Partner Exchange

Integrated Care – a model of service delivery across health and social care

Julian Hartley, CEO, NHS Improving Quality
Elaine Bayliss, Improvement Manager, Long Term Conditions & Domain Lead EoLC and EPaCCS NHS Improving Quality
Sheena Hennell, Commissioning Manager, Wirral CCG
Peter Tomlin, Senior Manager, Wirral Council
Integrating Care and Support

Julian Hartley
CEO
NHS Improving Quality
7th June 2013
Content

- What is integration and why does it matter?
- The national collaboration
- Delivering the challenge
- Consider current national and local approaches to supporting integration initiatives
- Discussion
“We are sick of falling through gaps. We are tired of organisational barriers and boundaries that delay or prevent our access to care. We do not accept being discharged from a service into a void. We want services to be seamless and care to be continuous.”

National Voices
A definition:
“Care and support is integrated when it is person-centred & co-ordinated”

The person-centred narrative:
“I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me.”

National Voices
The national collaboration
The National Collaboration on Integrated Care and Support

- A partnership of 13 national organisations and bodies
- Signed up to a single vision of making person-centred, coordinated care and support the norm across England
- Recognising the nation, system, local and human challenges of integrated care & support
- Committed to a pioneer-led programme of work to enable and encourage local innovation, address barriers and disseminate & learning
- For the benefit of patients, people who use services and local communities.
The collaborative will support and allow teams to:

- Rapidly build new strategic partnerships
- Lead large scale transformation of the system
- Engage patients & the public as partners
- Mobilise people across the health & care system
- Tackle local cultural and organisational barriers to find different ways of working to improve coordinated care
- Test radical options in a safe environment
- Inform and influence change at national level

Integrated care pioneer sites will be more successful if they are supported to build their transformational change.
NHS IQ role and remit
NHS IQ: improving health outcomes by providing and delivering improvement and change expertise

- Working across whole pathways and systems
- With the intent that care for the patient, family and carers is integrated, coordinated and in the best place
- Working with both commissioners and providers, voluntary and third sector
- Continually learning
- Providing support with capacity, capability, learning and spread for the pioneer localities
THE PIONEER PROGRAMME
Why a pioneer programme?

Integrated care is complex. To achieve change the pioneer sites need to:

- engage large numbers of stakeholders,
- lead across boundaries and
- inspire commitment, rather than compliance, to ensure delivery.

This kind of large scale change requires

- a strong sense of shared purpose,
- clear vision,
- strategies that can cope with the unexpected, and
- new approaches to empowerment, measurement and leadership.
How will it work?

- Regular practical support, capability building with skills for improvement and large scale change, shared learning

- Meaningful measurement: defining aims, measures and outcomes, and regular reporting on progress, learning and delivery

- Identifying and sharing outcomes for spread and sustainability
IN CONCLUSION
“I can plan my care with people who work together to understand me and my carer(s), allowing me control and bringing together services to achieve the outcomes important to me.”

National Voices
Find out more about Pioneer Localities

Visit the NHS IQ stand today for more information or go to:
http://www.england.nhs.uk/2013/05/14/c-care/
or

Applications should be submitted to pioneers@dh.gsi.gov.uk by 28th June 2013
QUESTIONS
The Path to Integration
Health and Social Care

The Wirral Way
2013

Peter Tomlin
Sheena Hennell
Focus of Session

The Wirral Way

The why?? and the how!!
The Wirral Way

The Wirral

[Map of the Wirral region]
Long Term Conditions

- 23% of Wirral people have a long term condition
- 70% of health and social care spend
- 70% Unscheduled Admissions
- 55% GP Consultations
The Wirral Way

Mrs Smith
Our Patients View

- To be treated as a whole person
- For the NHS and social services to work as one team
- LTC needs to be supported across organisational boundaries
The Wirral Case for Change

- Improve support to patients with LTC in their own homes

- Reduce care home admissions upon discharge.
  - *Proportion of people aged 65+ discharge direct to residential care:*
    - *NW av. 2.5% - Wirral av. 4.5%*
  - *Proportion of local authority ASC spend on aged 65+ on res/nursing care:*
    - *NW av. 53% - Wirral av. 62%*

