

# Islington Council and Clinical Commissioning Group

## Adult Joint Commissioning Strategy

2017-2020



## Foreword

In Islington, commissioning is a vital part of what we do as partners to improve the health and wellbeing of our residents. Joint commissioning is about the council and the clinical commissioning group working together with our partners to shape the system, enabling residents to improve their own health and wellbeing.

The next three years are going to see a huge amount of change in Islington. Many of our residents will continue to face inequality, poverty and poor health and wellbeing and need support from us to achieve their goals. The financial pressure on our organisations is likely to continue to grow, demand for services we commission is increasing every day in many cases, and plans, approaches and organisations will need to change in response. We are working in a complex, fast-moving and ever-changing environment, so this strategy is not a plan that sets out everything that is going to happen over the next three years, because that would simply not be possible or practical.

Instead, this strategy sets out our principles, our values, and our priorities for the next period. These are the concepts and attitudes that we will use to guide ourselves as commissioners and which we will build into everything we do. We will focus our energy and our resources on supporting residents to be **healthy and well**, be **connected**, and be **in control**. As we work towards these priorities, we will seek to behave in a way which is **person-centred**, **outcome-focused**, and which delivers **fair and effective use of public resources**.

From listening closely to our residents, we are confident that these are their priorities for us, and over the next three years we will work hard, in partnership with service users and carers, with providers and with our partners to achieve these outcomes for the residents of Islington.

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Islington Council

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## Understanding Islington

- Islington is the most densely populated local authority area in England and Wales, with 15,517 people per square km. This is almost triple the London average and more than 36 times the national average.
- Islington is the third smallest, but most built up of all London boroughs covering 14.86 km squared.
- 1 in 6 adults in Islington have a diagnosed mental health condition.
- Only 13% of the borough's land is green space, the second lowest proportion of any local authority in the country.
- The 2015 Index of Multiple Deprivation shows that Islington has improved from being the 11th most deprived borough in the country to the 26th most deprived. This overall progress has come about as a result of significant improvements in a number of individual areas.

### What does good look like?

- Services that work together
- Helped to help myself
- Supported at home and to be part of my community
- Helping me take control
- Support for carers

**Service users and carers have consistently told us about what they want from adult services in Islington. 'What does good look like?' collates all this information, including learning from Making It Real, under five themes.**

## Case study 1: Introducing NHS health checks in drug and alcohol treatment services

Islington's adult drug and alcohol services are working with an ageing population. This presents new challenges and different service user needs which practitioners have not had to consider before. Professionals need to work in an environment which allows them to adapt and develop new skills required to respond to these changing needs.

As a Public Health commissioned service, drug and alcohol commissioners are in regular contact with Public Health colleagues, so they have been engaged and involved in discussions around the commissioning intentions of their department. Opportunities like this should become more common now that we have been able to co-locate commissioning teams across Children's Services, Adult Social Care and Public Health in one office, which is also, very conveniently, next door to the Islington CCG offices.

This joint working has enabled discussions between commissioners of drug and alcohol services and lifestyle services, specifically NHS Health Checks and Stop Smoking, to consider how the two areas could work better together. Lifestyle service providers would, with the support of specialist drug and alcohol staff, gain experience of working with more complex service users (who wouldn't ordinarily access their services); in exchange - drug and alcohol service providers could work with lifestyle services to offer sessions on their sites which would encourage better attendance at appointments by service users and provide a more rounded and joined up offer of support.

While this new approach is still at an early stage, the uptake of the services on offer has been positive and there is commitment from all parties to continue joint working. Collaboration like this is a key way of working we want to pursue over the life of our new joint commissioning strategy with a whole range of partners.

## Outcome: Being healthy and well

Having good mental and physical health and wellbeing is fundamental to good quality of life; enabling us to realise our full potential, to live independently and to helping us make positive contributions to our communities.

We are committed to reducing the impact and incidence of physical and mental ill-health for all our residents by reducing health inequalities across the borough, keeping people as healthy as possible and living independently in their community. We aim to do this by ensuring services provide effective, personalised care and support, enabling people to live better, more fulfilled lives and to achieve their own goals.

Islington's focus is to prevent problems arising and to intervene early to help people stay healthy longer, reduce the escalation of health problems and foster a good level of wellbeing rather than responding to poor health. Not only will this ensure we focus on building a healthy population, it will also reduce demand for expensive services and help us deal with the financial pressures we face. Making sure people can access services early, before they reach a crisis point, will be a key part of this.

