Integrated Care in North West London

Making the Business Case ‘stack up’

Daniel Elkeles
Director of Strategy NHS NW London

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Producing our business case required us to address 5 areas:

1. **Joint Governance**
   - Integrated Management Board with a shared performance and evaluation framework

2. **Aligned Incentives**
   - through an innovative financial model

3. **Information sharing**
   - to access and analyse data in a timely fashion

4. **Patient, user and carer engagement and involvement**

5. **Organisation and culture development**
The NWL Integrated Care Pilot

**Improve the quality of patient care for patients with diabetes and the elderly**

Local Multi-Disciplinary Groups…  …working in a Multi-Disciplinary System

1. Patient registry
2. Risk stratification
3. Clinical protocols & care packages
4. Care plans
5. Care delivery
6. Case conference
7. Performance review

**What are we trying to achieve in NWL?**

1. Improve patient outcomes and experience through collaboration and coordination care across providers (4 hospitals, 3 community providers, 93 GP practices, 5 social care organisations) with shared clinical practices and information
2. Over 5 years decrease hospital usage including emergency admissions by 30% and nursing home admissions by 10% for diabetics and frail elderly through better more proactive care
3. Reduce the cost of care for these groups by 24% over 5 years

SOURCE: NWL ICP Operations Team
A large number of providers taking part in this pilot

Ealing CCG
Great West CCG (Hounslow)
West London CCG (K&C)
Westminster CCG
Hammersmith and Fulham CCG

Chelsea and Westminster Hospital
Central London Community Healthcare

Ealing CCG
Great West CCG (Hounslow)
West London CCG (K&C)
Westminster CCG
Hammersmith and Fulham CCG

Ealing Hospital
West London Mental Health
Over the last 6 months, the ICP providers have organised themselves into 10 multi-disciplinary groups (MDGs) that reach over 550K patients.
**A simple way of describing the ambition**

<table>
<thead>
<tr>
<th>Unit of measurement across pilot</th>
<th>GP</th>
<th>Practice</th>
<th>Pilot</th>
<th>Catchment</th>
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<tbody>
<tr>
<td><strong>Reduction in emergency admissions</strong></td>
<td>▪ Avoid 7 admissions per ~2,000 patients</td>
<td>▪ Avoid 28 admissions per ~8,000 patients</td>
<td>▪ Avoid 1,753 admissions across pilot of 506,000 population</td>
<td>▪ Avoid 2,080 admissions across catchment of 600,000 population</td>
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<tr>
<td><strong>Reduction in A&amp;E attendances</strong></td>
<td>▪ Avoid 15 attendances per ~2,000 patients</td>
<td>▪ Avoid 59 attendances per ~8,000 patients</td>
<td>▪ Avoid 3,700 attendances across pilot of 506,000 population</td>
<td>▪ Avoid 4,390 attendance across catchment of 600,000 population</td>
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<td><strong>Total reduction in emergency care</strong></td>
<td>▪ Saving of £50,000 from emergency admissions and £1,250 from A&amp;E</td>
<td>▪ Saving of £200,000 from emergency admissions and £5,000 from A&amp;E</td>
<td>▪ Saving of £12.3m from emergency admissions and £0.2m from A&amp;E</td>
<td>▪ Saving of £14.6m from emergency admissions and £0.4m from A&amp;E</td>
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How are we doing so far?

Very preliminary data

Emergency admissions

**April 2011 - September 2011**

<table>
<thead>
<tr>
<th>SLA base line activity 2011/12</th>
<th>5,561</th>
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<tr>
<td>Actual emergency admissions</td>
<td>5,040</td>
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<td>Difference</td>
<td>521</td>
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**Compared to April 2010 - September 2010**

- Emergency admissions across NWL: -1%
- Emergency admissions in ICP cohort: -4%
Joint Governance - We created a virtual organisation to run the pilot
We set out clearly the responsibilities of each provider in the ICP

