Contents

1. EXECUTIVE SUMMARY 3

2. 2013/14: MOVING FROM ICP TO WELLWATCH 4
   2.1. Development of integrated care in Central London 4
   2.2. Developing integrated care in 2013/14 4

3. PRIORITY AREAS FOR 2013/14 4
   3.1. Patient registry 5
   3.2. Risk stratification 5
   3.3. Clinical care pathways 5
   3.4. Proactive care planning 6
   3.5. Care delivery and innovation 6
   3.6. Multi-Disciplinary case conferences 7
   3.7. Performance review 7
   3.8. Governance 8

4. OUTCOMES 2013/14 9
   4.1. Non-elective admissions 9
   4.2. Outpatients 11

5. FUNDING REQUIREMENTS 11
   5.1. Income budget 12
   5.2. Savings 13

6. ROLE OF THE IMB 13

7. ALIGNMENT WITH WHOLE SYSTEMS INTEGRATED CARE 14

8. CONCLUSION AND SUMMARY PROPOSALS 14

APPENDIX 1 - SUMMARY 2013/14 15
APPENDIX 2: LONG TERM PRIORITIES 26
1. EXECUTIVE SUMMARY

The Inner North West London (‘NWL’) Integrated Care Pilot (‘the Pilot’) was an ambitious programme launched in 2011/12 in the boroughs of Westminster, Central London, and Kensington and Chelsea. Its aims of bringing providers together through a shared vision of collaborative working continues and has expanded further into the four inner boroughs as well as boroughs in Outer NWL. 2012/13 has been characterized by further implementation and consolidation of the Pilot. A full summary of 2012/13 can be found in Appendix 1.

2013/14 is a critical year for the pilot, as it seeks to decentralize and embed within local structures in order to meet its central aim of sustaining and developing integration efforts to support the vision of the Central London Clinical Commissioning Group’s Out of Hospital (OOH) Strategy. As a group of provider organisations the Pilot proposes to embed efforts in line with the clearly articulated wishes of the CCG, and to meet the NCB mandate to:

‘Co-ordinate a major drive for better integration of care across different services, to enable local implementation at scale and with pace from April 2013’(NHS Mandate 2012, 2.7).

Over 2013/14, it is anticipated that the Pilot will move away from the centralised model that was necessary for implementation, towards a more localised and bespoke model which facilitates deep local integration and aligns with local CCG thinking in terms of new ways of commissioning health and social care services.

Central London are asked to support an application for £555,000 against the 70% NEL marginal rate savings fund. The Independent evaluation implied that savings should be realised from year 3-5, and we have projected savings in year 3 which, on the basis of each participating practice saving 1 NEL per month will break even, and if practices meet the stretch target of saving 2 NEL, then savings of £ 0.75m will be made. These have been netted off against the Wellwatch QIPP scheme to ensure no double counting.
2. 2013/14: MOVING FROM ICP TO WELLWATCH

2.1. Development of integrated care in Central London

In 2012, Central London CCG articulated a vision for care that would shift patients from utilisation of unscheduled care to planned care by identifying individuals at greatest risk of admission, developing and implementing care plans for high risk patients, organising as multi-disciplinary groups around the patient and remodelling services to match the vision for care.

This vision has been implemented through the Wellwatch case management service which targets the 61-91 centile risk stratified patient cohort to maintain and improve health and wellbeing. The ICP will work in partnership with this service to further establish integration as the norm.

2.2. Developing integrated care in 2013/14

The priorities for Central London have been developed with extensive engagement with a range of stakeholders, including members of the CCG, the senior management team, CCG Governing Body, The Wellwatch Leads and providers. The priorities for 2013/14 will be to develop build on the current model to deliver higher impact integrated care, through alignment with the Wellwatch programme and the broader development of whole systems integrated care.

Specifically in Central London the pilot will focus on:

1. Developing and embedding a locally-led and accountable governance structure within Central London, which clarifies the relationship between providers and the CCG, facilitates a more business as usual approach to integrated care, and supports the CCG’s out of hospital strategy.
2. Building on the current integrated platform to further embed and develop the potential of integration.
3. Supporting the transition to the next phase of integration which is the “whole systems” focus.

3. PRIORITY AREAS FOR 2013/14

The Wellwatch service is based on supporting people with a range of conditions between the 61-91 centile of the risk scores, and works with a range of providers in the health, social and third sector to support these people. The integrated care pilot will further support Wellwatch through the formation of initially one Wellwatch/ ICP multidisciplinary case conferences per month, and from quarter three, three Wellwatch/ ICP locality based case conferences per month.

Wellwatch selects patients on their relative risk score, rather than by pathway. This provides helpful insight and learning to the wider ICP, who plan to transition to this approach for high risk patients over the course of 2013/14.

As a member of the pilot, integrated care will be developed to achieve Central London’s aims and incorporate the lessons from the independent review. The eight priorities areas are outlined below, which align closely with the steps for integrated care:

1. Patient registry
2. Risk stratification
3. Clinical care pathways
4. Proactive care planning
5. Care delivery and innovation
6. Case conferences and multidisciplinary working
7. Performance review
8. Governance
9. Critical Enablers: Training and Organisational development, Patient Co-design

3.1. Patient registry

The IT supporting integrated care is a critical enabler, and in order to deliver the aspirations of 2013/14, immediate priorities have been established to improve the clinical function of the tool:

- Adopting the Outer ICP care planning templates which sit on GP host systems. This will both reduce clinical user frustration with the IT tool, and enable a more standardised disease management and care planning approach across the Inner ICP. These have already been rolled out in some areas; Central London clinicians are currently reviewing the templates.
- We plan to implement the COPD and CHD care planning pathways by June 2013 and start development on next priority pathways thereafter.
- Central London may choose to adopt these templates, which are based on extensive evidence review and best practice.

3.2. Risk stratification

Risk stratification is central to the delivery of integrated care, and offers significant benefits to the delivery of care.

Wellwatch have adopted this approach since the service was commenced, and the pilot will use learning from the Wellwatch experience to inform the wider pilot, which are planning to transition from a approach which selects patients on the basis of pathways, to one based on selecting patient on the basis of their relative risk score. Wellwatch may choose to use the ICP risk stratification tool if they wish.

