Whole System Integrated Care workshops

Executive summary

Background

The Local Government Association supported by Integrating Care hosted three half-day engagement workshops from 17th to 19th July 2013, attended by representatives of health, local government and third sector from across the country. The events were used as a platform for communication, engagement and co-design, drawing on local experiences to help prioritise and develop support options for whole-systems integration. The workshops also gave attendees the opportunity to share learning around different ways that they had managed to overcome barriers to integrated care already.

The outputs from the workshops will be used to develop a practical support package to enable local authority and health leaders to bring health and social care services together and help make person-centred, coordinated care a reality. This support will include providing value cases and a toolkit to further understanding of the impact of different models of integration on the quality and efficiency of services in local areas. This project has been commissioned by the Local Government Association and is a key part of the national work partners' work plan to support integrated care locally.

Recommendations

Overall it was felt that the value cases and toolkit could help with:

- Providing simple guidance and rules to help navigate the integration process
- Spotlighting ways of jointly managing budgets / shared resources
- Supporting effective risk stratification
- Providing examples of successful integration
- A template for a comprehensive plan for delivering integrated care that could be shared between all organisations
- Assistance in modelling the financial implications of integrated care
- Providing relevant examples of international models and comparators
- Ensuring that patients and service users are at the centre of future models of care

The following pages describe the specific recommendations relating to each project deliverable.

Value cases

The value cases must be able to speak to the key concerns and opportunities for all the audiences concerned, as outlined below.

Audience	Key messages / approach
Patients, service users, carers and families	• Managing people's expectations of integrated care, including the reasons for change and impact on local services of new models of care. • Focus on the role of self-management, opportunities and responsibilities attached to this. • Understanding how these changes can help deliver improved individual outcomes.
General public, media, business and other societal stakeholders	• Provide a common and understood definition of integrated care and how this can help to deliver better quality local services. • Build a case for change that goes beyond financial savings to look at developments from a patient, carer and service user perspective.
Elected members of all parties	• Driven by demonstrating the overall good for the population. • We need to make a compelling case that allows elected members to advocate for better integration and its local implications.
Council (including Directors of Adult Social Services and Health & Wellbeing Boards)	• Needs to speak to both a corporate and frontline audience. • Needs to engage beyond social care to the opportunities and implications for other local service managers and leaders including in the areas of housing, leisure and public health.
CCGs	• Provide examples of different commissioning models to support better integrated care. • A clear business case to ensure integration remains a priority in the other financial pressures.
Acute providers	• We need to make the case for upfront investment by the acute sector in integration as part of developing future sustainable models of care. • Need to be mindful that acute providers may be financial losers and will need help to adjust to new models of care delivery, but will also be critical to their success.
GPs	• We will need to be clear about the role they will have in a new system. • Encourage / support information sharing at practice level in the patient interest. • Need to address professional concerns, e.g. who will be co-ordinating and providing specific care.

Voluntary and community sector	• Building the case around reducing isolation, increasing resilience, capitalising on existing assets and reducing demand. • This includes how integration will help in connecting people and early prevention, improving independence and self-sufficiency.
Workforce / health and social care professionals, including clinicians	• Supporting frontline workers to elaborate the case for change, including in relation to specific patient and service user experiences.
National politicians	• We need to be able to make a case to ensure that the integration agenda remains at the forefront of national policy and that political support is sustained including when difficult decisions are required around future services. • Should be highlighting current issues, for example in relation to information governance and data sharing that require national / statutory solutions.
NHS England	• Need a case that helps NHSE to support local commissioning plans.
Public health	• Developing a long term, sustainable case for change including both physical and mental wellbeing.
Universities, educators and trainers	• Need to understand new roles and ways of working in an integrated system, how they can support these developments and how this will impact on future educational needs.

Overall structure and content of the value cases

V1. Each value case should be a concise document.

V2. We need to be specific about what is being proposed as 'integrated care' and promote a standard definition.

V3. Outline contents:
   a. What is the required infrastructure to make integration work?
   b. How can integrated care work in practice?
   c. What is the impact on individuals and across the system?

V4. It would be useful to have a 'benefits wheel', listing all players / stakeholders and the benefits for each one from their perspective. The patient / user voice should be at the centre of this.

V5. A value case should include the business case in terms of improved outcomes / patient experience as well as practical steps to achieving this set out in a way that speaks to the different audiences involved.

