City of Westminster

Westminster Health & Wellbeing Board

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Title:	Whole Systems Update and Outcome Framework
Report of:	Councillor Heather Acton, Chairman of the Health & Wellbeing Board Dr Neville Purssell, Chairman, NHS Central London Clinical Commissioning Group
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1. EXECUTIVE SUMMARY

1.1 At its meeting on 16 November the Health and Wellbeing Board considered and endorsed the Integrated and Accountable Care Strategy presented by Central London CCG and the Integrated Care Commissioning Strategy presented by West London CCG.

1.2 This report provides an update of work that has taken place since then. In particular, West London CCG have led work with providers to consider how an Integrated Community Team might be established, initially using an Alliance Agreement and utilising existing contractual arrangements during 2018/19.

1.3 Central London CCG have led work to develop a Joint Outcomes Framework in order to ensure that residents across Westminster and Kensington and Chelsea experience similar service standards and that consistent priorities are set.

1.4 Work also continues to consider how Council services could be improved through a more integral approach and initial conclusions about this are anticipated in March 2018.

2. RECOMMENDATIONS

2.1 The Health and Wellbeing Board is invited to:

a) note and comment upon the early thinking for the Integrated Community Team set out in sections 4 and 5 of this report and highlight any priorities that need to be addressed;

b) consider and comment upon the patient case studies which will be presented at the meeting to identify challenges for the co-design process and opportunities for improving the quality of care;

c) note and comment upon the draft Outcomes Framework presented in section 6 and appendix 1 of this report.

3. BACKGROUND

3.1 At its meeting on 16 November the Health and Wellbeing Board considered and endorsed the Integrated and Accountable Care Strategy presented by Central London CCG and the Integrated Care Commissioning Strategy presented by West London CCG.

3.2 The proposed strategies committed the system to an approach which will be underpinned by the concept of:

'One system, One budget, Better outcomes'.

3.3 They also committed partners to a set of guiding principles:

- ✓ **Resident-focussed** – we expect all our residents to be supported by a single health and social care team, using a single assessment and support process, supported by a single care plan if necessary
- ✓ **Community-focussed** – the care system will by default provide support in the community and make use of hospital or other bedded care only when necessary
- ✓ **Geographically relevant** – the approach to care must recognise the unique geography of Westminster and provide tailored solutions for people living in the north, centre, and south of the borough
- ✓ **Collaborative** – local approaches to care must be co-designed with local people and a wide range of local interest groups
- ✓ **Preventative** – the care model will focus on prevention and self-help, giving residents power over their own choices, health, and wellbeing

3.4 The Health and Wellbeing Board noted that 50,000 residents living in Queens Park and Pimlico receive primary and community health services which are

commissioned by West London CCG while the remainder of Westminster residents receive primary and community health services funded by Central London CCG. It therefore requested and required that a single whole system solution be developed for all Westminster residents whether they live in the north of the borough or the south receive a high quality and consistent health and social care service.

3.5 This paper presents an update on the work that has taken place since then to develop the strategy further and to achieve the Health and Wellbeing Boards aim of an integrated solution for all Westminster Residents. Work has taken place in three areas:

- West London CCG have led work with providers to understand how services are currently provided and how under existing contractual arrangements and through establishing an **Alliance Arrangement** staff from different organisations might work together in local multi-disciplinary community teams to provide better services for residents through the establishment of an **Integrated Community Team**.

  Though contractual arrangements and the amount of available infrastructure and resource is different across Central and West London, work continues to examine the feasibility of replicating the West London model across Central London.

  Though at an early stage initial conclusions are anticipated in March 2018. More information about current thinking is presented below

- Central London CCG have led work on developing a shared **Outcomes Framework** across Central and West London CCG in order to ensure that wherever residents live in the two boroughs the quality of care they should expect and the service standards delivered should be the same.

  A draft **Outcomes Framework** has been developed and shared with key stakeholders for comment. This is presented below for consideration by the Health and Wellbeing Board.

  It is anticipated that a final draft of the **Outcomes Framework** and a summary of the comments submitted and chances made will be presented to the March meeting of the Health and Wellbeing Board. More information is presented below.