3.3. Clinical care pathways

The Wellwatch service already has many interventions based on supporting people to maintain and improve their health. A potentially useful addition is the best practice pathways which provide evidence based disease specific management for clinical care planning. Two new pathways will be formally launched in 2013/14, COPD, and CHD, on a borough by borough roll out. Wellwatch and Central London can choose to be a part of this roll out if they wish, which is aimed at both reminding people of best practice and local guidance and in line with the Wellwatch philosophy of supporting self-care, through improving patient empowerment.

We have requested funding to support the development of two new pathways in 2013/14, which will be clinically developed with a range of expertise from across health and social care organisations in CWHH. The priorities will be agreed across all four CCG’s before commencing work to deliver additional pathways across INWL in 2013/14. £200K has been set aside for this from the operations team budget.
3.4. Proactive care planning

Wellwatch already undertake care planning for their patients, and it is proposed that enhanced care plans are undertaken, which are above the care plans thresholds already commissioned by CLCCG.

We have budgeted to allow a maximum of 2,612 care plans for Central, which is, as with the other CCG’s based on the top 20% of people with LTC’s.

3.5. Care delivery and innovation

To support care delivery and enable MDG’s to focus on service gaps, the Pilot made available innovation funds. However, the independent evaluation found that the innovation funds were not well utilised. Reasons for this include a relatively complex process, funding being granted too late in the year to enable delivery, and relatively small sums of money being available.

In order to overcome these issues, the funds will be changed in two ways:

- A single local approval process early in the financial year will approve all funding.
- Each locality will be able to bid to support local innovations or have central schemes which benefit the entire borough, (or a combination of both).

Discussion with the Wellwatch service and the CCG has indicated that Medicines Optimisation service, trialled in the ICP in 2012/13 would be of interest to Central CCG. A pilot of the MOP’s service has shown that there is significant quality and savings improvement in undertaking drug reviews for housebound patients. Review of service utilisation by risk score shows that those with a CPM of 50 or over are on average prescribed over 10 drugs per annum, and it seems that this scheme could be expanded and improved over the coming year by basing some of the activity in GP surgery’s, and therefore improving through put, and continuing to support reviews for housebound patients.

Specialist access

Several CCG’s, including Central London have identified that they may wish to have increased access to specialist support more frequently than during MDG’s. A previous innovation fund showed low utilisation of this model, and we believe there is an important piece of scoping work to be undertaken to understand both what access and what specialists are required and how this may be configured. The Wellwatch team has recommended rotating specialists at the MDGs (i.e. cardiology, respiratory, elderly care, diabetes, psychiatry and dementia) and this is one step towards improving this access.

Simplified approval process for innovation funding

In 2013/14, we believe the approval process can be simplified and enhanced to ensure maximum local benefit. To this end, we plan to have a single approval process in May. The meeting to allocate funding for the year will be chaired by a Clinical Commissioner from the Central London Board and be attended by MDG co-chairs and provider and patient representatives. This will enable commissioners and providers to agree funding in line with commissioning concerns and priorities, and also ensure that a full year of impact is assessed for each of the proposals.
The approved schemes will then be sent to the IMB to enable funding to be released, and mobilisation of the scheme. The proposed time lines and process is below:

**Innovation Fund decision-making process and timeline**

<table>
<thead>
<tr>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMB Business Plan approved</td>
<td>Business Plan approved by MIB</td>
<td>Business Plan approved by MIB</td>
<td>Innovation funding proposals provided to the CSM for consideration</td>
<td>Borough Meetings Proposals approved at exceptional CSM provider forum in each Borough</td>
</tr>
<tr>
<td>CGG priorities multi-organisation funded discussions with providers and commissioners</td>
<td>CGG priorities multi-organisation funded discussions with providers and commissioners</td>
<td>CGG priorities multi-organisation funded discussions with providers and commissioners</td>
<td>CGG priorities multi-organisation funded discussions with providers and commissioners</td>
<td>CGG priorities multi-organisation funded discussions with providers and commissioners</td>
</tr>
<tr>
<td>Innovation proposals requested from MDS and provider organisations</td>
<td>Innovation proposals requested from MDS and provider organisations</td>
<td>Innovation proposals requested from MDS and provider organisations</td>
<td>Innovation proposals requested from MDS and provider organisations</td>
<td>Innovation proposals requested from MDS and provider organisations</td>
</tr>
<tr>
<td>Ongoing CPD Ops Team to support MDS and providers to deliver projects and monitor outcomes</td>
<td>Ongoing CPD Ops Team to support MDS and providers to deliver projects and monitor outcomes</td>
<td>Ongoing CPD Ops Team to support MDS and providers to deliver projects and monitor outcomes</td>
<td>Ongoing CPD Ops Team to support MDS and providers to deliver projects and monitor outcomes</td>
<td>Ongoing CPD Ops Team to support MDS and providers to deliver projects and monitor outcomes</td>
</tr>
</tbody>
</table>

### 3.6. Multi-Disciplinary case conferences

The Wellwatch model is promoting a new type of case conference, aimed at supporting higher risk patients, or those with a rapidly changing risk profile, and using a rotational model of specialist support in line with the multi-condition nature of the Wellwatch service. The four specialities which will rotate are depression, respiratory, cardiac and diabetes. The case conferences will invite attendance from GP’s whose patients are part of the Wellwatch service, as well community teams, social care, mental health and geriatricians.

The case conferences will be two hours in length and include a component of training, which GP’s can decide if they wish to use for CPD purposes, in line with RCGP policy. A standard certificate will be issued as proof of attendance.

