# EVIDENCING THE IMPACT OF PERSONALISED AND INTEGRATED CARE

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### AIM OF THIS PRESENTATION

 Share experience from a previous systems change pilot for people with multiple and complex needs

 Reflect on learning for the Out of Hospital Care Model sites when it comes to evidencing impact or making the business case?

What help do sites want in developing their business case?













## The hypothesis

"If agencies in Hertfordshire pool resources and work more closely together to identify and deliver services to adults with complex needs and chaotic lifestyles, they will be able to achieve a more cost-effective service, and deliver interventions, solutions or improvements which are more customer focussed and effective."

















### THE APPROACH TO COMMISSIONING

- Theory of change / logic model that presented an integrated and personalised system that delivered improved outcomes to people and reduced service costs
- Audited need and costs across the system to calculate how much was being spent, where and with what impact?
- Co-produced with professionals and people who use services to understand what would make the difference in a system
- Developed a partnership and pooled budget to fund an evaluated model of care delivered through a two year pilot

# SCOPING AND FEASIBILITY

Rank	2 Year Cost Hertsmere	2 Year Costs Three Rivers
1	£136,584	£124,277
2	£129,654	£84,359
3	£90,434	£67,111
4	£85,921	£64,674
5	£83,371	£57,900
6	£79,263	£51,570
7	£70,566	£48,407
8	£70,061	£43,552
9	£59,910	£33,143
10	£57,327	£26,404
Total	£863,092	£601,397
Cost per		
week	£8,298.97	£5,782.66

### CO-PRODUCTION AND ENGAGEMENT

### **Initial interviews:**

Small group of individuals whose historic service use was audited.

### What they wanted:

- Consistent Trusted Professional
- Choice when, where and how they receive support
- To create their own package of care
- Support at points of transition e.g. moving from Hospital or Prison back in to the community or leaving care

# CO-PRODUCTION IN SHAPING THE TEAM AND THE SERVICE OFFER

- Co-production in recruiting the team, developing branding and delivery
- Key values and principles to inform recruitment and teams way of working
  - Person centred
  - Genuine collaboration
  - Optimistic and forward looking
  - Holistic whole person
  - Honesty
  - Trust

# THE EVALUATION OUTCOME STAR ASSESSMENTS

- Greatest change management of money, social networks, drug and alcohol, physical health and emotional well-being
- Use of time, tenancy management, offending, motivation and self-care all reported sustained, steady improvements



## **REDUCING COSTS**



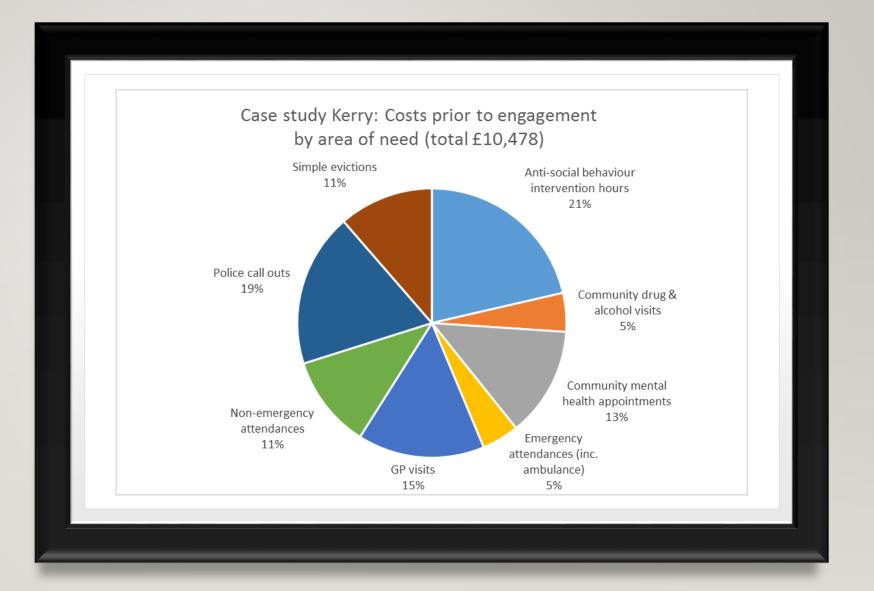
### About service use

- Significant reductions at 8 and 11 months in: A&E admissions, A&E Mental Health Liaison, Mental Health Inpatient
- Significant reductions at 11 months in: Drug and Alcohol Community Support, Inpatient Detox, Mental Health Act Assessments