<table>
<thead>
<tr>
<th>Actively participate at case conferences</th>
<th>Support and take part in care planning</th>
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<tr>
<td>• Identify and prepare patient cases for discussion (e.g., inpatients, social service users with health issues, etc.)</td>
<td>• Support MDGs in creating initial care plans for all diabetic patients and 50% of patients aged 75 and over (e.g., by providing seconded nurses to the MDG)</td>
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<td>• Give specialist input on patient cases brought by other participants</td>
<td>• Modify care plans with patients’ GPs as needed</td>
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<td>• Be the expert for the MDG on the full range of available services and resources</td>
<td>• Discuss MDG performance, identify opportunities for improvement, and allocate out-of-hospital investment</td>
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<td>• Follow-up on questions and actions generated through the case conference</td>
<td>• Identify system gaps and opportunities</td>
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<td>• Use the ICP IT tool to see range of patient data and history across multiple settings</td>
<td>• Identify best practice across MDGs</td>
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<td>• Complete “actions” (referrals) and regularly monitor activity</td>
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<td>• Collaborate with MDG partners on day-to-day basis (e.g., direct phone call to GP upon A&amp;E attendance)</td>
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Change how care is delivered

Review performance & identify improvement
Aligning financial incentives – Funds flow from the Commissioner directly for guaranteed payments funded recurrently without taking from providers up front

Funding flows (2011/12)

Providers paid for activity using existing contracts – PbR for acute and block for MH / Community

Commissioner

Does the IC pilot deliver improvements?

Yes

No

Infrastructure / IT

MDG Resource

Integrated Management Board allocates funding

70% marginal rate for emergency activity over 08/09 baseline held by SHA

Readmissions top slide held by PCTs

Commissioner Balance

QIPP saving

SOURCE: Integrated Care Project Steering Group
The costs of running the pilot are £3.4m

Estimated cost, £ ‘000

- Commissioner Retained: £1.2m
- Infrastructure: £1.8m
- MDG Out of Hospital: £2.5m
- Total Funding: £5.5m

Full year cost for MDGs in the pilot will need to increase to £2.8m

1. Commissioners retained £1.2m for other work streams
2. Includes non-recurring set-up costs
3. Resource envelope available for Care Planning, Case Conference and Performance Reviews

SOURCE: NWL ICP Operations Team
**Patient Risk Stratification**

- Identify high risk patients using population segmentation and risk stratification
- This enables proactive care to be planned

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**Integrated Patient Care Planning**

- Plan care for patients, share these plans across settings, and monitor progress
- This helps better coordinate care

**Action: Review by falls service**
- Action status: Completed

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**Patient Medical Information Sharing**

- View patient medical information from multiple settings
- This enable integrated care to be provided

**Patient records:**
- GP
- Hospital
- Community

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**Performance Evaluation**

- Track and evaluate the performance of GP’s surgeries and Multi-Disciplinary Groups
- This helps spread best practice in patient care
Things we learnt on route…

• Ground conversations by reminding people we are doing this because we want to improve patient care and make professional’s jobs better
• Be able to explain the concept simply and agree a single performance metric
• Identify patient cohorts which aligned to NWL PCTs clinical case for change
• Build a ‘bolt on’ to the existing NHS infrastructure and rules
• Don’t try and redesign the NHS financial payment mechanisms
• Don’t create a new organisation
• Don’t challenge existing or emergent NHS policy
• Take the minimum of funding out of providers up-front
• Invest sufficient resource to set up the pilot and deliver operationally on the ground the new ways of working
What’s next for integrated care in North West London?

- Enhance integration with local authorities and other providers
- Continue to develop and enhance the IT tool
- Conduct robust evaluation at the end of the pilot year to understand impact
- Scale up within North West London
  - Additional +10 practices in INWL already added, including Chelsea Pensioners
  - Roll out across more practices in Inner North West London and include Hounslow
  - Roll out across more Pathways in North west London (COPD, CHD and Mental Health)
  - Replicate in Outer North West London
- Expand beyond North West London
  - Commercial interest in IT tool

SOURCE: NWL ICP Operations Team
What does a Multi-Disciplinary Group do?

1. **Patient registry**
   - Each MDG holds a register of all patients who are over the age of 75 and/or who have diabetes.

2. **Risk stratification**
   - The MDG uses the ICP information tool to stratify these patients by risk of emergency admission.

3. **Shared clinical protocols**
   - All providers in the MDG agree to provide high quality care as laid out in the Pilot’s recommended pathways and protocols.

4. **Care planning**
   - Each patient is then given an individual integrated care plan that varies according to risk and need.

5. **Care delivery**
   - Patients receive care from a range of providers across settings, with primary care playing the crucial coordinating role and every body using the ICP IT tool to coordinate delivery of care.

