Brent Health & Wellbeing Board

Whole Systems Integrated Care

Brent Early Adopter – Update on Activities & Next Steps

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Purpose

1. The purpose of this report is to update the Health and Wellbeing Board on the activities of the Whole Systems Integrated Care (WSIC) Brent Early Adopter Project, and to outline key activities in the next phase of implementation planning.

2. The report provides details of the emerging implementation plan and presents an opportunity for the Health and Wellbeing Board to comment on the proposals for Brent's WSIC early adopter project. Specifically this is an opportunity for the Board to influence the development and scope of the Early Adopter Implementation Plan. It is also an opportunity to assess the strategic fit of the WSIC Early Adopter within the wider framework of Brent's Health and Wellbeing Strategy and Brent's Better Care Fund Plan.

Recommendations for the Board

3. Following the development of the WSIC Implementation Plan for Brent's Early Adopter, the Board is requested to review Brent's vision for Whole Systems Integrated Care and the Model of Care to deliver the vision.

4. To note Brent's next phase planning activities, and in particular the deadline of 31st October 2014 for submission of the Implementation Plan and the emerging changes, challenges and opportunities in health and social care services that need to be overcome to deliver whole systems integration.

5. For Board members to note the positive feedback from the Expert Panel for the process of coproduction and the WSIC Outline Plan.

6. For Board members to note the forthcoming opportunities for engagement and coproduction in the WSIC Brent Early Adopter Project and an opportunity to influence the development of the Early Adopter Implementation Plan. Specifically, the coproduction of the vision for WSIC, the Model of Care and the outcomes for measuring success of whole systems integration for the target cohort of patients.

7. Following the development of the WSIC Implementation Plan for Brent's Early Adopter, the Board is requested to review Brent's vision for Whole Systems Integrated Care and the Model of Care to deliver the vision.

8. To note that the next review point, prior to formal approval at the October Health and Wellbeing Board.

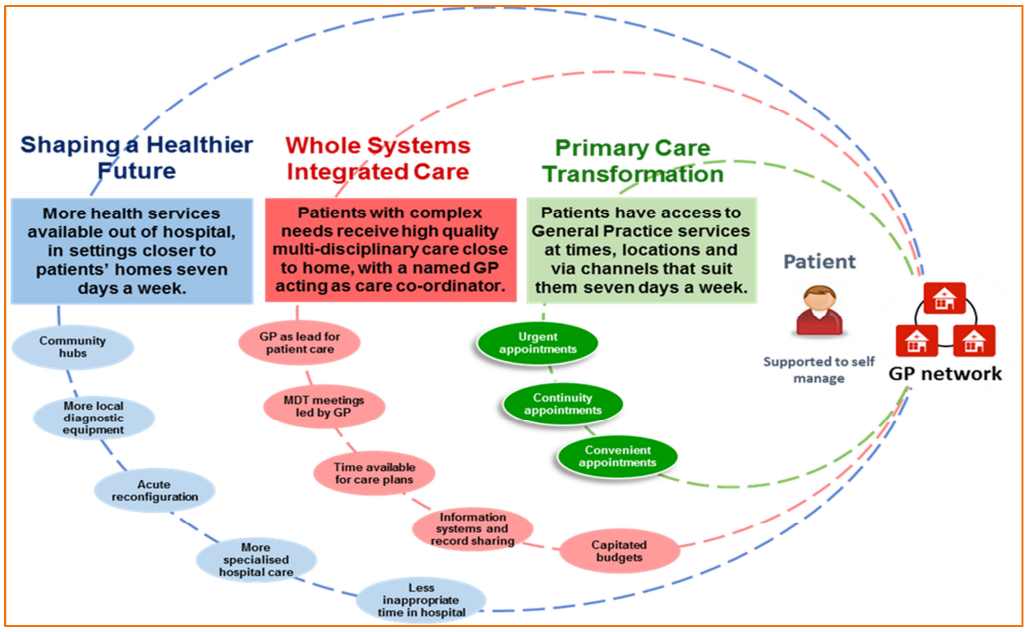
Introduction & Background to WSIC Vision