### About costs

- Significant reduction in mental health costs (about £3,250 per person at 11 months)
- £232k of service costs were reduced per annum, this equates to a 29% of services used previously used

# CASE STUDY: COSTS PRIOR TO YOU CAN



# CASE STUDY: COSTS FOLLOWING ENGAGEMENT



# THE LEGACY FOR PEOPLE WITH COMPLEX NEEDS



- New service commissioned in one of the pilot areas
- Worked with one of the CCGs to explore the development of a service targeting frequent attenders at Hospital in East Herts
- County wide complex needs service established for time limited interventions for some people, although at lower level of complexity
- County wide strategy group for adults with complex needs
- Multi agency information sharing agreement in place

# THE LEARNING - THREE COMPLEMENTARY APPROACHES THAT CAN SUPPORT BUSINESS CASE

- A. Logic Model Develop and communicate widely the vision and impacts showing what needs to be in-place to enable the system to work more effectively
- B. Co-produce Involve people who use services and frontline professionals from the outset this grounds the service through person-centred practice and supports integration
- C. Economic Case Studies Capture activity and costs across the whole system and creatively think about how to communicate the impact to a variety of audiences

# APPROACH A) - "LOCAL" LOGIC MODEL / THEORY OF CHANGE

- Present a Logic Model that articulates outcomes the systems change locally that could be / is being achieved
- Build on reports by KCL / LSE and others and as part of work nationally e.g. HICM and Transforming out-of-hospital care for people who are homeless Support Tool
- A local logic model will highlight where the strengths are within the system to support your case and surfaces the gaps and therefore where funding or resources need to be targeted
- Working to demonstrate how this can be used to underpin a business case adapting SCIEs Logic Model for Integrated care <a href="https://www.scie.org.uk/integrated-care/measuring-evaluating/logic-model">https://www.scie.org.uk/integrated-care/measuring-evaluating/logic-model</a>

### Logic Model for Integrated Care

#### Enablers

Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)

Strong, system-wide governance and systems leadership

Integrated electronic records and sharing across the system and with service users

Empowering users to have choice and control through asset-based approach, shared decision making and coproduction

Integrated workforce: joint approach to training and upskilling of workforce

Good quality and sustainable provider market that can meet demand

Joined-up regulatory approach

Pooled or aligned resources

Joint commissioning of health and social care

### Components of integrated care

Early identification of people who are at higher risk of developing health and care needs and provision of proactive care

Emphasis on prevention through supported self-care, and building personal strengths and community assets

Holistic, cross-sector approach to care and support (social care, health (and mental health) care, housing, community resources and non-clinical support)

Care coordination: joint needs assessment, joint care planning, joint care management and joint discharge planning

locally

determined

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2

Outputs

SERVICES

SYSTEM

Seamless access to community-based health and care services, available when needed (e.g. reablement, specialist services, home care, care homes)

Joint approach to crisis management: 24/7 single point of access, especially to urgent care, rapid response services, ambulance interface

Multi agency and multi-disciplinary teams ensure that people receive coordinated care wherever they are being supported

Safe and timely transfers of care across the health and social care system

Care assessment, planning and delivery are personalised and, where appropriate, are supportive of personal budgets and IPC

Care teams have ready access to resources, through joint budgets and contracts, to provide packages of integrated care and support

High-quality, responsive carer support

### Outcomes

Taken together, my care and support help me live the life I want to the best of my ability

I have the information, and support to use it, that I need to make decisions and choices about my care and support

I am as involved in discussions and decisions about my care, support and treatment as I want to be

When I move between services or care settings, there is a plan in place for what happens next

I have access to a range of support that helps me to live the life I want and remain a contributing member of my community

Carers report they feel supported and have a good quality of life

The integrated care delivery model is available 24/7 for all service users, providing timely access to care in the right place

The model is proactive in identifying and addressing care needs as well as responsive to urgent needs, with more services provided in primary and community care settings

Professionals and staff are supported to work collaboratively and to coordinate care through ready access to shared user records, joint care management protocols and agreed integrated care pathways

