healthwatch Islington

NHS Islington Clinical Commissioning Group

ISLINGTON
Working in partnership

Islington's Joint Health and Wellbeing Strategy 2017-2020:

Draft for consultation

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FOREWORD

We have a lot to be proud of in our vibrant borough, but poor health outcomes and health inequalities continue to affect local people's life chances. We are committed to making Islington a fairer place: Improving residents' health and giving people the support they need to improve their wellbeing is at the heart of this agenda. In working towards this goal, we recognise that more needs to be done to help prevent those things that contribute to health inequalities and to provide better early intervention, to make a real difference to the lives of our residents.

Over the past three years, we have made some real progress in improving the health and wellbeing of Islington residents. To name but a few of these successes, we have significantly increased childhood immunisation rates, reduced overall mortality rates from preventable causes, and made improvements in treatment recovery rates for patients with mental ill health. We will build on this positive progress as we refresh and take forward a new Islington Joint Health and Wellbeing Strategy for 2017-2020. We will continue to maintain a focus on three important areas - giving every child the best start in life, preventing and managing long term conditions, and promoting and improving mental health and wellbeing - in order to achieve our ambition of improving health and wellbeing and reducing health inequalities to make Islington a fairer place.

This refreshed Joint Health and Wellbeing Strategy focuses on those specific areas where there is evidence of most pressing need and where we can make the greatest impact. The strategy also looks at those health and wellbeing issues that cut across our three priority areas, and across the health and wellbeing system in its broadest sense. This includes, for example, the impact of poor housing, the environment, or lack of employment on wellbeing. It is in tackling these more complex, cross-cutting issues that the Health and Wellbeing Board, in its key role as a system leader, can add most value and where a systematic focus on prevention and early intervention can deliver real benefits by preventing the emergence or escalation of problems. We also understand that the health of our residents and communities is affected by much more than access to and the quality of health services. Health and wellbeing is shaped by the conditions in which we live, the extent of our social connections, and whether we have stable and supportive work, amongst other things. Our Joint Health and Wellbeing Strategy for 2017-2020 underlines the importance of addressing these wider determinants of health.

The health and care landscape looks significantly different to when we published our previous strategy in 2012/13, and further changes are likely. This new strategy is intended to help maintain a focus on those key issues that impact on the health and wellbeing of Islington residents, in the context of a complex and changing health and care landscape. We see these changes as an opportunity for continued close working between partners to drive system transformation and a step-change in outcomes, under the leadership of the Health and Wellbeing Board.

Cllr Richard Watts
Leader
Islington Council

Dr Jo Sauvage
Chair
Islington Clinical Commissioning Group

INTRODUCTION

What is this strategy?

This is Islington's Joint Health and Wellbeing Strategy (JHWS) and it sets out Islington's overarching plan for improving the health and wellbeing of people living in Islington for 2017-2020. Islington's Health and Wellbeing Board (HWB) is responsible for finalising the JHWS and monitoring progress with its delivery between 2017 and 2020.

Over the past three years, we have focused on three priorities:

- Ensuring every child has the best start in life
- Preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities
- Improving mental health and wellbeing

We will continue focusing on these three priorities for 2017-2020, building on our successes so far and working on areas where challenges remain. For each of the priorities, areas of focus have been selected where we feel the HWB and a partnership approach across and beyond Islington can make the biggest impact and drive real improvements in the health and wellbeing of Islington residents. It is not intended to be an exhaustive list of all of the work that we do to improve health and wellbeing in the borough.

Through this strategy, we want to achieve a stronger focus on health and wellbeing within the context of the family and/or household. Risk and protective factors at this level, as well as at the social and community level, are a key determinant of an individual's health and wellbeing across the life course and are important for a thriving population.

What is the role of Islington's Health and Wellbeing Board?

The role of Islington's Health and Wellbeing Board (HWB) is to improve the health and wellbeing of Islington's population. It brings together leaders across the health and care system to work together on important cross-cutting issues. There is a statutory duty for the Board to produce a high-level plan for improving the health and wellbeing of people living in Islington. This is our Joint Health and Wellbeing Strategy (JHWS).

The role of the Board is to provide leadership across the whole health and care system and beyond, championing health and wellbeing as everyone's business, holding ourselves and our partners to account and using the Board's collective influence to break down any barriers to progress.

How has the Joint Health and Wellbeing Strategy been developed?

Under the sponsorship of the HWB, this JHWS has been developed in partnership with a number of stakeholders over several months. In April 2016, Islington's HWB agreed to maintain a focus on the three priorities from the previous strategy. HWB members have worked together to discuss the areas of focus within this refreshed strategy, drawing on input from strategic partners and stakeholders across Islington, including feeding in input and insights from a range of resident, service user, and voluntary and community sector organisations, groups and engagement activities.

What has informed the Joint Health and Wellbeing Strategy?

Islington's most recent Joint Strategic Needs Assessment (JSNA) has formed the basis for Islington's JHWS. The JSNA and JHWS go hand in hand, with the former detailing Islington's population health needs, and the latter outlining how we plan to meet those needs. Other current knowledge, evidence and intelligence have shaped the JHWS.

