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ISLINGTON

Governance and Human Resources
Town Hall, Upper Street, London, N1 2UD

AGENDA FOR THE EXECUTIVE

A meeting of the Executive will be held in Committee Room 4, Town Hall, Upper Street, N1 2UD on, **15 January 2015 at 7.30 pm.**

John Lynch
Head of Democratic Services

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Despatched	:	7 January 2015

Membership 2013/14	**Portfolio**
Councillor Richard Watts	Leader of the Council
Councillor Janet Burgess	Executive Member Health and Wellbeing
Councillor Joe Caluori	Executive Member Children and Families
Councillor Paul Convery	Executive Member Community Safety
Councillor Andy Hull	Executive Member Finance and Performance
Councillor Rakhia Ismail	Executive Member Community Development
Councillor James Murray	Executive Member Planning and Development
Councillor Claudia Webbe	Executive Member for Environment

Quorum is 4 Councillors

Please note
It is likely that part of this meeting may need to be held in private as some agenda items may involve the disclosure of exempt or confidential information within the terms of Schedule 12A of the Local Government Act 1972. Members of the press and public may need to be excluded for that part of the meeting if necessary. Those items are at Section H of the agenda - Paragraph 3, Schedule 12A of the Local Government Act 1972 applies.

Details of any representations received about why the meeting should be open to the public – none received.

Declarations of interest:

If a member of the Executive has a **Disclosable Pecuniary Interest*** in an item of business and it is not yet on the council's register, the Councillor **must** declare both the existence and details of it at the start of the meeting or when it becomes apparent. Councillors may also **choose** to declare a Disclosable Pecuniary Interest that is already in the register in the interests of openness and transparency. In both the above cases, the Councillor **must** leave the room without participating in discussion of the item.

If a member of the Executive has a **personal** interest in an item of business they **must** declare both the existence and details of it at the start of the meeting or when it becomes apparent but may remain in the room, participate in the discussion and/or vote on the item if they have a dispensation from the Chief Executive.

***(a) Employment, etc -** Any employment, office, trade, profession or vocation carried on for profit or gain.

(b) Sponsorship - Any payment or other financial benefit in respect expenses in carrying out duties as a member, or of election; including from a trade union.

(c) Contracts - Any current contract for goods, services or works, between the Councillors or their partner (or a body in which one has a beneficial interest) and the council.

(d) Land - Any beneficial interest in land which is within the council's area.

(e) Licences- Any licence to occupy land in the council's area for a month or longer.

(f) Corporate tenancies - Any tenancy between the council and a body in which the Councillor or their partner have a beneficial interest.

(g) Securities - Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

NOTE: Public questions may be asked on condition that the Chair agrees and that the questions relate to items on the agenda. No prior notice is required. Questions will be taken with the relevant item.

Requests for deputations must be made in writing at least two clear days before the meeting and are subject to the Leader's agreement. The matter on which the deputation wants to address the Executive must be on the agenda for that meeting.

C.	**Performance and Monitoring Matters**	**PAGE**
6.	GP Appointment Systems - recommendations from the Health and Care Scrutiny Committee	67 - 140
D.	**Service Related Matters**	
7.	Diesel Surcharge on Permits	141 - 149
E.	**Procurement Issues**	
8.	Approval of the Procurement Strategy for Universal Child Health Services, including request for a two year extension to the School Nursing contract.	149 - 158
9.	Approval of contract award for the Young People's Sexual Health Service	159 - 166
10.	Contract Award for the provision of 23 new homes and a new community centre on Ivy Hall, Holly Park Estate	167 - 170
11.	Procurement Strategy Approval for the transformation of Sexual Health Services	171 - 180
12.	Pre-procurement Approval: Extra Care Sheltered Housing	181 - 194
F.	**Urgent non-exempt matters**	
	Any non-exempt items which the Chair agrees should be considered urgently by reason of special circumstances. The reasons for urgency will be agreed by the Chair and recorded in the minutes.	
G.	**Exclusion of press and public**	
	To consider whether to exclude the press and public during discussion of the remaining items on the agenda, in view of their confidential nature, in accordance with Schedule 12A of the Local Government Act 1972.	
H.	**Confidential / exempt items for information**	
13.	Approval of contract award for the Young People's Sexual Health Service - exempt appendix	195 - 196
14.	Contract Award for the provision of 23 new homes and a new community centre on Ivy Hall, Holly Park Estate - exempt appendix	197 - 200
I.	**Urgent Exempt Matters**	
	Any exempt items which the Chair agrees should be considered urgently by reason of special circumstances. The reasons for urgency will be agreed by the Chair and recorded in the minutes.	

The next meeting of the Executive will be on 12 February 2015

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London Borough of Islington

Executive - 27 November 2014

Minutes of the meeting of the Executive held at Committee Room 4, Town Hall, Upper Street, N1 2UD on 27 November 2014 at 7.30 pm.

Present: **Councillors:** Watts, Burgess, Caluori, Convery, Hull, Ismail, Murray and Webbe

Councillor Richard Watts in the Chair

59 **APOLOGIES FOR ABSENCE**
None.

60 **DECLARATIONS OF INTEREST**
None.

61 **MINUTES OF PREVIOUS MEETING**

RESOLVED:

That the minutes of the meeting on 23 October 2014 be confirmed as a correct record and the Chair be authorised to sign them.

62 **FINANCIAL POSITION AS AT 30 SEPTEMBER 2014**

RESOLVED:

1.1. That the overall forecast revenue outturn for the General Fund of a £1.2m overspend be noted. **(Paragraph 3.1, Table 1 and Appendix 1 of the report).**

1.2. That the application of £0.4m of in-year corporate funding to the structural overspend within the Housing General Fund temporary accommodation budget be agreed. This is a net nil impact overall as the corporate underspend is reduced, in respect of this applied funding, by the same amount. **(Paragraph 4.11 of the report).**

1.3. That the HRA is forecast to break-even over the financial year be noted. **(Paragraph 3.1, Table 1 and Appendix 1 of the report).**

1.4. That the latest capital position be noted. **(Section 6, Table 2 and Appendix 2 of the report).**

63 REDRESS SCHEME FOR LETTINGS AGENCY WORK AND PROPERTY MANAGEMENT WORK

RESOLVED:

1.1 That the implementation and enforcement of The Redress Schemes for Lettings Agency Work and Property Management Work (Requirement to Belong to a Scheme etc.) (England) Order 2014 (2014 No.2359) dated 3rd September 2014, be delegated to the Corporate Director of Environment and Regeneration in consultation where appropriate with the Corporate Director of Housing and Adult Social Services be agreed.

1.2 That day to day enforcement of the Order will be undertaken by officers in the Trading Standards Service in accordance with the existing authorisation in the Constitution be agreed.

1.3 That the Corporate Director of Environment and Regeneration be authorised, in consultation with the Executive Member for Housing and Development, to determine the monetary penalties for non-compliance with the Order, taking the recommendations of the final Department of Communities and Local Government guidance into account once it has been issued to local authorities, be agreed.

64 BUILDING MORE COUNCIL HOMES: PROPOSED APPLICATION FOR A COMPULSORY PURCHASE ORDER (CPO) IN RESPECT OF LEASEHOLD AND COMMERCIAL PREMISES IN BUNHILL AND CLERKENWELL

RESOLVED:

1.1 That authority be delegated to the Corporate Director for Finance and Resources, in consultation with the Executive member for Housing and Corporate Director for HASS, to take all necessary steps, including the making of Compulsory Purchase Orders (CPO) under section 226(1)(a) of the Town and Country Planning Act 1990, General Vesting Declarations or Notices to Treat to ensure that the leasehold and any other interests in the properties described in the table below where attempts to negotiate a voluntary acquisition of the leasehold interest in accordance with the development timetable have failed be agreed.

Address of premises				**Interest to be acquired**
Number	**Block/Estate**	**Street**	**Postcode**	
5	Charles Simmons House	Margery Street	WC1X 0HP	Residential long leasehold
13	Charles Simmons House	Margery Street	WC1X 0HP	Residential long leasehold
2	Telfer House	Lever Street	EC1V 3QX	Residential long leasehold
3	Telfer House	Lever Street	EC1V 3QX	Residential long leasehold
4	Telfer House	Lever Street	EC1V 3QX	Residential long leasehold

15	Telfer House	Lever Street	EC1V 3QX	Residential long leasehold
169	Redbrick Estate	Old Street	EC1V 9NJ	Commercial lease

1.2 That, where the Corporate Director of Finance and Resources approves the making of a CPO , the Assistant Chief Executive (Governance and HR) is authorised to take all necessary steps to secure the making, confirmation and implementation of the CPO, including the approval of agreements with the owners and any objectors for the withdrawal of objections to the CPO, the settling of compensation and the acquisition of all interests in the properties on terms recommended by the Corporate Director of Finance and Resources, be agreed.

1.3 That the use of CPO powers in respect of the properties identified in this report is being exercised after balancing the rights of the individual property owners with the requirement to obtain possession of the properties in the public interest be agreed.

1.4 That the interference with the human rights of the property owners affected by the proposals in this report, and in particular their rights to a home and to the ownership of property, is proportionate, given their rights to object and to compensation, and the benefit to the economic, social and environmental wellbeing of the areas of Islington affected by these proposals be agreed.

65 DISPOSAL OF SURPLUS LAND IN HILLRISE WARD FOR HOUSING

RESOLVED:

1.1 That the disposal of that part of the former Ashmount School Site (shown edged blue on the attached plan at Appendix 1) to ISHA be agreed.

1.2 That authority be delegated to the Corporate Director of Finance and Resources, in consultation with the Executive Member for Children and Families, the Corporate Directors of Children's Services, Housing and Adult Social Services and the Assistant Chief Executive (Governance & HR), to agree the terms of the disposal to ISHA be agreed.

1.3 That the Corporate Director of Finance and Resources be authorised to dispose of the freehold of the retained land on the terms agreed and to instruct the Assistant Chief Executive (Governance & HR) to enter into all necessary legal documentation to give effect to the agreed terms be agreed.

1.4 That the above recommendations are subject to the following be noted:

i) the outcome of a judicial review on the application of the Ashmount Site Action Group of the Secretary of State's decision to give the Council consent under section 77 of the 1998 Act and Schedule 1 of the 2010 Act to dispose of the former Ashmount School and:

ii) an exchange of contracts by 31st December 2014 to grant a 125 year lease in respect of space in the New River PRU development at Dowrey Street to the Bridge Integrated Learning Space Free School (BILS).

66 **PROVISION OF ADDITIONAL PRIMARY SCHOOL PLACES AND SOCIAL HOUSING AT THE FORMER RICHARD CLOUDESLEY SCHOOL SITE, GOLDEN LANE, LONDON, EC1**

RESOLVED:

1.1 That the proposed development of the RCS site and AEC by CoLC to provide a mixed development of an estimated 70 to 90 new social housing units and additional primary school places for 210 pupils and nursery for 26 pupils plus provision for 12 two year old places be agreed.

1.2 That the proposal for the CoLC to provide the additional nursery and primary school places that will be required by September 2017 be agreed.

1.3 That the target to develop the maximum possible social housing units subject to planning with a mix of 1, 2 and 3 beds with 50% nominations rights for Islington be approved.

1.4 That authority be delegated to the Corporate Director of Finance and Resources, in consultation with the Executive Member for Children and Families, the Corporate Directors' of Children's Services, Housing and Adult Social Services and the Assistant Chief Executive (Governance & HR), to conclude the negotiation and final terms of disposal and development of the RCS site in accordance with the principles set out in the Heads of Terms set out in Appendix 2 (Exempt) be agreed.

1.5 That the Corporate Director of Finance and Resources be authorised to dispose of the freehold of the RCS site to CoLC on the terms agreed and to instruct the Assistant Chief Executive (Governance & HR) to enter into all necessary legal documents to give effect to the agreed terms be agreed.

1.6 That the Assistant Chief Executive (Governance and HR) be authorised to apply to the Secretary of State for consent to dispose of the RCS site under Para.4 of Schedule 1 of the Academies Act 2010 and any consent necessary under s123 of the Local Government Act 1972 be agreed.

67 **LEISURE FEES AND CHARGES 2015**

RESOLVED:

1.1 That the 2015 schedule of leisure fees and charges as set out in Appendices 1 and 2 of the report be agreed.
1.2 That authority be delegated to the Corporate Director of Environment and Regeneration to authorise any in-year changes to leisure fees and charges following consultation with the relevant Executive Member be agreed.
1.3 That the revised scheduling for future leisure fees and charges proposals, to be presented in February for implementation from 1st of April each year from 2016, be agreed.

68 CEMETERY FEES AND CHARGES 2015

RESOLVED:

1.1 That the fees and charges detailed in Appendix 1 of the report be agreed for introduction on the 1st January 2015.

1.2 That authority be delegated to the Corporate Director of Environment and Regeneration, in consultation with the Executive Member for Environment, to agree any in-year changes to Cemeteries fees and charges be agreed.

69 WASTE (ENGLAND AND WALES) (AMENDMENT) REGULATIONS 2012: REQUIREMENT FOR SEPARATE COLLECTIONS OF RECYCLING

RESOLVED:

That the review of the implications of the Waste Regulations on recycling services in Islington, and that as a result of this review a change from the current commingled recycling collection services is not required be noted.

70 FORMAL VARIATION LONDON COUNCILS TRANSPORT & ENVIRONMENT COMMITTEE GOVERNING AGREEMENT

This item was withdrawn from the agenda to allow some additional information, recently received, to be properly considered before a decision on the recommendations in the report is made. The decision will be taken by the Leader of the Council, before 23 December 2014. The decision will be taken in public and a notice will be posted on the Council's website advising the date of the decision.

71 CENTRAL LONDON FORWARD GROWTH DEAL PILOT

RESOLVED:

1.1 That authority to finalise the procurement strategy for CLF Growth Deal Pilot be delegated to the Assistant Chief Executive (Strategy and Community Partnerships) in consultation with the Leader of the Council be agreed.

1.2 That authority to award the resulting contract be delegated to the Assistant Chief Executive (Strategy and Community Partnerships) in consultation with the Leader of the Council be agreed.

72 ADVENTURE PLAY STRATEGY NEXT STEPS AND PROPOSED STAFF LED MUTUAL

RESOLVED:

1.1 That support for the implementation of the proposed staff-led mutual for adventure play to be able to manage and operate the six playgrounds which are currently operated by the council's Play and Youth Service from April 2016, if successful in a competitive tender, be agreed.

1.2 That the council will provides support to the staff-led mutual in the ways set out at section 6 of this report be agreed.

1.3 That the procurement strategy to re-tender, through a transparent procurement process, the management and operation of the six adventure playgrounds currently operated within the voluntary sector from April 2016 be agreed.

1.4 That an annual investment in adventure play of £1.2million from April 2016 until March 2019 as a minimum, the details of which are set out in Appendix 1 of the report, be agreed.

1.5 That authority to award the contracts for adventure play be delegated to the Corporate Director of Children's Services, following consultation with the Executive Member for Children and Families be agreed.

73 CONCIERGE AND ASSOCIATED SECURITY SERVICES CONTRACT

RESOLVED:

1.1 That the available options as set out in Section 4 of the report be noted.

1.2 That the concierge service, currently provided under contract with CIS Security Limited, come back under the councils direct management with effect from 1 April 2015 be agreed.

74 DELIVERING MORE COUNCIL HOMES: ACQUISITION OF A POTENTIAL DEVELOPMENT SITE ON TOLLINGTON WAY

RESOLVED:

1.1 That the acquisition of the unencumbered freehold interest in the site of a former nursery at 52 Tollington Way, N7 6QX, subject to contract, be agreed.

1.2 That authority be delegated to the Corporate Director of Finance and Resources, in consultation with the Corporate Directors' of Housing and Adult Social Services and the Assistant Chief Executive (Governance & HR) to agree the terms to ensure that the proposed acquisition is affordable and represents value for money for the council be agreed.

1.3 That the Corporate Director of Finance and Resources be authorised to acquire the freehold interest in the site of the former nursery on Tollington Way and to instruct the Assistant Chief Executive (Governance & HR) to enter into all necessary legal documents to give effect to the agreed terms be agreed.

75 CONTRACT AWARD FOR THE CONSTRUCTION OF 34 NEW HOMES, A NEW LIBRARY AND ASSOCIATED ESTATE IMPROVEMENT WORKS

RESOLVED:

That the award of a contract to Higgins Construction PLC for the construction of 34 new homes, a new library and associated estate improvement works on the site of John Barnes Library and land to the rear of Camden Road be agreed.

76 **OFFICER DECISION SUMMARY**

Noted.

77 **DISPOSAL OF SURPLUS LAND IN HILLRISE WARD FOR HOUSING - EXEMPT APPENDIX**

RESOLVED:

That the exempt information in the appendix to agenda item C7 be noted (see Minute 65 for decision).

78 **PROVISION OF ADDITIONAL PRIMARY SCHOOL PLACES AND SOCIAL HOUSING AT THE FORMER RICHARD CLOUDESLEY SCHOOL SITE, GOLDEN LANE, LONDON, EC1 - EXEMPT APPENDIX**

RESOLVED:

That the exempt information in the appendix to agenda item C8 be noted (see Minute 66 for decision).

79 **CONTRACT AWARD FOR THE CONSTRUCTION OF 34 NEW HOMES, A NEW LIBRARY AND ASSOCIATED ESTATE IMPROVEMENT WORKS - EXEMPT APPENDIX**

RESOLVED:

That the exempt information in the appendix to agenda item D17 be noted (see Minute 75 for decision).

MEETING CLOSED AT 7.55 pm

Chair

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ISLINGTON

Finance and Resources Department
7 Newington Barrow Way, London, N7 7EP

Report of : Executive Member for Finance and Performance

Meeting of	**Date**	**Ward(s)**
Executive Policy & Performance Scrutiny Committee Executive Council	15th January 2015 22nd January 2015 12th February 2015 26th February 2015	All
Delete as appropriate	~~Exempt~~	Non-exempt

BUDGET PROPOSALS 2015-16

1 INTRODUCTION

1.1 The budget report is a strategic financial document which encapsulates the Council's priorities in an overall budget package for the financial year 2015-16. The principal purpose of this report is for the Executive to recommend proposals in respect of the 2015-16 budget, as the basis for setting the 2015-16 budget and council tax. The Policy and Performance Scrutiny Committee will review the proposed budget at its meeting on 22nd January 2015 and its comments will be taken into account in setting the final budget and level of council tax at Council on 26th February 2015.

1.2 The contents of this report are summarised below:

Section 2 sets out the recommendations.

Section 3 sets out the 2015-16 General Fund revenue budget and Medium Term Financial Strategy (MTFS).

Section 4 details the Housing Revenue Account (HRA) for 2015-16 and its MTFS.

Section 5 details the 2015-16 to 2017-18 Capital Programme.

Section 6 will set out the Treasury Management Strategy in the final version of the budget report to be considered by Executive on 12th February 2015 and Council on 26th February 2015, following its consideration by the Audit Committee on 29th January 2015.

Section 7 will show the detailed, statutory council tax calculations in the final version of the budget report to be considered by Executive on 12th February 2015 and Council on 26th February 2015, following its consideration by the Audit Committee on 29th January 2015.

Section 8 details matters to consider in setting the budget.

List of Appendices

Appendix A	MTFS 2015-16 to 2017-18
Appendix B	Revenue Savings 2015-16
Appendix C	General Fund Fees and Charges 2015-16
Appendix D1	HRA MTFS 2015-16 to 2017-18
Appendix D2	HRA Fees and Charges 2015-16
Appendix E	Capital Programme 2015-16 to 2017-18
Appendix F	Resident Impact Assessment

2 RECOMMENDATIONS

The General Fund Budget 2015-16 and MTFS (Section 3)

2.1 To agree the 2015-16 net Council cash limits as set out in **Table 1** (**paragraph 3.1.4**) and the MTFS at **Appendix A**, which include the revenue savings in **Appendix B.**

2.2 To agree, within the 2015-16 revenue budget, £0.6m to continue to provide a Resident Support Scheme following the cessation of Local Welfare Provision funding by the Government, and to note that we will review expenditure on the Resident Support Scheme in the first three months of 2015-16 and supplement this funding as required from the Housing Benefit Reserve up to the level of the government grant for 2014-15 that is being cut (£1.44m). (**Paragraphs 3.2.5 to 3.2.6**)

2.3 To note the requirement to report on the number of maintained schools that have completed the Schools Value Financial Standard (SVFS) by 31st March to the Department for Education by 31st May each year. (**Paragraph 3.2.15**)

2.4 To agree the fees and charges policy and the schedule of 2015-16 fees and charges. (**Paragraph 3.2.16-17** and **Appendix C**)

2.5 To agree the Council's policy on the level of General Fund balances and the estimated use of the Council's earmarked reserves. (**Paragraph 3.2.21-22** and **Table 3**)

The HRA Budget and MTFS (Section 4)

2.6 To agree the balanced HRA 2015-16 budget within the HRA MTFS at **Appendix D1.**

2.7 To agree the proposed increases in 2015-16 for HRA rents and other fees and charges. (**Paragraphs 4.4 to 4.9**, **Table 5** and **Appendix D2**)

The Capital Programme 2015-16 to 2017-18 (Section 5)

2.8 To agree the 2015-16 capital programme and note the provisional programme for 2016-17 to 2017-18, which includes funding for an expanded Phase 2 Bunhill heat and power scheme (funded on the expectation that it will be a priority for planning gain from developments in Bunhill). (**Paragraph 5.1**, **Table 6** and **Appendix E**)

2.9 To agree that the Corporate Director of Finance and Resources applies capital resources to fund the capital programme in the most cost-effective way. (**Paragraph 5.3**)

2.10 To note the schemes that comprise the Capital Allowance pot of eligible affordable housing and regeneration schemes. (**Paragraph 5.4** and **Appendix E**)

Treasury Management Strategy (Section 6)

2.11 To note that the Treasury Management Strategy will initially be considered by Audit Committee on 29th January 2015 and then included for agreement within the final budget report to Executive on 12th February 2015 and Council on 26th February 2015.

Council Tax 2015-16, including Statutory Calculations (Section 7)

2.12 To note that the General Fund budget has been prepared on the basis that the basic amount of council tax in Islington (excluding the GLA precept) will increase by 1.99% in 2015-16.

2.13 To note that the detailed, statutory council tax calculations and the recommendations for the final 2015-16 council tax level, including the GLA precept, will be included in the budget report to Executive on 12th February 2015 and Council on 26th February 2015.

Matters to consider in setting the Budget (Section 8)

2.14 To note the Section 151 Officer's and the Monitoring Officer's comments in their determination of the revenue and capital budgets for 2015-16 and the basis for the level of council tax, including the Section 151 Officer's report in relation to his responsibilities under section 25 (2) of the Local Government Act 2003.

2.15 To note the Resident Impact Assessment (RIA) on the 2015-16 budget. (**Appendix F**)

3 GENERAL FUND BUDGET 2015-16

3.1 GENERAL FUND BUDGET - OVERVIEW

3.1.1 Following the significant cut in national Government funding since 2010, Islington Council has had to close a net budget gap of £112m over the four years 2011-15. For the financial year 2015-16, there is a further budget gap of £37m to close, following the announcement of further Government cuts to the Council's general grant funding (£25m) and further inflationary and demographic cost pressures (£12m).

3.1.2 There is significant financial uncertainty from 2016-17 onwards due in the main to the approaching General Election in May 2015 and the Spending Review that will follow.

3.1.3 The proposed General Fund revenue budget and net revenue cash limits for 2015-16 are shown within the MTFS at **Appendix A**. The MTFS includes the proposed 2015-16 General Fund savings, totalling £37m and included at **Appendix B**, and also details the forecast net expenditure over the medium term, based on current knowledge and expectations.

3.1.4 **Table 1** below shows the net budget figures for 2015-16 that are included within the MTFS at **Appendix A**, for agreement as part of the recommendations of this report.

Table 1 – Council Budget Requirement and Departmental Cash Limits 2015-16

	£000s
Departments	
Children's Services	73,944
Chief Executive	6,307
Environment and Regeneration	30,564
Finance and Resources	489
Housing and Adult Social Services	81,619
Public Health	0
Corporate and Democratic Core (CDC)/Unapportionable Central Overheads (UCO)	16,675
NET COST OF SERVICES	**209,598**
Net Corporate items	6,409
NET OPERATING EXPENDITURE	**216,007**
Other Budget Items:	
Transfer to/(from) Reserves	10,450
New Homes Bonus (net of estimated top-slice to London Local Enterprise Partnership)	(9,884)
Education Services Grant (Estimate)	(2,322)
AMOUNT TO BE MET FROM CORE GOVERNMENT FUNDING AND COUNCIL TAX	**214,251**

3.2 **GENERAL FUND BUDGET – DETAIL**

Provisional Local Government Finance Settlement 2015-16

3.2.1 The Provisional Local Government Finance Settlement, announced on 18th December 2015, detailed the Council's core Government funding allocation for 2015-16. An analysis is shown in **Table 2** below.

Table 2 – Core Government Funding 2015-16

	2015-16 Provisional £m
Revenue Support Grant	65.9
Retained Business Rates	57.0
Top-up Grant	20.4
Total Core Government Funding	**143.3**

3.2.2 Overall, total core Government funding will be cut by £25.1m (15%) in 2015-16.

3.2.3 The Government estimates that the Council will collect £190m in business rates in 2015-16. Of this, the Council is estimated to retain £57m (30%) towards core funding, with 20% and 50% going to the GLA and Central Government respectively.

3.2.4 2015-16 core Government funding also includes a £20.4m top-up grant because estimated business rates income is less than the Government determined funding need.

