

The Long Term Conditions Year of Care Commissioning Programme Implementation Handbook



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1. Executive summary

The aim of the Long Term Conditions (LTC) Year of Care Commissioning Programme has been to support the implementation of "integrated LTC care services to improve outcomes and experience for people."

The achievement of this aim was expected to depend on three key drivers¹: the identification of patients with long term conditions; the provision of holistic, person-centred, integrated health and social care services by an integrated care team; and the engagement of patients in managing their care. A major focus for the programme was to transform how integrated care could be commissioned and particularly how care providers could be incentivised to work together by funding care for these patients using a capitated budget.

The programme was experimental. The main task of the national team was to support the early implementer sites (EISs – the collection of health and social care commissioning and provider organisations running the programme locally) to test and pilot various techniques, approaches and service models that addressed the main programme aim. The EISs have built upon their learning to now begin putting in place integrated models and the back-office functions that support these service models.

It is not the intention of this guide to detail the tasks needed to implement integrated care services, as there are many other programmes aiming to do this. The EISs are clear that, at this time, there is not a single approach suitable for all care economies – a local approach should be part of **whole system transformation** change that is relevant to the local care economy. However, there are many similarities between the **integrated services** that have been planned, piloted or implemented by the EISs.

All have undertaken some form of patient engagement to help them co-produce their integrated care services, and to develop outcome metrics that are being used, or will be used, to measure the success of the service. All have multi-disciplinary integrated care teams at the heart of their service delivery. All have developed integrated whole population datasets and have conducted whole population analysis to understand current care service delivery to help them plan service improvements. All have investigated how they will need to change existing contracts and set up contracts for new organisation arrangements. All are planning changes to IT infrastructure and financial processes to allow them to use a capitated budget to fund their integrated care service.

Based on the learning of EISs, there is a core set of requirements to support the implementation of a Year of Care model:

- Secure commitment from leaders across all providers and at different levels and strong programme and project management to ensure the approach has the necessary buy-in and traction
- Engage with patients and care practitioners to agree the local vision and to understand the good and poor aspects of existing services, with a view to co-producing improved services and developing outcome measures for assessing the success of these services once they are implemented.
- Develop plans that link with **whole system transformation**, provider and commissioning organisation strategic plans, and national strategic plans. Don't plan in isolation, and don't plan only service and workforce changes also consider necessary changes to the supporting back office functions.
- Develop an integrated whole population dataset and undertake whole population analysis to understand your population's care needs and existing utilisation of care resources, with a view to planning improved services. The dataset will also support the financial transaction process for the capitated budget and whole system service performance measurement when the **integrated services** are operating.
- Develop an integrated multi-disciplinary team with a central role to deliver integrated out-of-hospital and hospital out-reach care services. In terms of volume, these are the services that will be most needed by patients with complex care needs.
- The integrated care team should undertake single assessment of patients' care needs and co-produce a personalised care plan with patients, carers and members of the integrated multi-disciplinary team. The care plan should address clinical, care and wellbeing of patients. Consider the roles of care co-ordinators (generally clinical) as well as 'care navigators' or a similar non-clinical service to work as part of the integrated multi-disciplinary team, to support the delivery of care and the well-being of patients.
- Encourage self-help and self-management of conditions by providing information, training and support to patients and carers.
- Encourage care practitioners and services who are not part of the integrated care team to work together and streamline working processes. Partly this can be supported by shared care clinical records and shared care plans.
- Develop a capitated budget by defining the patient cohort and services to be included within the budget. Use historical costs to set a capitated budget value (baseline) and a modified budget value to take account of the new service model being put in place and changes in the use of services over time.
- Consider contract options that fit the culture of your care economy, and potentially consider longer term contracts to help manage financial risk.
- Measure success using both outcome and output metrics. Patient experience should be one of the outcome measures. These measures should be used to: review patient care plans; assess the success of individual services and providers, and the success of the overall integrated service model; and link to payments.

Here, we describe the experiences and learning, and some of the thoughts and discussions of the EISs along their four-year journey². We have included some theory that the EISs have used. By sharing these experiences and early findings and describing the future plans of the EISs, we hope that other care economies are encouraged to expand the scope of their current local journeys toward the implementation of integrated year of care models.

We also hope that this information is useful for care economies as they develop whole-place commissioning or place-based commissioning plans. We expect that many care economies will undertake journeys similar to the EISs, as they develop and implement their Sustainability and Transformation Plans (STPs).³



 ² All of the EIS case studies referenced in this documents are available at: www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/ltc-year-of-care-commissionin g-model.aspx
 ³ www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp

2. Introduction

People with long term conditions need personalised care that allows them to access seamless health and social care services. This has been a key focus for many health and social care organisations for a number of years, culminating in the NHS Five Year Forward View⁴, which highlights the need to break down barriers between different provider organisations to create more integrated care services for patients. Traditionally, however, funding systems have been focussed on isolated episodes of care, rather than the patient journey and the needs of the individual.

The LTC Year of Care Commissioning Programme has over the past four years supported commissioners and service providers to improve outcomes for patients with complex care needs through the redesign of commissioning mechanisms and care models to deliver person-centred coordinated care.

The LTC Year of Care Commissioning Programme EISs consist of commissioners and providers of health and social care services within a local care economy. Although originally there were eight EISs, due to changes within organisations following the Health and Social Care Act 2012 only five EISs have been able to complete the programme. These are Leeds, West Hampshire, Kent, Southend and Barking and Dagenham, Havering and Redbridge (BHR).

This handbook describes of the journeys taken by our five EIS teams with a view to sharing the experience and knowledge they have gained. We hope that this information will help others when they undertake similar journeys.

In this document we capture learning at a moment in time. The LTC Year of Care Commissioning Programme has been running for four years and, while there is considerable learning to share from this period, many of the changes our EISs are implementing are difficult and complex, and therefore take time to achieve their full impact. The work and learning by the EIS teams continues, and they will continue to share their experiences.

2.1. National context

Integrated health and social care is cited as a key strategy to improve the quality of care delivered particularly to older patients with complex care needs⁵, and there is anticipation that integrated care will deliver services efficiently to individuals, although evidence proving that this is the case is mixed⁶.

Integrated care is not a new concept. The Department of Health encouraged greater personalisation of care and a shift in balance of care toward primary, community and social care providers in 'Our Health, our care, our say'⁷ from 2006, as a way to "develop services that are safe, high quality and closer to home". At the time of this publication, there was less emphasis on cost efficiency than there has been subsequently.

⁴ www.england.nhs.uk/ourwork/futurenhs

⁵ Nolte E and McKee M (2008) Integration and chronic care: a review, in Nolte E and McKee M (eds) Caring for People with Chronic Conditions: A health system perspective, pp 64-91. Open University Press, Maidenhead. Curry N and Ham C (2010) Clinical and service integration: The route to improved outcomes. The King's Fund, London (www.kingsfund.org.uk/publications/clinical-and-service-integration).

⁶ Mason A, Goddard M and Weatherly H (2014) Financial mechanisms for integrating funds for health and social care: and evidence review (www.york.ac.uk/che/publications/in-house/~tab-2). Nolte E and Pitchforth E (2014) What is the evidence on the economic impact of integrated care? Policy Summary 11, pp 1–46. WHO Regional Office for Europe and European Observatory on Health Systems and Policies, Copenhagen.

⁷ www.gov.uk/government/uploads/system/uploads/attachment_data/272238/6737.pdf

NHS organisations already use integrated care and **integrated payment systems** to deliver services to some patients. Most common is the use of integrated care to support individuals requiring a limited set of specific services; for example, maternity, musculoskeletal or diabetes pathways⁸. More recently, the focus has been on integrated care for a group of individuals who require different intensities of support and a diverse range of services; for example, elderly patients with multiple chronic conditions⁹, patients at the end-of-life, or patients with mental health conditions¹⁰. National policy initiatives over recent years continue to support the implementation of integrated care services¹¹, including the NHS Five Year Forward View¹², which sets out a clear vision for how integrated care services should look in the future.

The principles supporting the LTC Year of Care Commissioning Programme are most clearly stated in the NHS Mandate¹³, which directs the NHS to pursue care for individuals with long term conditions that "centres on the person as a whole rather than specific conditions" and "is coordinated around the needs of patients rather than the interests of organisations that provide care".

2.2. The LTC Year of Care Commissioning Programme

2.2.1. Background

The paper 'QIPP Long term conditions: Supporting the local implementation of the Year of Care Funding Model for people with long-term conditions'¹⁴ was the initiation document for the LTC Year of Care Commissioning Programme. It set out three key drivers for this work:

- Risk stratification of populations to select patients suitable for referral into the model of care (i.e. risk stratification for case-finding a rules-based method for identification of patients with long term conditions);
- Integrated multi-disciplinary teams to develop and manage care plans for patients with complex care needs, and to deliver services to these patients;
- Engagement of patients in managing their care and maximisation of the number of patients who can self-care.

⁸ Department of Health, Payment by Results Guidance for 2013-14

⁽www.gov.uk/government/collections/payment-by-results-pbr-in-the-nhs). RightCare (2015) Delivering and integrated musculoskeletal service in Oldham.

⁽www.rightcare.nhs.uk/index.php/resourcecentre/right-care-for-populations/a-case-study-of-an-integrating-pathway-hub-pennine-mus culoskeletal-partnership/).

⁹ Nolte E and McKee M (2008) Integration and chronic care: a review, in Nolte E and McKee M (eds) Caring for People with Chronic Conditions: A health system perspective, pp 64-91. Open University Press, Maidenhead. Curry N and Ham C (2010) Clinical and service integration: The route to improved outcomes. The King's Fund, London (www.kingsfund.org.uk/publications/clinical-and-service-integration).

¹⁰ Alzheimer Scotland (2012) Delivering Integrated Dementia Care: The 8 Pillars Model of Co Caregiving Well-Being: Community Support. Alzheimer Scotland, Edinburgh.

¹¹ Alderwick H, Ham C and Buck D (2015) Population health systems: Going beyond integrated care. The King's Fund, London (www.kingsfund.org.uk/publications/population-health-systems).

¹² www.england.nhs.uk/ourwork/futurenhs.

¹³ Department of Health (2013b) The Mandate: A mandate from the government to the NHS Commissioning Board: April 2013 to March 2015 (www.gov.uk/government/uploads/system/uploads/attachment_data/file/256497/13-15_mandate.pdf).

¹⁴ (www.gov.uk/government/publications/gipp-long-term-conditions-year-of-care-funding-model-early-implementers).

The LTC Year of Care Commissioning Programme approach is based on the following principles:

- The primary focus for the service model must be improved outcomes for individuals;
- Multimorbidity (more than one LTC) is common, and individuals with multimorbidity are likely to benefit from integrated health and care services;
- There should be a move from funding care for individuals with multimorbidity on an episodic basis towards integrated patient-centred care irrespective of the provider, and hence a pool of funding for a patient group will need to span more than one health and social care setting;
- An **integrated payment approach** (capitated budget) parallel to the integrated service model is likely to incentivise service integration and cost efficiency but, to achieve this, the new payment system must not be more complicated than current payment systems.

The national support team within the LTC Year of Care Commissioning Programme, encouraged EISs to innovate within this broad outline. We were purposely not prescriptive about the work undertaken by EISs, to encourage them to transform services in a way that matches their local care environment. As a consequence, there are many issues still undergoing testing.

We made choices about the support offered to EISs. We realised that the EISs were comfortable and confident about planning and implementing service change, and therefore we focussed national support on transforming the back office to support integrated care services – the IT and information, finance, contracting and commissioning tasks. We have supported the EISs to:

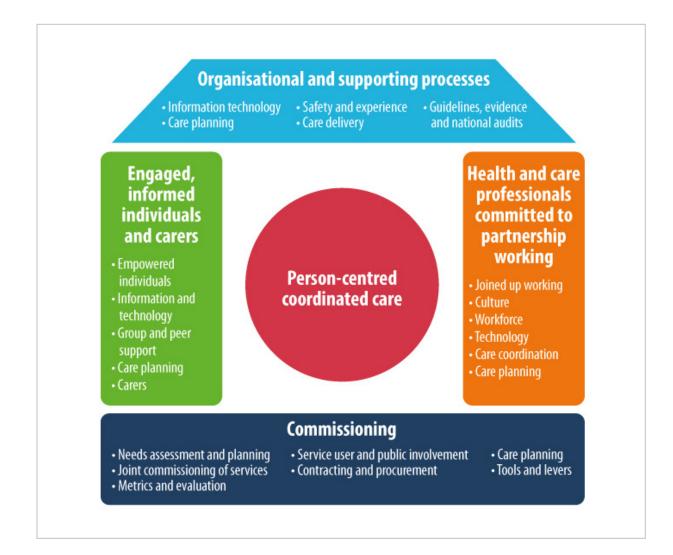
- Create an integrated whole population dataset and analyse whole population data to: (1) support the sharing of, and improve the quality of, information between all commissioners and providers in a care economy; (2) provide a base from which evidence-based decisions about service and workforce change could be made; (3) support the selection of services and patients, so that the right services could be targeted to the individuals who would benefit most from them; and (4) support outcome measurement and the financial transaction process for a capitated budget.
- Consider changes in financial, contracting, commissioning and performance monitoring at the same time, and in conjunction with, planned service change.
- Help EISs understand and influence the national move towards integrated care.

2.2.2. LTC framework

The EIS teams joined the LTC Year of Care Commissioning Programme to enable them to access national support. Their requirement for national support centred on the realisation that national policy and in many cases also the local vision was pushing them toward **whole system change**. Just concentrating on one aspect of the care delivery system was not adequate for delivering personalised integrated care. This is perhaps best expressed by the LTC Framework¹⁵.

The LTC Framework, illustrated by the House of Care model (Figure 1), sets out that, to deliver person-centred coordinated care, engaged individuals and carers must be supported by health and care professionals working in partnership, who are in turn supported by the organisational processes and commissioning arrangements.



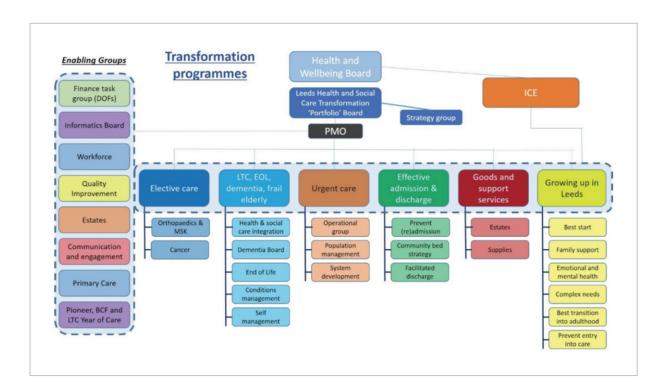


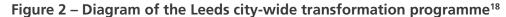
The LTC Year of Care Commissioning Programme focuses primarily upon the 'Commissioning' and 'Organisational and supporting processes' segments of the framework. Figure 1 makes it clear that the LTC Year of Care Commissioning Programme is only part of the transformation programmes that care economies are implementing to deliver person-centred coordinated care.