Refreshing Islington's JHWS has also been an opportunity to ensure the strategy reflects the evolving health and care landscape. Through the Islington and Haringey Wellbeing Partnership, health and care partners across the system in Islington and Haringey are working together to deliver improved health and wellbeing outcomes for our populations. Taking a whole population and place-based approach, Islington and Haringey are working together to address the shared challenges we face across the health and care system and to deliver integrated care and improve outcomes for our residents. We are also working with partners across North Central London to develop a strategic, place-based plan for transformation of the health and care system over the next five years. Collaboration and joint working on this wider geographical footprint, where it makes sense, can help drive improvements in outcomes, care quality and system sustainability.

Islington's JHWS does not stand alone. It links into a wide range of strategies and plans that are focused on improving the overall wellbeing of Islington's residents, and importantly which tackle the underlying determinants of health and inequalities in the borough, including Islington Council's Corporate Plan and the strategic plans of Islington's Clinical Commissioning Group (CCG).

We expect this strategy to be a "living document". We will use data and information to assess our progress, and adapt our approach if we are not on track to deliver our priorities. We want to make sure that our planning stays in touch with the changing needs of Islington's residents. The Health and Wellbeing Board will monitor progress in the three priority areas every six months. The Board will also review progress on the strategy as a whole after 18 months.

OUR VISION FOR ISLINGTON

Figure 1. The wider determinants of health. Adapted from Dahlgren and Whitehead

A healthier, fairer and more resilient population

Our vision for Islington is for a community of healthy, connected and resilient people. We want our residents to live, work and play in places that support and promote health, and for every resident to experience good and secure housing and employment. When people do experience poor health and other problems, we want them to know where to find help and the confidence to seek it - be it from friends or family, the voluntary sector or public services - and that they bounce back and thrive. We will focus on prevention and earlier intervention to prevent or reduce the escalation of problems. Finally, we want our residents to receive timely, quality and joined up public services when they are needed.

We recognise that good health is shaped by numerous factors, from our friends, neighbours and social connections, to our education or opportunities, and through to wider environmental and cultural conditions [see fig.1]. That is why we will continue working in partnership with colleagues across Islington to ensure that making healthier choices and living in healthier environments is easier, and that everyone has the opportunity to reach their potential. We describe our activities on these wider determinants of health in this refreshed JHWS.

Our guiding principles

We will put ourselves in the shoes of our residents, ensuring they are at the heart of what we do, and co-design our responses to challenges with our residents, and around their needs.

We will focus on the assets and strengths of our population, and we will build the resilience of individuals and communities to promote independence and reduce dependency.

We will focus on prevention and early intervention to improve outcomes and reduce escalation of need and demand.

We will work across professional, service and organisational boundaries to ensure a coordinated, collective approach to delivering our ambitions and plans, recognising and valuing the contribution of all parts of the system. We will focus on those areas and issues that require us to act in partnership and as system leaders to make the biggest difference.

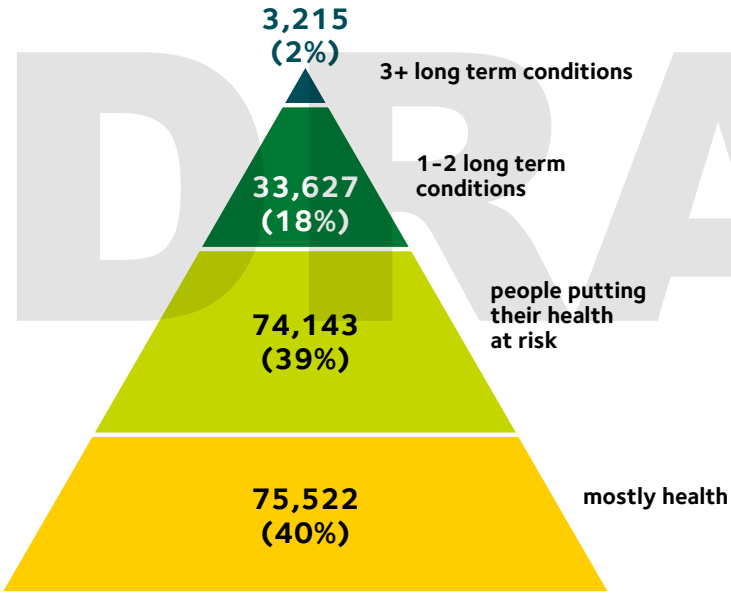
We will make Islington fairer and will focus on reducing inequalities in all that we do.

We will make every penny count by ensuring that we take an outcomes- and evidence-based approach.

OUR POPULATION IN ISLINGTON

Population segmentation is a way of grouping the population according to similar health and care needs. We have been using the pyramid risk stratification model in Islington, which also underpins the work of the Islington and Haringey Wellbeing Partnership. It divides the population into four broad segments: those who are healthy, those who are at risk of developing long term conditions[1], those who have 1-2 long term conditions and those who have 3 or more long term conditions. This helps to understand the needs and health and care experiences of these groups in order to plan and provide better, more integrated health and care, and to ensure a focus on what we can do to help people stay well and further 'down the pyramid'.

Pyramid of health risks for adults (18+) in Islington



The model is based on anonymous health data relating to individual residents and patients. An ambition going forward is to explore the potential for more sophisticated ways of segmenting and understanding our populations' health and care needs, including wider determinants and risk factors for health and wellbeing at both the individual, family and household level.

We also recognise that risk and protective factors at the family and/or household level are a key determinant of an individual's health and wellbeing and a healthy population.

