CASE STUDY 1: INTEGRATED CARE

Management of Long Term Conditions

In Islington, one in six people aged 18-74 years are diagnosed with a long term condition (LTC), of whom one in three have more than one long term condition. Convincing evidence shows that early identification, effective treatment, and intervention, benefits people with LTC’s such as COPD and diabetes, and so Islington has a long history of investment. Public Health, GPs, clinical colleagues, and patients have worked together to introduce innovative population and outcome based Local Enhanced Services (LES) to address health inequalities, as the following patient story shows.

**Imran’s story – Living with Chronic Obstructive Pulmonary Disease**

Imran, 73, was identified as a medium-risk COPD patient, when he presented to his GP with shortness of breath and a cough. The diagnosis was made possible at the practice via a population wide LES that incentivised case finding spirometry.

On meeting the practice nurse to discuss his condition, Imran was given some literature and referred to a community based self management programme, Pulmonary Rehabilitation (as per NICE guidance), run by respiratory nurses working across the community and local hospital as part of the Whittington Integrated Care Organisation (ICO). She also referred Imran for smoking cessation with the healthcare assistant.

His GP emailed the local hospital consultant, (who does sessions within community team), to discuss antibiotic options as Imran had other health problems. Imran was prescribed an “exacerbation pack”, along with instructions, to help manage his treatment when he experienced breathing difficulties.

Nowadays, Imran telephones his GP whenever he thinks about starting his “pack”. His GP sees him if there is uncertainty at the practice or on a home visit. Imran also frequents a local expert patient group, ‘Breathe Easy’, when he feels the need for peer support, (linked via rehabilitation programme). He recently had a community bone density scan because of regular steroid treatment. He has needed no admissions or outpatient appointments related to COPD since 2009.

Outcomes from the case finding COPD LES from 1.4.2010 to 31.3.2012, included increased COPD prevalence (22%); increased referrals to pulmonary rehab (93%); reduced admissions for COPD; reduction in PCT oxygen costs (23% or £73,000), and an 83.6% QOF population achievement, making Islington the 5th best PCT nationally for COPD.

Outcomes for the innovative targeted NHS health check programme concentrating on the ‘QRisk’ profiled population with over 20% CVD risk, include increased prevalence of diabetes, hypertension and other LTCs. The programme was delivered mainly by general practice, with hard to reach and unregistered patients targeted by community pharmacists and a tendered community service. Standardised data was collected electronically and fed back to practice databases to allow the cycle to continue. Islington was one of only a few PCTs in London to achieve all targets for health checks this year, despite the number of high risk patients invited.

Public Health and primary care have a unique agreed dataset of anonymised streamed data from all practices, for over 4000 Read Codes. We now have national permission to link this to secondary care data. Public Health have been able to model real time data regarding the
numbers of people living with multiple LTCs. All practices, except one, have the EMIS clinical system, and EMIS WEB will be rolled out within 12 months.

Faced with increasing need and an ageing population, Islington needs to improve capacity for dealing with LTCs and therefore plans to perform transformational change across a wide range of patient pathways. Our ‘Integrated Care Strategy’ development has been an iterative process reflecting change and improvement within primary and urgent care, reflecting new ways of working with the community and secondary care sectors and modernising use of data to create seamless, personalised care pathways. Patients have been and continue to be involved in these developments, and the CCG are also reflecting the pathways in the work we are doing around continuing care, supporting good mental health and those with learning disabilities in our joint commissioning strategies. The strategy is spearheaded by Vice Clinical Chair, Dr Josephine Sauvage, supported through Pan Islington Locality Forums and three locality GP leads, as we move into ‘Integrated Care Networks’.

In collaboration with local stakeholders, we have undertaken a series of facilitated multi-agency workshops to formulate stratified evidence-based pathways of care for key LTCs, such as CHD/CVD and Diabetes, optimising community-based care, but developing collaborative pathways into and out of our acute providers. With McKinsey, we have constructed a model of integrated care: GP practice networks, aligned to a complement of community services including social care, delivering services to populations of 50,000 patients. These cohorts will undergo risk stratification, proactive care planning, multi-disciplinary review of more complex patients and care co-ordination. Through our locality structure we are agreeing the rules of engagement for the network and working with local hospitals and community providers through “change boards” and contract regimens to implement the strategy.