### 3.7. Performance review

The current focus of the Pilot has been on input metrics, however, there is increasing focus on output metrics beyond the Pilot. In 2013/14 we will have much greater focus on comparative output metrics, as well as input metrics, in key areas:

<table>
<thead>
<tr>
<th>Area of measurement</th>
<th>Metrics</th>
</tr>
</thead>
</table>
| **Patient experience and quality** | • Audit of care planning numbers  
• Patient experience questionnaire  
• HbA1C, Falls, BP, Cholesterol  
• Those who have a more than 10 medicines per year (reducing target)  
• Dementia Diagnosis against expected prevalence rates |
## Area of measurement | Metrics
--- | ---
**Activity** | • NEL, (self-reported and monitored from SUS data) EL, OP, A&E attendances  
• Emergency orthopaedics  
• Nursing residential and EMI home LAS call outs (from LAS)  
• Number of patients with over 5 NEL per year+
**Input metrics** | • Number of care plans  
• Case conference attendance profile  
• Cost per case discussed  
• Average risk score of those discussed at care plans  
• High risk NEL admissions with an LTC who have not got a care plan
**Social Care metrics** | • Number of people having home care  
• Number of people in residential, nursing or EMI care accommodation

All these data will be delivered to each MDG for performance reviews and to the IMB in aggregate. Further work will be undertaken to both understand the information Wellwatch require, and the information source. The actual function of the case conferences will also be reviewed regularly to ensure delivery of the most effective way of working.

### 3.8. Governance

Discussions with Central London have made clear that meaningful locality governance requires:

- Normalised commissioning oversight of the Pilot;
- Ability to input and prioritise significant in-year funding questions; and
- Ability to make the Pilot part of the OOH solution in each CCG.

To deliver this, the ICP will attend the Out of Hospital Workshops to ensure maximum usage of the ICP, and ensure no duplication of effort. Therefore, it is proposed that one MDG co-chairs, and the borough MDG manager attend these meetings, in line with the localisation and decentralisation of the operations team, and report back to the wider provider forum the requirements of the board.

In addition, a member of each CCG has been invited onto the IMB in order to complete the governance circle and ensure that issues from locality are escalated to the wider IMB.

As part of the assurance process for CCG’s with regard to the transition to a local pilot, an update with the progress taken in this regard will be taken to the September CCG board meeting.

### 3.9 Critical Enablers:

**Training and organisational development**

Within the ICP, a significant shift of behaviour has occurred, as people work within the MDGs collaboratively. This needs to be further diffused, as both inside and outside the ICP, health and social care professionals increasingly required to work as multi-professional teams, to both manage patients and the associated resources. In addition,
empowering patients to improve their autonomy and health is an important skill in the context of moving to more proactive care models.

Together with both providers and CCG’s we believe that training programmes can be developed which support this work both within and beyond the pilot. We are already undertaking training for the MDG co-chairs but believe to have wider impact training programmes which include components of standardised communication training (e.g. SBAR), Motivational interviewing and goal setting, Root cause analysis training, and simulation events.

**Continuing To Aspire To Patient Co-Design.**

An important component of the pilot design is the significant level of patient engagement, which we will continue to develop and augment over the next year. Our ultimate aspiration is to move towards patient co-design of services, and as more and more services move towards the home, the patient and carer perspective is critical. Within the pilot we will work as partners with patients in:

- The design of new pathways
- The design and approval of the innovation bids
- Developing training and development
- Membership of each committee
- The research into and the solutions to transitioning to a risk based approach.

To support this we will request funding to resource the time we require from patients and third sector to actively engage, which can also support Putting Patients First as required.

**4. OUTCOMES 2013/14**

**4.1. Non-elective admissions**

The recent external evaluation stated that significant impacts on activity could more realistically be anticipated over years 3–5 of the pilot.

In its first years, cohort growth has been significantly higher than overall population growth. However, this is likely due to one-off improvements in case finding for diabetes. We have assumed growth will revert back to commissioners’ expectations over the next two years. (Though the cohort will be selected by risk, rather than pathway, we expect current frail elderly and diabetic patients to remain in scope as a result of their risk of admission.)

Future non-elective activity has been modelled against three scenarios:

1. The Pilot continuing as it is for another two years and restabilising performance.
2. The Pilot continuing in an enhanced form with GP practices saving one NEL per month.
3. The Pilot continuing in an enhanced form with GP practices saving two NELs per month.

The cohort of specialities will remain the same, although the IMB will continue to monitor impact on the general medical specialities in particular as this is an area the Independent evaluation believed showed promise.
Previous work estimated the cost of NEL admissions at various percentiles of cost (INWL ICP bus plan 2012/13), and these are described below. The costs have been recalculated to exclude any outpatient activity, but do include both PbR and non-PbR costs.

<table>
<thead>
<tr>
<th>(£)</th>
<th>95th percentile</th>
<th>75th percentile</th>
<th>50th percentile</th>
<th>25th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost per non-elective admission</td>
<td>9,658</td>
<td>5,931</td>
<td>3,342</td>
<td>1,008</td>
</tr>
</tbody>
</table>

We have used these same assumptions in 2013/14, but believe the likely savings will be driven by activity which is between the 75–25% cost percentiles.

The saving associated with the three different scenarios for changes in activity, outlined above are detailed below.

This assumes that the 10 practices included in the Pilot at the start of the year will increase to 30 in the middle of the year, and these practices will all deliver the targeted reductions on non-elective admissions.

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total practices</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>Total practices participating</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>Total activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue as-is</td>
<td>1,629</td>
<td>2,639</td>
</tr>
<tr>
<td>Reduce 1 NEL / practice</td>
<td>1,389</td>
<td>2,171</td>
</tr>
<tr>
<td>Reduce 2 NEL / practice</td>
<td>1,149</td>
<td>1,703</td>
</tr>
<tr>
<td>Reduction in activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce 1 NEL / practice</td>
<td>-240</td>
<td>-468</td>
</tr>
<tr>
<td>Reduce 2 NEL / practice</td>
<td>-480</td>
<td>-936</td>
</tr>
<tr>
<td>Savings (£000s): Reduce 1 NEL / practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75th cost percentile</td>
<td>-1,423</td>
<td>-2,776</td>
</tr>
<tr>
<td>50th cost percentile</td>
<td>-802</td>
<td>-1,564</td>
</tr>
<tr>
<td>25th cost percentile</td>
<td>-242</td>
<td>-472</td>
</tr>
<tr>
<td>Savings (£000s): Reduce 2 NEL / practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75th cost percentile</td>
<td>-2,847</td>
<td>-5,551</td>
</tr>
<tr>
<td>50th cost percentile</td>
<td>-1,604</td>
<td>-3,128</td>
</tr>
<tr>
<td>25th cost percentile</td>
<td>-484</td>
<td>-943</td>
</tr>
</tbody>
</table>

This suggests that Central London could avoid 240–480 non-elective admissions next year. This would offer a gross saving (using the 50th cost percentile) of £800k–1.6m in 2013/14. As a key enabler of the Wellwatch scheme, it may be that in 2013/14 these savings should be netted off against Wellwatch to ensure no double counting of savings.