9. The WSIC is the new name for the North West London Pioneer project. Brent, as part of a North West London consortium, submitted a successful bid to the national Pioneer programme in August 2013. The first phase (October 2013 – December 2013) of the NWL WSIC was the creation of the NWL toolkit (http://integration.healthiernorthwestlondon.nhs.uk/) to underpin all integration work in NWL. The second phase was the development of local, borough based, Early Adopters. Brent submitted an expression of interest to become an early adopter pilot in January 2014, and an outline plan was submitted to an *Expert Panel* on 30th May for further consideration.

10. The last update to the Brent Health and Well Being Board was in April 2014. The update was presented as part of the overarching update on the Better Care Fund plan. The WSIC Early Adopter pilot is a key component of Scheme 1 in the Brent Better Care Fund plan – *keeping people well in the community*.

11. In addition, the WSIC Early Adopter Project sits within a wider health transformation agenda, which is illustrated by the diagram below. The success of each strategy is dependent on the others and achievements in one will reinforce and amplify ambitions in the others.

Scope of WSIC Work and fit with wider transformation agenda



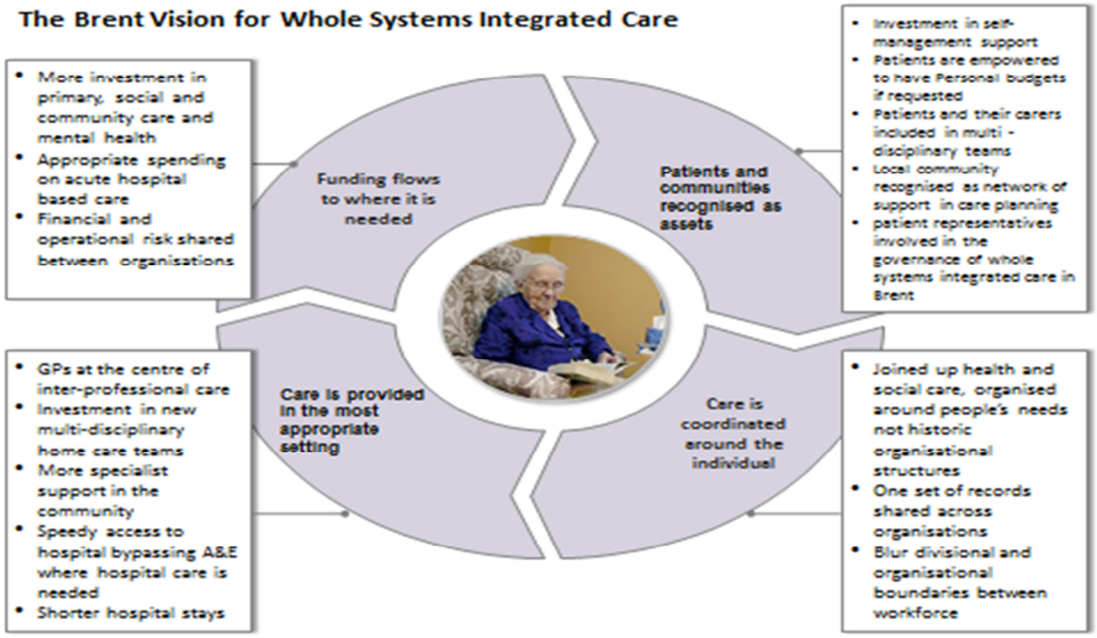
12. It is also an important part of delivering the Care Act 2014 which places new responsibilities on the Local Authority to integrate with health to achieve better outcomes for local people.

13. The Outline Plan detailing the Brent WSIC Vision, built on the good practice modeled in the first phase of the WSIC, and was coproduced through a series of workshops involving a wide range service users, clinicians and lay partners.

