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Integrated care pilot saved us £1m in one year

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Dr Alastair Bint explains why an integrated care pilot caught the eye of the health secretary.

Integrated care pilot, which generated net savings of £1m, was recently commended by health secretary Andrew Lansley for efforts to improve patient care. The partnership, between six practices in Guildford, Surrey and management support organisation IHP, came about through a shared recognition that patient services needed to be improved.

Established in January 2009, the group covered around 73,500 patients and was a collaboration of six GP practices, together with management support organisation Integrated Health Partners (IHP).

We have established ourselves as an integrated care organisation (ICO) and manage a capitated indicative budget of £59m (approximately £800 per patient to cover primary and secondary care). As well as making substantial savings – £1.6m in savings at a cost of £600,000 – taking an integrated approach to care allowed us to work more closely with health and social care professionals. It also meant we were able to simplify the patient journey and make it more seamless, particularly for patients who typically were dealing with care providers from several organisations.

As a member of the Guildford PBC cluster board in 2008, I felt PBC had some grand ideas. However, there were problems. It was difficult to implement the ideas as we often lacked data to start new projects, and getting them up and running tended to be a lengthy process. We also found it could be difficult to get GPs from different practices to agree on potential schemes.

Getting started

Our cluster lead, Dr David Eyre-Brook, set up a meeting with Dr Oliver Bernath, managing director of IHP and a consultant neurologist, to find out how they could assist us. As a result he was convinced that an ICO could help us to drive PBC forward. Six of the 13 practices in our cluster, including St Luke's surgery where I am a senior partner, decided to get involved, attracted by the possibility of being able to improve services and save costs.

Surrey PCT welcomed the ICO pilot and asked for bids to be submitted by September 2008. IHP drew up the costed bid after detailed discussions with the GPs.

Discussions between IHP and GPs, between partners in each practice and between different practices proved that we all shared a similar vision. Working with IHP gave us the clarity of vision to look at the difficulties with patient services and say: ‘Yes, we can make a difference.'

The eight areas where we felt services might be improved were: chronic disease management, end-of-life care, patient engagement, elective pathways management, claims validation, public health, medicines management, primary care in A&E.

Then, guided by IHP, we worked out the finer detail. The bid included estimates of costs, consisting of an allowance to the practices and to IHP for running the pilot, and the costs of service changes. All savings – estimated at £1m – would go back to the PCT. In October 2008 we won the bid.

The pilot carried little risk. The PCT paid for IHP's administrative costs to manage the budgets with the GPs, and for all service changes costs. It also gave practices an allowance to cover backfill costs for GP time to work on the scheme.

One of the benefits of being part of an ICO is that GP members are more accountable for their healthcare budgets. Our ICO had a capitated indicative budget of around £59m – an average cost of £800 per patient for using both primary and secondary care services (with some exclusions).

The key to getting all six practices to work together as an ICO was communication. Finding time to attend meetings to make sure our views were represented was one of the biggest challenges to getting the ICO up and running. But once schemes were established these meetings were fewer and focused on reviewing the results and seeing what more could be achieved.

Data sharing

Another challenge was getting all the practices to share data about prescribing and referrals, but once we realised that scrutiny of our practices would be used in a constructive way, we learned so much from the information we shared.

IHP had systems to track referrals, such as how many each practitioner was making to a particular specialty. Each partner of a practice would take responsibility for a specific clinical area. GPs could run referrals past them to find out about alternative services. Sharing data also highlighted areas where extra training might be needed.

As a result of data sharing we reduced outpatient appointments throughout the ICO by 0.7%, compared to a 5.2% increase during the same period in practices outside our project, resulting in savings of £230,000.

At first there wasn't much involvement from secondary care colleagues – they were probably at bit wary of what we were doing and our initial focus was on primary care. But this improved with increased information sharing and discussion as the pilot year progressed.

Every scheme we established had a steering group to oversee its development and a clinical GP lead and a management lead from IHP to make it happen. This ensured clear lines of responsibility and accountability were built into each project.

Initiatives

I was involved in some of the pilot's elective care initiatives. This involved improving some of the common intermediate care services. I looked at creating different elective pathways for patients, which would be

beneficial for care and involve less cost, such as using the skills of GP colleagues with specialist interests like dermatology.

I also led on a single point of access (SPA) scheme. I focused on patients who were on the cusp of requiring an emergency admission to hospital and looked at how to avoid this through alternative sources of care. This meant going through admission lists with the support of IHP to identify whether a hospital stay was necessary.

We ensured patients had rapid access to community physiotherapy services, offering occupational health visits to patients at home and giving them access to community beds. Together with our local community provider, we also established rapid-access care packages. So for example, if an elderly, frail person had fallen over at home, but was still able to, say, bathe or manage their shopping, I would ensure they had access to carers at home.

We established a direct line to intermediate care services so a community matron was always around to keep GPs updated about what services were available.

Achievements

Integrating services

A major achievement was integrating social services on to the specifically designed intermediate care referral form. Traditionally they had been separate, yet patients would sometimes fall in between the cracks between the NHS and social services care packages. We agreed with social care that they would accept a referral form when a patient needed their services as a way of avoiding a hospital admission.