These estimates are based on the average cost of non-elective admissions, outlined above, and the targets for reductions in non-elective admissions per practice in the Pilot.

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1 Average across the year.
It is expected that the savings will increase in 2014/15 as the number of practices across NWL will increase, there will be no ramping of activity during the year and by the end of 2013/14 significant costs such as the data warehouse will be part of the CSU data warehouse.

In addition, the ICP will be a critical enabler in 2013/14 of wider system changes. It will support Central London to embed good practice for OOH delivery, facilitate further integration, and continue to support planned care.

In 2013/14, this activity will continue to be tracked via the data warehouse, supplemented with and validated by self-reporting by MDG practices.

4.2. Outpatients

The evaluation of the 16 pilot sites in the UK showed a reduction in OP attendances of approximately 5%. There may therefore benefit to commissioners in the number of outpatient attendances for patients in the Pilot.

To understand the impact of the Pilot on outpatient activity, we will be tracking outpatient and elective activity in 2013/14, with potential targets set against these areas once risk is better understood.

5. FUNDING REQUIREMENTS

The budget has been created taking into account the developments and proposals within the 2013/14 Pilot business case. The budget, as presented, covers the full running cost of the Pilot for the financial year 2013/14. A budget has not been set to cover for risk and inflationary pressures, as this is considered to be minimal.

The funding for running MDGs will be allocated to Central London and forms part of the localising resource supported by the central programme team. The central programme team will provide both strategic direction and operational performance measurement support to Central London and the other CCGs included in the Pilot.

<table>
<thead>
<tr>
<th>Cost pool</th>
<th>Assumptions</th>
<th>Central London Funding request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Planning</td>
<td>Care Plans reimbursed at £40, for ICP pathways above commissioned targets</td>
<td>£104,480</td>
</tr>
<tr>
<td></td>
<td>The budget allows for 2,612 care plans for Central London in total</td>
<td></td>
</tr>
<tr>
<td>MDG</td>
<td>1 two hour MDG months 1-6, 3 MDG’s months 7-12. Performance Reviews at the end of quarterly MDG’s Core membership includes Wellwatch team, GP’s (or practice nurses), Community Nurse, Social Care, Mental Health and care of the elderly physicians, with rotational specialists thereafter. Time reimbursed on basis of attendance. Covers costs of current MDG manager and administrator establishment</td>
<td>£260,917</td>
</tr>
<tr>
<td>Cost pool</td>
<td>Assumptions</td>
<td>Central London Funding request</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Innovation funds</td>
<td>Enable MDG’s to deliver at scale projects which support out of hospital care, with evaluation to enable commissioners to decide whether to put it into core intentions. Allocation of funding based upon the number of people with a LTC and a CPM score of 30 or more in borough, reimbursed at £280/ person.</td>
<td>£168,840</td>
</tr>
<tr>
<td>Training and Education</td>
<td>Deliver training and education which enables the clinical teams in localities to develop, and to empower patients to self care, such as motivational interviewing.</td>
<td>£50,000</td>
</tr>
<tr>
<td>Transition from Pathways to risk</td>
<td>Costs will cover scoping work, across CWHH, and any additional on costs to support delivery.</td>
<td>£50,000</td>
</tr>
<tr>
<td><strong>Central team, including hosting and development</strong> Staff pay and non-pay costs</td>
<td>Support the project and implementation focus of the pilot. Develop 2 new pathways which can sit on host GP systems by the end of 2013/14, based on agreed INWL priorities. Hosting costs with CLCH cover the use of accommodation, telephony, copiers with some corporate support services. The staff costs cover the central programme management team, and include the chair, medical directors, senior management team, finance and administration support. Non pay costs cover room bookings and miscellaneous expenditure. Reimbursement of third sector time, and support to enable effective patient codesign. Cost to reduce over 2013/14 as decentralisation takes effect.</td>
<td>£117,137</td>
</tr>
<tr>
<td>Informatics, analysis and IT MSA costs</td>
<td>Maintain and manage data warehouse, analyst support. Informatics includes the ITMSA plus data analysts. The data warehouse costs should have been replaced with the new Business Intelligence platform early in the new financial year; however it now appears that the current arrangements will have to be extended. Had the new BI contract been in place it would be expected that these costs would have reduced considerably.</td>
<td>£79,695</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>£831,069</strong></td>
</tr>
</tbody>
</table>

5.1. Income budget

The pilot has carried forward £2.2m from 2012/13, due to practices in Hounslow, QPP and Central London engaging in the Pilot later than expected, resulting in fewer care plans and MDGs than forecast. This underspend has been apportioned across the CCGs.
participating in the Pilot based on their cost requirements: therefore, £275,789 will be used to offset Central London’s costs for 2013/14.

This results in a net budget requirement of £555,280.²

<table>
<thead>
<tr>
<th>INCOME TO PILOT 2013-14</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG INCOME 2013-14</td>
<td></td>
</tr>
<tr>
<td>Funding Requirement</td>
<td>831</td>
</tr>
<tr>
<td>Less carry forward</td>
<td>-276</td>
</tr>
<tr>
<td>TOTAL INCOME BUDGETED IN 2013-14</td>
<td>555</td>
</tr>
</tbody>
</table>

5.2. Savings

As outlined above, the Pilot is expected to make a gross saving of £800k–1.6m in 2013/14.

Net of costs, this means the Pilot is expected to save £247k if all practices save one non-elective admission a month in 2013/14. Performance above this – saving two non-elective admissions per practice in 2013/14 – will offer net savings of £1m.

The savings associated with avoided activity has been prudently targeted at the 50th percentile cost, rather than the previously deployed 75th percentile cost. This coupled with a realistic achievable avoided admissions target means the pilot will achieve breakeven, but set against a target to stretch the organisational delivery to 2 avoided emergency admissions the savings accrued would be £1m per annum.

Central London has, however, £750,000 of Wellwatch savings expected in 2013/14, which would need to be removed from any net saving to ensure we are not double counting.