Development of WSIC Vision

14. The WSIC vision puts the patient's or service user's needs at the heart of the design and delivery of our health and social care services. Whole Systems Integrated Care will remove the barriers and obstacles to meeting the patient's needs and coordinate delivery of their care through multi-disciplinary teams and through the introduction of 'care coordinators'.

    An overview of the Brent Vision is provided in the diagram below:



15. We will design a system that it is responsive to the needs of the people who use it, and will reflect the services and support they need to make a difference in their lives. This means challenging ourselves to think not only about traditional health and social care responses, but instead to understand the impact of other support from other sectors can have on issues such as social isolation and financial insecurity which have a significant impact on well being.

16. The patient or service user will be fundamentally central to the provision of services. Around the service user are arrayed four key overarching aspects to the WSIC Vision:

    a. Self-Care Management,

    b. Joined-up Seamless Services Coordinated around the Individual,

    c. Provision of Care in the Most Appropriate Setting,

    d. Fluid and Dynamic Resource Allocation to ensure investment is made where most appropriate for patient-centred care.

17. The NWL WSIC toolkit starts with a focus on people and outcomes. Working with clinicians, professionals, voluntary sector partners and lay partners, we segmented the population

according to need in order to create a new organising logic for a new system. This segmentation creates a clear focus on people, rather than organisations.

Whole Systems approach to population grouping

Age	*Mostly healthy*	*Defined episode of care*	*Single LTC*	*Multiple LTC*	*Cancer*	*Serious and enduring mental illness*	*Advanced organic brain disorders*	*Learning disability*	*Severe physical disability*	*Socially excluded groups*
0-15 (Children)	▪ The programme is currently not focused on integrated care for children ▪ There may be innovative care models that we could trial, but that would be the focus of a future phase									
16-74	1 Mostly healthy adults		3 Adults with one or more long-term conditions		5 Adults and elderly people with cancer	6 Adults and elderly people with SEMI[1]	7 Adults and elderly people with advanced organic brain disorders	8 Adults and elderly people with learning disabilities	9 Adults and elderly people with severe physical disabilities	10 Adults and elderly people who are socially excluded[2]
75+	2 Mostly healthy elderly people		4 Elderly people with one or more long-term conditions							

In addition, there will be several **cross-cutting themes** that should be used to prioritise the particular approach within each grouping, e.g., frailty, deprivation, behaviour, social involvement, utilisation risk, presence of a carer, a person's own caring responsibilities

1 Severe and enduring mental illness
2 For example, the homeless, people with alcohol and drug dependencies
Source: Whole Systems Integrated Care module working group

18. In Brent the initial discussion focused on all people with one or more long term conditions as partners felt these people would benefit most from the integrated approach. However, we recognised that this population group would be very large and would be difficult to manage in a transformational pilot. Therefore, the current early adopter project will initially focus on delivering whole systems integrated care for over 75's with one or more long-term conditions. The opportunity to take part in the Early Adopter project was given to all GP localities, but in the end it was Harness and Kilburn GP Networks, who volunteered to take part. Therefore, the Early Adopter project will focus on all people over 75 who have one of more long term conditions and are registered with a Harness or Kilburn GP. This equates to approximately 6500 registered patients. This will create challenges for Borough wide services, but these have been recognised and will be tackled.

19. Further work is underway to better understand the characteristics of this group; for example, analysis is being undertaken or is planned to be undertaken to evaluate the key care pathways currently used to navigate the provision of services. We are currently mapping the current landscape of services and support across all sectors to describe and understand their accessibility and settings.

20. Through this analysis of the current health and social care landscape we aim to better understand the gaps and challenges in services, and the potential obstacles and risks to

developing whole systems integrated care services. This analysis will contribute to our understanding of the necessary interventions and levers required to deliver the WSIC vision. It will also deepen our understanding of the implications and impact of the WSIC Vision. This vision will develop and evolve as the detail of the Model of Care emerges and new patient pathways are developed to capitalise on innovations in self-care management, primary care services, and new treatments in community settings and in the patient's own home.