- Reduce demand on the Ambulance Service

- Improve hospital flow & timely discharge to improve the patient journey
Making Integrated Care Happen

Chris Ham (Kings Fund)

• Scale and pace
• Decade of austerity

• 16 steps
• Its not the how but it is a framework with suggestions
• Lessons from experience

Wirral Goals

- 20% reduction in unscheduled admissions
- 25% reduction in LOS for LTC
- 20% reduction in care home use
- Improved patient experience
- By 2014/15 compared to baseline
The Aims

- A risk stratification tool
- Integrated Teams (by October 2013)
- Self care and shared decision making
The Wirral Way

The How

- Project group with all partners set up April 2012
- Engagement workshops with key stakeholders
  - Thematic analysis
- R&D evaluation strategy
- Communication Bulletin
- CCG commissioning intention 2013/14
The Wirral Way

The How

- Integrated LTC Programme Board
- Executive level support and sign up
- Partnership agreement
- AQUA/Kings Fund Integration discovery Community
  - 8 domains for integrated teams
- Programme Manager
- Domain leads
The Wirral Way

Risk Stratification

Risk Stratification Summary Screen

Wirral Risk Stratification Model Outcomes

GP Practice Name: MIRIAM MEDICAL CENTRE

Risk Category Level: All Patients

Population Size: 5123

<table>
<thead>
<tr>
<th>Long Term Condition</th>
<th>Number</th>
<th>Incidence</th>
<th>QOF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>858</td>
<td>16.7%</td>
<td>428</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>50</td>
<td>1.0%</td>
<td>67</td>
</tr>
<tr>
<td>Cancer</td>
<td>60</td>
<td>1.2%</td>
<td>80</td>
</tr>
<tr>
<td>CHD</td>
<td>170</td>
<td>3.3%</td>
<td>212</td>
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<tr>
<td>COPD</td>
<td>103</td>
<td>2.0%</td>
<td>179</td>
</tr>
<tr>
<td>Dementia</td>
<td>21</td>
<td>0.4%</td>
<td>30</td>
</tr>
<tr>
<td>Depression</td>
<td>872</td>
<td>17.0%</td>
<td>578</td>
</tr>
<tr>
<td>Diabetes</td>
<td>143</td>
<td>2.8%</td>
<td>281</td>
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<tr>
<td>Epilepsy</td>
<td>74</td>
<td>1.4%</td>
<td>52</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>30</td>
<td>0.6%</td>
<td>40</td>
</tr>
<tr>
<td>Hypertension</td>
<td>516</td>
<td>10.1%</td>
<td>652</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>23</td>
<td>0.4%</td>
<td>30</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>104</td>
<td>2.0%</td>
<td>17</td>
</tr>
<tr>
<td>Stroke</td>
<td>44</td>
<td>0.9%</td>
<td>96</td>
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</table>

LTC Practice Population Incidence Percentage

LTC Practice Incidence vs QOF Registers
The Wirral Way

Risk Stratification cont...

Patient View

Wirral Risk Stratification Model - ST. GEORGES MEDICAL CENTRE

<table>
<thead>
<tr>
<th>PSEUDO No:</th>
<th>55115</th>
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<tbody>
<tr>
<td>AGE BAND:</td>
<td>Age 85-89 years</td>
</tr>
<tr>
<td>GENDER:</td>
<td>Male</td>
</tr>
<tr>
<td>GP PRACTICE:</td>
<td>N85012</td>
</tr>
<tr>
<td>RISK CATEGORY:</td>
<td>Very High</td>
</tr>
<tr>
<td>RISK SCORE:</td>
<td>0.840875307</td>
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</table>

LONG TERM CONDITIONS

- Asthma
- Atrial Fibrillation
- Cancer
- CHD
- COPD
- Dementia
- Depression
- Diabetes
- Epilepsy
- Heart Failure
- Hypertension
- Learning Disabilities
- Palliative Care
- Stroke

