



NWL Whole Systems Integrated Care (WSIC) Dashboards

London Borough of Hammersmith & Fulham
Health & Wellbeing Board

20th June 2017

Appendix 1

Objectives of today's session

1. Introduce the NWL WSIC Dashboards that provide an integrated view of patient activity and cost
2. Explain how the WSIC Dashboards are being used to coordinate care for NWL patients.

Who is developing the WSIC Dashboards?

Key enabler to North West London's Sustainability and Transformation Plan (STP)

Key facts • Over 2 Million People • Over £4bn Annual Health & Care Spend • 8 Local Boroughs • 8 CCGs & Local Authorities • Over 380 GP Practices • 10 Acute & Specialist Hospitals • 2 Mental Health Trusts • 2 Community Health Trusts

CCGs

- Central London Clinical Commissioning Group
- Harrow Clinical Commissioning Group
- Ealing Clinical Commissioning Group
- Hounslow Clinical Commissioning Group
- Hillingdon Clinical Commissioning Group
- HammerSmith and Fulham Clinical Commissioning Group
- Brent Clinical Commissioning Group
- West London Clinical Commissioning Group

Social Care

- London Borough of Hounslow
- City of Westminster
- Brent
- h&f
- Harrow COUNCIL LONDON
- Ealing

Acute

- The Hillingdon Hospitals NHS Foundation Trust
- Chelsea and Westminster Hospital NHS Trust
- London North West Healthcare NHS Trust
- Imperial College Healthcare NHS Trust

GP Practices

400

Mental Health

- Central and North West London NHS Foundation Trust
- West London Mental Health NHS Trust

Community

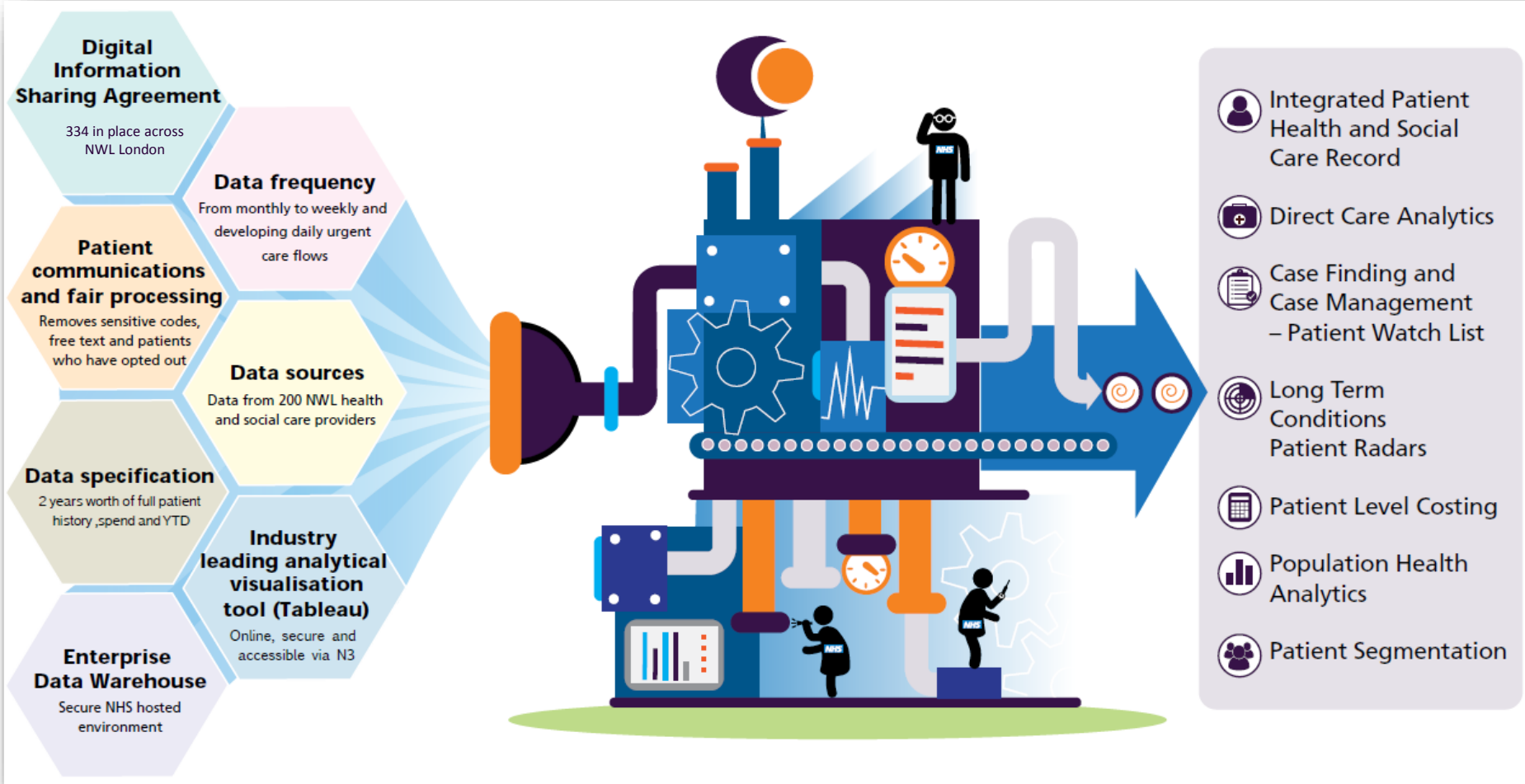
- Central London Community Healthcare NHS Trust
- Hounslow and Richmond Community Healthcare NHS Trust

