Islington Pioneer Programme – Profile

1.1 What is your area like?

Although Islington has a reputation as a wealthy borough with some of the highest house prices in the country, it is a borough of contrasts, with rich and poor living side by side.

- It is the 5th most deprived borough in London and 14th most deprived in England
- 13% of the population live with one or more long-term condition
- More than 30,000 adults have a mental health problem, with the highest incidence of psychotic disorders in England
- A seven-year gap in life expectancy between men in the highest income group and those in the lowest
- A 10% gap in attainment between the most affluent and least affluent children by the time they leave primary school
- One of the highest levels of child poverty in the country

1.2 What are you aiming to achieve?

Islington's vision, "Working together to deliver better care with the people of Islington", reflects a desire to develop more co-ordinated and person-centred care for our residents and to use integrated care to improve the overall health of our population.

Key aspects of our vision for better care include:

- Greater prevention and early intervention to prevent people becoming acutely ill or losing their independence
- Planning within a life course approach
- Supporting people to manage their own health conditions
- Personalised services with care designed around the individual
- A locality offer that brings integrated care closer to communities
- Improving care pathways, eg for long-term conditions, children, mental health and last years of life
- Facilitating those aspects of our work that make the vision possible – workforce development, contract form and information technology

We will know we have succeeded when we have:

- Improved patient/user experience
- Improved health and care outcomes and reduced health inequalities
- A sustainable health and care system with an efficient locality-based model of care and a lean acute provider sector
- A system that can manage growing demand so that our residents receive the right care, in the right place at the right time

The business case for integrated care focuses on 28,000 people or the **intensive users** of services with the following features:

- Over half are under 75 years old
- Saving £11m through reducing acute activity
- Investing £8.7m for the first three years to build community capacity
- Investment to develop new services for co-ordinated home and community care, earlier diagnosis and better management
- In years 2-5 evaluate impact, and where successful scale up across the system

1.3 What have been the highlights of your first year?

- **Understanding the local system** through risk stratification, systems resilience planning, collaborative work and a robust Better Care Fund (BCF) plan
- **Developing new ways of working** including proactive ambulatory care, an integrated community ageing team, proactive work with care homes across health and care , an integrated psychiatric liaison and assessment team, locality navigators and community paediatric nurses
- **Developing co-production and personal approaches** by linking personalised health and social care budgets, co-production, collaborative care planning and self-management
- **Developing a locality offer** learning from local pilots and eight 'test and learn' sites
- **Developing our enablers** including integrated information technology, a Community Education Provider Network (CEPN)
- **Developing new commissioning approaches**, for example value-based commissioning for diabetes and psychosis

1.4 Details of the year

Integrated care is one of four key strategies for Islington Clinical Commissioning Group (CCG). We have a board that meets bi-monthly with representation from across the CCG, the council, providers, local Healthwatch and the co-chair of the Making it Real Board (overseeing personalisation of social care) who is a patient and user of local services.

The headings below describe progress over the past year in a number of key areas.

1.4.1 Understanding the local system

- We have used a tool to risk stratify our population and agreed the target cohort. This is the top 2% at risk of hospital admission or long-term care plus those where clinical judgement highlights benefits from co-ordination
- Through our systems resilience planning we have "walked through" patient journeys from A&E, to wards and discharge to understand how patient flow works in our local system. This has led us to understand bottlenecks and to manage flow

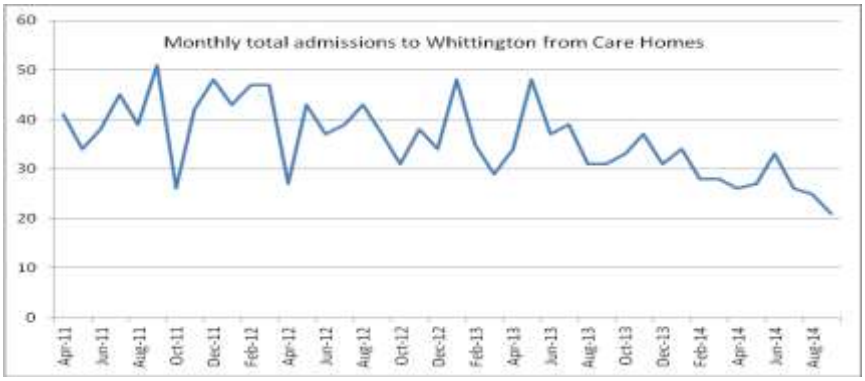
- We have developed a collaborative approach across health and social care – bringing frontline staff together for learning as well as undertaking more detailed analysis when things go wrong
- Our BCF plan was developed in line with our integrated care plans

1.4.2 New ways of working

A proactive model of ambulatory care with pathways into the community enables people to be cared for at home instead of hospital, for example by administering IV antibiotics at home, a virtual ward and rapid response function. This has increased system resilience, for example, A&E performance in 2014/15 has been maintained at 2013/14 levels within the Whittington health economy.

New services to support integrated working include:

- The Integrated Community Ageing Team (ICAT) delivering a community geriatrician service. This is now extending from care homes to supporting older people in their homes.



- Integrated Liaison and Assessment Team (ILAT) providing access to mental health assessment and treatment at A&E and on the wards, showing an excellent impact on length of stay and a downward trend in admissions and readmissions:

Oct 2014 - Sep 2015	Whittington Baseline (any MH diagnosis)	ILAT intervention
AVLOS (days)	5.56	2.59
Readmission rate	10.22%	2.27%

- Locality navigators – beginning January 2014, providing low-level support, advice and signposting to community services.