Local Welfare Provision Funding/Resident Support Scheme

3.2.5 It was confirmed as part of the provisional local government finance settlement that there will be no Government funding for Local Welfare Provision (LWP) from 2015-16; the funding therefore stops in the financial year 2014-15. It is recommended that £0.6m is provided from the General Fund in 2015-16 to continue to provide a Resident Support Scheme. This can be provided for within the revenue budget due to the level of 2015-16 savings that have been found, including in particular £500k from reducing the number of refuse collection vehicles required by moving towards a communal kitchen waste and green waste collection service.

3.2.6 We are concerned, however, that this level of funding may not cover the demand for such support in 2015-16. As a result, we will review expenditure on the Resident Support Scheme in the first three months of 2015-16 and supplement this funding as required from the Housing Benefit Reserve up to the level of the government grant for 2014-15 that is being cut (£1.44m). The Housing Benefit Reserve is being held to allow for the management of the transition from housing benefit to universal credit and for the ongoing requirement to run a council tax support scheme. The commencement of universal credit has continually been delayed by the Government and although our Islington start-date has not yet been fixed, we have recently been told that it will not be prior to October 2015 for new claimants and not until 2016-17 for current claimants. This delay should allow for the release of some temporary funding from the Housing Benefit Reserve as required in order to meet demand from some of the borough's most vulnerable residents through the Resident Support Scheme.

New Homes Bonus Scheme

3.2.7 The Council will receive £13.8m New Homes Bonus income in 2015-16. Islington is the sixth highest recipient of New Homes Bonus in England, directly attributable to the number of new homes built in the borough over the past five years.

3.2.8 In 2015-16, an estimated £3.9m of our New Homes Bonus income will be top-sliced to fund London Local Enterprise Partnership (LEP) projects.

Health/Social Care Funding

3.2.9 The Better Care Fund is a pooled budget to help improve the integration of health and care services that are currently commissioned by the NHS and local authorities. The revenue funding for Islington of £17m is from within Islington Clinical Commissioning

Group budgets and will be pooled along with £1.4m of social care capital grants. The NHS and local authorities must agree locally through Health and Wellbeing Boards how the funding will be spent across health and care services. Not all of these funds are transferring to the Council and £8.6m is existing NHS funding to support social care with health benefits, carers and reablement plus a further allocation for new burdens arising from the Care Bill.

3.2.10 The Council will receive £25.4m Public Health Grant in 2015-16, ring-fenced for spending on public health services.

Children's Services Funding 2015-16

3.2.11 The Dedicated Schools Grant (DSG) is a ring-fenced grant for spending on education. The Schools Forum makes recommendations about how the grant awarded to Islington should be allocated to schools and the Council (including the Early Years Service) as appropriate.

3.2.12 The Department for Education has committed to a DSG cash floor of minus 2% per pupil for 2015-16, to ensure that a minimum funding guarantee of minus 1.5% per pupil at school level can be maintained (excluding sixth form funding) and before the Pupil Premium is added. The DSG priorities for 2015-16 are being developed in conjunction with the Schools Forum.

3.2.13 The Pupil Premium is a specific grant to support disadvantaged pupils in mainstream and special schools, Pupil Referral Units, and 14 to 15 year olds in Further Education colleges. It is being extended to disadvantaged 3 and 4 year olds in early years provision from 2015-16. It is estimated that total Pupil Premium funding for Islington (including Academies) will be around £15.6m in 2015-16, to be announced in early 2015.

3.2.14 Education Services Grant (ESG) – The Department for Education has announced indicative allocations of this grant for 2015-16, with the Council's allocation being provisionally reduced by £0.5m in 2015-16 to £2.3m in line with an overall reduction in this funding stream at a national level.

Statement of Assurance on Schools

3.2.15 The Council has a system of audit in place that provides adequate assurance over maintained schools' standards of financial management and the regularity and propriety of their spending. The Council is required to report on the number of maintained schools that have completed the Schools Value Financial Standard (SVFS) by 31st March to the Department for Education by 31st May each year. The SVFS returns are also used by the Council to inform its programme of financial assessment of maintained schools and audit.

Fees and Charges 2015-16

3.2.16 Some fees and charges are laid down by statute and are not within the Council's power to vary locally; others are discretionary and are set with Council's approval. The Council's proposed discretionary fees and charges for 2015-16 are set out in the schedule included at **Appendix C** and incorporated in the overall revenue budget.

3.2.17 It is the Council's policy to increase its discretionary fees and charges in line with inflation (2.4% at Quarter 3 2014, this being the quarter average) unless a variation is approved by Council or Executive. The relevant extract of the Council's fees and charges policy is set out below:

> "There will be an overall annual increase in fees and charges in line with the Retail Price Index (RPI), subject to the following:
>
> (i) use of the Quarter 3 RPI (All Items)
>
> (ii) appropriate rounding of charges for the purposes of administration and collection
>
> (iii) statutory changes to fees and charges being excluded
>
> (iv) fees and charges on which the Council has or decides to have a specific policy may be varied by report to the Executive

Where the Quarter 3 RPI (All Items) is negative all fees and charges will be frozen, subject to provisions (ii) to (iv) above."

3.2.18 Fees and charges in relation to Leisure Services and Cemeteries were agreed separately by the Executive on 27th November 2014 and will take effect from 1st January 2015.

Local Initiatives Fund

3.2.19 The Local Initiatives Fund is £240k, with £15k being allocated to each ward. Members decide on allocations locally and formal decisions will continue to be taken in-year by the Voluntary and Community Sector Committee.

General Balances and Reserves

3.2.20 The Government has reserve powers under the Local Government Act 2003 to set a minimum level of reserves for which an authority must provide in setting its budget. These powers would only be used where there were grounds for serious concern about an authority and there is no intention to make permanent or blanket provision for minimum reserves under these provisions.

3.2.21 The Section 151 Officer is required to report to the authority, when it is making the statutory calculations required to determine its council tax, on the estimates included in the budget and the adequacy of reserves. The report of the Section 151 Officer is included within **Section 8** of this report. The estimated level of earmarked reserves and general balances for use in 2015-16, after taking into account existing and estimated allocations against these reserves, are shown in **Table 3** below:

Table 3 – Estimated Reserve and General Balances 2015-16

	2015-16 £m
Redundancy Reserve	2.0
Contingency Reserve	1.9
Housing Benefit Reserve	7.3
Levies Smoothing Reserve	0.8
General Fund Balances (excluding schools)	10.6
Schools Balances	10.9
Total	**33.5**

3.2.22 It is recommended that the Council agrees the same policy as previous years on the level of general balances for the 2015-16 budget. This is as follows:

"The policy of the Council is to set a target level of General Fund balances (excluding schools balances) at 5% of the net budget requirement (excluding schools expenditure) over the course of the medium-term financial strategy. The rationale for this level is based upon an assessment of the level of risk inherent within the Council budget over the medium-term financial planning period. The level of General Fund balances should be adequate to meet working balance requirements and to provide a reasonable allowance for unquantifiable risks that are not already covered within the Council's budgets and contingency sums. The Chief Finance Officer (Section 151 officer) shall be responsible for reporting to the Council on the adequacy of the reserves and balances."

Corporate Levies

3.2.23 The Council is required to pay levies to a number of other bodies, which must be met from within the overall budget requirement. The latest 2015-16 levy estimates are detailed in **Table 4**.

Table 4 – Levy Estimates 2015-16

Levies by Body	2015-16 Budget £m
Concessionary Fares (Freedom Pass)	11.923
North London Waste Authority	7.881
Lee Valley Regional Park Authority	0.226
Traffic and Control Liaison Committee	0.324
Inner London North Coroners Court	0.295
London Pensions Fund Authority	1.204
Environment Agency (Thames Region)	0.163
London Boroughs Grants Scheme	0.231
Total	**22.247**

4 THE HOUSING REVENUE ACCOUNT

HRA Overview

4.1 The HRA MTFS covers the cost of managing and maintaining council owned housing stock, servicing debt and contributing towards the long term investment in the stock, all of which is funded primarily from rents and tenant/leaseholder service charges.

4.2 The HRA MTFS is balanced over the medium term, accommodating the impact of inflation, the reintegration of the repairs service and the HRA's contribution towards the pension fund deficit. The proposed HRA budget for 2015-16 and the forecast budgets over the medium term, based on current knowledge and expectations, are shown within the HRA MTFS at **Appendix D1**.

4.3 A significant HRA budget risk over the medium term is the potential impact of the Government's welfare reforms. At this stage it is difficult to predict the financial impact with any degree of accuracy, but indicative modelling suggests costs in respect of additional staffing and rent arrears could be in the region of £5m.

Rental Income and Other HRA Fees and Charges

4.4 It is Council policy to continue to apply the principles of rent restructuring by moving actual rents towards target rents over time, subject to the affordability cap of prior year rent plus Consumer Price Index (1.2% at September 2014) plus 1% plus £2.

4.5 **Table 5** below sets out the proposed average rent increase for 2015-16.

Table 5 – Weekly Rent 2015-16

	Proposed 2015-16
Average Weekly Rent	£115.89
Increase (£)	£4.40
Increase (%)	3.95%
Average Weekly Target Rent	£122.72

4.6 All other HRA fees and charges are set out at **Appendix D2** and increased in line with inflation in 2015-16 (Retail Price Index at September 2014, 2.3%) unless there are agreed reasons for doing otherwise. These exceptions are outlined below.

4.7 **Heating and Hot Water Charges** will not be increased in 2015-16. In addition, depending on the actual cost of energy in 2015-16, an energy fund will be established to mitigate against future energy price increases.

4.8 **Estate Parking Charges** will be increased to more closely reflect market charges.

4.9 **Concierge Charges**: a new £1 charge will be introduced where coverage is provided by a small number of cameras to enable anti-social behaviour issues to be addressed.

5 CAPITAL PROGRAMME

5.1 The 2015-16 to 2017-18 capital programme is summarised in **Table 6** below and shown in full at **Appendix E**. This will deliver projects of £326m over the next three years and includes the continuation of existing programmes of investment in new homes (£119m), housing major works and improvements (£122m) and school buildings (£19m). This is a significant level of investment at a time when Government capital grants have been substantially scaled back.

Table 6 – Capital Programme 2015-16 to 2017-18

	2015-16 £000	2016-17 £000	2017-18 £000	Total £000
Housing and Adult Social Services	84,508	81,860	83,104	**249,472**
Children's Services	16,165	4,000	0	**20,165**
Environment and Regeneration	28,342	15,425	8,326	**52,093**
Finance and Resources	1,500	1,500	1,500	**4,500**
Total Capital Programme	**130,515**	**102,785**	**92,930**	**326,230**

5.2 The capital programme includes funding for an expanded Phase 2 Bunhill Heat and Power scheme (£7.3m). This scheme is funded by external grant (£1m) and Council funding (£6.3m), on the expectation that the Council's contribution will be a priority for planning gain from developments in Bunhill.

5.3 Whilst uncertainty surrounds the level and timing of capital receipts estimated to be available over the medium-term, the Council is forecasting that there will be sufficient resources to fund the 2015-16 programme and the provisional programme for 2016-17 to 2017-18. The Corporate Director of Finance and Resources will continue to apply capital resources to fund the ongoing capital programme in the most cost-effective way.

5.4 A key element of the Capital Medium Term Strategy is that the Council maximises the capital resources it has available for investment. This includes ensuring that the Council has a sufficient 'Capital Allowance' pot for affordable housing and regeneration schemes to avoid having to pay over housing capital receipts (excluding Right to Buy receipts which are covered by separate regulations) into the national pool. The schemes included in the Capital Allowance pot of eligible affordable housing and regeneration schemes are designated at **Appendix E**.

6 THE TREASURY MANAGEMENT STRATEGY 2015-16

6.1 The Council's 2015-16 annual treasury management and investment strategy will initially be considered by Audit Committee on 29th January 2015 and then included for agreement within the final budget report to Executive on 12th February 2015 and Council on 26th February 2015.

7 COUNCIL TAX 2015-16 (INCLUDING STATUTORY CALCULATIONS)

7.1 The revenue budget for 2015-16 has been prepared on the basis of an assumed council tax rise of 1.99%. A grant has been made available by the Government worth the equivalent value of a 1% increase in council tax for freezing council tax in 2015-16. However, the freeze grant is one-off funding only and would not compensate for the permanent loss in additional council tax income that a council tax freeze would represent. An increase of 1.99% on Islington's council tax will cost a Band D (average) council tax payer around an extra 40p per week.

7.2 The detailed, statutory council tax calculations and the recommendations for the final level of the 2015-16 council tax, including the GLA precept, will form part of the budget report to Executive on 12th February 2015, for onward recommendation to Council on 26th February 2015.

7.3 The 2015-16 budget incorporates the Council decision on 4th December 2014 to leave unchanged for 2015-16 the existing Council Tax Support Scheme.

7.4 The 2015-16 budget report to be considered by Executive on 12th February 2015 will incorporate the decisions on the level of the overall council tax base to be agreed by Audit Committee on 29th January 2015.

8 MATTERS TO CONSIDER IN SETTING THE BUDGET

COMMENTS OF THE SECTION 151 OFFICER

8.1 The Council, when determining the budget and thereby the level of council tax, must take into account the report of its Section 151 Officer. The report must comment on the robustness of the estimates included in the budget and parallel consideration of the adequacy of the Council's proposed reserves. This section of the report includes consideration of these specific areas and enables the authority to discharge its duty to take account of the statutory report under section 25(2) of the Local Government Act 2003.

8.2 The process for challenging, compiling and collating the budget begins in April prior to the year for which the council tax is being set. The process involves all of the spending departments, and assumptions are scrutinised throughout the year. It is the thoroughness of this process which provides the assurance that all strategic, operational and financial risks facing the authority have been taken into account, as far as they are reasonably anticipated to be incurred by the Council in the next financial year. It is the opinion of the Section 151 Officer that the estimates for 2015-16 have been prepared on a robust basis, and further that where there are uncertainties, for instance on the levels of service demand, that these can be covered by an adequate corporate contingency provision.

8.3 In setting the level of general reserves and balances, account has been taken of the key financial assumptions underpinning the budget, the views of the Council's auditors, the level of earmarked reserves and provisions, and the risks facing the Council over the medium term. The MTFS assumes contributions such that over the planning period the Council is forecast to attain the target of general balances at 5% of the budget requirement.

COMMENTS OF THE MONITORING OFFICER

8.4 This report sets out the basis upon which a recommendation will be made for the adoption of a lawful budget and the basis for the level of the council tax for 2015-16. It also outlines the Council's current and anticipated financial circumstances, including matters relating to the General Fund budget and MTFS, the HRA, the capital programme, and borrowing and expenditure control.

8.5 The setting of the budget and council tax by Members involves their consideration of choices. No genuine and reasonable options should be dismissed out-of-hand and Members must bear in mind their fiduciary duty to the council taxpayers of Islington.

8.6 Members must have adequate evidence on which to base their decisions on the level of quality at which services should be provided. Where a service is provided pursuant to a statutory duty, it would not be lawful to fail to discharge it properly or abandon it, and where there is discretion as to how it is to be discharged, that discretion should be exercised reasonably. Where a service is derived from a statutory power and is in itself discretionary that discretion should be exercised reasonably.

8.7 The report sets out the relevant considerations for Members to consider during their deliberations and Members are reminded of the need to ignore irrelevant considerations. Members have a duty to seek to ensure that the Council acts lawfully. They are under an obligation to produce a balanced budget and must not knowingly budget for a deficit. Members must not come to a decision which no reasonable authority could come to; balancing the nature, quality and level of services which they consider should be provided, against the costs of providing such services.

8.8 Under the constitutional arrangements, the setting of the Council budget is a matter for the Council, having considered recommendations made by the Executive. Before the final recommendations are made to the Council on 26th February 2015, the Policy and Performance Scrutiny Committee must have been given the opportunity to scrutinise these proposals and the Executive should take into account its comments when making those recommendations.

RESIDENT IMPACT ASSESSMENT

8.9 The Equality Act 2010 sets out the requirement for the Council to pay due regard in the exercise of its functions to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristic and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not.

8.10 A Resident Impact Assessment (RIA) of the 2015-16 budget proposals is set out at **Appendix F**. It is supplemented at a departmental level by detailed RIAs of major proposals. These demonstrate that the Council has met its duties under the Equality Act 2010 and has taken account of its duties under the Child Poverty Act 2010.

8.11 While the majority of the 2015-16 savings proposals relate to efficiencies, it is difficult to make savings on the scale required without any impact on residents and there will inevitably be some impact on particular groups, including those with protected characteristics as defined by the Equality Act. The Council is not legally obliged to reject savings with negative impacts on any particular groups but must consider carefully and with rigour the impact of its proposals on the Public Sector Equality Duty (as set out above), take a reasonable and proportionate view about the overall impact on particular groups and seek to mitigate negative impacts where possible. In this context, the Council's proposals for achieving savings are considered to be reasonable overall and take adequate account of the three duties set out under the Equality Act.

8.12 Members are asked to note the Resident Impact Assessment.

Final report clearance

Signed by

7 January 2015

Executive Member for Finance and Performance — Date

Responsible Officer : Mike Curtis, Corporate Director of Finance and Resources
Report Author : Tony Watts, Head of Financial Planning

MEDIUM TERM FINANCIAL STRATEGY 2015-16 TO 2017-18

APPENDIX A

	2014-15	2015-16					2016-17					2017-18				
	Budget	Inflation	Adjust.	Growth	Savings	**Projected**	Inflation	Adjust.	Growth	Savings	**Projected**	Inflation	Adjust.	Growth	Savings	**Projected**
	£000	£000	£000	£000	£000	**£000**	£000	£000	£000	£000	**£000**	£000	£000	£000	£000	**£000**
DEPARTMENTS																
Chief Executive	**7,268**	176	1,079		(2,216)	**6,307**	149	(140)			**6,316**	150	(65)			**6,401**
Children's Services	**76,994**	758	1,649		(5,457)	**73,944**	413				**74,357**	417	(635)			**74,139**
Environment and Regeneration	**36,215**	877	2,286		(8,814)	**30,564**	400	(10)			**30,954**	404				**31,358**
Finance and Resources	**7,647**	757	(4,499)	600	(4,016)	**489**	592				**1,081**	600				**1,681**
Housing and Adult Social Services	**83,737**	2,082	5,250	1,650	(11,100)	**81,619**	266				**81,885**	269				**82,154**
Public Health	**0**	0	2,101		(2,101)	**0**	0				**0**	0				**0**
TOTAL SERVICES	**211,861**	**4,650**	**7,866**	**2,250**	**(33,704)**	**192,923**	**1,820**	**(150)**	**0**	**0**	**194,593**	**1,840**	**(700)**	**0**	**0**	**195,733**
Corporate Democratic Core / Non Distributed Costs	**16,626**		49			**16,675**					**16,675**					**16,675**
NET COST OF SERVICES	**228,487**	**4,650**	**7,915**	**2,250**	**(33,704)**	**209,598**	**1,820**	**(150)**	**0**	**0**	**211,268**	**1,840**	**(700)**	**0**	**0**	**212,408**
Corporate Growth / Savings	**2,525**		1,066		(3,300)	**291**	1,000		6,000		**7,291**	1,000	(6)	2,000		**10,285**
Demographic Contingency	**2,377**		(2,377)			**0**					**0**					**0**
Corporate Financing Account	**(13,276)**		(2,853)			**(16,129)**					**(16,129)**					**(16,129)**
Levies	**22,273**	(26)				**22,247**	2,026				**24,273**	700		3,000		**27,973**
NET OPERATING EXPENDITURE	**242,386**	**4,624**	**3,751**	**2,250**	**(37,004)**	**216,007**	**4,846**	**(150)**	**6,000**	**0**	**226,703**	**3,540**	**(706)**	**5,000**	**0**	**234,537**
Insurance Fund	**(300)**		300			**0**					**0**					**0**
Contingency	**1,300**		(900)		(400)	**0**					**0**					**0**
Transfer to Capital Reserve (Ongoing Capital Programme)	**5,000**					**5,000**					**5,000**					**5,000**
NHBS Tranche 1: Transfer to Capital Reserve (Until 2016-17)	**3,000**					**3,000**					**3,000**		(3,000)			**0**
Transfer to/(from) Other Earmarked Reserves	**(1,273)**		6,523			**5,250**		(5,250)			**0**					**0**
Transfer to/(from) General Balance	**0**		(2,800)			**(2,800)**		2,800			**0**					**0**
New Homes Bonus	**(12,007)**		(1,774)			**(13,781)**					**(13,781)**		3,706			**(10,075)**
New Homes Bonus top-sliced to London Local Enterprise Partnership	**0**		3,897			**3,897**					**3,897**					**3,897**
One-off Return of New Homes Bonus Top-slice	**(261)**		261			**0**					**0**					**0**
Education Services Grant	**(2,850)**		528			**(2,322)**					**(2,322)**					**(2,322)**
Government Grant for Freezing Tax in 2014-15 (2nd Tranche of 2-year Grant)	**(878)**		878			**0**					**0**					**0**
AMOUNT TO BE MET FROM REVENUE SUPPORT GRANT, BUSINESS RATES RETENTION AND COUNCIL TAX	**234,117**	**4,624**	**10,664**	**2,250**	**(37,404)**	**214,251**	**4,846**	**(2,600)**	**6,000**	**0**	**222,497**	**3,540**	**0**	**5,000**	**0**	**231,037**
CHANGE COMPARED TO PREV YEAR (%)	**-7.33%**					**-8.49%**					**3.85%**					**3.84%**
Revenue Support Grant	**(91,548)**			25,599		**(65,949)**		1,726	10,033		**(54,190)**			13,157		**(41,033)**
Retained Business Rates	**(55,929)**	(1,069)				**(56,998)**					**(56,998)**					**(56,998)**
Top-up Grant	**(19,998)**	(382)				**(20,380)**					**(20,380)**					**(20,380)**
SETTLEMENT FUNDING ASSESSMENT (SFA)	**(167,475)**	**(1,451)**	**0**	**25,599**	**0**	**(143,327)**	**0**	**1,726**	**10,033**	**0**	**(131,568)**	**0**	**0**	**13,157**	**0**	**(118,411)**
Additional Retained Business Rates	**(250)**		(40)			**(290)**					**(290)**					**(290)**
Transfers (from)/to the Collection Fund including Lloyd Square	**500**		(500)			**0**					**0**					**0**
NET COUNCIL TAX REQUIREMENT	**66,892**	**3,173**	**10,124**	**27,849**	**(37,404)**	**70,634**	**4,846**	**(874)**	**16,033**	**0**	**90,639**	**3,540**	**0**	**18,157**	**0**	**112,336**

REVENUE SAVINGS 2015-16 APPENDIX B

LINE #	DIRECTORATE	SERVICE	SAVINGS DESCRIPTION	2015-16 £000s
1	CE	All	Reduce non-essential budgets (e.g. staff training and non-staff overheads) and increase income (e.g. through Assembly Hall hire) across the Chief Executive's department.	330
2	CE	Community Safety	Restructure the community safety team and delete vacant police posts.	280
3	CE	Human Resources	Reduce Human Resources transactional services (e.g. recruitment and payroll) and integrate internal training functions across the Council into a single corporate team.	140
4	CE	Islington Learning and Working (ILW) & Business and Employment Support Team (BEST)	Remodel service delivery and secure external funding (e.g. from New Homes Bonus and European Social Fund) for Islington Learning and Working and the Business and Employment Support Team.	440
5	CE	Legal Services	Delete one post in the Legal department.	40
6	CE	Strategy, Equality, Performance (SEP) and Communications	Integrate the 'Strategy, Equality and Performance' and 'Communications' teams and generate additional income (e.g. from selling printing services).	400
7	CE	Voluntary Sector Grants and Third Sector Partnerships	Reduce staff and administration costs in the Partnerships team, delete spare capacity in the Discretionary Rate Relief budget and reduce the Local Initiatives Fund to £15k per annum per ward.	246
8	CE	Voluntary Sector Grants and Third Sector Partnerships	Use funding from Section 106 to replace (not reduce) core council funding for the voluntary sector.	340
9	CORP	Contingency	Remove the corporate contingency budget (contingencies to be managed through reserves and balances).	400
10	CORP	Pensions	Charge Schools and the Housing Revenue Account their full share of the c£10m pension fund annual lump sum contribution.	1,900
11	CORP	Property	Use the Council's property portfolio more efficiently, including increased income from commercially letting vacant properties.	1,400
12	CS	All	Transfer funding of some health-related services to Public Health, Clinical Commissioning Group and Schools budgets and make efficiency savings through alternative use of government grant.	2,080
13	CS	All	Make planned reductions in administration and commissioning posts across Children's Services.	420
14	CS	Learning and Schools	Make savings in Early Years through grant aid saving, bringing the after-school childcare budget into line with demand and placing one Early Years Centre onto the standard funding formula.	200
15	CS	Learning and Schools	Shift funding from the General Fund to the Dedicated Schools Grant for pupil, school and early years support services, as agreed by Schools Forum, and continue traded schools services.	1,370
16	CS	Learning and Schools	Complete the reduction in the Connexions service, with schools taking their legal responsibility for youth careers advice.	550
17	CS	Learning and Schools	Reform and re-focus childcare subsidy, progressively distributing increases in charges via a graduated scale through the income bands and introducing additional bands at the top, so those on the lowest incomes face the lowest rises.	37
18	CS	Targeted Specialist Children and Families	Procure Independent Fostering Placements jointly and improve the procurement of residential provision.	800
19	E&R	All	Increase income generation across the Environment and Regeneration department, including through additional income from the new leisure contract, increasing our Commercial Waste business and establishing a trading company (iCo) to sell services such as energy advice.	3,671
20	E&R	All	Integrate separate enforcement teams across the Environment and Regeneration department into a multi-disciplinary team.	150
21	E&R	All	Make efficiencies in the Environment and Regeneration department, including in support functions and procurement.	1,466
22	E&R	Parks	Rationalise grounds maintenance in parks through revised maintenance routines for out-of-season and lower priority works.	96
23	E&R	Parks	Adopt a risk-based approach to locking parks, leaving only the lowest-risk parks unlocked.	70
24	E&R	Planning and Development	Restructure the Planning and Development service, reducing senior management, and increase the fees for the Design Review Panel service.	216
25	E&R	Street Environment Services	Review recycling points on estates to make them more accessible and, following pilots, move to communal recycling on the estates where doorstep recycling is currently still offered.	150
26	E&R	Street Environment Services	Introduce the 'village principle' into Street Environment Services by creating area-based teams.	150
27	E&R	Street Environment Services	Reduce the number of refuse collection vehicles by, following pilots, moving towards communal kitchen waste and green waste collection.	500
28	E&R	Street Environment Services	Complete planned reduction in the Bright Sparks service's reliance on Council funding.	125
29	E&R	Traffic and Parking	Review Pay and Display Charges to manage bay occupancy and availability.	1,000
30	E&R	Traffic and Parking	Introduce a 'diesel surcharge' for parking permits for diesel and heavy oil vehicles, with appropriate exemptions, to encourage residents to use cleaner vehicles.	880
31	E&R	Traffic and Parking	Increase the price of visitor vouchers, while introducing pensioner discounts for all visitor vouchers.	340