This is perhaps best illustrated by those EISs undertaking whole-city transformation. In Leeds, the Integration Care Pioneers programme¹⁶, BCF (Better Care Fund)¹⁷ and LTC Year of Care Commissioning Programme are considered as enabling groups to support a much larger city-wide transformation programme (Figure 2). The LTC Year of Care Commissioning Programme feeds into a range of enabling groups (e.g. finance, informatics, workforce, quality improvement) as well as supporting changes that are being planned across a wide-range of services.

¹⁶ www.england.nhs.uk/pioneers; a national programme supporting care economies to develop integrated care for older people and people with complex care needs.

¹⁷ www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan; a fund set to "ensure a transformation in integrated health and social care" by creating a single pooled budget across NHS and Local Government to incentive these organisations to work more closely together for the health and care and well-being of people. This was the transformation programme structure as it was when the Leeds South and East Clinical Commissioning Group developed it's 2-year operational plan 2014/15–2015/16.





2.2.3. Transformation approach

We encouraged EISs to take a relatively formal 'Plan, Do, Study, Act' (PDSA) approach¹⁹ to service change, supported by the familiar Commissioning Cycle (Figure 3).

The PDSA approach allows you to "test an idea by temporarily trialling a change and assessing its impact" before wholesale implementation. It "gives stakeholders the opportunity to see if the proposed change will work".

The four steps in a PDSA approach are:

- **Plan** Define the objective, questions and predictions. Plan the trial. Plan to answer: Who? What? Where? When? Plan the collection of data and evaluation strategy.
- Do Carry out plans. Collect and analysed data from the trial.
- Study Complete evaluation by comparing outcomes from the trial to predictions.
- Act Decide whether the trial suggests that wholescale implementation is likely to succeed. Plan and implement wholescale change.

¹⁹ www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html.

¹⁸ This was the transformation programme structure as it was when the Leeds South and East Clinical Commissioning Group developed its 2-year operational plan 2014/15 – 2015/16 (http://democracy.leeds.gov.uk/documents/s53416/Appendix%202a.pdf). This structure has now changed.

Some of the trialling that EISs have undertaken as part of the programme (that will be discussed in later section of this handbook²⁰) include:

- Seeking the views of patients and care practitioners about planned service change to ensure that the change will be beneficial to patients and supported by care practitioners.
- Testing planned service changes using simulation modelling.
- Undertaking pilot testing of service changes.
- Engaging with research organisations to gather evidence of existing service changes to inform local planning.

The Commissioning Cycle is explained in the NHS England 'Commissioning for Effective Service Transformation: What we have learnt'²¹ and supported by resources on the NHS England planning website²². In this latest version of the Commissioning Cycle, the cycle of 'planning – securing (or delivering) – monitoring' is supported by a foundation of strong leadership and co-production.

For EISs, the LTC Year of Care Commissioning Programme has been a core foundation – an enabler – for **whole system change**.

²⁰ See LTC Year of Care Commissioning Programme case studies 'North Staffordshire and Stoke – Patient engagement for outcomes', 'Engaging with patients to develop integrated care teams', 'Integrated care organisations in East Kent', 'The Wellness practice – Health 1000'.

²¹ www.england.nhs.uk/wp-content/uploads/2014/03/serv-trans-guide.pdf

²² www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/sop/

Figure 3 – The Commissioning Cycle



The structure for this handbook is based on the seven key themes grouped to the foundation and the three stages of the commissioning cycle (table 1). We show the practical implementation of the commissioning cycle with respect to the EIS journey as part of the programme.

Table 1 – The structure of this handbook

Foundation and three stages	Seven key themes	Learning handbook sections
Foundation	Bold and brave leadership	Leadership and engagement across the system
	Strong and effective participation and co-production	Co-production
Planning	Creating a vision for local service provision	Whole population analysis and understanding your population
	Designing the services for the future	Planning for service change
Securing	Selecting the commissioning mechanism that will drive improvement	Calculating a capitated budget
	Focusing on delivering improved value and outcomes	Implementing service changes
Monitoring	Using activity management to today's services to plan future service transformation	Evaluation and planning for the future



3. Leadership and engagement across the system

3.1. Leadership

Leadership and strong project management are important to the success of any change programme. Our EISs have found leadership and engagement with stakeholders across the care system vital for their **whole system transformation** programmes.

The King's Fund response to the NHS Five Year Forward View²³ considers three aspects of leadership: (1) the development and training of local leaders; (2) system leadership, i.e. local leaders thinking of the whole population and all the care services that are needed rather than part of the service provision; and (3) provider leadership, i.e. the leadership needed for the new service delivery organisations. Our EISs have considered each of these.

For example, Kent EIS are planning for the implementation of a series of accountable care organisations across the county²⁴. Of the many interesting strategies that they are putting in place, two are:

- Their promotion of the Local Health and Wellbeing Boards as the local system leader, who will eventually commission integrated health and social care services.
- Their ambition to "grow their own" future workforce locally. They are working with local universities to develop education and training packages to ensure that their future workforce is fit for practice, realistic and affordable. These include packages for frontline clinicians and practitioners across health and social care who will lead the delivery of **integrated services**.

3.1.1. System leadership

Southend EIS have the same goal as Kent (to have a single local system leading organisation to commission integrated health and social care services) but are using a different organisational arrangement – they have set up formal joint CCG-Council commissioning arrangements that are commissioning all care for their population. Additionally they have an inter-organisational project team involving clinical and managerial leads from the CCG, practices, social care and the acute and community providers managing their integrated care transformation programme. The programme reports to the CCG and local authority, and the health and wellbeing board oversees and monitors the programme.

(www.kingsfund.org.uk/publications/implementing-nhs-five-year-forward-view).

²³ Implementing the NHS Five Year Forward View: aligning policies with the plan

²⁴ See LTC Year of Care Commissioning Programme case study 'Integrated care organisations in East Kent'.

One of Southend EIS's top tips for the success of their programme is to 'ensure senior team buy-in'. In their case study²⁵, Steve Downing from Southend EIS states:

"Senior level support for the project, with clearly articulated aims and anticipated local benefits, is very valuable to ensure progress".

He believes that strong clinical leadership has been key to the progress made so far:

"Clinical leadership has been really important in shaping the programme and in engaging practices in the hub model. All the partners are very clear that our shared aim is to improve pathways of care for local people."

These views are not only restricted to Southend. The 'top tips' from two separate LTC Year of Care Commissioning Programme case studies state:

- Have the right group of people steering the project: Having the right clinical and managerial representatives from all the partner agencies can help ensure good progress (West Hampshire EIS)²⁶.
- Align strategic priorities: There will be lots of ideas and enthusiasm across the system. However, to really make progress there needs to be a senior-level shared vision and alignment of strategic priorities across all partners (BHR EIS)²⁷.

The EISs stress the importance of continual and sustainable engagement at a top-level for the success of transformation programmes. For example, the success of the Leeds Transformation Programme has depended on senior managers and clinicians agreeing to and taking responsibility for transformation. The Leeds Health and Social Care 'portfolio' Board includes all the chief executives from the major provider and commissioning organisations.

System leadership does not necessarily rely only on the most senior leaders in the care economy. In Leeds, the finance group includes all the directors of finance from the major provider and commissioning organisations, and each of the six service change areas is led by a senior manager or a clinical leader from the local organisations. To pull such a complex programme together, the project management office (PMO) in Leeds has been charged with managing robust and effective planning for the changes, and maintaining control and coordination such that the goals of the transformation programme are achieved.

For the development of the Leeds integrated whole population dataset, Leeds EIS recommends that you "Ensure that a project management structure is in place, particularly a leader (project sponsor/champion) for the project, engagement from stakeholders, dedicated resources for the project, and a signed-off project plan"²⁸. Similarly, in Kent, the whole population dataset and reporting dashboard would have been less robust without the leadership and programme management supporting this work²⁹.

²⁵ LTC Year of Care Commissioning Programme case study 'Southend looks to GP hubs to embed capitated Year of Care budgets'.
²⁶ See LTC Year of Care Commissioning Programme case study 'Development of budgets to support people with long term conditions in West Hampshire'.

²⁷ See LTC Year of Care Commissioning Programme case study 'Innovative integrated provider model offers personalised care for people with long term conditions'.

²⁸ See LTC Year of Care Commissioning Programme case study 'Creating an integrated whole population dataset for the Leeds population'.

²⁹ See LTC Year of Care Commissioning Programme case study 'Developing a dashboard to support integrated care'.

3.1.2. Provider leadership

Whereas system leaders need to consider services across organisational boundaries, provider leaders³⁰, those leading integrated care organisations or leading integrated care teams that take their membership from several organisations, need to work to **integrated services** that often, previously, are just a collection of individual services.

In addition to the Kent example above, both BHR and West Hampshire EISs have deeply considered the leadership of integrated service delivery organisations or teams. The integrated care teams in West Hampshire have a three-way leadership, with a GP sharing leadership of the team with senior clinical leaders from community services and social care³¹. However, they ensure that the 'whiteboard meetings' (the main multi-disciplinary team meetings where patient care is coordinated) are chaired by a single lead, and each patient is assigned a single leading clinical care coordinator. They have found that successful delineation of roles and responsibilities is important for their model of integrated care service delivery.

The BHR Health 1000 complex care organisation gave leadership for the organisation to a consultant geriatrician because, since the majority of patients were elderly, it was felt that this care practitioner had the best breadth of skills for the position³². The operation and management of Heath 1000 is overseen by an independent board, which in turn reports to the transformation programme board that brings together the CCGs, local authorities, and health, social services and community providers to oversee a range of aligned projects³³.

3.2. Engagement of stakeholders

Perhaps the main requirement from system leadership for the delivery of integrated care is that they encourage and ensure engagement across the care economy. West Hampshire EIS states:

A "crucial ingredient for integrated care in West Hampshire has been the engagement and buy-in of all key partner organisations and a shared understanding of needs by all service delivery teams and cross-cutting work-streams"³⁴.

The Leeds EIS believes that the Leeds Data Model (its local integrated whole population dataset that was developed through substantial engagement of local stakeholders) has helped to create a shift in thinking from silo-based delivery of care (i.e. separately analysing primary care, secondary care, mental health services and social care) towards whole population health care³⁵. Similarly, successful development of the dashboards that sit over the Kent integrated whole population dataset relied on working with all commissioners and providers to determine what should be reported in the dashboard, and keeping all stakeholders involved throughout the development process to ensure that what was developed continues to meet the needs of users³⁶.

³⁰ Implementing the NHS Five Year Forward View: aligning policies with the plan

⁽www.kingsfund.org.uk/publications/implementing-nhs-five-year-forward-view).

³¹ See LTC Year of Care Commissioning Programme case study 'Using whiteboard meetings to deliver integrate care for patients'.

 ³² See LTC Year of Care Commissioning Programme case study 'Choosing staff for an accountable care organisation'.
 ³³ See LTC Year of Care Commissioning Programme case study 'Innovative integrated provider model offers personalised care for

³³ See LTC Year of Care Commissioning Programme case study 'Innovative integrated provider model offers personalised care for people with long term conditions'.

³⁴ See LTC Year of Care Commissioning Programme case study 'Engaging with patients to develop integrated care teams'. ³⁵ See LTC Year of Care Commissioning Programme case study 'Creating an integrated whole population dataset for the Leeds population'.

³⁶ See LTC Year of Care Commissioning Programme case study 'Developing a dashboard to support integrated care'.

Part of the success of the BHR Health 1000 complex care practice results from the support by their local acute Trust. The acute provider saw that the preventative care approach that Health 1000 was offering as a way to reduce severe over-crowding in both in A&E and an emergency wards. They were particularly supportive of the admission avoidance and early discharge initiatives that are part of the service model.

However, the BHR Health 1000 accountable care organisation found engagement with local GPs more of a challenge which impacted on the recruitment of patients³⁷. One of the top tips from BHR EIS is:

"Engagement is often challenging but crucial and there can never be 'too much' engagement. Don't forget the community and voluntary sector who can be an invaluable source of ideas and resources to support patients"³⁸.

In Kent, there is a strong focus on using partnership working to develop new, shared ideas about how organisations work together. Partners have worked together to understand the current evidence base and then jointly developed a way forward that works best for all organisations. Stakeholders are not only informed but are actively part of the design and build of the new service model of care. They believe that working in partnership can achieve more than working apart.

Perhaps nothing illustrates this approach better than the cooperative philosophy behind their work in developing the contracting and financial arrangements to support their planned accountable care organisations. Four examples highlight this approach include³⁹:

- After an extensive review of available contracting models, the EIS decided against a lead provider model for their integrated care organisation because they believed that this model would not necessarily overcome problems associated with boundaries between organisations (i.e. would not necessarily promote integration of services across organisational boundaries), since the lead provider may be seen as the commissioner by the other organisations.
- While no contract for integrated care services is in place, Kent EIS has a compact agreement between all partner organisations in South Kent Coast. This agreement is part of all provider contracts and sets out the joint commitment to work towards delivering integrated care. It strengthened the joint accountability for integrated care outcomes that was already part of the philosophy of local organisations and recognises that the desired outcomes for patients can only be achieved if everyone plays their part working towards the same goals.
- One of four workstreams for development of an accountable care organisation 'Partnership, Collaboration and Leadership' – is concerned with how the organisations work together to shape the integrated service delivery model.
- Another of the workstreams 'Financial Incentive and Risk' is developing a shadow place-based transparent (open book⁴⁰) capitated budget for older people and physically disabled individuals, managed by the local Health and Wellbeing Board. This budget would bring together funds from CCGs and councils at a neighbourhood level for a selection of services.

³⁷ See LTC Year of Care Commissioning Programme case study 'The patient journey at an accountable care organisation'.

³⁸ See LTC Year of Care Commissioning Programme case study 'Innovative integrated provider model offers personalised care for people with long term conditions'.

³⁹ See LTC Year of Care Commissioning Programme case studies 'Integrated care organisations in East Kent' and 'Developing service and contracting models for integrated care for the Kent population'.

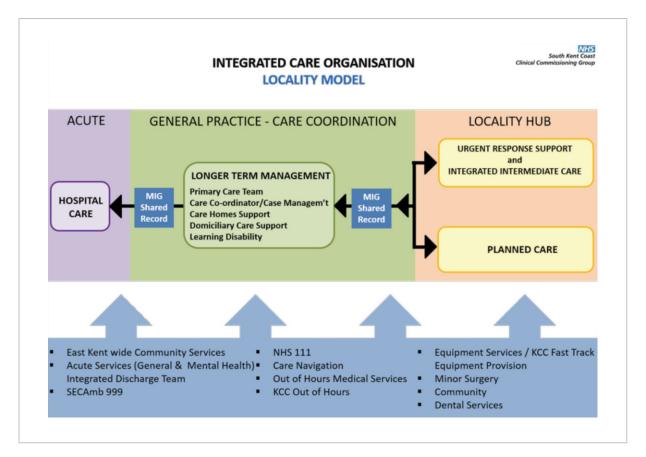
⁴⁰ Where all providers and commissioners open their accounts to all local organisations to improve transparency during negotiations and discussions.

