
CONFERENCE ABSTRACT

Developing Integrated Care Teams Across the North West London System

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The health needs of the North West London population are changing. People are generally living longer and as a result a growing number are suffering from complex, long-term health conditions. This inevitably creates pressure on available services, to the point where there is a need to look at how these can be better provided. In North West London, the way hospitals and community health services are provided is being transformed to deliver a more co-ordinated and person centred service, achieved through close working between all statutory, voluntary and charitable partners delivering effective person centred outcomes. The focus is on GPs being at the centre of organising and coordinating care so that it is accessible and provided in the most appropriate setting.

This new way of working, has required staff to work in a fundamentally different way – redefining their boundaries, empowered to take more responsibility and work as equal partners with their patients and service users. Care will be delivered via a collaborative multi-disciplinary team working to a single shared care plan, where the patient or service user will be supported to manage their health and wellbeing.

As a result of this new way of working, there has been a need to take a new approach to supporting the workforce through these changes. North West London have developed a 'Change Academy' to build personal and collective capacity and capability for delivering person-centred integrated care using approaches involving critical thinking, team working and innovative ideas and approaches which can make a significant impact on the lives of people who access services.

The Change Academy is an organisational development programme for clinical and operational leaders, frontline teams and patients/service users to ensure they have the knowledge and skills to deliver care in the new way – across the whole system without boundaries. The programme was developed by identifying the learning needs and interviewing a number of stakeholders including lay members (patients and service users), clinicians, commissioners, social care and the voluntary sector. The programme identifies who the key members of the 'integrated team' will be in order to be able to implement a 'whole systems' approach to delivering care. This team works together with the support of a 'change navigator' to develop a localised approach. This has involved implementing new models of care for the over 65s and working towards the development of an Accountable Care Partnership for this target population. The programme has supported the development of this team to work together

effectively to develop the partnership. Within the programme there are core modules e.g. leading across boundaries, problem solving techniques, using data to improve how care is delivered as well as developing softer skills including dealing with conflict, having challenging conversations and using health coaching with patients to support them to achieve their health and wellbeing goals. In addition team coaching is being used as a way of develop the team and build sustainability into the programme.

A prototype has been implemented in two geographic areas in North West London. In one area, the programme has supported the development of multi-disciplinary teams working around the patient to develop an integrated approach to managing their care. This has included the development of a holistic care plan led by the GP (with specialist skills) and supported by a core care team including a senior nurse, pharmacist, Consultant Geriatrician, social worker, care coordinator and the third sector. The care plan is co-produced with the patient focusing on their goals as well as the critical medical interventions required to manage them safely in the community. In the other area two 'hubs' have been developed where the patient can access a variety of specialist services in one place including ultrasound, x-ray, cardio and respiratory clinics, physiotherapy, OT, social work, third sector services as well as an extended appointment with the GP. With the support of the Change Academy both of these areas are working towards the development of Accountable Care Partnerships.

Early evaluation of the Change Academy is demonstrating the effectiveness of the approach to develop integrated care teams. Specifically, the two areas have most valued that the Change Academy has provided a space and time to work through challenges that are stalling progress. Bringing together key stakeholders from across the system inevitably brings challenges and being able to discuss how care will be delivered in the future in a safe, supportive space has enabled progress to be made and a shared vision for the future.

Prior to the team coaching, one to one interviews were held with each of the participants of the prototype. These interviews have helped to shape the content and gain further engagement with the programme. This has also provided clarity on the change goal the team are working on and a baseline evaluation measure. At the end of the team coaching, the evaluation survey will be repeated in order to fully assess the impact that the Change Academy has had on the implementation of the new model of care. It is expected that the Change Academy enables teams to clarify goals and objectives, identify roles and responsibilities of team members as well as supporting action planning to ensure progress is made in implementing the new model of care.

The Change Academy is proving to be an effective way of enabling the health and social care system to deliver true integrated care to people across the North West London geography.

Keywords: integration; holistic; empowering patients