REVENUE SAVINGS 2015-16 APPENDIX B

LINE #	DIRECTORATE	SERVICE	SAVINGS DESCRIPTION	2015-16 £000s
32	F&R	All	Reduce senior management in the Finance and Resources department.	475
33	F&R	Financial Management	Reduce finance support by reducing the costs of the Finance Support service, finance systems contracts, the Parking and Small Payments teams, cash flow management and external audit.	1,861
34	F&R	Procurement and Internal Audit	Reduce the level of control over compliance functions in procurement and internal audit.	245
35	F&R	Housing Benefits, Business Rates and Council Tax Collection	Protect income collection and restructure benefits processing.	835
36	F&R	ICT and Customer Interactions	Improve information and communications technology to allow more online customer self-service and integrate Council advice services.	600
37	HASS	Adult Social Services	Reduce the cost of support services in Adult Social Services by centralising training and making non-pay efficiencies.	550
38	HASS	Adult Social Services	Recommission grants to voluntary sector organisations and non-statutory services such as counselling.	600
39	HASS	Adult Social Services	Tailor the amount of care offered to people who are eligible for social services support, while maintaining adult social care for people with Moderate needs.	300
40	HASS	Housing Needs and Strategy	Reduce spending on temporary accommodation by doing additional work to prevent homelessness, use more private sector accommodation at lower rents and move people out of temporary accommodation faster.	500
41	HASS	Housing Needs and Strategy	Reduce staffing costs through improving processes and deleting vacant posts.	100
42	HASS	Integrated Community Services	Review assessment and care management functions and intermediate care services, increasing service user independence, signposting to external services where appropriate and increasing self-assessment online.	800
43	HASS	Integrated Community Services	Use preventative telecare to reduce and delay admission into residential care.	200
44	HASS	Integrated Community Services	Move to more personalised, community-based services, reducing double-up homecare and increasing the number of users of Direct Payments.	600
45	HASS	Integrated Community Services	Collaborate with the NHS to secure funding and reduce costs, using the Better Care Fund to integrate work across health and social care, including through shifting activity from acute and residential provision to community-based services, investment in reablement and reduction in permanent admissions to residential and nursing care homes.	4,550
46	HASS	Learning Disabilities	Increase independence for people with learning disabilities through the development of a new supported accommodation scheme and expanding the Shared Lives scheme and the Community Access Project.	750
47	HASS	Strategy and Commissioning	Make commissioning efficiencies in Housing Related Support and change the funding source for appropriate Housing Related Support from the General Fund to the Housing Revenue Account.	1,950
48	HASS	Strategy and Commissioning	Reduce transport costs by providing services closer to home rather than out-of-borough placements.	200
49	PH	Adult Health Improvement Services	Streamline, integrate and co-locate (e.g. in pharmacies or online) some adult health improvement services.	467
50	PH	All	Reduce staffing by deleting vacant posts.	300
51	PH	Sexual Health Services	Transform the way we pay providers for genito-urinary medicine and sexual health services, redesign sexual health services and review sexual health prevention and promotion.	390
52	PH	Substance Misuse Services	Review substance misuse services and contracts and redesign systems to reduce duplication and focus on services geared towards recovery.	944
			TOTAL	**37,404**

Fee / Charge		Type (Discretionary / Statutory)	Fee or Charge 2014-15	Proposed Fee or Charge 2015-16	% Change	Explanation if % change varies from RPI Quarter 3 Average inflation (2.4%) other than appropriate rounding for the purposes of administration and collection
CHIEF EXECUTIVE'S DEPARTMENT						
Registrars						
Charge for Births, Deaths and Marriages Certificates / Registration						
Licence for Approved premises	Licence for a three year period	Discretionary	£1000 per 3 year period	£1500 per 3 year period	50.00%	Benchmarked other Register Office fees. Fee not increased in last 4 years and the Approval is operational for a 3 year period.
Licensed Venues external to Town Hall	Monday to Saturday	Discretionary	£500.00	£580.00	16.0%	Benchmarked other Register Office fees
Licensed Venues external to Town Hall	Sunday	Discretionary	£600.00	£680.00	13.3%	Benchmarked other Register Office fees
Licensed Venues external to Town Hall	Bank Holiday	Discretionary	£900.00	£700.00	-22.2%	Benchmarked other Register Office fees
Licensed Venues external to Town Hall (out of hours 6pm to 10pm)	Monday to Saturday	Discretionary	£600.00	£680.00	13.3%	Benchmarked other Register Office fees
Licensed Venues external to Town Hall (out of hours 6pm to 10pm)	Sunday / Bank Holiday / Christmas Eve, New Years Eve	Discretionary	£1,000.00	£700.00	-30.0%	Benchmarked other Register Office fees
Richmond Room	Saturday only (2pm to 6pm with max 60 guests)	Discretionary	£480.00	£480.00	0.0%	
Mayor's Parlour - marriage or civil partnerships	Tuesday, Wednesday, Thursday, Friday	Discretionary	£300.00	£300.00	0.0%	
Mayor's Parlour - marriage or civil partnerships	Saturday	Discretionary	£580.00	£580.00	0.0%	
Mayor's Parlour - marriage or civil partnerships	Sunday	Discretionary	£700.00	£680.00	-2.9%	Benchmarked other Register Office fees
Room 99 - Marriages or Partnership ceremonies	Basic ceremony (max 30 guests): Monday	Discretionary	£50	£54	8.0%	Benchmarked other Register Office fees
	Basic ceremony (max 30 guests): Tuesday, Wednesday, Thursday	Discretionary	£120.00	£120.00	0.0%	
	Basic ceremony (max 30 guests): Friday	Discretionary	£180.00	£200.00	11.1%	Benchmarked other Register Office fees
	Saturday (max 30 guests)	Discretionary	£250.00	£250.00	0.0%	
Re-booking of ceremony		Discretionary	£35.00	£35.00	0.0%	
Council Chamber - marriage or Civil Partnership or Renewal of vows & Naming Ceremonies	Tues, Weds, Thurs, Fri	Discretionary	£300.00	£350.00	16.7%	Benchmarked other Register Office fees
	Saturday	Discretionary	£580.00	£580.00	0.0%	
	Sunday	Discretionary	£700.00	£680.00	-2.9%	Benchmarked other Register Office fees
	Use of balcony	Discretionary	£300.00	£180.00	-40.0%	Benchmarked other Register Office fees
Births, deaths, marriages and civil partnership certificates	Express same day within 1 hour (walk in service before 11am)	Discretionary	£20.00	£20.00	0.0%	
Births, deaths marriages and civil partnership certificates	Express same day within 2 hours (Contact centre order before 2 pm)	Discretionary	£16.00	£16.00	0.0%	
Nationality check and send (incl. VAT) for citizenship applicants (Mon-Fri)	Per child	Discretionary	£30.00	£30.00	0.0%	
	Per single adult application	Discretionary	£55.00	£55.00	0.0%	
Nationality check and send (incl. VAT) for citizenship applicants - Saturday Service &	Per child	Discretionary	£35.00	£35.00	0.0%	
	Per single adult application	Discretionary	£70.00	£70.00	0.0%	
Settlement check and send (incl. VAT) for settlement applicants - (Mon-Fri)	Per single adult application	Discretionary	£90.00	£90.00	0.0%	
Settlement check and send (incl. VAT) for settlement applicants - Saturday Service & evening appointments	Per single adult application	Discretionary	£100.00	£100.00	0.0%	
Private Citizenship Ceremony (Mon - Fri)	Per single adult	Discretionary	£150.00	£150.00	0.0%	
Private Citizenship Ceremony (Sat)	Per single adult	Discretionary	£180.00	£180.00	0.0%	
Islington Assembly Hall						
Commercial Rates -						
Wedding package Monday-Thursday, inc VAT	10-hire hour of venue, including security, basic AV support, room set-up and staffing. Drinks package additional.	Discretionary	£2,000.00	£1,900.00	-5.0%	Want to encourage more weekday weddings, especially during summer months, so making the rate more attractive. Have offered this rate and secured our first weekday wedding reception.
Wedding package Friday-Sunday, inc VAT	10-hire hour of venue, including security, basic AV support, room set-up and staffing. Drinks package additional.	Discretionary	£2,462.00	£2,900.00	17.8%	Last year's figure didn't include VAT. Not looking to increase rates until more demand for the venue. Looking to do more promotion of it as a wedding venue and possibly do offers for quiet months.
Civil ceremony package Monday-Thursday, inc VAT	6-hire hour of main hall, including security, basic AV support, room set-	Discretionary		£1,200.00	N/A	
Civil ceremony package Friday-Sunday, inc VAT	6-hire hour of main hall, including security, basic AV support, room set-up and staffing. Drinks package additional.	Discretionary		£1,900.00	N/A	
Private / corporate hire event Mon-Wed hourly rate, inc VAT	6-hire hour of main hall, including basic AV support, room set-up, and	Discretionary	£240.00	£240.00	0.0%	
Private / corporate hire event Thur-Sun hourly rate, inc VAT	6-hire hour of main hall, including basic AV support, room set-up and	Discretionary	£360.00	£360.00	0.0%	
Non-Commercial Rates -						
Council event full-day Monday-Wednesday	8-hour hire of main hall, including basic AV support, room set-up and staffing	Discretionary	£1,000.00	£1,000.00	0.0%	
Council event half-day Monday-Wednesday	4-hour hire of main hall, including basic AV support, room set-up and staffing	Discretionary	£600.00	£600.00	0.0%	
Council evening event Monday-Wednesday	6-hire hour of main hall, including basic AV support, room set-up, bar staffing	Discretionary	£1,200.00	£1,200.00	0.0%	
Community and charity rates	We can offer a reduction on the private / corporate hire rates on Mon-Wed, subject to availability.	Discretionary	Rates not published but we do offer discounts to a certain level and also run the free hire scheme.			
CHILDREN'S SERVICES						
Primary School Meals		Discretionary	2.00	2.00	0.0%	This has not been increased for 3 years and is covered by the Council's Universal Free School Meals Scheme.
EARLY YEARS DAY CARE CHARGES - all increasing by 2% from September 2014. All prices are per child per week.						
COMMUNITY NURSERIES						
TERM TIME						
Under 2's						
Band 1 (Up to £24,999)	Per week	Discretionary	170.48	173.89	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	180.41	184.01	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	196.32	200.25	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	217.55	221.90	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	244.08	248.96	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	275.91	281.43	2.0%	2% across all Early Years Day Care Charges

Fee / Charge		Type (Discretionary / Statutory)	Fee or Charge 2014-15	Proposed Fee or Charge 2015-16	% Change	Explanation if % change varies from RPI Quarter 3 Average inflation (2.4%) other than appropriate rounding for the purposes of administration and collection
Band 7 (£80k and above) Marketed	Per week	Discretionary	312.26	318.51	2.0%	2% across all Early Years Day Care Charges
2 to 3's						
Band 1 (Up to £24,999)	Per week	Discretionary	167.14	170.48	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	176.87	180.41	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	192.47	196.32	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	213.28	217.55	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	239.29	244.08	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	270.50	275.91	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	283.87	289.55	2.0%	2% across all Early Years Day Care Charges
3&4						
Band 1 (Up to £24,999)	Per week	Discretionary	117.00	119.34	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	123.81	126.28	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	134.73	137.43	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	149.30	152.28	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	167.50	170.85	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	189.35	193.14	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	198.71	202.69	2.0%	2% across all Early Years Day Care Charges
HOLIDAYS						
Under 2's						
Band 1 (Up to £24,999)	Per week	Discretionary	170.48	173.89	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	180.41	184.01	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	196.32	200.25	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	217.55	221.90	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	244.08	248.96	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	275.91	281.43	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	312.26	318.51	2.0%	2% across all Early Years Day Care Charges
2 to 3's						
Band 1 (Up to £24,999)	Per week	Discretionary	167.14	170.48	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	176.87	180.41	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	192.47	196.32	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	213.28	217.55	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	239.29	244.08	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	270.50	275.91	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	283.87	289.55	2.0%	2% across all Early Years Day Care Charges
3&4						
Band 1 (Up to £24,999)	Per week	Discretionary	133.71	136.39	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	141.49	144.32	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	153.98	157.06	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	170.63	174.04	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	191.43	195.26	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	216.40	220.73	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	227.10	231.64	2.0%	2% across all Early Years Day Care Charges
NON-PRIMARY SCHOOL BASED CHILDREN'S CENTRES						
TERM TIME						
Under 2's						
Band 1 (Up to £24,999)	Per week	Discretionary	170.48	173.89	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	180.41	184.01	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	196.32	200.25	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	217.55	221.90	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	244.08	248.96	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	275.91	281.43	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	312.26	318.51	2.0%	2% across all Early Years Day Care Charges
2 to 3's						
Band 1 (Up to £24,999)	Per week	Discretionary	167.14	170.48	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	176.87	180.41	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	192.47	196.32	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	213.28	217.55	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	239.29	244.08	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	270.50	275.91	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	283.87	289.55	2.0%	2% across all Early Years Day Care Charges
3's						
Band 1 (Up to £24,999)	Per week	Discretionary	117.00	119.34	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	123.81	126.28	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	134.73	137.43	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	149.30	152.28	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	167.50	170.85	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	189.35	193.14	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	198.71	202.69	2.0%	2% across all Early Years Day Care Charges
4's						
Band 1 (Up to £24,999)	Per week	Discretionary	66.86	68.19	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	70.75	72.16	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	76.99	78.53	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	85.31	87.02	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	95.72	97.63	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	108.20	110.37	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	198.71	202.69	2.0%	2% across all Early Years Day Care Charges
HOLIDAYS						
Under 2's						
Band 1 (Up to £24,999)	Per week	Discretionary	170.48	173.89	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	180.41	184.01	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	196.32	200.25	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	217.55	221.90	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	244.08	248.96	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	275.91	281.43	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	312.26	318.51	2.0%	2% across all Early Years Day Care Charges
2 to 3's						
Band 1 (Up to £24,999)	Per week	Discretionary	167.14	170.48	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	176.87	180.41	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	192.47	196.32	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	213.28	217.55	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	239.29	244.08	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	270.50	275.91	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	283.87	289.55	2.0%	2% across all Early Years Day Care Charges
3's						
Band 1 (Up to £24,999)	Per week	Discretionary	133.71	136.39	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	141.49	144.32	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	153.98	157.06	2.0%	2% across all Early Years Day Care Charges

Fee / Charge		Type (Discretionary / Statutory)	Fee or Charge 2014-15	Proposed Fee or Charge 2015-16	% Change	Explanation if % change varies from RPI Quarter 3 Average inflation (2.4%) other than appropriate rounding for the purposes of administration and collection
Band 4 (£40,000 - £49,999)	Per week	Discretionary	170.63	174.04	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	191.43	195.26	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	216.40	220.73	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	227.10	231.64	2.0%	2% across all Early Years Day Care Charges
4's						
Band 1 (Up to £24,999)	Per week	Discretionary	133.71	136.39	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	141.49	144.32	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	153.98	157.06	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	170.63	174.04	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	191.43	195.26	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	216.40	220.73	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	227.10	231.64	2.0%	2% across all Early Years Day Care Charges
CHILDREN'S CENTRES IN PRIMARY SCHOOLS						
TERM TIMES						
Under 2's						
Band 1 (Up to £24,999)	Per week	Discretionary	170.48	173.89	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	180.41	184.01	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	196.32	200.25	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	217.55	221.90	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	244.08	248.96	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	275.91	281.43	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	312.26	318.51	2.0%	2% across all Early Years Day Care Charges
2 to 3's						
Band 1 (Up to £24,999)	Per week	Discretionary	167.14	170.48	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	176.87	180.41	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	192.47	196.32	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	213.28	217.55	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	239.29	244.08	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	270.50	275.91	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	283.87	289.55	2.0%	2% across all Early Years Day Care Charges
3&4's						
Band 1 (Up to £24,999)	Per week	Discretionary	66.86	68.19	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	70.75	72.16	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	76.99	78.53	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	85.31	87.02	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	95.72	97.63	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	108.20	110.37	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	198.71	202.69	2.0%	2% across all Early Years Day Care Charges
HOLIDAYS						
Under 2's						
Band 1 (Up to £24,999)	Per week	Discretionary	170.48	173.89	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	180.41	184.01	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	196.32	200.25	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	217.55	221.90	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	244.08	248.96	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	275.91	281.43	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	312.26	318.51	2.0%	2% across all Early Years Day Care Charges
2 to 3's						
Band 1 (Up to £24,999)	Per week	Discretionary	167.14	170.48	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	176.87	180.41	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	192.47	196.32	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	213.28	217.55	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	239.29	244.08	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	270.50	275.91	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	283.87	289.55	2.0%	2% across all Early Years Day Care Charges
3&4's						
Band 1 (Up to £24,999)	Per week	Discretionary	133.71	136.39	2.0%	2% across all Early Years Day Care Charges
Band 2 (£25,000 - £30,999)	Per week	Discretionary	141.49	144.32	2.0%	2% across all Early Years Day Care Charges
Band 3 (£31,000 - £39,999)	Per week	Discretionary	153.98	157.06	2.0%	2% across all Early Years Day Care Charges
Band 4 (£40,000 - £49,999)	Per week	Discretionary	170.63	174.04	2.0%	2% across all Early Years Day Care Charges
Band 5 (£50,000 - £59,999)	Per week	Discretionary	191.43	195.26	2.0%	2% across all Early Years Day Care Charges
Band 6 (£60,000 - £79,999)	Per week	Discretionary	216.40	220.73	2.0%	2% across all Early Years Day Care Charges
Band 7 (£80k and above) Marketed	Per week	Discretionary	227.10	231.64	2.0%	2% across all Early Years Day Care Charges
FINANCE & RESOURCES						
Telecare						
Monitoring Service	Per week	Discretionary	3.30	3.37	2.1%	2% is the annual inflation charged on our contracts and services.
Full Service	Per week	Discretionary	6.53	6.66	2.0%	2% is the annual inflation charged on our contracts and services.
HOUSING & ADULT SOCIAL SERVICES						
Adult Social Services						
Community care charges	No unit charge, individually assessed charge under Government regulations. The Care Act 2014 provides local authorities with the power to charge adults in receipt of care and support services.					
Residential care charges	No unit charge, individually assessed charge under Government regulations. The Care Act 2014 provides local authorities with the power to charge adults in receipt of care and support services.					
Meals in the home		Discretionary	3.00	3.00	0.0%	No change
Meals in day care centres		Discretionary	3.00	3.00	0.0%	No change
Deferred Payments	Admin Fee	Statutory	500.00	512.00	2.4%	
Deputyship	Annual management fee	Statutory				Various fixed rates
Protection of Property	Admin Fee	Statutory	250.00	256.00	2.4%	
Protection of Property	Fee per hour	Statutory	25.00	25.60	2.4%	
Protection of Property - Pets	Flat fee per week - for a dog	Statutory	15.00	15.35	2.3%	Rounding
Protection of Property - Pets	Flat fee per week - for a cat	Statutory	10.00	10.20	2.0%	Rounding
Housing Needs & Strategy						
Furniture Storage		Discretionary	132.74	135.93	2.4%	
ENVIRONMENT & REGENERATION						
Library & Heritage Services						
Fax Charges	Charge for use of fax - to help with cost replacement of machine in future years and running expenses	Discretionary	£1 first page then 50p subsequent page	£1 first page then 50p subsequent page	0.0%	
Sale of Obsolete Stock	Sales - to help with the purchase of new books	Discretionary	10p to £2 on books, 50p to £2 on CD, computer games, video, DVDs	10p to £2 on books, 50p to £2 on CD, computer games, video, DVDs	0.0%	

Fee / Charge		Type (Discretionary / Statutory)	Fee or Charge 2014-15	Proposed Fee or Charge 2015-16	% Change	Explanation if % change varies from RPI Quarter 3 Average inflation (2.4%) other than appropriate rounding for the purposes of administration and collection
Digital images (Local history)	Per image	Discretionary	£15.00	£15.00	0.0%	
Reservation charges for items not in stock	Service charge - for books obtained via library interloans scheme	Discretionary	£3.60	£3.60	0.0%	
PC Printing	Hire charge - cost recovery	Discretionary	20p b/w 50p colour	20p b/w 50p colour	0.0%	Charges increased last year- need to maintain comparative charges.
Genealogical Research	Service charge - cost recovery	Discretionary	£15 per half-hour (Minimum 1 hour)	£15 per half-hour (Minimum 1 hour)	0.0%	
Local history photography pass	Per day	Discretionary	£5.00	£5.00	0.0%	
Charges for Overdue Books	Fines - to help ensure the timely return of books for other users of the Library Service	Discretionary	16p per day (£7.20 maximum charge per item)	16p per day (£7.20 maximum charge per item)	0.0%	Increased by more than inflation last year.
Hire of Music	Hire charge for CDs	Discretionary	50p; 60+ free	50p; 60+ free	0.0%	Need to maintain competitive price and avoid any further reduction in use of service.
Photocopying	Charge for use of photocopier - cost recovery	Discretionary	10p A4 b/w; 20p A3 b/w; 50p A4 colour; £1 A3 colour	10p A4 b/w; 20p A3 b/w; 50p A4 colour; £1 A3 colour	0.0%	Some charges increased by more than inflation last year.
Hall Lettings	Hall lettings	Discretionary	Increase in line with inflation (round to £29 to £175 per hour)	Increase in line with inflation (round to £29 to £175 per hour)	0.0%	
Charges for Lost Items	Cost of replacing lost items	Discretionary	Original purchase price	Original purchase price	0.0%	
Replacement Library Cards	Cost of replacing lost card	Discretionary	£2.00	£2.00	0.0%	Increased by more than inflation last year.
DVDs Hire charge per night	New feature films	Discretionary	£2.00	£2.00	0.0%	
DVDs Hire charge per night	Other / Non feature films	Discretionary	£1.50	£1.50	0.0%	
Local History and re-sale materials sales	Sales - cost recovery	Discretionary	Price range from 25p to £25	Price range from 25p to £25	0.0%	
Local History Centre - Commercial reproduction charges (price per image unless otherwise stated)						
Books, periodicals, printed material, e-books, CD_ROMs						
Front cover / jacket	UK rights (World rights double fee)	Discretionary	£75.00	£75.00	0.0%	
Interior	UK rights (World rights double fee)	Discretionary	£50.00	£50.00	0.0%	
Leaflets and brochures	UK rights (World rights double fee)	Discretionary	£50.00	£50.00	0.0%	
Advertising in newspapers and periodicals	UK rights (World rights double fee)	Discretionary	£75.00	£75.00	0.0%	
Postcards*, greetings cards*, giftware, calendars, posters, publicity material	UK rights (World rights double fee)	Discretionary	£125.00	£125.00	0.0%	
* +100 copies						
Commercial interior design and decoration						
Commercial interior design and decoration	For up to 5 images, additional images £25	Discretionary	£250.00	£250.00	0.0%	
Television						
Per transmission	one showing, one country including TV advertisements	Discretionary	£75.00	£75.00	0.0%	
5-year unlimited transmission	Excluding video & DVD	Discretionary	£250.00	£250.00	0.0%	
DVDs, films, videos & CD-ROMS						
DVDs, films, videos & CD-ROMS	UK rights (World rights double fee)	Discretionary	£120.00	£120.00	0.0%	
Exhibitions						
Exhibitions		Discretionary	£75.00	£75.00	0.0%	
Web use						
Web use	Including blog posts and social media	Discretionary	£75.00	£75.00	0.0%	
*** Discounts can be negotiated where:** **Works are educational / non-profit making** **Works require a large number of images (over 10)** **Print runs are below 1500 copies**						
Education Library Service						
Primary School	Per pupil	Discretionary	£17.00	£17.00	0.0%	
Secondary School	Full subscription	Discretionary	£5,235.00	£5,235.00	0.0%	
	Tutor Box Only	Discretionary	£2,500.00	£2,500.00	0.0%	
PVI Nurseries		Discretionary	£165.00	£165.00	0.0%	
Out of Borough schools : Artefact Topic boxes	Per box + £15 delivery and collection charge	Discretionary	£65.00	£65.00	0.0%	