3.3. Whole system change

Perhaps the best illustration of engagement across the system is that our EISs don't talk about implementing integrated care services in isolation, but consider this to be part of **whole system transformation**. The LTC Year of Care Commissioning Programme and other local programmes within the EIS's are only part of **whole system change**. In West Hampshire, it is part of the 'West Hampshire Integrated Care Transformation Programme'. In Leeds it is part of the 'Leeds city-wide Transformation Programme' In North Staffordshire and Stoke, it was part of the 'North Staffordshire and Stoke on Trent Cross Economy Transformation Programme'.

Some of the diagrams that the EISs have produced usefully help to illustrate the **whole system transformation** they are planning. Figure 4 shows how coordinated primary care service delivery will work with, and be supported by, the array of other local care services. Figure 16 illustrates that it is not just care services that will be integrated. BHR is planning an extensive integration of their IT systems, with a view that this will substantially improve the operation of integrated care services.

Figure 4 – Illustration of the whole system integrated care delivery planned in South Kent Coast



4. Co-production

4.1. Introduction

Co-production and engagement with patients is a feature of the programmes of all the EISs – not just for the design of services but also: the design of information databases and use of information; the development of shared care records; and the development of outcome metrics. Furthermore, it is not just co-production with patients that is important. Our EISs have used co-production of **integrated services** with care practitioners as a way to encourage engagement of stakeholders and to ensure that staff, as well as patients, are happy and enthusiastic with the joined up services that they develop.

4.2. Co-production with patients and staff

Southwark & Lambeth (a former EIS) and Leeds EIS have both contributed to the Nesta People Powered Health Programme⁴¹. As part of this study, Leeds EIS describe how co-production with patients is part of its overall innovation strategy, and how co-production has contributed to improvements in self-management support and the development of new services.

In general, the main purpose for which our EISs have engaged with patients was to develop their service model. By understanding what patients thought was good and poor about the current service they were receiving, the EISs have been able to more effectively plan their new **integrated services**. This has been a feature of the programme of all EISs but the process is perhaps best illustrated in the West Hampshire case study⁴². Here, they used the feedback from patients and care practitioners to: (1) develop a set of recommendations for the new service; then (2) use these recommendations to set the core requirements for the service; and then (3) use the core requirements to develop a set of key performance indicators and outcome metrics that are being used to assess the success of the integrated care teams. Both Leeds⁴³ and Kent⁴⁴ have undertaken similar engagement exercises to support the development of their planned service models and outcome metrics.

The West Hampshire engagement exercise sought the views of individuals in their population, as well as local and national care practitioners. The exercise received input from over 400 local individuals with long term health care conditions or their carers, and 110 local care practitioners (GPs, practice nurses, pharmacists, community team members, community specialists, hospital specialists, adult social care professionals and voluntary service officers). The EIS also held discussions with regional and national leads for specific long term conditions (cardiac, stroke, diabetes, respiratory and neurological conditions). Feedback from these meetings was combined with the National Voices' principles for integrated care⁴⁵ to shape the local culture and develop the integrated care teams that they now have in place.

⁴³ Development of strategies and priorities in Leeds West CCG

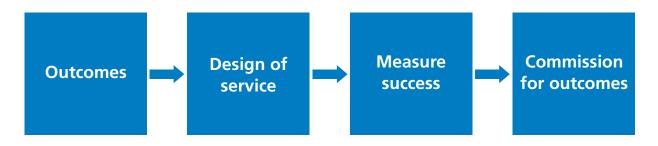
⁴⁵ National Voices (www.nationalvoices.org.uk/principles-integrated-care)

⁴¹ The business case for people powered health (www.nesta.org.uk/publications/business-case-people-powered-health).

⁴² See LTC Year of Care Commissioning Programme case study 'Engaging with patients to develop integrated care teams'.

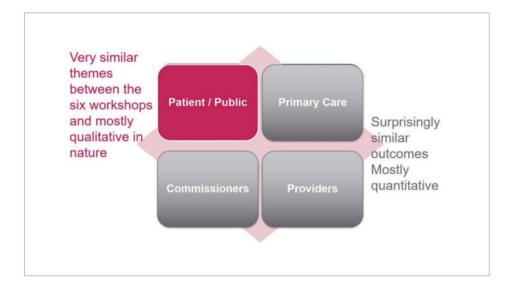
⁽www.dropbox.com/s/0jzeu5dzd6a7vy5/TransformingParticipationinHealthcare_Resources_CaseStudies_VisionAims%26ValuesLeeds.pdf). ⁴⁴ LTC Year of Care Commissioning Programme case study 'Integrated care organisations in East Kent'.

Similarly, at North Staffordshire and Stoke (another former EIS) they believed that patient views should inform the whole development and implementation process. When they were part of the LTC Year of Care Commissioning Programme, they anticipated using the view of patients to understand the outcomes that patients wished for from their health and social care services, to design services, to develop a set of outcome metrics to measure the success of the services for patients, and finally to adjust the payment that service providers receive (i.e. the payment to service providers may be 'topped-up' for good performance or reduced for poor performance, with service quality based on both outcome metrics and patient experience). The North Staffordshire and Stoke case study⁴⁶ briefly illustrates their approach and the outcomes they defined.



The North Staffordshire and Stoke EIS set up a range of workshops for key stakeholder groups, one workshop each for commissioners (CCG and social care), providers (acute, community, mental health and social care – both practitioners and managers), and separately for primary care (GPs, other healthcare practitioners and managers), and six workshops for patient/public groups.

The three health and care service workshops (commissioners, providers and primary care) created a list of similar outcomes. In general, these were about the system – how the system could be changed to work better for the care practitioners or changes to help the movement of patients around the system. In contrast, but perhaps not surprisingly, the patient/public workshops suggested more patient-focused outcomes that were more about the quality of services. Patient and public groups were keen to describe how the service wasn't working for them and their impression about the difficulties that care practitioners faced when attempting to provide quality services to patients.



For most of the EISs, engaging with patients was one of the first tasks they undertook on starting their **whole system transformation**, and is something that they have continued throughout their journey. For example, Leeds EIS sought the views of patients within GP practices when commencing the development of the Leeds Care Record (LCR) and revisited patients in the same GP practices to gauge the success of their communication strategy about the LCR ten months later⁴⁷.

The Leeds engagement exercise that informed the way in which information is collected and used was called 'Joined Up Leeds'. This exercise proactively sought the views of individuals during an intense two-week period. Individuals could take part in Joined Up Leeds in four different ways – city-wide (one-to-one conversations), network (via internet), media (letters or phone call in response to media advertisements) and via a survey (obtainable from all care organisations, but particularly within GP practices).

The conversations gave participants the opportunity to discuss how clinical and social information could best be used for the benefit of the people in Leeds. In particular, participants discussed how their health and wellbeing data could and should be shared, the benefits of sharing data, and the concerns they had.

The South Kent Coast region of the Kent EIS has run a series of 'people's panels' to co-design and drive change. The views of these people's panels and feedback from earlier engagement workshops have been used to build and develop a shared 'big picture' of what integrated care should look like⁴⁸. The engagement in South Kent Coast has not only been to shape the design of services but also to identify the care needs of local people, the opportunities for their community (for developing integrated care services), and how most might be made of existing community assets.

Co-production with staff has been used to develop a workforce plan for both the short-term and long-term as part of the South Kent Coast accountable care organisation development programme. With the help of universities across Kent, Surrey and Sussex, the EIS has run workshops for frontline clinicians and practitioners across health, social care and the voluntary sector, focusing on the skills required to deliver the planned integrate care service model. The

⁴⁷ See LTC Year of Care Commissioning Programme case study 'The Leeds Shared Care Record'

⁴⁸ See LTC Year of Care case study 'Developing service and contracting models for integrated care for the Kent population'

workshops are supporting the development of a common purpose, a genuine sense of affiliation and a common code of ethics across the local clinical and care community (with quality as the primary focus).

The outcomes from these workshops are, amongst other planning forums, being fed into the development of workforce plans. The plans describe how the Kent EIS expects to "grow our own" future workforce locally. To support this approach, they held an open day focusing on careers working in health and social care. All schools were invited with the aim of developing young people's interest in health and social care of the future.



5. Whole population analysis and understanding your population

5.1. Introduction

Our EISs believe that only by understanding their population can they develop appropriate care services for their citizens. If their population (or sections of it) would benefit from integrated care services, then an integrated whole population dataset is required to understand how patient access services that cross organisational boundaries.

The EISs committed a great deal of resource into developing an integrated whole population dataset during our programme because they saw this as the only resource that could help them effectively plan and manage services that were integrated across all health and social care providers. An integrated whole population dataset is helping the EISs to:

- Understand their population and plan integrated services and workforces. In particular, it is helping the EISs follow the patient pathways across health and social care providers and understand how to overcome boundaries between providers. The dataset is helping EISs understand the care needs of segments of their population, develop service improvement and workforce strategies, and to set capitated budgets.
- Set up the financial transaction process and the performance management structure that they will need to manage a capitated budget and integrated service delivery. They need to marry units of activity delivered by individual providers with capitated budget funds that sit across many providers. Similarly, they need to match the performance of services delivered by individual providers with outcome metrics that measure the benefit to patients across their whole care pathway.
- Share information between clinicians about patient care. Some of the EISs are planning that information from the integrated whole population dataset will flow into a shared care record and into personalised care plans to help clinicians manage the care of patients and to support the care need's assessment process.

The integrated whole population datasets developed by our EISs include activity, cost, demographic and (for some EISs) performance information linked at individual level. All individuals within the care economy (whether they use care services or not) are included. The activity and cost information should be sourced from at least acute, community, mental health, GP practice, primary care and adult social care providers, with the expectation that this might expand to include ambulance, out-of-hours, voluntary and other council services at some stage in the future. Where possible, data should be sourced from existing systems and datasets so that there is no extra burden placed on service provider organisations.

The Leeds EIS case study⁴⁹ provides a useful overview of their journey creating an integrated whole population dataset. Some of the EISs have shared their learning by contributing to documents written by national organisations that describe, in detail, how to develop an integrated whole population dataset. The two most important papers are:

- National Information Board (2014) 'Personalised health and care 2020: Using data and technology to transform outcomes for patients and citizens, A framework for action'⁵⁰
- Monitor (2015) 'Meeting local information needs for integrated care: a technical guide for creating local person-linked data sets'⁵¹

In addition, Southend EIS has been at the forefront of the Information Governance Alliance's work to clarify the rules covering information governance with respect to integrated whole population datasets.

5.2. Whole population analysis

The LTC Year of Care Commissioning Programme has championed whole population analysis as a method for gaining the depth of understanding of a local population that is necessary to demonstrate the linkage between care services and assess the impact of service change across the provider landscape.

Dr Abraham George from Kent EIS describes the importance of whole population analysis⁵²:

"Failure to consider the wider system makes it more difficult to plan holistically for the care needs of patients, particularly those with more complex needs who will often receive care from a wide range of providers."

And Dr Tom Mason from Leeds EIS states⁵³:

"The Leeds integrated whole population dataset (locally referred to as the Leeds Data Model) supports commissioners to make evidence-based decisions. It is helping commissioners understand whether they are targeting the right services to the right patients, whether health care providers are using resources effectively, and whether service changes are having a positive impact for patients."

⁵⁰ Kent and Leeds EISs contributed case studies, ideas and experience to this paper

(www.gov.uk/government/publications/personalised-health-and-care-2020).

⁵¹ Kent and BHR EISs contributed case studies, ideas and experience to this paper

(https://bettercare.tibbr.com/tibbr/resources/596/file.download?_ref_=tibbr, and referenced in

⁴⁹ See LTC Year of Care Commissioning Programme case study 'Creating an integrated whole population dataset for the Leeds population'

www.gov.uk/government/publications/integrated-care-how-to-comply-with-monitors-requirements/complying-with-monitors-integrated-care-requirements).

⁵² See LTC Year of Care Commissioning Programme case study 'Whole population analysis – the Kent experience'

⁵³ See LTC Year of Care Commissioning Programme case study 'Creating an integrated whole population dataset for the Leeds population'

Based on the experience of the EISs, Table 2 lists the purposes for an integrated whole population dataset and whole population analysis. Some of the whole population analyses that Kent EIS have undertaken or are undertaking because they have an integrated dataset in place include⁵⁴:

- Risk score population stratification to understand the various care needs of different segments of the Kent population.
- Support for a cost review of palliative care services, using linked data between hospice and council services⁵⁵.
- Bed modelling and demand management. The analysis sought to understand the impact of planned service changes on the demand for beds across a care economy. This included assessing demand for acute, community, mental health and social care beds (including those within care homes).
- Assessment of the benefit on health and social care of frail elderly individuals resulting from home safety checks carried out by the fire service.
- Evaluation of telehealth services.
- Analysis to understand the contribution of physical multimorbidity on the care needs of patients with learning disability.

Table 2 – Purposes for an integrated whole population dataset and whole population analysis

Purposes for an integrated whole population dataset	Purposes for whole population analysis
Purposes for whole population analysis	Contribute more detailed analysis and analysis of integrated care services into strategic plans and joint strategic needs assessments (JSNA).
Support whole population analysis.	Support whole population analysis.
Engage stakeholders in understanding linkage and interactions between services.	Understand the linkages and interactions between services.
Allow tracking of the services used by a cohort of patients.	Understand historical service usage as a baseline from which to estimate the impact of new or changed services, particularly with respect to the impact on existing services.
Provide additional information into shared care records and care plans.	Provide analysis and evidence to support service change business cases.
Support the financial transaction process for a capitated budget.	Evaluation of the impact of service changes.
Allow the calculation of input and outcome metrics to support service performance monitoring.	

⁵⁴ See LTC Year of Care Commissioning Programme case study 'Whole population analysis – the Kent experience'.
⁵⁵ Results have been shared with the NHS England Pricing Team have been reviewing palliative care activity to support the development of national currencies for palliative care. The approach taken and the draft palliative care currency documents are available at www.england.nhs.uk/2015/03/05/palliative-care-funding.

5.3. Creating an integrated whole population dataset

To be useful, an integrated whole population dataset should incorporate data from a wide range of routine (currently existing) datasets. To prevent an extra burden on provider organisations, new datasets should not be created, although additional data-fields might be part of data quality improvements that support the integrated whole population dataset.

The Kent EIS has summarised the data they link together to create their integrated whole population dataset in the text box below⁵⁶. An integrated whole population dataset should incorporate:

- Patient demographic information (e.g. age, sex, registered GP, QOF registered conditions, etc.), including mortality information (including out-of-hospital mortality)
- Activity and cost information from routine administrative datasets
- Person-level outcome metric information (i.e. clinical outcomes and patient experience) that can be aggregated for a cohort of patients to assess the performance of new or changed services.