Development of the Model of Care

21. The WSIC Vision will be updated and set out in greater clarity in the final draft of the Implementation Plan. It will provide the framework in which the new Model of Care will be described and navigated. Work is commencing to flesh out the Model of Care, plot the pathways and describe the interventions which will deliver the Vision. The Model of Care will embody key principles that together will govern the approach to delivering whole systems integration.

22. For example, where appropriate we will respond proactively so patients have the information, choice and control to manage their care to best meet their needs. Through the early adopter WSIC work patients will feel empowered and given the support to better manage their own treatment.

23. But where a patient requires treatment in a health setting we will respond reactively with rapid and timely interventions to deliver seamless patient-centred care; our aim is to keep people well, as long as possible in their homes and in their communities but be there to provide urgent care when they need this.

24. To deliver the above ambitions it has been determined that the Brent model of care should include 4 evidence based principles:
    1. A Collaborative Multi-Disciplinary Team structure
    2. Care Coordination
    3. Self-Management by the Patient
    4. A Single Shared Care Plan

25. In addition to this the Brent local vision has developed emerging principles to govern integrated care models that are developed. These include:

    - Jointly commissioning for quality of life and independence outcomes
    - Single point of access to health and social care services
    - Single named coordinator/lead professional– who is best placed to care for patients
    - Single care coordination approach that is holistic and person centered to empower and enable independence, dignity and quality of life
    - Shared information and patient registration to maximize wellbeing and user experience
    - Removal of professional and institutional barriers
    - Network led to ensure equity of access and care

- Consistency and continuity of 24/7 across health and care
- Supporting carers to care and improve patient experience

26. The far reaching transformation of social and healthcare services delivered by whole systems integration will fundamentally change the way we provide health and social care services, and this will result in challenges and opportunities in the system. However, given the small size of the initial target group the impact will be limited. There is an advantage in this in that we will take the opportunity of the Early Adopter experience to consider and test the potential mitigation strategies required when WSIC is rolled out to cover other patient cohorts.

27. To illustrate how the proposed changes will make things different for the patient, consider how in the current set-up your GP will not help patients with non-health issues, and instead is likely to direct you to social services or the voluntary sector. This leaves the patient with the job of finding out the relevant contact and help they need; a responsibility that not all patients are capable of fulfilling. In the future, adult social services and Age UK would be part of the multi-disciplinary Locality Team. They would all have joint responsibility and would be working together.

28. There would not only be better understanding of what is available (avoiding unnecessary referrals), but they could also make direct referrals, direct to another member of the Locality Team who would help immediately. All of these professionals would be working together on a daily basis and they would be identifying the gaps in services and support, and would work together to commission what was needed locally based on a shared understanding of the gaps, and a shared understanding of the impact – the impact it would have on the well being of the people they support, and the impact it would have on the budget available to the locality team for its population.

29. A fundamental part of the Early Adopter process is the idea of a 'capitated budget'. This means the Locality would know how much money it has to spend on its population across all services, and could then make decisions about where to spend money, which services and support would make the greatest difference, rather than at the moment where different organisations are focus on their organization outcomes and spend money according to those organisational priorities.

30. In addition, the care coordinator role in the Locality Team would have a more explicit role in accessing support outside of the Locality Team that would have a significant impact on an individual's well being. For example, there are no plans for Housing to be part of the Locality Team, but we know that Housing has a major impact on people's well being. Therefore, there is an expectation that the Locality Team would have strong links with Housing and the Care Coordinators would help people to navigate the housing system to find solutions. They would help them to understand what may or may not be on offer, and help them to access what is on offer, rather than just saying 'you will need to speak to housing'.