Fee / Charge		Type (Discretionary / Statutory)	Fee or Charge 2014-15	Proposed Fee or Charge 2015-16	% Change	Explanation if % change varies from RPI Quarter 3 Average inflation (2.4%) other than appropriate rounding for the purposes of administration and collection
PUBLIC PROTECTION						
Land Charges LA Searches (NB These charges need to be set to recover costs only by law. Charges are set based upon an analysis of prior year spend and income.)						
LLC1	Additional parcel £1	Discretionary	£21.00	£21.00	0.0%	Freeze due to on-going legal challenge
Con29R	Additional Parcel £20	Discretionary	£93.00	£93.00	0.0%	Freeze due to on-going legal challenge
Enhanced Personal search		Discretionary	£23.00	£23.00	0.0%	Freeze due to on-going legal challenge
Information search		Discretionary	£49.00	£49.00	0.0%	Freeze due to on-going legal challenge
Personal inspection of the Local Land Charges Register under EIR		Discretionary	£0.00	£0.00		Freeze due to on-going legal challenge
Part 2 (Con29O) questions		Discretionary	£10.50	£10.50	0.0%	Freeze due to on-going legal challenge
Part 3 (your own) questions		Discretionary	£21.00	£21.00	0.0%	Freeze due to on-going legal challenge
Right of Light Registration		Discretionary	£69.00	£69.00	0.0%	Freeze due to on-going legal challenge
LAND SEARCH ENQUIRIES						
Per reply letter		Discretionary	£64.00	£64.00	0.0%	Freeze due to on-going legal challenge
Per copy of consent		Discretionary	£1.00	£1.00	0.0%	Freeze due to on-going legal challenge
SCIENTIFIC SERVICES **Environmental Protection Act 1990** **Statutory Registers** **Copies and Entries:**						
First Copy (per sheet)		Discretionary	£12.00	£12.00	0.0%	
Each subsequent (per sheet)		Discretionary	£4.20	£4.20	0.0%	
ANIMAL SERVICES						
Dog Recovery		Discretionary	£27.00	£27.00	0.0%	
Animal Rehoming		Discretionary	£49.00	£49.00	0.0%	
Animal Boarding		Discretionary	£10.70	£10.70	0.0%	
Register of Seized Dogs		Discretionary	£3.80	£3.80	0.0%	
Animal Boarding Establishments Act 1963						
Licence		Discretionary	£320.00	£320.00	0.0%	
Renewal		Discretionary	£320.00	£320.00	0.0%	
Breeding Dogs Act 1973						
Licence		Discretionary	£262.00	£262.00	0.0%	
Renewal		Discretionary	£262.00	£262.00	0.0%	
Dangerous Wild Animals Act 1976						
Licence		Discretionary	£320.00	£320.00	0.0%	
Renewal		Discretionary	£320.00	£320.00	0.0%	
Performing Animals (Regulations) Act 1925						
Registration (once only)		Discretionary	£51.00	£51.00	0.0%	
Copy Certificate		Discretionary	£18.00	£18.00	0.0%	
Pet Animals Act 1951						
Licence		Discretionary	£320.00	£320.00	0.0%	
Renewal		Discretionary	£320.00	£320.00	0.0%	
Riding Establishments Act 1964						
Licence		Discretionary	£465.00	£465.00	0.0%	
Renewal of Provisional Licence		Discretionary	£465.00	£465.00	0.0%	
Pest Control						
Contracted Pest Control treatments - per hour plus VAT		Discretionary	£160.00	£160.00	0.0%	
Residential Environmental Health						
Notices served under Housing Act 2004 Sections 11 & 12		Discretionary	£570.00	£585.00	2.6%	Rounded up to nearest £5.
HMO licensing	Per letting	Discretionary	£200.00	£260.00	30.0%	Increases in line with those proposed for possible new Additional Licensing Areas. Not to be implemented until after any Exec decision to declare areas. Charge covers a 5 year period.
HMO licensing - accredited landlords	Per letting	Discretionary	£160.00	£220.00	37.5%	
HMO licensing - assisted applications	Per HMO	Discretionary	£310.00	£325.00	4.8%	
Renewal of HMO licence after 5 year term from 11/12	Per letting	Discretionary	£160.00	£200.00	25.0%	
Renewal of HMO licence for accredited landlord after 5 year term from 11/12	Per letting	Discretionary	£140.00	£180.00	28.6%	
HMO Licensing of large student accommodation blocks	Per letting	Discretionary	£25.00	£30.00	20.0%	
Commercial Environmental Health						
Food Hygiene Training		Discretionary		£75.00	N/A	New charge
PROPERTY RECORD VIEWING, PHOTOCOPYING & VIEWING (CHARGE PER PROPERTY)						
Solicitor's enquiry (24 hour response)		Discretionary	£115.00	£115.00	0.0%	
TRADING STANDARDS						
Weighing and Measuring Equipment						
Charges for examining, testing, certifying, stamping, authorising or reporting on special weighing or measuring equipment. Charges are per officer/hr.		Discretionary	£92.00	£94.00	2.2%	
Weights						
Exceeding 5kg or not exceeding 5g		Discretionary	£13.00	£13.50	3.8%	
Other weights		Discretionary	£12.00	£12.50	4.2%	
Measures						
Linear measures not exceeding 3m		Discretionary	£13.00	£13.50	3.8%	
Weighing machines						
Not exceeding 15kg		Discretionary	£32.00	£33.00	3.1%	
15kg to 100kg		Discretionary	£50.00	£51.00	2.0%	
100kg to 250 kg		Discretionary	£64.00	£66.00	3.1%	
250 kg to 1 tonne		Discretionary	£115.00	£118.00	2.6%	
1 tonne to 10 tonne		Discretionary	£200.00	£205.00	2.5%	
10 tonne to 30 tonne		Discretionary	£390.00	£400.00	2.6%	
30 tonne to 60 tonne		Discretionary	£580.00	£595.00	2.6%	
Measuring Instruments for Intoxicating Liquor						
Not exceeding 150 ml		Discretionary	£22.00	£22.50	2.3%	
Other		Discretionary	£23.00	£23.50	2.2%	
Measuring Instruments for Liquid Fuel and Lubricants						
Container Type (unsubdivided)		Discretionary	£92.00	£94.00	2.2%	
Multigrade						
a) solely price adjustment		Discretionary	£115.00	£118.00	2.6%	
b) otherwise		Discretionary	£200.00	£205.00	2.5%	
Other types-single outlets						
a) Solely price adjustment		Discretionary	£91.00	£93.00	2.2%	
b) otherwise		Discretionary	£116.00	£119.00	2.6%	
Other types - multi outlets - rate per meter		Discretionary	£116.00	£119.00	2.6%	

Fee / Charge		Type (Discretionary / Statutory)	Fee or Charge 2014-15	Proposed Fee or Charge 2015-16	% Change	Explanation if % change varies from RPI Quarter 3 Average inflation (2.4%) other than appropriate rounding for the purposes of administration and collection
Other Charges						
If without prior notice an appointment is cancelled or altered significantly by the person requesting the service, a minimum charge of £92 (£138 in respect of appointments outside the hours 9.00 a.m. - 5.00 p.m. Monday to Friday) will be made for the first hour or part thereof and then at a rate of £92 (£138) per hour thereafter. This will include travelling time to and from the premises.						
When a visit is made by a Trading Standards Officer to any premises for the purpose of carrying out any of the functions or activities listed above, each visit may be subject to a minimum charge of £92 per Officer per visit regardless of the nature or amount of work requested or completed.						
If the Service has to hire additional weights or equipment to carry out any testing or examination, then the additional cost will be payable by the submitter.						
GLC General (Powers) Act 1984						
Sale of Goods by Competitive Bidding		Discretionary	£222.00	£227.00	2.3%	
Poisons Act 1972						
Inclusion on List		Discretionary	£71.00	£73.00	2.8%	
Alteration		Discretionary	£31.00	£32.00	3.2%	
Retention		Discretionary	£71.00	£73.00	2.8%	
Scrap Metal Dealers Act 2013						
Scrap Metal Dealer - Site Licence	licence is of 3 years duration	Discretionary		£490.00	N/A	
Scrap Metal Dealer renewal		Discretionary		£490.00	N/A	
Scrap Metal Dealer variation		Discretionary		£245.00	N/A	
Scrap Metal Collector		Discretionary		£295.00	N/A	
Scrap Metal Collector renewal		Discretionary		£295.00	N/A	
Scrap Metal Collector variation		Discretionary		£235.00	N/A	
Duplicates (for either)		Discretionary		£5.00	N/A	
GAMBLING ACT 2005						
Licence Fees						
Bingo Club - New Application		Discretionary	£1,840.00	£1,885.00	2.4%	
Bingo Club Annual Fee		Discretionary	£930.00	£955.00	2.7%	
Bingo Club - Variation		Discretionary	£1,290.00	£1,325.00	2.7%	
Bingo Club - Transfer		Discretionary	£155.00	£160.00	3.2%	
Bingo Club - Re-instatement		Discretionary	£155.00	£160.00	3.2%	
Bingo Club - Provisional Statement		Discretionary	£1,840.00	£1,885.00	2.4%	
Bingo Club - New Application from Provisional Statement holder		Discretionary	£155.00	£160.00	3.2%	
Betting Premises excluding Tracks - New Application		Discretionary	£1,840.00	£1,885.00	2.4%	
Betting Premises excluding Tracks Annual Fee		Discretionary	£530.00	£545.00	2.8%	
Betting Premises excluding Tracks - Variation		Discretionary	£940.00	£965.00	2.7%	
Betting Premises excluding Tracks - Transfer		Discretionary	£155.00	£160.00	3.2%	
Betting Premises excluding Tracks - Re-instatement		Discretionary	£155.00	£160.00	3.2%	
Betting Premises excluding Tracks - Provisional Statement		Discretionary	£155.00	£160.00	3.2%	
Betting Premises excluding Tracks - New Application from Provisional Statement holder		Discretionary	£1,840.00	£1,885.00	2.4%	
Tracks - New Application		Discretionary	£1,840.00	£1,885.00	2.4%	
Tracks - Transfer		Discretionary	£380.00	£390.00	2.6%	
Tracks - Re-instatement		Discretionary	£380.00	£390.00	2.6%	
Tracks - Provisional Statement		Discretionary	£1,840.00	£1,885.00	2.4%	
Tracks - New Application New Application from provisional statement holder		Discretionary	£380.00	£390.00	2.6%	
CCTV Enquiries/Requests form info Solicitors, Lawyers, Court Officers (Police Exempt)						
Search only		Discretionary	£10.00	£10.00	0.0%	
Research / Reply		Discretionary	£50.00	£50.00	0.0%	
Research / Reply multiple cameras / images (up to 5)		Discretionary	£65.00	£65.00	0.0%	
Research / Reply multiple cameras / images (6+)		Discretionary	£85.00	£85.00	0.0%	
PLANNING & DEVELOPMENT						
Photocopying Correspondence & Other Items						
Each page		Discretionary	£0.80	£0.80	0.0%	
Research fee						
Admin time per hr		Discretionary	£37.00	£37.00	0.0%	
Policy documents						
UDP Adopted June 2002		Discretionary	£56.00	£56.00	0.0%	
Core Strategy		Discretionary	£47.00	£47.00	0.0%	
Proposals Maps (UDP and Core Strategy)		Discretionary	£7.00	£7.00	0.0%	
Development Management Policies DPD (once formally adopted)		Discretionary	£47.00	£47.00	0.0%	
Site Allocations DPD (once formally adopted)		Discretionary	£47.00	£47.00	0.0%	
Finsbury Local Plan (once adopted formally)		Discretionary	£47.00	£47.00	0.0%	
Environmental Design SPD		Discretionary	£21.00	£21.00	0.0%	
Affordable Housing Small Sites Contributions SPD		Discretionary	£0.00	£0.00	0.0%	
Streetbook SPD (new version, Oct 2012)		Discretionary	£21.00	£21.00	0.0%	
Inclusive Landscape Design SPD (Oct 09)		Discretionary	£16.00	£16.00	0.0%	
Planning Obligations SPD (July 2009)		Discretionary	£16.00	£16.00	0.0%	
Accessible Housing SPD (March 2009)		Discretionary	£0.00	£0.00	0.0%	
Archway Development Framework SPD (September 2007)		Discretionary	£0.00	£0.00	0.0%	
Nag's Head Town Centre Strategy SPD (May 2007)		Discretionary	£0.00	£0.00	0.0%	
Urban Design Guide SPD (Dec 06),		Discretionary	£16.00	£16.00	0.0%	
King's Cross Framework SPD (July 2005)		Discretionary	£0.00	£0.00	0.0%	
Statement of Community Involvement (July 2006)		Discretionary	£0.00	£0.00	0.0%	
Angel Town Centre Strategy		Discretionary	£0.00	£0.00	0.0%	
Mount Pleasant		Discretionary	£16.00	£16.00	0.0%	
Student Accommodation Contributions for Bursaries SPD (once adopted)		Discretionary	£0.00	£0.00	0.0%	
Shop front Design		Discretionary	£7.00	£7.00	0.0%	
Conservation Area Design Guidelines		Discretionary	£19.00	£19.00	0.0%	
Planning Briefs		Discretionary	£10.00	£10.00	0.0%	
Other Documents						
Street Index with No Areas		Discretionary	£13.00	£13.00	0.0%	
Maps						
Street Maps		Discretionary	£5.20	£5.20	0.0%	

Fee / Charge		Type (Discretionary / Statutory)	Fee or Charge 2014-15	Proposed Fee or Charge 2015-16	% Change	Explanation if % change varies from RPI Quarter 3 Average inflation (2.4%) other than appropriate rounding for the purposes of administration and collection
Plan Printing						
(Other than plans from planning applications)						
A4		Discretionary	£3.80	£3.80	0.0%	
A3		Discretionary	£3.80	£3.80	0.0%	
A2		Discretionary	£5.20	£5.20	0.0%	
A1 23" * 20"		Discretionary	£5.20	£5.20	0.0%	
A1 40" * 30"		Discretionary	£5.20	£5.20	0.0%	
A0		Discretionary	£5.20	£5.20	0.0%	
60" * 40"		Discretionary	£5.20	£5.20	0.0%	
Pre-application and other advice fees						Charges will apply immediately upon approval
Duty Planning Officer Slot		Discretionary		£55.00	N/A	New Charge
Householder application		Discretionary	£155.00	£220.00	41.9%	To reflect costs
Householder application with site visit		Discretionary	£260.00	£360.00	41.9%	To reflect costs
Householder follow up meeting /site visit		Discretionary	£105.00	£140.00	33.3%	To reflect costs
Listed building consent		Discretionary	£210.00	£330.00	57.1%	To reflect costs
Listed building consent with site visit		Discretionary	£320.00	£470.00	57.1%	To reflect costs
Listed Building consent follow up meeting		Discretionary	£110.00	£140.00	27.3%	To reflect costs
Small scale minor application (up to 3 residential units, or 499 sq.m commercial)		Discretionary	£470.00	£500.00	6.4%	To reflect costs
Small scale minor application with site visit		Discretionary	£710.00	£730.00	2.8%	To reflect costs
Small scale minor follow up meeting		Discretionary	£240.00	£360.00	50.0%	To reflect costs
Larger scale minor development (4-9 residential units, or 500-999 sq.m commercial)		Discretionary	£1,290.00	£1,400.00	8.5%	To reflect costs
Large scale minor follow up meeting		Discretionary	£650.00	£750.00	15.4%	To reflect costs
Major application up to 20 units		Discretionary	£3,100.00	£3,200.00	3.2%	To reflect costs
Major application >20 units		Discretionary		£4,200.00	N/A	New charge
Major application per extra meeting		Discretionary	£1,370.00	£1,500.00	9.5%	To reflect costs
Planning Performance Agreement		Discretionary		£6,000.00	N/A	New charge
Planning Performance Agreement (conditions)		Discretionary		£3,000.00	N/A	New charge
Planning Performance Agreement (follow up)		Discretionary		£1,500.00	N/A	New charge
Design review panel		Discretionary	£2,850.00	£3,085.00	8.2%	
Design review panel follow up		Discretionary	£2,270.00	£2,360.00	4.0%	
Officer research/ correspondence per hour		Discretionary		£110.00	N/A	New Charge
Express Enforcement correspondence		Discretionary		£500.00	N/A	New charge
BUILDING CONTROL						
Property Record Viewing, Photocopying & Viewing (Charge Per Property)						
Enquiry Charge - all information readily available on back-office/land charges or statutory register		Discretionary	£25.00	£90.00	260.0%	Charged at standard hourly rate and assumes one hour (or part thereof) of work .
Enquiry Charge - additional research required	Additional hours (or part thereof) to deal with enquiry to be charged at standard hourly rate.	Discretionary		£90.00	N/A	New Charge
Additional page/drawing		Discretionary	£1.00	£1.00	0.0%	Copies of plans and documents to be charged at Plan Printing rates above.
Each single copy of microfiche		Discretionary	£8.50	£10.00	17.6%	Required to pay for rental and maintenance of equipment
Solicitor's enquiry (48 hour response)		Discretionary	£126.00	£270.00	114.3%	Standard hourly rate for research and preparing document - assuming 3 hours of work.
Temporary Structure-Renewals						
Professional/Technical time per hr	Standard Hourly Rate	Discretionary	£90.00	£90.00	0.0%	Standard Hourly Rate
Administrative time per hr	To be charged at standard hourly rate (£90+VAT)	Discretionary	£41.00	£90.00	119.5%	All services to be charged at standard hourly rate - currently £90 + VAT
Demolition notice under section 10 of the London Local Authorities Act 2004	Standard applications	Discretionary	£429.00	£450.00	4.9%	Charged at hourly rate and assuming 5 hours of officer time to deal with application.
Demolition notice under section 10 of the London Local Authorities Act 2005	Complex applications	Discretionary	£795.00	£810.00	1.9%	Charged at hourly rate and assuming 9 hours of officer time to deal with application.
Temporary Structure-New Structures & S21 London Building Ct 1939						
Minimum charge	Minimum charge is £300 paid on application, with additional charges to be assessed on a case by case basis based on nature of structure and resources required in order to deal with application.	Discretionary		£300.00	N/A	New Charge
Dangerous Structures						
Standard Charge on issue of Notice		Discretionary	£105.00	£315.00	200.0%	Charge based on standard hourly rate of £90+VAT and on assumption of 3 hours work in preparation for issuing notice.
Site visits and time spent on dealing with matter to be charged at standard hourly rate	Time to be charged at standard hourly rate	Discretionary	On application	On application	N/A	Time to be charged and invoiced at standard hourly rate.
Miscellaneous Charges						
Misc. charges and services delivered that are not specifically stated		Discretionary	On application	On application	N/A	
Refunds and Cancellations	£100 + any time spent on application charged at hourly rate	Discretionary	£100.00	£105.00	5.0%	
Street Naming and Numbering						
New sites or developments						
1-9 units		Discretionary	£185.00	£185.00	0.0%	
10-20 units		Discretionary	£240.00	£240.00	0.0%	
For each additional unit over 20		Discretionary	£35.00	£35.00	0.0%	
Naming a new street (including access ways, mews, cul-de-sacs)		Discretionary	£220.00	£220.00	0.0%	
Existing property						
Renaming a street		Discretionary	£390.00	£390.00	0.0%	
Naming or re-naming of a property		Discretionary	£220.00	£220.00	0.0%	
Renumbering of a property		Discretionary	£220.00	£220.00	0.0%	
Postcode enquiries		Discretionary	£0.00	£0.00	N/A	
Resubmission with new proposals if original application refused and within 1 month of refusal		Discretionary	£0.00	£0.00	N/A	
ENVIRONMENTAL SERVICES **HIGHWAYS GROUP** **NEW ROADS & STREET WORKS ACT** **Streetscene Records:**						
Staff viewing charge		Discretionary	£45.00	£45.00	0.0%	
First page copying - per page		Discretionary	£5.20	£5.20	0.0%	
Subsequent pages - per page		Discretionary	£0.90	£0.90	0.0%	
Restoration of database if required		Discretionary	£560.00	£560.00	0.0%	
Provision of information by post		Discretionary	£57.00	£57.00	0.0%	
Provision of accident data		Discretionary	£68.00	£68.00	0.0%	

Fee / Charge		Type (Discretionary / Statutory)	Fee or Charge 2014-15	Proposed Fee or Charge 2015-16	% Change	Explanation if % change varies from RPI Quarter 3 Average inflation (2.4%) other than appropriate rounding for the purposes of administration and collection
Enquiries/Requests form info Solicitors, Developers/Business Orgs						
Search only		Discretionary	£40.00	£40.00	0.0%	
Research/Reply		Discretionary	£79.00	£79.00	0.0%	
Research/Reply multiple questions (up to 5)		Discretionary	£140.00	£140.00	0.0%	
Research/Reply multiple questions (6+)		Discretionary	£195.00	£195.00	0.0%	
Supply Lamps						
Per lamp		Discretionary	£13.00	£13.00	0.0%	
Per night		Discretionary	£117.00	£117.00	0.0%	
Deposits						
Deposit Handling Charge		Discretionary	£75.00	£75.00	0.0%	
Deposit based on full replacement cost of highway (m2)		Discretionary	£171.00	£200.00	17.0%	
Highway Licences						
Section 50 opening of highway - Excavation up to 0.9 metres		Discretionary	£300.00	£310.00	3.3%	
Section 50 opening of highway - Excavation 0.9 - 1.5 metres		Discretionary	£640.00	£700.00	9.4%	
Section 50 opening of highway - Excavation over 1.50 metres		Discretionary	£1,800.00	£1,845.00	2.5%	
Section 50 opening of highway - Non excavation		Discretionary	£220.00	£225.00	2.3%	
Temp X over Section 50 opening of highway - Standard Vehicle		Discretionary	£640.00	£700.00	9.4%	
Temp X over Section 50 opening of highway - Heavy Duty Vehicle		Discretionary	£1,800.00	£1,845.00	2.5%	
Section 81 - First and second notifications		Discretionary	£0.00	£0.00	0.0%	
Section 81 - Remedial works including survey		Discretionary	£0.00	£0.00	0.0%	
Extension fees for agreed and non agreed Section 50 - excavations and temporary crossovers		Discretionary	£135.00	£140.00	3.7%	
Site Inspection fee for valid complaints or unauthorised overstay		Discretionary	£135.00	£140.00	3.7%	
Tables and chairs						
Management fee - all bands		Discretionary	£395.00	£405.00	2.5%	
Band A - Price per seat up to 12		Discretionary	£69.00	£75.00	8.7%	
Band A - Price per seat 13 upward		Discretionary	£49.00	£55.00	12.2%	
Band B - Price per seat up to 12		Discretionary	£49.00	£50.00	2.0%	
Band B - Price per seat 13 upward		Discretionary	£32.00	£35.00	9.4%	
Band C - Price per seat up to 12		Discretionary	£27.00	£30.00	11.1%	
Band C - Price per seat 13 upward		Discretionary	£20.00	£25.00	25.0%	
A Boards & Tables and Chairs						
Band A price per A board added to existing Tables and Chair licence		Discretionary	£264.00	£275.00	4.2%	
Band B price per A board added to existing Tables and Chair licence		Discretionary	£190.00	£195.00	2.6%	
Band C price per A board added to existing Tables and Chair licence		Discretionary	£75.00	£80.00	6.7%	
A Boards only						
Band A price per A board		Discretionary	£372.00	£380.00	2.2%	
Band B price per A board		Discretionary	£269.00	£275.00	2.2%	
Band C price per A board		Discretionary	£109.00	£115.00	5.5%	
Dispensers (newspapers et al)						
All bands		Discretionary	£340.00	£345.00	1.5%	
Skips						
Skip license - admin		Discretionary	£75.00	£85.00	13.3%	
Materials license fee						
deposit value <£1500		Discretionary	£300.00	£315.00	5.0%	
£1501<£3000		Discretionary	£435.00	£500.00	14.9%	
£3001<£6000		Discretionary	£780.00	£800.00	2.6%	
£6001<		Discretionary	On application	On application	N/A	
Scaffold license fee						
deposit value <£1500		Discretionary	£300.00	£315.00	5.0%	
£1501<£3000		Discretionary	£435.00	£500.00	14.9%	
£3001<£6000		Discretionary	£780.00	£800.00	2.6%	
£6001<		Discretionary	On application	On application	N/A	
Scaffold Gantry licence fee						
deposit value <£1500		Discretionary	£610.00	£650.00	6.6%	
£1501<£3000		Discretionary	£955.00	£1,000.00	4.7%	
£3001<£6000		Discretionary	£1,270.00	£1,300.00	2.4%	
£6001<		Discretionary	On application	On application	N/A	
Hoarding license fee						
deposit value <£1500		Discretionary	£300.00	£315.00	5.0%	
£1501<£3000		Discretionary	£435.00	£500.00	14.9%	
£3001<£6000		Discretionary	£780.00	£800.00	2.6%	
£6001<		Discretionary	On application	On application	N/A	
Extension fees for Material, Scaffolding & Hoarding		Discretionary	£135.00	£150.00	11.1%	
Site Inspection fee for valid complaints or unauthorised overstay		Discretionary	£135.00	£150.00	11.1%	
Crane Operation licenses						
Oversailing the highway		Discretionary	£540.00	£750.00	38.9%	Change in lifting technology. Site evaluations required. To be approved by qualified person.
Operation on the highway		Discretionary	£335.00	£350.00	4.5%	
Overhang licence section 177	NEW LICENCE TYPE	Discretionary		£325.00	N/A	Documentation approval by engineer prior to submission to Legal
Shoring and whaling						
One off fee per m2 of enclosed highway land		Discretionary	£215.00	£250.00	16.3%	
Monthly charge for occupation		Discretionary	£65.00	£75.00	15.4%	
Containers						
Admin fee		Discretionary	£160.00	£175.00	9.4%	
Weekly storage fee on the highway		Discretionary	£175.00	£185.00	5.7%	