Whole population analysis – linking 'routine administrative datasets'

Providers hold 'administrative datasets' that they use to keep track of the clinical care delivered to individual patients, as well as for a number of secondary uses (e.g. data from patient records in hospital patient administration systems feed into payment systems for billing and monitoring activity levels). Each of these datasets is a valuable source of information about the patient care provided within that service. However, in isolation, each dataset cannot provide the whole picture. By linking datasets from different sources at the individual patient level, it is possible to more fully understand how patients access services and the current patterns of service utilisation as patients progress through care pathways.

Whole population datasets need to link data from all (or as many as possible) providers of health and social care services, for example:

- Hospital services (Secondary Uses Service (SUS) and local data)
- Community services
- Mental health
- Out of hours
- Ambulance services
- Hospices
- Social care

Linking multiple provider datasets at the patient level can be achieved if all providers record patient NHS Numbers, such that NHS Numbers provide a common patient reference in all datasets. To comply with information sharing guidelines, providers need to share data that is not directly identifiable (i.e. is pseudonymised), which in Kent is achieved through a process called 'one way hashing'. Creating an integrated whole population dataset takes time. A great deal of preparation and planning is required before you begin linking data, and there will be many improvements that you need to make once you have begun to link data.

Monitor, in its document "Meeting local information needs for integrated care: a technical guide for creating local person-linked data sets'⁵⁷, suggests that you will need at least six months to create the first version of your integrated whole population dataset. The first three to six months require little staff capacity or financial investment, but a lot of energy and enthusiasm by a few local leaders. The next three to six months covers the building of the dataset itself and requires a greater commitment of working-level informatics and finance staff.

Leeds EIS provide a skeleton of the issues to consider during development in the text box below⁵⁸.

Recommended steps to creating an integrated whole population dataset

i) Project management

• Ensure that a project management structure is in place, particularly a project sponsor/champion, engagement from stakeholders, dedicated resources for the project, and a signed-off project plan.

ii) Identify potential uses for the data

- What are the purposes for the data? This will determine your data sources and the data items you wish to include.
- Seek the views of patients. This information should also shape how the information will be used.

iii) Process considerations

- Identify your main data sources.
- Determine the current data flows from these data sources. Can these data flows be altered to supply the integrated whole population dataset (i.e. can extra data items be added?).
- What information governance rules will shape the data flow process?
- How will you formalise the data flow process? Can it be written into existing contracts?

iv) Technical considerations

- Work with stakeholders (at least data suppliers and DSCRO) to determine standardised dataset formats and timescales.
- Work with stakeholders to set up appropriate data sharing agreements.
- Work with your DSCRO to write the technical specification describing how the DSCRO will manage and process the data.

v) Now begin linking data

vi) Working with your integrated whole population dataset

- Develop analyses and processes to deliver outcomes for your current patients, and promote your work to encourage commissioners and providers to use the dataset for the benefit of patients.
- Identify gaps in your data and work towards filling these gaps.
- Identify poor data quality and work towards improving this.

⁵⁷ https://bettercare.tibbr.com/tibbr/resources/596/file.download?_ref_=tibbr, and referenced in

www.gov.uk/government/publications/integrated-care-how-to-comply-with-monitors-requirements/complying-with-monitors-integrat ed-care-requirements.

⁵⁸ From its LTC Year of Care Commissioning Programme case study 'Creating an integrated whole population dataset for the Leeds population'.

5.3.1. Creating a whole population dataset - key learning points

Based on learning from the EISs, the development of an integrated whole population dataset requires:

- Leadership, engagement and enthusiasm from the data source organisations.
- A plan for management and usage of data that is shaped by public opinion. Effort is required to help your population understand what and why you are creating an integrated whole population dataset, and you should use feedback from the public to inform your development.
- Water-tight information governance arrangements developed at the start of the project.
- A single patient identifier used by all data source organisations that is present as a data field in all datasets.
- A data quality improvement plan. Data quality is vital to ensuring that providers and commissioners, clinicians and finance managers will use and believe the output from the integrated whole population dataset.
- A variety of ways to communicate the output from the dataset. Communication should be tailored to different audiences and for different purposes. Communication is important to demonstrate the benefit of the dataset and to help commissioners and providers use the evidence from whole population analysis to shape improved services for patients.

5.4. Information governance

Information governance for person-level linked healthcare datasets is complex, and is made more difficult by the addition of social care data (information governance for social care data is currently different from information governance for healthcare data).

Our EISs have navigated a great deal of upheaval in the information governance landscape caused principally by the reorganisation of NHS organisations in April 2013 and the tightening of information governance rules in response to the 'Caldicott 2' document⁵⁹. These two changes created a great deal of uncertainty that the Information Governance Alliance (IGA)⁶⁰ is now helping organisations to clear up. The IGA have produced a large number of useful documents and make reference to many more⁶¹.

With respect to integrated whole population dataset, our EISs have discussed at length the benefits of clear (patient-identifiable) and pseudonymised datasets, and the information governance consequences of both.

For whole population analysis, records can be pseudonymised. Processes for managing pseudonymised records within an integrated whole population dataset are described in detail elsewhere⁶².

⁵⁹ Information: To share or not to share? The information governance review.

⁽www.gov.uk/government/publications/the-information-governance-review).

⁶⁰ The Information Governance Alliance is a group of national health and care organisations who are working to provider a joined up and consistent approach to information governance. The core members of the IGA include the Department of Health, NHS England, the Health and Social Care Information Centre (HSCIC), Public Health England, the Information Commissioner's Office and the National Data Guardian. (www.systems.hscic.gov.uk/infogov/iga).

⁶¹ www.systems.hscic.gov.uk/infogov/iga/resources

⁶² See LTC Year of Care Commissioning Programme case study 'Whole population analysis – the Kent experience' and the document by Monitor (https://bettercare.tibbr.com/tibbr/resources/596/file.download?_ref_=tibbr, and referenced in

www.gov.uk/government/publications/integrated-care-how-to-comply-with-monitors-requirements/complying-with-monitors-integrated-care-requirements).

Once individuals have been assessed (i.e. care needs have been assessed and patients and their carers have agreed that a care plan would be beneficial) and a care plan developed, then patient consent can be sought for sharing of information. The patient's consent should include data sharing for both clinical reasons (primary use – care planning and clinical service delivery) and for the non-clinical uses (secondary use – the financial transaction process, monitoring performance of service delivery and evaluation of service change).

The grey area in terms of information governance is the identification of individuals for referral for assessment (i.e. case-finding⁶³). All the EISs have developed a set of local rules for selecting individuals who would most likely benefit from personalised integrated care. Most often these rules have been applied within the whole population dataset. The potential difficulty (in terms of information governance) is the 're-identification' of individuals so that these individuals can be referred to care practitioners for assessment of their care needs. Risk stratification and other patient identification methods can be applied to pseudonymised records but, if these individuals are then to be referred to a GP (or other care practitioner) so that their care needs can be reviewed, the patient record must have a patient identifier (i.e. the data must be 'clear' rather than pseudonymised). 'Clear' health and care data for secondary use can only legally be handled by the HSCIC, unless prior patient consent has been obtained or an exception from the Health and Social Care Act 2012 has been granted.

Southend EIS has a temporary (section 251) exemption from the Health and Social Care Act 2012 (within very strict criteria – see text box below) to allow them to link patient identifiable (clear) records within their integrated whole population dataset. They are using this temporary exception until they are able to develop alternative data sharing processes. Their journey, supported by the Information Governance Alliance on behalf of all care economies who are planning to create an integrated whole population dataset, is described in their case study⁶⁴.

⁶³ Case-finding is a term used to describe any method for identifying patients for personalised care management, most often so that better care services can be offered to these patients. A common method of case-finding is the IT-based algorithm using in risk population stratification software, where selection criteria are used to search care usage and diagnosis information in patient records to identify patients. Any case finding using IT-based method should be validated using 'human intelligence' – i.e. a care practitioner should review patients selected using IT-based methods to determine whether they would benefit from the services on offer.
⁶⁴ See LTC Year of Care Commissioning Programme case study 'Information Governance – the Section 251 process at Southend'.

Some of the requirements that Southend CCG were asked to address before final approval of its section 251 exemption application:

- The CCG and the council had to demonstrate that there were strong information governance processes in both organisations, including assurance that commissioners were unable to access any system that may be able to re-identify patient information.
- The CCG had to develop a robust communication plan (including patient information leaflets, posters and a local media strategy) to ensure that patients were fully informed about the reasons for data sharing and outlining the benefits to patients.
- The CCG had to state clearly to patients that it had the right to opt out of the data sharing (which it can do at any time), and describe how it could do this.
- The CCG had to ensure that the GP practices were aware of their legal responsibility as data controllers of the primary care data and, as a consequence, the CCG had to obtain signed consent from all practices approving the receipt of data from its medical care record system and the sharing of this data within the integrated whole population dataset.
- The Commissioning Support Unit (CSU) through which the CCG sourced both nationally-reported and locally-reported data from hospital providers had to demonstrate that it had clear processes for receiving information from HSCIC and providers, and secure processes for sharing the information with the organisation holding the whole population dataset.

5.5. Data quality

Data quality is an often forgotten but essential part of developing an integrated whole population dataset. Much of the data held in an integrated whole population dataset will not have been analysed before to support integrated care, and therefore quality may need to be improved to make it useful for this purpose. Excellent data quality is vital if service and finance managers are to give credence to any whole population analysis based on the data. As Dr Bruce Pollington from Kent EIS states:

"In Kent, we take the quality of our integrated whole population dataset seriously. From an early stage, we understood that the credibility of our dataset was vital to maximising the benefit gained from whole population analysis for commissioners, providers and for patients." As part of the Kent LTC Year of Care Commissioning Programme, a data quality strategy was developed that considered three particular priorities⁶⁵:

1. Data linkage and standardisation (i.e. ensuring there is standardisation in the use of NHS Number such that records can be linked, and standardisation of codes and descriptors such that duplicate records can be identified).

2. Quality profiling and gap analysis (i.e. understanding what data is missing and planning ways to bring this data in), and 'reality checking' and 'triangulation' of data (e.g. comparing costs in the integrated whole population dataset with costs in contracts and budget).

3. Monitoring and consistency over time (i.e. ensuring that dataset formats do not change over time, ensuring that there are automatic processes for rejecting or correcting poor quality data and ensuring that data quality is monitored so that data providers can check their performance).

5.6. Analysis of patients with complex care needs using a whole population dataset

The main reason for creating an integrated whole population dataset is to understand the services delivered to patients. Above (section 5.2), we listed many ways in which Kent EIS are using their dataset.

With respect to patients with complex care needs, our EISs have used their integrated whole population dataset to understand the current services delivered to these patients with a view to supporting the development of **integrated services** and an **integrated payment system**. The early stage of this journey for the West Hampshire EIS is summarised in a case study⁶⁶.

Kent EIS have published a much more extensive analysis describing care usage for patients with complex care needs⁶⁷. The main conclusions from this analysis were:

- Multimorbidity (where individuals have more than one long term condition) is common, particularly for older patients⁶⁸.
- Many individuals with a physical long term condition also have a mental health long term condition, and vice versa.
- There is a strong relationship between the number of long term conditions assigned to patients and the total annual cost of care for these patients (Figure 5), and this relationship is stronger than the relationship between age and the total annual cost of care⁶⁹.
- The higher cost for individuals with more long term conditions is largely a result of greater costs for non-elective care in acute hospitals (Figure 5).

⁶⁶ See LTC Year of Care Commissioning Programme case study 'Development of budgets to support people with long term conditions in West Hampshire'.

⁶⁷ Population level commissioning for the future

⁶⁵ See LTC Year of Care Commissioning Programme case study 'Maximising data quality of an integrated whole population dataset'.

⁽www.nhsiq.nhs.uk/media/2514788/population_level_commissioning_for_the_future.pdf).

⁶⁸ See also paper by Payne et.al., 2013, The effect of physical multimorbidity, mental health conditions and socioeconomic deprivation on unplanned admissions to hospital: a retrospective cohort study.

⁽www.cmaj.ca/content/185/5/E221.full?sid=bce47eec-116a-426d-96bb-f26263857b0e).

⁶⁹ See also Kasteridis et.al., 2014, The importance of multimorbidity in explaining utilisation and costs across health and social care settings: evidence from South Somerset's Symphony Project.

 $⁽www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP96_multimorbidity_utilisation_costs_health_social%20care.pdf).$

- Risk segmentation of a population (selecting those individuals with the greatest risk of an emergency admission in the following year) identifies a different group of individuals than selecting patient using multimorbidity. That is, not all those patients with the highest risk scores have many long term conditions, and not all those patients with many long term conditions have high risk scores.
- There appears to be a crisis curve for the patient cohort with the highest risk score, where patients have high total annual cost of care in the year that they were identified (i.e. a large percentage of selected patients require 'crisis' emergency admission to hospital) and lower total annual cost of care in following years (Figure 6).

This analysis has helped Kent during planning for their Integrated Care Organisations⁷⁰. In particular, information from their integrated whole population dataset has helped them understand the current spread of costs across care organisations (Figure 7). This is necessary information as they plan changes in services and the potential move towards development of capitated budgets.

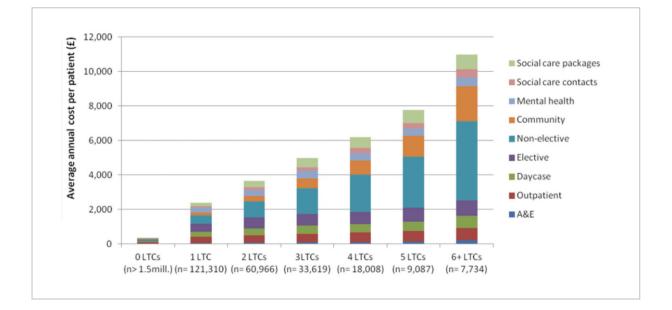


Figure 5 – The association between the number of long term conditions and annual care costs for the Kent population.

