Integrated Care in North West London

Innovation in Managing Long-term Conditions

Kings Fund Presentation

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Integrated care results in a more structured and streamlined patient journey across care settings.
Our business case addressed 5 key 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

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
What does a Multi-Disciplinary Group do?

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

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

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

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

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

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

7. The MDG meets regularly to review its performance and decide how it can improve its ways of working to meet the Pilot goals.

Icons are illustrative only: any number of other professionals may be involved in a patient's care, a case conference or performance review.
The ICP IT supports 4 key processes

1. **Patient Risk Stratification**
   - Identify high risk patients using population segmentation and risk stratification
   - This enables proactive care to be planned

2. **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

3. **Patient Medical Information Sharing**
   - View patient medical information from multiple settings
   - This enable integrated care to be provided
   - Patient records: GP, Hospital, Community

4. **Performance Evaluation**
   - Track and evaluate the performance of GP's surgeries and Multi-Disciplinary Groups
   - This helps spread best practice in patient care
NWL ICP Information System Overview

ICP Data Feed and Network Diagram

Service User

User Log in Details

ICP Data / Care Plan Information

CPM / Risk Score

Virtual Server (Backup)

Data Analyst for ICP

GP

SUS

Daily A&E

ICH

EDC

Ealing ICO

HRCH

Local Authority

Walk in Centre

Urgent Care

Community

N3

Server at St Charles

ICP Web Based Application

Key:

- Patient List Returned to Provider
- Data Transfer One Way
- Two Way Access
The INWL ICP partners have organised themselves into 10 multi-disciplinary groups (MDGs) that reach over 550K patients.

**Acton**
- Practices: 12
- Diabetes: 1,551
- Elderly: 2,845
- Total patients: 54,917

**Chiswick**
- Practices: 9
- Diabetes: 1,015
- Elderly: 2,218
- Total patients: 41,630

**H&F North Central**
- Practices: 9
- Diabetes: 2,134
- Elderly: 2,528
- Total patients: 72,486

**H&F Small Practices**
- Practices: 11
- Diabetes: 1,221
- Elderly: 1,325
- Total patients: 37,951

**H&F Central**
- Practices: 5
- Diabetes: 1,113
- Elderly: 1,790
- Total patients: 39,908

**H&F South Fulham**
- Practices: 6
- Diabetes: 688
- Elderly: 1,700
- Total patients: 38,302

**K&C North**
- Practices: 17
- Diabetes: 2,109
- Elderly: 3,407
- Total patients: 74,370

**CLH**
- Practices: 13
- Diabetes: 2,723
- Elderly: 3,420
- Total patients: 63,636

**H&F South Fulham**
- Practices: 6
- Diabetes: 688
- Elderly: 1,700
- Total patients: 38,302

**K&C South**
- Practices: 14
- Diabetes: 1,667
- Elderly: 3,635
- Total patients: 73,492

**Victoria**
- Practices: 8
- Diabetes: 1,225
- Elderly: 2,618
- Total patients: 47,674

**K&C North**
- Practices: 17
- Diabetes: 2,109
- Elderly: 3,407
- Total patients: 74,370

**CLH**
- Practices: 13
- Diabetes: 2,723
- Elderly: 3,420
- Total patients: 63,636

**SOURCE: NWL ICP Operations Team**
A simple way of describing the ambition

**Unit of measurement across pilot**

- **GP**
  - Reduction in emergency admissions
    - Avoid 7 admissions per ~2,000 patients
  - Reduction in A&E attendances
    - Avoid 15 attendances per ~2,000 patients
  - Total reduction in emergency care
    - Saving of £50,000 from emergency admissions and £1,250 from A&E

- **Practice**
  - Reduction in emergency admissions
    - Avoid 28 admissions per ~8,000 patients
  - Reduction in A&E attendances
    - Avoid 59 attendances per ~8,000 patients
  - Total reduction in emergency care
    - Saving of £200,000 from emergency admissions and £5,000 from A&E

- **Pilot**
  - Avoid 1,753 admissions across pilot of 506,000 population
  - Saving of £12.3m from emergency admissions and £0.2m from A&E

