Integrated Care Pilots

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Integrated Care Pilots: overview

The programme of Integrated Care Pilots (ICP) is a two-year Department of Health (DH) initiative. Its purpose is to explore different ways of providing health and social care services to help drive improvements in local health and wellbeing.

Integrated care is an important building block within the strategic plan for improving the health and wellbeing of the population of England, as highlighted in both the NHS Next Stage Review report High Quality Care for All and the concordat Putting People First. Both documents stress the importance of improving local health and care services by offering personalised, flexible and high quality services, where the individual is at the centre and engaged in service organisation. Integration may refer to partnerships, systems and models as well as organisations; crossing boundaries between primary, community, secondary and social care.

Each of the 16 pilot sites participating in the national programme has developed an integrated model of care to help respond to particular local needs. Using their in-depth knowledge of the local population, the pilots are designing services that should be flexible, personalised and seamless.

The ICP programme is one of a number of initiatives looking to deliver these objectives. All pilots will be working with local organisations involved in world class commissioning (WCC) assurance Year 2, and participation in ICP should enable sites to demonstrate success against many of the competencies for WCC assurance.

The following pages provide summaries of the work each pilot will be doing over the next two years as they explore the potential and impact of their models, whilst identifying learning and best practice to be shared with others.

For further information email the ICP team via: integratedcare@dh.gsi.gov.uk or visit: www.dh.gov.uk/integratedcare
Integrated Care Pilots: national evaluation

DH has asked a team comprising Ernst & Young, RAND Europe, and the Nuffield Trust, to evaluate the national ICP programme.

The team will evaluate:
• how the pilot sites have integrated services
• which integration approaches have worked well
• what impact the different pilots have had on different groups
• the resource implications of integration
• which approaches to integration are the most suitable, feasible and acceptable.

There are three key aspects to the national evaluation:
• quantitative evaluation (including individually-matched controls)
• qualitative evaluation
• deep dives (including further quantitative and qualitative evaluation).

It is important to note that the evaluation will look at the impact of integration through the programme as a whole, and not at the level of individual sites.

Quantitative evaluation
The quantitative evaluation will collect a range of measures of use of care services, and assess the impact of integration on these. These will include outpatient referrals, accident and emergency usage, and inpatient care (including emergency admissions, ‘ambulatory sensitive’ admissions, and length of stay for selected conditions). Each site will collect a standard set of ‘national measures’ plus a small number of individually-selected ‘local measures’.

The quantitative evaluation will also assess its impact on outcomes for users of health and social care services through questionnaires that users, or their carers, will complete. Staff involved in delivering the integration will also complete questionnaires. In all sites user and staff questionnaires will be carried out both before and after the integration is introduced, though the precise way in which this will be done will vary between sites depending on the nature of their integration.

The evaluation will compare the impact of integration with other similar populations where services have not been integrated. It will also benefit from a new approach, which will compare the impact on individuals who have benefited from the integration with other individuals with matching risk profiles, who have not been part of integration pilots. This innovative and more detailed approach to evaluating the impact will be carried out by the Nuffield Trust as part of the overall evaluation.

Qualitative evaluation
Much of the insight into integration is likely to come through the qualitative evaluation. The qualitative evaluation will review sites’ documentation on their integration, and in particular through ‘Living Documents’, which require sites to answer specific questions about their intervention. Sites will complete this periodically through the evaluation.

Deep dives
Six pilots have been selected for further investigation by the evaluation team who will visit these pilots at the start and end of the evaluation. They will collect more detailed qualitative information, through interviews with staff and users/carers, and quantitative information, including data on costs. The six deep dive sites are Church View, Cumbria, Northamptonshire, Norfolk, Principia and Torbay.
Patient/Service user group and key focus:

Dementia patient pathway. There are two main elements to the service, which will initially be rolled out in the Westbourne locality. Firstly the development of low level services and access to a dementia advisor; and secondly to establish a specialist intermediate care team. This service will be provided for any adults with cognitive impairment, who are registered with one of the four GPs in the Westbourne locality.

Objectives of pilot:

The pilot is a GP-led model aimed at improving early intervention and signposting of services for people with memory impairment and diagnosed dementia. The pilot will have consultants, specialist mental health nurses, social workers, physiotherapists, occupational therapists, supporting people, third sector agencies and intermediate care assistants working together to improve outcomes for vulnerable individuals, for example enabling self-support and maintaining health in the community.