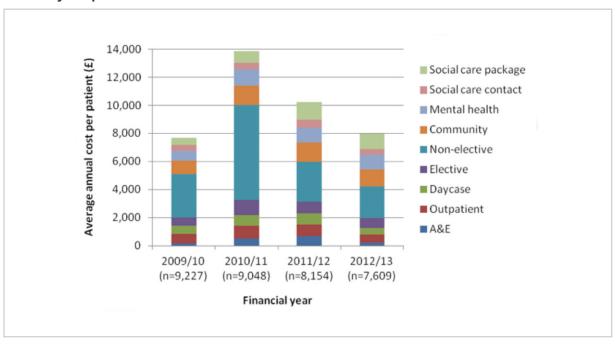
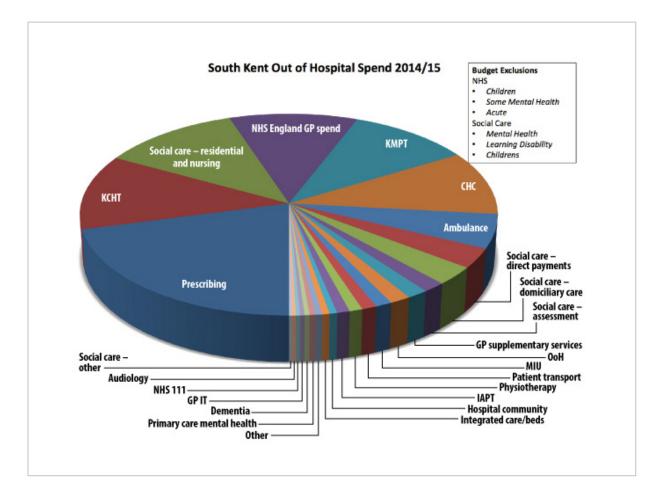


Figure 6 – The 'crisis curve' for the patient group with highest risk scores – the average annual care costs for one group of patients with high risk of admission to hospital over a three-year period.

Figure 7 – The out-of-hospital costs for the South Kent Coast population



5.7. Sharing whole population analysis with others

Creating and analysing an integrated whole population dataset is only part of the story. More important is using this important resource to influence and shape improved services for patients. As Pete Gough from the Kent EIS states:

"The stakeholders in Kent felt that there was little use in creating an integrated whole population dataset if commissioners and providers could not use the information it contained to understand the services used by their patients."⁷¹

The EISs have taken different approaches to sharing information from their integrated whole population datasets. For example, Kent EIS has developed IT dashboards to sit above their integrated whole population dataset to display the data in different ways for different audiences and for different purposes⁷². They have different dashboards for public health colleagues (to help them understand the care usage for the whole population), for service planners (to help them understand services used by particular groups of patients for whom they wish to improve services; e.g. Figure 8), and for analysts (to provide data that they can use for their own analysis).



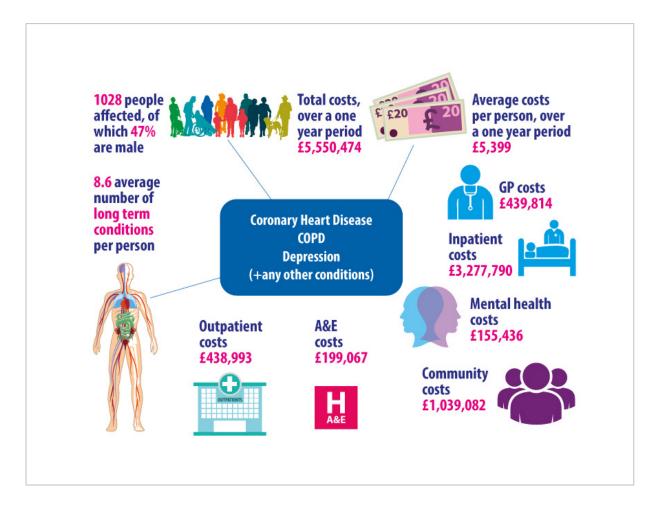
Figure 8 – View of the Kent integrated whole population dashboard

⁷² LTC Year of Care Commissioning Programme case study 'Developing a dashboard to support integrated care'.

In Leeds, the EIS has developed an interactive IT selection tool and datapacks for CCGs and GP practices⁷³. It can take the IT selection tool into meetings to give an instant view of the care usage for groups of patients while service planners are making decisions about the services they wish to develop. The datapacks provide an overview of demographics and care usage for a population or group of patients (Figure 9). GP Practices have found this 'instant view' of their population particularly interesting – it is not a view that they have seen before.

The Leeds datapacks have borrowed display ideas from the Commissioning for Value data packs⁷⁴. The LTC Year of Care Commissioning Programme has worked with NHS England and the RightCare team to help shape future plans for the 'complex patient information' in their Integrated Care Commissioning for Value packs.

Figure 9 – Example sheet from the Leeds data pack, illustrating the care usage for a group of patients with many long term conditions



⁷³ See LTC Year of Care Commissioning Programme case study 'Helping audiences utilise integrated whole population data'.

⁷⁴ www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value, or www.rightcare.nhs.uk/index.php/commissioning-for-value.

As for all other tasks connected with integrated whole population datasets and analysis, communicating information requires planning. The Kent EIS has suggested the following 'top tips' for the development of an IT dashboard linked to an integrated whole population dataset⁷⁵.

Top tips (on the basis that an integrated whole population dataset linked at patient level already exists)

- Work with all commissioners and providers to decide what you want to be reported in the dashboard
- Agree what IT platform will be used (ask yourself which one best aligns with what you are already using for holding and reporting information from the integrated whole population dataset)
- Treat the development of the reporting suites as an exploratory process new ideas may come out of initial attempts and keep the dashboard in developmental mode. Don't consider the work finished once a reporting suite has been published.
- Consider you various audiences. Maybe develop a multi-dimensional cube based on the integrated whole population dataset to enable ad-hoc reporting and investigations.
- Keep all stakeholders involved throughout the process and ensure you have good feedback mechanisms to ensure that what you are developing continues to meet the needs of your users.



6. Planning for service change

6.1. Introduction

In their case studies, the EISs describe many tasks associated with planning for service change that they have undertaken; for example, the work to develop integrated care teams in West Hampshire⁷⁶ and the thoughts behind the development of accountable care organisations in BHR⁷⁷ and South Kent Coast⁷⁸. Here we highlight only two areas: the use of audit and simulation to help gather evidence.

6.2. Simulation to support service planning

Simulation is the imitation of the operation of a real-world process. A simulation model attempts a detailed representation of a real world process such that a planned change to the process can be tested. The LTC Year of Care Commissioning Simulation Model⁷⁹ is an IT-based tool that allows users to test the impact of introducing an integrated care service for individuals with complex care needs.

The LTC Year of Care Simulation Model allows users to compare a planned service change (a scenario) with the current service (baseline) to understand the impact of the planned change in terms of activity, cost and staff resources over a three-year period. The tool can help users answer 'what if' questions – e.g. what would be the impact on costs if we introduced an integrated care service, what annual capitated budget would meet the cost of care for our selected group of patients, what shifts in workforce might we predict if we changed the service we offer to patients?

The tool includes pre-populated scenarios where the service change assumptions are based on research evidence and evaluation of actual service change. These are included to help users understand the types of service change that can be explored using the tool, and to help analysts understand how they might adapt the data within the tool to match local planned service changes.

The tool includes activity and cost data from acute hospital, community, mental health and GP practice services, and has the facility to add social care activity and cost data and data from other services. Care economies can use the data already in the tool to test the impact of a planned service change, or can replace the data in the tool with local data to adapt the simulation more closely to the local population, a local population cohort and a local planned change.

The tool includes 'real life' data from the BHR EIS. The output can be used as an informed estimate of the likely shift in funds and workforce necessary to support the implementation of an integrated care service (for example Table 3). In this example, we have assumed that an enhanced primary/community/mental health integrated service would result in a shift in service out of acute hospitals into the community.

- 78 See LTC Year of Care Commissioning Programme case study 'Integrated care organisations in East Kent'.
- ⁷⁹ See www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/ltc-year-of-care-commissioning-model/ long-term-conditions-year-of-care-commissioning-simulation-model.aspx to download the IT tool and to access user guides, a demonstration video and FAQs about how, why and when you should use the tool.

 ⁷⁶ See LTC Year of Care Commissioning Programme case study 'Engaging with patients to develop integrated care teams'.
 ⁷⁷ See LTC Year of Care Commissioning Programme case studies 'The Wellness Practice – Health 1000' and 'Choosing staff for an accountable care organisation'.

These results show that the new integrated service (scenario) would be less expensive to deliver for patient cohorts 1 and 2 (those with the most complex care needs), but more expensive to deliver for patients with less complex care needs (cohort 4).

A recent evaluation of the costs of the BHR EIS Health 1000 complex care practice by the Nuffield Trust almost exactly replicated these predictions. This evaluation found that, if BHR EIS relaxed its entry criteria for the recruitment of patients (i.e. it began recruiting patients with less complex care needs), then the integrated service model that it has in place would no longer be financially viable.

Table 3 – Output from the LTC Year of Care Simulation Model	
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Percentage of total population	Number of patients	Mean annual care cost per patient (£)		
		Current (baseline)	New service (scenario)	
Cohort 1 (0% to 0.5%)	2,854	£10,179	£9,854	
Cohort 2 (0.5% to 2.0%)	9,203	£7,454	£7,341	
Cohort 3 (2.0% to 5.0%)	19,930	£4,537	£4,555	
Cohort 4 (5.0% to 10%)	33,941	£3,085	£3,136	

The EISs have used the tool as one input to the service change planning process, in particular to understand the likely impact of a new service model (i.e. a GP practice-based accountable care organisation) on existing services.

6.3. Using rehabilitation, recovery and reablement clinical audits to support service planning

Rehabilitation, recovery and reablement (RRR) describes the phase of care following an acute intervention. For example, a patient receives hip replacement surgery. After the operation, once the patient is medically stable, they receive care that is no longer 'acute', but is aimed at aiding their RRR from the surgery.

RRR care can be received in a variety of settings – in the acute hospital, in step-down facilities or at home. To ease pressure on capacity in acute hospitals and to improve the experience for patients, it would be beneficial if patients did not receive RRR care in acute settings but were discharged to home or community setting. The aim of the RRR element of the programme was to "improve the quality of patient care and outcomes by delivering a seamless RRR service for acute admitted patients – based on their clinical and bio-psycho-social needs, rather than just their diagnosis or where the care is currently delivered"⁸⁰.

The EISs undertook RRR clinical audits to gather evidence about the discharge process from acute care following admission for chronic conditions, with a view to encouraging earlier safe discharge from hospital. The step-by-step guide published as a result of their experiences describes the audit methodology, an audit report presents an analysis of their results, and an RRR simulation IT-tool is available to help care economies predict the impact of a change to the discharge planning processes⁸¹.

The RRR clinical audits were developed as a way to gather evidence to support the unbundling of RRR services from the acute national tariff, so that funds from the national tariff would be made available to deliver these services in alternative settings (i.e. at home or in the community) if this was found to be the most appropriate setting. This is ongoing work.

The EISs found the RRR clinical audits to be very useful in understanding the blockages to their current discharge processes. About half of the patients who required RRR services were delayed in hospital because services were not immediately available in the community (Figure 10). Discharge from hospital was delayed for these patients because:

- Suitable services did not exist in the community.
- Patients were waiting for an assessment by community, mental health or social care staff, including waiting for assessment for a change in care plan from an integrated care team.
- Patients were waiting for residential accommodation (in a step-down facility, nursing home or social care facility).
- Patients were waiting to be discharged home because the home was not suitable (i.e. a carer was not immediately available or the home required some modification) or a care package could not be put in place immediately to support the patient in their home.

Some of the EISs have used the evidence from their RRR audit to help integrate and streamline discharge planning from acute hospitals and intermediate care support for patients on discharge.

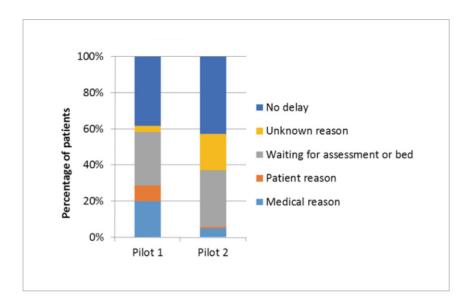


Figure 10 – Delay in discharge from acute care for patients with chronic conditions assessed as having a need for RRR care.

⁸¹ 'Unbundling recovery: a step-by-step guide to audit and modelling', and 'Unbundling recovery: recovery, rehabilitation and reablement national audit report'

(www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/ltc-year-of-care-commissioning-model/long-term-conditions-year-of-care-commissioning-unbundling-recovery-simulation-model.aspx).

7. Calculating a capitated budget

7.1. Introduction

One of the main objectives for the LTC Year of Care Commissioning Programme was to support EISs to develop a capitated budget for patients with long term conditions⁸². The expectation is that an **integrated payment system** aligned with integrated service delivery will incentivise care provider organisations to work together. The **integrated payment system** chosen for the programme was a Year of Care tariff for each individual in a patient cohort based on agreed currencies, where the sum of individual person tariffs calculates a capitated budget. The capitated budget should pay for all care services required by individuals in the patient cohort⁸³.

7.2. Selecting a patient cohort

The planned or piloted Year of Care tariffs and the total capitated budgets calculated by each EIS were different, because local circumstances determined that the budget apply to a different patient group or different service model⁸⁴. However, the steps for development of the capitated budget used by all EISs were essentially the same:

- Define the patient cohort and services to be included within the capitated budget.
- Use historical costs to set a capitated budget value (baseline).
- Modify this budget value to take account of the new service model being put in place and changes in the use of services over time.

The EISs have spent a great deal of time discussing the first of these bullet points, and much of the whole population analysis undertaken as part of the LTC Year of Care Commissioning Programme⁸⁵ has investigated the last two of these bullet points.

Some of the discussion and conclusions from the EISs about the selection of a patient cohort for a capitated budget is captured in the case study 'Identifying the LTC Year of Care patient cohort'⁸⁶. The main learning from the EISs is:

• Different IT-based (population stratification) selection methods identify different groups of patients. It appears that selection of patients based on multimorbidity criteria identifies a more stable patient cohort (i.e. the patient turn-over from one year to the next is lower) than selection based on risk stratification.

 ⁸² 'QIPP Long term conditions: Supporting the local implementation of the Year of Care Funding Model for people with long-term conditions' (www.gov.uk/government/publications/qipp-long-term-conditions-year-of-care-funding-model-early-implementers).
 ⁸³ While the ultimate goal is to include all care services required by individuals in the patient cohort, the LTC Year of Care Commissioning Programme case study 'Selecting services for a capitated budget' discusses a number of current difficulties that EISs have encountered when attempting to include all services. In reality, most EISs are considering excluding some services at this point in time. For this reason, when we state 'capitated budget' in this handbook, we really mean 'partial capitated budget'.
 ⁸⁴ See LTC Year of Care case studies 'Identifying the LTC Year of Care patient cohort' and 'Selection of services for a capitated budget'.

⁸⁵ For example, Population level commissioning for the future

⁽www.nhsiq.nhs.uk/media/2514788/population_level_commissioning_for_the_future.pdf), but also see 'Whole population analysis and understanding your population' in this guide.

⁸⁶ www.nhsiq.nhs.uk/media/2753646/patient_cohort_case_study.pdf

- The selection of patients should be rules-based (to maintain objectivity for the selection of patients), but that the rules might be both an IT algorithm and clinical. Certainly, if an IT algorithm is used, then selection should be a two-stage process with patients selected by the IT algorithm reviewed by a care practitioner (i.e. there is a need for 'human intelligence' to support any 'IT-based intelligence').
- There should be a direct link between the selection rules and the service model; i.e. the selection rules should be set such that the patient group who would most benefit from the service model is identified. This should also ensure that financial risk for the capitated budget is reduced because patients with similar care needs (and similar resources needs to pay for these services) are selected.
- To ensure that financial risk is not too high, the patient cohort must be of reasonable size⁸⁷.

