

Refereed paper

The Integrated Care Pilot in North West London

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Key message(s)

It is possible to set up a large scale project that engages partners in health and social care to reshape a system to improve patient experience and improve quality while delivering cost-saving efficiencies

Why this matters to me

I have long been concerned about increasing health need without increased health resources, and about variable care in all parts of the system. I see the Integrated Care Pilot as a mechanism to resolve some of these problems by improving the efficiency of inter-professional working.

ABSTRACT

In 2011–2012 partners in the provision of health in social care came together in North West London from five local authorities, two major acute trusts, two community trusts, two mental health trusts, two 'third sector' organisations and over 100 general practices. Their aim was to support collaborative working in geographic areas of about 50 000 population for improved patient experience, quality of outcomes and cost-efficiency.

Patients with diabetes and those over 75 were targeted with care plans and locally-led innovation. Through monthly workshops practitioners from

different organisations shared their insights into ways to improve care for specific individuals and also to improve the functioning of the system as a whole.

The pilot is still under review and evaluation but has produced some positive results so far both in patient and clinician experience and the suggestion that this way of working results in reduced emergency admissions to hospital.

Keyword: Integrated care

The challenge

Meeting the health and social care needs of a population that is both growing and ageing when no additional resources are available is a challenge that faces many healthcare systems. In 2010 a group of commissioners, managers and clinicians came together to discuss how this challenge could be tackled in North West London. It was clear that in this part of the capital there was an indefensible variability in clinical outcomes and patient satisfaction, particularly among the elderly and those with long term conditions. The cost of managing these patients in the acute setting was growing at 3–4 times the rate of population growth. A paradigm shift was needed in the way we thought

about health and social care if we were to have any chance of improving quality of care, and the experience of care for both patients and professionals, while achieving financial savings.

Learning from others

Patient/user groups and the third sector in North West London were also discussing these issues and the possible solutions. Their ideas mirrored those

discussed in the National Voice's article '*Making it real*', that the key to making progress centred on a few essential factors:

- flexible integrated care and support, giving the patient/user control in the planning of their care and support
- access to the necessary information and advice when and where it is needed
- active and supportive communities
- a strong workforce to provide the care and support, and
- risk enablement, making sure that patients/users feel in control and safe.

These ideas were reinforced by reports about how other systems were making improvements. Everywhere people were recognising that the current payment mechanisms were rewarding activity rather than quality. The burning question was – How do we create a system that recognises that quality and efficiency are two sides of the same coin?

We began to see common themes in the experience of others around the UK and internationally. It was clear that any solution would need to be led by patients and users, and centred on their individual social and healthcare needs. A number of the models we looked at identified proactive care-planning as key to this process. We started to develop ideas about a multi-disciplinary system in which care plans were developed in discussion between professionals, patients and users, and (where relevant) their carers. The interventions in the care plans would be delivered by professionals working together, according to an agreed care pathway. And the providers of care would work together to make sure those patients most at risk benefitted from the expertise of specialists, while being cared for as close to home as possible. We envisaged multidisciplinary groups (MDGs) managing this process and monitoring their own performance by reviewing shared data.

Enablers of success

We knew that an undertaking like this would need financial investment to get going. We developed the business case for an integrated care pilot that focused on patients with diabetes and those aged over 75 years; two groups chosen because together they represented just 10% of the population of North West London, but accounted for nearly 30% of the healthcare costs. The registered population covered by those providers who were interested in participating in the pilot was 350 000. We calculated that if every participating General Practitioner (GP) was able to reduce non-

elective admissions among the two target groups by just one per month, the savings would amount to £10m in one year, a strong financial argument for investing in the pilot.

We knew that for the pilot to succeed, we would have to ensure:

- engagement of patients and users
- shared governance among the partners in the pilot
- aligned financial incentives
- shared data using information technology
- clinical leadership.

The aims of the pilot

Although there is no doubt that the economic downturn and constrained financial resources had stimulated interest in a new approach, it was the shared conviction that we must improve the quality of care for our patients that created a determination to act. Clinicians and managers, commissioners and providers, acute specialists and GPs, all shared a sense of frustration that we were unable to do a better job for patients. Working together, we formulated these aims for the Integrated Care Pilot (ICP):

- improve patient and user outcomes and experience through collaboration and coordination of care across providers
- improve the experience of health and social care professionals
- reduce the cost of care by reducing unnecessary non-elective admissions.

Progress in year one

Fortunately the ideas were sufficiently appealing to attract the participation of over 100 general practices, two major acute hospital trusts, two mental health trusts, three community care providers, five social care providers and two voluntary organisations, mainly in the 'Inner Sub-cluster' of West London (Westminster, Kensington and Chelsea, Hammersmith and Fulham) with some participants from other boroughs. This makes it the largest integrated care pilot undertaken in the United Kingdom. With those numbers involved, we hoped to be able to make a measurable and significant difference to clinical outcomes, but we were warned by others to be patient and not to expect to see anything in the first year, which would be about engagement and culture change, agreeing a shared vision and governance, setting up the multidisciplinary system and getting the ideas into operation.