Overview of pilot:

The service will employ community mental health nurses (CMHN) as support workers who will pro-actively case find using carer’s registers, vulnerable person’s registers and dementia registers. The CMHNs will have strong links with community mental health teams, and have access to mental health consultants and the specialist intermediate care team.

“This gives us the opportunity to target services at people who may have symptoms which aren’t often picked up until a much later stage. This project is particularly important in bringing together the whole community to look out for signs that older people, many of whom will be living alone, are developing an illness which we can help them manage.”

Elaine Atkinson, Portfolio Holder for the Borough of Poole
### Patient/Service user group and key focus:

The pilot will establish a model for the integration of primary care, secondary care and community health services delivering end of life (EOL) care across East and South Cambridgeshire and Cambridge City.

### Objectives of pilot:

The goal is to enable people to die in their place of choice – the pilot goals will be measured locally, and are:

1. 50% of individuals, who know they are dying, die in the place of their choice by the end of the pilot period
2. 95% of deaths occur in the individual’s preferred place of care by 2011
3. implementation of EOL care tools across partner organisations
4. 100% of practices within Assura Cambridge Limited Liability Partnership will be using an EOL register, which includes individual preferred priorities of care, by the end of the pilot period.

### Overview of pilot:

The pilot will agree a definition of individuals in the last stages of life and develop practice registers for those people, agree practice coding for EOL care, and implement care tools across partner organisations. Community-based services will be improved through greater integration with primary and secondary care to support individuals nearing the end of life by providing care out of hospital. Specific planned initiatives include:

- improving integration between different IT systems to allow real-time sharing of data
- providing an available, updated service directory through a single phone call from the patient or their carer
- a marketing campaign to raise local public awareness of death and dying
- training provision for staff in care homes to assess needs and use all support agencies available.
The prevalence of chronic diseases within the practice population, such as asthma, chronic obstructive pulmonary disease (COPD) and stroke/transient ischemic attack are all above the PCT and England average. The pilot aims to identify those individuals at high risk of admission, working as an integrated team to prevent avoidable admissions, concentrating on the care of the elderly user group.

The pilot aims to prevent avoidable admissions achieved through early intervention management for individuals with emerging risk, and intensive case management for very high-risk individuals.

The pilot will seek to replicate the use of ‘virtual ward-rounds’ to review individuals within secondary care and those identified as emerging or high risk which would involve care of older people, primary care and specialist clinicians. The contractual aspect of the pilot will involve a variation to the Primary Medical Services (PMS) contract currently held by Church View Medical Practice.
### Patient/Service user group and key focus:

New approaches to helping individuals with chronic disease to manage their own care. The pilot will initially focus on elderly care and diabetes care, adding additional pathways as the project develops including chronic obstructive pulmonary disease and end of life care.

### Objectives of pilot:

The pilot aims to test two different models of integrating care, one based on a whole locality, and the other based around two towns in west Cumbria. Both involve horizontal integration of GP and community services, with differing approaches to the vertical integration with specialist services. They will also test the feasibility and benefits of integrating commissioning and providing within a single organisational framework. The pilot is expected to achieve reduced emergency hospital admissions, re-admissions and emergency care, and improvements in chronic disease management.

### Overview of pilot:

The pilot will adopt different approaches depending on the model of integration being tested. These include:

- establishing organisational arrangements that effectively integrate all GP and community nursing services and directly provide or contract all core community provision of health care and therapy services
- creating a single integrated IT system for primary and community care
- providing a whole system of care designed to deliver appropriate services in a community setting through community hospital beds and a virtual ward in the community.
### Durham Dales

| **Patient/Service user group and key focus:** | The pilot will focus on improving services within the Durham Dales practice-based commissioning (PBC) cluster. This will be based upon several workstreams: fuel poverty; transport services; care closer to home; provision of GP beds; integrated emergency care; rural mental health; and vascular screening. The workstreams involve primary and secondary care, mental health and social services, and the service user group(s) will vary depending on the workstream being considered. |
| **Objectives of pilot:** | The aim of the project is to ensure that service users covered by the Durham Dales PBC cluster are able to access all primary and secondary healthcare services and social services without undue difficulties, ensuring that individuals are offered a choice of locally-based services, as well as a choice to go elsewhere for specialist care. This will help achieve prevention of disease, reduced emergency admissions, and produce more cost-effective services. |
| **Overview of pilot:** | In delivering these workstreams, the pilot aims to improve the links between health and social services by developing a structured framework of joint working between the local authority and healthcare providers. A key aspect of the workstreams is around providing a single point of access to combinations of services, for example district nursing, social services and therapy services. This aims to simplify access to, and promote faster delivery of, community, primary and secondary care services to the population as near to their homes as possible, but also in a market developed to allow more local choice. This will include the development of shared information and intelligence, which will enable user-centred care planning to provide a seamless delivery of service. |
The pilot will form a virtual dementia team of key staff, drawn from a range of health and social care organisations, anchored around GP practices, providing and directly commissioning care to all individuals registered on a GP’s dementia register. The pilot will also establish tiered levels of integrated case management for dementia at a practice level.

