, so how can we keep the momentum going with this in mind?

Workforce
- Need to move towards integrated behaviours of frontline staff: currently interfaces can be difficult.
- Need to be specific about integrated working in contracts, particularly GP contracts - redesigning the primary care business model in order for this to work.

Other barriers and challenges
- Lacking trust between organisations
- Clarity on decision making – who is actually making the decision?
- The system is complex, we need simple rules
- Importance of acute sector involvement
- Controlling service demand
- Making integration between local services a reality
- Information governance and sharing data – especially along the pathway flow

Round table discussion
Each group tackled three tasks over an hour long discussion to help build an overall picture of the support required for different audiences and appropriate format, the tools necessary to overcome some of the barriers to integrated care that the attendees are currently facing, and the information requirements to underpin both of these forms of support.

Task 1: Requirements and audiences
- **What are the key barriers and challenges to integration you are facing?**
- **How might value cases and a toolkit support you in overcoming these?**
- **Who are the different audiences these need to address?**
- **How should we tailor support for each of these groups?**

Barriers / issues to address
- Financial challenges and leadership:
  - Need to ensure GPs are key part of HWBs
- Risk aversion
- Transactional / contractor requirements predominate
- Organisational complexity e.g. Kent with 7 CCGs and 1 Council
- Culture
- Information governance – the rules need sorting out!
- Different funding streams – provider development is key to changing financial flows
- Defining what we mean by integrated care
- Defining the target population for integrated care
- Dealing with multiple priorities and different models
- Clarity of roles and responsibilities
- Making a 'toolkit' fit for purpose
- Overload of information on integrated care
- Information governance
- Lack of guidance leading to multiple systems in place and duplication of effort
- Obtaining buy-in from multiple stakeholders
- Achieving co-delivery

Support to overcome barriers
- Make use of legal drivers e.g. Mental Health Act, conceptual drivers and financial drivers.
- Need rules around conflict resolution.
- Create clear definition of what integrated care means, including costs etc.
- There are some clear examples of what works and does not – we need to work out these cases and apply them to our work.
- Producing pooled budgets may facilitate joint decision making.
- Multi-disciplinary activity will build trust.

- To counteract information overload, we should take teams and give them a day long workshop on what is a practical route to integration? This needs to be pithy, and set out the results in clear statistics: evidence of impact, especially savings.
- We should use HWBs as a legal starting point for pushing integration agenda through all parts of the system.
- Clinicians need to change the way they think, NHSE should be promoting changes in practice.
- Risk stratification will help to identify the target population.

Value case requirements
- The groups wanted value cases that would both tell a story and demonstrate benefits, including pitfalls and examples of bad practice – what would you have done differently?
- The value cases should tell the patient / user's story and should describe patient / user engagement.
- Make a strong financial case for how you use resources across the system for integrated care initiatives.
- Broader narrative for why we want to integrate services.
- How do you really get patient engagement? Need the key principles in a value case:
  - Social networking
  - Focus groups
  - Engaging with existing groups but taking a wide and representative sample

Toolkit requirements
- Key plans and components of successful integration, with a focus on what works practically.
- Needs both technical evidence and narrative. It would be helpful to have a modular structure.
- Toolkit should be modular: including factsheets and inserts for different audiences.

Audience
- In terms of audience, the main groups would be:
  a. Patients / service users
  b. NHS provider trusts, including FTs
  c. CCGs
  d. LAs, particularly DASS'
  e. Elected members
  f. Politicians
  g. All providers
  h. Frontline staff
  i. Voluntary sector
  j. Public Health
  k. NHS England
  l. Elected members – need to demonstrate the benefits to them using a value case
  m. GPs
  n. Health and Wellbeing Boards – how do you involve providers with these?
  o. General public
  p. HR
  q. Clinicians
  r. Boards

Task 2: Structure of toolkit

Overall structure of toolkit
- Should contain resource allocation and workforce modelling for out of hospital care.
- Detail on financial modelling process: how do you do it? Play in the numbers and get the cost output to build a business case financially (cost / benefit analysis) and establish whether an integrated care team is more effective (and if so, how).
- We need to have the patient at the centre constantly and continuously: this should be reflected in the project outputs.
- The toolkit should be a signposting document – including dynamic places to go to find out the current best practice, so it remains a living tool and doesn't get out of date.
- The toolkit content should consider the role of other services e.g. housing.
- A "how to" guide for integration would be useful: no one size fits all as people are at different starting points.
- Something addressing current information governance issues would be very useful.
- Groups also wanted content on how to get engagement with all partners, including patients / users, and achieve true co-design.
- Some principles on transformational change would be useful.