### What we know

- Number of admissions to long term residential care in 2016/17 – 157 (Performance spreadsheet)
- 1,532 people with mental health needs receive social care support in an average year (Evidence Hub – mental health factsheet)
- The gap in healthy life expectancy between the least and most deprived areas of Islington is 7.7 years for women and 10 years for men (State of equalities)

### What are we going to do about it?

What are our priorities in this area?	What actions do we need to take?
<b>Responding to increasing complexity of need:</b> enabling timely access to interventions and recovery; reducing the burden on acute services, residential and nursing care; taking a consistent approach across commissioning to ensuring residents are able to receive the right support by a suitably skilled workforce.	<ul style="list-style-type: none"><li>• Work with partners across Islington and Haringey through the Wellbeing Partnership to ensure those with complex needs get rapid, co-ordinated and effective treatment.</li><li>• Enable that focus on those with complex needs by ensuring most people get the support they need from mainstream services in their community.</li><li>• Ensure that services have a workforce with the right skills and competencies to be able to support people with increasingly complex needs.</li></ul>

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**Improving mental health:** supporting individuals and communities to effectively manage their wellbeing and mental illness, close to home; and where needed, providing continuity of care and support around the needs of individuals and communities

- Develop services that deliver support and treatment for mental health and physical health holistically.
- We will ensure that the mental health of our residents is considered in all services we commission.
- Increase awareness and understanding, across partnership organisations, and championing action that promotes positive attitudes about mental health and wellbeing.
- Bring together mental health interventions with other services as part of a coordinated and integrated approach, reducing silo working, including through the Haringey and Islington Wellbeing Partnership.

**Promoting self-management:** empowering Islington residents to better manage their own health and enabling them to be well-informed about making healthy choices.

- Continue to design services that support people to make healthier choices to regain and maintain good health and independence, reducing the need for ongoing formal services and enabling people to live in their own homes.
- Ensure there is more accessible information on how people can self-manage and the community support available.
- Embed a focus on wellbeing into all services we commission and influence others to do the same.
- Support people, especially those with complex needs, to make healthier choices and to gain control over their own care through personal budgets, including through the Integrated Personal Commissioning programme.

**Improving access to mainstream services** ensuring that mainstream services truly serve all our residents

- Work with universal health services and preventative services to manage the range of needs more effectively. This will enable service users to remain within mainstream services, retain links with the wider community and avoid the duplication of similar offers.
  - Focus on mainstream services that offer support close to home and out of hospital wherever possible.
  - Ensure that interventions to improve early diagnosis, treatment and care of long term conditions encourage participation and access from all population groups.
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**Recognising and addressing the wider determinants of health:** strengthening partnership work across the public and voluntary sector to develop the best support for residents; building an awareness across health and care of how important employment, housing, poverty, education and other wider determinants impact on health.