“People with dementia are just that, first and foremost PEOPLE with dementia. Like everyone, they have complex and overlapping needs... Our mission is to design integrated services that are simple to use... because we know that’s what they need, what they want and what they deserve.”

**Beverley Chapman**, Lead Dementia Nurse, NHS Cornwall & Isles of Scilly PCT

Newquay has a concentration of both older people and care homes, and in turn, sees a clustering of people with dementia. The programme will aim to raise community awareness of dementia, proactively case find people with early dementia and aim to support families and carers.

The pilot aims to develop an integrated care pathway for dementia in Newquay, de-coupling dementia from the traditional silo of secondary care based “Older People’s Mental Health Services”. Dementia will be treated as a long term condition best managed through integrated and preventative case management in primary care.
Northamptonshire Integrated Care Partnership

**Patient/Service user group and key focus:**
Northamptonshire Integrated Care Partnership is a new, clinically-led enterprise, working in a new way to improve the health and wellbeing of individuals with long term conditions.

**Objectives of pilot:**
The pilot intends to improve the health and wellbeing of people with long term conditions by developing high quality, innovative and coherent pathways which are designed to:
- increase user satisfaction
- provide better patient outcomes
- use resources more effectively, developing a sustainable health economy that encourages ambition and strengthens partnership collective vision.

**Overview of pilot:**
The pilot will risk assess its entire practice population and respond to high-risk service user needs through a series of initiatives, including:
1) a) roll out of pro-active care early intervention initiative to cover 98% of the population of Northamptonshire by December 2009
   b) extended case management
2) medicines management service for all people discharged from hospital
3) depression management for people with long term conditions
4) development of integrated end of life pathway
5) development of personalised health care budgets
6) specific urgent care schemes to reduce the number of emergency admissions: care homes scheme; GP in hospital pilot; IV antibiotics in the community; and ambulance admission avoidance pilot.
### Patient/Service user group and key focus:

NHS Norfolk, Norfolk County Council and groups of general practices engaged in practice-based commissioning wish to establish a series of fully integrated, local health and social care teams comprising GPs, community health staff and adult social care staff to provide cohesive, pro-active and personalised care for older and vulnerable people.

### Objectives of pilot:

The pilot objectives are patient, organisational and staff focussed:

- to achieve an increase in user satisfaction
- to increase support available to carers
- to reduce waiting times
- to reduce current levels of unplanned admissions to secondary care and thereby achieve savings
- to reduce levels of placements into long term residential care and thereby achieve savings
- to support more people to live at home utilising personal health and social care budgets
- to achieve an increase in staff satisfaction.

### Overview of pilot:

The programme will establish six integrated local pilot teams, which will focus on developing integrated ways of delivering care to users who have the greatest levels of need and typically have long term conditions and limited social support. The teams will identify their target populations through the use of a predictive risk tool, develop a common assessment process and manage users through a key worker. Staff teams will be co-located wherever possible.

“In Norfolk we know that our population want: better co-ordination of services; general practice as the natural focus for care; care locally; one person to act as their key worker and know their story; to avoid repeat assessments; clear, easy to use information such as a single telephone number; to be treated with courtesy and respect when professionals visit them at home. Our integrated care pilot is the means by which we can make this a reality for all of our population.”

**Mark Taylor**, Director for Integrated Provision & Market Development, Norfolk County Council
## Patient/Service user group and key focus:

Improving access to mental health services for the rural population (18+) of north Cornwall.

## Objectives of pilot:

The pilot aims to reduce variation in service delivery and provide a greater standardisation of assessment, formulation and treatment.

The pilot also aims to deliver improvements in physical healthcare for people with mental health problems and particularly those with severe mental illness. A further aim is to improve a range of social care outcomes for people using services.