A series of GP stakeholder events ensured that the new structures for integrated care were agreed and modelled organically, and underpinned by a grass-roots local narrative. The network groupings will support pan-Islington educational initiatives, utilising outcomes data to drive up performance and develop more pathway specific rather than service led commissioning intentions. The development of the GP networks is reliant on identification of local clinical and managerial leaders, to be supported through our CCG Organisational Development work stream to coordinate the health system and lead relationships across the local area.

We have an established Integrated Care Programme Board and documented commitment to collaborative working from all represented stakeholders. In support of this over arching strategy all CCG member practices will be signed up to the vision of seamless care and health improvement through our CCG Constitution.

This is a complex programme of change and the approach will be monitored through clear outcome measures designed to monitor service integration as well as patient and carer reported outcome measures, both quantitative and qualitative. We are developing meaningful data sets to support educational development across the provider landscape, as well as inform future commissioning intentions. The strategy implementation plan will be delivered in Autumn 2012, with clear milestones for achievement and implementation in provider contracts 13/14 onwards.

Our larger community provider, Whittington Health ICO, is an NHS London pilot site for integrated care. It aims to test whether organisational integration of an acute provider with community resource, might be better able to develop synergies to improve patient care,
through key enablers. They are also exploring a ‘Year of Care’ bundled tariff based payment for the management of LTCs across the whole patient pathway. They have been leaders in the pilots for the Health Foundation’s ‘Co-creating Health’ model of supportive self-management in LTCs, working with local clinicians over recent years, and are currently piloting how best to implement this learning as an integral part of both systemic change and clinician and patient education.

Supported by a best-in-class public health team, we have a clear understanding of those factors contributing to poorer outcomes in patients affected by LTCs and evidence-based recommendations of how outcomes might be improved. In all our strategy we aim to reduce health inequality in the borough so that every resident is able to access high quality, responsive care, whilst maximising the use and streamlining the flow of clinical information. It is also important that we respond to the challenges of the individual patient by working closely with our partners in the local authority and recognising the impact of psychological well-being on the management of LTCs. Gloria’s story illustrates a typical pathway under the management of an integrated care network although many of the features around the level of care are evident today. We start from a strong foundation of joint commissioning with the Local Authority and single point of access support services.

**Gloria’s story – Coronary Heart Disease Patient**

Gloria is a 77 year old lifelong Islington resident. She is a widow with no children and often depends on her neighbour, Daniel, in emergencies. Gloria has a history of angina and, two months ago, began to experience shortness of breath and swelling in her legs. A quick BNP blood test (Brain Natriuretic Peptide) done at her appointment, and prioritised echocardiogram, allows Gloria’s GP to identify her as an at-risk CHD patient for whom early intervention is needed. With support from cardiac specialists from Whittington ICO, a care plan is devised following a multi-disciplinary case conference.

The integrated care plan includes referral to a cardiac heart failure nurse who sees her in a community setting. She is offered psychological support for her anxiety and is assigned a Case Manager from the social services team, who will visit her at home to develop a care package. This is explained to Gloria by her GP, working closely with Case Manager, who helps her identify local services best suited to her needs from a Directory of Services (developed with London Borough of Islington). She is given some materials to take home and reflect on, and if she wishes to, she can share with her neighbour.

Gloria is referred into a cardiac rehabilitation programme to support and develop her ability to self-care and understand her condition. Her treatment is proactively discussed by all providers at regular case conferences and treatment optimised in an ongoing way with support from specialists without the need to attend hospital. Her GP feels more confident and Gloria less anxious and more independent as she knows going to hospital is less likely, and she is less reliant on her neighbour.

In the future, if Gloria must go to hospital, providers can access her records to help make better decisions about her care. The hospital will work with her nurse and social care team to plan her discharge. Her GP will have access to her hospital records in order to track her care and ensure that the necessary discharge arrangements are made.