healthwatch Islington

Care Closer to Home Networks

Islington Patient Group meeting, 11th July 2017

Dr Katie Coleman (Vice Chair) and Clare Henderson (Interim Director of Commissioning) from Islington Clinical Commissioning Group presented.

By way of introduction Katie reminded attendees about the Sustainability and Transformation Plan discussed at the previous meeting, November 2016. These plans are required by NHS England. Commissioners must work across borough and across health and social care. Plans must demonstrate how health and care services for residents will be both more integrated and more efficient.

Islington is part of a North London (formerly North Central London) plan, with partners in Barnet, Camden, Enfield and Haringey. The North London plan needs to contribute towards saving the NHS £22 billion nationally.

The North London plan aims to achieve better health outcomes for the local population in a time of increasing demand and limited resourcing. It aims to achieve financial balance through efficiency, so bringing health and social care services together, and good planning. Katie emphasised that it is not about closing Emergency departments, expecting primary care to do more for less, cost shunting to Local Authorities, or rationing care.

As part of the work set out in this plan, commissioners want to set up 'Care Closer to Home Networks' bringing more services out of hospital so that people can be seen more quickly and conveniently at less cost to the system.

These networks may be **virtual or physical networks** [see below], and will most likely cover a population of around 50,000 – 80,000 people. They will be home to a number of services including general practice, the voluntary and community sector including housing, mental health, schools, care homes, eye care and voluntary organisations supporting well-being. Hospitals will also be included and may be able to provide **direct contact with consultants** [see below].

Islington is likely to have three networks, one in the north of the borough, one in the south east and one in the south west.

- To provide a more integrated and holistic, person-centred community care model
- To make it easier and quicker to meet **agreed patient outcomes** [see below],
- Includes health and social care integrated multi-disciplinary teams (MDTs), care planning and care coordination for identified patients

- Interventions focussed on the strengths of residents, families and communities,
- Improving quality in primary care and reducing unwarranted variation.

Networks will have their own Quality Improvement Support Teams (QIST) to provide hands-on practical help for individual GP practices to ensure a consistent quality standard and offer to all patients.

These networks will link in with existing services that improve access such as the IHUB service (extended hours GP opening), practice-based mental health workers, practice-based pharmacists and integrated networks which support patients with more complex needs. All of this work will be complemented by work on digital health records, which with patient consent make records accessible to the relevant clinicians co-ordinating their care.

Questions from the audience and responses

Q: Where's the money coming from? Where will these services be located?

A: If we can support everyone to attain best practice we will reduce variation in care and reduce spending. Costs were calculated at a rate of £10 per patient for each Network and £10 per patient for each Quality and Improvement Support Team.

There is also work being done to attract national funding to renovate buildings and looking at using buildings differently, by potentially sharing premises with other organisations, eg public services.

Q: The language is confusing, what do these networks mean? Where has the name come from?

A: There are historical patterns of practices working together. Basically we mean a network of GP practices and other services. It would be good to find a term that made sense to patients.

The team could be physical (located in one place and meeting face-to-face) or virtual (an email group for example), whatever is easier for those working in the team.

Q: What do you mean by 'agreed patient outcomes'?

A: We mean that we know people are living longer and we want them to be doing this in good health, for those with long-term conditions to receive the care they need, and for all us to be able to die where we want, rather than necessarily in a hospital environment.

Q: You mention direct access to Consultants, does this mean a telephone hotline? Can we (the patients) contact them?

A: This has been suggested as a way of preventing some referrals and admissions to hospital.

Q: There has been lots of emphasis on talking to patients, what's the plan for this and how can we be involved?

A: The first stage has been working with patients some time back to develop statements of aspiration from the patient perspective. We are calling these 'I statements' because they relate to what the patient (or carer) - in this case the 'I' - want and need. We are also working with information that we already have from talking to local people and that Healthwatch has gathered.

Q: Is this scheme optional or will all GP practices have to take part?

A: We want to ensure we get complete population coverage across the borough, so all practices will be expected to take part. Practices are signing up to try this.

Q: Are these networks to be funded from existing budgets or is this new money?

A: We recognise that in order to make change we do need to make new investment into the community. We will also be working to understand where money is being spent across a range of services so that we can look at opportunities of moving resources (eg staff) to where it is needed.

Q: How can small voluntary sector organisations contact commissioners so that they can be linked in to the networks?

The Third Sector Forum is where these conversations can take place.

Table discussion summary on Care Closer to Home Networks

Potential benefits

- Improved choice and access if waiting times can be reduced,
- Convenience if services are nearer home,
- Hospitals are intimidating, it's good to avoid them,
- Patients are more likely to know staff in GP practices than hospital.

Concerns

- Where will the staff come from,
- Is there space for this outside of hospital?
- Too much change – confusing for patients,
- Potential for patients to lose access to specialist advice (for example if physiotherapy was moved in to the community),
- Transport connections, would these be good enough
- Could create more demand, meaning more pressure on staff and the system,
- Don't want to hinder continuity of care for those patients who value this,
- Will it save money – what happens if it doesn't.

Opportunities

- Could more services be delivered door to door? May be difficult for GPs to do home visits, but what about pharmacy?
- More holistic services.

Other

Appetite for information to manage their own health conditions, such a sessions with practice nurses.

Information needed about what organisations need to do to let commissioners know they exist.