## Overview of pilot:

The pilot will develop a pathway that links key members of a virtual team and ensures referrals for mental health interventions are directed to the most appropriate location. Referrals into service will be triaged and managed by a practice-attached link worker from the partnership trust and an improving access to psychological therapies worker. The third sector will develop closer working with practices and through involvement with the assessment process seek to support people sooner into their pathway.
### Patient/Service user group and key focus:

Falls and blackouts can have a serious impact both on the lives of individuals and the wider health economy. The pilot is targeted at those people who are at risk of falls and blackouts. These residents will be chosen from the North Tyneside population over the age of 59.

### Objectives of pilot:

The pilot’s emphasis is on prevention rather than treatment. It aims to broaden the current falls and blackouts service provision to ensure that unmet need is targeted and treated by establishing a novel, high quality, comprehensive rapid access falls and syncope service in the community. The service aims to enhance the case finding, appropriate referral and management of older people at risk of falls. One of the key outcomes will be the reduction in the number of falls and fractures caused by falling when compared with the rising trend line.

### Overview of pilot:

There are two stages within the pilot. The first phase will focus on identifying existing high-risk individuals through a practice-based audit of medical records with strong indicators of falls and blackout risk. This will be followed by a triage risk assessment, which will identify individuals who should be referred to the service. The second phase is a community-based falls prevention clinic for those identified at phase one. The clinic will be delivered by a multi-disciplinary team providing a medical, physiotherapy and healthcare review. The review will lead to an individual care plan and, for selected individuals, a community-based strength and balance training course.
## Patient/Service user group and key focus:

The pilot will focus on support for individuals with chronic obstructive pulmonary disease (COPD) within the North Tyneside population through a proactive and systematic care planning approach.

## Objectives of pilot:

To improve compliance with the locally-agreed COPD pathway and improve user experience and self-management. It is anticipated that this may reduce hospital admissions, length of stay, and achieve fewer/less severe exacerbations through accurate assessment of disease severity and therapy review. This will be delivered through the initiation of appropriate treatment, agreed with the individual, combined with education and information about treatment and its benefits which should also improve adherence.

## Overview of pilot:

The pilot will enhance the services provided to people with COPD by improving the way individuals’ services and care needs are delivered and integrated, and ensuring individuals’ needs can be met close to or in their own homes. Key to the pilot’s approach is the use of a named skilled key worker using an individualised care planning approach with tailored self-management plans, and use of patient-held records.

The key worker will be responsible for co-ordinating COPD-related elements of their health and social care and assisting the individual/carer in navigating the system. This will include links with the British Lung Foundation and other third sector support. Care plans will be held by service users and will include social aspects of care. Users will be encouraged to make their plans available to the intermediate care team and social workers to aid communication, reduce duplication and enable more seamless provision of care.
Principia Partners in Health

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<td>Principia Partners in Health is a social enterprise company limited by guarantee in Rushcliffe, which brings together health practitioners, managers and patients to decide on and deliver local health services, and improve the health of the community. Principia’s major strategic initiative is improving the approach to long term condition management, which is currently fragmented, reactive and poorly co-ordinated with insufficient focus on the potential for prevention and health promotion.</td>
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<td>The Principia pilot is designed to help create more informed and empowered users, to improve co-ordination of care, increase user satisfaction and reduce hospital admissions. Principia saw the benefits of being an integrated care pilot as an opportunity to be involved in creating the evidence base for integrated care.</td>
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| The pilot will involve partners working through two projects:  
1) establishing community wards, building on the strengths of team working in hospital wards (horizontal integration)  
2) integrating care along the chronic obstructive pulmonary disease clinical pathway (vertical integration).  
The pilot will establish the following for the target population:  
• agreed end to end pathways with specified services and agreed quality (including user-led) standards  
• whole population risk profiling and management  
• individual care planning  
• individual care co-ordination and navigation  
• strengthening of integration between formal and informal systems of care to improve self care and carer support  
• alignment of financial incentives and managerial accountability to best support integrated working. |
Tameside and Glossop

Objectives of pilot:
The pilot’s main objective is to reduce the risk of people developing CVD and ultimately reducing the mortality rate over the long term. The project will also aim to reduce avoidable and reactive interventions, particularly those requiring acute hospital care as well as reducing the risk of individuals being treated in high cost and inappropriate settings, where excellent and effective care can be provided closer to home.

