LEARNING FROM THE INTEGRATED HEALTH AND CARE EVALUATIONS

TOWER HAMLETS TOGETHER
Delivering better health through partnership

STAFF ENGAGEMENT EVENT
16TH OCTOBER 2018

A word which describes how to make integrated health and care happen?

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Integrated Care;

What does the research evidence say?

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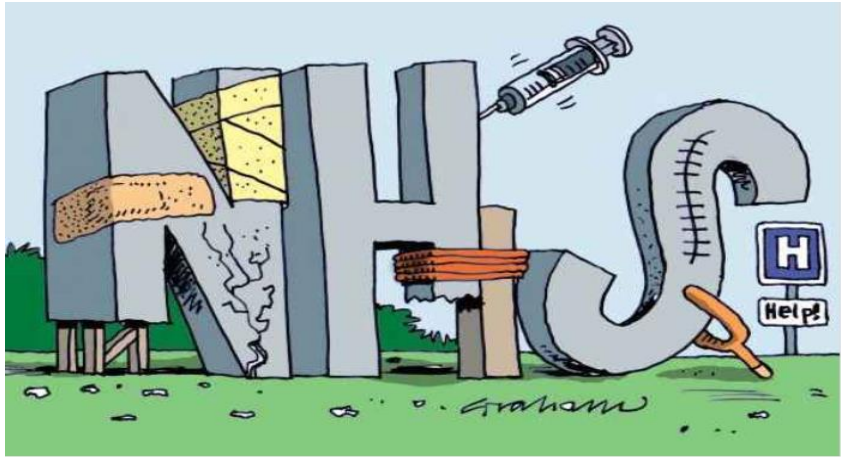
Institutional fragmentation in the UK's NHS

'The weakness of the present structure lies in the fact that the NHS is in three parts, is operated by three sets of bodies having no organised connection with each other and is financed by three methods'

Guillebaud Report 1955

- 1948 separation of hospital, general practice, community and local government services
- Pressures of specialisation
- Funding mechanisms
- Depersonalisation of system
- Failure to join up policy making
- Competition
- Financial pressures on local government



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UK integration policy initiatives 2001 - 2018

2001: Health and Social Care Act
- Formation of 'Care Trusts'

2006: Our Health, Our Care, Our Say
- 'Cultural integration'

2009: Integrated Care Pilots
- 15 small scale demonstrators

2013: Integrated Care Pioneer Programmes
- 25 sites appointed, 5 years support

2013: Better Care Fund
- £3.8bn pooled budget for 2 years plus incentives

2014: GP incentive scheme
- £20k per practice to manage high risk patients

2015: New Models of Care
- 28 'vanguard' models, £200m funding

2018: Sustainability and Transformation
- 44 partnerships around England holding budget

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Lesson 1

Explain what integration means

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- Types (organisational, professional)
- Breadth (vertical, horizontal)
- Degree (linkage to full integration)
- Processes (structural, cultural)

'My care is planned with people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to deliver my best outcomes'

National Voices, 2013

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Lesson 2

Learn from the research evidence

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What does the evidence tells us?

Australian co-ordinated care trails (2002)

No impact on outcomes; increased service use; some evidence of improved user experience

UK 'Evercare' community matrons (2005)

17% (non-significant) increase in emergency admissions and hospital bed days

Netherlands 'bundled payments for diabetes' (2010)

Mixed impact on clinical outcomes, provider services, and patient experience

UK Integrated care pilots (2012)

Significant 9% increase in emergency admissions, patient experiences more negative

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What does the evidence tells us?

% of studies with a positive outcome for health	% of studies with positive outcome for patient experience	% of studies which showed reduction in cost
55.4%	45.2%	17.9%

Powell Davies et al., Med J Aust 2008; 188 (8): S65-S68.

www.health.vic.gov.au/pcps/downloads/careplanning/system_review_noapp.pdf

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But how much attention should we pay to the research evidence?

- Unstable interventions – evolve and change during the course of the evaluation, often slow to start
- Difficulty accessing data from multiple providers
- Difficulty findings controls in an ever changing environment
- Under developed tools to measure service user perspective and outcomes
- Failure to understand context

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So we rely on promising case studies…..