- **Catchment**
  - Avoid 2,080 admissions across catchment of 600,000 population
  - Avoid 4,390 attendances across catchment of 600,000 population
  - Saving of £14.6m from emergency admissions and £0.4m from A&E
Case conference activity
YTD (Jul 11 – Mar 12)

- Number unique attendees: 300+
- Number unique organisations: 113
- Number patients discussed: 823
- Average number of patients discussed per case conference: 7
- Average GP attendance: 74%
- Cost per case discussed: £276
- Percent agree that case conferences are a good learning experience: 90%
- Percent agree that the advice they gave or received will help avoid an emergency admission: 61%

1 In addition, nine case conference were completed in March by 13th of the month
2 Four case conferences in Kensington & Chelsea doubled up (and were counted as two) in February
3 Percentage of respondents selecting “agree” or “strongly agree”
Trend in non-elective medical admissions

All non-elective medical admissions for patients aged 75 and over
Seven months Jul-Jan each year

<table>
<thead>
<tr>
<th>Participating INWL practices</th>
<th>Non-participating INWL practices</th>
<th>All NWL</th>
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<tbody>
<tr>
<td>-6.6%</td>
<td>+0.3%</td>
<td>+6.5%</td>
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<thead>
<tr>
<th></th>
<th>10/11</th>
<th>11/12</th>
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<th>10/11</th>
<th>11/12</th>
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<th>10/11</th>
<th>11/12</th>
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<tbody>
<tr>
<td>2,937</td>
<td>2,742</td>
<td>-195</td>
<td>1,156</td>
<td>1,160</td>
<td>+4</td>
<td>15,111</td>
<td>14,195</td>
<td>+916</td>
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ONWL’s growth rate over the same period was +11.0%

SOURCE: SUS data Apr 2009- Jan 2012
**Scope and required investment for 2012/13**

2012/13 costs, £m

<table>
<thead>
<tr>
<th>Options</th>
<th>Cost</th>
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<tbody>
<tr>
<td>Continuation of the ICP “as is”</td>
<td>3.5</td>
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<td>Extension of evaluation &amp; research</td>
<td>0.3</td>
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<tr>
<td>Introduction of education &amp; organisational development programme</td>
<td>0.5</td>
</tr>
<tr>
<td>Inclusion of CHD &amp; COPD pathways¹</td>
<td>0.4</td>
</tr>
<tr>
<td>Expansion to Hounslow and QPP²</td>
<td>1.0-1.1</td>
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1. Assuming an autumn start (half of the equivalent annual cost)
2. Lower end of range includes diabetes and elderly pathways, higher end of range also includes CHD and COPD pathways
**Feedback from clinicians has been positive**

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<tr>
<th>Identifying at-risk patients</th>
<th>Quotes</th>
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<tbody>
<tr>
<td>“The ICP CPM Score has provided me and our primary care team with great insight into which patients are at most risk. We have been able to focus on these patients and review them in depth with the knowledge of the score rating. Prior to using the tool, we were unaware of how 'vulnerable' some of our patients are to recurrent admissions ... we have been able to provide care plans where before we would not have identified these patients.” – GP</td>
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<tr>
<th>Improving individual patient care</th>
<th>Quotes</th>
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<td>“I’ve seen a few patients in clinic who were previously discussed at case conferences. It helped to have understood the problem from the GP perspective in a way that is not always obvious in a referral letter. I like the idea of closer relationships in patient care.” – Acute consultant</td>
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<td>“I have been very impressed with the vast experience within the ICP group. Views from different levels and specialities are discussing a client and input from different people means the action plan is detailed... I really enjoy this as the networking between clinicians is expanded and we get to know our individual roles and other services available out there to promote quality care.” – Community matron</td>
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**SOURCE:** NWL ICP Operations Team; Feedback from case conferences (clinicians & external observers)
A large number of providers taking part in this pilot

North West London

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

Imperial College Healthcare

Chelsea and Westminster Hospital

Central London Community Healthcare

Central and North West London

Ealing CCG

West London Mental Health

Ealing Hospital

www.ealing.gov.uk

City of Westminster

The Royal Borough of Kensington and Chelsea

Imperial College Healthcare

Charity

London Borough of Hounslow