Overview of pilot:
The pilot will develop a new service model that builds on existing provision, expanding it to provide a more integrated approach through a virtual integrated care organisation involving social services, primary and secondary care. The model will create a system that promotes the whole pathway from pre-disease to the management of complex care. This involves raising risk awareness through social marketing and campaigns, provision of a CVD risk assessment screen, developing personalised care plans, in addition to providing health improvement and self care programmes. This will be delivered through multi-disciplinary services to make best use of the skill mix of clinicians and other professionals across all disciplines and organisations, for example health trainers, practice nurses and care workers.

Patient/Service user group and key focus:
The cardio vascular disease (CVD) mortality rate in Tameside and Glossop is significantly higher compared to the national average. The pilot will focus on people with known CVD and those at risk of developing CVD in the next 10 years.

“CVD is a real problem here and we are determined to both reduce the number of people who suffer from it and improve care for those who do. The ICP scheme will combine the existing expertise of local GPs with the influence of local people to get the best support and treatment possible.”

Melanie Sirotkin, Director of Public Health
### Patient/Service user group and key focus:

Older people over 65 with co-morbidities and following complex care pathways. This is due to the demographics of Torbay, where currently 23% of the population are over 65 and 10% are over 80.

### Objectives of pilot:

The pilot aims to enhance the integration of Torbay Care Trust to incorporate the services of both the acute hospital and the mental health services of Devon Partnership Trust, specifically for the older people (65+) of Torbay. The overall objective is to ensure that care is seamless and user experience optimised regardless of the complexity of individuals’ needs.

### Overview of pilot:

The pilot is focussing specifically on two projects:

1) facilitating hospital discharge across acute, community and intermediate care settings and developing more robust communications across organisations

2) integrating our end of life strategy in Torbay, specifically focusing on individuals with chronic obstructive pulmonary disease and congestive cardiac failure to enhance communication and the quality of care provided between the care trust and the hospital.

The pilot will also develop a virtual pooled budget for older people’s care between all partner organisations.

“**In Torbay Care Trust we have a clear focus of putting the patient at the heart of services. This pilot will enable us to trial more innovative and effective methods of achieving what is right for the patient and ensuring their needs are met in a seamless manner across organisational boundaries.**”

_Mandy Seymour_, Acting Operations Director, Torbay Care Trust
The goals of the Tower Hamlets integrated care programme are to:

- empower individuals to manage their own health and wellbeing
- reduce the variation in delivery and quality of care delivered across the borough
- reduce the gap between observed and expected prevalence for key LTCs
- where appropriate, deliver care to people closer to home
- commission a model of integrated care across health and social care, based on outcomes
- improve provider capabilities, access to primary care, choice and patient experience
- ensure value for money, for instance through secondary care avoidance.

“By working closely and in partnership with patients this programme will change the way patient care is planned and managed. It will also give us the opportunity to open up new, holistic treatments, providing accessible care closer to home.”

Tower Hamlets ICP site
Wakefield Integrated Substance Misuse Services (WISMS)

Patient/Service user group and key focus:

The WISMS pilot will continue to improve the delivery of substance misuse (and associated) services in the Wakefield District area to drive forward quality, make improvements for service users, families and communities, and further develop workforce skills.

Objectives of pilot:

The WISMS pilot aims to achieve a step change in:
- prevention – services tackle determinants of health
- personalisation – service users exert choice and control
- raising aspirations – service users; staff; clinical engagement
- “Think Family” – considering community and family impact
- subsidiarity – building recognition that partners are interdependent on resources and finances, and defining economic indicators of progress
- methodologies that are transferable, to ensure they can be implemented elsewhere
- social return on investment – measuring the impact of service investment and innovation upon wider social factors.

Overview of pilot:

The WISMS pilot will undertake four streams of work:
1) implementing the balanced scorecard, including workforce development, psycho-social interventions, and alcohol abuse
2) information management and technology – to manage shared patient records within data sharing protocols
3) communications and social marketing, including website and social networking capability to engage current and potential service users with the services and options available to them
4) enhanced shared care project, providing additional support to GP practices to facilitate the mainstreaming of substance misuse services into local practice. This will be tested initially in a sample of practices and rolled out across Wakefield District from April 2010.

“The WISMS ICO is committed to ensuring that various population groups... can access information in a way that is relevant to them. This is at the heart of the Balanced Scorecard, a dashboard of outcomes measuring the success of our ambition in respect of social reintegration for substance misusers.”

Linda Harris, Clinical Lead, WISMS pilot