Building capacity in primary care including:

- Paediatric nurses providing support and advice to practices. Special areas include asthma, gastro-oesophageal reflux, constipation
- Community pharmacists employed to support medicines management for older people in the community – plans now in place to bring pharmacists into GP practices.

1.4.3 Developing co-production and personalised approaches

We have worked with social care colleagues to develop one point of contact across health and care for the personal health budget (PHB) offer. We now have 20 people using PHBs, the majority with continuing healthcare needs although mental health is now building. Eight GP champions have worked with us to develop our approach and to promote the offer to patients.

The joint Council/CCG Making it Real Board has operated for over a year and is co-chaired by a service user and the service director for Adult Social Care. An important part of this first year has been training up experts by experience. An action plan sets out key priorities for the group for 2015.

A new locally commissioned service covers all long-term conditions with the intention of expanding collaborative care planning and promoting supported self-management. This is using the principles of the House of Care framework that we believe has already made an impact (measured through the LTC6 questionnaire).

We have also rolled out of Patient Activation Measures (PAM) to help us to understand our population, people's ability to manage their conditions and to consider how to target interventions most effectively.

1.4.4 Developing a locality offer

- In 2014 we evaluated our multi-disciplinary (MDT) teleconferences in operation, discussing around 500 patients since November 2012. Early findings included:
    - 27% reduction in A&E attendances,
    - 25% reduction in inpatient admissions
    - 4% decrease in outpatient appointments
    - Evidence of patients feeling heard
- Piloting new approaches, for example, bringing together social care and community therapists to deliver co-ordinated care in the N19 postcode area, leading to a reduction in the number of 'handoffs' in the system and improved patient/user and staff satisfaction. See case study: N19.
- Developing a model of integrated health and care teams based on in eight GP practice test and learn sites. See case study: Locality model of integrated health and care.
- Developing a home from hospital model for children with agreed pathways into hospital services when needed.
- Through a mixture of quantitative and qualitative assessment we are trying to use a process of continuous quality improvement to understand what is working well.

1.4.5 Developing our enablers

- We want to develop three local IT solutions namely:

    - Integrated digital care record
    - Integration engine that will enable IT inter-operability (we are now at the point of commissioning this facility)
    - Person-held record

- Public and patient participation with a focus on overcoming barriers to access, co-production of care plans, and feedback informing commissioning.
- Launch of Community Education Provider Network in April. See case study: Developing the workforce.
- New ways of commissioning for outcomes using value-based commissioning as a model – leading for North Central London to develop value-based commissioning approaches for diabetes and mental health.

1.4.6 Communicating with our partners and the public

A communications strategy with a weekly bulletin, an animation and public facing posters: (https://www.youtube.com/watch?v=M5-6d87ykhQ&feature=youtu.be)

1.5 What has been the most exciting aspect?

Being chosen as an integration pioneer site has generated a huge amount of energy among our partners and clinical leads. Senior-level interest has been instrumental in developing system leadership and partnership, moving us from a small "community of interest" to what we hope will be a movement for change. It has been great to see GPs and hospitals around the table.

1.6 What has been the most challenging aspect?

- Alignment of priorities across the system – financial challenge for some organisations has an impact on driving change
- Good quality local data – for example we have not yet been able to bring social care data into our risk stratification tool and find it difficult to understand impact across the whole system
- Governance – being clear what decisions can be made by the board, how financial and investment decisions are made and the extent to which the programme is driven equally by partners.
- Commissioning arrangements and provider models –supporting the development of primary care so that we build capacity for delivery is an iterative process and one which requires commissioner as well as provider leadership.
- Contract form – moving from traditional payment by results contracts to supporting integrated models
- Scaling up our locality offer – moving from test and learn to universal coverage.
- Cross border flows – work is beginning with other boroughs to understand the cross border flows, particularly in relation to our registered and non registered populations.

1.7 What are you planning to do next year?

- We will continue to build on the work of 2014/15 in order to develop a full locality offer. This will include:
  - A clear focus on prevention
  - Services that are person centred and support self-management
  - Community health and care wrapped around primary care

    - Proactive, rapid responses, with interface between hospitals and the community
    - Developing a single point of access across health and care
- We have started the procurement for an integration digital care record
- We will develop workforce plans under the Community Education Provider Network
- We will be running a shadow year for our value based commissioning. We will build learning into the development of a commissioning framework for the locality

1.8 What is your advice for areas starting on their own integration journey?

Whole-system transformational change will only occur if we have the right leadership in place. We have found it invaluable to have mentoring/coaching support for the senior leadership team. Understanding financial issues is one area where the group will need to come together to explore implications in an open and honest way.

Through the pioneer programme we have had an experienced programme enabler who brings board members together to reflect, share and challenge – we know that if we want to shift the workforce to a new ethos and culture, we need to start at the top.

Clear communications – have a communications plan with different communication channels so that you are in constant touch with stakeholders and can keep up the energy for integration.

Co-produce with staff and patients/users – systems leaders have given the mandate for change, but change will only happen if it is co-produced with staff and users/patients.

Contact: Clare Henderson, Integrated Care Programme Director
Islington CCG/Islington Council
Email: Clare.Henderson4@nhs.net