

Evaluation of the first year of the Inner North West London Integrated Care Pilot

Summary

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In partnership with

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The North West London Integrated Care Pilot is a large-scale programme incorporating a range of organisations. In its initial stages work has focused on developing new forms of care coordination and planning for two key groups; people with diabetes, and those who are over 75 years of age. The pilot has undertaken a considerable amount of work in pooling information and using an IT tool which allows for the identification of patients needing intensive case management, while multidisciplinary groups of local care providers meet on a regular basis to review and plan people's care. This evaluation covered the pilot's first year of operation (between September 2011 and July 2012) with a view to assisting its progression beyond its first year, and to inform other integrated care initiatives in the UK and overseas.

The full reports on which this summary is based are available to download from: www.nuffieldtrust.org.uk/publications/evaluation-nw-london-icp

Key Points

- This ambitious project made considerable progress in formalising engagement between a wide range of organisations in a relatively short time. This set-up phase has been helped by financial and other support from NHS London; this enabled investment in IT, pilot leadership, coordination of multidisciplinary groups, and project management. The pilot will need to consider carefully how best to embed its support structures, to ensure long-term cost-effectiveness beyond the pilot phase without risking loss of momentum.
- Health care professionals were found to have a high level of commitment to the integrated care pilot, in particular to the care planning process. They reported that work on care planning, and multidisciplinary groups, had resulted in improved collaboration across different parts of the local health and social care system.
- Analysis of the first tranche of patients treated under the new case management arrangements did not show any significant reduction in emergency admissions – but we recognise that it is probably too early for definitive conclusions. The evaluation was able to identify person-level matched controls for 1,236 of the first patients recruited, and monitored a range of measures of service use during the first three months of each patient's intervention. This analysis found there were no significant differences from the matched control patients during this period.
- There were some changes in the process of care recorded on GP information systems. For example, there was a marked increase in diagnoses of dementia after August 2011 (when the pilot started) and in the frequency of testing for diabetes, and a significant increase in the provision of care plans for patients with dementia.

- Better care planning has real potential to improve patients' experience of care, in particular in reducing duplication and improving access. Patients who had a care plan reported improved access to NHS services (64%), that they now had to spend less time booking appointments to see their GP and other health professionals (55%), and that health care staff asked them fewer questions about their medical history (67%). However, this information was based on relatively small patient numbers, so should be treated with some caution. In the coming year, there is a need to embed care planning and continue monitoring of patient experience and outcomes.
- The care planning IT tool had led to dissatisfaction amongst many practitioners, with concerns aired about duplication of data entry, problems with interoperability, and functionality. Professionals did nonetheless concede that the IT tool allowed the pilot to track and capture health and social care usage in ways that were not possible before, and that this was vital to the new care planning approach.
- International evidence points to the fact that integrated care takes years to develop, and a minimum of three to five years is needed for such initiatives to show impact in relation to activity, patient experience and outcomes. Key areas for future work for the pilot should include: embedding governance systems and support so that they can survive in a different financial climate; improving the quality of care planning; ensuring consistency among the multidisciplinary groups; refining the IT tool; and working with patients to improve their involvement in their own care.

Acknowledgements

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Foreword

I feel privileged to have been part of such an exciting and innovative project over the past two years since the set up of the transitional Integrated Management Board (IMB) of what is now known as the Inner North West London Integrated Care Pilot (ICP) in January 2011.

We were fortunate in being granted the funding for the evaluation from the Imperial College Healthcare Charity. The evaluation teams of Imperial College London and the Nuffield Trust developed a strategy to capture both qualitative and quantitative data. Data were collected from September 2011, just three months after the launch of the ICP, and before the process of care planning had got underway. Through interim reports and presentations they shared their findings with the IMB as the ICP progressed through its first year, so that corrective steps could be taken without delay.

Examples of changes made in response to the evaluation include:

Review of governance to develop a locality-based model. With the establishment of the clinical commissioning groups, changes to the governance and support of the pilot were clearly required and these are now in progress.