US case studies of high performing health systems (Shih 2009)

High performing health systems such as Kaiser are well-integrated e.g. Among its members in Northern California, the rate of heart disease mortality decreased by 26 per cent from 1995 to 2004

US and European case studies of integrated care (Rosen 2010)

Integration is difficult but benefits are seen for patients and for organisations

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Lesson 3

Recognise and enable the facilitators of effective programmes

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1. A strong focus on service users, engaging, encouraging self care, shared care and prevention
2. Work on improving processes rather than changing structures
3. Use multiple aligned interventions
4. A targeted approach to high risk populations (e.g. top 20% of those at risk of unplanned hospital admissions)
5. Invest in primary and community care

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6. Ensure continuity of leadership and relationships
7. Invest in informatics
8. Embed process-oriented evaluation
9. Align funding mechanisms and incentives (needs based capitation, outcomes funding, pathway funding, alliance contracting, pooling)

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Lesson 4

Recognise and manage the barriers to change

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1. Poorly aligned policies (e.g. piecemeal payments)
2. Ignoring the unintended consequences of policies (e.g. competition, targets)
3. Pushing too hard and too fast
4. Unwillingness to fully integrate across system (e.g. education, housing)
5. Failure to invest in building capacity and capability (e.g. new roles, training, curricular change)

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Conclusion

Service integration is….

1. …the right thing to do
2. …difficult
3. …more likely to be successful if you adhere to a few simple principles

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Tower Hamlets Together Vanguard Evaluation

Staff engagement seminar

16 October 2018

Background

The vanguard programme was a major NHSE initiative to develop new care models nation-wide to improve patient care