- Westminster City Council and the Royal Borough of Kensington and Chelsea have begun an in-depth examination of the existing approach to providing social care to consider the risks and benefits of participating in an integrated approach to health and social care.

  Initial conclusions are that closer working between different organisations should reduce referrals and duplication and improve the person

experience and the quality of care supported. However both council's have limited resources and need to ensure that they continue to provide high quality services and meet their statutory social care functions and so further work is required and underway to consider the practicalities of this approach.

4. VISION FOR INTEGRATED COMMUNITY TEAM

4.1 West London CCG have led work to develop proposals for a new Integrated Community Team (ICT) to be established utilising existing contractual arrangements and an "Alliance Agreement" from April 2018. This will involve a step by step approach but it could include staff working together from a range of different services including those currently working in community and specialist nursing, the 'My Care My Way' service, the Community Independence Service (CIS), the voluntary sector and potentially, some staff currently working in Adult Social Care.

4.2 A key element of the ICT proposal is the creation of an integrated multi-disciplinary management team which will help to reduce duplication through better management of local resources. This single management function will mean that, when a service user presents with a health or social care need, following a multi-disciplinary assessment the best person in the local Integrated Community Team will be identified and assigned to that person. This member of staff will then provide ongoing support for that person to coordinate their care and enable that person to take control of their own health and social care needs, by drawing on the wide range of skills and expertise within the ICT to support their care.

4.3 By providing continuity of care and through working as part of a local Integrated Community Team with other health and social care professionals, the professional designated to provide and co-ordinate support for the patient will ensure that the right support is provided more quickly, and without onward referral. For instance, the professional will ensure that if the person needs medication advice, then a pharmacist will be identified to deliver that advice; they will also ensure that if there are social care needs, these are arranged for the person. In other words, support will be tailored around the person, they will have a single main contact and less time will be spent passing responsibility for the person from one organisation to another.

4.4 This will be better because people, families and those who work in the community often find existing systems difficult to navigate and the specific responsibilities of different individuals and organisations difficult to understand.

4.5 The Integrated Community Team will be better for patients and carers by:

- Creating a system where service users and carers only have to tell their story once.
- Providing more timely interventions by reducing the delays to patient care caused by onward referrals between different community services.
- Sharing information more effectively so that service users' requirements and wishes are understood and respected.

- Enabling the system to respond more rapidly and appropriately to people's needs, by bringing together medical, nursing, therapy and social care professionals, to prevent hospital admissions;
- Reducing the number of professionals that the service user and their family have to interact with. Providing care in a range of venues, focused around our two Integrated Care Centres/ Health and Wellbeing Hubs (which are located in the North and South of RBKC) and also delivered through local 'spokes' and also offering home-based care to housebound patients.
- Offering proactive planned care to better prevent ill health and early escalation of risk when a patient becomes unstable.
- Offering a more personalised unplanned response by ensuring service users' case managers are involved as soon as possible when a patient requires unplanned care.
- Improving people's experience of the health and social care system by making delivery feel seamless.
- Creating a 'one system' ethos. This will be enabled by the development of an Alliance Agreement between existing providers, underpinned by a single Outcomes Framework (see below), to promote closer working.

4.6 An Integrated Community Team will be better for practitioners, staff and volunteers by:

- Shifting the focus of support from providing a specific, specialist intervention towards providing more long term, holistic person focussed support to meet wider health and care needs.
- Simplifying referral and clinical pathways and reducing bureaucracy by empowering teams to own and resolve service user needs themselves, without the need for onward referrals between different services.
- Spending less time doing administration – as records are shared and fewer people are involved in providing different elements of people's care;
- Having more contact with service users over a longer period of time;
- Working more closely with colleagues from other organisations and other professions – allowing for increased learning and development opportunities;
- Working with improved IT and digital solutions – e.g. virtual MDTs and shared records;
- Increasing skills and competencies of the workforce through more structured access to specialist colleagues and knowledge.
- Creating more opportunities for training, development and career progression;
- Making it simpler to provide the right care in the right place, removing bottlenecks and obstacles (e.g. strict referral criteria and cumbersome processes);
- Making it easier for practitioners, staff and volunteers to communicate with colleagues and access specialist advice;

5. CO-DESIGN PROCESS FOR ESTABLISHMENT OF AN INTEGRATED COMMUNITY TEAM

5.1 To assist with the development of thinking for the Integrated Community Team a comprehensive programme of engagement and co-design is now underway. So far, over 100 different individuals from a range of provider, commissioner and

patient organisations have been involved in the process and more than 30 co-design events facilitated.