6. ROLE OF THE IMB

As the Pilot localises, and the Continuity of Care Board provides regular governance, the role of the IMB will change. To support all the CCGs involved with the Pilot, the IMB will:

- Focus on performance and outcomes, including the oversight of the cross-borough implementation plan on behalf of each of the CCGs.
- Bring providers together to solve problems which potentially undermine the scale and capacity of the Pilot.
- Share good practice to support integration.
- Test solutions to ensure they work across provider landscape.
- Continue the conversation about large scale integration.

The relationship between the IMB and the four CCGs involved with the Pilot is outlined below.

²The total budget for the INWL ICP will be drawn down and accounted for via the pre-existing Trust deed, with CCGs being the successor organisations to the current PCTs within the terms of the Trust Deed, and CLCH continuing as the host organisation.
7. **ALIGNMENT WITH WHOLE SYSTEMS INTEGRATED CARE**

The on-going development of whole systems integrated care has delivered a vision for the next stage integration, which moves the care of high risk patients into a provider grouping that considers the persons whole needs. This work is being led by commissioners across NWL, and it is important the ICP complements this agenda.

Achieving this vision of care without boundaries is complex as it requires a significant shift of behaviour across each the health and social care sectors. This potentially overlaps with the work of the Pilot. To avoid this, the Pilot will have gateways at each stage of the programme to review its own position and ensure that the current integrated care platform can be effectively transitioned as appropriate.

CL CCG and Wellwatch are already working in a special interest group with community nursing, adult and social care, to devise an integrated approach of step up, step down for patient through 3 different levels of care- 1) top high need patients- (usually known to DN teams, LAS, Rapid nursing etc)(, 2) Wellwatch team – known to HSCC and local coordinators, CNWL, social care etc 3) low risk- mostly preventative care for pts with LTC-known to practices –Gps and nurses- engagement and patient education being vital , pts being aware of voluntary sector services.

8. **CONCLUSION AND SUMMARY PROPOSALS**

2013/14 represents a critical year for the Pilot. From a period of implementation and consolidation, the Pilot must now be embedded so it can be sustained and developed at a local level in subsequent years. In addition, the efforts for deeper integration must continue to promote better more continuous service for people served by Central London health and social care services and its neighbouring CCGs, providers and local authorities.
APPENDIX 1 - SUMMARY 2013/14

The Pilot was an ambitious programme set up in June 2011 to engage a range of health and social care providers, including general practices, acute and mental health specialties and community care, across Inner North West London in collaborative and proactive working for a defined group of higher risk patients. Much of the first year concerned the mobilisation of the pilot including developing clinical pathways, forming multi-disciplinary groups (MDGs) and implementing the IT solution / tool. The second year has been characterised by consolidation, localisation and further expansion of the pilot.

1. POPULATION COVERAGE AND PARTNER SIGN UP

In its first 18 months of operation the reach of the ICP has substantially increased from that of its original design. In the first year the Pilot exceeded its target of 375,000 registered patients and to date, with the expansion of the Pilot into Hounslow and others parts of West London such as Queens Park and Paddington, the population of registered patients is approximately 750,000.

The Pilot gained 21 new general practices and four new MDG groups in its second year. This has been complimented by the re-engagement of the Central London areas through their newly created case management service - Wellwatch.

The expansion into Hounslow saw a West Middlesex University Hospital (‘WMUH’) join the Pilot and they will now engage their specialist clinicians in the MDGs as well as share their patient clinical data to further improve patient management and performance management across north west London.

Acton, a locality in the Borough of Ealing, has been engaged with the Pilot since mid-2011 and have proved to be a strong and well embedded group. The remainder of Ealing joined the Outer ICP during 2012/13 with the intention for Acton to transition across to the Outer Pilot at the commencement of 2013/14.
Figure 1: Borough Practice and Current MDG profile

<table>
<thead>
<tr>
<th></th>
<th>Total Practices</th>
<th>Practices Participating</th>
<th>MDG MONTH</th>
<th>GP</th>
<th>Acute Consultant</th>
<th>Social Worker</th>
<th>Community Nurse</th>
<th>SP Nurse</th>
<th>Pharmacist</th>
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<tr>
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<td>54</td>
<td>35</td>
<td>3</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Central London</td>
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<td>34*</td>
<td>1</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>H and F</td>
<td>31</td>
<td>30</td>
<td>4</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Hounslow</td>
<td>56</td>
<td>23</td>
<td>4</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>×</td>
<td>×</td>
</tr>
</tbody>
</table>

*Westminster GP involvement is through Wellwatch

2. OVERALL BENEFITS OF THE ICP

The overall benefits of the Pilot can be described in terms of:

1. MDGs and case conferences;
2. Care planning;
3. Quality;
4. Quality through innovation; and
5. Activity impact.

2.1 MDGs and case conferences

Multidisciplinary groups are the clinical unit of the Pilot, and all participants have worked hard to establish good relationships between providers and a functional forum in which to discuss complex patients, learn and share good practice. In 2012/13 the role of the MDG co-chair was developed and there are now a mix of social care, mental health, acute, community care and GP co-chairs. The case conferences continue to provide the only forum where:

- Representatives from all participating sectors of health and social care meet to improve the care of individuals with more complex needs;
- GPs are facilitated to provide mutual support across practices in a formalised way;
- Local services are discussed and understood with a view to improve patient care; and
- Providers from different parts of the health and social care economy come together to review joint performance aspirations.

As well as the MDGs and case conferences being cited as the most beneficial aspect, it remains a key priority of the Pilot to continue to develop these units, whose provider function can be expanded to support many elements of the CCGs’ OOH Strategies. Over the last year significant improvements have been made to the configurations of MDGs to meet local needs and improve efficiency of discussions and learning. Feedback collected from the case conferences demonstrates that over 60% of clinicians believe that the advice given in a case conference has prevented an emergency admission for their patient.

Below is a comparison of some of the key activities for MDGs in 11/12 and 12/13:
2.2 Care Planning

Proactive care planning is a key component of the Pilot. Primarily undertaken by clinicians in a general practice setting it involves an appointment with specifically targeted diabetic and elderly patients to proactively discuss their health, wellbeing and social care needs and to determine how best the patient can be supported.