6. **Case conference**
   - A small number of the most complex patients will be discussed at a multidisciplinary case conference, to help plan and coordinate care.

7. **Performance review**
   - The MDG meets regularly to review its performance and decide how it can improve its ways of working to meet the Pilot goals.
Why clinicians enjoy the being part of an MDT

- **Improved awareness of available local services** e.g. Falls service
- **Increased awareness of the scope of other professionals’ roles and abilities**, e.g. role of community matrons
- **Shared learning** about a variety of conditions, drugs and services e.g. the impact of needle length on insulin effect
- **Highlighted areas that may need further attention**, in individual patients and the overall population, e.g. the need for formal cognitive assessments in many of the elderly
- **Valuable discussions involving all disciplines**, taking a holistic view e.g. complicated diabetics with psychiatric co-morbidity & heavy drug burden
- **Professional support**, e.g. reassurance that there is no more that can be done, or alternatively, suggestions for investigations and management in complicated case
- **Increased Coordination and collaboration with Social care**, only forum where Health and social care specialists meet regularly to discuss coordinated health and well-being actions
- **Reduction in inappropriate Outpatient referrals**, through improved communication and focused care planning, inappropriate referrals should be reduced

SOURCE: NWL ICP Informatics group
What is required to build a successful Integrated Care virtual organisation

<table>
<thead>
<tr>
<th>Leadership</th>
<th>Establish leadership coalition—Pathfinder leads, PCT Cluster, Hospital CE(s), Community Health Service CE/MD, Local Authority CE/DASS</th>
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<td>Crucial to ensure buy-in to vision and appetite to make #1 agenda item</td>
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<td>Joint governance</td>
<td>Establish Integrated Management Board with executive level leadership (CE/MD level) for participating organisations including terms of reference, voting rights</td>
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<td>Establish committee structure (e.g., pathways, info, finance, etc, co-chairs and members)</td>
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<td>Clinical pathways and MDG mechanics</td>
<td>Select pathway, informed by clinical evidence, best practice and local needs</td>
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<td>Establish clinical working group with leading clinicians (i.e., heads of relevant department in hospital, leading GPs and community health leaders)</td>
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<td>Agree risk stratification and care package including resourcing envelope</td>
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<td>Agree key metrics for monitoring</td>
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<td>Define mechanics for multi-disciplinary working (i.e., balance time needed from specialists)</td>
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<td>Financial</td>
<td>Profile health economy with patient level data on activity and cost</td>
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<td>Model savings from interventions and cost of care coordination and care packages</td>
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<td></td>
<td>Establish scale up impact based on population in pilot, pathways in pilot and timeline</td>
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<td>Agree incentive mechanism and implication for all providers</td>
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<td>Agree how upfront investment is used to fund additional activity and operational team</td>
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<td>MDG formation, application and development</td>
<td>Identify local clinical leaders, supporting them to build clinical coalition leading to MDGs</td>
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<td>Agree on resource plan principles, content and peer-review process</td>
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<td>Define local MDG operating and financial model, and complete resource plan submissions</td>
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<td>Begin holding MDG meetings— and for into a true team</td>
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<tr>
<td>Information</td>
<td>Build technical requirements for sharing data, care planning, risk strat and performance</td>
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<td>Evaluate existing IT solutions, and determine scope for required bespoke IT development</td>
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<td>Design a usable ‘front-end’ clinical portal with regular interaction with clinicians</td>
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<td>Build ‘back-end’ datawarehouse by integrating all required data sets</td>
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<td>Review IG requirements and build into security rules</td>
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<td>Complete legal data sharing agreements</td>
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<td>Organisational development</td>
<td>Establish organisation team</td>
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<td>Train frontline users on use of information tool</td>
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<td>Continue to reinforce ‘new ways of working’ via team events</td>
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Each MDG must go through an intensive multi-step ‘mobilisation stage’

**Formation and governance**
- Sign-up
- Approve resource plan
- Clarify governance
- Establish baseline

**Data extraction**
- Authorise data extraction
- Complete data extraction

**Care planning design & set-up**
- Sign-off templates
- Map services
- Customise IT tool

**Care planning roll-out**
- Plan rate of activity
- Organise support
- Set-up & train users [MDG]
- Set-up & train users [GPs]
- Risk-stratify patients
- Invite patients

**Start care planning**

**SOURCE:** NWL ICP Operations Team