Improved quality of care planning. In response to the report, the focus has been on improving the quality of care planning and ensuring that patients are involved and engaged. A further audit is currently being carried out.

Performance of multidisciplinary groups. As the report makes clear, these groups have proved one of the most successful features of the pilot, enhancing communication and collaboration among professionals. A co-chair development programme has been introduced to ensure that these groups perform consistently and effectively.

Shared data and IT. The report rightly records the widespread frustration felt with progress in developing a user-friendly tool for recording care planning that also has all the functionality that partners would wish to see. A tool which can deliver all this is still in the future, but efforts are currently being made to procure something close.

Increased efforts to engage and involve patients in the pilot. In response to the evaluation, representatives from the Patients and Users Committee were appointed full members of the IMB and its committees, and have contributed to the development of the ICP's policies and processes.

A second and even larger pilot building on the model developed in inner North West London has since been established in outer North West London, and together both are looking at moving to a more ambitious 'whole systems' approach, based on risk stratification rather than disease pathways.

As the report makes clear, whatever ups and downs in activity have been captured in the course of the first year, we must wait three to five years before we can reliably judge the impact of these new ways of working on the quality and cost of care. In the mean time we hope that this evaluation will help those starting on a similar journey.

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Chair of Inner North West London Integrated Care Pilot*

Introduction

The North West London Integrated Care Pilot (ICP) is a large-scale innovative programme designed to improve the coordination of care for people over 75 years of age, and adults living with diabetes. The pilot, which started in July 2011, was originally intended to run until March 2012, but extended to March 2013. It received funding support from NHS London for initial set up, and then from NHS North West London for pilot running costs.

The pilot aims to:

- improve outcomes for patients
- create access to better, more integrated care outside hospital
- reduce unnecessary hospital admissions
- enable effective working of professionals across provider boundaries.



The pilot seeks to develop individual care plans for people with diabetes, and those who are over 75 years of age

The pilot seeks to develop individual care plans for people with diabetes, and those who are over 75 years of age. The development of care plans is enabled by an innovative IT tool that segments patients according to risk; shares care plans across care settings; identifies patients needing intensive case management; and enables monitoring of care plan implementation. The IT tool is invaluable in combining data from GP practices, acute trusts, mental health providers, community health care providers, and social care.

New multidisciplinary groups of local care providers meet on a regular basis to review and plan people's care. All staff involved in the pilot, together with representatives of local patient organisations and providers, come together in an Integrated Management Board (IMB). There are various committees within the pilot that report to the IMB, and the whole pilot receives project management and other specialised support from a dedicated operations team.

Evaluation of the pilot

A team of researchers from Imperial College London and the Nuffield Trust (an independent charitable research foundation) was engaged to carry out an evaluation of the first year of operation of the new integrated care programme. The period of the evaluation was September 2011 to July 2012, when the pilot was in its early stages of development, and the study was funded by the Imperial College Healthcare Charity. The evaluation comprised four distinct streams of work:

- strategic implementation and the policy context (Nuffield Trust)
- quality of care and health outcomes (Imperial College London)
- patient and professional experience of the pilot (Imperial College London)
- impact on service use and cost (Nuffield Trust).

The evaluation aimed to describe the implementation of the ICP and its early impact, with a view to assisting the pilot in its progression beyond its first year, and to inform other integrated care initiatives in the UK and overseas.

Key findings

Strategic implementation and the policy context

The pilot has been successful in creating a clear vision of what it intends to achieve, and in drawing together organisations from across health and social care. The voluntary and ‘virtual’ nature of the pilot (not forcing any organisational mergers) has been critical in securing and sustaining engagement.

Sophisticated governance structures have been put in place for the pilot, reflecting its complex nature. These structures appear to have worked well, and have been critical to the engagement of stakeholders across North West London. The challenge ahead is to embed these arrangements for the longer term, and to balance local autonomy and freedom (within multidisciplinary groups) with overall accountability for delivering the pilot’s aims.

