



## Islington's Approach to Integrated Care

This paper focuses on Islington's House of Care model and Patient Activation Measures



Islington is the most densely populated borough in the country and has a young and highly diverse population (42% of residents were born outside of the UK and 20% do not speak English as their first language). Islington is the 5<sup>th</sup> most deprived Borough in London and 14<sup>th</sup> most deprived in England. It also has one of the highest rates of child poverty in the country. There is an unusual spatial distribution of affluence and poverty across the borough, with rich and poor living cheek-by-jowl.

The high level of deprivation is reflected in substantial inequalities in health and outcomes:

- 28,000 people in Islington (13% of the population) are living with 1 or more long-term conditions.
- More than 30,000 adults experiencing some form of mental health problem.
- 7-year gap in life expectancy between men in the highest income group and those in the lowest income group.
- 10% gap in attainment between the most affluent and least affluent children by the time they leave primary school.
- 22% of people living in areas with high levels of social housing have a long-term condition compared to 9% of people living in areas with low levels of social housing.
- The highest incidence of people with psychotic disorders in England.
- Highest rates of male suicide and alcoholic mortality in London.

Islington has established an Integrated Care programme, governed by an Integrated Care Board and the purpose of the programme is to:

- Bring together different provider projects to provide support and coordination, to highlight duplication and gaps and to encourage shared learning.
- Provide feedback on the overall impact of improving the quality and cost of care for adults with long term conditions.
- Provide overarching commissioning processes to drive integrated care.

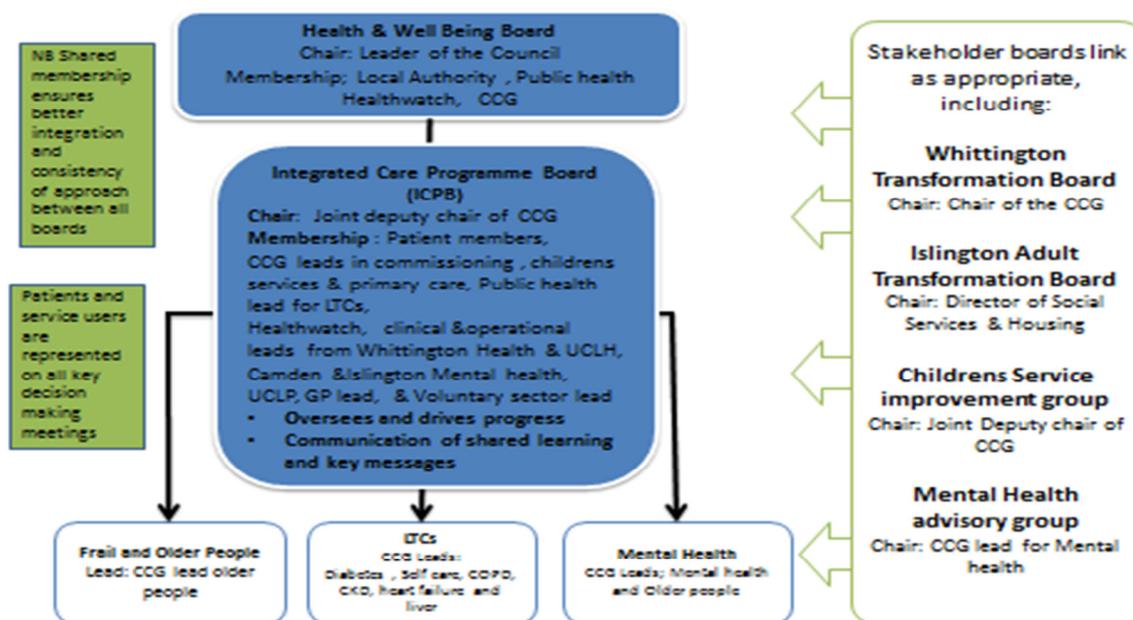
Within our 5 year strategic plan Islington CCG has identified four key delivery programmes, and key long-term priorities within each programme, to deliver our strategic objectives and address the case for change. One of these four key delivery programmes focuses on Integrated Care and will deliver:

#### b) Integrated Care Programme (London priority)

Develop new ways of commissioning and delivering healthcare so that care is planned and managed close to home through changes to:

- Commissioning approach focusing on both intensive users of health and social care, and health and wellbeing of the broader population.
- New pathways of care for people with long-term conditions including cancer, chronic obstructive pulmonary disease (COPD, mental health, diabetes, cardiovascular disease and frailty.
- A focus on self-care, personalisation, patient activation and mobilisation of community assets.
- A better alignment of urgent care services across centres co-located with A&E, NHS 111 number, GOP out-of-hours and general practice.
- A better alignment of physical and mental health services particularly for people with long-term conditions including mental health.

## Islington Integrated Care Governance Structure

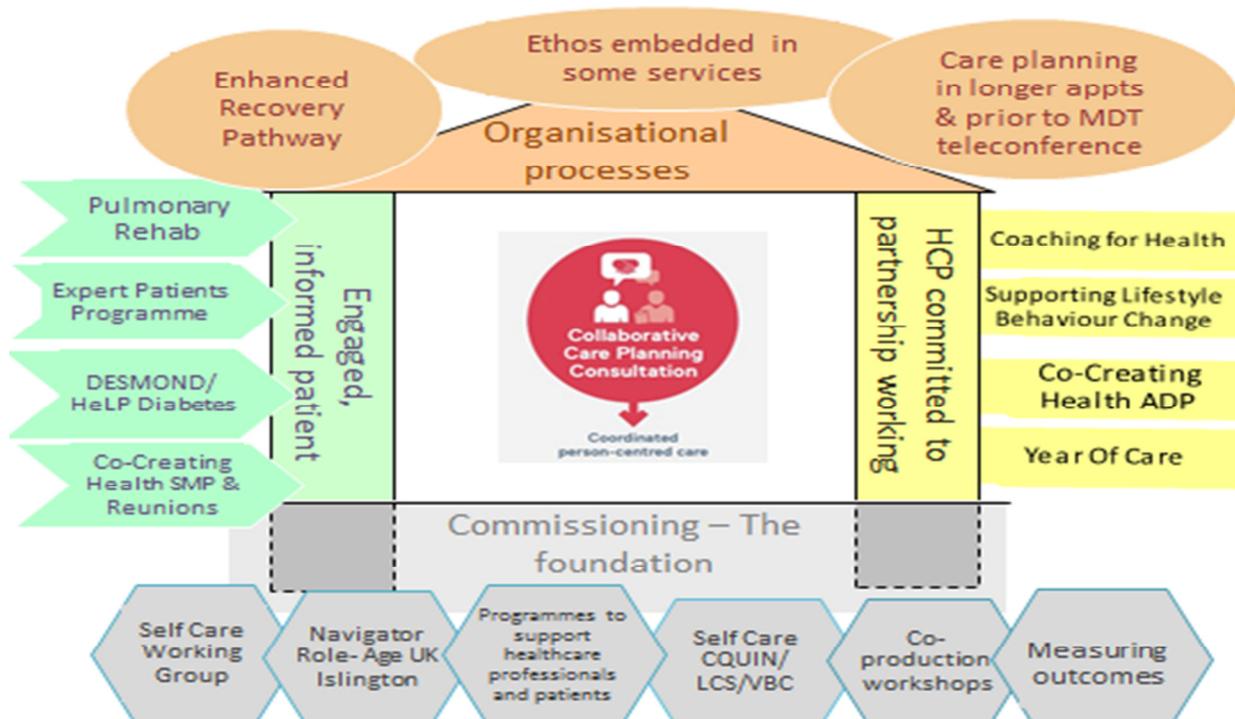


In November 2013 Islington was selected from over 100 applicants to be part of the national Integrated Care and Support Pioneer Programme. The purpose of the programme is to drive forward plans for integration of health and social care with the support of national partners who agreed to support and address the national challenges and barriers all fourteen Integrated Care and Support Pioneer sites faced when implementing integrated care models.