During the pilot year, emergency admissions grew by 2.8% compared with a 6.3% growth for non-pilot practices. There was also a reduction in medical emergency admission bed-days of 7.8% compared to an increase in 0.3% for other practices in the area. The scheme prevented 51 admissions, which typically cost around £3,000 each.

Medicines management

We also looked at medicines management; ICO members were happy to share data, be advised on areas that could be improved and address wasteful prescribing.

PCT pharmacists worked with us to review patients' medical records. About 300 patient medication reviews took place in care homes and patients' homes and we reduced our prescribing spend by 3% compared with the previous year.

The rest of Surrey increased their prescribing spend by 1.1% over the same time period. The scheme achieved gross savings of £345,000.

End-of-life care

We were keen to focus on end-of-life care, ensuring that those who wished to were able to spend the last days of life at home.

To prevent needless admissions we adopted the Gold Standards Framework (GSF) for end-of-life care and the standards set by the Liverpool care pathway. All partners at the six practices attended end-of-life care training, organised by one of the palliative care hospitals in Guildford. We ran multidisciplinary meetings every six weeks, attended by Macmillan nurses and palliative care colleagues, to discuss the needs of patients with terminal illnesses and to ensure care was in place to allow them to stay at home if they wanted to.

Often, patients with terminal illnesses are admitted by out-of-hours doctors overnight because they are unaware of their specific wishes. We made sure providers were aware of their needs, which also prevented unnecessary admissions.

During the pilot we doubled the number of patients on the GSF and increased the number of patients who died in their preferred place by 6 percentage points. This will increase further this year as the patients registered on the GSF last year will now be able to die at home. The service meant 20 admissions were prevented in the pilot period, saving about £60,000.

Long-term conditions

The ICO also focused on enhancing the care of patients with long-term conditions. With IHP's assistance we were able to identify and prioritise those at highest risk. We believed if we were more proactive about intervening in the health of patients with conditions such as diabetes and COPD, we could reduce the number of times they would need to attend hospital.

We asked our community matrons to visit patients with long-term conditions at home to check their status. The ICO also held meetings to look at the list of patients regularly attending hospital and at ways to improve their care, for example by having district nurses make regular visits to those most at risk of hospital admissions.

In this way we were able to reduce hospital admission rates by 0.6% in a year compared with an increase of 4.6% in other Guildford practices. We also managed to reduce the total bed-days for emergency admissions by 7.8%.

The future

By April 2010, the ICO had made an overall saving of £1m. Our achievements prompted a visit from Andrew Lansley, then shadow health secretary, to St Luke's surgery. He commented on how great it was that GPs in the area had taken on responsibility for budgets and for making decisions about patient care.

Patients were also impressed. Throughout the pilot year, we encouraged them to help us improve services, with questionnaires and local patient partnership groups. Feedback was positive as patients perceived the services as being more responsive and joined-up.

Despite the ICO's achievements the PCT decided not to continue the scheme. This decision was made in April this year, prior to the general election. As the savings weren't ring-fenced they became absorbed in the PCT's general savings. However, we still believe there is the scope for an ICO to continue, and discussions are under way with IHP and the PCT to see how we might move this project forward.

Whatever the outcome, the lessons learned, such as the value of sharing referral data between practices, will benefit us greatly, and can be carried forward through GP commissioning. Now that we're back in our commissioning clusters, GPs who took part in the pilot are hoping to encourage other practice members to carry on the good work we started as an ICO. And the close relationships with social care continue.

Being part of an ICO was empowering and has given us the confidence to explore new possibilities in terms of GP commissioning. In light of the white paper regarding incentives for commissioners, IHP believes that GP providers could be in a powerful position. Care and pathway management is fundamentally a role for integrated providers, not commissioners. For the white paper to work, primary care will have to come together in powerful, integrated-provider organisations to do the job that the commissioning consortiums need the providers to do. So there is nothing to stop us identifying services that we could run more efficiently as GP providers.

To any GP considering becoming part of an ICO, I would advise them to grasp the opportunity. Don't be afraid of working with other practices and take the chance to share data in a constructive way. But to make an ICO work you will also need the support of a company like IHP, which can give an overview of how to improve services, while sharing your vision and becoming intimately involved in your work.

Dr Alistair Bint is a senior partner at St Luke's surgery in Guildford, Surrey

Guildford summary Breakdown of £1.6m annualised savings

Referral management

Practices conducted in-house peer review of elective referrals. The impact of their efforts was relayed to them and discussed in detail at monthly performance management sessions. Saving – £230,000

Walk-in centre integration

Following a detailed diagnostic project, the local walk-in centre was integrated into A&E to increase efficiency. Saving – £258,000

Prescribing

An enhanced medicines management initiative was implemented with closer multidisciplinary working, project management and more up-to-date data discussed at monthly performance management sessions. Reviews were also done in care homes. Saving – £345,000

Inpatient activity

A number of initiatives, in addition to referral management, concentrated on inpatient activity. These included end-of-life care, chronic disease management and extending the cover of the hospital in-reach team. End-of-life care focused on supporting non-cancer patients to die at home. Chronic disease management focused on identifying patients at risk and then establishing a multidisciplinary team to oversee their care. The in-reach team's main role was to facilitate patient discharge into the community. Savings – £560,000

Claims validation

An extensive analytical review of hospital codings was conducted. Savings – £200,000