2012/13 has seen a steady increase in the number of new care plans created, as well as those that have been reviewed. Activity is expected to accelerate in Q4 of 2012/13 to coincide with other Quality Outcomes Framework and primary care activities traditionally undertaken in Q4, as was seen in 2011/12. In 2012/13 to date 22,885 care plans have been completed, a significant increase on the 18,000 care plans completed in the first year. The quality of the care planning process has been a key focus in 2012/13 and as the Pilot continues it is expected that improved data transfers, new GP-host system templates and more training will help improve these outcomes.

2.3 Quality

The Pilot has continued and increased its efforts to ensure that patients in north west London receive high-quality care. The evaluation of the first year of the Pilot identified a promising outcome of the work, demonstrating the significant increase in the rate of diagnosis of dementia. This was reported as being a direct result of proactive care planning and integrated working – something the Pilot hopes to replicate in other areas. Below is a graph showing dementia diagnosis rates since the start of the Pilot, demonstrating a continued pattern of growth over the last 12-18 months.
Improving rates of dementia diagnosis is a key objective of the North West London CCGs and the North West London Cluster and these results show alignment of the Pilot’s activities with mainstream care to demonstrate improved patient outcomes.

Another important testimonial to the improvement made to patient care as a result of the Pilot is demonstrated by the results of the patient survey, undertaken as part of the independent evaluation.

Below is a summary of some of the results:

The results convey a positive message from the patients who took part in the independent evaluation survey about the improved levels of control patients felt as a result of care planning, and their increased appreciation of primary care services.

The patients demonstrated a clear desire to be more involved in their care, noting that they would like their own copy of the care planning outcomes, as well as a greater understanding of the care planning process. The learning gained from the survey forms an essential part of the next steps described for 2013/14.

2.4 Quality through innovation

Innovation funds have been deployed by MDGs in accordance with the objectives of the Pilot, aiming to improve innovative practice, reduce unnecessary hospital admissions and improve integrated working. A range of schemes has been supported, from Tai Chi for the elderly to improve muscle strength and balance to prevent falls, to increased administrative support to clear the waiting lists generated for memory clinics through improved diagnosis. The wider benefits of the process are that it supports locality based service review and commissioning, and enables clinicians to work together to solve common problems.

Some of the schemes have had significant and immediate impact, such as the case study presented below. However, it is noted that the funding approval process is complex and efforts to simplify this will be made in 2013/14 with:

- An increased level of funding for innovation funds within the Pilot, enabling better scale and potential; and
- A single process in 2013/14 which will improve governance and decision making and enable the Pilot to fully utilise innovation funds.
2.5 Activity Impact

The results of both proactive care planning and MDG case conferences are seen in a number of ways; patient and user experiences (above), professional experiences and non-elective (NEL) acute activity.

The monitoring of NEL performance is an important focus of the pilot. The Independent Evaluation found that there had been no evidence of impact upon activity, but cited international evidence that demonstrated we should expect to start seeing savings from year 3 onwards. In addition, the independent evaluation highlights the challenge of finding a suitable population control. As a result, we are reviewing activity compared to the ICP cohort, which tells us what the impact/1000 admissions is.

We have undertaken analysis which shows that the NEL rate per 1,000 cohort population has decreased slightly during 2012, Fig 1, 2. Though the cohort has growth during 2012, as discussed above, the number of non-elective admissions for these patients has decreased.

Whilst this is to be expected, we believe that 2013/14 needs increased focus in order to ensure the expected savings, which are around more targeted interventions and relentless focus on performance.
Rate of NEL
Rate of emergency admissions for elderly and diabetic patients at Imperial and C&W Hospitals per 1,000 ICP patients
2012 (exc. ZLOS)

Date
Jan-12 Feb-12 Mar-12 Apr-12 May-12 Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12

Rate of non-elective admissions per 1,000 patients

Rate of NEL
Number of emergency admissions for elderly and diabetic patients at Imperial and C&W Hospitals and number of ICP patients
2012 (exc. ZLOS)

Date
Jan-12 Feb-12 Mar-12 Apr-12 May-12 Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12

Activity
Cohort

Non-elective admissions

Patients registered with the ICP
3. FINANCIAL POSITION

Financial Forecast Year End position 2012-13

<table>
<thead>
<tr>
<th></th>
<th>Care planning cost</th>
<th>Total case conference</th>
<th>Performance review costs</th>
<th>Innovation Fund</th>
<th>Chair and Co-Chair</th>
<th>Total MDG costs</th>
<th>Central Budget &amp; Informatics</th>
<th>Reserves</th>
<th>Total</th>
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<tbody>
<tr>
<td>Total</td>
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<td>972,243</td>
<td>161,104</td>
<td>787,817</td>
<td>190,000</td>
<td>3,912,413</td>
<td>2,092,154</td>
<td>1,116,463</td>
<td>7,123,030</td>
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<tr>
<td>Forecast Year End</td>
<td>1,671,830</td>
<td>540,639</td>
<td>48,821</td>
<td>557,836</td>
<td>40,967</td>
<td>2,860,093</td>
<td>2,013,755</td>
<td>60,000</td>
<td>4,933,848</td>
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<tr>
<td>Underspend</td>
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<td>431,604</td>
<td>112,283</td>
<td>229,981</td>
<td>149,033</td>
<td>1,052,320</td>
<td>78,399</td>
<td>1,058,463</td>
<td>2,189,182</td>
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</tbody>
</table>

The Pilot is forecast to be underspent by £2m at 31 March 2013. The above information covers the last two months of the Pilot’s first operational year, ended 31 May 2012 and the ten months of the second operational period to 31 March 2013.

Since the Pilot had only commenced in June 2011, despite having a full year of funding, in 2012/13 funding was given to cover the remaining ten months of 2012/13, and align it with normal NHS funding cycles. The second operational period covers the period from 1 June 2012 to 31 March 2013, and was funded to the value of £4,916k with £2,207k brought forward from 31 May 2012.

The underspend in 2012/13 is due mainly to deployment slippage, where the planned start dates for MDGs and subsequent case conferences and performance reviews were delayed. In addition, reserves were held for new care pathway design, whole systems baselining and IT deployment, and all three of these actions have also been delayed.