### Islington's House of Care

Islington have tested their House of Care<sup>1</sup> model by initially building on the pilot they undertook for Diabetes Care planning. Each part of the foundations of the House of Care play a critical role to success of this model of care - patient, clinician, system/organisational processes, underpinned by commissioning. Each brick of the house makes up an essential part – if any of the walls are missing, the structure is not fit for purpose. It is important with the House of Care model to recognise that people have different levels of skills and confidence therefore different forms of care and support planning are needed to address these different levels of need. There is room for misunderstanding about both the house and care and support planning, both of which are exactly about supporting people wherever they are on their journey. Care and support planning is about helping people think through what is important to them, what they would like to achieve and how they plan to achieve it. That will be different for each person. The House of Care is a framework to help health communities and teams work through how they will implement this to enable care and support planning (the centre of the house).

<sup>1</sup> The House of Care model has been developed and tested nationally through Year of Care Pilots and supported by Year of Care Partnership. NHS England Issued guidance in June 2014 on the House of Care and more information is available at: <http://www.england.nhs.uk/house-of-care/>



### What has worked well in Islington to date?

Already it is possible to see some positive outcomes in Islington that can be categorised across the following four areas

1. Patients
2. Health and Care Professionals
3. Systems and Organisational Processes
4. Commissioning

### Patient Outcomes:

- 2967 self-management plans are in place for people with Chronic Obstructive Pulmonary Disease (COPD); this represents 82% of the patient cohort.
- 3574 care plans have been reviewed for people with diabetes; this represents 42% of the patient cohort.
- Patients referred to a choice of self-management support programmes e.g. Expert Patient Programme.

### Health and Care Professionals Outcomes:

- Clinicians trained in motivational interviewing and coaching techniques.
- Clinician satisfaction - advocates and change agents.
- Further opportunities as Integrated Care Pioneer via Community Education Provider Network (CEPN).
- Recognition - Health Education NCEL award.

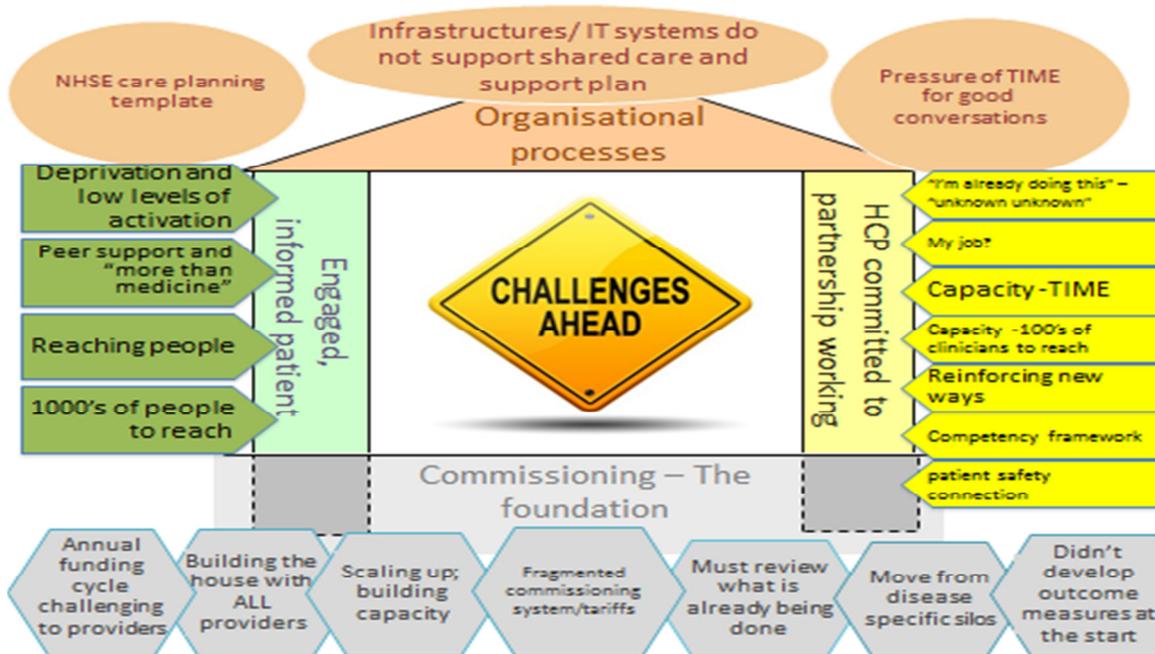
### Systems and Organisational Processes

- Data collecting appointments, followed by the sharing of findings in advanced of a longer care and support planning appointment, enabling better conversations in primary care.
- MSK chronic pain service; diabetes; respiratory team.