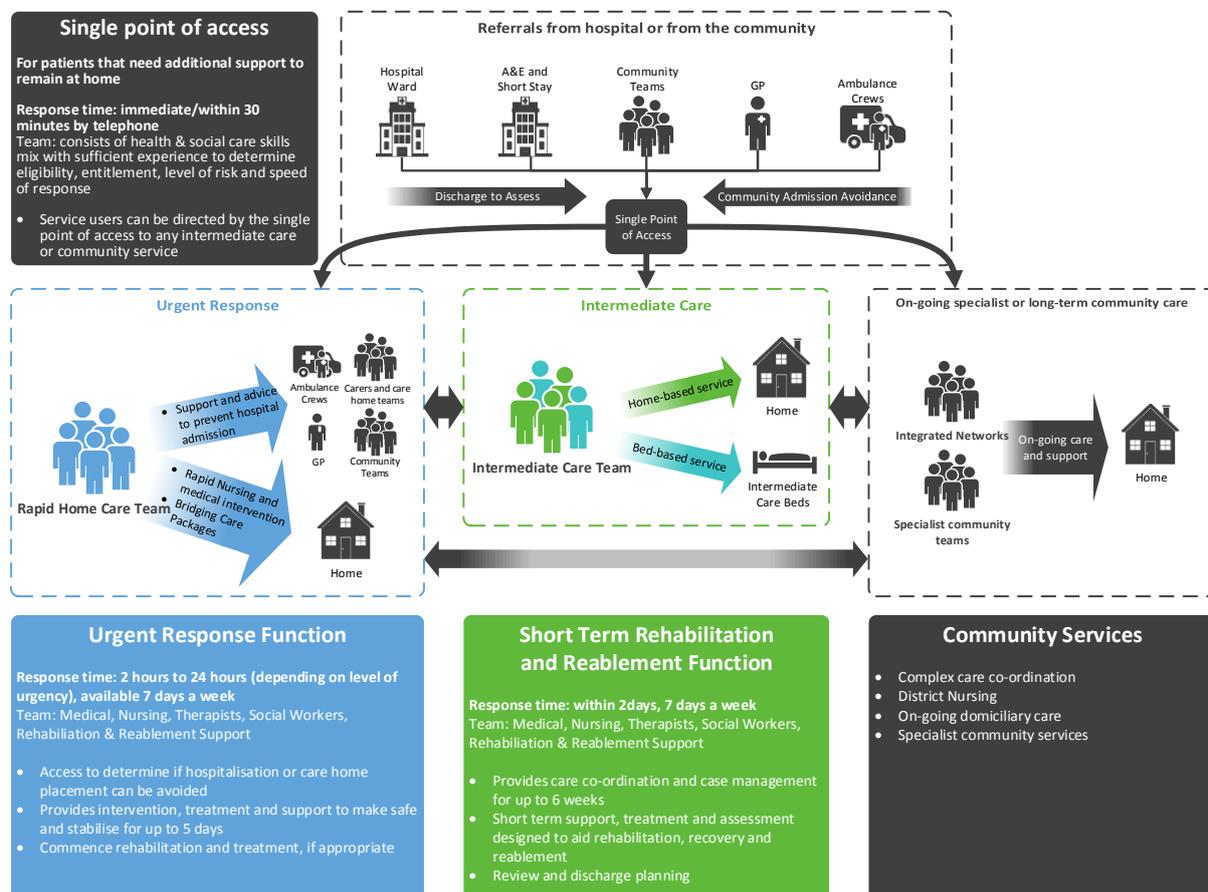
- Improve outcomes for our populations by focusing on helping people to stay well, addressing the broader social factors that impact on mental and physical health
- Work with employers, education and training providers, to support people with poor mental health to gain and stay in work, education or training; and to support all employees and students to maintain their mental wellbeing.
- Work with our housing colleagues and partners to ensure better joined up working and tackle housing-related poor health and wellbeing.
- Continue to strengthen our relationship with services for children and young people, thinking family and taking a whole life course approach to planning services.

## Case study 2: Improving Intermediate Care in Haringey and Islington

We have been working to align and coordinate intermediate care services (services provided after leaving hospital or to people at risk of hospitalisation) across Haringey and Islington in order to:

- Meet current and future need for rehabilitation and reablement
- Reduce our community's dependence on hospital, residential and domiciliary care
- Improve access to services, particularly for those with complex needs
- Improve value for money across the system

The reason we are looking to do this across Islington and Haringey is because we have similar models of intermediate care and a shared community provider, but most importantly a shared ambition to improve intermediate care and meet rising population need. Working at scale presents opportunities to enhance skill mix, make better use of real estate and increase flexibility, and working together provides more opportunity to re-profile bed-based services.



We are designing a much simpler system with a single point of access for both hospital and community referrals: combined with changes to the discharge pathways the model will work on a 'home first' basis and have an emphasis on avoiding unnecessary hospital visits and increasing independence.

## Outcome: Being connected

Being connected does not necessarily mean being connected to services. We aspire for our communities to be **resilient** and empowered to **self-manage**, but more than that we hope to see people actively engaged with one another; volunteering, caring for others, employed in good, fairly-paid jobs and participating in a whole range of ways in the many communities that make Islington the extraordinary and vibrant place it is.

Being connected is about people feeling part of a wider **community** that is **active** and **supportive**, and in which people feel **useful**, meaningfully **involved** and socially **included**. Building and sustaining a strong set of connections to support and opportunities through our families, our friends and our community is vital to a healthy and fulfilled life.