Household and families

Family: Almost half of people (44.3%) in Islington live in a family (includes couples with and without children) of which:

23.6% are a couple with dependent children

20.8% are single-parent families with dependent children

36.0% are a couple without children

Everyone else is a single parent or couple with non-dependent children

Living alone: 38.7% of people in in Islington live alone, of which over 1 in 5 (21.0%) people are aged 65 and older.

Shared living: 17.0% of people in Islington are living in a shared house with others, of which almost 1 in 10 (8.1%) are living with other students

1. Long term conditions included for the purposes of the pyramid: Chronic kidney disease, diabetes, myocardial infarction and coronary artery disease, atrial fibrillation, heart failure, depression, stroke/transient ischaemic attack, chronic obstructive pulmonary disease, cancer, peripheral arterial disease, dementia, serious mental illness, chronic liver disease, and learning disabilities.

ISLINGTON'S HEALTH AND WELLBEING PRIORITIES

In the following sections of the JHWS, we describe where we are now in relation to each of the priority areas, and what we will do to make further progress and improvements in these areas. We have also defined a number of measures of success in each area.

Although the JHWS is organised around the three broad priority areas of giving every child the best start in life, preventing and managing long-term conditions and improving mental health and wellbeing, each of the priority areas strongly interlinks with one another and do not sit in isolation. For example, parental mental health is a crucial factor determining health and developmental outcomes for children during their early years. People suffering from a range of physical long term conditions are at increased risk of common mental health problems, and improving the physical health of people with severe mental health problems is key to improving life expectancy for this population group. Moreover, a range of common issues and themes are important for health and wellbeing outcomes in all priority areas, including social isolation, resilience, and coordinated and integrated care. A joined up approach to addressing these cross-cutting issues is key to how we will take forward delivering the JHWS. Box 1 gives an example of how we are taking forward work to improve outcomes for residents with complex multiple needs.

BOX 1: Improving outcomes for people with multiple and complex needs

The Council and its partners are committed to working in new ways to reduce the scale of deep social challenges. There are a significant minority of Islington residents who experience multiple disadvantage and a range of health and wider social issues, including substance misuse, mental health and domestic violence, all of which impact negatively on their quality of life and health and wellbeing outcomes. The Council, together with local health partners, other public services, and the voluntary sector is developing a programme of work focused on how we improve outcomes for residents experiencing multiple disadvantage. This includes not only joining up and integrating services and support for this population group, but also taking every opportunity to intervene early to prevent problems escalating and demand increasing. There is a strong recognition that no one partner can solve these complex issues alone but through a strong partnership can and looking beyond our own service lens and organisations, we can respond better through taking a system-wide approach.

The programme brings together commissioners and providers across health and social care, community safety, housing and crimila justice, and service users to better understand the needs and assets of this population group, current responses to these "needs" from the system and challenges and gaps, in order to develop and test out new solutions and approaches.

PRIORITY 1

Ensuring every child has the best start in life

Why is this important for Islington?

Early experiences have profound and enduring effects on children's health, wellbeing and learning. In the context of Islington's commitment to fairness and equality, reducing health and education inequalities to ensure that children have the best possible start in life is vital. We want our children to start school healthy and ready to thrive in every sense. We know that supporting children throughout their childhoods and into adulthood is important, but creating the best foundation for children and their families is essential.

Islington's pregnancy-to-five vision expresses factors that are key to ensuring all children have the best start in life. It captures a set of stressors, such as domestic violence and poverty, and a set of factors that build resilience, including engagement with high quality early childhood services and supportive relationships and social networks.

All families in Islington engage with early childhood services, many in multiple ways. From maternity services and primary care, through to health visiting and children's centres, to nurseries and childminders, we have great potential to support families to give their children the best start; providing early, highly effective support to those who need it most, while offering universal services which create a connection with every family and act as a gateway for those who need targeted and specialist services. We also aim to continue working in an integrated way. This involves professionals who work with children and families having an understanding that they have shared aims, goals, data and learning with other professionals, and that closer and more effective work together will be of benefit to children and families and prevent duplication of scarce resources.

Where are we now?

In Islington we have a strong commitment to early childhood services, and families use a wide range of services to help children thrive and develop in the first five years. Over the last few years we have seen big improvements in child health and development in the early years. We know our children's centres are hugely valued by parents, with more than 90 per cent satisfaction reported in our latest parents' survey and that, at their best, they provide a range of support for families which enables them to develop the resilience they need. But we know we can do more to support children to develop by the end of reception so that they are healthy, happy and ready for school. Furthermore, unprecedented funding pressures mean that we have to reshape our services to make them sustainable.

Over the past two years, the Islington First 21 Months programme focused on developing our understanding of how different services, such as maternity, health visiting and children's centres could more effectively work together. As a system, we collectively learnt a lot and made important strides forward. However, we now need to build on our successes and our learning to ensure that our collective resources, whether Council, NHS, private or voluntary sector are used as effectively as possible to achieve the best outcomes for children.