Integrated assessment, care and discharge teams report they are readily able to access joint resources to meet the needs of service users

Transfers of care between care settings are readily managed without delays

Integrated care improves efficiency because, by promoting best value services in the right setting, it eliminates service duplication, reduces delays and improves services user flow

Effective provision of integrated care helps to manage demand for higher cost hospital care and to control growth in spending

Integrated care shifts service capacity and resources from higher cost hospital settings to community settings

The system enables personalisation by supporting personal budgets and Integrated Personal Commissioning, where appropriate

### Impact

#### IMPROVED HEALTH AND WELLBEING

- Improved health of population
- Improved quality of life
- Reduction in health inequalities

#### ENHANCED QUALITY OF CARE

- Improved experience of care
- People feel more empowered
- Care is personal and ioined up
- People receive better quality care

#### VALUE AND SUSTAINABILITY

- Cost-effective service model
- Care is provided in the right place at the right time
- Demand is well managed
- Sustainable fit between needs and resources

# APPROACH B) EMBED CO-PRODUCTION

Working with three sites to develop co-production that engages people who use services and front line staff to deliver change, improve services and communicate impacts and outcomes

- Workshop in Greater Manchester working with VCS partners to develop "I statements" to ensure user voice is central to development
- Nottingham are working with established user group at Opportunity Nottingham (Fulfilling Lives) to inform the pilots development
- Two workshops in Cornwall... focussed on values and principles across the system.....

# CORNWALL PRINCIPLES AND VALUES WORKSHOP

Two principles and values workshops in Cornwall to engage service users and front line staff to explore what's strong with the system and where the system fails to live up to the principles and values

### "The team are doing a good job when they......

- 1 .....are nurturing, positive and supportive
- 2 .....make me feel like I am cared for
- 3 ....help me take steps to move forward and help me be motivated and hopeful
- 4 ....are assertive and persistent in safeguarding and empowering me to be safe
- 5 ....they treat me as an equal and unique, with empathy and are non judgmental
- 6 ....listen to me and are considerate and understanding of my past experiences
- 7 ...recognise and celebrate my skills and talents"

A video was produced for the second event where people who used the service also fedback on their experiences <a href="https://youtu.be/-wpzy3iNzCl">https://youtu.be/-wpzy3iNzCl</a>

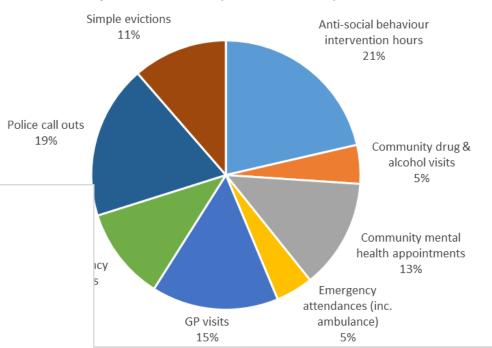
Harbour the accommodation provider have also ran series of online blogs that showcase new fully accessible self contained units at Little Cosgarne <a href="https://www.youtube.com/watch?v=Vx\_UplpXTBc">https://www.youtube.com/watch?v=Vx\_UplpXTBc</a>

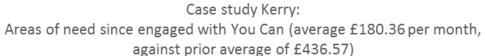
# APPROACH C) MAKING THE ECONOMIC CASE

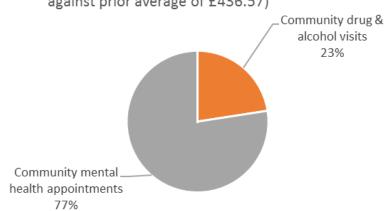
 Working Michela and Michelle from the national evaluation team to support Cornwall to identify 2-3 early case studies that will illustrate both the individual outcomes for people alongside economic evaluation of the pre intervention and post intervention costs to the system.

• The aim is to produce similar case studies to Kerry's earlier in the presentation.

# Case study Kerry: Costs prior to engagement by area of need (total £10,478)







# QUESTIONS AND DISCUSSION

What are you doing to make the case for funding or change once the pilot funding stops?

What would make the difference to your business case – could one of these approaches help?

If you would like to discuss using logic models, co-production or economic case studies as part of your business case development then please get in touch

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