Innovation funds are underspent mainly due to the time lag in getting bids approved and signed off by MDGs and shadow CCGs, and a combination of the delivery time frames with an end date of the 31 March 2013. It is anticipated that a more refined process for allocating innovation funds in 2013/14 will help to rectify this issue.

4. DEVELOPMENTS 2012/13

4.1 Localisation of approach

As the pilot becomes more embedded in each borough, an increased level of localisation is to be expected and welcomed. A key example of this is the operational model agreed with the Westminster CCG. CLCCG had been working on an integrated care model based on risk stratification (Wellwatch) since 2009

Central London CCG

In Central London integrated case conferences will be provided through the Wellwatch case management service. The first Wellwatch / Pilot case conference is at the end of January 2013. It is an important development for the Pilot, as it embeds the Pilot’s objectives within a locality structure which is focussed on the CCGs OOH strategy, and therefore represents an evolution of the Pilot.

Hounslow CCG

In Hounslow, Chiswick MDG has been part of the Pilot since it commenced in 2011. In 2012, following discussions and agreement with the CCG, the ICP started to work with a wider group of practices and commenced 3 new MDGs, with case conferences held in Q3 of 2012/13. These groups mirror the current clinical networks that have been established by the CCG, showing strong alignment with core activities. In total there are now 23 practices and 4 MDGs involved in the inner Pilot across Hounslow, with further engagement planned for Q4 2012/13.
Another positive development is the addition of WMUH as a Pilot partner in North West London, and specifically Hounslow. This will enhance professional input to MDGs across the borough as well as offer a more comprehensive patient data set. Clinical data is expected to be extracted in Quarter 1 of 13/14 in order to facilitate performance management and integrated data sharing. While MWUH configure their consultant job plans for remainder of the year, in Q3 2012/13 Hounslow are being supported by clinicians from Imperial College Hospital, which shows a real collaborative approach from Pilot provider organisations.

**West London CCG**

Practices and partners in Kensington and Chelsea continue to be engaged as long standing members of the Pilot. A key development for this CCG in 2012/13 was the addition of Queens Park and Paddington as a new MDG. 7 of the 14 practices have now signed up to participate, case conferences have taken place and an MDG chair has been identified.

**Central London CCG**

In Central London, the relative stability of the MDGs has enabled much innovation, especially of case conferences, with a range of teleconferencing options, and models to enable smaller practices to effectively participate in the Pilot.

Overall the Pilot continues to work with emerging CCGs and clinical leaders to develop and implement OOH plans via local forums and working groups. For example, in West London the Pilot is engaged in the Putting People First programme, which is currently seeking to scope out integrated initiatives and co-ordinate and improve OOH care. There are similar groups across all four inner north west London boroughs.

4.2 Patients as partners

Key to the success of the Pilot in terms of design, decision making and care delivery is the involvement of patients and service users in virtually every aspect of the Pilot. Wellwatch in Central London, had used patients in codesigning their service back in 2009. This has meant positive support from patient groups in engaging and feeding back re the service. The ultimate aspiration is to have patient co-design at service level. Currently patients support the operational and strategic thinking of the Pilot in all forums apart from case conferences and performance reviews. The Patient and Carer Committee, chaired by third sector representatives, has been established to help further shape the pilot. This substantial level of engagement has been facilitated through the leadership and support of Age UK and Diabetes UK, who have helped develop expertise in both patients and the ICP operations team.

4.3 Education impact – patients and professionals

Following the results of the evaluation and feedback from the MDGs, the ICP has focused on providing more structure around education and sharing information in the second year of the Pilot. Providing care in an integrated way draws on unique skills and education and information sharing are seen as the strongest enablers to a successfully and sustainable integrated system.

2012/13 has seen the Pilot conduct and support a programme of structured education for participants, with events for patients and users, front-of-house staff, middle-grade doctors, and the MDG co-chairs. The programme has largely focused on two key elements - understanding the experiences of each group in the current system and using this information to make changes and improvements to care, and providing training in
the different skills each group might require to participate effectively in an integrated care system. Each event has built on the last and has aimed to leave a legacy for cultural and behavioural changes that will continue beyond the pilot. It is envisaged that the education programme will continue into 13/14 to build on the successes of the second pilot year.

Another important consideration of the ICP is how best to further share the learning associated with the ICP and MDG Case Conferences and operational activities with wider clinicians, professionals and organisations not yet engaged in integrated care delivery. Some of this is achieved by engaging with practices and partners in a regular and structured way throughout the Pilot, however it is recognised that more needs to be done to share and disseminate the lessons and learning across the North West London area.

4.4 Information technology

The Pilot is supported by an Integrated IT Platform, which is able to extract data from a range of organisations, providers and general practices to present a single snapshot in terms of patient history and risk factors. The front end platform seen by professionals has 3 key elements:

- Risk stratification;
- Performance management; and
- Care planning.

This is supported by the data warehouse that combines and processes the information.

The recent independent evaluation of the Pilot found that the IT tool was another key enabler when establishing the Pilot, and internationally is found to be a key component of integrated care delivery. However, whilst instrumental in supporting the concept of integrated care in north west London, it has also been a cause of frustration amongst clinicians and those using the tool, despite still being one of the only pieces of software nationally which integrates so much patient information into a single point. The frustration is caused by the duplication of data entry, and the lack of standardisation with regard to care planning, both of which will be addressed in 2013/14.

The care planning process, and therefore the use of the Integrated IT Tool, has lacked some of the standardisation necessary to ensure a single approach to care planning in NWL. In order to address this, care planning templates based on best evidence, and refined and endorsed by expert sub groups, have been created for the elderly and diabetes care pathways, for all NWL GP system platforms (Emis, Vision and SystmOne). This will deliver a standardised quality of care planning for patients and professionals and simplify processes and data collection. COPD and CHD pathway templates are also being designed. The plan is that the templates will interface directly with the ICP IT tool for performance reporting and risk stratification and therefore reduce double entry for clinicians and ease the burden of care planning.

Additional IT costs have been incurred through the increased number of stakeholders within the pilot, including an increase in IT infrastructure costs (data extraction, cleansing and uploading) and temporary additions to operational staffing.