HOSPITAL ACTIVITY

<table>
<thead>
<tr>
<th>Activity Model Indicator</th>
<th>Within Last Year</th>
<th>Last 12-24 Months</th>
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</thead>
<tbody>
<tr>
<td>1 or more A&amp;E attendances</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>1 or more distinct LTC-related IP admissions</td>
<td>Yes</td>
<td>-</td>
</tr>
<tr>
<td>1 or more emergency IP admissions</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>1 or more IP admissions with &quot;home&quot; discharge</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>1 or more IP admissions with procedure</td>
<td>Yes</td>
<td>-</td>
</tr>
<tr>
<td>1 or more OP visits</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>Highest number of distinct prescriptions 1 month</td>
<td>5-9</td>
<td>-</td>
</tr>
</tbody>
</table>

Previous Risk Score: 0.574486284
The Wirral Way

Puffell

ice

VCA Wirral

NHS

Improving Quality

Wirral Clinical Commissioning Group
The Wirral Way

Integrated Teams Model Essential

**Standard Referral Form**
- **Urgent Criteria**
  - Patient at risk of a hospital admission or care bed within next 4 hours
  - Patient about to be discharged from hospital
  - Safeguarding issue
  - Career breakdown
- **Timely Criteria**
  - Patient has been identified by risk stratification
  - Supported patient discharge within next two days

**Gateway**
- Accepted Urgent
  - Half an hour to an hour to commence initial assessment/screening
- Accepted Timely
  - Half day response to commence initial assessment/screening (if overnight next day assessment)

**Core Integrated Team Single Assessment/MDT (Daily)**
- Key worker
- Micro Commissioning
- Access to essential services

**Team around the person**
- MDT Ongoing Planning/Reviewing goals
- Acute Management Care Plan
- Shared Care

- Step down/Step up depending on need
  - Review Case Management

- Step Down
  - Shared Care Models
  - E.g. GP’s
  - NWAS
  - Intermediate Care
  - With review 6/12 or 12/12
  - With agreed plan

- If Acute/Risk Stratification

**MDT Integrated Team**
The Wirral Way

Integrated Teams Model

Essential Components:

- Risk Stratification
- Community Matron
- Community Nurses
- CPN
- Therapists (Physio & O.T.’s)
- Health Care Assistants
- Social Workers
- ASO
- G.P.
- Practice Nurse

- Timely and Appropriate
- Single Point Of Access Triage Criteria
- Single Assessment
- Signposting
Challenges for Service Redesign

- Terminology
- Current business processes (mapping exercise)
- Referral form
- Screening/initial assessment form
- MDT specification
- Care planning
- Core team and roles
- Estates
## Referral Form

**Reason for Referral**
- Does this require an automatic referral to a specialist? (Yes / No)
- If Yes, what is the appropriate service (NHS service)?

**Suggested Next Steps**
- List any concerns about the person's safety or any risk they present to others.
- We have discussed this with the person.

**Clinical Information**
- Other agencies involved and support provided (Please indicate organization, and name, contact details and support).

**Past Medical History** (Please include if the person has a mental health or long term physical condition):
Screening Tool
The Wirral Way

Other Domains

• Patient and carer
• Culture
• Leadership
• Workforce
• Finance
• IT
• Governance
Future Challenges

- Culture and challenge to workforce
- IT challenges
- Finance and funding models requires negotiation
- Programme deliverables
Any Questions??

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Quality of Life and Death
EPaCCS Improving End of Life Care

Elaine Bayliss
Improvement Manager, Long Term Conditions & Domain Lead EoLC and EPaCCS
NHS Improving Quality
The Challenge

Tackling a tough problem

Innovation meets many of the ambitions of the ministers vision around improving End of Life Care and care coordination

A ‘good death’ through cross organisational improvement enabling a culture change
EPaCCS - Supporting Delivery of The Goal

• A universal mechanism for care quality and care planning against key ‘touch points’ across the whole pathway - delivers against DH 2008 EoLC Strategy

• Meets patients aspirations alongside those articulated by our partners campaigning for excellent end of life care

• Focus of EPaCCS based on our goal of maximising the quality of care potential and removing the barriers