5.2 The process as a whole has been overseen and coordinated by the West London Integrated and Accountable Care Alliance Leadership Group, which is made up of senior leaders and lay members from key provider, commissioner and patient organisations.

5.3 The process has included a review and analysis of best practice and learning from elsewhere. A number of areas have already tried and tested similar models of care, both in the UK and world-wide. We are taking into account the principles, ways of working and lessons learnt from these approaches, to ensure that the new model reflects all available best practice in the field. It has also drawn on the recently undertaken evaluation of existing arrangements undertaken by New Bucks University and in particular the key conclusions that have been made about the benefits of effective care coordination.

5.4 A second key focus of the co-design process has been an analysis and consideration of the existing and future arrangements on current service users. This has been undertaken by the development and review of a series of case studies which identify how currently individuals can be referred from one organisation to another and how the quality of care could be improved through the development and implementation of Integrated Community Teams.

5.5 The Health and Wellbeing Board is invited to consider and comment upon the patient case studies which will be presented at the meeting to identify challenges for the co-design process and opportunities for improving the quality of care.

5.6 Another key focus has been on looking in detail at existing arrangements through a series of 10 service or function specific “deep dive reviews”, which have been examining the strengths and weaknesses of existing arrangements, the challenges in referring people from one service to another and the opportunities for more joint working between one service and another.

5.7 This process is now reaching completion and the conclusions are being collated so that they can be used to develop detailed proposals and a business case which will be considered by the Governing Bodies and Board of Directors of each participating organisation. Following this process, the analysis, conclusions and recommendations will be presented to the Health and Wellbeing Board for consideration.

6. DEVELOPMENT OF A JOINT OUTCOMES FRAMEWORK

6.1 The prime objective of the two CCGs’ integrated and accountable care work programmes is to improve health and wellbeing outcomes for people in Westminster and Kensington and Chelsea.

6.2 This means that how care is commissioned and provided needs to start with the question of ‘What matters to you?’ rather than ‘What’s the matter with you?’

6.3 The document attached as appendix 1 is part of the draft Outcomes Framework shared with participants on the Westminster Partnership Board for Health and Care in December 2017. Central London CCG and West London CCG are now working together to develop a single joint Outcomes Framework, which sets out the ambitions for what care services will help people to achieve. The production of a single framework across the two CCGs is designed to support the delivery of high-quality and consistent health and social care service to all Westminster residents, given the position of Queen's Park Paddington (see paragraph 3.4).

6.4 The Outcomes Framework is rooted in the extensive public engagement undertaken as part of the CCGs' Whole Systems Integrated Care programmes, which is the starting point for this present work.

6.5 This engagement gave rise to a series of 'I' statements. These are useful ways of describing people's expectations of what receiving care will help them to do and feel. Examples for people receiving care include 'I can maintain my mobility and independence', 'I can live at home', and 'I feel respected for my own experience and knowledge'. Other example of statements for people delivering care are 'I am supported by people who work well together' and 'I feel that I get the support and resources I need to do my job well'.

6.6 As the table below shows, these statements have been grouped into five outcome domains:

- People have an overall quality of life;
- Care is safe, effective and people have a good experience;
- Professionals experience an effective integrated environment;
- Care is financially sustainable; and
- Care team is efficient, process defined and personalised.

6.7 Examples of proposed outcomes, indicators, and metrics that sit within each domain are shown in the table below. The full set is shown in appendix XXX. This is a long list, ready for further public and professional engagement (see below). A sub-set of the final outcomes framework will be subject to financial incentivisation to encourage the service redesign and investment necessary to support the achievement of the relevant outcomes.