Out of area

- University College London Hospitals NHS Foundation Trust
- Moorfields Eye Hospital NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust
- Royal Free London NHS Foundation Trust
- Ashford and St. Peter's Hospitals NHS Foundation Trust

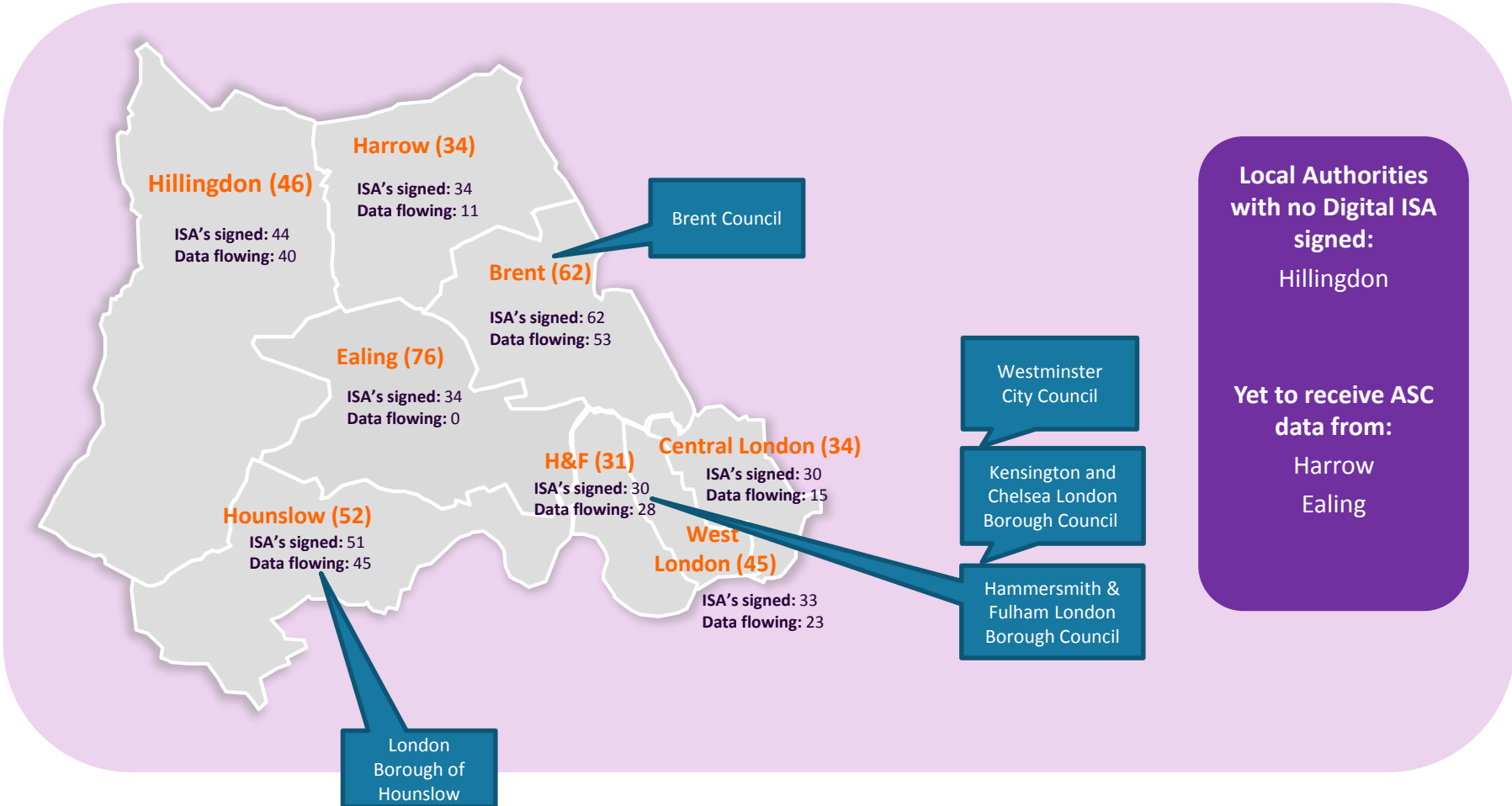
What are the WSIC Dashboards?