Our role is to shape the local market to deliver these aspirations and to broker and facilitate access to appropriate services as guided by what our residents want and need. Recognising the key role played in our residents' health and wellbeing by the wider determinants of health, this will just as often be support related to **employment, volunteering, skills** or **leisure and culture** as it will be health and care services directly.

### What we know

- According to the Census, 26% of the working age population who identified themselves as disabled or having a long-term health problem in Islington are economically active (State of Equalities)
- Every ward in Islington has at least one area that is among the 20% most deprived areas of England (State of Equalities)
- 75% of users of learning disabilities services are in settled accommodation (performance spreadsheet)

### What are we going to do about it?

What are our priorities in this area?	What actions do we need to take?
Ensuring our services actively promote and facilitate <b>employability, social inclusion and appropriate meaningful activity</b> .	<ul style="list-style-type: none"><li>• Put employment at the heart of everything we do as a key route to better health and wellbeing</li><li>• Embed outcomes about employment, social inclusion and meaningful activity in all its forms in contracts wherever possible</li><li>• Strengthening our focus on social value in procurement to maximise the benefit to our community from all contracts.</li></ul>
Taking responsibility for <b>carers</b> feeling connected and valued for their role.	<ul style="list-style-type: none"><li>• Work with operational teams and delegated services to ensure carers are offered a carers' assessment and supported in line with our duties under the Care Act</li><li>• Facilitate strong links between providers and local carer organisations</li></ul>

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- Highlight any gaps in need for carer groups through dialogue with carers themselves, including those who don't think of themselves as carers
  - Strengthen our engagement with young carers supporting our service users.

Ensure **information about local services** is readily available and residents have the skills to access it.

- Continue to improve the council's website and ensure it, and the Adults Directory, contain up to date, accurate and useful information for residents and providers
- Ensure providers support the delivery of local digital inclusion programmes, and help residents to access lifelong learning opportunities
- Promote innovative use of technology as a means for connecting people and tackling social isolation.

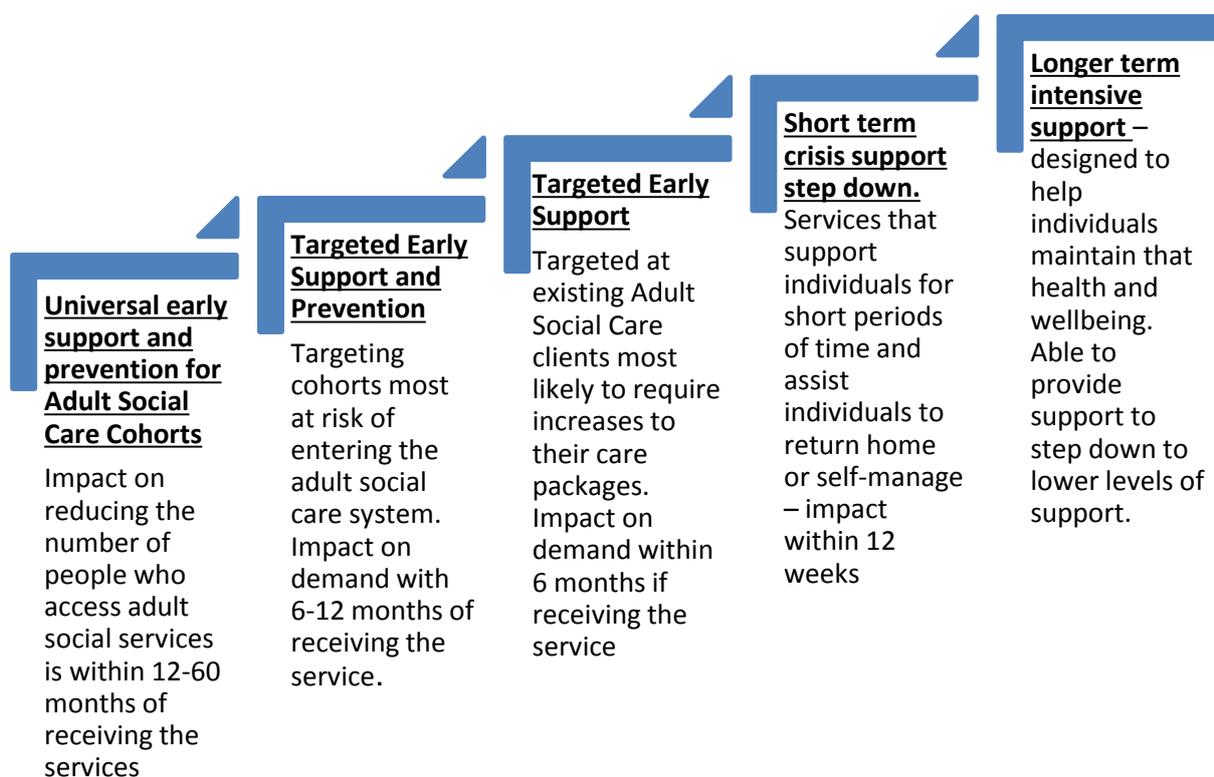
Building a **connected local system**, with shared responsibility for residents' outcomes across health, housing, education, welfare and social care rather than passing people between organisations.