There are approximately
3,000 births
in Islington every year, and
13,000 children
in Islington are aged 0-4 years

Rates of
Infant deaths have fallen
from above the London and national averages to below

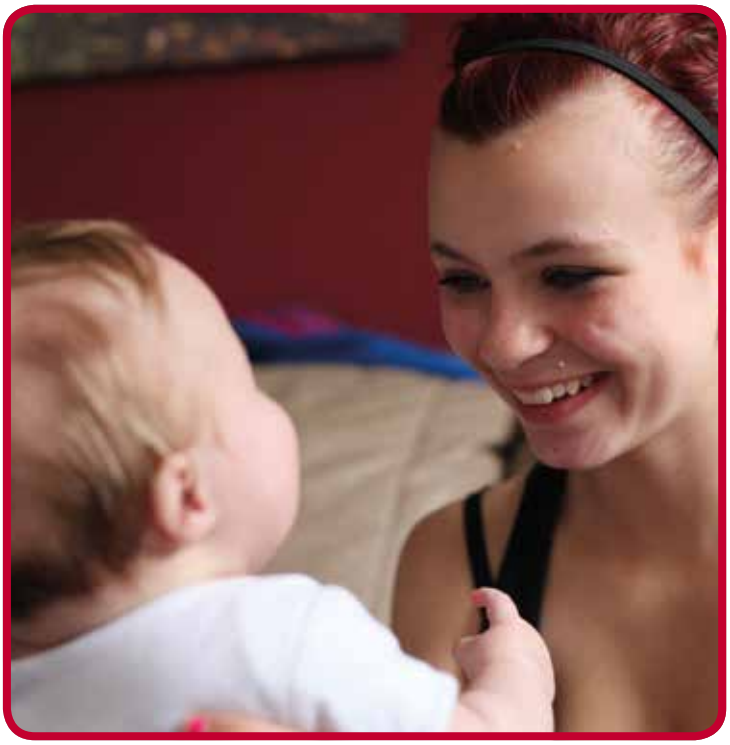
Immunisation rates for most of the major immunisation programmes have increased and are above London and national rates

School readiness has improved, but **64%** of 5 year olds in Islington achieved a "good level of development", which is below the national level of 66%

33%
of children in Islington come from low income families, compared to 18% nationally

What do we plan to do?

Over the next few years we will be transforming early childhood services in Islington. Our context is challenging, with increasingly constrained resources. We will be moving to a locality model to ensure services are organised more effectively around population need. We will also be developing a new early childhood service identity.



Improving outcomes for children and families

We are committed to designing, reviewing and evaluating our early childhood services for Islington families based on what the evidence tells us matters most, keeping a strong and determined focus on these children's outcomes. We will:

- Carry out a training needs analysis and develop a programme of training and professional development to ensure all early childhood professionals have the knowledge, confidence and skills in these key areas to support families within their areas of competence and support them to find specialist help where necessary.

Develop specifications which allow us to monitor how effectively commissioned services address the stress and resilience factors which contribute to improvements in children's outcomes.

Ensuring prevention and early intervention are at the heart of our work

We will measure our success both on the extent that we reach all families and children but also that our services support families with the greatest need most intensively We will:

- Maintain a strong set of universal early childhood services, organised across three localities in the borough which ensure easy access to all Islington families through our children's centres as well as other community locations.
- Improve our reach to the most vulnerable families through collaborative work across health visiting, family support and children's services.
- Develop a model based on the concept of parent champions to enable us to work more collaboratively with our disadvantaged families, including the most vulnerable, so as to ensure our services meet their needs.
- Improve early identification of children's health and care needs through improvements in the quality and take up of Healthy Child Programme and Early Help assessments and the integrated review at aged 2.

Driving integration across early childhood services

Concrete expressions of our integrated working include Islington's children's centres where many of our services co-locate around the needs of families, information sharing and a shared service identity. We will:

- Build a new early childhood service identity which brings difference services and professionals under a shared banner and where possible a shared roof
- Ensure clear protocols between agencies are agreed to enhance information sharing to ensure that professionals can effectively work together
- Build stronger co-location of professionals

How will we know when we've achieved it?

How will we know when we've achieved it?	How will we measure it?
Improved school readiness	➤ Percentage achieving the good level of development (GLD) and expected level in the prime areas (Foundation Stage Profile (FSP) data)
Improved outcomes at 2 year review	➤ We will develop an indicator for measuring our success
Reduced obesity at end of reception	➤ Percentage with Body Mass Index (BMI) equating to overweight/obesity measure – National Child Measurement Programme (NCMP)
Reduced oral health decay	➤ Percentage with oral health decay at age 3 or 5 (Oral Health epidemiology survey)
Increase in parents going into work	➤ Percentage of 3 and 4 year olds eligible and accessing the additional 15 hour entitlement (from Sept 17) (early years data)
Fewer children in care from mothers who have previously had a removal	➤ Number of repeat removals of children into care from the same mother (social care data)
Improved uptake of antenatal health visitor visits by women from target groups (to be identified)	➤ Percentage of pregnant women from target groups referred by maternity services to health visitor service and receiving a visit by 36 weeks pregnancy (health visitor data)
More women from target groups book early in pregnancy	➤ Percentage of pregnant women from target groups (to be agreed) book by end of 12th week of pregnancy (maternity data)
The most vulnerable families are making persistent use of early childhood services	➤ Sustained participation rate by children who are Children in Need (CIN), Child Protection (CP), Children Looked After (CLA) (early years data)
Children with specialist needs around social and communication, speech and language and Child and Adolescent Mental Health Services (CAMHS) receive timely intervention	➤ Appropriate waiting times for specialist services (Whittington Health data)
Women affected by domestic violence receive appropriate help and support	➤ Percentage of women disclosing to health visitor that there is domestic violence (health visitor data) ➤ Percentage of women in receipt of health visitor listening visits, Early Help, referred to specialist service (health visitor and early years data)
2 year olds in receipt of an integrated review	➤ Percentage of integrated reviews undertaken
Eligible 2 year olds benefit from their 15 hour entitlement	➤ Percentage of eligible 2 year olds accessing their entitlement overall and in settings which are good or better (early years data)
Improved access to early childhood services	➤ Percentage uptake in 3/4 year olds accessing the universal free entitlement (early years data) ➤ Percentage of under 5s registered with a dentist (NHS England) ➤ Percentage of children with 4 or more healthcare professional assessments (health visitor data) ➤ Universal reach to early childhood services (Children Centres) (early years data)