4.5 Independent evaluation and research

In 2011/12 an independent evaluation was commissioned, and carried out jointly by Imperial College and the Nuffield Trust, funded by the Imperial College Charity. This report concentrated on the initial period of operation in 11/12 and covered start up,
Central London Integrated Care Pilot (ICP) Business Plan 2013/14

implementation and mobilisation. The report was commissioned to describe the implementation of the Pilot, and its impact, with a view to assisting the Pilot as it progressed and to inform other integrated care initiatives in the NHS. The report has now been published and recommendations and learning will underpin our thinking for the third year operational model as well as contribute to the body of evidence being used by commissioners and providers across the UK and internationally.

It examined 4 key areas (work packages):

<table>
<thead>
<tr>
<th>AIM OF THE PILOT</th>
<th>EVALUATION WORK PACKAGES</th>
</tr>
</thead>
</table>
| Understanding the Pilot’s position within the broader integrated care agenda | WORK PACKAGE 1  
Qualitative analysis looking at the strategic nature of the Pilot, including: the type of integration produced, analysis within the national policy context and understanding the higher level decision-making processes involved. |
| Reduce unwarranted service utilisation and costs       | WORK PACKAGE 2  
Measuring service usage patterns in relation to secondary and social care, using a propensity-matched case control model, allowing cost changes to be understood. |
| Improve clinical outcomes and quality of care          | WORK PACKAGE 3  
Using a mixture of clinical process and outcome measures to observe service quality, both in primary and secondary care. |
| Improve patient and professional experience            | WORK PACKAGE 4  
A mixed methods approach to capture both professional and patient experiences of the integrated care process. It consists of: 1.) Non-participant observations of multidisciplinary meetings, patient case conferences and operational meetings; 2.) Focus groups with patients and professionals; 3.) Semi-structured interviews with patients and professionals; 4.) A mixed method survey with main stakeholders. |

5. KEY FINDINGS AND ACTIONS

From the evaluation work packages outlined above the Pilot has been able to identify the key findings and areas of learning and look at specific responses which will form the basis of the 2013/14 strategy. Below is a summary of those key points and actions:

- **Dementia diagnosis:** The improvement in the diagnosis of dementia is perhaps one of the most striking achievements of the Pilot, achieved almost immediately as a result of integrated working.
- **Effective governance structures:** The Pilot rapidly established workable governance and financial arrangements.
- **Well-aligned financial incentives:** It is acknowledged that financial incentives have had to overcome inherent tensions within the NHS. However, the report notes that “the financial arrangements within the ICP had been carefully designed to create aligned incentives” and that the “symbolism of the savings
Central London Integrated Care Pilot (ICP) Business Plan 2013/14

...have been critical in overcoming initial fears” [within acute trusts and primary care].

- **Connecting clinicians**: The report recognises the practical value of case conferences in connecting clinicians across different organisations. Specifically, “putting faces to names... [has been] very powerful in engendering a sense that [clinicians] are all working towards the same objective” (p. 29).
- **Increased provider collaboration across care levels**: The report found that 68% of providers surveyed believe that the Pilot has resulted in improved collaboration across the care sector.
- **Improved patient experience**: The report notes that “patients with a care plan demonstrated a great enthusiasm towards the new way of care planning”.

The report also highlighted areas which need to be improved, some of which have already started to be addressed, and others which will be addressed fully in the 2013/14 business plan. These include:

- Governance at IMB level should be streamlined and improved;
- Greater accountability and emphasis on quality outcomes is needed at MDG level;
- More priority should be placed on patient involvement in the care planning process;
- IT infrastructure and information should be exploited further;
- Education has an important role in cultural change and should be a focus;
- Innovation funding should be used effectively and fully utilised;
- Further alignment, engagement and communication is needed with partners if the Pilot is to succeed;
- Activity shifts should continue to be monitored, as improvements may take 3-5 years;
- Further increase patient involvement;
- Resolve some of the IT issues which are frustrating for users;
- Improve the care planning process, and ability to audit; and
- Savings may start to emerge between year 3-5.

The findings of the report will be addressed, and the solutions embedded in the Pilot design as it moves into a sustainable model over 2013/14.
APPENDIX 2: LONG TERM PRIORITIES

Significant work took place in partnership with the Outer Pilot to scope the needs of the data warehouse and the clinical requirements to most effectively deliver integrated care. The aim was to progress a single procurement for all elements of the IT solution and incorporating the development of the data warehouse for clinical commissioning. It was subsequently decided to de-couple the elements of the solution and progress each element separately whilst ensuring integrity of the overarching solution. The IT solution comprises of a number of layers a) Primary Care – Care Planning Templates b) Data warehouse to store and enable sharing data and c) Suite software modules to share care plans and review Pilot performance.

Figure 1 : IT requirements for integrated care

The first layer care planning templates have been developed to reflect the clinically-developed and agreed care pathways. Sitting within each practice system these enable practices to develop care plans for their patients. These templates are integrated with GPs’ existing practice systems and do not require a separate programme or web-portal to be opened; this has helped the ICP become a normal part of the daily routine in general practice.

The template:

- Helps structure the consultation according to the agreed care pathway, helping to ensure that the clinician asks the relevant clinical questions.
- Enables the clinician to record the key clinical data in a consistent way.
- Enables the recording of patient consent to sharing their data amongst the participating organisations in the ICP.

These templates are already in use in the Outer Pilot and there are plans to roll them out in the inner boroughs from January 2013. These templates will align with the CCGs’ strategic intention that all practices within the CCG choose to move to one clinical system.
The second layer the **data warehouse** is currently being procured by the North West London Commissioning Support Unit on behalf of the eight CCGs of NWL and the two Pilots. Until the data warehouse is live the Pilot will continue to use its existing warehouse. The Outer Pilot does not have access to a data warehouse.

The design of the third layer the **suite of software modules / second generation tool** awaits the procurement of the data warehouse. A collaborative approach has been taken across both Inner and Outer Pilots, and has been driven by clinicians. The second generation tool is designed to meet the needs of both of the Pilots into the future, in particular the drive towards whole systems integration within some boroughs, and the interoperability agenda across NWL. The second generation tool will now be subject to a separate business case which will be developed on behalf of the eight CCGs as appropriate. In the interim, the Pilot will continue to use its existing IT tool. The Outer Pilot does not have access to an IT integrator tool.