Financial metrics
- Set out the evidence base using financials.
- Need to use a common language.
- Need something that translates funding flow → workforce modelling (work with HEE, what kind of workforce is required to take us to an integrated level of care?)→ examples of different models e.g. "supercarer"

Operational metrics
- Modelling population needs against financial – how do we contain this?
- Move away from the hospital-centric – we need to incentivise 'whole' services.
  - How do we use metrics to tell the story about a longer stay at home and shorter stay at hospital?

Organisational models
- How can you make a collaborative, integrated workforce?
- Information on the different education and training required for new hybrid roles.
- Self-management: maximise this angle as opposed to focusing on case management. This is an opportunity for co-production. We need a workforce role that educates and enables the knowledge transfer required for self-management.
  - Teaching and thinking about "independence skills".
- Detail on clinical protocols that you can develop in the community and voluntary sector.

Outcomes
- There needs to be a heavy focus on outcomes, linking quality, activity and financials.

Overall structure of value case
- Should be no more than three sides
- Contents:
  - What is the infrastructure?
  - How does it work?

o What is the impact?
- One group felt strongly that they did want to have to contact other people to find this information and that it should be set out in the value case.
- It needs a broader narrative as well as technical specifications. We need to spell out the strategic reasons why we need to work towards integrated care in 3-4 simple key messages.
- We need examples of good practice, agreements and conflict resolution.
- Value focus should be on outcomes, user experience, and financials.

Task 3: Information requirements
- **What are the information requirements to support your work?**
- **What are the top 3 pieces of insight that would help you to change the system and through this the quality of care?**
- **How might we address current gaps?**

Information requirements
- We need to think about how we baseline ourselves, identifying where are we doing well and not.
- Use of a common language will enable cross-organisational information sharing, alongside simple presentation of data.
- Want to understand how to measure the difference of improved, integrated care.
- More information on self-management innovation e.g. end of life care: how many people were able to die in the place of their choice?
- Information on user engagement and defined outcomes.
- Understanding of who has done what and where so that we can call tap into this.
    o Information on how integrated systems that are in existence actually work.
- A 'how to' guide on:
    o Getting patients / users involved in co-production
    o Getting workforce involved at ground level
    o Commissioning jointly
    o Clarifying what integration will actually do – with timelines

Filling gaps
- The toolkit should use existing information services to fill gaps e.g. National Voices narrative.
- To address current gaps we should:
    o Use risk stratification: incorporate social care and mental health.
    o Sort the governance / Caldicott rules urgently, particularly around information sharing.
    o Create a common definition of outcomes, and how to record them.
- Put thought into solving information sharing at an identifiable level.

Expert panel concluding remarks

An expert panel provided feedback on what they had heard during the round table discussions and answered attendees' questions based on their own experience. The panel consisted of:
- Sir John Oldham, Chair, Independent Commission on Integrated Care
- Rachel Bartlett, Head of Out of Hospital Service Transformation, NHS London
- Peter Colclough, Former CEO of the Torbay Care Trust / Director of Adult Social Services for Torbay
- Dr Hugh Griffiths, Former National Clinical Director for Mental Health (England)

The panel then provided their concluding remarks:

- There is an emerging idea of a toolkit that can signpost you to where an integrated initiative / intervention has been tried and what outcome it had.
- We have heard that it would be good to be able to search the toolkit for outcomes and see how these could be delivered.
- Groups have also asked for information on the integration landscape: what's going on and where, so that we can effectively share learning.
- The role of the informal workforce (e.g. carers, receptionists, pharmacy) in integrated care is huge – we need to be leveraging these roles.
- Having good care coordinators will be key to the success of whole system integrated care: the question is around whom this should this be. Who has the authority to enact this role?
- Importance of focus on prevention and the role of Public Health. We must start with the patient / user and work outwards.
- We need to be able to track the patient's journey through the system using patient identifiable data.
  - Use this to make a model of the health and social care economy.
- There is an issue with attribution of benefits in an integrated system – it will be very different to how they are captured currently:
  - User-defined outcomes and new quality standards
- How can we tackle the changing needs of an ageing population and shifting demographics? Common themes:
  - Start with understanding and selecting the population
  - Employ integrated local teams
  - Focus on empowering patients / users and self-management