How will we know when we've achieved it?	How will we measure it?
Reduction in under 5s attending A&E	➤ Reduction in number of children attending for preventable accidents (To be confirmed) ➤ Reduction in number of children attending when Primary Care is more appropriate (To be confirmed)
Families show increased resilience and escalation to specialist services is avoided	➤ Increase in scoring of resilience domain in Family Star ➤ Track percentage of families in receipt of Early Help, health visitor listening visits/partnership and partnership plus, Family Nurse Practitioner (FNP) who are not subsequently referred to specialist services (early years family support data)
Families report services are high quality, accessible and focused around their needs	➤ Satisfaction rates of services through annual parent survey and Friends and Family Test (early years/Whittington Hospital)
Professionals report strength of integration	➤ Professionals experience measures ; integration supporting effective working across boundaries and supporting professionals in their role (data to be confirmed)
Professionals train and learn together	➤ Take up of integrated development opportunities by sector (data to be confirmed)

PRIORITY 2

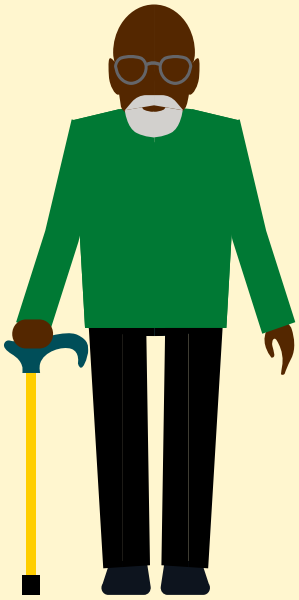
Preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities

Why is this important?

Long term conditions or chronic diseases are conditions for which there is currently no cure and include, for example, diabetes, chronic obstructive pulmonary disease, arthritis and hypertension. Long term conditions account for 50% of GP appointments and are estimated to account for up to around £7 in every £10 of total health and social care expenditure. Long term conditions are often preventable. People can be supported to live well with a long term condition, if diagnosed early and the condition is well managed. Prevention, early diagnosis and proactive management of long term conditions are critical to improving population health in Islington and to the quality of life of our residents. Our environments and lifestyles include a range of risk factors for developing long term conditions, from low levels of physical activity through to our employment opportunities. Preventing long term conditions therefore requires creating healthy environments and tackling a wide range of risk factors, which will also help promote better health and wellbeing for people with existing long term conditions.

The prevalence of long term conditions is set to continue to increase in Islington, with an increasingly ageing population and changing risk factors, such as the increasing prevalence in obesity. Currently, one in six adults aged between 18 and 74 years in Islington has a diagnosed long term condition, which amounts to around 28,000 adults in total. Moreover, one-third of residents with a long term condition in Islington have more than one condition, which underlines the need for and importance of holistic and joined up health and care, in order to improve outcomes and residents' experience of care.

Where are we now?



We have made good progress in terms of the prevention, earlier detection and management of long term conditions in Islington. In particular, through a focus on some of the major causes of premature ill health and death, such as cardiovascular disease, respiratory disease and cancer, we have now closed the gap between Islington and England in premature deaths (under 75 years). We have developed a range of innovative approaches to delivering proactive and coordinated care for people with long term conditions. The Integrated Care Pioneer Programme in Islington for example offers co-ordinated case management for adults with the most complex needs. This involves regular meetings with professionals across health, social care, housing and the voluntary sector to help develop plans to support people and carers to remain in the community. To make sure care is personalised, over 9800 local people have shared their preferences by the national Patient Activation Measure to make sure that care is tailored to the support people need. Islington is part of an early adopter of the National Diabetes Prevention Programme that has been rolled out locally in order to identify people at risk of developing diabetes and referring them into a structured programme of support focused on lifestyle changes and reducing the chance of developing diabetes. However, significant challenges remain.

203 people per 1000,000 Islington died from preventable causes during 2012-2014

2 in 5 people from manual and routine occupations in Islington smoke, compared to 1 in 5 people from other professions

38% of adults social care users have as much social contact as they would like

People with **higher levels of deprivation** are more likely to have a long term condition

1 in 10 people of working age in Islington are not able to work due to ill health

More people in Islington over the age of 65 **experience a fall** compared to London and England

Rates of hospital admissions due to **alcohol** in Islington are significantly higher than in London and England

What do we plan to do?

Our approach to promoting healthier longer lives is focused around four key themes – these are listed below along with our planned actions.

Embedding prevention and earlier intervention across the system

We will:

- Enhance awareness of residents' needs amongst frontline staff and maximise signposting to relevant services through the implementation of Making Every Contact Count (MECC) across HWB partners and the services that they commission.
- Work collectively across the Council, the NHS and the voluntary and community sector (VCS) to support and promote campaigns and awareness across our communities, including through estates and community centres.
- Include increasing 'social connections' as a requirement in all services that we commission.
- Explore approaches for embedding key performance indicators related to healthy lifestyle (such as smoking and alcohol harm reduction) across health and care commissioned services.