- Continue to develop strong pooled budget and joint-funding arrangements
- Lead on a 'think family' approach across all levels of operational and strategic departments within the council, CCG and health providers – and across borough boundaries with Haringey and other North London partners
- Build on the models of the prevention forum and integrated networks to build relationships between providers and enable holistic discussions about challenges and best practice
- Learn from Haringey's Local Area Coordination model for an integrated pathway for primary care, social care and community services.

Ensure, wherever possible, that people's **needs can be met closer to their home**, family and in the community by shaping a diverse local market with the required skills and competencies to deliver this.

- Work with providers to understand their training and development requirements to meet needs locally
  - Facilitate a whole systems approach to working in this way
  - Including through the council's spark programme and the STP, work with local partners to review how we use our buildings to maximise the benefit to our service users.
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## Our approach to prevention and early intervention



### Case study 3: employment and health

The Islington Individual Placement and Support (IPS) Employment Trial is a health-led intervention which supports people who are unemployed due to a health condition and/ or disability return to employment. The IPS Trial is one of the key projects for Islington's Wellbeing and Work Partnership, which is run jointly between Islington Council and Islington CCG (in partnership with JobcentrePlus). The purpose of the partnership is to promote and coordinate borough-wide efforts to improve employment and health outcomes for residents with a long term condition or disability.

There is a substantial evidence base for IPS supporting people using secondary care mental health services into work, and we are keen to understand whether it can support people with any health conditions or disabilities receiving care in a primary or community healthcare setting. The trial is part of a national programme of research to enable the NHS to measure how effective IPS could be, by comparing outcomes for people who receive IPS employment support with those who do not.

The trial is commissioned by Islington CCG and delivered by Camden and Islington Foundation Trust. The trial uses a randomised control method and is expected to recruit a minimum of 1000 patients; 500 of which will receive the intervention and 500 will be in a control group, signposted into existing 'business as usual' employment support within the borough. The trial went live in January 2017 and to date over 120 people are have registered to participate. Early estimates are that about a quarter of participants are moving into employment thanks to the intervention in the trial.

The biggest challenge for the trial is generating enough referrals in order to recruit the planned level of participants. Whilst the service is available to anyone registered with an Islington GP with a long term health condition and/ or disability it is expected that the majority of referrals will be related to people with mental health conditions, MSK, or diabetes (in part due to the high prevalence of these conditions amongst working age adults).

## Case study

*Client A, who has diagnoses of psychosis, diabetes and arthritis and has never done any paid work before, is now working part time for a local hospitality & events company.*

*The Employment Specialist met with patient A for a total of 9 hours over 5 appointments before the job offer was received, that was just 7 weeks from the initial appointment. These sessions covered vocational profiling (including looking at preferences, experiences, skills, strengths, and personal contacts), job searching, welfare benefits advice, discussions on the disclosure of mental and physical health conditions and interview preparation.*

*Client A currently works under 16 hours per week under the 'permitted work' scheme. This graded return to work enables clients to 'test out' work to see if it is something they are able to maintain. The Employment Specialist will continue to work with Patient A towards the long term goal of working full time and to provide support to ensure the client is settled and happy in the workplace.*

## Outcome: being in control

‘Our vision is to enable people to develop networks of support and increase community connections. People will be supported to be in charge of their life and to have real choice and control over their care and support to realise their full potential’ (Making it Real Islington 2016)

Islington’s Making It Real programme shared and validated nationally coproduced ‘I statements’ about what personalised health and social care services mean. Those statements are the foundations of our overall strategy.