During the early stages of the LTC Year of Care Commissioning Programme, the EISs tested whether the NHS continuing healthcare Decision Support Tool (DST)⁸⁸ could be used to reliably select patients suitable for a capitated budget. They found that the identification of patients using the tool was strongly influenced by the assessor, and thus this tool was unlikely to be useful for selecting a consistent set of patients across different care economies. However, within a single care economy, the DST could potentially be used alongside an IT algorithm as the rules-based 'human intelligence' method for identifying patients suitable for a capitated budget.

Kent EIS are testing another method of identifying patients for a capitated budget⁸⁹, they are identifying patients whose risk stratification score has been increasing over the past months. This method was developed in response to analysis that illustrated that risk scores (risk of emergency admission population stratification scores) tend to identify patients who are currently using high cost care services (mostly non-elective acute care services), and that risk score and care usage tend to decrease once patients have been identified (Figure 6)⁹⁰. Kent EIS wished to identify patients before they reached this 'crisis' stage, in time to put in place an intervention service that could prevent the 'crisis'. The method is still undergoing testing to understand whether the patients selected are a better 'fit' to the support services in place for this group than other selection methods.

Regardless of the method used to select patients, there will be changes in the resources required to support care for the patient cohort over time. The capitated budget must be set at a level to take account of these changes, and/or must be flexible. There are three particular changes in resource use over time that our EISs have considered⁹¹:

• The change in use of care resources by the patient cohort – i.e. the 'crisis' curve identified by Kent⁹², or the propensity of patients in the cohort to require more services over time (i.e. greater proportion of patients becoming frail or requiring 'end-of-life' services).

⁸⁷ This has been described as volatility risk (see Buckle and Davies (2015) 'Shared risk programmes and considerations for Clinical Commissioning Groups and prime providers'

⁽http://uk.milliman.com/insight/2015/Shared-risk-programmes-and-considerations-for-Clinical-Commissioning-Groups-and-prime-provi ders). A rough guide to the impact of cohort size on financial risk is presented in the Monitor paper 'Capitation: a potential new payment model to enable integrated care'

⁽www.gov.uk/government/publications/supporting-innovation-in-the-nhs-with-local-payment-arrangements). ⁸⁸ Decision support tool for NHS continuing healthcare

⁽www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhsfunded-nursing-care).

 ⁸⁹ LTC Year of Care Commissioning Programme case study 'Using risk scores as selection criteria for Year of Care patients'.
 ⁹⁰ 'Population level commissioning for the future'

⁽www.nhsiq.nhs.uk/media/2514788/population_level_commissioning_for_the_future.pdf).

⁹¹ See LTC Year of Care case study 'Identifying the LTC Year of Care patient cohort'.

⁹² 'Population level commissioning for the future'

⁽www.nhsiq.nhs.uk/media/2514788/population_level_commissioning_for_the_future.pdf).

- The difference between patients joining the cohort and those leaving the cohort i.e. many patients leaving a cohort might be using end-of-life services, whereas those joining the cohort might require less costly services.
- Changes in the services offered to patients over time for example, as our EISs have begun to implement integrated care service, they have modified the service model to improve the effectiveness of services for patients. The change in service model has resulted in changes to the cost of the services delivered to patients.

7.3. Selecting services

The ultimate aim of a capitated budget is that it should cover the cost of all care services that patients need. The EIS teams have identified four main reasons where, at this point in time, it may be difficult to include some services within a full capitated budget⁹³:

- There are a few high cost, small volume services (i.e. residential services) where the financial risk of including these costs within a capitated budget is high until more is understood about the variability in costs for these services or unless some mechanisms for mitigating financial risk associated with these services is in place.
- There are some services for which high quality cost data are not available (e.g. services funded using block payments⁹⁴ for which there is no activity data) where historical data does not allow an accurate estimation of a future budget. Also, tracking funds for these services as part of the financial transaction process for a capitated budget may be difficult.
- If we accept the premise that the main reason for introducing a capitated budget is to incentivise service providers to work together and that the transaction process for a capitated budget should not be more complicated than existing financial transaction processes⁹⁵, then there are some services that should not be considered for inclusion in a capitated budget (i.e. out-of-area services, and services currently commissioning by NHS England (excluding primary care services).
- There are some services not traditionally considered as 'care' services that have benefit for patients' health and wellbeing (e.g. council leisure services). These services might not be part of an initial capitated budget, but it would be useful to develop some way to incentivise inclusion within an integrated care service.

Further to this last bullet point, the EISs wish to make it clear that there can be a distinction between the services that are part of an integrated service model and services that are part of the capitated budget. For example, residential services and council leisure services might be part of the integrated care package offered to patients even though payment might, at present, occur outside of the capitated budget for these services.

Figure 11 presents the general view of EISs in terms of services for inclusion within the capitated budget.

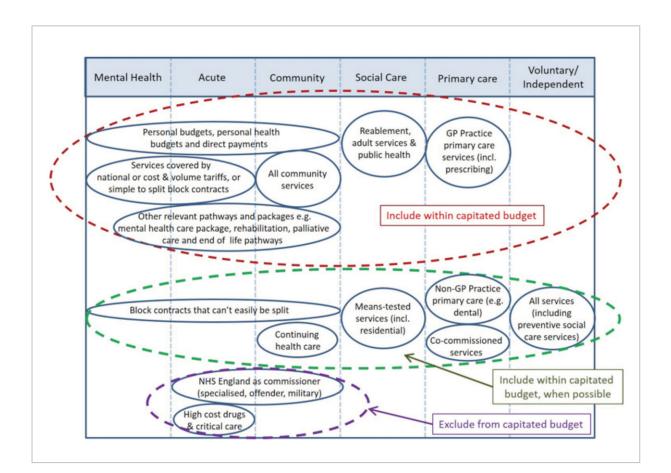
⁹³ See LTC Year of Care case study 'Selection of services for a capitated budget'.

⁹⁴ Block payment = a payment for a whole service regardless of the activity or the number of patients who use that service.

⁹⁵ 'QIPP Long term conditions: Supporting the local implementation of the Year of Care Funding Model for people with long-term conditions' (www.gov.uk/government/publications/qipp-long-term-conditions-year-of-care-funding-model-early-implementers: accessed 25 September 2012).

Figure 11 – Services that EISs are considering for inclusion within a LTC Year of Care capitated budget

In practical terms, handing over a capitated budget to an organisation at the same time as introducing a new service model may be difficult. This might be too much change all at once. For example, the BHR EIS set a capitated budget to pay for the care of patients with complex care needs within its Health 1000 accountable care organisation⁹⁶. The capitated budget was underwritten by the CCG for a period of time until it could more accurately understand the change in costs over time, understand the true costs of the new service delivery model, and until it could recruit enough patients into Health 1000 to ensure that the service model was financially viable⁹⁷.



⁹⁷ See LTC Year of Care case study 'The patient journey at an accountable care organisation'.

7.4. Technical considerations when calculating a capitated budget in Southend

Southend EIS has described its thinking and discussions with service providers about the calculation and management of a capitated budget in a series of case studies for the LTC Year of Care Commissioning Programme. It describes its current approach to understanding how it might calculate a capitated budget, the changes to current information and financial systems and processes that it is planning, and the discussions it is having with service providers about the management of financial risk.

The technical work at Southend EIS and other EISs is supported by a series of papers published by Monitor and NHS England to support the transition towards capitated budgets for integrated care services⁹⁸.

The current Southend EIS approach for the calculation of a capitated budget splits the patient cohort into a large number of categories based on the number and type of long term condition. Each category has a separate Year of Care tariff⁹⁹ with the aim of providing it with a flexible way to manage changes in the budget as the patient cohort changes. As patients die or their care needs change, or as new patients join patient cohort, the planned capitated budget can be easily adjusted by summing the individual Year of Care tariffs for each patient. It is using this facility to help it understand the potential changes in cost over time, with a view to setting a budget large enough to account for these changes during a year or to setting a budget with the ability to set a varying monthly payment schedule (like most CCGs already have in place with acute providers to account for season variations) if the costs change significantly.

The EIS's method also considers the impact of 'outliers' (those many patients in a cohort with very low annual care costs, and those few patients in the cohort with very high annual care costs) on the calculated capitated budget. By removing outliers from the budget, its calculated budget more accurately represents the annual care cost of the majority of patients in the cohort.

Southend EIS have also been planning for the changes needed to the financial transaction process for a capitated budget (i.e. changes to the existing financial transaction process for current budgets)¹⁰⁰. The capitated budget process must track payments at the patient level, compared with most existing payment processes which track payments at the provider or service level (not that a patient payment approach is unknown within the NHS). Payment for services in which case management is normal (i.e. Year of Care tariff for patients with cystic fibrosis, or payments for many specialised mental health services) will likely be calculated per patient.

98 'Capitation: a potential new payment model to enable integrated care'

(www.gov.uk/government/uploads/system/uploads/attachment_data/file/381608/MultiYearTariffFTI.pdf); 'Guidance on locally determined prices' (www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor). ⁹⁹ See Year of Care Commissioning Programme case study 'Calculating a capitated budget – modelling Year of Care tariffs'. Note,

the method described in this case study 'Southend looks to GP Hubs to embed capitated year of care budgets'.

¹⁰⁰ See Year of Care Commissioning Programme case study 'Calculating a capitated budget – setting up to manage the budget'.

⁽www.gov.uk/government/publications/supporting-innovation-in-the-nhs-with-local-payment-arrangements); 'Reforming the payment system for NHS services: supporting the NHS Five Year Forward View' (www.england.nhs.uk/resources/pay-syst/); 'Research on financial and non-financial incentives

⁽www.gov.uk/government/uploads/system/uploads/attachment_data/file/381930/FinanciaNonFinancialIncentives.pdf); 'Review of multi-year national tariff cycles'

The main reasons for a patient-level financial transaction process for a capitated budget is to prevent double payment for activity¹⁰¹. Southend EIS considers three things essential to prevent double payment:

- A register of patient who are part of the Year of Care cohort that includes the dates when patients join and leave the cohort, accessible to both providers and commissioners.
- A clear understanding of the services included for payment from within the capitated budget, i.e. a service map or register agreed by both commissioners and providers.
- The ability to tag activity records as they flow through national and local activity datasets.

Southend EIS has begun discussions with service providers as it moves towards implementing capitated budgets¹⁰². Much of this discussion has centred around the management of financial risk, particular during the early stages of the capitated budget when budget estimates might be poorer and the service model to which the budget is attached is 'bedding down', and setting up rewards to ensure that service providers are incentivised to work together.

For the management of risk, the discussion has focussed mainly around two elements: the CCG holding the risk for a period of time until the service model is in place and budget estimates are better; and setting longer term budgets so that annual budget under and over spend can be shifted between years.

Southend EIS believes there should be a link between the capitated budget and outcome metrics. It plans to use outcome metrics both to incentivise providers to deliver **integrated services** and to measure performance. It believes that outcome metrics are required at both the population or integrated service level (i.e. including service delivered by many providers) as well as at the individual provider or service level, and that both financial and other types of incentives should be considered.



¹⁰¹ For example, payment for a community contact for a patient within the Year of Care cohort should be paid from within the capitated budget but, unless both the provider and commissioner understand that this activity should be excluded from the community block contract, then there is potential for payment also from this budget. Potential for double payment is one of the financial risks listed by Monitor and NHS England in their paper 'Capitation: a potential new payment model to enable integrated care (www.gov.uk/government/publications/supporting-innovation-in-the-nhs-with-local-payment-arrangements).
¹⁰² See LTC Year of Care Commissioning Programme case study 'Calculating a capitated budget – managing financial risks associated with a capitated budget'.

8. Implementing service changes

8.1. Introduction

The overarching objective for the LTC Year of Care Commissioning Programme was to improve outcomes for patients with long term conditions through integrated care services. The initiation document for the programme¹⁰³ states:

"It (the programme) is aimed at health and social care commissioners and providers who are implementing integrated LTC care services to improve outcomes and experience for people."

Over the four years of the programme, the EISs have tested and piloted various techniques and approaches towards putting in place integrated service models for the benefit of patients.

8.2. Common features of service models

The two examples below and the planned service models of the other EISs suggest that there are a number of features that are common to integrated care service models within the LTC Year of Care Commissioning Programme:

- Development of integrated **multi-disciplinary teams** with particular focus on delivering primary, community and social care services, and integrating with acute and mental health care services.
- **Single assessment** of care needs by the integrated multi-disciplinary team.
- **Co-production of a care plan** by patients, carers and members of the integrated multi-disciplinary team.
- **Care co-ordinators** (generally clinical) and **care navigators** or similar non-clinical service workers as part of the integrated multi-disciplinary team, to support the well-being of patients.
- Encouragement of self-help and **self-management** of conditions by providing information, training and support to patients and carers.
- A shared care clinical record and shared care plan.

All of these features are illustrated in the EIS case studies – in particular the series of case studies written by the West Hampshire and BHR EISs. Here, we wish to illustrate a few of features.

8.3. The BHR pilot – Health 1000

BHR was the first of the EISs to implement a pilot service delivery organisation. Their Health 1000 **accountable care organisation** is purposely limited to a maximum of 1000 patients with complex care needs as a first step toward full implementation of place-based services for all patients.

To these patients, the Health 1000 complex care practice offers a combined primary, community, mental health and social care integrated service that delivers personalised and responsive care seven days a week. The **multi-disciplinary team** delivering these services consists of nurses, GPs, hospital consultants, physiotherapists, geriatricians, occupational therapists, social workers and voluntary care navigators. They help patients manage their health and wellbeing, and help them to stay out of hospital and remain independent for as long as possible¹⁰⁴.

Patients with many long term conditions (multimorbidity) are selected as eligible to join Health 1000. Mostly these are elderly patients. Selected patients are referred to their GP, and the GP undertakes an initial **assessment** of the patient's needs – most often inviting the selected patient in to the practice for an appointment. If the patient chooses to move, they deregister from their current GP practice and re-register with Health 1000¹⁰⁵.

New patients might be seen by Health 1000 staff many times during the first month to ensure that they receive all the services from which they might benefit. A **care plan** is developed by the Health 1000 staff in conjunction with the patient. As well as clinical care goals and expectations, the care plan also incorporates information about the patient's wellbeing gathered during a 'guided conversation' undertaken by volunteer AgeUK **care navigators**. The care plan is regularly reviewed – Health 1000 staff hold twice-weekly review meetings to discuss and adjust care plans and to adjust the management of care for patients.

Unusually for a GP practice, the organisation is led by a **consultant geriatrician** rather than a GP. This clinical lead was chosen because the Health 1000 stakeholders felt that a geriatrician would have a wider knowledge of the care needed by the majority of Health 1000 patients.