V6. There needs to be a broader narrative for why we want to integrate services as well as specifying how this can be achieved in practice. We need to spell out the strategic reasons why we need to work towards integrated care in 3-4 simple key messages.

V7. The 'value' focus should be on outcomes, user experience, and financials.

V8. The groups wanted value cases that would tell a story as well as demonstrating benefits / value add, including pitfalls and examples of bad practice – what would you have done differently?

V9. The value case should tell the patient / service user's story and look to bring together other support and networks beyond health and social care, e.g. the role of existing groups like Dementia Cafés.

V10. There should be examples of good practice, information sharing, agreements and conflict resolution.

V11. The value case should set out the process for engagement to get stakeholder support from the outset, including the key principles on achieving true patient engagement.

V12. It should also include a realistic timeline for implementation of integrated care and instruction on how to use resources across the system for integrated care initiatives.

Overall structure of the toolkit

T1. The groups at the workshops felt it would be useful to have a toolkit that could signpost you to where an integrated initiative / intervention has already been tried and what outcome it had.
   a. Capitalise on and collate existing tools and information rather than "reinventing the wheel".
   b. The toolkit should be a hub that collects knowledge on the integration landscape: what's going on and where, so that we can effectively share learning.
   c. It should include dynamic 'places to go' to find out the current best practice, in order to ensure that it remains a living tool and does not get out of date.

T2. The toolkit would need to be functional and easy to use in order to be fit for purpose.
   a. The information should be arranged in a way that people are able to search the toolkit for outcomes and see how these could be delivered (or vice versa: search an initiative / intervention and see the outcome that this might have).
   b. It would be helpful to follow a modular structure, breaking the toolkit up into subject areas e.g. patient engagement, population selection etc.

T3. Important to consider pace in relation to this work – the toolkit must be published to match the pace of developments locally.

Overall content of the toolkit

T4. We need to create system tools that would help to integrate care – at a practical level of granularity, e.g. how to do things / make decisions / make templates.

T5. A "how to" guide for integration would be useful: no "one size fits all" as people are at different starting points. Particular request for "how-to":
   a. Get patients / users involved in co-production
   b. Get workforce involved at ground level
   c. Commission jointly
   d. Clarify what integration will actually do, with timelines

T6. The toolkit should contain resource allocation and workforce modelling for out of hospital care.
   a. Include different organisational models

T7. It should also include detail on the 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).
   a. Financial and operational metrics need to be at a level of granularity that makes the assumptions and decisions behind them transparent.
   b. It would be good to have a tool to help people understand financial flows

T8. The toolkit content should consider the role of other local services e.g. housing.

T9. The toolkit should address current information governance issues including the use of existing tools for sharing information.

T10. Some principles on transformational change would be useful.

T11. Tools on cultural / relationship development to address organisational boundary issues.
    a. Tools should focus on process as well as activity e.g. having difficult conversations

T12. Content on how to get engagement with all partners, including patients / users, and achieve true co-design.
    a. Focus on vision

Information and modelling requirements

I1. The model should consider ways to baseline ourselves, identifying what we are doing well and what less so.

I2. In order to do this, we need to create an "as-is" baseline from accurate sources about:
   a. Skills / workforce
   b. Current level of integration between services
   c. "Community" capacity, e.g. voluntary sector, carers etc.
   d. Utilisation
   e. Estates
   f. Asset mapping
   g. Sectors
   h. Co-terminosity and boundaries
   i. Contacts
   j. Patient level data
   k. Inefficient handover of care
   l. Benchmarking of best practice
   m. Perspective of all stakeholders (organisations, users)
   n. Activity "overlap"
   o. Finances
   p. Needs and projected need
   q. Demographics and different populations
   r. Quality
   s. JSNAs

I3. We need a model which would enable localities to map need to services and then to outcomes.

I4. As a requirement we should ensure that everyone has the information to be clear about the real benefits of integrated care and how to measure this, e.g. ROI, what metrics are required?

I5. A tool to help areas share information, access relevant information, understand / interpret the evidence base and drive up quality of data would be valued, in an easy to access, common dataset.
   a. Need examples of how to get around data sharing issues e.g. SPISAS, GPs as data controllers and MASH systems.
   b. Clear definitions and use of common language cross-organisationally may help to address this.

I6. It would be very useful to have a model which tracked people's activity over time and their interventions and service settings – and costs associated with this.