Fee / Charge		Type (Discretionary / Statutory)	Fee or Charge 2014-15	Proposed Fee or Charge 2015-16	% Change	Explanation if % change varies from RPI Quarter 3 Average inflation (2.4%) other than appropriate rounding for the purposes of administration and collection
Legal notices and works						
Temporary Traffic Restriction Orders/Notices (incl statutory press notices) under section 14 for max of 3 months		Discretionary	£3,200.00	£3,200.00	0.0%	No increase - currently set at higher than the London average
Extension to section 14 closure per month		Discretionary	£375.00	£450.00	20.0%	Deterrent to avoid overstay
Temporary Traffic Restriction Orders/Notices (incl statutory press notices) under section 16 and Section 22 to accommodate Filming		Discretionary	£3,400.00	£3,200.00	-5.9%	No fee for non commercial events Parity with Section 14 closures
Permanent traffic orders under all sections of the highways, traffic regulation and road traffic acts		Discretionary	£2,150.00	£2,200.00	2.3%	
Parity with Section 14 closures						
Access Bar Marking installation and consultation		Discretionary	£356.00	£400.00	12.4%	
Professional fees for works		Discretionary	25% of total value for works up to 20,000 in value then 17.5% of total value	25% of total value for works up to 20,000 in value then 17.5% of total value	0.0%	
Emergency call out works		Discretionary	£560.00	£600.00	7.1%	
Waste Management						
COMMERCIAL WASTE CHARGES						
Sacks (per 50 sacks)	Per 50	Discretionary	£86.00	£86.00	0.0%	
Bulk (per metre)	Metre = 12 bags	Discretionary	£22.00	£22.00	0.0%	
Paladin	Per lift	Discretionary	£14.00	£14.00	0.0%	
Paladin	Annual hire	Discretionary	£114.00	£114.00	0.0%	
Wheelie Bin 240 litre	Per lift	Discretionary	£6.80	£6.80	0.0%	
Wheelie Bin 330/360 litre	Per lift	Discretionary	£8.50	£8.50	0.0%	
Eurobin 550/660 litre	Per lift	Discretionary	£11.00	£11.00	0.0%	
Eurobin 550/660 litre	Annual hire	Discretionary	£120.00	£120.00	0.0%	
Eurobin 770 litre	Per lift	Discretionary	£12.00	£12.00	0.0%	
Eurobin 770 litre	Annual hire	Discretionary	£140.00	£140.00	0.0%	
Eurobin 1100 litre	Per lift	Discretionary	£15.00	£15.00	0.0%	
Eurobin 1100 litre	Annual hire	Discretionary	£176.00	£176.00	0.0%	
Eurobin 1280 litre	Per lift	Discretionary	£16.00	£16.00	0.0%	
Eurobin 1280 litre	Annual	Discretionary	£190.00	£190.00	0.0%	
Skips Light Waste (8 yarder)	Per lift	Discretionary	£274.00	£274.00	0.0%	
Skips Building Material (8 yarder)	Per lift	Discretionary	£331.00	£331.00	0.0%	
Special Collections (Minimum Charge)	One off	Discretionary	£79.00	£79.00	0.0%	
Confidential Waste Collection	One off	Discretionary	£64.00	£64.00	0.0%	
To purchase Eurobins:						
240 litre		Discretionary	£52.00	£52.00	0.0%	
360 litre		Discretionary	£95.00	£95.00	0.0%	
660 litre		Discretionary	£370.00	£370.00	0.0%	
770 litre		Discretionary	£390.00	£390.00	0.0%	
1100 litre		Discretionary	£420.00	£420.00	0.0%	
1280 litre		Discretionary	£430.00	£430.00	0.0%	
CHARITY/EDUCATIONAL ESTABLISHMENT WASTE CHARGES						
Sacks (per 50 sacks)	Per 50	Discretionary	£42.00	£42.00	0.0%	
Paladin hire	Per lift	Discretionary	£8.00	£8.00	0.0%	
Paladin hire	Annual hire	Discretionary	£111.00	£111.00	0.0%	
Wheelie Bin 240 litre	Per lift	Discretionary	£4.00	£4.00	0.0%	
Wheelie Bin 330/360 litre	Per lift	Discretionary	£6.00	£6.00	0.0%	
Eurobin 550/660 litre	Per lift	Discretionary	£6.40	£6.40	0.0%	
Eurobin 550/660 litre	Annual hire	Discretionary	£120.00	£120.00	0.0%	
Eurobin 770/800 litre	Per lift	Discretionary	£7.50	£7.50	0.0%	
Eurobin 770/800 litre	Annual hire	Discretionary	£140.00	£140.00	0.0%	
Eurobin 1100 litre	Per lift	Discretionary	£8.00	£8.00	0.0%	
Eurobin 1100 litre	Annual hire	Discretionary	£176.00	£176.00	0.0%	
Eurobin 1280 litre	Per lift	Discretionary	£9.10	£9.10	0.0%	
Eurobin 1280 litre	Annual hire	Discretionary	£190.00	£190.00	0.0%	
Skips Light Waste (8 yarder)	Per lift	Discretionary	£191.00	£191.00	0.0%	
Skips Light Waste (12 yarder) perm	Per lift	Discretionary	£206.00	£206.00	0.0%	
Special Collections (Minimum Charge)	One off	Discretionary	£95.00	£95.00	0.0%	
Confidential Waste Collection	One off	Discretionary	£64.00	£64.00	0.0%	
To buy Eurobins						
240 litre		Discretionary	£52.00	£52.00	0.0%	
360 litre		Discretionary	£96.00	£96.00	0.0%	
660 litre		Discretionary	£370.00	£370.00	0.0%	
770 litre		Discretionary	£390.00	£390.00	0.0%	
1100 litre		Discretionary	£420.00	£420.00	0.0%	
1280 litre		Discretionary	£430.00	£430.00	0.0%	
Duty of Care Document Charge	Quarter	Discretionary	£15.00	£15.00	0.0%	
	Half year	Discretionary	£31.00	£31.00	0.0%	
	Annual	Discretionary	£62.00	£62.00	0.0%	
CLINICAL WASTE CHARGES						
Removal of Bagged Clinical Waste						
Min charge per visit & up to 7 bags (inclusive)	Up to 7 bags	Discretionary	£34.00	£34.00	0.0%	
Each additional bag over 7 collected	Each bag	Discretionary	£5.40	£5.40	0.0%	
Sharps						
Min charge per visit & up to 5 boxes (inclusive)	Up to 5 boxes	Discretionary	34.00	34.00	0.0%	
Each additional box over 5 collected	Each box	Discretionary	5.40	5.40	0.0%	
PARKING						
PARKING PERMITS						
Blue Badge						
Blue Badge processing		Statutory Maximum Limit	£0.00	£0.00	0.0%	Up to £10 set by government
Associated residents permit for Blue Badge holders		Discretionary	£0.00	£0.00	0.0%	
Blue Badge replacement for lost 1st one in 3 years		Statutory Maximum Limit	£0.00	£0.00	0.0%	Up to £10 set by government
Blue Badge replacement for stolen 1st one in 3 years		Statutory Maximum Limit	£0.00	£0.00	0.0%	Up to £10 set by government
Blue Badge replacement for lost subsequent ones in 3 years		Statutory Maximum Limit	£10.00	£10.00	0.0%	Up to £10 set by government

Fee / Charge	Type (Discretionary / Statutory)	Fee or Charge 2014-15	Proposed Fee or Charge 2015-16	% Change	Explanation if % change varies from RPI Quarter 3 Average inflation (2.4%) other than appropriate rounding for the purposes of administration and collection
All Diesel Vehicles - Surcharge in additional to Standard Resident Permit Prices - subject to some vehicle-type policy exemptions					
1 month permit	Discretionary		£8.00	N/A	New charge
3 month permit	Discretionary		£24.00	N/A	New charge
6 month permit	Discretionary		£48.00	N/A	New charge
12 month permit	Discretionary		£96.00	N/A	New charge
Residents Parking Permit - based on CO2 emissions					
Band A - (up to 100g/km) - 1 month permit	Discretionary	£0.00	£0.00	0.0%	
Band A - (up to 100g/km) - 3 month permit	Discretionary	£0.00	£0.00	0.0%	
Band A - (up to 100g/km) - 6 month permit	Discretionary	£0.00	£0.00	0.0%	
Band A - (up to 100g/km) - 12 month permit	Discretionary	£0.00	£0.00	0.0%	
Band B - (101-110g/km) - 1 month permit	Discretionary	£5.75	£6.00	4.3%	
Band B - (101-110g/km) - 3 month permit	Discretionary	£5.75	£6.00	4.3%	
Band B - (101-110g/km) - 6 month permit	Discretionary	£7.75	£7.95	2.6%	
Band B - (101-110g/km) - 12 month permit	Discretionary	£15.50	£15.90	2.6%	
Band C - (111-120g/km) - 1 month permit	Discretionary	£5.75	£6.00	4.3%	
Band C - (111-120g/km) - 3 month permit	Discretionary	£7.00	£7.20	2.9%	
Band C - (111-120g/km) - 6 month permit	Discretionary	£14.00	£14.35	2.5%	
Band C - (111-120g/km) - 12 month permit	Discretionary	£28.00	£28.70	2.5%	
Band D - (121-130g/km) - 1 month permit	Discretionary	£6.25	£6.35	1.6%	
Band D - (121-130g/km) - 3 month permit	Discretionary	£18.50	£18.95	2.4%	
Band D - (121-130g/km) - 6 month permit	Discretionary	£37.00	£37.90	2.4%	
Band D - (121-130g/km) - 12 month permit	Discretionary	£74.00	£75.80	2.4%	
Band E - (131-140g/km) - 1 month permit	Discretionary	£7.50	£7.70	2.7%	
Band E - (131-140g/km) - 3 month permit	Discretionary	£22.50	£23.05	2.4%	
Band E - (131-140g/km) - 6 month permit	Discretionary	£45.00	£46.10	2.4%	
Band E - (131-140g/km) - 12 month permit	Discretionary	£90.00	£92.15	2.4%	
Band F - (141-150g/km) - 1 month permit	Discretionary	£8.25	£8.30	0.6%	
Band F - (141-150g/km) - 3 month permit	Discretionary	£24.25	£24.85	2.5%	
Band F - (141-150g/km) - 6 month permit	Discretionary	£48.50	£49.65	2.4%	
Band F - (141-150g/km) - 12 month permit	Discretionary	£97.00	£99.30	2.4%	
Band G - (151-165g/km) - 1 month permit	Discretionary	£10.00	£10.35	3.5%	
Band G - (151-165g/km) - 3 month permit	Discretionary	£30.25	£31.00	2.5%	
Band G - (151-165g/km) - 6 month permit	Discretionary	£60.50	£61.95	2.4%	
Band G - (151-165g/km) - 12 month permit	Discretionary	£121.00	£123.90	2.4%	
Band H - (166-175g/km) - 1 month permit	Discretionary	£11.50	£11.90	3.5%	
Band H - (166-175g/km) - 3 month permit	Discretionary	£34.75	£35.65	2.6%	
Band H - (166-175g/km) - 6 month permit	Discretionary	£69.50	£71.25	2.5%	
Band H - (166-175g/km) - 12 month permit	Discretionary	£139.00	£142.50	2.5%	
Band I - (176-185g/km) - 1 month permit	Discretionary	£14.00	£14.00	0.0%	
Band I - (176-185g/km) - 3 month permit	Discretionary	£40.75	£41.75	2.5%	
Band I - (176-185g/km) -6 month permit	Discretionary	£81.50	£83.50	2.5%	
Band I - (176-185g/km) - 12 month permit	Discretionary	£163.00	£167.00	2.5%	
Band J - (186-200g/km) - 1 month permit	Discretionary	£17.50	£17.60	0.6%	
Band J - (186-200g/km) - 3 month permit	Discretionary	£51.50	£52.75	2.4%	
Band J - (186-200g/km) - 6 month permit	Discretionary	£103.00	£105.50	2.4%	
Band J - (186-200g/km) - 12 month permit	Discretionary	£206.00	£211.00	2.4%	
Band K - (201- 225g/km) - 1 month permit	Discretionary	£20.00	£20.50	2.5%	
Band K - (201- 225g/km) - 3 month permit	Discretionary	£60.00	£61.50	2.5%	
Band K - (201- 225g/km) - 6 month permit	Discretionary	£120.00	£123.00	2.5%	
Band K - (201- 225g/km) - 12 month permit	Discretionary	£240.00	£246.00	2.5%	
Band L - (226-255g/km) - 1 month permit	Discretionary	£28.00	£28.75	2.7%	
Band L - (226-255g/km) - 3 month permit	Discretionary	£84.00	£86.00	2.4%	
Band L - (226-255g/km) - 6 month permit	Discretionary	£168.00	£172.00	2.4%	
Band L - (226-255g/km) - 12 month permit	Discretionary	£336.00	£344.00	2.4%	
Band M - (256g/km and above) - 1 month permit	Discretionary	£36.50	£37.00	1.4%	
Band M - (256g/km and above) - 3 month permit	Discretionary	£108.50	£111.00	2.3%	
Band M - (256g/km and above) - 6 month permit	Discretionary	£217.00	£222.00	2.3%	
Band M - (256g/km and above) - 12 month permit	Discretionary	£434.00	£444.00	2.3%	
Residents Parking Permit - pre-2001 vehicles - based on engine sizes					
Band A - 1 month permit	Discretionary	£0.00	£0.00	0.0%	
Band A - 3 month permit	Discretionary	£0.00	£0.00	0.0%	
Band A - 6 month permit	Discretionary	£0.00	£0.00	0.0%	
Band A - 12 month permit	Discretionary	£0.00	£0.00	0.0%	
Band B - (1-900cc) - 1 month permit	Discretionary	£5.75	£6.00	4.3%	
Band B - (1-900cc) - 3 month permit	Discretionary	£5.75	£6.00	4.3%	
Band B - (1-900cc) - 6 month permit	Discretionary	£7.75	£7.95	2.6%	
Band B - (1-900cc) - 12 month permit	Discretionary	£15.50	£15.90	2.6%	
Band C - (901-1100cc) - 1 month permit	Discretionary	£5.75	£6.00	4.3%	
Band C - (901-1100cc) - 3 month permit	Discretionary	£7.00	£7.20	2.9%	
Band C - (901-1100cc) - 6 month permit	Discretionary	£14.00	£14.35	2.5%	
Band C - (901-1100cc) - 12 month permit	Discretionary	£28.00	£28.70	2.5%	
Band D - (1101-1200cc) - 1 month permit	Discretionary	£6.25	£6.35	1.6%	
Band D - (1101-1200cc) - 3 month permit	Discretionary	£18.50	£18.95	2.4%	
Band D - (1101-1200cc) - 6 month permit	Discretionary	£37.00	£37.90	2.4%	
Band D - (1101-1200cc) - 12 month permit	Discretionary	£74.00	£75.80	2.4%	
Band E - (1201-1300cc) - 1 month permit	Discretionary	£7.50	£7.70	2.7%	
Band E - (1201-1300cc) - 3 month permit	Discretionary	£22.50	£23.05	2.4%	
Band E - (1201-1300cc) - 6 month permit	Discretionary	£45.00	£46.10	2.4%	
Band E - (1201-1300cc) - 12 month permit	Discretionary	£90.00	£92.15	2.4%	
Band F - (1301-1399cc) - 1 month permit	Discretionary	£8.25	£8.30	0.6%	
Band F - (1301-1399cc) - 3 month permit	Discretionary	£24.25	£24.85	2.5%	
Band F - (1301-1399cc) - 6 month permit	Discretionary	£48.50	£49.65	2.4%	
Band F - (1301-1399cc) - 12 month permit	Discretionary	£97.00	£99.30	2.4%	
Band G - (1400-1500cc) - 1 month permit	Discretionary	£10.00	£10.35	3.5%	
Band G - (1400-1500cc) - 3 month permit	Discretionary	£30.25	£31.00	2.5%	
Band G - (1400-1500cc) - 6 month permit	Discretionary	£60.50	£61.95	2.4%	
Band G - (1400-1500cc) - 12 month permit	Discretionary	£121.00	£123.90	2.4%	
Band H - (1501-1650cc) - 1 month permit	Discretionary	£11.50	£11.90	3.5%	
Band H - (1501-1650cc) - 3 month permit	Discretionary	£34.75	£35.65	2.6%	
Band H - (1501-1650cc) - 6 month permit	Discretionary	£69.50	£71.25	2.5%	
Band H - (1501-1650cc) - 12 month permit	Discretionary	£139.00	£142.50	2.5%	
Band I - (1651-1850cc) - 1 month permit	Discretionary	£14.00	£14.00	0.0%	
Band I - (1651-1850cc) - 3 month permit	Discretionary	£40.75	£41.75	2.5%	
Band I - (1651-1850cc) - 6 month permit	Discretionary	£81.50	£83.50	2.5%	
Band I - (1651-1850cc) - 12 month permit	Discretionary	£163.00	£167.00	2.5%	
Band J - (1851-2100cc) - 1 month permit	Discretionary	£17.50	£17.60	0.6%	
Band J - (1851-2100cc) - 3 month permit	Discretionary	£51.50	£52.75	2.4%	
Band J - (1851-2100cc) - 6 month permit	Discretionary	£103.00	£105.50	2.4%	
Band J - (1851-2100cc) - 12 month permit	Discretionary	£206.00	£211.00	2.4%	
Band K - (2101-2500cc) - 1 month permit	Discretionary	£20.00	£20.50	2.5%	
Band K - (2101-2500cc) - 3 month permit	Discretionary	£60.00	£61.50	2.5%	

Fee / Charge	Type (Discretionary / Statutory)	Fee or Charge 2014-15	Proposed Fee or Charge 2015-16	% Change	Explanation if % change varies from RPI Quarter 3 Average inflation (2.4%) other than appropriate rounding for the purposes of administration and collection
Band K - (2101-2500cc) - 6 month permit	Discretionary	£120.00	£123.00	2.5%	
Band K - (2101-2500cc) - 12 month permit	Discretionary	£240.00	£246.00	2.5%	
Band L - (2501-2750cc) - 1 month permit	Discretionary	£28.00	£28.75	2.7%	
Band L - (2501-2750cc) - 3 month permit	Discretionary	£84.00	£86.00	2.4%	
Band L - (2501-2750cc) - 6 month permit	Discretionary	£168.00	£172.00	2.4%	
Band L - (2501-2750cc) - 12 month permit	Discretionary	£336.00	£344.00	2.4%	
Band M - (2751cc and above) - 1 month permit	Discretionary	£36.50	£37.00	1.4%	
Band M - (2751cc and above) - 3 month permit	Discretionary	£108.50	£111.00	2.3%	
Band M - (2751cc and above) - 6 month permit	Discretionary	£217.00	£222.00	2.3%	
Band M - (2751cc and above) - 12 month permit	Discretionary	£434.00	£444.00	2.3%	
Motorcycle Parking Permits					
Solo Motorcycle - 1 month permit	Discretionary	£6.50	£6.50	0.0%	
Solo Motorcycle - 3 month permit	Discretionary	£12.50	£12.70	1.6%	
Solo Motorcycle - 6 month permit	Discretionary	£24.75	£25.35	2.4%	
Solo Motorcycle - 12 month permit	Discretionary	£49.50	£50.70	2.4%	
Residents Match day permit - valid only during match or event days	Discretionary	£0.00	£0.00	0.0%	
Hire Car permit (linked to hire car vouchers)	Discretionary	£13.40	£13.75	2.6%	
Residents permit - black taxi driver concession - one band lower than the norm	Discretionary	Various	Various	N/A	
Residents Parking Permit refunds for unused permits (per complete month, based on annual permit surrender)					
Band A	Discretionary	£0.00	£0.00	0.0%	
Band B	Discretionary	£1.30	£1.30	0.0%	
Band C	Discretionary	£2.35	£2.40	2.1%	
Band D	Discretionary	£6.20	£6.30	1.6%	
Band E	Discretionary	£7.50	£7.70	2.7%	
Band F	Discretionary	£8.25	£8.30	0.6%	
Band G	Discretionary	£10.25	£10.35	1.0%	
Band H	Discretionary	£11.75	£11.90	1.3%	
Band I	Discretionary	£14.00	£14.00	0.0%	
Band J	Discretionary	£17.75	£17.60	-0.8%	
Band K	Discretionary	£20.00	£20.50	2.5%	
Band L	Discretionary	£28.25	£28.75	1.8%	
Band M	Discretionary	£37.00	£37.00	0.0%	
Admin fee - refund handling charge	Discretionary	£21.75	£22.25	2.3%	
Diesel vehicle surcharge refund - 1 month	Discretionary		£8.00	N/A	New charge
Visitor parking vouchers					
Half hour vouchers (books of 20)	Discretionary	£8.80	£10.40	18.2%	Has to be in 20p multiples
3-hour vouchers (books of 10)	Discretionary	£24.40	£29.20	19.7%	Has to be in 20p multiples
All day voucher	Discretionary	£11.20	£13.40	19.6%	
Half hour vouchers (concessionary)	Discretionary	£4.60	£5.20	13.0%	Has to be in 20p multiples
3-hour vouchers (concessionary)	Discretionary	£12.20	£14.60	19.7%	Has to be in 20p multiples
All day voucher (concessionary)	Discretionary		£6.70	N/A	New concession
E-visitor voucher charges (per hour)	Discretionary	£1.00	£1.20	20.0%	Not yet implemented
E-visitor voucher charges (concessionary)	Discretionary	£0.50	£0.60	20.0%	Not yet implemented
Hire car permit holder vouchers - half hour (books of 20)	Discretionary	£7.00	£8.40	20.0%	Has to be in 20p multiples
Hire car permit holder vouchers - 3 hour (books of 10)	Discretionary	£20.20	£24.20	19.8%	Has to be in 20p multiples
1-hour business voucher (books of 10)	Discretionary	£11.20	£11.40	1.8%	Has to be in 10p multiples
New parents vouchers - 40 hours free	Discretionary	£0.00	£0.00	0.0%	
1-hour business visitor vouchers	Discretionary	£49.60	£50.80	2.4%	Has to be in 20p multiples
Business Visitor parking vouchers					
Business visitor Half hour vouchers (books of 20)	Discretionary	£12.40	£12.80	3.2%	Has to be in 20p multiples
Business visitor All day voucher	Discretionary	£27.50	£28.15	2.4%	
E-business visitor voucher charges (per hour)	Discretionary	£1.20	£1.40	16.7%	Not yet implemented
Other permits					
Doctors parking permit - annual	Discretionary	£237.50	£243.20	2.4%	
(New Doctors parking place installation - includes 1 permit)	Discretionary	£2,685.00	£2,749.50	2.4%	
Essential Services Permit - annual (formerly Teacher Permit)	Discretionary	£335.00	£343.00	2.4%	
Business permit - annual (under 150kg/m2 or up to 1600cc)	Discretionary	£670.00	£686.00	2.4%	
Business permit - annual (under 150kg/m2 or up to 1600cc) 2nd permit	Discretionary	£890.00	£911.40	2.4%	
Business permit - annual (over 151kg/m2 or over 1600cc)	Discretionary	£1,110.00	£1,136.60	2.4%	
Business permit - annual (over 151kg/m2 or over 1600cc) 2nd permit	Discretionary	£1,320.00	£1,351.60	2.4%	
Business permit - electric	Discretionary	£516.00	£528.40	2.4%	
Business permit - annual permit linked to vouchers scheme	Discretionary	£16.75	£17.15	2.4%	
Match day and event day trader permits - annual	Discretionary	£610.00	£624.60	2.4%	
Permission to Park - per day	Discretionary	£23.25	£23.80	2.4%	
Permission to Park - per week	Discretionary	£95.00	£97.30	2.4%	
Permission to Park - per month	Discretionary	£377.00	£386.00	2.4%	
Universal all-zone permit - annual only (1-25 fleet vehicles)	Discretionary	£3,670.00	£3,760.00	2.5%	
Universal all-zone permit - annual only (26-50 fleet vehicles)	Discretionary	£2,440.00	£2,499.00	2.4%	
Universal all-zone permit - annual only (50+ fleet vehicles)	Discretionary	£1,240.00	£1,270.00	2.4%	
Universal permit - discounted fee for electric vehicles	Discretionary	£2,660.00	£2,720.00	2.3%	
Universal permit - discounted fee for registered charities	Discretionary	£2,660.00	£2,720.00	2.3%	
Car club permit	Discretionary	£222.00	£227.30	2.4%	
Trader's Permit	Discretionary	£22.25	£22.80	2.5%	
PARKING PLACE SUSPENSIONS					
Permission to place a licensed skip in a parking place - no dedicated suspension	Discretionary	£55.75	£57.00	2.2%	
Suspension admin charge (non residents) - first day	Discretionary	£180.00	£184.00	2.2%	
Suspension admin charge (residents) - first day	Discretionary	£88.00	£90.00	2.3%	
Suspension admin charge (all applicants) - subsequent days, per day	Discretionary	£27.50	£28.15	2.4%	
Yellow line essential parking waiver (day rate)	Discretionary	£55.00	£56.30	2.4%	
PAY AND DISPLAY TARIFFS					
Minimum made order - band 1 (per hour)	Discretionary	£1.20	£1.20	0.0%	No change - dependant on occupancy
Minimum made order - band 2 (per hour)	Discretionary	£1.80	£1.80	0.0%	No change - dependant on occupancy
Minimum made order - band 3 (per hour)	Discretionary	£2.00	£2.00	0.0%	No change - dependant on occupancy
Minimum made order - band 4 (per hour)	Discretionary	£2.40	£2.40	0.0%	No change - dependant on occupancy
Minimum made order - band 5 (per hour)	Discretionary	£3.00	£3.00	0.0%	No change - dependant on occupancy
Minimum made order - band 6 (per hour)	Discretionary	£3.60	£3.60	0.0%	No change - dependant on occupancy
Minimum made order - band 7(per hour)	Discretionary	£4.00	£4.00	0.0%	No change - dependant on occupancy
Minimum made order - band 8 (per hour)	Discretionary	£4.80	£4.80	0.0%	No change - dependant on occupancy
Minimum made order - band 9 (per hour)	Discretionary	£5.00	£5.00	0.0%	No change - dependant on occupancy
Minimum made order - band 10 (per hour)	Discretionary	£5.40	£5.40	0.0%	No change - dependant on occupancy
Minimum made order - band 11 (per hour)	Discretionary	£6.00	£6.00	0.0%	No change - dependant on occupancy
Motorcycle P&D					
All day parking band 1	Discretionary	£0.50	£0.50	0.0%	No change - not yet implemented
All day parking band 2	Discretionary	£1.00	£1.00	0.0%	No change - not yet implemented
All day parking band 3	Discretionary	£1.20	£1.20	0.0%	No change - not yet implemented
All day parking band 4	Discretionary	£1.50	£1.50	0.0%	No change - not yet implemented
All day parking band 5	Discretionary	£1.80	£1.80	0.0%	No change - not yet implemented
All day parking band 6	Discretionary	£2.20	£2.20	0.0%	No change - not yet implemented
Abandoned vehicle disposal					
Removal of abandoned vehicle from private land	Discretionary	£200.00	£200.00	0.0%	