**Commissioning:**

- Patient involvement in the process.
- Good collaborative working across the patch.
- Move from disease specific approach to generic Long Term Conditions approach via locally commissioned services in general practice.

In Islington we still recognise we are on a journey with embedding our house of care model. We have identified we need to tackle the following challenges:



**Patient Activation Measures**

From October 2014 Islington will commence collecting a **Patient Activation Measure (PAM) score** for all patients registered with a long-term condition. The PAM (Professor Judith Hibbard, Professor in Public Health, University of Oregon) is a validated tool, helping to understand and link patient activation (skills, knowledge and confidence), subsequent behaviour and graded need for support to achieve better outcomes. The use of PAM may help inform commissioning decisions in Islington so that self-management support initiatives are commissioned according to a co-produced implementation plan. In April 2014 the voluntary community sector, through Age UK, have been commissioned to deliver local service navigators who will use the tool to better structure support depending on need.

**Use of PAM in Co-Creating Health in Islington**

PAM has been used pre and 6 months post patient participation in the Long Term Conditions Self-Management Programme (SMP) for people with Diabetes. The following outcomes were captured:

- There were high numbers of completers of Self- Management Programme with few DNAs.

- SMP attendance provided knowledge, skills and confidence to become better self-managers.
- There had been an improvement in glycaemic control without weight gain.
- This improvement had been achieved in a group of patients with an average duration of diabetes of 10 years.
- The Co-Creating Health (CCH) self-management programme has the potential to make a clinically important difference in patients with established diabetes and makes as much difference in reductions in HbA1c being roughly equivalent to newer anti-diabetic drugs such as Sitagliptin – costing £434 per year.
- Pre SMP the mean HbA1c among participants was 8.02%. Post SMP there was a statistically significant drop in the mean to 7.81%.
- A sub group analysis demonstrated that those with the poorest control of HbA1c prior to SMP of >9% had the greatest drop in HbA1c and weight loss.

For someone to become actively engaged in their healthcare they need to see it as important, they need to feel confident that they can do the things they need to do, and they need to have the ability to solve problems when they come up against them. All of these things are amenable to change with the right support. People may have had a condition for many years and still be at the beginning of the journey. Ideally, the intervention and the services on offer should be flexible enough to match where they are in their journey. The journey is not strictly linear. Someone might be doing well for a while and then fall back.

We often have high expectations of what our patients should do – only people at stage 4 would do all we ask of them. The ethos behind Co-Creating Health (CCH) is to turn this approach around to challenge ourselves about **what can we do to help take people on the journey?**

The 3 key “enablers” that enable people to Self- Manage are:

- shared agenda setting;
- collaborative goal setting;
- timely goal follow-up.

Using Patient Activation Measures will enable Islington to:

- Measure to assess the impact of initiatives across Islington (as a totality) on patient activation;
- Before and after measure of patient education/support programmes currently set up and running;
- Questionnaire to be sent to all patients with LTC on practice registers, scored and number recorded on patients EHR;
- To identify opportunities for providing tailored interventions based on an individual’s level of activation.

Islington are keen to continue using Patient Activation Measures in the future:

- To develop a population view of activation;
- To embed the score into the CCGs risk stratification tool;
- Support targeted use of resources.

## Further Information

For more information on this paper please contact either Clare Henderson, Islington's Director for Integrated Care at [Clare.Henderson@islingtonccg.nhs.uk](mailto:Clare.Henderson@islingtonccg.nhs.uk); telephone number 020 3688 2945 or Katie Coleman, Joint Vice-Chair (Clinical) Islington CCG at [katie.coleman@nhs.net](mailto:katie.coleman@nhs.net).



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