Another unusual feature of the staffing model for Health 1000 is the **key worker**. This position is a new type of healthcare worker – part administrative officer, part nursing assistance, part patient advocate¹⁰⁶. The key worker works for the patient – managing appointments and regularly phoning patients and care practitioners to ensure that patients are receiving the services they require. They undertake medicine management for the patient – dressing wounds, linking patients with social support, and working with the patient to understand their conditions and treatments.

Communication is a key part of the Health 1000 service model. The key workers and volunteer care navigators speak to the patient often to help them manage their own care and to communicate patient needs to the care professional team between appointments. All Health 1000 patients have a **shared care record** that allows clinicians in local service providers to easily and quickly access medical history.

¹⁰⁴ See LTC Year of Care Commissioning Programme case study 'The Wellness Practice – Health 1000'.

¹⁰⁵ See LTC Year of Care Commissioning Programme case study 'The patient journey at an accountable care organisation'.

¹⁰⁶ See LTC Year of Care Commissioning Programme case study 'Choosing staff for an accountable care organisation'.

8.4. Integrated care teams in West Hampshire

West Hampshire EIS undertook an extensive **engagement** exercise that brought together patient and care practitioner views on the care they wanted (including from the National Voices' principles for integrated care¹⁰⁷) with learning from integrated care service transformation programmes elsewhere in England and overseas¹⁰⁸. This exercise helped the care economy develop their integrated service model, but was also used to develop a set of **outcome metrics** upon which success of the services will be measured.

The resulting service is organised around the needs of individuals. At its heart is the **integrated care team**, led jointly by primary care, community and social care practitioners. The integrated care team can call upon support care practitioners from across the system – consultant geriatricians, specialist nurses, pharmacists, mental health practitioners, therapists and care navigators.

Patients are selected using IT-based methods or through referral to the community team, and their clinical notes are reviewed by the GP or community care practitioner before being brought to **'whiteboard' meetings**¹⁰⁹. The whiteboard meeting is where **care coordination** happens. It is where **care plans** are initially developed (and then later, fully developed in conjunction with patients) and reviewed, where care practitioners liaise with each other about the delivery of care to patients, and where the care and wellbeing needs of patients are brought together to ensure that the delivered service is holistic.

8.5. Developing the workforce for integrated care teams

A critical element (and challenge) of delivering integrated care services for South Kent Coast region of the Kent EIS is a sustainable and skilled future workforce¹¹⁰.

Upon gathering evidence to support the development of workforce plans, the programme team found that primary care was of particular concern. A future shortage of GPs and a number of imminent retirements are expected – all at the time when the workload for primary care services is increasing. The programme team needs to address this issue before integrated care services can be put in place.

The South Kent Coast programme team worked with universities across Kent, Surrey and Sussex to develop workforce plan for both the short term and long term. As part of this partnership, a series of packages are being developed that provide guidance and advice on the development and delivery of education and training to ensure future workforce is fit for practice, realistic and affordable.

The universities and the programme team have also facilitated workshops for frontline clinicians and practitioners across health, social care and the voluntary sector, focusing on the skills required to deliver integrated care services. These workshops are developing a common purpose, a genuine sense of affiliation and a common code of ethics across the local clinical and care community (with quality as the primary focus). Feedback from the workshops is also feeding into the development of a future workforce plan, including (hopefully) creative ways to address the shortage of GPs issue.

¹⁰⁷ National Voices (www.nationalvoices.org.uk/principles-integrated-care)

¹⁰⁸ See LTC Year of Care Commissioning Programme case study 'Engaging with patients to develop integrated care teams'.

¹⁰⁹ See LTC Year of Care Commissioning Programme case study 'Using whiteboard meetings to deliver integrated care for patients'.

¹¹⁰ See LTC Year of Care Commissioning Programme case study 'Integrated care organisations in East Kent'.

Part of the South Kent Coast ethos is to "grow our own" future workforce locally. Both BHR and West Hampshire EISs have taken similar approaches to develop staff for roles for which there is no formal training. For example, upon commencing as care navigators the staff tend to have a range of skills and experiences which, while potentially useful for aspects of the care navigator service, need to be enhanced to fulfil the particular service that care navigators provide¹¹¹.

BHR EIS have created a new type of 'key worker' for their Health 1000 accountable care organisation (see section 8.3). The recruitment of 'key workers' was difficult because the roles were new and required a diverse set of skills. No-one interviewed for the 'key worker' positions had a complete set of the skills and experience required, so Health 1000 set up in-house training to equip the new staff to these positions. For example, part of their training equipped them to undertake some phlebotomy tasks within patients' homes.

8.5.1. Care navigators

Care navigators are a feature of both the BHR Health 1000 and the West Hampshire integrated care services¹¹² They are non-clinical staff who focus principally on the wellbeing of patients and helping people lead independent lives. Care navigators might advise patients on issues such as keeping warm, safe, fit and eating well. They work to reduce social isolation, and direct patients to social or leisure facilities and help them to access these services. Care navigators create a non-formal and non-clinical link between the patient and carers and care practitioners – informing the care practitioners of needs and goals that are less likely to be identified in a formal care setting (e.g. a GP practice appointment).

The Eastleigh Southern Parishes Network (ESPN) care navigation service is part of the West Hampshire care economy. This service commenced in early 2015 with the appointment of five care navigators.

The care navigators in this service have shifts that span seven days a week across the five practices that make up the network. There is a named care navigator who attends integrated care team 'whiteboard' meetings¹¹³. The five care navigators generally work as a team, but each has an individual list of patients best supported by their individual skills and availability.

One of the main tasks for care navigators is to ensure that the patient and carers understood their care plan. They provided reassurance, allowed time for discussion, confirm that the care plan meets the patient's need, gather feedback from the patient and carers about whether the plan is right for them, and discuss wellbeing and social issues. This information is fed back to the clinical team to help adjust the care plan.

The feedback from patients on the success of the care navigator service has been overwhelmingly positive. Here are a couple of the comments received from patients:

"Well done NHS. Something for once that actually helps us to stay as independent as possible."

"The care navigator actually takes time to get to know you and not just the surface things. She actually talks to me about ME and she made me feel important again and I haven't felt like that in a long time."

8.6. The Leeds shared care record

Leeds, BHR, West Hampshire and some CCG areas of Kent EIS all have a shared care record, where clinicians have access to clinical details and care plans for patients collated from many the local care providers.

For example, the Leeds Care Record (LCR) is the locally developed shared care record¹¹⁴. It was developed after extensive patient **engagement**, and after overcoming some significant information governance and interoperability¹¹⁵ hurdles. Patient records from GP practices, community, mental health, acute and social care providers are brought together to give care practitioners a broad view of a patient clinical details, including diagnostic information, test results, allergies, medications and discharge information (Figure 12). There are plans to further expand the range of local providers whose information is brought together, and to develop methods so that patients have control over the information that is shared.

The main advantages of a shared care record are: patients are happier because they are no longer asked the same medical history questions by different staff; clinicians can make more informed decisions about patient care; and care practitioners have more time with patients because they do not need to spend as much time chasing up information by phone or fax¹¹⁶.

Probably the main direct advantages of a shared care record have been for staff. Dr Adrian Rees from the Leeds EIS states:

"I have found it (the Leeds LCR) an invaluable aid to my clinical practice. It gives me a window into the hospital – I can see when my patients have appointments and which have been admitted to hospital, and it allows me to view letters and results that may have not yet arrived at the practice. It has saved a considerable amount of practice administration time – our administration staff no longer have to spend hours on hold on the telephone trying to find out when the patient's next outpatient appointment is. It is a really useful and easy-to-use system that bridges a major health care gap in the city."

¹¹⁴ See LTC Year of Care Commissioning Programme case study 'The Leeds Shared Care Record'.

- ¹¹⁵ The technical term used to describe the ability of different IT systems to exchange data.
- ¹¹⁶ See LTC Year of Care Commissioning Programme case study 'The Leeds Shared Care Record'.

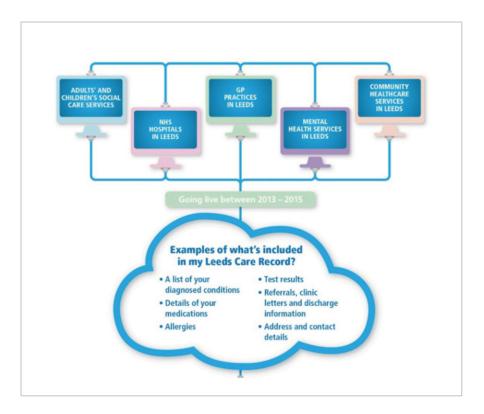


Figure 12 – Illustration of the data sources for the Leeds Care Record

8.7. Kent contract and compact agreement

The South Kent Coast region within the Kent EIS has a good relationship between all commissioners and providers. These organisations have a joint commitment to work towards delivering integrated care. They recognise that to achieve better outcomes for patients, everyone must play their part working towards the same goals. The organisations have used this relationship to select a contract type that works for them.

Kent EIS commissioned the University of Kent to help them understand contracting and service delivery models from England and overseas¹¹⁷. The preferred locally-developed contract model is most similar to alliance contracts used elsewhere¹¹⁸.

As a step towards implementing its contract, it has formalised a set of principles by including them in a compact agreement that is part of all commissioner-provider contracts. This has only been possible because all commissioners and providers have committed to shared accountability for outcomes and have shared ideas about how the local organisations work together. The compact agreement will be expanded into a contract by the legal work-stream, one of the four main work-streams within the South Kent Coast programme.

¹¹⁸ Barnsley, another LTC Programme site, are also developing an Alliance-type contract, see

www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/ltc-year-of-care-commissioning-model/rightcar e-barnsley-case-study.aspx

¹¹⁷ See LTC Year of Care Commissioning Programme case study 'Developing service and contracting models for integrated care of the Kent population'.

9. Evaluation and planning for the future

9.1. Introduction

The experimental nature of the LTC Year of Care Commissioning Programme incorporated an expectation that EISs evaluated the processes and service models that they tested. Evaluation is part of the learning process upon which EISs planned improved processes and service models.

In addition to evaluation at the programme level, the EISs have included evaluation as a key part of the **integrated services** that they offer to patients. Gathering patient feedback regularly is one information source that the multi-disciplinary teams use to adjust care plans. This feedback, along with other outcome measures, is also used to assess the quality of **integrated services**, and is eventually expected to be used to adjust payment to providers.

Here, we describe some of the evaluation that the EISs have undertaken – both to assess the success of the processes and service models that they have tested, and to assess the quality of services delivered to patients. We then briefly describe how this evaluation has translated into the development of future plans for integrated care services by EISs.

9.2. Evaluation of processes and service models

9.2.1. The BHR pilot – Health 1000

The PDSA¹¹⁹ learning approach recommended by the LTC Year of Care Commissioning Programme is clearly illustrated by the pilot testing of Health 1000 by BHR EIS. They planned the Health 1000 service model (Plan), set it up (Do), evaluated success (Study) and are now planning and implementing their next integrated care developments (Act).

BHR EIS used a matched cohort evaluation methodology to evaluate Health 1000. This methodology¹²⁰ matches patients within Health 1000 to similar patients outside of Health 1000 (Figure 13). The comparison of the activity and cost, patient experience and outcomes for these two groups of patients provided an assessment of the impact of the service. The evaluation also included staff experience of the new service.

Based on the evaluation, both staff and patients believed the Health 1000 service to be beneficial, and the analysis indicated that the service was having a beneficial impact on patient's care and wellbeing. Some care for Health 1000 patients has shifted out of hospital¹²¹. Some specific feedback included:

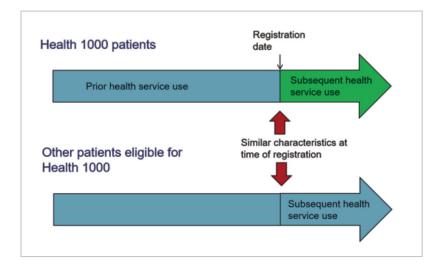
- Patients experience was particularly positive for the regular medication reviews, the focus on the quality of life and the continuity of care.
- Patients considered that the distinct ethos of Health 1000 compared favourably with existing primary care services. They described Health 1000 as personalised, friendly, positive and enthusiastic.
- Staff felt that the Health 1000 integrated care team was delivering a more coordinated and higher quality service.

(www.nuffieldtrust.org.uk/publications/evaluation-complex-health-care-interventions-using-retrospective-matched-control-analysis). ¹²¹ See LTC Year of Care Commissioning Programme case study 'Learning from our pilot to plan for the future'.

¹¹⁹ Plan, Do, Study, Act (see Handbook introduction chapter).

¹²⁰ This methodology is explained by, for example, the Nuffield Trust report 'Evaluation of complex health and care interventions using retrospective matched control methods

Figure 13 – Illustration of the patient comparison groups in a matched cohort evaluation study



The quantitative evaluation of Heath 1000 was hampered to some extent by the slow recruitment of patients¹²². BHR EIS thought that patients would all wish to receive the comprehensive services that Health 1000 offers, but many were happy with the service they are receiving from their current GP. BHR EIS also thought that GPs would be happy for their patients with complex care needs to receive the extra services that Health 1000 offers, but this hasn't always been the case. Because Health 1000 is a pilot for two years, what happens at the end of this period has been an issue for both patients and GPs.

In response to this difficulty, BHR EIS undertook a range of actions to improve the rate of patient recruitment. They relaxed their entry requirement for eligibility to Health 1000 so that family members of edible patients could also join (their evaluation highlighted that some patients were reluctant to join Health 1000 unless their spouse or carer were also able to join). They undertook a broad communication campaign with GPs to help them understand the Health 1000 concept and to outline the transition strategy for patients at the end of the two year period. They also brought in some financial incentives for GPs to encourage them to promote the benefits of the Health 1000 service to patients. These efforts have resulted in an increase in the rate of patient recruitment.

Patient recruitment was only one of many changes to the service put in place as a result of evaluation. Changes were made to the services within Health 1000 and to services that link with Health 1000 (i.e. the team worked to better align services delivered by physiotherapy and social care teams by local authorities), including IT and administration processes, workforce planning and training, and communication¹²³.

¹²³ See LTC Year of Care Commissioning Programme case study 'Learning from our pilot to plan for the future'.

9.2.2. Leeds Care Record

Because of the sensitivity of patient information sharing, Leeds EIS put much effort into **communication** with patients about the purposes for and uses of patient data as part of the development of their Leeds Care Record¹²⁴ (shared care record). They used their communication strategy to gather the views of patients about information sharing (to help them develop a shared care record that matched with people's expectations and requirements) and also to inform patients about the local changes that the Leeds EIS were undertaking.

Evaluation of the success of their communication strategy was important to Leeds EIS. They felt that a better informed population was a key outcome of the Leeds Care Record programme.