HRA MEDIUM TERM FINANCIAL STRATEGY	**2014-15 Approved £m**	**2015-16 Proposed £m**	**2016-17 Estimate £m**	**2017-18 Estimate £m**
HOUSING REVENUE ACCOUNT:				
HRA INCOME:				
Income From Dwellings				
Tenants Rents	147.7	152.3	158.2	164.5
Tenants Service Charges	10.3	10.5	10.7	11.0
Income From Dwellings	158.0	162.8	169.0	175.5
Commercial Property Rents	1.7	1.7	1.8	1.8
Heating Charges (Tenants and Leaseholders)	2.3	2.4	2.5	2.7
Leaseholder Annual Service Charges	7.3	7.1	7.2	7.4
Leaseholder Charges for Major Works	2.1	2.1	2.2	2.3
Other fees	0.1	0.1	0.1	0.1
Leaseholder Charges	9.5	9.3	9.5	9.7
Other Charges for Services and Facilities	3.9	4.1	4.2	4.6
Private Finance Initiative Government Subsidy	22.9	22.9	22.9	22.9
Interest Receivable	0.4	2.0	2.8	3.5
Transfers from the General Fund for Shared Services	0.8	0.9	0.9	0.9
GROSS INCOME SUB TOTAL	**199.5**	**206.0**	**213.6**	**221.6**
HRA EXPENDITURE:				
General Management	45.8	48.6	49.4	50.1
Private Finance Initiative - Payments	39.3	40.1	40.7	41.5
Special Services	15.0	16.0	16.5	17.1
Repairs and Maintenance	23.1	29.7	30.2	30.8
Rents, Rates, Taxes and Other Charges	0.7	0.8	0.8	0.8
HRA Contributions to the Capital Programme	10.6	10.4	10.6	10.9
Interest Charges on Debt	14.6	14.5	15.8	17.3
Provision For Debt Repayment	17.2	12.7	15.4	18.3
Depreciation - Contribution to the Major Repairs Reserve (to fund the Capital Programme)	28.8	29.5	30.3	31.1
Total Capital Financing Costs	60.6	56.8	61.5	66.7
Increase In Bad Debt Provision	0.8	0.8	0.8	0.8
HRA Contingency	3.5	3.0	3.0	3.0
GROSS EXPENDITURE SUB TOTAL	**199.5**	**206.0**	**213.6**	**221.6**
HRA IN-YEAR DEFICIT (+) / SURPLUS (-)	**0.0**	**0.0**	**0.0**	**0.0**

APPENDIX D2

HRA FEES AND CHARGES 2015-16

Tenant Service Charges and Digital TV Charges

	Proposed weekly charge or compensation sum
Caretaking and Cleaning	£7.10
Estate Services (estate lighting, communal estate and grounds maintenance)	£2.91
Tenant Service Charge	**£10.01**
Digital TV	£0.31
Compensation for loss of caretaking service	£1.70 per day (after 5 consecutive days of lost service)
Note: The weekly tenant service charge for caretaking and estate services increases in line with inflation (2.3% RPI Sept.14) from £9.78 in 2014-15 to £10.01 in 2015-16, an increase of 23p per week.	

Heating and Hot Water Charges

	Bedsit Weekly Charge £	**1-Bed Weekly Charge £**	**2-Bed Weekly Charge £**	**3-Bed Weekly Charge £**	**4-Bed Weekly Charge £**
Heating and Hot Water	10.33	11.45	13.58	15.98	18.10
Heating Only (60% Full Charge)	6.20	6.87	8.15	9.59	10.86
Spa Green (18 hours/day, 18c at night)	10.98	12.17	14.43	16.98	19.24
Bunhill Energy Network (St Luke's, Stafford Cripps and Redbrick)	9.39	10.41	12.34	14.53	16.46
Note: Charges for 2015-16 have been frozen in absolute terms at 2014-15 rates.					

Estate Parking Charges

	EMISSION BANDS / CHARGES			
CARBON EMISSION AND ENGINE SIZES:	BAND A	BAND B	BAND C	BAND D
Carbon CO2 Rating G/km (Grams per kilometre)	0-120	121-150	151-185	186+
Engine Size CC (Cylinder Capacity)	0-1100	1101-1399	1400-1850	1851+
	Weekly Charge £	**Weekly Charge £**	**Weekly Charge £**	**Weekly Charge £**
LBI Residents:				
- Garage	9.07	18.13	18.13	19.93
- Car Cage	4.24	8.47	8.47	9.32
- Parking Space	2.32	4.63	4.63	5.09
- Internal Garage	6.25	12.48	12.48	13.74
Non LBI Residents:				
- Garage	17.29	34.55	34.55	37.99
- Car Cage	8.12	16.15	16.15	17.77
- Parking Space	4.76	10.14	10.14	13.94
				£
Garages Used For Non-Vehicle Storage – LBI Residents				19.93
Garages Used For Non-Vehicle Storage – Non LBI Residents				37.99
A 50% or 100% discount is offered on all vehicle parking charges to holders of an Islington Council disability parking blue badge				
VAT will be added to the above charges where applicable				
Note: LBI Resident Charges increase in line with inflation (2.3% RPI September 2014). For example the charge to an LBI resident for a garage with a Band B vehicle increases by 41p from £17.72 to £18.13. Non LBI Resident charges have been increased to more closely reflect current market rates.				

Concierge Service Charges

	Weekly Charge £
Category A (Concierge Office in Block)	7.06
Category B (Concierge Office in Estate)	5.29
Category C (Concierge Office – Remote multiple cameras)	3.18
Category D (Concierge Office – Remote a small number of cameras)	1.00
Note: Charges increase in line with inflation (2.3% RPI September 2014). For example the charge to tenants who receive a Category B service increases by 12p from £5.17 to £5.29. Introduction of new Cat.D £1 charge to enable service expansion and ASB issues to be addressed through maximising monitoring capacity at Concierge Offices whilst keeping charges to an affordable level.	

APPENDIX D2

Parking Charge Notices (PCN)

	Council Estates £
Parking Charge Notices	100.00
Parking Charge Notices (Paid within 14 days of issue)	60.00
Note: The maximum charges for unauthorised parking on council estates (off-street parking) are fixed by the British Parking Association on behalf of the Home Office. For on-street parking (outside council estates), the Council charges between £80 and £130 depending on the seriousness of the offence.	

Storage Units

	Weekly Charge £
LBI Residents	1.63
Non-LBI Residents	3.25
Note: Charges increase in line with inflation (2.3% RPI September 2014). The charge to residents has increased by 4p from £1.59 to £1.63 and that for non-residents has increased by 7p from £3.18 to £3.25.	

CAPITAL PROGRAMME 2015-18

APPENDIX E

DEPARTMENT / BUDGET HEADING	2015-16 Total Programme £000	2016-17 Total Programme £000	2017-18 Total Programme £000	Total Programme 2015-16 to 2017-18 £000	Total Corporate Funding 2015-16 to 2017-18 £000	Capital Allowance Scheme
HASS						
Aids and Adaptations	**2,340**	**2,411**	**2,483**	**7,234**	0	Yes
Other Adult Social Services Capital	**1,038**	**0**	**0**	**1,038**	86	Yes
ADULT SOCIAL SERVICES	**3,378**	**2,411**	**2,483**	**8,272**	**86**	
Major Works and Improvements	**40,345**	**41,016**	**41,046**	**122,407**	1,284	Yes
New Homes Programme	**40,785**	**38,433**	**39,575**	**118,793**	54,102	Yes
HOUSING	**81,130**	**79,449**	**80,621**	**241,200**	**55,386**	
SUBTOTAL HOUSING & ADULT SOCIAL SERVICES	**84,508**	**81,860**	**83,104**	**249,472**	**55,472**	
CHILDREN'S SERVICES						
Newington Green Refurbishment	**250**	**0**	**0**	**250**	250	Yes
Moreland School & Children's Centre	**6,100**	**4,000**	**0**	**10,100**	10,100	Yes
Dowrey Street / Primary Pupil Referral Unit	**3,300**	**0**	**0**	**3,300**	2,000	Yes
Bridge Free School	**3,767**	**0**	**0**	**3,767**	0	Yes
Winton Windows	**176**	**0**	**0**	**176**	176	Yes
Gillespie Windows	**79**	**0**	**0**	**79**	79	Yes
Sacred Heart School	**1,300**	**0**	**0**	**1,300**	0	Yes
Bulge Classes	**183**	**0**	**0**	**183**	183	Yes
PRIMARY SCHOOLS	**15,155**	**4,000**	**0**	**19,155**	**12,788**	
Two Year Old Capital	**1,010**	**0**	**0**	**1,010**	1,010	Yes
EARLY YEARS	**1,010**	**0**	**0**	**1,010**	**1,010**	
SUBTOTAL CHILDREN'S SERVICES	**16,165**	**4,000**	**0**	**20,165**	**13,798**	
ENVIRONMENT AND REGENERATION						
Archway Development	**120**	**0**	**0**	**120**	120	Yes
Section 106	**2,000**	**2,000**	**2,000**	**6,000**	0	Yes
Transport Planning	**0**	**50**	**0**	**50**	50	Yes
PLANNING AND DEVELOPMENT	**2,120**	**2,050**	**2,000**	**6,170**	**170**	
Disabled Facilities	**601**	**601**	**601**	**1,803**	0	Yes
Empty Properties	**100**	**0**	**0**	**100**	100	Yes
Private Sector Housing	**1,400**	**1,300**	**1,000**	**3,700**	3,700	Yes
PUBLIC PROTECTION	**2,101**	**1,901**	**1,601**	**5,603**	**3,800**	
Energy Saving Council Buildings	**800**	**0**	**0**	**800**	800	Yes
Combined Heat & Power	**3,425**	**3,425**	**0**	**6,850**	6,050	Yes
External Wall Insulation	**2,203**	**0**	**0**	**2,203**	2,203	Yes
Greenspace	**807**	**0**	**0**	**807**	807	Yes
Highways	**1,400**	**1,400**	**1,400**	**4,200**	4,200	Yes
Leisure	**3,380**	**2,449**	**825**	**6,654**	6,654	Yes
Traffic & Engineering	**3,606**	**4,200**	**2,500**	**10,306**	5,100	Yes
Vehicles	**8,500**	**0**	**0**	**8,500**	8,500	Yes
PUBLIC REALM	**24,121**	**11,474**	**4,725**	**40,320**	**34,314**	
SUBTOTAL ENVIRONMENT AND REGENERATION	**28,342**	**15,425**	**8,326**	**52,093**	**38,284**	
FINANCE & RESOURCES						
Corporate ICT Programme	**1,500**	**1,500**	**1,500**	**4,500**	4,500	
SUBTOTAL FINANCE & RESOURCES	**1,500**	**1,500**	**1,500**	**4,500**	**4,500**	
TOTAL	**130,515**	**102,785**	**92,930**	**326,230**	**112,054**	

APPENDIX F

RESIDENT IMPACT ASSESSMENT

Title of plan, policy and/or procedure being assessed	**Budget Savings Proposals 2015-16**
Name of Service Area Assessed	Council-wide
Staff conducting assessment, including contact details	Lela Kogbara (lela.kogbara@islington.gov.uk) Olvia Fellas (olvia.fellas@islington.gov.uk)
Date of assessment	November to December 2014

1. Introduction

1.1 The purpose of this report is to provide an analysis of the likely impact of the Council's budget savings proposals for 2015-16 on residents and employees with different "protected" characteristics as defined by the Equality Act 2010. It also enables consideration of the impact on child poverty and socio-economic disadvantage. The nine protected characteristics are: age, disability, gender reassignment, marriage and civil partnerships, race, religion and belief, pregnancy and maternity, sexual orientation, and gender. The Act requires the Council to comply with the Public Sector Equality Duty (PSED) and have "due regard" in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation;
- Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it; and
- Foster good relations between persons who share a relevant protected characteristic and those who do not share it.

1.2 The precise wording of the PSED is set out at the end of this document (15.1).

1.3 This report provides a summary of the more detailed Resident Impact Assessments (RIAs) performed on individual savings proposals. It first considers the resident impacts by service, goes on to consider the cumulative impact on different groups and then considers the impact on employees. In addition, Islington's policy is to assess the socio-economic, human rights and safeguarding impact of proposals, so this report also does that.

1.4 A range of savings options have been considered over the last six months. As part of that process, equalities risks have been flagged up and proposals which posed the greatest such risks with insufficient mitigation were ruled out.

2. Synopsis

2.1 It is difficult to make savings on the scale required (£37m over the next year) without any impact on residents and there will inevitably be some impact on particular groups, including those with protected characteristics. The Council is not legally obligated to reject savings with negative impacts on any particular groups but must consider carefully and with rigour the impact of its proposals on the PSED (as set out above), take a reasonable and proportionate view about the

overall impact on particular groups and seek to mitigate negative impacts where possible.

2.2 Although the resident impact assessment by service identifies some savings proposals where there is a risk of disproportionately negative impacts for some groups, overall there is no group where significant actual negative impacts have been identified that are not mitigated. That is not to say that none of the savings will have a negative impact on anyone with a protected characteristic. But the overall impact is deemed to be relatively minor in relation to the size of the populations with protected characteristics. In this context, the Council's proposals for achieving savings are reasonable overall and take account of the three requirements of the Public Sector Equality Duty.

2.3 It is not always possible to anticipate every potential impact and the data available (e.g. on service users) may not always be sufficient to assess risk, so it is possible that in a few cases proposals could unwittingly negatively impact on groups with protected characteristics. The report highlights the following areas where we need to monitor the actual impact on residents and monitor the effectiveness of the proposed mitigation:

- Community Safety – impact on women of the restructuring relating to Violence Against Women and Girls (VAWG).
- Adult Social Care – impact on older people and disabled people of the transformation programme under way
- Temporary Accommodation – impact on the homeless population of the changes proposed
- Adult Health Improvement Services – impact on men, disabled people, older people and BME people.
- Staff reorganisations – impact by ethnicity and gender

2.4 These and any other unforeseen negative impacts will need to be brought to the attention of management in a timely fashion to facilitate remedial action where this is considered appropriate.

3. Resident Impact by Service: Areas of Actual and Perceived Risk

3.1 The Council has suffered a sharp reduction in Government grant since 2010 and this is set to continue. In addition, demand for services, particularly from vulnerable residents, continues to grow and we face unavoidable rises in some costs. Some challenging choices have to be made and they will have an impact on the services we deliver. Throughout the budget process we have tried to make reductions in a way that is fair and protects those most in need of our support, mostly comprising groups that have historically suffered disadvantage and discrimination.

3.2 The service analyses below highlight areas where there are likely to be actual risks relating to budget proposals or where there are likely to be perceived risks. Assurance is given where it is considered that there is no real risk or that the mitigation envisaged is sufficient.

4. Chief Executive's Department

Community Safety Projects

4.1 The reduction in project budget is the same as the projected underspend on that budget and so no risks arise from that proposal.

Violence against Women and Girls (VAWG)

4.2 The extension of the senior VAWG role to cover all victims and the deletion of the VAWG Project Officer reduces the Council's capacity for work that focuses specifically on vulnerable females and, within that, BME, refugee and Muslim women who are disproportionally affected by specific issues such as Female Genital Mutilation, honour-based violence and trafficking. There could be a risk that any reduction in capacity has a negative impact on these groups. However, additional VAWG capacity has been created as we have significantly mainstreamed VAWG, with 3 new commissioned advice, advocacy and support services, specialist staff at Whittington hospital, GP practice changes, and a newly established, proactive investigation team within Islington police.

4.3 The Council is also extending work to cover other vulnerable victims (e.g. victims of religious and homophobic hate crime) and this could result in the total equality focus being greater than it is at present. Working differently and more effectively with offender services and partners could mitigate the aforementioned risks. It will be necessary to monitor what happens in practice and to optimise the overall impact on protected groups.

Merger of 'Strategy, Equality and Performance' with 'Communications'

4.4 This proposal and the reduction in staffing it entails could present a risk to the Council demonstrating compliance with the PSED, but this can be mitigated by the relevant managers ensuring equalities priorities are addressed, for instance by setting equality objectives and ensuring that RIAs are done. Only the No Recourse to Public Funds (NRPF) casework team works directly with residents, all of whom are BME and either families with children in need or vulnerable adults (e.g. disabled or mentally ill). The two caseworkers have a steadily growing caseload which now stands at 173 clients in 80 households and so no savings are proposed for this team. Moreover, the existing level of dedicated Equalities resource is to be maintained.

Voluntary Sector

4.5 The Local Initiatives Fund (LIF) is allocated by ward councillors to different initiatives each year and so it is difficult to be precise about which protected groups might be affected by a reduction in this budget.

5. Corporate

Premises

5.1 No negative impacts are anticipated as a result of property savings. Where organisations working with specific equality groups are affected (e.g. Disability Action in Islington) steps have been taken to ensure that their client groups will still have access to services and that accessibility needs such as premises and

transport will be met. It is also worth noting that the client numbers for these organisations are small compared with the relevant populations.

Council Tax

5.2 A comprehensive RIA was undertaken a year ago on the Council Tax Support Scheme and found that sufficient measures had been taken to mitigate impacts on disabled people, older people and families on low incomes. Although no equality data is collected on all those who pay council tax, the main impact will potentially be on people who are not eligible for discounts but with low disposable income on whom any additional financial demands will increase pressure.

Customer Access

5.3 No equalities data is collected on residents calling Contact Islington, so it is difficult to identify potential impacts of the move towards self-service. Older residents may be less IT-literate and those without a computer may be less able to access online services. This will be mitigated by having computers available in the customer service centre and in libraries and free wifi access in certain parts of the borough, and assistance will be provided by staff where necessary.

6. Children's Services

6.1 Savings proposals for Children's Services will be perceived to disproportionately affect young people. However, it is not anticipated that there will be any significant negative impacts overall because the majority of savings are being achieved by schools picking up costs previously borne by the Council and so in most cases there will be no service loss.

Childcare

6.2 Approximately 1,400 families could be affected by these proposals to a greater or lesser extent. Some 250 users are likely to be lone mothers (18 per cent of the total group), while it is estimated that 750 will be from BME communities (55 per cent of the group). It should be noted that these are estimates based on January 2014 census data and proportions of the population with children aged 0-4.

6.3 Steps are being taken to further reduce the burden on low-income families. The actual impact will not be known until decisions are made about which income bands are included.

Youth Careers

6.4 There is a risk that the proposed savings relating to Youth Careers could have a disproportionate effect on vulnerable young people who constitute the majority of the service caseload as summarised below and within which BME males are over-represented:

Special Educational Needs and Disabilities	500
In care, leaving care or within the Youth Justice System	70
Not in Education, Employment or Training (NEET)	260
At risk of being NEET at the end of Year 11	320

6.5 As part of implementing the recommendations of the Employment Commission, external funds have already been secured to support youth careers work and the Council intends to bid for further funds. Arrangements will be put in place to ensure that the first three groups cited above as a minimum will be provided with a service.

7. Environment and Regeneration

Parks

7.1 In relation to savings on grounds maintenance work in parks, the overall impact on residents is anticipated to be minimal in terms of parks' usage. 29 per cent of all households live in overcrowded or severely overcrowded housing, so reliance on parks is essential for households with children. Of this group, "Other" ethnic groups have the highest proportion of overcrowded homes (42 per cent).

Refuse and Recycling

7.2 The move from doorstep to communal re-cycling on estates could have a potential impact on older people and disabled people who may not be able to access communal recycling points easily. 27 per cent of residents live in council rental properties. Of this group, 25 per cent are over 65. We do not have data on the number of disabled residents living in council rental properties but it is reasonable to assume that a significant proportion of the 18 per cent of disabled residents in the borough do.

7.3 The introduction of communal green waste and kitchen waste collections could likewise disproportionately affect older or disabled people who may have difficulty accessing recycling centres or local sites. Both these initiatives will be trialled throughout the borough before any wholesale change is implemented and these matters will be fully explored through those trials. We also plan to consider concessionary charges for older people, should it be decided to confirm a charge for the doorstep collection of green waste, and an assisted collection service will be offered where this is needed for disabled residents.

8. Adult Social Services

8.1 We provide a broad range of day activities across the voluntary and non-statutory sector, as well as Council-run provision, providing support to 3,432 adults in total. These cover all service groups, including people with mental health needs, physical impairments, learning disabilities and older people. The profile of users is shown in the table below. This is based on data that are reported to us from external providers, and not all information is available to us at this stage. Therefore, numbers will not all add up to the total number of service users.

Gender	Male	1132	33.0%
	Female	1842	53.7%
Age	18-29	149	4.4%

	30-49	617	18.0%
	50-65	449	13.1%
	65+	1233	35.9%
Ethnic Group	White British	1305	38.0%
	Black British, Caribbean, African and other	483	14.1%
	Irish	199	5.8%
	Asian Indian, Pakistani, Bangladeshi and other	133	3.9%
	White Other	186	5.4%
	Other	770	22.4%
	Not known	358	10.4%

8.2 There were 3,516 users of community, nursing and residential care services in 2013-14, some of whom also used day opportunities. The user profile is similar. Some services are under-utilised, with some of the target population not using the services that are commissioned. Additionally, benchmarking information shows that some services are more expensive than comparators in other boroughs and that services are not adequately delivering a 7-day service across the system.

8.3 People who use social care services are more likely to have one or more protected characteristics than other residents. Therefore, it might be expected that changes would pose a disproportionate risk to disabled, older, female and BME people due to their higher prevalence in our services. However, all the changes in Adult Social Services are part of a transformation programme that will better integrate adult and health services and invest in activities that support people to be active and connected in the community, which should lead to better outcomes. There is therefore no anticipated negative impact on any groups with protected characteristics.

9. Housing Needs and Strategy

9.1 69 per cent of people in temporary accommodation (TA) are women and 48 per cent are from BME backgrounds. The aim of the proposed changes to provision is to continue preventing homelessness and reduce numbers going into TA by incentivising landlords to rent out their properties to TA tenants. The objective is by year 2 to be able to provide more cost effective TA. Clients are assessed on need, circumstances and availability so it is unlikely that this proposal will affect people on the basis of their possession of protected characteristics.

10. Public Health

Adult Health Improvement

10.1 The proposal is to achieve savings through contracting efficiencies and delivering interventions in lower cost settings. Services would be redesigned to commission a more integrated adult health improvement 'offer' for our residents, so they could access a range of different interventions in a single setting or via a particular channel e.g. through their local pharmacy, and/or through a single point of assessment and referral (including online). This should offer residents a more integrated package of lifestyle support, particularly for those people with multiple risk factors (smokers, overweight, inactive etc.).

10.2 There are some risks for older people, disabled people, men and some ethnic groups.

- The decommissioning of Bowel Cancer Screening will affect people aged 60-64 years who will not be provided with an endorsement letter or reminder letter as part of the local service. They will, however, still receive all of the standard communications from NHS England about bowel cancer screening and the bowel cancer screening kit through the post. NHS England is also considering setting up a similar national service to our locally commissioned one over the next couple of years.
- There is generally a need for more intensive adult health improvement services for disabled people, such as those with mental health problems.
- The prevalence of unhealthy behaviours varies by race / ethnicity. It will be important that services are delivered proportionate to need and are culturally specific and sensitive if they are to be successful. Bowel Cancer Screening uptake has been noted to be lower in BME groups,
- There are some differences in how men and women engage with services and men generally have poorer health than women in Islington.

10.3 The intention is to ensure through the design and commissioning processes that the needs of these groups are addressed and that any negative consequences that become apparent are mitigated. We will need to ensure age-appropriate models of delivery, addressing the specific needs for adult health improvement of the ageing population. We also need to ensure that any service redesign takes the needs of people with different disabilities into account. There will need to be ongoing monitoring of the actual impacts and the effectiveness of any mitigation.

Sexual Health

10.4 The proposal is to achieve savings by transforming the way we pay providers for sexual health services, redesigning services and reviewing prevention and promotion services.

10.5 The number of Islington residents that need these services is significant. In 2013, the total number accessing genito-urinary medicine (GUM) and sexual reproductive health services were 22,824 and 17,082 respectively. The sexually transmitted infection (STI) rate of 1,875 acute STIs per 100,000 is significantly higher than London and England rates. STI diagnoses vary by age, gender, ethnicity and sexual orientation.

10.6 HIV remains a serious communicable disease for which there is no cure or vaccine. According to the Department for Health's Framework for Sexual Health Improvement in England (2013) the groups most at risk are gay and bisexual men and Black Africans originating from sub-Saharan Africa.

10.7 The proposed service changes should not in themselves have a negative impact on service user experience and should not therefore have a negative equality impact. However, given that new service models are proposed, it is not yet possible to be definite about the impacts and so monitoring will be required.