Challenges and Opportunities

31. Initial thinking on challenges and opportunities suggests the following potential situations arising:

- Institutional and professional challenges to organisational change such as the development of multi-disciplinary teams and creation of new job roles like care coordinators

- Service redevelopment opportunities resulting from the emergence of financial winners and losers as transformation re-routes care pathways and patients, mainly from secondary to primary care and treatment in the community and home; where the resource is attached to patients under Payment By Results Acute Trusts face a significant risk caused by reduced activity and the knock-on effect on revenue. Similarly, increased incidence of home and community treatment could result in increased costs to social care, nursing homes and individual carers. In primary care it is to be hoped that the provision of broader array of treatments historically provided in acute inpatient or acute outpatient settings will be offset by savings achieved through the cheaper unit costs of primary care interventions compared to secondary care interventions.

- With the opportunity for service redesign there is a challenge of 'efficient reallocation of resources' to reflect the changes in patient pathways. If the mechanism for redistributing costs and reallocating is weak or absent, for example a Provider Network founded without a legal basis or strong organisational support and suffering from weak leadership, then the system will not be able to react quickly enough to reallocate resource within a capitated budget to match system changes or will lack the credibility to enforce the reallocation decisions it makes.

- There are challenges and opportunities connected with data sharing and the information governance and interoperability consequences of this work. This is connected to the development of Brent's bid (as part of a larger NW London reference bid) as a 'Pioneer' for money available under the Government's Tech Fund Bid.

- This will help to ensure systems are inter-operable and we have the Information Governance and IT capabilities to link patient records. Without this capability we will not be able to either construct the capitated budget from the bottom up or monitor patient activity and associated costs. Also if Providers are unable to communicate and share patient data quickly and dynamically in realtime patient care could suffer and impact adversely on clinical outcomes and quality of life outcomes as the ability to coordinate care and implement joint care planning and decision-making is impaired or wholly absent. The mitigation to a data sharing risk is being considered now as IT and information governance products and activities have long lead-times and decisions need to be made now.

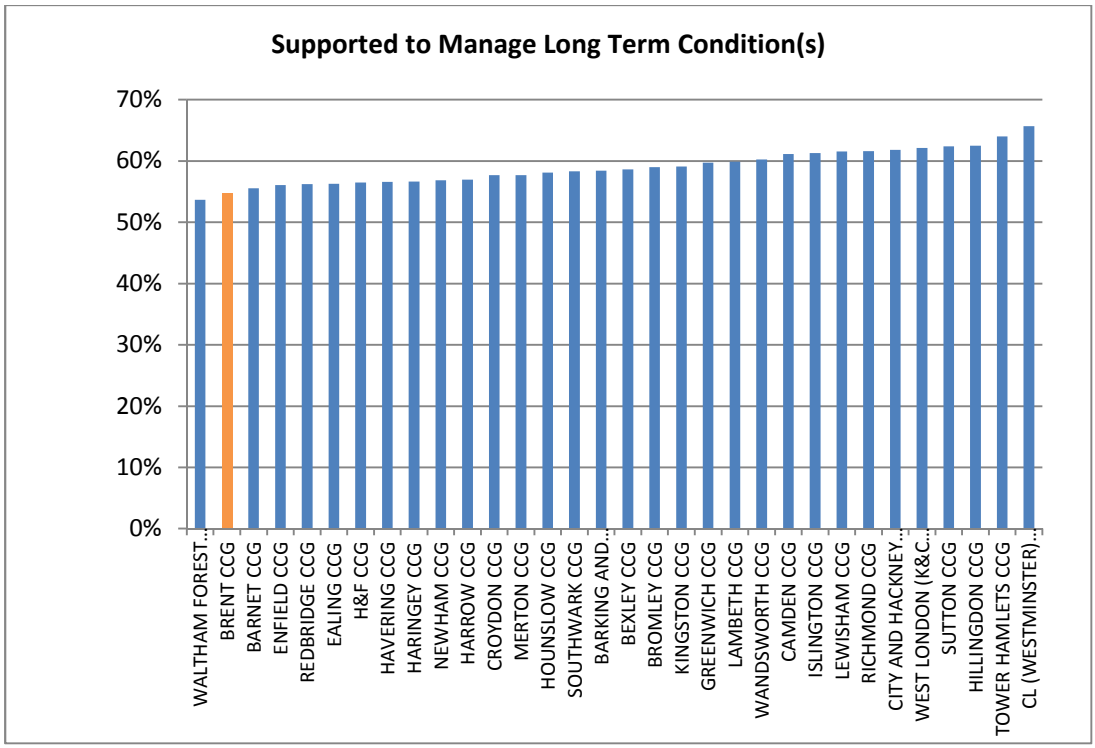
- To fully take advantage of the opportunities created through patient-centred care, safeguards for patient safety and service-user welfare will be developed as delineated roles and responsibilities are replaced by multi-disciplinary teams and shared responsibility for problems if things go wrong.