WSIC secure data warehouse, integrated care per patient records



GP practice and Borough data being shared and linked with acute, mental health and community providers across NLW

Digital Information Sharing Agreements (ISA) in place with 334 health and social care providers across the NWL system – covering over 816,263 people



Local Authorities with no Digital ISA signed:
Hillingdon

Yet to receive ASC data from:
Harrow
Ealing

Create lists of patients using a pre-determined set of filters using the Patient Radar for the purpose of case finding and patient selection

Care Professionals View | Patient radar

Please use the icons below to Navigate the workbook rather than the tabs above

Financial values represent commissioner costs and include estimates or averages where payments are not linked to specific patients

Filter and sort your patients into a priority list for proactive patient management

Use the drop down menus below to manage the patient list...

CCG (All) GP Network (All) GP Practice (All) Patient Segment (All) Watch List Reason (All) Filter Category 1 All Filter Category 2 All Sort By... Number of watch lists

Click on a row of information below to see analysis options...

Name	NHS Number	Gender	Age	Number Of Watch Lists	Number Of LT Cs	Total Spend YTD	Has Care Plan	Care Plan up to date	Community Care User	Mental Health User	Social Care User
0000435433	000 043 5433	Male	76	4	2	£0	✓	-	✓	-	-
0000439201	000 043 9201	Female	69	4	5	£0	✓	-	-	-	-
0000489509	000 048 9509	Male	77	4	9	£0	✓	-	✓	✓	-
0000659098	000 065 9098	Male	64	4	8	£0	✓	-	-	-	-
0000001002	000 000 1002	Female	73	3	1	£0	✓	-	✓	-	-
0000002919	000 000 2919	Female	61	3	4	£0	✓	-	✓	-	✓
0000003603	000 000 3603	Male	86	3	2	£0	✓	-	✓	-	-
0000003611	000 000 3611	Male	83	3	4	£0	✓	-	✓	-	✓
0000004771	000 000 4771	Male	88	3	0	£0	✓	-	✓	✓	✓
0000004847	000 000 4847	Male	77	3	4	£0	✓	-	✓	✓	-
0000004971	000 000 4971	Male	70	3	5	£0	✓	-	✓	-	-
0000005431	000 000 5431	Male	98	3	4	£0	✓	-	✓	✓	-
0000006423	000 000 6423	Male	98	3	4	£0	-	-	✓	-	-

Navigation icons: Home, Search, Filter, Patient Radar (highlighted)

New features and functionality in the Patient Activity timeline...

Use the drop down menu below to choose you

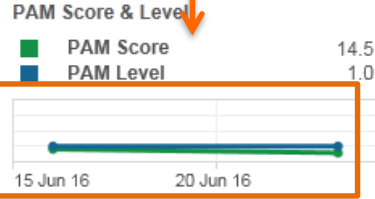
For patients where a PAM score and level is recorded, it will be displayed at the top of the activity screen

A national tool for assessing frailty based upon a set of 36 indicators (deficits)
Frailty is classed as one of the following:
Fit/Mild/Moderate/Severe

Care home flag will appear for patients in in nursing/residential homes

Lives in care home

Long term condition(s):
Asthma COPD Dementia
Diabetes Hypertension



Key outcomes
Days not in hospital: 77, 78, 79
Total spend: £115,203

EFI: 0.47 (Severe Frailty)

- Care plan up to date ●
- Community care user ●
- Mental health user ●
- Social care user ●

1 Sep 14 1 Nov 14 1 Jan 15 1 Mar 15 1 May 15 1 Jul 15 1 Sep 15 1 Nov 15 1 Jan 16 1 Mar 16 1 May 16 1 Jul 16



Separate lane for urgent care activity

Direct feeds from:

- Imperial
- CNWL

Emergency support

Planned acute hospital care

Care Type

Planned care outside acute hospital

Potential warning signs



First LTC specific view of the data for Diabetes now live and available for use...