Substance Misuse

10.8 There are an estimated 15,000 Islington residents that use illicit drugs and Islington is in the top 5 London boroughs for alcohol-related deaths and hospital admissions.

10.9 The savings plans are based on streamlining current pathways of care, for example to reduce duplication of services, and enhancing the focus on recovery-oriented services. The plans include re-negotiating and re-tendering the major contracts for drug and alcohol services provided by Camden & Islington Foundation Trust and Whittington Health.

10.10 At present the demographic of those using drug and alcohol treatment services in Islington comprises predominantly white males between 40 and 60 years of age. Although there are women, BME groups and younger people (18-24) accessing treatment services, these groups are under-represented in the treatment population in comparison to the estimated need within the local population.

10.11 There is a current arrangement in place with Children's Services to ensure priority free access to early years' childcare for parents who require drug or alcohol treatment. The arrangement was set up in order to promote access for women who could require but could not access treatment because of a need for childcare. This arrangement remains in place in order to promote treatment access to women who are traditionally under-represented in treatment services.

11. Resident Impact by Protected Characteristic

11.1 Equalities analysis shows that users of council services are more likely to be female, young or old (i.e. fewer in the 25 to 50 age bracket), disabled, BME and from lower socio-economic groups. These are therefore the groups most likely to be affected by service changes. However, it is worth noting that universal services have a greater impact than targeted services on all groups.

11.2 Data on sexual orientation is not routinely provided by residents accessing services and so the assessment of risks for this group is missing from most of the analysis, although a specific risk is flagged up in relation to the Sexual Health Transformation Programme.

11.3 Similarly, data on religion/belief is not routinely provided by residents accessing services. But there is a correlation between some ethnic groups and religion and so it is possible to extrapolate risks.

11.4 Although the resident impact assessment by service identifies some savings proposals where there is a risk of disproportionately negative impacts for some groups, overall there is no group where significant actual negative impacts have been identified that are not mitigated. That is not to say that none of the savings will have a negative impact on anyone with a protected characteristic.

11.5 Some proposed changes could have impact interdependencies with others, in terms of where service provision is picked up. Some changes cumulatively are more likely to create an adverse impact, even though the individual impact would be negligible. These should be considered together to reduce the risk of impacting negatively upon one or more groups or areas.

11.6 Whilst some changes should lead to an improved service, the Council should be aware of multiple changes which may cause disruption or uncertainty for vulnerable groups, and ensure the change is managed and communicated effectively.

11.7 The key issue for the Council to be alert to is potential negative impacts on small numbers of people who may face multiple disadvantage where poverty combines with other characteristics. The council is continuing to fund a range of support, advice, outreach and advocacy services which minimise the likelihood that people will be negatively impacted without any voice or recourse.

Child Poverty and Socio-Economic Disadvantage

11.8 Poverty combined with other characteristics is perhaps the most significant risk for individuals and communities. Islington has the second highest rate of child poverty in the country and of the 15,000 children living in poverty 86% are in workless households and disabled people and certain BME groups are over-represented. We believe that the best way to support people out of poverty is through employment and the Islington Employment Commission was established to look at the best ways of supporting our residents into sustainable employment, including a specific focus on parents. Over £2m has been secured from New Homes Bonus bids to support the implementation of the recommendations of the Employment Commission, and based on the work that the Council has done to date it is reasonable to expect that this will have a positive impact on reducing poverty in general and reducing the disadvantage faced by disabled people and some BME groups.

Disabled People

11.9 As well as mitigating the impacts of proposals relating to services that are specifically for disabled people, the Council needs to ensure that universal services are appropriate and accessible. Several proposals will change services for disabled residents. For individuals affected by more than one of these, this represents significant change which needs to be coordinated, communicated and managed effectively.

12. Staff Equality Impact

12.1 The current equality profile of the Council workforce for each department is as follows:

	Chief Exec's	Children's Services	E&R	Finance and Resources	HASS	Public Health	Council Total
Total Employees	332	882	1132	750	1368	53	4517
Female	67%	76%	32%	48%	50%	81%	52%
Male	33%	24%	68%	52%	50%	19%	48%
16 to 24	5%	3%	4%	4%	2%	2%	3%
25 to 39	39%	36%	26%	34%	27%	62%	31%
40 to 49	27%	31%	30%	28%	27%	23%	29%
50 to 64	27%	29%	38%	32%	42%	13%	35%
65+	1%	1%	2%	2%	2%	0%	2%
BME Total	36%	40%	24%	45%	37%	15%	35%
Asian Bangladeshi	2%	2%	1%	3%	1%	0%	1%
Asian Indian	4%	2%	2%	6%	2%	4%	3%
Asian Other	3%	1%	1%	2%	1%	0%	2%
Asian Pakistani	2%	0%	0%	1%	0%	2%	1%
Black African	4%	7%	5%	13%	12%	2%	9%
Black Caribbean	9%	16%	7%	12%	13%	4%	12%
Black Other	5%	4%	3%	3%	4%	0%	3%
Mixed	5%	5%	3%	3%	2%	2%	3%
Not Declared	3%	7%	16%	5%	15%	15%	11%
Other	2%	2%	3%	3%	2%	2%	2%
White British	45%	34%	43%	36%	31%	49%	37%
White Irish	5%	3%	4%	4%	5%	2%	4%
White Other	11%	16%	13%	11%	12%	19%	13%
Disabled	8%	5%	7%	5%	8%	2%	7%
Not disabled	14%	15%	10%	4%	18%	53%	14%
Not stated	78%	79%	83%	90%	73%	46%	80%
Heterosexual	50%	37%	46%	34%	40%	72%	41%
LGB	5%	3%	3%	3%	3%	0%	3%
Not Stated	44%	59%	50%	64%	57%	29%	56%
Buddhist	0%	1%	1%	0%	1%	0%	0%
Christian	24%	19%	20%	19%	25%	21%	21%
Hindu	2%	1%	1%	2%	1%	0%	1%
Jewish	1%	0%	1%	1%	1%	2%	1%
Muslim	3%	2%	4%	5%	3%	2%	4%
No Religion	9%	4%	9%	5%	6%	19%	6%

	Chief Exec's	Children's Services	E&R	Finance and Resources	HASS	Public Health	Council Total
Not Known	0%	0%	0%	1%	0%	0%	0%
Not Stated	45%	61%	55%	62%	55%	27%	56%
Other Religion	10%	9%	5%	3%	6%	19%	6%
Pagan	0%	0%	0%	0%	0%	0%	0%
Prefer not to say	2%	1%	3%	1%	1%	6%	2%
Roman Catholic	2%	1%	2%	1%	1%	4%	1%
Sikh	1%	0%	0%	0%	0%	2%	0%

12.2 Our overall staffing numbers are at an all-time high following the Kier TUPE in August 2014. Based on the data available from London Councils we have just overtaken Camden and are now the 4th largest council in London by headcount. We now have 48.4 per cent of the workforce made up of males, the highest proportion on record. 6.7 per cent of staff have declared a disability and 35 per cent of staff are from a BME background.

12.3 Evidence suggests that the equality issues that arise from Islington Council reorganisations have their roots not in the reorganisations themselves but in historic issues such as horizontal and vertical professional segregation which extend well beyond Islington's boundaries. Examples include men, women and people from different social classes being steered towards (or choosing) to go into different professions; and e.g. a high proportion of qualified accountants from Black African backgrounds never progressing to senior financial strategy/policy roles.

12.4 Services have just embarked upon reorganisation proposals and there will be individual equality impact assessments for these. Until reorganisations are completed it is not possible to know what the actual impacts will be but there are a few risks to flag up at this stage:

- Correlation analysis shows that divisions where the savings are being made have higher concentrations of female and BME staff.
- There are very high numbers of BME staff in Service Finance and so a large number of BME staff's posts will be deleted as a result of the savings proposals. Although it is unlikely that this will be disproportionate within the service itself, it may have an impact on disproportionality for the Council as a whole.
- Of the 179 employees that have applied for voluntary redundancy, disabled and non-BME employees are over-represented.
- BME staff make up approximately 42 per cent of scale 1 – SO1 roles, meaning any reorganisations focused on administrative functions may impact BME staff more.

12.5 The high proportion of "not stated" for disability, sexual orientation and faith is a concern as it makes it impossible to assess the actual impact of reorganisations.

12.6 To address the high numbers of BME staff at scale 1 – SO1 roles, the Council has developed an Inspiring Leadership (IL) initiative to inspire people from BME backgrounds to be leaders and to encourage existing BME leaders to provide

inspiration. For all staff, periods of organisational change can be an unsettling and anxious time. Human Resources provide a range of support to staff including free training opportunities, information, support and guidance. Staff whose posts are being deleted are also able to apply for other vacancies across the Council through the redeployment pool. Working Transitions provide support to staff who are unable to be redeployed within the Council and are coming to the end of their employment. Support includes face to face career coaching, telephone coaching, job information, company research, a career manual, job databases and a personal help line.

13. Safeguarding Implications

13.1 The Corporate Director of Children's Services and the Service Director for Adult Social Services have reviewed all the savings proposed and have confirmed that there are no inherent safeguarding risks that arise as a result of them.

14. Human Rights Implications

14.1 In assessing human rights implications, we have looked at the cumulative impact of changes that could give rise to human rights implications. There is a need to ensure we provide the right resources to ensure fair access to assessing needs, and access to services and support. **There are no potential human rights breaches arising from any of the proposals.**

15. Public Sector Equality Duty

15.1 Section 149 of the Equality Act 2010 provides that:

(1) A public authority must, in the exercise of its functions, have due regard to the need to—

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

. . .

(3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—

(a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;

(b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;

(c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

(4) The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

(5) Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—

(a) tackle prejudice, and

(b) promote understanding.

(6) Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.

(7) The relevant protected characteristics are—

age;
disability;
gender reassignment;
pregnancy and maternity;
race;
religion or belief;
sex;
sexual orientation

15.2 The savings proposed for 2015-16 are in keeping with the requirements of this legal duty.

ISLINGTON

Finance and Resources Department

Report of: Corporate Director of Finance and Resources

Meeting of:	Date	Ward(s)
Executive	15th January 2015	

FINANCIAL POSITION AT 30th NOVEMBER 2014

1. SYNOPSIS

1.1 This report presents the forecast outturn position for 2014-15 as at 30th November 2014. Overall, the forecast is a £0.7m General Fund underspend including corporate items. The Housing Revenue Account (HRA) is forecast to break-even over the year. It is forecast that £93.0m of capital expenditure will be delivered in 2014-15.

2. RECOMMENDATIONS

2.1. To note the overall forecast revenue outturn for the General Fund of a £0.7m underspend. **(Paragraph 3.1, Table 1 and Appendix 1)**

2.2. To note that the HRA is forecast to break-even over the financial year. **(Paragraph 3.1, Table 1 and Appendix 1)**

2.3. To note the latest capital position and agree the slippage over £1m on an individual scheme. **(Section 6, Paragraph 6.2, Table 2 and Appendix 2)**

3. CURRENT REVENUE POSITION: SUMMARY

3.1. A summary position of the General Fund and Housing Revenue Account is shown in **Table 1** below with further detail contained in **Appendix 1**.

Table 1: General Fund and HRA Estimated Outturn at 30th November 2014

	VARIANCE Month 8 (£000)
GENERAL FUND	
Finance and Resources	0
Chief Executive's	(95)
Core Children's Services (Excluding Schools)	(855)
Environment and Regeneration	51
Housing and Adult Social Services	1,925
Public Health	0
Net Departments	**1,026**
Corporate Items	(1,691)
Total excluding contingencies	
Unallocated contingency budgets	0
TOTAL PROJECTED (UNDER)/OVERSPEND	**(665)**
HOUSING REVENUE ACCOUNT	
NET (SURPLUS) / DEFICIT	**0**

4. GENERAL FUND

Finance and Resources Department (zero variance)

4.1. The Finance and Resources Department is currently forecasting a break-even position.

Chief Executive's Department (-£0.1m)

4.2. An underspend of (-£0.1m) is forecast in the Chief Executive's Department, due to staffing variances and some additional income.

Children's Services (General Fund: -£0.8m, Schools: -£4.1m)

4.3. An underspend of (-£0.8m) is forecast for the General Fund (non-schools) Children's Services budget. This is due to an underspend against the Council's Universal Free School Meals budget following the introduction of statutory free school meals for all pupils in Reception to Year 2 (-£0.3m); a staffing underspend due to vacancies in the Play and Youth Service and Youth Careers (-£0.2m); the early delivery of 2015-16 administrative savings within the Partnerships and Support Services division (-£0.1m); an underspend due to staffing vacancies in Children's Centres and lower than expected spend against the Grant Aid budget in Early Years (-£0.1m); and a staffing underspend due to vacancies in School Improvement (-£0.1m).

Schools (-£4.1m)

4.4. A Dedicated Schools Grant (DSG) underspend of (-£4.1m, 2.7% of DSG) is forecast. This is due to the carry forward of Early Years DSG funding from 2013-14 that will be used to smooth in expected DfE funding reductions for the statutory entitlement for free childcare for deprived 2-year olds from 2015, when funding will be allocated to local authorities based on take-up (-£3.6m); Schools Forum have agreed to hold off allocating £0.4m from the 2013-14 DSG carried-forward underspend pending confirmation of sufficient headroom from the growth in DSG in 2015-16 and 2016-17 to enable re-designed pupil, school and early years services to be funded (-£0.4m); and a forecast underspend in Early Years in relation to the provision of nursery places for 3 and 4 year

old places reflecting demand following the October Census (-£0.1m). DSG variances are managed through the Schools Forum.

Environment and Regeneration (zero variance)

4.5. The Environment and Regeneration Department is currently forecasting a break-even position. This is after the £0.9m in-year corporate savings previously applied to structural overspends in the department. There is a remaining pressure in relation to the Houses in Multiple Occupation (HMO) Licence income shortfall (+£0.2m). However, this and other volatile income streams are being managed allowing the department to forecast a balanced position.

Housing and Adult Social Services (+£1.9m)

- **Adult Social Care (-£0.2m)**

4.6. There is a small, net forecast underspend of (-£0.2m) for Adult Social Services, spread across a number of budget areas. This forecast includes the agreed allocation of demographic contingency for the full-year effect of 2013-14 placements of (+£0.5m) and the part-year effect of 2014-15 placements (+£1.0m), and the agreed allocation of general contingency (+£1.4m) to enable the contractors of the Provision of Comprehensive Domiciliary Care Services in Islington to pay the London Living Wage.

- **Housing General Fund (+£2.1m)**

4.7. The Housing General Fund continues to be impacted by increased demand for temporary accommodation (TA) and the increased cost of supplying it, exacerbated by ongoing changes to the housing benefit regulations (implementation of Local Housing Allowance caps) and the changes to the welfare support system. This has resulted in a net financial pressure of £2.1m in 2014-15 (after the previous application of £0.4m in-year corporate savings to structural overspends within the temporary accommodation procurement and rental income budgets).

4.8. There has been some mitigation of the impact of the £500 per week benefit cap in that TA households affected are currently in receipt of transitional Discretionary Housing Payment protection.

4.9. The main actions being taken to control the pressure are:

4.9.1. Options and service delivery strategies have been considered and are currently in the process of being implemented that aim to reduce: the numbers of admissions and consequently the number of families being placed in TA; the length of stay; and the cost of procuring TA.

4.9.2. The extent to which the different approaches/strategies are successful is under constant review and the financial impact will be closely monitored as the financial year progresses.

Public Health (zero variance)

4.10. Public Health is funded via a ring-fenced grant of £25.4m for 2014-15. The public health grant is committed against existing public health services and programmes, continuing from the previous year and transferred to the Council via a transfer scheme in April 2013, and public health services and programmes included in larger NHS contracts. The grant is forecast to be spent in line with the overall allocation. Any underspend at year-end is ringfenced and carried forward to the following year earmarked for Public Health.

Corporate Items (-£1.7m)

4.11. The Council continues to follow a successful Treasury Management Strategy of shorter-term borrowing at low interest rates. The current forecast is that this will save the General Fund (-£1.9m) in interest charges over the financial year. The Treasury Management Strategy is kept under constant review to ensure that available resources are optimised and the longer-term interest rate position reviewed.

4.12. Joint work between Council departments has resulted in the streamlining and consolidation of funding for a wide range of service contracts which has resulted in savings of (-£1.0m) across the Council.

4.13. In addition, there is an upfront income saving of (-£0.5m) from leasing street furniture to network operators and) and a (+0.6m) saving in respect of the 2.2% pay award with effect from 1st January 2015 (3 months) compared to the full year 1% provided in the 2014-15 budget.

4.14. These savings are offset by:

4.14.1. Corporate savings of (+£1.3m) being applied to the structural overspends in Environment and Regeneration and Housing General Funding. This is a net-nil impact overall as the Environment and Regeneration Department and Housing General Fund overspends are reduced, in respect of this applied funding, by the same amount.

4.14.2. There is a pressure of (+£1.0m) created by uncontrollable expenditure due to the Council's statutory duty to provide assistance to all destitute clients who are Non-European Union nationals and can demonstrate need under Section 21 of the National Assistance Act, 1948. This is commonly referred to as No Recourse to Public Funds (NRPF).

Contingencies (zero variance)

4.15. Following the allocation of demographic contingency to Adult Social Services relating to the full-year effect of 2013-14 placements (+£0.5m) and the part-year effect of 2014-15 placements (+£1.0m), and the allocation of general contingency (+£1.4m) to Adult Social Services to enable the contractors of the Provision of Comprehensive Domiciliary Care Services in Islington to pay the London Living Wage, the 2014-15 contingency budget has been fully allocated.

5. HOUSING REVENUE ACCOUNT

5.1. The HRA is forecast to be balanced in 2014-15, after the application of contingency and a drawdown from working balances. The detailed variances are as follows:

5.1.1. A projected overspend on repairs and maintenance as a result of the refurbishment of Brewery Road (+£1.2m); purchase of vehicles (+£2.4m), other repairs costs including IT, tooling, protective clothing and workshop costs (+£1.2m); the impact of Kier undertaking the completion of incomplete jobs at the same time as LBI undertaking new jobs (+£0.7m); part-year effect of bringing the housing repairs service in-house (+£2.6m); part-year effect of bringing other corporate and clienting repairs functions in-house (+£0.7m); and the part-year effect of the ongoing pressure of bringing the Gas Service in-house (+£1.1m).

5.1.2. One-off pressures due to the impact of the Welfare Reforms (+£0.7m); improvements to Open Spaces (+£0.4m); additional CCTV project costs (+£1.0m).

5.1.3. A pressure of (+0.3m) following the increase in the employer superannuation rate.

5.1.4. Loss of rental and service charge income arising from the increase in right-to-buys over 2013-15, a reduction in voids leading to less re-lets and therefore fewer properties moving straight to target rent and less new builds ready for let than anticipated (+£0.3m).

5.1.5. Water Rates Commission underachievement of income (+£0.1m).

5.1.6. Increase in court fee costs of (+£0.1m).

5.1.7. The above pressures of (+12.8m) are offset by:

5.1.8. A (-£2.9m) saving from reduced interest on borrowing and capital charges.

5.1.9. Additional income from commercial properties (-£0.5m).

5.1.10. Reduced energy costs of (-£0.7m).

5.1.11. Reduced demand for aids and adaptations work in HRA properties (-£0.8m).

5.1.12. Annual leaseholder service charges saving (-£0.2m).

5.1.13. Number of void repairs less than budgeted (-£0.7m).

5.1.14. In-year drawdowns from HRA annual contingency budget of (-£3.5m) and HRA working balances of (-£3.5m).

6. CAPITAL PROGRAMME

6.1. It is forecast that £93.0m of capital expenditure will be delivered by the end of the financial year with forecast slippage of £4.0m to 2015-16. This is set out by department in **Table 2** below with the latest 2014-15 capital programme detailed at **Appendix 2**.

Table 2: 2014-15 Capital Programme by Department at 30th November 2014

Department	2014-15 Capital Budget (£m)	2014-15 Forecast Expenditure (£m)	Forecast Slippage (£m)
Adult Social Services	3.4	3.1	(0.3)
Housing	56.0	56.0	0.0
Children's Services	9.7	8.9	(0.8)
Environment and Regeneration	24.2	21.3	(2.9)
Finance and Resources	3.2	3.2	0.0
Corporate Projects	0.5	0.5	0.0
Total	**97.0**	**93.0**	**4.0**

Slippage for Executive Approval

6.2. Under the Council's financial regulations, approval of slippage over £1m on an individual scheme is a function of the Executive. The forecast slippage in **Table 2** above includes the following slippage over £1m for approval:

Environment and Regeneration

6.3. Corporate Fleet Programme (£1.5m) – The lead time for new refuse collection vehicles means that delivery of the vehicles will run into the next financial year.

7. IMPLICATIONS

Financial Implications

7.1. These are included in the main body of the report.

Legal Implications

7.2. In practical terms the law requires that the Council must always plan to balance its spending plans against resources so as to avoid a deficit occurring in any year. Accordingly, Members need to be reasonably satisfied that expenditure is being contained within budget and that the net savings targets for the current financial year will be achieved so as to ensure that income and expenditure balance.

Environmental Implications

7.3. This report does not have any direct environmental implications.

Resident Impact Assessment

7.4. A resident impact assessment (RIA) was carried out for the 2014-15 Budget Report approved by Full Council. This report notes the financial performance of the Council for the year to date but does not have any direct policy implications; therefore, it is not considered necessary to carry out a separate RIA for this report.

Background papers: None

Responsible Officer:
Mike Curtis
Corporate Director of Finance & Resources

Report Author:
Tony Watts
Head of Financial Planning

Signed by

5 January 2015

Executive Member for Finance and Performance

Date

Appendix 1 - Revenue Budget Monitoring Month 8 2014-15

GENERAL FUND					
Department / Service Area	**Original Budget**	**Current Budget**	**Forecast Outturn**	**Variance Month 8**	**Variance Month 6**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
FINANCE AND RESOURCES					
Property	1,527	(5)	206	211	179
Financial Management	(2,564)	(3,248)	(3,495)	(247)	(247)
Corporate Director of Finance and Resources	25	0	(43)	(43)	(93)
Financial Operations and Customer Services	8,047	6,741	6,734	(7)	(7)
Digital Services and Transformation	(31)	17	103	86	87
Internal Audit	643	729	729	0	0
Total	**7,647**	**4,234**	**4,234**	**0**	**(81)**
CHIEF EXECUTIVE'S DEPARTMENT					
Chief Executive	(140)	(18)	(78)	(60)	(60)
Governance and Human Resources	462	1,599	1,564	(35)	3
Strategy and Community Partnerships	6,678	7,899	7,899	0	3
Total	**7,000**	**9,480**	**9,385**	**(95)**	**(54)**
CHILDREN'S SERVICES					
Learning and Schools	29,408	29,967	25,042	(4,925)	(3,855)
Partnerships and Support Services	9,984	11,866	11,766	(100)	(100)
Targeted and Specialist Children and Families	37,602	40,762	40,762	0	0
Total	**76,994**	**82,595**	**77,570**	**(5,025)**	**(3,955)**
ENVIRONMENT AND REGENERATION					
Directorate	0	(92)	(92)	0	0
Planning and Development	2,311	2,902	3,056	154	134
Public Protection	10,761	10,883	11,208	325	268
Public Realm	23,143	26,202	25,774	(428)	(392)
Total	**36,215**	**39,895**	**39,946**	**51**	**10**
HOUSING & ADULT SOCIAL SERVICES					
Temporary Accommodation (Homelessness Direct)	612	1,073	3,223	2,150	2,300
Housing Benefit	880	880	880	0	0
Housing Needs (Homelessness Indirect)	1,908	1,954	1,954	0	0
Housing Development and Strategy	248	248	248	0	0
Housing Administration	1,993	2,340	2,340	0	0
Housing General Fund Total	**5,641**	**6,495**	**8,645**	**2,150**	**2,300**
Adult Social Care	31,314	31,447	31,669	222	222
Community Services	15,219	16,988	16,791	(197)	(197)
Strategy and Commissioning	31,563	33,471	33,221	(250)	(250)
Adult Social Services Total	**78,096**	**81,906**	**81,681**	**(225)**	**(225)**
HASS Total	**83,737**	**88,401**	**90,326**	**1,925**	**2,075**
PUBLIC HEALTH					
NHS Health Checks	358	390	361	(29)	(21)
Obesity and Physical Activity	863	863	874	11	(13)
Other Public Health	(21,069)	(21,259)	(21,241)	18	443
Sexual Health	8,546	8,231	8,310	79	76
Smoking & Tobacco	665	820	634	(186)	(184)
Substance Misuse	8,858	9,176	9,223	47	(303)
Children and Young People	1,779	1,779	1,656	(123)	(173)
	0	**0**	**(183)**	**(183)**	**(175)**
Less Projected Ring-Fenced Schools Related Underspend			4,170	4,170	3,315
Less Projected Ring-Fenced Public Health Underspend			183	183	175
GROSS DEPARTMENT TOTAL	**211,593**	**224,605**	**225,631**	**1,026**	**1,310**

Appendix 1 - Revenue Budget Monitoring Month 8 2014-15

Department / Service Area	Original Budget	Current Budget	Forecast Outturn	Variance Month 8	Variance Month 6
	£'000	£'000	£'000	£'000	£'000
CORPORATE ITEMS					
Corporate and Democratic Core / Non Distributed Costs	16,626	16,675	16,675	0	0
Insurance Fund	(300)	(300)	(300)	0	0
Transfer to/(from) Reserves	6,727	831	831	0	0
Levies	22,273	22,273	22,473	200	200
Appropriations / Technical Accounting Entries	0	0	0	0	0
Provisions	0	0	0	0	0
Corporate Financing Account	(13,276)	(13,276)	(15,176)	(1,900)	(1,900)
Unringfenced Grants	(15,996)	(15,996)	(15,996)	0	0
Other Corporate Items	2,524	(963)	(1,986)	(1,023)	577
Core Government Funding / Council Tax	(234,117)	(234,117)	(234,117)	0	0
No Recourse to Public Funds	268	268	1,300	1,032	1,032
Corporate Items Total	**(215,271)**	**(224,605)**	**(226,296)**	**(1,691)**	**(91)**
TOTAL NET OF CORPORATE ITEMS	**(3,678)**	**0**	**(665)**	**(665)**	**1,219**
Demographic Contingencies	2,377	0	0	0	0
General Contingencies	1,300	0	0	0	0
GENERAL FUND TOTAL	**0**	**0**	**(665)**	**(665)**	**1,219**