Addressing wider causes of health: particularly housing, employment and isolation

We will:

- Continue to work across the Council, the local NHS and the employment support system to develop and deliver the Wellbeing and Work programme, including.
  - Providing training to employment practitioners on how they can support people with health conditions into work and refer into appropriate services.
  - Promoing the importance of workplace wellbeing amongst local employers to ensure people at risk of poor health and with health conditions are supported to stay in appropriate employment.
  - Developing and testing the effectiveness of Individual Employment Support and job retention services for people with long term conditions as a way to support people back into employment.
- Redesign Islington's tenancy management offer to ensure health is integrated holistically in our local approach.

- Develop a programme of work focused on tackling loneliness and social isolation, including working with partners across the statutory, voluntary and community sectors to identify residents at risk of social isolation, map out the range of services and community assets that promote social connectivity, and find new ways of connecting residents and at risk groups.
- Develop an integrated, multi-disciplinary approach to falls prevention, supported by improved local intelligence and data around how and where falls are occurring, and the development of approaches to identify and target those most at risk of falls.

Promoting and enabling healthier lifestyles

We will:

- Reduce the prevalence of smoking:
  - Transform our approach to stop smoking services to better meet residents' needs.
  - Proactively promote smoke free environments, with a particular focus on protecting children by creating environments where children are not exposed to smoking, including the home, outside schools and in playgrounds.
- Promoting healthier and more active families
  - Develop a healthy environment to encourage access to healthy food, physical activity and active travel (including walking) for families in their everyday lives. Make better use of local assets such as parks, leisure facilities and free community groups.
  - Ensure advice and support on being active and maintaining a healthy lifestyle is part of the care people receive for long term illnesses such as diabetes.
- Reduce alcohol related harm:
  - Raise awareness of the harms caused by alcohol, encouraging a healthy approach to alcohol.
  - Ensure we promote responsible retailing and reduce harmful consumption, including a proactive approach to licensing and enforcement by all responsible authorities.
  - Reduce long-term harm by improving the identification and support provided to alcohol-dependent drinkers by strengthening links between primary care, local hospitals and alcohol support services.
  - Fully understand, identify and address the impact drinking can have on those affected by someone else's alcohol use, particularly focusing on children.

Providing a collaborative, coordinated, and integrated care offer to residents

We will:

- Improve case finding, treatment and management of long term conditions and address variation across primary care, with a particular focus on diabetes, hypertension and atrial fibrillation.
- Address and manage proactively and holistically the complex problems experienced by those with health conditions– making sure the physical health needs of those with mental health conditions are addressed effectively.
- Ensure self-care and care planning are central to our approach. Services and interventions will be adapted to meet individual needs, with care better targeted and personalised, whilst making use of innovative technology.
- Improve the holistic care of people with mental health needs who use or misuse substances. Ensure the development and systematic implementation of relevant training and accompanying policies, protocols and pathways.
- Ensure services continue to be developed focusing on the needs of residents with long term conditions, rather than organisations, services or professionals. Our local approach to service and pathway delivery will be focused on delivering outcomes and value, achieved by different organisations working together to ensure care and support is provided by the most appropriate person and in the most appropriate setting at the right time.
- Ensure carers are recognised, valued and supported. We will achieve this through strengthening the way we identify carers, supporting people to identify themselves as carers at an early stage, improving the way we support carers to remain mentally and physically well and influencing all partners, service providers and employers to 'think carer'.

How will we know when we've achieved it?

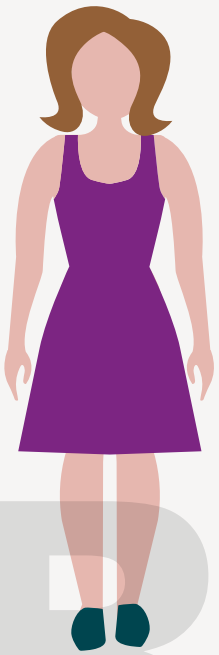
How will we know when we've achieved it?	How will we measure it?
More people living with long term conditions will report that they feel able and supported to manage their own care	➤ Percentage of people with a long term condition who have a care plan (GP Patient Survey) ➤ Percentage of people feeling supported to manage their conditions (NHS Outcomes Framework (NHSOF)) ➤ Percentage decrease in injuries due to falls in people aged 65 and over (Public Health Outcomes Framework (PHOF))
Residents will be more activated: those living with long term conditions will have improved skills, knowledge and confidence to self-manage.	➤ Patient Activation Measures (collected by Islington CCG)
Reductions in hospital admissions directly related to alcohol, alcohol related crime and liver disease mortality.	➤ A local alcohol dashboard will be developed to monitor and address alcohol related harm
Fewer residents who smoke	➤ Smoking prevalence (PHOF) ➤ Number of people who have quit smoking (Stop Smoking Services)
Fewer residents who are obese or overweight	➤ Percentage of adults with excess weight (PHOF) ➤ Percentage of physically active adults (PHOF)
Reduction in people who report being lonely	➤ Percentage of social care users with as much social contact as they would like (PHOF) ➤ We will develop local indicators for measuring social isolation
Improved access and awareness of services	➤ Percentage of service users who find it easy to get information (Adult Social Care Outcomes Framework) ➤ Making Every Contact Count (MECC) indicators: Increase in lifestyle and wider determinants knowledge amongst staff trained, increase in understanding of behaviour change amongst staff trained, and increase in confidence to have healthy and/or difficult conversations
Residents with long term conditions and disabilities are supported to find and keep work	➤ Percentage of people with a long term condition who are in employment (NHSOF/PHOF) ➤ Percentage of supported adults with a learning disability who are in paid employment (Public Health Profiles/ National Adults Social Care Intelligence Service Short and Long Term (NASCIC-SALT) survey) ➤ We will develop specific, measurable outcomes as part of the delivery of an action, taking forward an integrated approach to health and housing.
More patients reporting a positive experience of integrated care, and fewer avoidable emergency admissions to hospitals	➤ Average score for health-related quality of life for people with long-term conditions (NHSOF) ➤ People's experience of integrated care (NHSOF - Indicator to be launched soon) ➤ Patient Activation Measures (collected by the CCG) ➤ Frontline staff experience measured by Social Kinetic survey ➤ Percentage of people who have an avoidable non elective emergency admission ➤ Percentage of people who are admitted into care/residential homes