The Diabetes Radar is based on the existing CWHHE Excel dashboard developed by Dr Tony Willis. This automated radar has been deployed to NWL GP Practices

- ✓ Demographic (Age, Gender)
- ✓ Number of A&E attendances
- ✓ Diabetes diagnosis (Type)
- ✓ Completion of 9 key care processes (+ latest result, trends and individual targets where applicable)
- ✓ Self care info (Diabetes Education, PAM, care plan, patient goals).

First iteration of Diabetes Radar

Click on a traffic light to view the trend of that indicator for the selected patient

GP Practice: (All) Diabetes Type: (All) Sort by: Latest Blood Pressure Outstanding care process: None selected 396 patients on list

Patient Name (demo)	Age	# of LTCs	Diabetes Type	# of A&E visits	# of Care Processes incomplete (past year)	Care Process									Self Care						
						BMI	HbA1c	Blood Pressure	Cholesterol	eGFR	Urine ACR	Retinal Screening	Smoking Status	Foot check	Diabetes Education	Care Planning	Patient Goals				
Patient Name	78	10	Type 2	0	4	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Patient Name	36	3	Type 2	0	9	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Patient Name	79	7	Type 2	0	4	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Patient Name	65	5	Type 2	0	2	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Patient Name	72	4	Type 2	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Patient Name	58	5	Type 2	0	3	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Patient Name	63	2	Type 2	0	9	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Patient Name	76	4	Type 2	0	9	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

● Last activity in past 12 months
● Last activity in past 12-15 months
● Last activity > 15 months old

Forename Surname, 79 (F)
NHS #: NHS Number

Long term conditions:
Anxiety Asthma CKD Depression Diabetes Hypertension Obesity

■ Systolic BP ■ Diastolic BP

Patient: Patient Name, 79 (F)
 Smoking Status: Non-smoker
 Completed: 23 Sep 2015
 GP Practice: NWL Medical Centre (E00000)

Patient View | Patient Diabetes Summary

Review completion of the 9 key care processes for diabetic patients

Click on a traffic light to view the trend of that indicator for the selected patient

NHS Number: 1234567890 Latest available data ranges from 31/08/2016 to 26/09/2016. Hover over the 'T' button below for more detail.

Patient Name: 77 Age: 5 # of LTCs: 2 Diabetes Type: 0 # of A&E visits: 3 # of Care Processes incomplete (past year): 3

Care Process: ● Blood Pressure ● BMI ● eGFR ● Urine ACR ● HbA1c ● Retinal Screening ● Smoking ● Foot check ● Diabetes Education ● Care Planning ● Patient Goals

Patient Name: 77 (M) NHS #: 123 456 7890 Smoking Status: Smoker (3 Feb 2015)

Long term conditions:
 CHD Diabetes Hypertension Ischaemic Heart Disease Peripheral Arterial Disease

Indicators Explained
 Blood pressure is recorded with two numbers. The systolic pressure (higher number) is the force at which your heart pumps blood around your body. The diastolic pressure (lower number) is the resistance to the blood flow in the blood vessels.
 Cholesterol is a fatty substance known as a lipid and is vital for the normal functioning of the body. It's mainly made by the liver, but can also be found in some foods. Having an excessively high level of lipids in your blood (hyperlipidaemia) can have an effect on your health.
 HbA1c is a measure of blood sugar levels.
 eGFR is the result of a blood test that's used to work out how well your kidneys are working. The test measures the levels of a waste product called creatinine in your blood.
 Urine ACR (albumin to creatinine ratio), also known as urine microalbumin, helps identify kidney disease that can occur as a complication of diabetes.

We have developed an Asthma Radar that is currently being piloted...

Care Professionals View | Asthma radar

Filter and sort your patients with asthma into a priority list for proactive patient management



Use the drop down menus below to manage the patient list...