Financial incentives have been designed in order to support the aims of the pilot in relation to care planning, collaborative care management, and the development of innovative alternatives to hospital admission. Whilst in many ways symbolic, these incentives (for example the potential to share and re-invest savings) have been important in securing the involvement of local providers.

The voluntary/third sector has been engaged in pilot governance structures and providing important advice on concerns of patients and the public. It is recognised that in the second year, there is a need for more direct engagement of service users in the planning and delivery of integrated care.

Design and roll out of the IT tool for care planning have been slower and more complex than anticipated. This has led to some frustrations, for it is recognised that shared and timely data are critical to the new approach to care planning and management.

Substantial financial and other support was made available to the pilot by NHS London; this enabled investment in IT, pilot leadership, coordination of multidisciplinary groups, and project management, which is considered to have been a significant enabler of pilot progress. The pilot will need to consider carefully how best to embed its support structures, to ensure long-term cost-effectiveness beyond the pilot phase without risking loss of momentum.

Quality of care and health outcomes

It was perhaps too early to look for changes in patient outcomes, hence the study examined changes in the process of care. The research revealed some evidence of changes in how patients were being treated in North West London. For example, there was a marked increase in diagnoses of dementia after August 2011 (when the pilot started) until January 2012 (when there was a particular push by the pilot in respect of care planning).

There was also a significant increase in the provision of care plans for patients with dementia – 42% of those on dementia registers in North West London have a care plan. Over the second year of the pilot, it will be important to continue to measure quality of care and health outcomes for people with dementia, given this evidence of increased diagnosis and care planning.

Similarly, there was some evidence of an increase in the frequency of testing for diabetes, but no evidence of improvements in the proportion of patients with good control as measured by HbA1c.¹ Care planning should help those with poor diabetic control, and it will be important to track this in the second year of the pilot.

There was no evidence of a change in the rate of admissions to hospital of people suffering fractures and falls up to March 2012. However, given that this was just a few months into the establishment of care planning for older people in the pilot, it will be important to track such trends over a longer period of time.

Patient and professional experience of the pilot

Professionals

Health care professionals were found to have a high level of commitment to the ICP, in particular to the care planning process. They reported that work on care planning and multidisciplinary groups had resulted in improved collaboration across different parts of the local health and social care system.



Over three quarters of professionals surveyed reported that new multidisciplinary case conferences enhanced inter-professional working

Multidisciplinary groups were considered to be useful for sharing knowledge, best practice, experience of local services, and are a valuable opportunity for networking. Over three quarters of professionals surveyed reported that new multidisciplinary case conferences enhanced inter-professional working and levels of professional knowledge.

The care planning IT tool had led to dissatisfaction amongst many practitioners, with concerns aired about duplication of data entry, problems with interoperability, and functionality.

Over half of professionals felt that the new model of care in the pilot had increased their workload. However, it was acknowledged that the IT tool allowed the pilot to track and capture health and social care usage in ways that were not possible before, and that this was vital to the new care planning approach.

Local health professionals view the sustainability of the ICP as dependent on the continued involvement of front-line practitioners, a high level of engagement by local health and social care organisations, and resolving issues with the IT tool.

1. HbA1c measures average blood glucose levels over time. It is commonly used in the assessment and treatment of diabetes.

Patients

Information from patients was based on relatively small numbers, so should be treated with some caution. The majority of patients surveyed did not recall that they were part of the ICP. It is however arguably more important that patients have effective care planning, than being specifically aware of being part of an NHS pilot.

Patients who were aware of being part of the pilot were found to understand its values and goals, and were very supportive of the attempt to change the planning and delivery of care.

Patients who had a care plan reported improved access to NHS services (64%), that they now had to spend less time booking appointments to see their GP and other health professionals (55%), and that health care staff asked them fewer questions about their medical history (67%).

Patients reported that they felt involved in the development of their care plan (81%) and that they had a clear understanding of how care planning works (88%). However, only 13% of patients reported that they had a copy of the care plan that was created with their GP, and over 60% had not experienced any changes to the provision of their care.