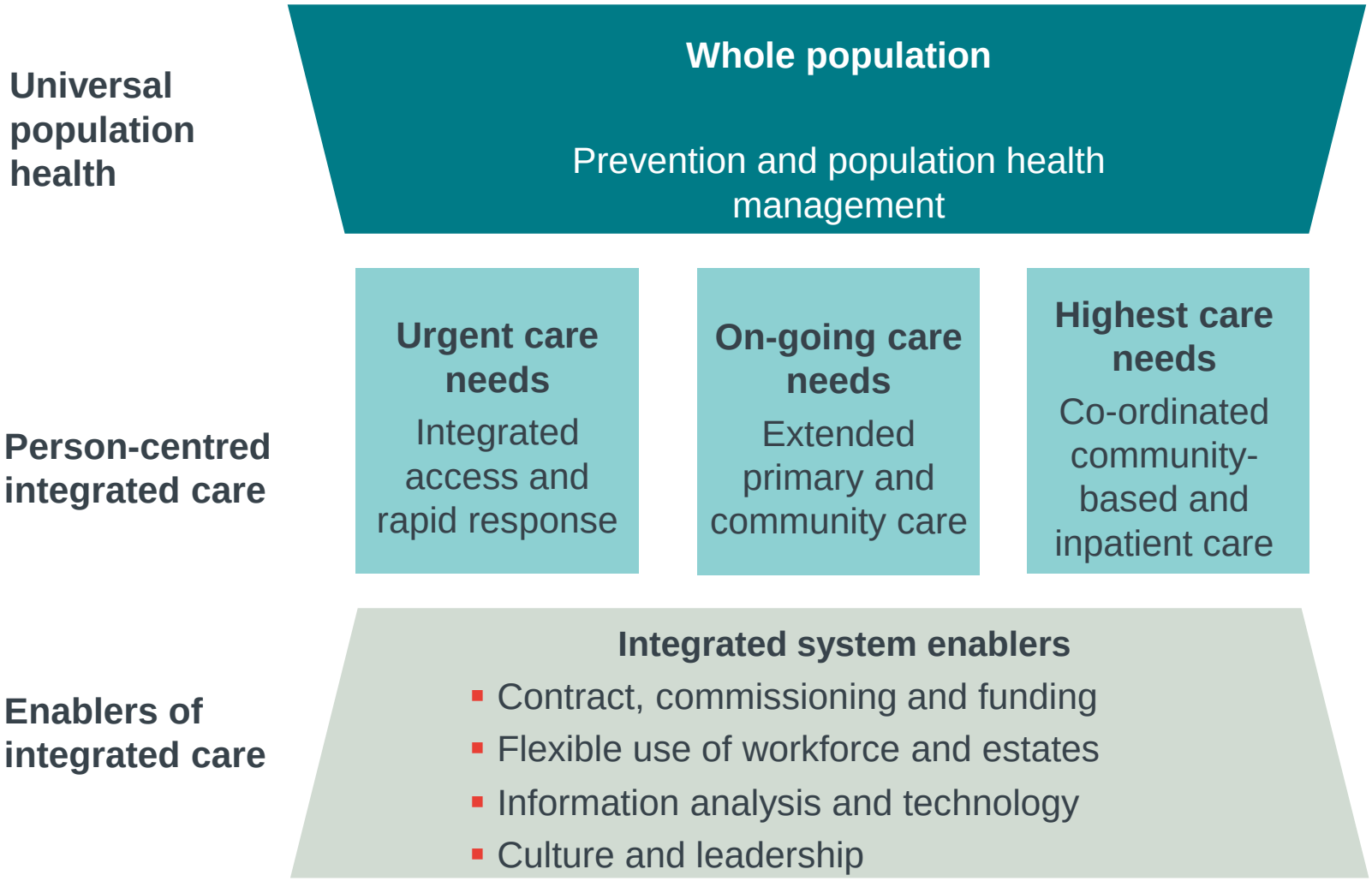
The vanguard programme

- NHSE provided £346 million for 50 vanguard programmes across the country to run over 2014/15 to 2017/18.

Tower Hamlets Together (THT)

- Tower Hamlets Together successfully applied to be a vanguard, building on a strong foundation of partnership working over many years.
- The THT vanguard was to be an enabler of deeper integration.

The THT vanguard received £10.8 million from NHSE and consisted of 62 projects across several models of care



The evaluation

Developing the evidence to learn what works, under what circumstances and what we could do better

We used qualitative and quantitative evidence – thank you to all of you who kindly helped us with this!