For the evaluation they surveyed people, mostly while waiting within GP Practices but also in non-care settings, before and after they introduced the Leeds Care Record. The evaluation indicated that there is more work to do to communicate about information sharing to patients. Despite significant effort advertising the shared care record in GP Practices, Leeds EIS found that 74% of patients where still unaware of its existence. However, two-thirds of patients believed that this information was already regularly shared and over three-quarters of patients believed that sharing this information would be beneficial to their care.

It also identified that the most effective 'advertising' was via TV screens within GP Practices. As a result of the evaluation, the Leeds EIS communication strategy is now better targeted.

9.3. Evaluation and performance monitorings

Engagement with patients has been a strategy used by all EIS's to support co-production and co-design of integrated care services. They have also used this interaction with patients to develop sets of outcome measures that they use to assess the success of services. Three LTC Year of Care Commissioning Programme case studies – from North Staffordshire and Stoke, West Hampshire and Kent – describe patient engagement and the multiple uses for the feedback from these processes – including the development of outcome measures for evaluation purposes¹²⁵.

Evaluation and performance monitoring are central to the delivery of integrated care in West Hampshire. They used feedback from their patient and staff engagement exercises to develop a range of quality and performance measures that are now being used by the West Hampshire integrated care board to monitor the effectiveness of the integrated care teams and the quality of service delivery to patients by service providers.

The quality and performance measures are reported through a dashboard that was specifically designed to monitor the performance of integrated care teams, and the selected measures were linked with the integrated care team strategic aims and objectives (Table 4). The dashboard also provides valuable insight for the integrated care teams themselves. The teams can make adjustments to the ways they work in order to improve their performance as assessed by the indicators in the dashboard.

Only a limited number of outcome measures were selected. These were identified as key indicators that would give a wide view of effectiveness rather than a narrow view of specific parts of the service. It was assumed that by measuring the effectiveness of integrated care teams and integrated care services as a whole, this would also measure the quality of the units that make up the integrated care teams and services.

¹²⁴ See LTC Year of Care Commissioning Programme case study 'The Leeds Shared Care Record'.

¹²⁵ See LTC Year of Care Commissioning Programme case studies 'North Staffordshire and Stoke – Patient engagement for outcomes', 'Engaging with patients to develop integrated care teams', and 'Developing service and contracting models for integrated care for the Kent population'.

Table 4 – ICT outcomes dashboard used in West Hampshire

Strategic aims	Objectives	Key performance indicators	Outcome
People receive the right care in the right place and the right time	 Maintain constant focus on long term quality of care and the achievement of outcomes for users Ensure that fairness and equality in its broadest context underpins every decision we make Give service users and their families choice and control over their own outcomes 	 Reductions in permanent admissions to residential and nursing care, per 100,000 population Reduction in non-elective emergency admissions (within targeted HRGs¹²⁶); and reduction in average length of stay Reduction in the number of excess bed days Reduction in delayed transfers of care More even spread of discharges across seven days 	Achieve long term quality outcomes
Promoting greater care co-ordination			Ensure our services meet demand
Work collaboratively to deliver integrated care services that promote independence and recovery	• Protect the sustainability of services to meet current and future demographic, financial and statutory requirements	• Minimum of 65% of service users return home after a period of rehabilitation or reablement	Ensure our system is financially sustainable

In South Kent Coast, they have developed a similar outcome metrics framework – where the individual deliverable metrics (similar to the KPI's (Key Performance Indicators) in Table 4) are linked to outcomes for the integrated care service as a whole that were developed using the engagement exercise with patients. In Kent, all care providers who will contribute to their integrated care services have agreed joint accountability for these outcomes.

The South Kent Coast framework includes a broader range of performance metrics than are used in West Hampshire, such that there are metrics for both individual providers, as well as metrics that span the whole integrated service.

9.4. Evaluation using patient experience

The metrics in Table 4 are quantitative. They are metrics that can be reasonably easily measured and easily reported through a dashboard. BHR (for Health 1000) and the Leeds Care Record describe evaluation using patient experience feedback. The EISs agree that evaluation is likely to be most comprehensive if the metrics are both quantitative and qualitative (patient and staff experience feedback), and include metrics that measure the performance of individual services as well as the integrated service.

The BHR Health 1000 pilot and the West Hampshire Integrated Care Teams use patient feedback not only for performance monitoring, but also for the evaluation of patient care plans. In both service models, the regular review of care plans by the multi-disciplinary team is a central part of their service delivery¹²⁷. Feedback from Health 1000 patients has resulted in some excellent patient stories¹²⁸.

9.5. Planning for the future

9.5.1. South Kent Coast accountable care organisation

The South Kent Coast programme team in the Kent EIS are developing an accountable care organisation to deliver integrated care services using a PDSA approach like BHR (Figure 14). They plan to build (Do) their embryonic integrated care accountable care organisations in 2017/18, shadow test (Study) the operation of these organisations in 2018/19, and implement (Act) fully accountable organisations in 2019/20¹²⁹.

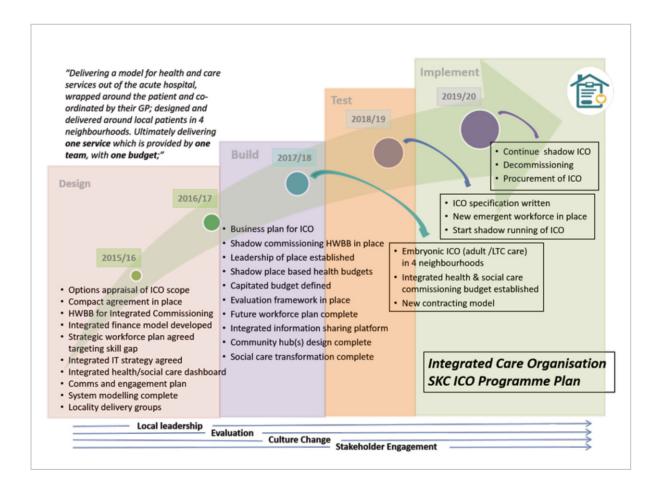
Despite planning implementation over five years, they still believe achieving this goal is ambitious. This is perhaps not surprising when considering the **'whole system transformation'** illustrated in Figure 14, and not surprising when taking into account all the change that is needed (i.e. all the parts of the LTC Framework needed to support the delivery of person-centred coordinated care; Figure 1). However, the work in Kent is based on firm foundations. They have comprehensive whole population information, strong stakeholder engagement, and examples of shared care records, evaluation for outcomes and financial modelling working within their care economy. They are also well underway with defining their contracting models.

¹²⁷ See LTC Year of Care Commissioning Programme case studies 'The patient journey at an accountable care organisation' and 'Using whiteboard meetings to deliver integrate care for patients'.

¹²⁸ See LTC Year of Care Commissioning Programme case study 'The patient journey at an accountable care organisation'.

¹²⁹ See LTC Year of Care Commissioning Programme case study 'Integrated care organisations in East Kent'.





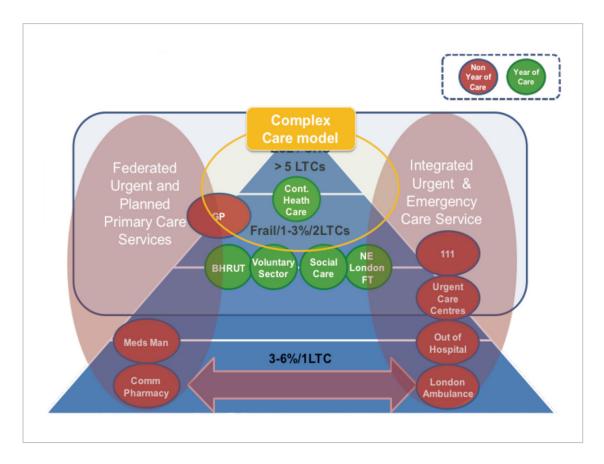
Two organisations will gain prominence in South Kent Coast during the development of the accountable care organisations – the Kent county-wide and the local district Health and Wellbeing Boards (HWBB's). The programme team recognise that the HWBB's provide a genuine opportunity to develop the link between delivery and commissioning of integrated health alongside care services and a preventative approach to improving health inequalities as well as the wider determinants of health. The HWBB is a local leader in the care economy and, with further development, could provide the foundations on which wider devolution of health and care, that is truly responsive to local needs, could be built.

In South Kent Coast, the HWBB's have been exploring how they could become a commissioning and decision making body (and hence perhaps eventually hold the South Kent Coast Alliance contract for integrated care services with providers). They have also been involved in the development of a proto-type devolved locality care and council budget. There are plans to shadow-monitor a place-based health and social care capitated budget for neighbourhoods by August 2016/17, with full integrated Health and Social Care commissioning budgets in place for 2017/18.

9.5.2. BHR integrated care in the future

Piloting and evaluating Health 1000 has provided BHR EIS with a wealth of learning, which is now being fed into more ambitious plans. They are linking their support services for patients with complex care needs (similar to the Health 1000 service) to their existing and developing Integrated Urgent Care services and their Federated primary care services as part of **whole system transformation**¹³⁰ (Figure 15). The Health 1000 service model will be adapted to create 14 locality primary care organisations. The whole BHR care economy is developing plans to create a devolved accountable care organisation for all health and care services.

Figure 15 – BHR Health 1000 complex care service model (part of whole system transformation)



BHR EIS also have an equally ambitious IT development programme as part of their **whole system transformation**¹³¹ (Figure 16). The IT plan will build upon their current integrated whole population dataset and shared care record to link patient records from all local service providers and to securely manage different levels of access for different users (patients, care practitioners, and managers). For example, they have begun to give limited access to a summary care record (not patient identifiable) to their local 111 service so that, on receiving a call, the 111 operator can direct patients with a care plan to the responsible clinician rather than to an ambulance service. This change has begun to result in a reduction in ambulance travel and A&E activity for patients with care plans.

¹³¹ See LTC Year of Care Commissioning Programme case study 'Learning from our pilot to plan for the future'.

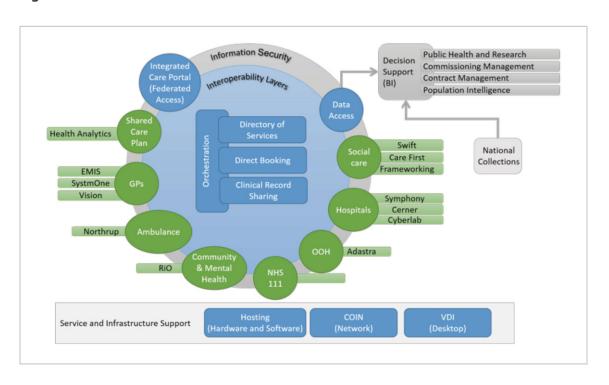


Figure 16 – Vision for IT infrastructure across BHR

9.5.3. West Hampshire

The West Hampshire Integrated care teams will continue to be developed, based on evaluation through their local outcome dashboard (Table 4). They plan improvements in workforce, most specifically to develop the role of care navigators and to develop the skills of care practitioners to liaise and work together. They plan greater communication to help care practitioners to understand more about the populations they are supporting (i.e. using data packs similar to those developed by Leeds EIS¹³²). These and more changes will contribute to a local accountable care organisation planned for the area.

Perhaps one of the major plans for the EIS is to pick up again on the development of some back office processes to support integrated care services that have had less recent focus. For example, their current integrated care service model is currently funded using existing budget arrangements¹³³.

While they began to undertake whole population analysis and consider a capitated budget some time ago¹³⁴, it is only now that their **integrated services** are operating, that they are thinking more deeply about the benefits of and the practical implications of applying a capitated budget payment system to the new service delivery model. They are working to understand how their current clinical method for selecting patients and the services delivered by the integrated care teams sit with the technical requirements of operating a capitated budget. They are also planning improvements and extensions to their shared care record and sharing of care plans (through the Hampshire Health Record system)¹³⁵.

- ¹³³ See LTC Year of Care case study 'Engaging with patients to develop integrated care teams'.
- ¹³⁴ See LTC Year of Care case study 'Development of budgets to support people with long term conditions in West Hampshire'.

¹³² LTC Year of Care case study 'Helping audiences utilise integrated whole population data'.

¹³⁵ See LTC Year of Care case study 'Development of budgets to support people with long term conditions in West Hampshire'.

9.5.4. Leeds

The Leeds **whole system transformation** is progressing at a number of different levels. Many of the back office developments required to support integrated care services (e.g. the Leeds Data Model and Leeds Care Record, the communication strategies, workforce planning, evaluation framework and quality improvement, and the contracting and financial process development) and the overall strategies for care services (e.g. Urgent Care, Elective Care, Care for complex patients, and effective admission and discharge) are being developed city-wide (see Figure 2). The service models however are being developed at a more local (CCG) level.

The two main local planned developments are (1) service models, and then (2) capitated budgets and contracts to support these service models. The planned service models for the different CCGs include locality-based models for specific geographically-based populations, and models focussed on particular patient groups (e.g. multi-organisational, multi-disciplinary mental health service model; or a multi-disciplinary proactive care model to particularly support elderly patients which will link with existing integrated neighbourhood teams).

Similarly, Leeds CCGs plan to shadow test capitated budgets in 2016/17, again for either geographically-based populations or for particular services or patient groups. In one CCG, there are plans to shadow-test a capitated budget for both the whole population managed by a group of GP practices, and also for a selected group of patients with complex care needs.

9.5.5. Future for the LTC Year of Care Commissioning Programme

The National LTC Year of Care Commissioning Programme has now ended. Its national legacy has and will continue to support care economies in making progress in other national initiatives aimed at delivering personalised integrated care services. Our expectation is that our EISs and other care economies will use some of the information presented here to develop and implement whole-place commissioning or place-based commissioning plans.

The work of EIS's will continue. Much of the work of EIS's during 2015/16 has been to 'mainstream' their local LTC Year of Care Commissioning Programmes, to ensure that the learning and experience supports the development of integrated care within the context of their overall economy wide transformation programmes. The EISs have used the knowledge that they have gained to develop their Sustainability and Transformation Plans (STPs).

The progress of the EIS's will continue to be captured and shared. We expect the EIS's will want to continue to connect with each other and support others in doing so, so that they can continue to learn from the programmes operating in different care economies.

The LTC Year of Care Commissioning Programme was only one of a number of programmes within the Long Term Conditions and integrated care Improvement Programme (latterly part of NHS England Sustainable Improvement Team). In conjunction with the sister programme – the Long Term Conditions Improvement Programme – the LTC Year of Care Commissioning Programme has supported a community of practice, 40-50 care economies who are at various stages along a journey towards delivering integrated care services in their local area. These care economies and the EIS's will continue to receive support from the NHS England Sustainable Improvement Team with a focus for the near future on the self-care components of their programmes.

The contact details for EIS's are included at the end of each individual EIS case study. These case studies can be found at www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/ltc-year-of-care-commissioning-model.aspx.



For further information or any questions about the overall programme please contact england.longtermconditions@nhs.net