Better care planning has real potential to improve patients' experience of care

Better care planning has real potential to improve patients' experience of care, in particular in reducing duplication and improving access. In the coming year, there is a need to embed care planning and continue monitoring of patient experience and outcomes.

Impact on service use and cost

This analysis was clearly limited by the requirement to analyse change after just a few months of the implementation of care planning and review. The evaluation looked for changes in hospital activity for patients whose care was being targeted by the ICP – older people and those with diabetes. Changes were measured by comparing patterns of service use in North West London to those in other areas.

The study revealed some notable reductions in the level of emergency admissions for the whole population of North West London, but it is difficult to say that these were solely due to the impact of the ICP as they are not restricted to older people and those with diabetes. Emergency admissions across North West London were strongly related to trends at Imperial College Healthcare NHS Trust, but seem broadly comparable with the national picture.

For older people and those with diabetes, in the period from July 2011 to March 2012, emergency admissions rose by 0.8% in practices within the ICP. This compared however with a fall of 0.9% in other inner North West London practices, and rises in emergency admissions seen in South West London (1.1%) and England as a whole (0.4%).

Evaluators were able to identify person-level matched controls for 1,236 of the first patients recruited into the ICP. Focusing on this smaller group allowed the study to evaluate the impact on service use of people having a care planning intervention, as opposed to the effect of being registered with a practice that is part of the pilot. There were no significant differences between the pilot cohort and matched control patients with respect to changes in emergency admissions, A&E attendances, hospital cost of emergencies, or total hospital costs.

Longer-term tracking of activity and costs would allow more time for the effects of the pilot on patients' use of services to become visible, and plans are in place for this.

Conclusion

The Inner North West London ICP is an ambitious programme of transformational change, being implemented at a time of major reform of the NHS in England. The findings from the evaluation of its first year offer important lessons, not just for the pilot itself, but also for other integrated care programmes elsewhere in the NHS and overseas.

This evaluation reveals that the pilot has made substantial progress in designing and implementing a highly complex intervention, and in underpinning this progress with sophisticated governance arrangements, and new financial incentives.

“ The pilot has successfully brought together diverse health and social care providers, focused on planning and delivering better coordinated care for older people, and those living with diabetes

The pilot has successfully brought together diverse health and social care providers, focused on planning and delivering better coordinated care for older people, and those living with diabetes. This improved collaboration between professionals has resulted in better communication across teams and organisations, more extensive use of care planning, and there are early signs of benefit for patients in respect of improved diagnosis and care planning for people with dementia, and increasing levels of testing for diabetic control.

The pilot remains, however, in the early stages of change and it is too early to demonstrate benefits in terms of changes in service use and patient outcomes. Evaluation data reveal achievements and challenges that would be familiar to those who have attempted to bring about large-scale change in the NHS in the past. The foundations for change have been laid and, as the pilot moves into its second year, it should build on its achievements, address areas of challenge, and remain focused on assessing the impact of its work.

Key areas for future work include: embedding governance and support in a sustainable manner; improving the quality of care planning; ensuring consistency and sustainability of performance of multidisciplinary groups; continuing to refine and improve the IT tool; working with patients to improve their involvement in their own care; and undertaking strategic planning for beyond the end of the formal pilot phase.

The benchmarks set in this first evaluation report provide a sound basis upon which the pilot can continue to assess its progress, particularly in relation to activity, cost and health outcomes. It should be noted that international evidence points to the fact that integrated care takes years to develop, and a minimum of three to five years is needed for such initiatives to show impact in relation to activity, patient experience and outcomes.

The Nuffield Trust's evaluation work

As innovations emerge in health and social care, evaluation is vital to spreading best practice. At the Nuffield Trust we have considerable expertise mining rich information sources to help policy-makers and professionals decide where to direct investment in the interests of patients and taxpayers.

We are supporting the NHS to find new ways of conducting evaluations which make maximum use of data collected by the service. For example, we are developing a series of linked pseudonymous data sets for use as a data laboratory. These data sets cross organisational divides, spanning health and social care. Their purpose is to capture events for whole populations in order to promote more comprehensive analysis and greater understanding of care services provided at the person level.

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