Outcome domain	**Outcome**	**Indicator**
People have an overall quality of life	Taken together, my care and support gives me the opportunity to contribute and help me live the life I want to the best of my ability.	Potential years of life lost (PYLL) from causes considered amenable to healthcare
		Health related quality of life for older people. Average health status score for adults aged 65 and over as measured using the EQ-5D scale
		Adults using mental health services who live independently

		Unmet needs in domains of control, dignity, personal care, food & nutrition, safety, occupation, social participation, accommodation (from the adult social care survey)
Care is safe, effective and people have a good experience	I feel safe, in control and well-informed. I am respected for my own experience and knowledge. I know people are there when and where I need them.	Proportion of patients who at any point during a twelve-month period achieve (or exceed) a minimum increase in six points within Patient Activation Measure level 1 or 2
		Proportion of patients who, in last six months, felt they had enough support from local services or organisations to help manage their long-term condition(s)
		Proportion of people admitted in hospital for any ambulatory care sensitive condition
		Bereaved carers' views on the quality of care in the last three months of life
Professionals experience an effective integrated environment	Professionals involved with my care talk to each other. They all work as a team.	Professionals who agree they are working in an integrated way to support services users and carers
		Professionals are able to deliver the patient care they aspire to
		Professionals who would recommend their integrated care partnership as a place to work
Care is financially sustainable	The care I receive is part of a service built on long-term sustainability.	Shift in spend/activity from acute services to out-of-hospital services
		Reduction in emergency admissions for persons ≥65 years per 100,000 population
		For the population cohort managed by the [intensive community care teams], reduction in emergency admissions for people ≥65 years
Care team is efficient, process defined and personalised	I am supported by people who respect my time and I am not being admitted into hospital unnecessarily.	Reduction in emergency readmissions within 30 days of discharge from hospital for patients aged ≥65
		Proportion of older people (aged ≥65) who are still in a non-acute care setting (usual place of residence including own home, nursing home, residential home) 91 days after discharge from hospital into reablement services
		Weekend discharge rate % in comparison with weekday discharge rate %

6.8 This framework is a draft for further engagement with a wide range of stakeholders, including local residents and providers of care. This engagement will be taking place from January to March 2018.

6.9 Particular issues for consideration are:

- Do the domains reflect what we all want from a comprehensive community care across Westminster and Kensington and Chelsea?
- Are the indicators a fair reflection of the outcomes that the Health and Wellbeing Board would seek to achieve through a more integrated approach to health and social care?
- Should any other indicators should be prioritised, given local population needs?

7. FINANCIAL IMPLICATIONS

7.1 At this stage there are no direct financial implications arising from these proposals but it should be noted that the successful development of these proposals and in particular the success of the new arrangements in reducing demand on hospitals will play a key part in achieving the financial targets set out in the Sustainability and Transformation Plan.

7.2 In the short term all partners have a range of financial and savings targets which need to be delivered on 2018/19, which means that there are limited resources available to develop new ways of working and a likelihood that overall investment in community health services will reduce in 2018/19

8. LEGAL IMPLICATIONS

8.1 Careful consideration of the legal implications of adopting new ways of working will be required, including any procurement risks associated with putting in place an Alliance arrangement or extending, terminating or re-letting existing or new contracts. These will be considered as final proposals are developed and in parallel to considering detailed business cases.

Background papers:

Westminster Joint Health and Wellbeing Strategy 2017-21
Integration and Better Care Fund Plan 2017/18
NWL Sustainability and Transformation Plan
NHSE: Five Year Forward View
Central London CC Integrated and Accountable Care Strategy

West London Integrated Care Strategy

LIST OF APPENDICES:

Appendix 1: Draft Outcomes Framework

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

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Appendix 1: Extracts from Draft Outcomes Framework