Measuring success and the impact on service users and providers

32. The success of the Model of Care will be evaluated through the measurement of key outcomes and key performance indicators. Central to this evaluation will be quality of life outcomes. Measures of quality of life are the best indicators of service-user priorities; improvement in these outcomes will denote improvement in service-users' quality of life and as a result service-user satisfaction. Improvement will therefore demonstrate we have delivered the WSIC Vision and contributed towards the delivery of key Health and Well-being ambitions.

33. For example, Brent currently is rated very low by patients in terms of feeling 'supported to manage long term conditions'. We aim to change this so Brent is amongst the top performers and patients report a very high level of satisfaction and confidence with the support offered to them to manage their long term condition.

Chart: Feeling Supported to Manage Long Term Conditions



34. The ultimate aim of whole systems integration is to improve patient's quality of life. Whilst we are planning further work to develop patient related outcomes, initial engagement shows that for over 75s quality of life means:

a. Living independently
b. Meeting personal goals
c. Being at home
d. Feeling safe
e. Having enough to eat
f. Opportunities to maintain choices
g. Feeling in control
h. Ability to direct support
i. Being listened to
j. Not feeling isolated

35. The WSIC early adopter Outline Plan we have co-developed sets out the vision for delivering improvements in these quality of life indicators. The goal of delivering improvements in these outcomes highlights the case for change and the key drivers that together denote the importance and priority of this work.

36. Success will also be measured by performance and professional related outcomes and in particular financial savings. Whole systems integrated care will provide patient-centred seamless care in settings convenient to the patient and which will deliver the best clinical outcomes. In practice this means planned care, reductions in expensive emergency admissions, reductions in avoidable admissions and readmissions, and the transfer of treatments from secondary care to primary care resulting in reduced bed-days and length of stay.

37. Whilst the primary objective of WSIC is improvement in patient related outcomes, the impact of the implementing the new Model of Care will be a reduction in costs for both health and social care services. Further work is required to evaluate costs associated with the new Model of Care and plan the realisation of benefits to the patient and to organisations along the care pathway. Once the Model of Care has been developed and costs associated with its interventions have been mapped, we will understand the relative affordability of the WSIC Early Adopter Project in comparison to the current care landscape for the target patient cohort.

38. A benefits realisation plan will be developed to plot the trajectory of cost and benefits. Experience and previous pilots always show that costs of integrated care programmes are incurred near the beginning of the programme lifecycle and there is a gap before financial savings are realised in provider organisations. For some interventions, requiring specialist training and a learning curve, such as some self-care management techniques it is to be expected that there will be long lead-times before benefits are accrued. Other interventions could be relatively 'quick-wins', for example innovations that directly reduce emergency admissions. We will plan the implementation of the Model of Care to ensure as far as possible that the system experiences speedy realisation of benefits to offset initial costs.

Expert Panel Evaluation of Brent's Outline Plan

39. The last update to the H&WB Board described the contents of the Early Adopter Outline Plan. The document sets out the local vision, initial planning on critical elements of the new system such as the model of care and planning to prepare full business cases and an implementation plan.

40. The Outline Plan was reviewed by an 'Expert Panel', who the Brent partnership presented to on the 12th June, 2014. The Expert Panel comprised of industry leaders and innovators, senior directors from NHS England, the Chair of Monitor and a patient representative.