We have also linked these to local service user and carer feedback on “What does good look like?” for services – describing how services are delivered, qualities and skills of staff, and what they help our residents to achieve.

We have continued to drive towards these ‘markers for change’, but we acknowledge that more work needs to take place in social care and across Islington to fully achieve our aspirations, and those of our residents, for personalisation.

We want to do more to make the strengths and assets of individuals, families, groups and community organisations our starting point, rather than beginning with ‘what's wrong’ and deciding which services can ‘fix’ things for people.

We will prioritise genuine transfer of power in our local system over the life of this strategy, building the capability in service users, carers, providers and ourselves to create services that are person-centred, co-produced and respond to genuine and individual need appropriately.

### What we know

- 650 service users and 710 carers are taking up the option of receiving a direct payment to manage their own care and support (performance spreadsheet)
- Helping me take control I statements (what does good look like)
  - “I have good information and advice on the range of options for choosing my support staff”
  - “I am in control of planning my care and support”
  - “I have care and support that is directed by me and responsive to my needs”

### What are we going to do about it?

What are our priorities in this area?	What actions do we need to take?
Supporting people to have <b>power and control</b> over their care beyond simply controlling the budget.	<ul style="list-style-type: none"><li>• Wherever possible ensure services have funds set aside for personal budgets across health and social care, and we will use information on what people spend their money on to support both commissioners and providers to be more responsive to individual choice.</li></ul>
Making sure <b>services fit around people’s needs</b> and requirements rather than people fitting into services.	<ul style="list-style-type: none"><li>• We want people with care and support needs to have conversations with practitioners which focus on what matters to them and what is working and not working in</li></ul>

their lives. We will ensure services embrace this personalised, asset-based approach.

- Ensure people have the tools they need to be more resilient, so even during challenging and difficult times, they are better placed to utilise their own talents, resources and connections to solve difficulties and sustain positive change in their lives, with proportionate support when it's needed.

Growing a **strong local market** that offers real choice to service users beyond the services traditionally put into place to support peoples care and support needs ensuring access to safe and quality services.

- Work in honest and close partnership with everybody who provides services in Islington, and make our commissioning plans clear through our "Market Development Strategy" and "Market Position Statement"
- Develop a commissioning strategy for peer support, as recommended by the Making It Real Board.

Expanding the **voluntary sector offer**, working closely with partners to increase universal access to services that will cross borough boundaries where the need exists.

- Strengthen our links with the council's voluntary sector team and work with them on shared priorities
- Establish and sustain an ongoing dialogue with voluntary and community groups in Islington to learn from them, whether or not they are commissioned providers
- Promote voluntary sector partnerships as a priority in multi-borough programmes

Working to ensure people with care and support needs experience **integrated processes and services** that are focused on them, their needs and their goals.

- We recognise that for care and support to be person-centred in this way, organisations need to work well together, so we will join up budgets, workforce and processes across organisations
- Wherever we can, promote models that include a single named co-ordinator or key worker, or other approaches to person-centred, integrated support.
- Improve the understanding among staff across the borough of the benefits system.

Using **co-production** to transfer power in the system to service users and carers and away from ourselves

- Build a strong and sustainable legacy for the outstanding work of the Making It Real Board
- Ensure co-production is embedded in all our commissioning processes and the work of all our providers