A structure for implementation

Before the pilot could be launched, a governance structure had to be set up, to bring the partners together. The Integrated Management Board (IMB) was established. This included representatives from each of the provider organisations and the GPs who were to chair the MDGs. The role of the IMB was to maintain and develop the pilot's vision, set a strategic direction and enable the partners to hold themselves to account. It was a provider collaboration rather than a board in the usual sense, and has pursued a policy of inclusiveness and decision-making by consensus. Committees of the IMB included Finance and Performance, Evaluation and Research, Clinical & Education, and Information Technology.

The next step was to establish the MDGs. Each MDG was chaired by a GP and included GPs from around 10 practices, acute consultants, community specialists, mental health clinicians and social care professionals, jointly accountable for delivering care to an average patient population of approximately 40 000. Their role was to enable the planning and coordination of care for patients in the target groups, according to the patient's level of risk. Each MDG was responsible for carrying out its own performance review, comparing its performance to that of peers. MDGs were also responsible for allocating innovation funding for local projects to meet local need.

Box 1 The seven elements of an integrated care system

- 1 A patient registry
- 2 Risk stratification
- 3 Common clinical protocols and defined but tailored care package
- 4 Individual care plans
- 5 Proactive care delivery
- 6 Case conferences by multidisciplinary groups
- 7 Performance review

A culture of collaboration

Colleagues from primary care, community care, secondary care, social care, mental health and patient charities have worked together to a common goal. This required a fundamental shift in attitudes and working practices, moving from individual to collaborative decision-making, and from reactive *ad hoc* care to proactive care along agreed patient pathways.

Case conferences have been occurring monthly in each MDG since the launch of the pilot. They have

regularly been cited as one of the 'best things' about being in the ICP. In a survey carried out by the evaluation team, participants expressed a 'keen desire to learn how to do things in a new way, overcome organisational challenges, focus on patient empowerment, introduce a wide range of incentives, not just financial, and share resources and information in a way that has never been done before'. This type of culture change has been recognised in other studies as critical to success in integrating care.

Results of the first year

Despite teething troubles and delays with IT, by the end of the first year the *Care Integrator* tool held care plans for around 20 000 patients in the target groups. It has increased the capability of GPs to manage their most vulnerable patients by enabling risk stratification using the *Combined Predictive Model* (CPM).

The number of cases of dementia recognised among the over 75s rose, as a result of screening questions asked during face to face care planning meetings.

Patient and user engagement increased, with a vigorous Patients and Users Group. Representatives from the Group were full members of the IMB Committees. A patient engagement event was held at which patients expressed their strong support for the pilot and its aims, anxious only that it would not be able to deliver.

Clinical leaders have emerged, taking on roles as chairs or members of MDGs or committees or leading local innovations.

One hundred and sixty case conferences were held, discussing over 1000 high risk patients and leading to changes in their medications, access to services and altered social care packages.

'The ICP CPM Score has provided me and our primary care team with great insight into which patients are most at 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

The reach of the ICP has substantially increased from its original design over the past year, exceeding its target of 375 000 registered patients by nearly 50% to 550 000 registered patients. While this expanded the ICP's reach, it also increased pressure on the operational team and information technology infrastructure.

It is too early to know whether the pilot will have a sustainable impact on hospital admissions or costs. In the first six months of the pilot, between July 2011 and

January 2012, non-elective medical admissions among the over 75s within the pilot fell by around 6% compared with the previous year, but that reduction was not repeated in the second six months. However, as the trend had been for admissions in this group to rise year on year, even holding still would be an advance.

Next steps

The ICP model has caught the imagination of clinicians throughout West London as a way to systematically enable collaboration between multiple agencies for patient care. From August 2012 a second wave of the project started that included the remaining West London boroughs (Ealing, Brent, Harrow, Hounslow and Hillingdon). Learning from the first wave, it includes training for the MDG Chairs to facilitate whole system change – recognising their potential as leaders of transformational change as described in the paper by Deirdre Kelley-Patterson in this edition of LJPC.

In the next stage of the ICP we aim to move further towards the vision of improved patient care, professional experience and cost-effectiveness through collaborative working by:

- improved capacity and capability of the IT tool

- more complete, better quality and richer care planning
- improved engagement of clinicians and social care
- streamlining governance
- more leadership and accountability at MDG level
- more encouragement of innovation, and
- better education and development of all staff.

Since the ICP was designed, there have been significant developments in the wider landscape of health and social care. Specific changes have included the development of borough-level Clinical Commissioning Groups, Local Health & Wellbeing Boards, and out-of-hospital strategies. Social care also remains the responsibility of borough-based local authorities (excepting Inner NWL, which has merged into a Tri-borough management model). How to best integrate with these new structures and with multiple local initiatives to produce sustainable partnerships for on-going collaborative improvements is a challenge for this next stage of development. If this is successful, the ICP could help to create a culture of collaboration for whole system improvement, making integrated care *‘the way we do things round here.’*

ETHICAL APPROVAL

This was an education paper which did not involve primary data collection so did not need ethical committee approval