CCG Name
 GP Network
 GP Practice Name

Asthma review due
 Yes No

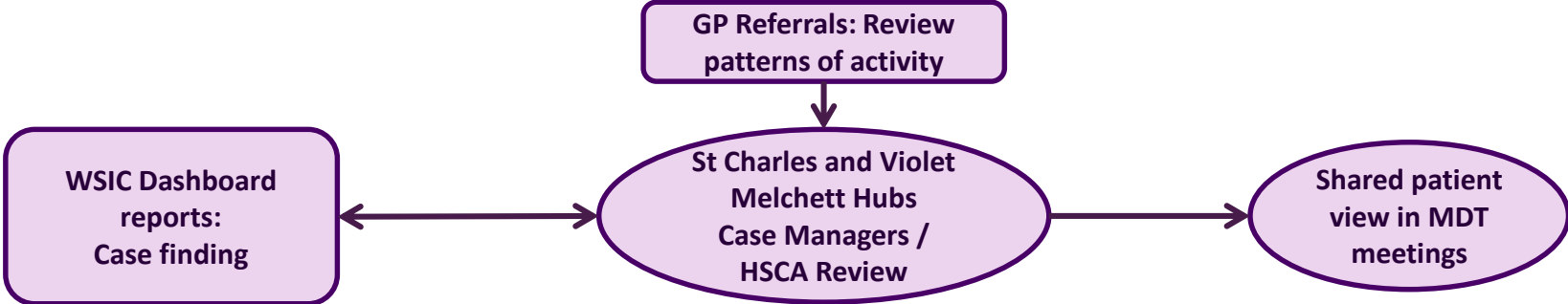
Click on a row to get more information

NHS Number	Name	Gender	Age	Number of LTCs	Number of Prescriptions	Latest Reivew Date	Latest Asthma Admission	Number of asthma admissions (source: SUS) ⌵							
								0	2	4	6	8	10	12	14
		Female	62	7	0	1-Jan-00	9-Apr-16	[Bar chart showing 15 admissions]							
		Male	43	1	0	1-Jan-00	7-Aug-16	[Bar chart showing 10 admissions]							
		Female	82	5	0	26-Jan-16	24-Jun-16	[Bar chart showing 9 admissions]							
		Female	58	6	13	14-Mar-16	26-May-16	[Bar chart showing 9 admissions]							
		Female	30	1	0	1-Jan-00	28-Jul-16	[Bar chart showing 7 admissions]							
		Female	50	2	7	1-Jun-16	8-Jul-16	[Bar chart showing 6 admissions]							
		Female	21	2	0	1-Jan-00	23-Feb-16	[Bar chart showing 6 admissions]							
		Female	69	6	0	2-Nov-15	5-Jul-16	[Bar chart showing 6 admissions]							
		Female	48	3	0	23-Sep-15	13-Aug-16	[Bar chart showing 5 admissions]							
		Female	30	1	0	1-Jan-00	18-Jun-16	[Bar chart showing 5 admissions]							
		Female	55	6	0	13-Apr-15	2-Aug-16	[Bar chart showing 5 admissions]							
		Male	51	5	0	23-Dec-15	10-Feb-16	[Bar chart showing 4 admissions]							
		Female	35	2	0	1-Jan-00	26-Feb-16	[Bar chart showing 4 admissions]							



West London CCG and the WSIC Dashboards

The WSIC Dashboards are used by My Care My Way staff regularly to check patients that they are due to see to understand patterns of system activity and to case find using the reports detailed below



Case Managers use the WSIC Dashboards to create the following reports...	Timeframe	Where information will be found in the WSIC Dashboards
Care Plan tracking - List of patients with out of date care plans	Monthly	Using the 'Care Plan out of date' Watch List
Review of most expensive patients - Case find expensive patients that have not been referred into My Care My Way (WL WSIC Hub)	Fortnightly	Use the 'High Cost' filter in the Patient radar
Produce list of patients with recent LTC diagnosis - use list a case finding pointer or prompt for care plan review	Monthly	Using the 'Recently Diagnosed with a LTC' Watch List
Produce list of regular In patient users - use list as case finding pointer or prompt for care plan review	Monthly	Using the 'Regular Inpatient attender' filter in patient radar
Produce list of most frequent A&E attenders - Review as a prompt for Care plan review and case finding	Monthly	Using the 'Frequent A&E attendee' Watch List
Produce LTC care plan out of date lists for follow up	Monthly	Using the 'Care Plan out of date' Watch List

All WL practices incentivised to use the WSIC Dashboards in CLS Plan for 2017/18 to identify top 25 high cost patients for review

How the WSIC Dashboards are being used to coordinate care for NWL patients

Using Betty's story.....

Meet Sam and Betty



- Betty 87, suffers from COPD, Type 2 diabetes and arthritis.
- Coping well until Sam passed away, but now lonely and increasingly depressed.
- Frequently visits her GP and if she can't get hold of her GP in a crisis calls for an ambulance.

Using the WSIC Dashboards

- Care coordinator identifies Betty as a frequent A&E user and regular inpatient user on the patient radar
- Her activity timeline shows the care coordinator:
 - A sudden increase in her activity across the system, including a number of inpatient stays and A&E visits over the weekends;
 - She has not been treated for anything major in hospital;
 - She had a referral to social care but did not attend her appointment; and
 - She is attending at the practice weekly.



We require support from the H&F Health and Wellbeing Board as follows....

1. How to raise awareness of the WSIC Dashboards across the system
2. Identify applications for local use of WSIC Dashboards
3. Understand how this tool can help with Health and Wellbeing priorities across H&F.