## Case study 4: Transforming Care for people with learning disabilities and autism

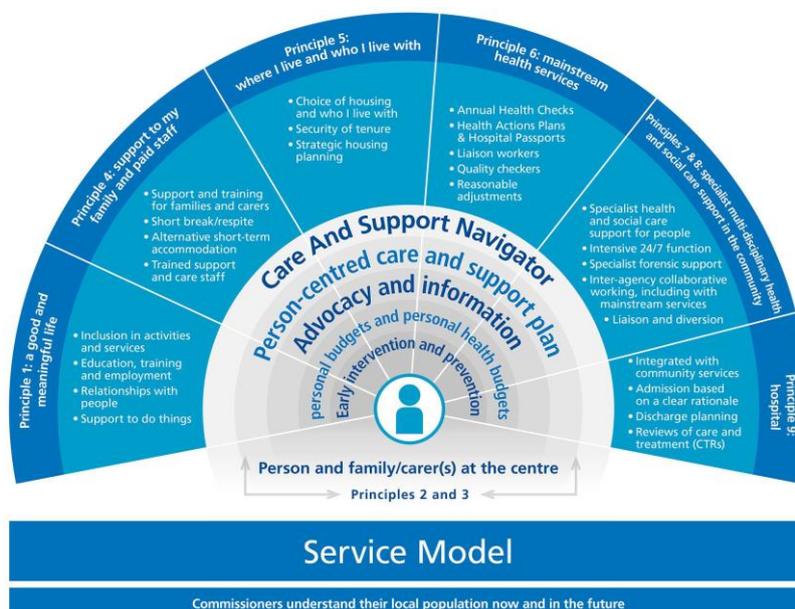
Transforming Care is a national programme which followed the exposure of abuse at the Winterbourne View Hospital in 2011. It relates to people with learning disabilities and/or autism who also have challenging behaviours and/or a mental health condition. The programme aims to transform the lives of some of our most vulnerable and complex people by improving support in our communities and avoiding unnecessary stays in specialist hospital care.

Islington is committed to the vision and principles of the Transforming Care Programme which strongly aligns with our three key priorities and our commissioning approach. We are working to improve outcomes for individuals by:

- Working with partners across North Central London to commission better local services
- Working across all ages, planning for the whole life-course and working with a Think Family approach to consider the holistic needs of the person and their family and support network
- Strengthening support in the community as an alternative to more restrictive hospital care
- Working across service areas such as housing, mental health services, criminal justice system, health & social care and the community and voluntary sector to plan support around individuals

For individuals this means making our key priorities a reality in their lives:

- **Being in control:** We are supporting those with the most complex needs to make decisions about where they live, who they live with and how their support and care is organised and delivered, through person centred and outcomes-focused support planning
- **Being connected:** We are making sure people live in local communities and near their family and loved ones so that people can access natural support networks and live ordinary lives in our communities
- **Being healthy and well:** We aim to keep people healthy and well with person-centred professional assessments that help us understand what this means for them and with support to manage their physical, mental and emotional health in a proactive and positive way



## Our approach to strategic commissioning

In Islington, we believe that good strategic commissioning can help people be healthier, more connected and more in control. Ultimately, it is about improving people's lives, and we are proud of what we do.

Good commissioning is by no means limited to buying services. Sometimes what we do involves procurement and contract management, but just as often we are influencing, supporting and mobilising rather than spending money. Many of the services we commission are delivered in-house by Islington Council, and we aim to be just as engaged in supporting those as outsourced services. Above all our role is to take a strategic view, and to ensure that services are focused on need and delivering outstanding outcomes for our residents. Every intervention we make needs to add value, and be focused on what residents tell us they want and need in order to be healthier, better connected and more in control.

We also know that part of delivering these ambitions means recognising we need to break down barriers and work in new ways with new partners. As well as working with service users, carers and providers as equal partners, this also means working with our neighbours across North London Partners in Health and Care and with our partners in Haringey through the Wellbeing Partnership. It will also involve us building stronger partnerships with other council departments and finding new and innovative ways to serve our communities.

In making our ambitions and those of our residents a reality, as strategic commissioners we will embody three key principles in how we act: we will be person-centred and outcome-focussed, and we will make effective, fair use of resources.

### Person-centred – how we work

- We 'think family' and take a personalised, holistic and 'whole life course' approach to commissioning to put the person at the centre of our commissioning practice
- We co-produce services with service users, carers, providers and professional stakeholders to ensure services are designed with the people that use them
- We consider the diversity of need in our local communities when commissioning services, including the protected characteristics under the Equality Act (2010) and the social, economic and physical environments in which people live
- We build relationships and support collaboration across the system to ensure we work together where this will improve service user experience and outcomes
- We make sure that there is the right support to help people navigate and choose the services and support they need.