Qualitative

- Interviews and workshops
- Observations
- In-depth fieldwork from researchers in residence

Quantitative

- Administrative data
- Operational data from service teams
- THT patient-level linked data developed by THCCG

We explored a number of aspects to learn about implementation, costs and outcomes

Implementation of the vanguard

The extent of partnership working at all levels - what could be done better going forward?

Were projects delivered on time and what could have been done better?

Were communications /engagement sufficient and how could they be improved?

Outcomes and costs of the vanguard

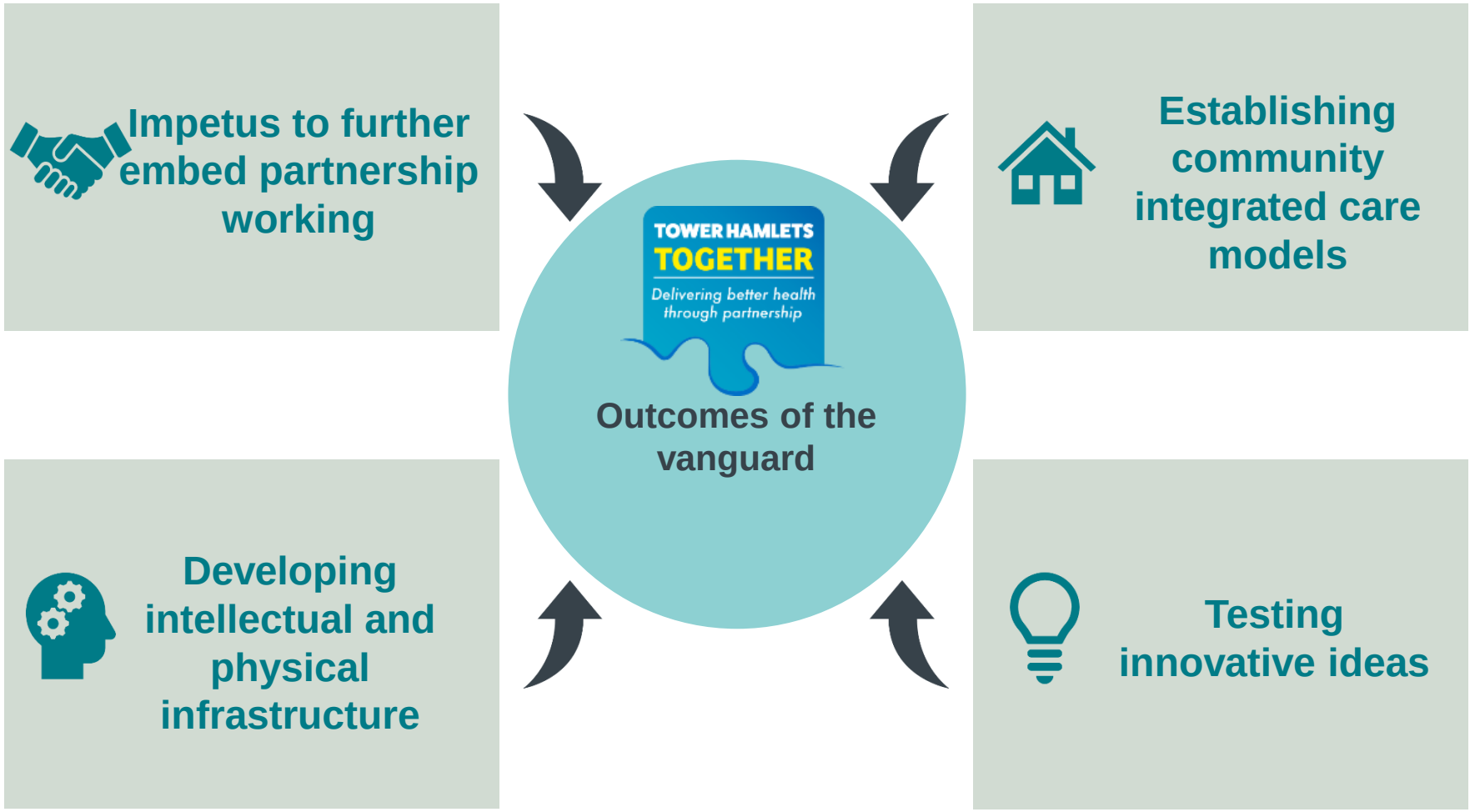
How much was invested in the interventions and what was the context?

