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Health and care integration in Islington – what the long term plan means for us

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The Long Term Plan – key points

- Published in January 2019
- Plan setting out ambition to improve health and care
- 3 key themes:
    - Making sure everyone gets the best start in life
    - Delivering world class care for major health problems
    - Supporting people to age well

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The Long Term Plan – key points

We will do this by:

- **Doing things differently** – giving people more control of their care, joining services up, more care closer to home
- **Preventing ill health** – increasing health prevention initiatives
- **Increasing the workforce** – making the NHS a better place to work, creating more routes into the NHS, and recruiting more professionals
- **Increasing digital** – make accessing the NHS more convenient, better digital services and patient records, improved use of data for planning
- **Value for money** – reduce duplication, and spend on administration

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The NHS Long Term Plan has a number of commitments and issues where we need to focus further 2019-23

Personalisation

- Consistent social prescribing approach (new link workers in primary care)
- Developing personal health budgets (e.g. extended offer to people with cancer) and clear linkage with personal budgets in social care
- Personal care records and care plans
- Use of telehealth and remote monitoring

Workforce

- A partnership approach with local councils and other partners (e.g. skills advisory panels)
- Better use of technology and smarter working across partners (e.g. maternity passport)
- Extend support and use of volunteers / apprentices
- Further commitments and targets to be released in April

Primary Care

- Development of primary care network infrastructure to support improved service delivery
- Support to prevention and lifestyle management (social prescribing)
- Care home support

Prevention

- Support to self-care and building local resilience
- Community wealth building / regeneration – work / leisure / crime (the wider determinants of health)
- Emphasis on health inequalities (linked to London Mayor's Health Inequality Strategy)

Resources

- Pooling of resources to support transformation
- Shifting resources into community and primary care from hospitals
- Need to ensure that health and care systems become "sustainable"

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So what does that mean for us in Islington?

- We want to build upon our integrated care work
- We want to boost "out of hospital" care and focus on prevention
- We want to deliver care that is more personalised
- We want to focus on population health and outcomes
- This means working more closely with the council and with providers – GPs, Whittington hospital, Camden and Islington FT, UCH and others eg the voluntary sector
- We want to look at our resources across the NHS and council and consider how we can use them together to make more impact

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Our ambition for integration in Islington

- We want to build a **broad place based approach** which maximises the opportunities presented by collaboration between health partners and the local authority including and beyond Adult Social Care in order to ensure Islington residents are as well and independent as possible and leading fulfilling lives. This will:
  - Focus on **prevention and early intervention**
  - Represent an **all age** approach, recognising that people are part of families and communities and rely on all of the assets and resources in the place where they live.
  - Build on the existing work in primary care in a more joined up and **holistic** way recognising that lifestyle choice and changes, use of community services and assets and good quality housing have more impact on people's health and wellbeing than good quality clinical care.
- We know that **people are experts in their own lives**. Providing joined up high quality advice, support and universal services that keep people independent and able to care for themselves and their families will be at the heart of what we do.
  - We will take a **strengths based** approach to ensure that what matters to people drives what we do
  - We will support people at home and in their communities with high quality, consistent care when needed.
  - We will make best use of all of the assets in a place, whether that be the budget, the multi–agency workforce, buildings, leisure and recreation facilities or the local voluntary and community offer.
  - We will aim to co-locate and integrate the workforce where possible.

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So what's been going on to support this?

What does that mean for residents?

How are we involving patients?

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1. Localities

- We have developed localities under the Health and Care Closer to Home programme of the STP
- In Islington we have three localities, North, Central and South
- We have developed new ways of working eg moderate frailty service in the north, health checks for adults with SMI started in south, now across whole borough
- These are firmly rooted in primary care working in partnership with others, eg Islington GP Federation, Whittington Health, CIFT and Age UK
- We have largely relied on **professionals** working together to understand the needs of the local population and to develop responses to those needs
- The North locality has worked with patients and their families to get structured feedback on their experiences within the moderate frailty service

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2. North Islington Locality "prototype"

- We are working with partners on a **North Islington "prototype**" where we want to start working differently eg:
- We want to see if we can develop local hubs where residents can access a range of services eg GPs, social workers, community nurses, employment support, information on leisure and culture
- We recognise that we need to work with the staff on the ground to help them understand what is on offer so they can provide more holistic care to residents
- But **appetite to engage** with local people – so far residents have been invited to groundwork events, plus successful session with the voluntary sector and a "market place"
- Lots of voluntary sector partners work with local people and help make the links

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3. Primary Care Networks (PCNs)

- The Long Term Plan has set out an ambition for integrated care in community settings, around primary care
- Our practices have decided to work in four networks – 1 in the north locality, 2 in central and 1 in the south
- Primary Care will be given resource to employ new roles and build locality teams in partnership with other providers
- Early roles include – Clinical Director for networks; social prescribers followed by physiotherapists, physician associates and paramedics
- Practices will involve their own patients through their PPGs, and we hope that social prescribers will build on the work we have already been doing to support patients in different ways with navigators
- However, what more could we be doing to involve patients?

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So, what does that mean for residents?

- We are continuing our journey to better integrate care – we want care to be co-ordinated around the individual
- We want to support people more effectively by "nipping problems in the bud", being more proactive
- Residents will see some of their services co-located, this starts with Newington Barrow Way - co-locating primary care, social care, housing, employment, community services – changing culture of staff

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Questions

1. Lots of "top down" change, but we want to co-produce and have done some of this to date– any thoughts about how to build on that?
2. What health needs and inequalities do you think we should be addressing?
2. How do you think health and care could feel differently in Islington in five years time?