PRIORITY 3

Improving mental health and wellbeing

Why is this important?

Our mental health and wellbeing helps us realise our potential to the best of our abilities, builds coping skills and resilience, enables us to work productively and fruitfully, and helps us to make a contribution to the community. It is as fundamental to our health and wellbeing as physical health, and the two are closely linked.



Mental health conditions are major causes of ill health and disability across the population, and the leading cause of poor health among adults of working age. Groups affected by deprivation, disadvantage and discrimination are at higher risk of developing most mental health conditions, but mental health conditions have an important impact across almost all population groups in the borough.

The impacts of poor mental health conditions in Islington are wide-ranging. For instance, it was estimated that the economic impact of mental health conditions in the borough in 2014/15 was at least £650 million, taking into account the treatment and care of people with mental health conditions, lost economic output, the impact on other public services and spending and the human costs of mental health problems.

Where are we now?

There are many actions in place already for commissioning and providing services that promote and address mental health and wellbeing in Islington, reflecting the importance that all partners on the HWB place on improving mental health. A three track approach is important, that promotes good mental health, prevents mental ill health, and supports timely access to effective interventions and recovery. Bringing together mental health interventions with other services as part of coordinated and integrated action is important to improve outcomes for groups with complex, multiple needs where mental health conditions can often be a significant factor.

Child and Adolescent Mental Health Services (CAMHS) are delivered in a range of settings across Islington, including health clinics, youth settings, school and children's centres. Services report that in recent years they are seeing children and young people with a greater degree of complexity or seriousness of conditions. This has had a significant impact on increasing waiting times in some parts of the service. Our local CAMHS Transformation Plan sets out our vision for transforming services locally by 2020. A key focus of this plan for the current year is to increase access to services and improve waiting times to a maximum of 8 weeks – 4 weeks for an initial appointment and a further 4 weeks to commence treatment. Services work in collaboration with a range of stakeholders particularly education and social care colleagues recognising the importance of the 'think family' approach, which brings together services for children and adults. Young people aged 16-21 can access counselling in youth settings, and there is increased adult mental health services input into social care services for children and families, such as Children Looked After, Early Help, Families First, Children in Need and the Stronger Families Programme. Specific CAMHS input is also provided locally into the Youth Offending Service and the Integrated Gangs Team recognising the high prevalence of mental health issues in these groups

Where are we now?

of young people. An innovative new mental health promotion initiative, i-MHARS, has been developed locally and launched in a number of Islington schools.

There has been substantial local focus on achieving parity of esteem for services for people with mental health conditions, and through the Crisis Care Concordat, improving the response across agencies to people with urgent or emergency needs related to their mental health. Perinatal mental health services have also been a focus for improvement, linking into local early years services. Islington's Improving Access to Psychological Therapies service, i-Cope, for people with depression and anxiety exceeded the national target of seeing 15% of people with these conditions, and recently additional talking therapies have been commissioned to support those groups that have specific vulnerabilities, such as refugees or those who have experienced trauma and abuse. Significant progress has been made on supporting more people with mental health conditions to successfully find and stay in employment. A new 'value based commissioning' programme has been developed, which will focus on improving the experience of and outcomes for people with psychosis, with a strong focus on reducing the gap in life expectancy between people with serious mental illness and the general population in Islington. Early Intervention services for psychosis have been extended to those aged 35-65 providing a greater intensity of service to help manage the condition more successfully. Earlier diagnosis with improved support for people with dementia has been a local as well as national priority, and it is estimated that a higher proportion of people with dementia have had their condition diagnosed in Islington than anywhere else in the country. In 2015/16 a total of 750 local staff, volunteers and members of the community have been trained in mental health first aid and mental health awareness programmes.

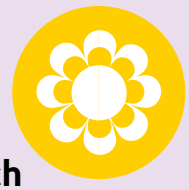
1 in 6 adults in Islington have at least one diagnosed mental health condition

Of children with a mental health condition in Islington,

more than half are undiagnosed

Between 2012-2014, there were

55 deaths from suicide in Islington, which is similar to London and national rates



18% of the total eligible population entered first treatment via Improving Access to Psychological Treatment (IAPT) services in Islington, which is above the 15% target.