What were the impacts on NHSE core metrics (acute care activity)?

What were the impacts on service usage and service costs for particular groups of patients?

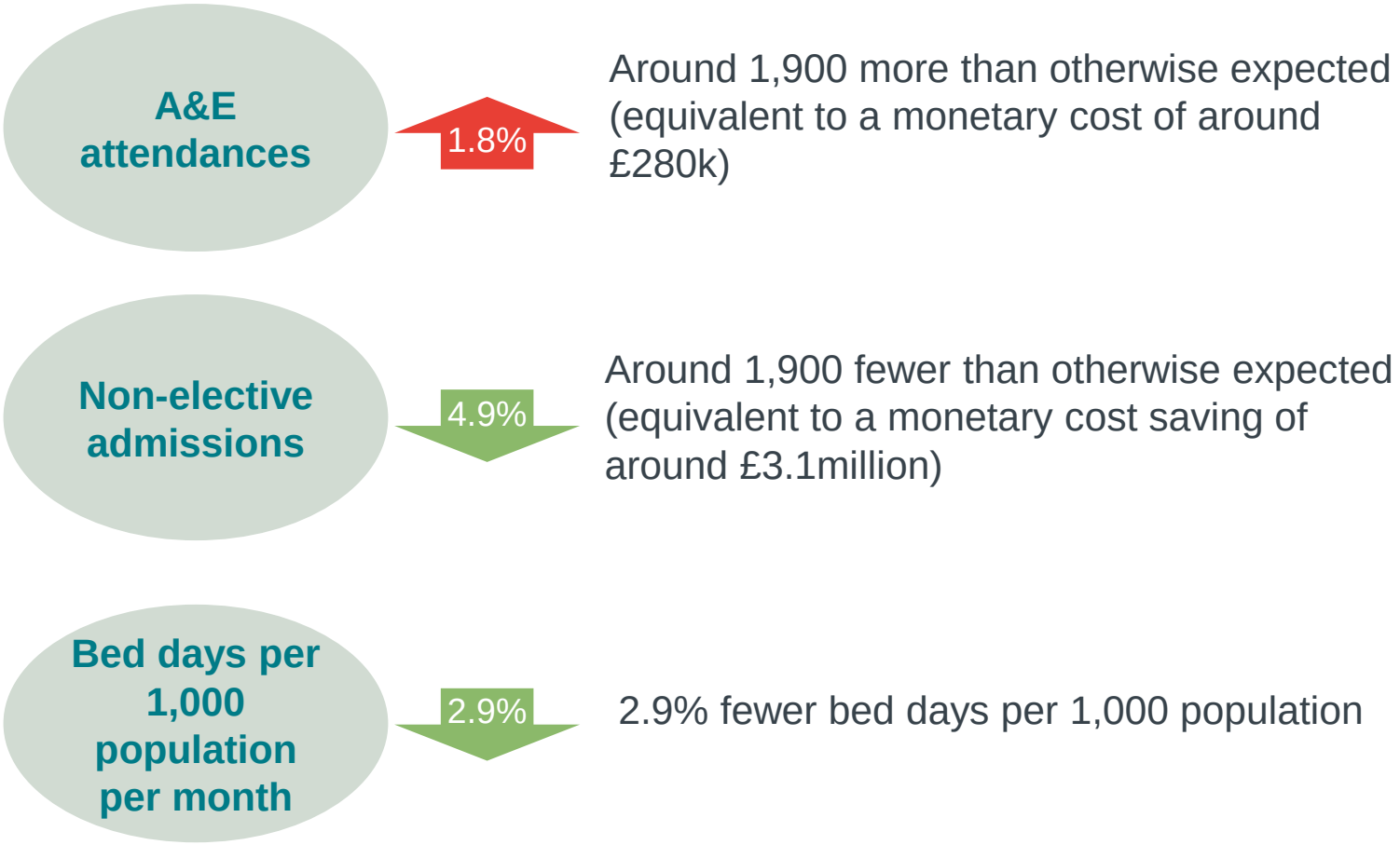
Evaluation findings – what we learned

The vanguard primarily delivered benefits in four key ways



We found that the vanguard and other policies/factors over 2015/16 to 2017/18 led to hospital activity being different from what would otherwise have been expected

Relative to our best view of what might otherwise have been observed in Tower Hamlets we found:



Source: Frontier analysis of NHSE data over 2014/15 to 2016/17

THCCG has used quantitative evidence to define the user profile of A&E services to provide insights for improvement

People with long term conditions

- Long term conditions explain repeated visits to A&E within the same year. The following long term conditions are key drivers of repeated visits to A&E:
  - patients who are epileptic
  - patients on AnticoagRx
  - patients with a Mental Health condition
  - patients in Palliative Care

Children and mostly healthy adults

- More than half of our A&E attendances are low acuity
- Children under 9 years of age and young people between 25-39 years of age constitute the majority of our A&E low acuity users
- Adults who are Mostly Healthy tend to go to A&E one time per year on average, and constitute the majority of our A&E low acuity users

GP – changes to appointment booking

- New appointment systems have been put in place in some GP practices to improve access.

- These new systems, however, have shown that they serve as an extra support for people with long term conditions, but they are not flexible enough to deter young healthy people going or parents taking their children to A&E

Source: THT/ELHCP Data Repository 2016/17

Source: THT/ELHCP Data Repository 2015/16-2018/19

Qualitative information from Healthwatch offers insights of why young healthy people and children use A&E instead of going to their GP

'…I have to phone up and say I want an appointment…. Then I have to wait for a ring back. It's not like I have to waiting around for the phone call, because I just give them my mobile in case I'm out and about, but still, you can't just walk in and ask for a phone number. I want to be able to walk in, not have to ring up and wait to be rung back. It's a good surgery other than that.'

'…I said there should be flexibility for people who really do need to see a doctor not just blocking everyone. What happened is you called in and the reception then get a doctor to call you back to see if you need to come in. The thing is you could wait for hours before you get a call back then offered a time slot that is not even remotely possible for you to visit the clinic, what do you do? Wait another day or until it's too late and you can't be saved?! …'

'…The surgery expects you to call in at 8am to book an appointment on the day. This is incredibly frustrating as most people call at this time and the line is busy until 9/10 am and by then you're told to call again the next day and the process of not getting an appointment just repeats.'

'The only downside I see is the morning appointment system. They really need to get more people on the phone lines or have a good online system. Otherwise the receptionist to the doctors I'd say are top class.'

Source: Tower Hamlets Healthwatch data

Qualitative evaluation evidence revealed valuable insights for learning and continual improvement

- **Board composition and functioning**
- **Leadership and personal commitment**
- **Communications and engagement**
- **Partnership working**
- **Vanguard programme design and management**
- **Planning for the post-vanguard period (legacy)**
- **Maximising the value of evidence**
- **System's capacity for change**

Key findings from the evaluation of the WELC integrated care programme in 2015/16

1. **Culture Change**: Increase focus on system wide organisational, professional and cultural development to enable further progress.

2. **Management v. operational level**: Work to bridge gap between high level management and operational delivery of IC.

3. **Health and social care staff**: Further develop integration between health and social care professionals at the level of service delivery.

4. **Organisational integration**: Ensure shared strategic vision is supported and owned by organisations.

5. **Person centred IC**: Increase focus on empowering people and communities, involving them as collaborative partners.

6. **Crowded policy context**: Ensure existing areas of work are aligned internally and across the local system to avoid confusion and system inertia.

7. **Value of collaborative**: Ensure clarity about value of WEL/ TST and maximise opportunities for the collaborative to add value.