41. The Expert Panel comprised of industry leaders and innovators, senior directors from NHS England, the Chair of Monitor and a patient representative. The panel included integrated care trailblazers from the USA (the Chief Medical Officer from ChenMed, Dr. Greg Tanios, and the Chief Executive of Kaiser Permenente, Mr. Hal Wolf), the NHS England Director of Primary Care, a senior GP with experience of implementing integrated care solutions and the Chair of Monitor and a patient representative with a perspective of true patient-centred care.

42. The Brent Partnership jointly presented to the panel, which showed we have a shared vision and explained the challenges of the work from all perspectives. This had the impact of reinforcing the fact that we are all equally committed to the work and are all enthusiastic supporters of patient-centred care.

43. The Panel, who had previously read the Outline Plan, gave our presentation a warm reception and displayed real enthusiasm for our vision which they said was well articulated and conveyed a deep understanding and support for developing integrated services that were designed around the service-user to best their needs. Special mention was made of Brent's commitment to consulting and engaging with different resident and service-user groups, and commended our approach to co-production which they stated was evident in the way we developed the Outline Plan and how it featured prominently in our vision and presentation.

44. The next phase of 'Implementation Planning' continues our journey of engagement and coproduction. We reiterate our local commitment to finding and using representation from grassroots organisations and lay members, including the general public. We wish to engage a diverse wide range of people whose views are representative of all the local issues faced by service-users in Brent.

Next Steps and Implementation Planning

45. There will be a number of opportunities to engage with the coproduction of the Implementation Plan and particularly the development of the new Model of Care. We will be implementing the necessary structures and processes to ensure alignment of all Brent engagement work and to ensure adequate communication of progress, including regular updates on key programmes of work. This will include regular updates on WSIC Early Adopter Phase 2 Implementation Planning for the H&WB Board where appropriate.

46. Of particular interest to the H&WB Board will be the development of the WSIC Early Adopter Vision and the new Model of Care to deliver the vision. Members will also have a special interest in the development and selection of outcomes to measure success. The Board will have opportunities through coproduction to influence the development of the Vision and Model of Care.

47. To ensure the Vision and Model of Care fit within the broader aims of the Health and Wellbeing Strategy and within the wider transformation agenda in Brent and NW London, including the Better Care Fund, it is proposed that before the 31st October deadline a final draft of the WSIC Brent Early Adopter Implementation Plan will be submitted to the Board to explain the Vision, the Model of Care and the outcomes chosen to measure success. A early version of the Benefits Realisation Plan will also be shared to provide a high-level view of the cost/benefit trajectory.

48. Subject to approval by the H&WB Board the Implementation Plan will then be submitted to meet the 31st October deadline. The headline timeframe to develop key components of the Implementation Plan is described below. The development of deliverables will be managed by a Task & Finish working group for each workstream who will report to the Brent WSIC Steering Group, which is accountable to the Better Care Operational Board.

49. Key Milestones and Activities for the next period:

Workstream deliverables	Activities	Timeframe
Vision Model of Care Outcomes	Map existing care pathways and integrated care initiatives	July-August
	Sharing of 'best practice'	August
	Develop NW London-wide Outcome Framework	August-September
	Coproduction workshops to develop interventions (including external preparatory work)	August-September
	Testing with patients	September
Costs & Benefits	Costing Tool Available First draft Benefits Realisation Plan	End August October
Operational Strategy	Development of Capacity & Demand Planning	End September
Provider Network	Convene Accountable Care Partnership (NWL)	End July
Multi-Disciplinary Teams	NWL Clinical Reference Group: Provide job descriptions	End August
Workforce	Facilitate discussion with national stakeholders	Start end July
Data Protocols	Provide data in correct format Decision on preferred contracting vehicle	End July Mid-September
Information Governance & Information Technology	Data warehouse available (including ability to access PID with correct IG Protocols)	October
Finance / Commissioning	Provider & Commissioner dashboards Linked dataset and Capitated budget values	End September End October
Organisational Development	Design OD Programme & present delivery options (NWL)	Start September

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