Outcome Domain		Outcome	Indicator	
1	People have an overall quality of life	Taken together, my care and support gives me the opportunity to contribute and help me live the life I want to the best of my ability.	1	Potential years of life lost (PYLL) from causes considered amenable to healthcare
			2	Healthy life expectancy at birth (male and female measures)
			3	Unmet needs in domains of control, dignity, personal care, food & nutrition, safety, occupation, social participation, accommodation (patient) Average quality of life score (based on patient responses to Adult Social Care Survey – eight domains) Of those who completed survey, % of patients scoring 14 or above (out of 24) for self-reported quality of life.
			4	Number of days in hospital (emergency)
			5	People with a care plan who have reported an improvement in quality of life an independence. ICP Care Planning Survey distributed to all patients who have received an initial ICR care plan or had a care plan review
			6	Health related quality of life for older people. Average health status score for adults aged 65 and over as measured using the EQ-5D scale
			7	Improved patient experience - Self-reported “I” statements (as part of patient surveys / interviews). ICP care planning survey distributed to all patients who have received an initial ICR care plan or had a care plan review
			8	Adults using mental health services who live independently
			9	Adults using mental health services who have a job
			10	Physical checks for people with severe mental illness
			11	Gap in employment rates - mental health

			12	Adults with a learning disability who live in their own home or with their family
			13	Adults with a learning disability who have a job
			14	Gap in employment rates - learning disabilities
2	Care is safe, effective and people have a good experience	I feel safe, in control and well-informed. I am respected for my own experience and knowledge. I know people are there when and where I need them.	15	Proportion of patients who at any point during a 12-month period achieve (or exceed) a minimum increase in 6 points within PAM level 1 or 2.
			16	Health literacy - enabler for prevention
			17	Reduction in number of non-elective admissions due to falls, for 65 years and over, per 100,000 population (develop as a lead indicator for flagging frailty factors affecting uptake of health and social care)
			18	Proportion of patients who, in last 6 months, felt they had enough support from local services or organisations to help manage their long-term condition(s)
			19	Proportion of patients who helped compile written care plan e.g. setting goals / choosing how to manage health
			20	Preferred place of death
			21	Proportion of people admitted in hospital for any ambulatory care sensitive condition (ACSC)
			22	Knowledge of prescribed medications
			23	Care planning goals
			24	In the past year, have you generally found it easy or difficult to find information and advice about support services or benefits?

			25	How confident are you that you can manage your own health?
			26	Quality of life for people who are carers. Carers can balance their caring roles and maintain their desired quality of life.
			27	Satisfaction with out-of-hours primary care
			28	Bereaved carers' views on the quality of care in the last 3 months of life
			29	Quality of palliative care
3	Professionals experience an effective integrated environment	Professionals involved with my care talk to each other. We all work as a team.	30	Professionals who agree they are working in an integrated way to support services users and carers
			31	Professionals are able to deliver the patient care they aspire to
			32	Professionals who would recommend their integrated care partnership as a place to work
4	Care is financially sustainable	The care I receive is part of a service built on long-term sustainability.	33	Shift in spend/activity from acute services to out-of-hospital services
			34	Reduction in emergency admissions for persons ≥65 years per 100,000 population
			35	For the population cohort managed by the [Care Connection Teams], reduction in emergency admissions for people ≥65 years
5	Care team is efficient, process defined and personalised	I am supported by people who respect my time and I am not being admitted into	36	Year-on-year impact on aggregate first to follow-up ratio
			37	Reduction in emergency readmissions within 30 days of discharge from hospital for patients aged ≥65
			38	COMMISSIONER BASELINE: delayed transfers of care (from hospital and those attribute to adult social care per 100,000 population)

		hospital unnecessarily.	39	PROVIDER BASELINES: delayed transfers of care (from hospital and those attribute to adult social care per 100,000 population)
			40	Proportion of older people (aged ≥65) who are still in a non-acute care setting (usual place of residence including own home, nursing home, residential home) 91 days after discharge from hospital into reablement services
			41	Weekend discharge rate % in comparison with weekday discharge rate %
			42	**[PLACEHOLDER]** Identification of the percentage of people aged ≥65 referred by MCP who access either short- or long-term social care services
			43	**[PLACEHOLDER]** Identification of the number of people accessing third sector services offered and outcomes from these interventions for individual users