• Harnesses technology – national standardisation / freedom for local configuration
Delivering Improved Outcomes

- **Survey of 77 former PCTs Autumn 2012**
  14 have implemented an EPaCCS (9% of all former PCTs)
  10 are part way through implementation (7% of all former PCTs),
  17 are planning a system (11% of all former PCTs)

- This is a huge improvement since 2010/11 when there were just 8 known EPaCCS pilot sites.
Information Across all Care Providers

- Community Nurses
- GPs
- Out Of Hours GPs
- NHS 111 London
- London Ambulance Service
- Acute Hospitals inpatient wards and outpatient depts + A&E
- Hospices
- Home
- Care Homes & Nursing Homes
- Social Services
- Marie Curie, Macmillan & Specialist Nurses
- London CCGs
Patient consent is required prior to other information being added: demographics, care plan, carer details, resuscitation status etc.

Patient List reports support GSF meetings.
CMC Case Example
Patient Outcomes

- Implemented across 97% of London.
- 5273 patient records created
- 5025 trained users across both voluntary and NHS organisations

- 973 patients have a place of death recorded (over last 31 months)
  78% died in the community, 21% in hospital,
  By contrast 59% patients died in hospital in London in 2010 (ONS).

- Of those patients who had a preferred place of death (PPD) documented,
  77.4% achieved their PPD
- 50% of patients on CMC have a non-malignant diagnosis.

- Improvements replicated across mature EPaCCS deployments country wide
Outcomes Continued

Evidence from an independent economic evaluation of EPaCCS suggests that -

• There is a correlation between EPaCCS implementation and the number of people being able to die in the community in line with their wishes with -

• An additional 90 deaths occurring in a person’s usual place of residence per 200,000 population each year, over and above the underlying increase in rates being experienced across England.

• An increase in DIUPR of 15,451 +9.5%. (N= 24 sites)

• Can save at least £35,910 per 200,000 population each year

• Recurrent savings after four years will be over £100k pa and cumulative net benefit over 4 years of c.£270k for a population of 200,000 people

Strategic Benefits

Leeds EPCCS benefits dependency network

Key Project Enablers

- Develop and deliver EPCCS
  - Patient's EOL prognosis is shared
  - End of Life Care (EoLC) preferences are available and accessed by all clinicians, including in emergency situations
  - All patients’ preferences are recorded in one place

Key Business Changes

- Fewer complaints
- Reduced number of unnecessary hospital admissions
- Reduced number of unnecessary ambulance journeys
- Increased numbers of carers identified and supported
- Improved clinician productivity
- Reduced number of times a patient has to have a “difficult” conversation with a clinician
- Increased number of patients die in a place of their choice

Drivers

- Reducing spend in EOL care
- Patient choice and quality of care
- Efficiency savings
- No decision about me without me
- Achieving CQUINS
Adding Value to End of Life Care and Beyond:

EPaCCS deployment –

• Has put the individual in control
• Is a tangible system driver – a ‘disruptive innovator’
• Is a key driver and catalyst for workforce and culture change
• Has wider transferability across the LTC landscape (portability of the EPaCCS solution, ITK developments, and the information standard)
• Helps reduce inequalities and variation
• Has ensured financial benefits are not at the expense of patient or carer
• Facilitates conformance with the national information standard for care coordination
Supporting Wider Implementation

- NHS Improving Quality & Health and Social Care Information Centre
- National implementation guidance and support
- Case for change
- Economic Evaluation of EPaCCS
- Development of interoperability standards and architecture plans
- Survey of local activity
- NHS Networks - EPaCCS forum

- National End of Life Care Intelligence Network, Public Health England
- ISB – End of life care co-ordination: core content data set; a national information standard
“EPaCCS... is an outstanding example of how a national initiative can be instigated and supported, with high quality evidence in improvement in outcomes.

Having run a large EPaCCS programme across the south west, with many thousands of people currently registered on EPaCCS...... (t)here is much satisfaction to be had in putting effort into supporting people to have as good an experience as possible at end of life, and EPaCCS is a critical part of this.”

Dr Julian Abel - Consultant Palliative care
QUESTIONS