There is a

65% gap

in employment rate between those in contact with secondary mental health services and the overall employment rate.

People in contact with specialist mental health services in Islington have a

mortality rate 3.6 times higher

than that of the general population in London and England

What do we plan to do?

Increasing focus on mental health and wellbeing for children and families

We will:

- Continue to develop the 'think family' approach between adult and children's mental health services
- Further develop the transition for young people and young adults experiencing, or at risk of, longer term mental health conditions.
- Improve waiting times for CAMHS/counselling.
- Roll-out of i-MHARS across Islington schools (primary and secondary).

Increasing employment opportunities and workplace health

We will:

- Give a high priority to supporting people with mental health conditions who are long term workless to return to employment, education and training, and work with employers to promote workplace wellbeing.

Working better as a system

We will:

- Build on local progress bringing together partners to provide a holistic service to people with multiple complex needs which include mental health problems.
- Improve long term individual outcomes and support more efficient local services through inclusion of mental health as a parameter within the 'Adults with Multiple Complex Needs Project'.

Focusing on reducing violence and the harm it causes

We will:

- Support psychological interventions and access to services designed to reduce violence.
- Improve understanding of, and response to, the mental health impact on victims and survivors of violence, including domestic violence.

Improving the physical health of people with mental health conditions

We will:

- Reduce the number of people with serious mental illness who die early from preventable causes, through system-wide action (the Value Based Commissioning programme).
- Ensure that lifestyle and health behaviour interventions and action to improve early diagnosis, treatment and care of physical long term conditions address and target the needs of people with mental health conditions, and encourage participation and access.

Supporting social connectedness

We will:

- Enhance frontline staff's awareness of residents' needs and maximise signposting to relevant services, through Implementation of Making Every Contact Count (MECC) across HWB partners and the services they commission.
- Work collectively across the Council, the NHS and voluntary and community sector to support and promote campaigns and awareness that promote positive mental health, prevent mental ill health and provide timely support and help including through our estates and community centres. We will include increasing 'social connections' as a requirement of all local services we commission.

Preventing suicide

We will:

- Develop and implement the priorities of the local suicide strategy, developing and agreeing new approaches to address risks and support people bereaved or affected by suicide (postvention).

Increasing awareness and understanding

We will:

- Champion action that promotes understanding, better recognition of signs and symptoms, and positive attitudes about mental health conditions – including within partner organisations and including Islington's mental health first aid initiatives.

Focusing on dementia

We will:

- To improve the post diagnosis offer for people diagnosed with dementia.
- Continue to improve dementia diagnosis rates taking into account increasing prevalence due to an ageing population.

Improving service access

We will:

- Increase access to IAPT to 19% of the target by 2020.
- Increase the presence of mental health professionals in primary care settings to support earlier intervention and reduce stigma.
- Develop a new Health Based Place of Safety to provide safe, comfortable and appropriately resourced settings for individuals in crisis.
- Review services to support people in crisis to help avoid hospital admissions.

How will we know when we've achieved it?

How will we know when we've achieved it?	How will we measure it?
Healthier lifestyles for people with serious mental illness (SMI)	➤ Smoking quits among people with serious mental health conditions (CCG data)
Improved physical health of people with SMI	➤ Number of deaths under 75, by cause, among people with serious mental health conditions (PHOF) ➤ The number of preventable emergency admissions for long term conditions (NHSOF) ➤ The number of premature years of life lost (NHSOF)
Reduction in deaths due to suicide	➤ Number of deaths due to suicide or undetermined injury, or reported as suspected suicides. Office for National Statistics (ONS)/PHOF
Multiple / complex needs	➤ We will develop local indicators to measure progress in this area
Improved outcomes for people involved with gangs	➤ Percentage of gang nominals referred to the Integrated Gangs Team (Information Governance toolkit (IGT)) who have case consultation and mental health screening (IGT data) ➤ Number of gang nominals in the IGT requiring mental health support who have a mental health assessment (IGT data) ➤ Number who have a positive reduction in psychometric measures of mental health outcomes at end of the intervention e.g. Generalised Anxiety Disorder (GAD) or PHQ (type of patient health questionnaire for depression) or STAXI-III (type of phsychological assessment) (IGT data) ➤ Number of individuals who are referred to adult mental health services, who receive a service from the gang psychologist (IGT data)
Improved service access for people with domestic violence	➤ Number of people accessing talking therapy services with a history of domestic violence (IAPT data) ➤ Number of mental health staff trained on identification and referral of domestic violence (MH team) ➤ Number of people accessing drugs and alcohol treatment with a history of domestic violence (Drugs and alcohol provider data)
Increased employment among people with mental health conditions	➤ Numbers of people with mental health conditions supported into employment (CCG data) ➤ Numbers of people with mental health conditions supported to stay in employment (CCG data)
Improved understanding and ability to respond to mental health conditions	➤ Participation in mental health first aid training and related initiatives, evaluated for impact (Public health team)
Improved social connectedness	➤ We will develop local indicators to measure progress in this area
Improved service access for people with dementia	➤ Ensure children and young people wait no longer than a maximum of 4 weeks for an initial appointment and a further 4 weeks to commence treatment ➤ Increase access to CAMH services by 25% by 2020 (CAMHS data) ➤ Develop out of hours crisis care pathways – working towards 24 / 7 access by 2020 ➤ By 2020 increase access to IAPT to 19% of the target population (IAPT data)

DRAFT