To explore partnership working in more detail we generated a wide base of evidence

- We generated our evidence directly from:
  - 80 interviews
  - over 200 hours of observations
  - documentary analysis

  …with senior/middle managers and frontline staff acute, primary, community care and social services to understand how integration/coordination across THT at different levels

- We interpreted data and worked with frontline staff participating in the study to co-produce recommendations

We identified several barriers and enablers for effective partnership working

Organisational

- Continuous efforts to build collaboration across organisations – THT aligning management, governance and financial structures
- On the ground, barriers between organisations e.g. access to shared data
- Not enough bottom up engagement?
- Limited communication about new services/roles

Cultural/professional

- *Everyone favours*
- *multidisciplinary work and*
- *local evidence that co-location*
- *has provided the basis for integration but….*
- Different management lines
- Different organisational pressures (e.g. funding of care packages)
- Different cultures

Contextual factors

- All parts of the system really stretched (difficulty in recruitment and retention)
- Cuts to social care: fewer social workers, particularly in the community
- High numbers of agency staff/ locum
- Difficulty of new services to embed within complex, highly fragmented and regulated system

Leadership makes a difference – we identified some key defining characteristics of leaders

Distribute leadership

Encourage innovation

Engage multiple stakeholders

Work across boundaries

Key example from the frontline:

Palliative champions meetings *organised by lead nurses in different localities in Tower Hamlets to raise awareness about palliative care and end of life pathways and strengthen joined-up working, with designated palliative champions in each team taking responsibility over training colleagues.*

Case study

Admissions avoidance and discharge service (AADS) and Rapid Response service

Multi-disciplinary team of therapists, nurses and social workers:

1. Avoid patients being taken into hospital
2. Get them home faster, with appropriate support at home

Collaborative working:

- AADS works closely with the Rapid Response team who receive referrals via the THT Single Point of Access – patients seen within 2 hours
- Works with hospitals to assess patients ready for discharge, with full assessment at patient's home
- Provide up to six weeks' multi-disciplinary community input post-discharge if appropriate

Benefits the patients and the system:

1. Return to home environment sooner
2. Rehab at home for older people avoids residential care

Over the first 3 months of 2018, the AADS and Rapid Response teams were able to prevent unnecessary admissions and get people home faster

Admissions avoidance

- 136 people per month were seen within the first 30 minutes of referral
- 78% of the patients assessed by the admissions avoidance team were discharged home
- An average of 74 admissions per month were avoided before the patient exceeded 4 hours A&E waiting time

Discharge service

- 77 patients seen per month (target was 30)
- 62 patients per month were discharged onto rehabilitation/reablement pathways from wards at RLH (target was 30)

Rapid response service

- Accepted 106 new patients per month (target was 35)
- 97% of referrals were seen within two hours, and of these, the team were able to avoid hospital admissions in 95% of cases

Source: Dashboard for AADS – April 18

Qualitative evidence on AADS identifies some very positive learning

- Admission Avoidance team well-embedded within the Royal London's A&E department
- Service recognised and used by hospital staff
- Team works well with A&E nurses and the social worker covering A&E and AAU
- Awareness of each other's roles
- Good example of effective horizontal integration
- Whole AAT and AAU social worker are locums but in post for some time
- Relatively low turnover and good understanding of the service across teams key to build relationship of mutual trust

The key learning

We have 6 key findings

Evidence-based learning (monitoring and evaluation) is essential to continually improve and make better decisions going forward.

The THT vanguard was a critical enabler of partnership working. It accelerated the borough on its journey towards system integration.

Workforce and organisational development have played an important role in supporting integrated working, though this needs to continue to be invested in - especially at the frontline.

There is a need to improve 2-way information flows between senior staff and the frontline.

Innovations were tested but evidence is needed on the drivers of success, cost effectiveness and conditions under which translation to business as usual would be effective.

Leadership is a critical enabler of integration and needs people with the skills and qualities to empower others.

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Life course work streams

Born Well Growing Well

Focus on maternity, children and young adults

Living Well

Focus on mainly healthy adults

Promoting Independence

Focus on complex and older adults

Adult Social Care & Health Integration

THANK YOU FOR LISTENING…

TOWER HAMLETS TOGETHER

Delivering better health through partnership

TOWER HAMLETS
GP CARE GROUP
thcvs Council for Voluntary Service
NHS
Barts Health NHS Trust
East London NHS Foundation Trust
Tower Hamlets Clinical Commissioning Group