### Outcome focussed – how we work

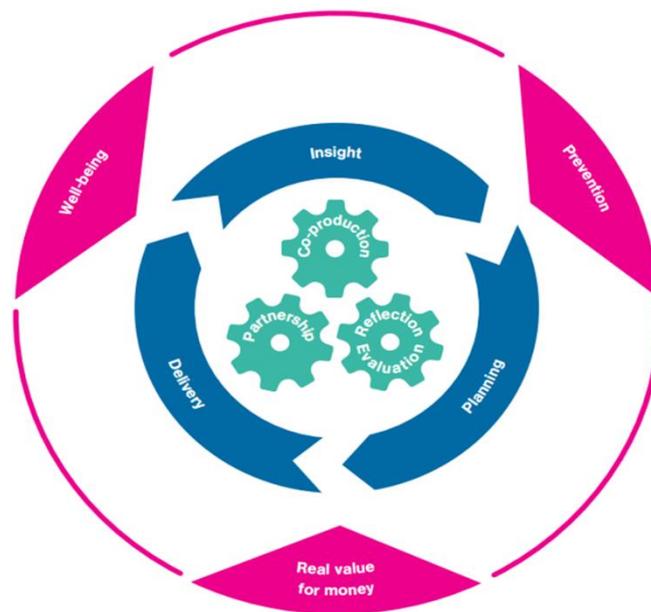
- We are open minded about how outcomes are achieved, building on people's strengths and natural community support networks
- We use evidence, values and best-practice to support decisions and activities.

- We constantly strive to use data better to help us understand our communities and their needs.
- We encourage a culture of learning and reflection to continuously improve how we achieve outcomes, working with providers to develop meaningful frameworks of measurement
- In line with the Social Value Act (2013), we consider the wider social, economic and environmental outcomes of the services we commission

## Effective, fair use of resources – how we work

- We commission services that are safe and high quality to ensure people have a good service experience
- We ensure all services offer best value for money to ensure we spend public money wisely and fairly
- We aim to keep our commissioning processes simple and proportionate to reduce the commissioning costs to us and our providers
- We ensure decision making is transparent and supported by clear lines of governance and accountability

## The commissioning cycle



**Components:** co-production, partnership, and reflection and evaluation are applied consistently throughout commissioning



**Phases:** the three phases of 'Insight', 'Planning' and 'Delivery' structure the commissioning cycle



**Aims:** prevention, well-being and real value for money are the objectives of commissioning, and are supported and strengthened by the components and phases

## Case study 5: perinatal mental health services

To help meet the objectives described in the NHS Five Year Forward View for Mental Health and the Sustainability and Transformation Plan, Islington Joint Commissioning has led the development of a new North London Partners Perinatal Mental Health Service, launched in 2017.

One in five mothers suffers from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. Suicide is the second leading cause of maternal death, after cardiovascular disease. Mental health problems not only affect the health of mothers but can also have long-standing effects on children's emotional, social and cognitive development. Costs of perinatal mental ill health are estimated nationally at £8.1 billion for each annual birth cohort, or almost £10,000 per birth.

Our new service builds on small existing Islington provision, to expand to the whole North London Partners geographical area, enabling more women to access specialist care. The service undertakes triaging, signposting of referrals, psychiatric assessments, treatment and care of women with severe mental illness during the antenatal period and for up to one year after birth. This includes mothers with bipolar disorder, mania, schizophrenia or severe depression. Women with more mild or moderate mental health needs will continue to access care and treatment from existing teams and organisations, but may be supported by the new specialist team.

Children and Adults Commissioners from the five Clinical Commissioning Groups, the local NHS Mental Health Trusts and women with lived experience collaborated to design the following outcomes for the service and local women:

- Women receive assessment and treatment in a timely way
- Care is consistent: women do not have to repeat their story; and experience care being 'joined up'
- Women are supported safely and effectively in the community
- Women avoid unnecessary admission to acute psychiatric inpatient departments and presentation at A&E
- Access to information: Women are informed about their care and treatment, their progress and what to expect
- Care and treatment received is personal to the individual woman
- Women have access to competent practitioners who have received perinatal mental health training appropriate to their role
- Women and their babies receive safe, holistic care
- Women receive support and treatment that enables their recovery

The new service has been developed in collaboration with women with lived experience. A group of women who experienced perinatal mental ill health have held focus groups to share their experiences of the health and care system and what improvements need to take place. Their meetings have been facilitated by Cocoon Family Support and have explored what support was available during their perinatal period, what should have been available and what the new NCL service should focus on, as well as the wider services that surround it. Their experiences and views have been used to shape the service outcomes and success measures. The women with lived experience were also involved in the recruitment of the team, and in the overall governance. Islington CCG are the lead commissioner for the service, which is enabled by NHS England funding collaboration and sustainability of the service.