Appendix 1 - Revenue Budget Monitoring Month 8 2014-15

HOUSING REVENUE ACCOUNT(HRA)

Department / Service Area	Original Budget	Current Budget	Forecast Outturn	Variance Month 8	Variance Month 6
	£'000	£'000	£'000	£'000	£'000
Dwelling Rents	(147,657)	(147,657)	(147,257)	400	900
Non Dwelling Rents	(1,708)	(1,708)	(1,908)	(200)	(200)
Heating Charges	(2,268)	(2,268)	(2,368)	(100)	0
Leaseholders Charges	(9,495)	(9,495)	(9,695)	(200)	0
Other Charges for Services and Facilities	(14,251)	(14,063)	(13,963)	100	100
HRA Subsidy Receivable	0	0	0	0	0
PFI 1 Credit	(6,140)	(6,140)	(6,140)	0	0
PFI 2 Credit	(16,715)	(16,715)	(16,715)	0	0
Interest Receivable	(390)	(390)	(390)	0	0
Reduced Provision For Bad Debt	0	0	0	0	0
Contribution from General Fund	(833)	(833)	(833)	0	0
Gross Income	**(199,457)**	**(199,269)**	**(199,269)**	**0**	**800**
Repairs & Maintenance	23,100	23,102	28,702	5,600	5,400
Revenue Contribution to Capital	10,594	10,594	14,844	4,250	4,250
General Management	44,657	44,996	45,664	668	568
PFI 1 Payments	10,921	10,921	10,921	0	0
PFI 2 Payments	28,355	28,355	28,355	0	0
Contribution to PFI Smoothing Fund	61	61	1	(60)	(60)
Special Services	16,184	15,655	15,032	(623)	(623)
Rents, Rates, Taxes and Other Charges	740	740	740	0	0
Capital Financing Costs	60,610	60,610	57,710	(2,900)	(3,150)
Bad Debt Provisions	750	750	750	0	0
HRA Contingency and Growth	3,485	3,485	0	(3,485)	(3,485)
Gross Expenditure	**199,457**	**199,269**	**202,719**	**3,450**	**2,900**
Drawdown from HRA Balances	**0**	**0**	**(3,450)**	**(3,450)**	**(3,700)**
Net (Surplus) / Deficit	**0**	**0**	**0**	**0**	**0**

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Appendix 2 - Capital Programme Monitoring Month 8 2014-15

	Capital Budget 2014-15						Year To Date	
	Original Budget £	Slippage In £	Capital Virements £	Changes In Resources £	Slippage Out £	Current Budget £	Expenditure £	% Spend Against Budget
ADULT SOCIAL SERVICES								
AIDS AND ADAPTATIONS	2,770,000	308,327	75,000	(500,000)	-	2,653,327	1,090,203	41.1%
OTHER ADSS CAPITAL	705,000	160,738	(75,000)	-		790,738	231,298	29.3%
TOTAL ADULT SOCIAL SERVICES	**3,475,000**	**469,065**	**-**	**(500,000)**	**-**	**3,444,065**	**1,321,501**	**38.4%**
HOUSING								
MAJOR WORKS & IMPROVEMENTS	**39,110,000**	**(1,480,820)**	**-**	**384,836**	**-**	**38,014,016**	**18,216,009**	**47.9%**
NEW HOMES	**23,979,000**	**2,460,280**	**-**	**(1,955,081)**	**(6,484,199)**	**18,000,000**	**6,622,929**	**36.8%**
TOTAL HOUSING	**63,089,000**	**979,460**	**-**	**(1,570,245)**	**(6,484,199)**	**56,014,016**	**24,838,938**	**44.3%**
TOTAL HOUSING & ADULT SOCIAL SERVICES	**66,564,000**	**1,448,525**	**-**	**(2,070,245)**	**(6,484,199)**	**59,458,081**	**26,160,439**	**44.0%**
CHILDREN'S SERVICES								
SCHOOLS	**5,486,813**	**1,632,558**	**63,888**	**4,448,358**	**(3,383,000)**	**8,248,617**	**3,951,224**	**47.9%**
EARLY YEARS	**1,290,000**	**188,284**	**-**	**600,000**	**(800,000)**	**1,278,284**	**379,030**	**29.7%**
YOUTH CENTRES	**-**	**143,666**	**-**	**-**	**-**	**143,666**	**130,643**	**90.9%**
CHILDREN'S OTHER	**-**	**80,441**	**(63,888)**	**-**	**-**	**16,553**	**11,007**	
TOTAL CHILDREN'S SERVICES	**6,776,813**	**2,044,949**	**-**	**5,048,358**	**(4,183,000)**	**9,687,120**	**4,471,904**	**46.2%**
ENVIRONMENT & REGENERATION								
PLANNING & DEVELOPMENT								
ARCHWAY DEVELOPMENT	255,000	23,557	-	-	-	278,557	56,240	20.2%
SECTION 106	2,000,000	-	(2,000,000)	-	-	-	2,135	
TRANSPORT PLANNING	40,000	10,000	-	21,400	-	71,400	24,049	33.7%
TOTAL PLANNING AND DEVELOPMENT	**2,295,000**	**33,557**	**(2,000,000)**	**21,400**	**-**	**349,957**	**82,424**	**23.6%**
PUBLIC PROTECTION								
CEMETERIES	-	-	-	19,545	-	19,545	19,545	100.0%
DISABLED FACILITIES	601,000	20,348	378,652	15,601	-	1,015,601	513,376	50.5%
EMPTY PROPERTIES	-	-	258,130	-	-	258,130	13,380	5.2%
LIBRARIES	100,000	2,623	-	(70,201)	-	32,422	7,505	23.1%
PRIVATE SECTOR HOUSING	1,300,000	52,986	(636,783)	-	-	716,203	224,462	31.3%
TOTAL PUBLIC PROTECTION	**2,001,000**	**75,957**	**(1)**	**(35,055)**	**-**	**2,041,901**	**778,268**	**38.1%**
PUBLIC REALM								
BOILER REPLACEMENT PROGRAMME	867,050	163,697	150,000	-	-	1,180,747	791,884	67.1%
COMBINED HEAT AND POWER	900,000	341,989	-	(205,764)	-	1,036,225	25,862	2.5%
FLEET MANAGEMENT	8,000,000	(967,318)	-	-	(1,000,000)	6,032,682	2,646,007	43.9%
GREENSPACE	883,000	274,412	574,038	98,914	(806,731)	1,023,633	320,263	31.3%
HIGHWAYS	1,400,000	362,706	769,264	(9,669)	-	2,522,301	418,650	16.6%
HOME ENERGY EFFICIENCY	-	115,583	-	-	-	115,583	53,389	46.2%
IRONMONGER ROW BATHS	-	434,003	-	-	-	434,003	154,294	35.6%
LEISURE	5,250,000	17,882	1,270,314	1,854,878	(4,327,882)	4,065,192	1,971,944	48.5%
OTHER ENERGY EFFICIENCY	2,500,000	-	(150,000)	-	(2,000,000)	350,000	-	0.0%
TRAFFIC AND ENGINEERING	3,180,000	393,123	(613,615)	2,031,132	-	4,990,640	1,154,441	23.1%
TOTAL PUBLIC REALM	**22,980,050**	**1,136,077**	**2,000,001**	**3,769,491**	**(8,134,613)**	**21,751,006**	**7,536,734**	**34.7%**
TOTAL ENVIRONMENT & REGENERATION	**27,276,050**	**1,245,591**	**-**	**3,755,836**	**(8,134,613)**	**24,142,864**	**8,397,426**	**34.8%**
FINANCE & PROPERTY								
FINANCE	-	96,128	-	-	-	96,128	-	0.0%
ICT	1,500,000	1,578,154	-	-	-	3,078,154	2,390,520	77.7%
TOTAL FINANCE	**1,500,000**	**1,674,282**	**-**	**-**	**-**	**3,174,282**	**2,390,520**	**75.3%**
TOTAL FINANCE AND PROPERTY	**1,500,000**	**1,674,282**	**-**	**-**	**-**	**3,174,282**	**2,390,520**	**75.3%**
CORPORATE								
CORPORATE PROJECTS	-	540,330	-	-	-	540,330	271,667	**50.3%**
TOTAL CORPORATE	**-**	**540,330**	**-**	**-**	**-**	**540,330**	**271,667**	**50.3%**
TOTAL CAPITAL PROGRAMME	**102,116,863**	**6,953,677**	**-**	**6,733,949**	**(18,801,812)**	**97,002,677**	**41,691,956**	**43.0%**

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ISLINGTON

Governance and HR
Town Hall, Upper Street, London N1 2UD

Report of: **Chair of Health and Care Scrutiny Committee**

Meeting of	**Date**	**Ward(s)**
Executive	15 January 2014	All

Delete as appropriate	~~Exempt~~	Non-exempt

SUBJECT: GP APPOINTMENTS SYSTEMS

1. Synopsis

1.1. This report requests that the Executive receive the recommendations in relation to the scrutiny review on "GP Appointment Systems" following completion of the scrutiny.

1.2. The Committee recognises the increased pressures GPs are facing. The review has looked specifically at the demand for GP appointments in Islington which has 37 registered practices some of which are small single-handed practices whilst others have multiple partners, nurses and health care assistants, and very large patient lists. It has also looked at their capacity to meet demand, having regard to the challenges posed locally and wider considerations such as public expectations, the availability of urgent care, the changing interface between acute and primary care, and the move towards integrated care which is being pursued by Whittington Health and others.

1.3. In light of the evidence received the Committee have formulated their key recommendations that they consider will help to improve access for patients and look to alleviate pressure on A&E departments, whilst also supporting GPs to optimise their approach to appointment systems. The Committee are of the view that its recommendations will assist in contributing to the good work that is already going on and hope that their recommendations will assist in improving patient experience in obtaining appointments.

1. Recommendations

1.1. To receive the report of the Health and Care Scrutiny Committee.

2. Background

2.1. The Health and Care Scrutiny Committee agreed the priority topics for scrutiny in November 2012 and agreed to carry out a scrutiny review focusing on GP Appointments Systems with the following objectives –

- To assess how effective urgent and non-urgent appointment systems are and how these vary across the borough.
- To examine GP appointments against current targets and identify any under-performing areas.
- To collect evidence of patient experiences and assess any unmet needs.

2.2. The recommendations in the report support ways in which the evidence gathered by the Committee can help the council with improving GP appointments systems.

2.3. The delay in reporting is due to integrating the committee's findings with a funded exercise carried out by Islington CCG to investigate access to urgent care across the Borough.

3. Implications

3.1. **Financial implications**
The proposals in the review would need to be costed by the Executive, to the limited extent they impact on Council obligations.

3.2. **Legal Implications**
There are no legal implications at this stage.

3.3. **Equalities Impact Assessment**
An Equalities Impact Assessment has not yet been completed because the decision being sought is only to consider the recommendations.

4. Conclusion and reasons for recommendations

4.1. The Committee recognises and commends the valuable service GPs provide and is aware of the extremely significant contribution they make to the health and social care system. The Committee would like to extend particular thanks to those witnesses who took the time to come and give evidence to the Committee.

4.2. The Committee are conscious that the NHS, including GPs, are subject to increasingly tight budgetary restrictions and we recognise that this may impact on services. The Committee are of the view that its recommendations will assist in contributing to the good work that is already going on and hope that their recommendations will assist in improving patient experience in obtaining appointments.

Background papers:

Final Report Clearance

Signed by

……. …….
Councillor Martin Klute Date

Report author: Rachel Stern
Tel: 020 7527 3308
E-mail: rachel.stern@islington.gov.uk

ISLINGTON

GP APPOINTMENTS SYSTEMS

REPORT OF THE HEALTH AND CARE SCRUTINY COMMITTEE

London Borough of Islington
October 2014

Contents

Chair's Foreword

December 2014

This scrutiny was originally initiated as a result of anecdotal evidence put to members that there was considerable difficulty in obtaining appointments at some GP practices (although not all) across the Borough. The issue has since become more-or-less national in scale, being regularly reported in the press, and is closely linked to the issue of rapidly escalating pressure on A&E facilities, with a growing body of anecdotal evidence suggesting that some patients simply by-pass their local GP and instead, present at A&E as an alternative initial point of contact with the Health Service. The Health Scrutiny Committee's (HSC) findings suggest that improvements to the way some GP surgeries manage their appointment systems could help to significantly relieve pressure on A&E departments, as well as positively impacting the key focus of this scrutiny: Improving patient experience in obtaining appointments.

The scope of the scrutiny is actually quite narrow – The effectiveness of GP appointment systems . However, it quickly became apparent in discussions that it had the potential to open up multiple supplementary lines of enquiry about staffing, NHS structures, and many other issues. We have resisted this temptation and stuck to the narrow focus of the terms of the scrutiny, in order to try and reach some meaningful conclusions. Even with this narrow focus, the subject has proved to be significantly complex, hence the slightly lengthy introduction.

Background:
The scrutiny was agreed and initiated in January 2013, and it had been intended to issue a final report and recommendations towards the end of that year. However, in April 2013 the newly formed Islington Clinical Commissioning Group (ICCG) launched a funded initiative originally called 'Improved Access to GPs', which used the services of the Primary Care Foundation (PCF) to pro-actively engage with GP practices across the Borough to establish current methods of working, and whether and how those working methods might be supported and improved. This programme ran from April 2013 to April 2014, and it seemed appropriate to delay issuing the HSC findings and recommendations until the PCF project had completed and reported, since there were highly likely to be areas of common ground between the two investigations. In the event, the PCF presented its findings to the HSC in September 2014, and this resulted in amendments to the HSC recommendations, which now draw on the PCF findings in addition to the committee's earlier conclusions, resulting in what I believe is much clearer and more practically focussed recommendations. Overall, some of the recommendations focus on the detail of the management of appointment systems, whilst other recommendations call for collaboration between all the various stakeholders, reflecting the complexity of the underlying issues.

It should also be noted that the HSC's original recommendations have been shared with and commented on by ICCG, NHS England (London) and the LMC, with the intention being that if we can achieve broad agreement with stakeholders on the Committee's recommendations, or at least agreement to differ, the recommendations will be pertinent and relevant, and have a higher likelihood of support and implementation. Feedback from these stakeholders has been incorporated into the recommendations wherever possible.

Findings of the Scrutiny:
Our early hope was that we could source some statistical evidence that would help demonstrate which practices were more effective at dealing with appointments, what systems they used, and where patients were preferring A&E attendance. However, we found that the available statistics did not suggest any obvious choice of pathway or approach that could be said to provide best outcomes. This is not a fault of the data collection, but a measure of the complexity of the issues of when, where and how patients present themselves. What we have found is that the more subjective and anecdotal evidence of patients, doctors, practice managers, ICCG, and A&E staff offers more revealing insight into the functioning of the system as a whole. In particular, we heard that different practices operate very different types of appointment systems, but equally successfully and effectively, that different

cohorts of patients prefer different approaches to appointments, and that different patients of the same practice sometimes have very different experiences of the effectiveness or otherwise of that particular appointment system. We have therefore concluded that it is more or less impossible to recommend that one specific approach to appointments is in itself more effective than another. The conclusion is rather that a system which offers some combination of alternative ways of accessing appointments, eg, walk-in, telephone, internet, telephone triage, telephone consultations and extended pre-booking, is more likely to offer equality of experience, provided the systems are effectively set up and managed.

A further piece of compelling evidence came from staff at Whittington A&E, who were kind enough to attend the HSC, and who were encouraged by the chair to present to the committee their more subjective views on issues such as whether they see more patients from one practice or another, whether certain profiles of patients are more likely to present than others, and any other impressions they might have of where their patients are coming from and why. It was clear from this presentation that a significant number of patients that present at A&E are best seen by the Urgent Care Centre rather than A&E, and that at least 20% of these could have seen their GP instead. We heard that GPs with an online or 24hr phone appointments system generally seem to deliver less patients to A&E. We heard that some parents take their children straight to A&E, bypassing their GP, because they believe that hospital is the 'safest place'. We heard that the implementation of the 111 service had not significantly increased attendances at A&E, once it had settled down. And most interestingly, we heard that the typical wait to see a doctor at the Whittington Urgent Care Centre (with no appointment) is **1.5 to 2 hours.** This makes a striking contrast with GP surgeries, where a same-day appointment can mean queuing before 8.30am, and waiting for up to 4 hours, sometimes at the surgery, to see a doctor, and where, if an appointment is not available on the day, the wait can often be 2 weeks for a 'bookable' appointment. This contrast in experiences can't help but suggest that there could, or even should, be a challenge to GPs to find ways of managing their appointment systems, to the point where patients no longer consider A&E/Urgent Care as an easier alternative to an appointment with their GP.

Overall, whilst we have learned that it is very difficult to compare the appointment systems of different GP practices because they operate so differently, there is statistical evidence from the PCF that some GP practices continue to be more successful in operating their appointment systems than others. The challenge therefore, is to establish some kind of voluntary benchmarking system, that can achieve a consistent measure across practices of their effectiveness in delivering appointments to patients, without being too prescriptive about how this is achieved. The PCF report has presented a number of useful indicators suggesting how this might be achieved, and the most pertinent of these can be found in the recommendations. We hope that GP practices will find these recommendations relevant and useful, and that they will agree the principle that practices across the Borough ought to be able to achieve broadly similar levels of performance in relation to appointments, whilst maintaining their individual approaches.

GP surgery premises:

One area where the HSC has allowed itself to look beyond the strict remit of the Scrutiny, is in relation to the need to provide additional GP services in response to population growth, and in relation to this, the more challenging issue of procurement of premises from which to operate these additional services. This issue has also found it's way into the National Press since the Scrutiny was commenced.

For some time now, anecdotal evidence has been suggesting that GP surgeries in certain areas of the borough are over-stretched, and it is a matter of fact that in areas such as Bunhill and Clerkenwell – one area where this issue has been raised - a number of high-volume residential developments have been or are currently being completed, with a corresponding increase in population, yet no increase in GP provision has been sought or delivered in response to these developments. What the committee has found, is that under the new Health and Social Care Act implemented in April 2013, there is no established process or structure either to assess projected needs for additional GP provision, or to procure that provision.

The committee put this point to NHS England (London) under the stewardship of Neil Roberts, who responded by quickly establishing a 'short-life group' (SLG) in early 2014 to look specifically at the perceived shortage of GP premises in Clerkenwell. The SLG endorsed the view that there is already undersupply of GP premises in the area and that once the 'City Forum' development on City Road is completed in 2020 there will be significant under-supply. The SLG recommended that the preferred solution to this problem would be to seek new GP premises within the City Forum development as Planning Gain from the scheme. However, the developers were only prepared to offer less than half the space required by the NHS, and the Mayor of London failed to take this requirement into account when he overturned Islington Council's refusal of the scheme. The opportunity to obtain new premises on this site has now been lost, and the NHS is left with the problem of attempting to find alternative space for GP provision that will serve, amongst others, the residents of the development site.

This chain of events highlights what threatens to become a crisis in the provision of GP premises, and hence appointments, if the issue of how the NHS can procure new premises via the Planning System in response to development is not resolved. This is to some extent a National issue which plays against the current Government's preference for deregulation of the Planning system. Our supplementary recommendation 1 does however suggest measures to improve aspects of the local approach as far as is possible.

Conclusion:
The Committee proposes to write to all stakeholders identified in the recommendations to formally present its recommendations, and to request that they be adopted as far as possible. We very much hope that the recommendations will be found to be constructive and useful, and that the main outcome, to improve consistency of patient experience of appointment systems across the Borough, can be achieved by consensus and joint working.

Councillor Martin Klute
Chair: Health and Care Scrutiny Committee
27/12/2014

Executive Summary

GP Appointments Systems Scrutiny Review

Aim

The review was started with the aim of assessing the performance of GP appointment systems and the service provided to residents.

Objectives of the Review

1. To assess how effective urgent and non-urgent appointment systems are and how these vary across the borough.

2. To examine GP appointments against current targets and identify any under-performing areas.

3. To collect evidence of patient experiences and assess any unmet needs.

Evidence

The review ran from November 2012 until September 2014 and evidence was received from a variety of sources including Islington Clinical Commissioning Group, Islington Health Watch, North Central London NHS Trust, GPs, Patients and the Primary Care Foundation.

Following agreement of the Scrutiny Initiative Document (set out in APPENDIX 3); officers designed a work programme for the Committee meetings, visits and documentary evidence.

The submissions are detailed in the minutes of the meetings of the Health Scrutiny Committee on the Council Democracy website (http://democracy.islington.gov.uk/) or from Democratic Services at the Town Hall (Tel: 020 7527 3308).

Key recommendations:

Key recommendations:

1. **Core and extended hours:** That NHS England (London) works with ICCG and local GPs to develop GP surgery opening hours that offer core and extended opening hours (evenings and 7 days per week) that are adequate and appropriate to meet the population's needs across the borough, including access for key population groups, eg working age adults. The extended hours offer should ideally be shared and co-ordinated across the Borough with cover being rotated between practices within the GP clusters.

2. **Performance benchmarking:** That NHSE works with the CCG, LMC and GP practices to agree and establish voluntary performance bench marks across the Borough for provision of appointments. Benchmarking should be based on the research findings of the Primary Care Foundation's (PCF) report 'Access and urgent care in general practice - Islington CCG' (see appendix 1), and should include ongoing monitoring (at intervals) of length of appointments, average number of appointments per patient per annum, % of patients seen by GP compared to other health professionals, length of phone calls taken by receptionists, availability of reception staff at key times, and balance of same day and book-ahead appointments. The PCF's recommendations on the appropriate levels for these benchmarks should be taken as a starting point, with GP practices allowed to deviate from these benchmarks on the basis of justifying any deviation. Benchmarking is proposed in order to reduce variability of accessibility and patient experience in obtaining appointments, which is a quality issue for the service.

3. **Book-ahead appointments:** The window for book-ahead appointments should be extended to six weeks as standard, following the recommendations of the PCF.

4. **Means of making an appointment:** All GP practices should offer a choice of access options for making appointments, including telephone, internet, and face-to-face, in order to achieve equality of access for all patient groups.

5. **Long term conditions (including SEN):** That patient management plans and allocation of a named GP be established for all patients (including children) with long-term conditions. Where patients require regular or repeat appointments, the appointment should be made by the doctor to avoid the patient having to repeatedly re-book under the daily appointment system.

6. **Social support functions:** That GP practices, LBI and the CCG work jointly to establish an alternative approach to providing social support services currently provided by GPs, such as school sick notes and letters in support of housing applications, to enable GPs to concentrate on core medical responsibilities. An example of an alterative approach would be, in the case of school sick notes, school nurses could be trained to assess children's fitness for school, in order to avoid taking up GP appointment slots.

7. **Telephone access:** That NHSE(London) and ICCG work with all GP practices across the borough to ensure training of reception staff, including the use of a script as a basis for taking calls, to ensure staffing levels are appropriate to match demand at peak times, and that GP practices support their reception staff on an ongoing basis. Where telephone triage is used, this should be carried out in accordance with agreed protocols on best practice, to maximise the

possibility that all patients have a positive experience, and to ensure that vulnerable patients are not challenged or distressed by their initial contact with the service.

8. **Practice information:** That GP practices be required to fully publicise information regarding the availability and means of obtaining GP appointments at their practice. This information should be clear, available through all currently recognised channels of communication, and explain when and how appointments can be made, give clear information about Out of Hours Options, and the range of medical services on offer from individual surgeries in addition to basic appointments. The committee also strongly recommends the use by all practices of SMS text reminders for appointments.

9. **Patient feedback:** That NHSE and the CCG should work with local GP practices to establish a basket of patient feedback strategies, including patient user groups and post-appointment surveys to supplement the NHS Choices internet feedback option. Surgeries should assess feedback from all these sources to ensure they capture a balanced view of patient experience. Patient feedback should be monitored regularly.

Additional recommendations:

1. **Procurement of additional GP services and premises:** That a mechanism be established jointly between NHSE, ICCG and LBI Planning department to assess present and future demand for GP services and facilities across the borough, especially in areas where population is increasing due to new developments. The purpose of the process would be to match the need for premises with options to procure those premises via the planning system. The committee recommends establishing a Borough-wide Improvement Plan, similar to Ward Improvement Plans, which identifies areas or locations in the borough where premises are needed, or anticipated to be needed, in order to inform planning officers of the requirement when negotiating planning gain with developers. (The mechanism of the Bunhill Short Life Group established by NHSE in early 2014, see report at appendix 2, could be used across the Borough as a model for the NHS to identify needs to be included in the Improvement Plan).

2. **Practice nurses:** That NHSE and ICCG work with GP practices to improve job security, Terms and Conditions, professional development and work opportunities for Practice Nurses. Measures could include rotating nurses between practices, and between practices and the Out of Hours service, in order to improve training opportunities, work experience, and to add variety and interest in the post. The possibility of establishing a jointly hosted employment scheme between practices should be investigated to assist with the implementation of the rotation scheme. This recommendation arises from evidence heard by the committee of a shortage of practice nurses, resulting in GPs having to carry out the duties of the practice nurse, taking time away from their core work as GPs.

3. **Funding allocation:** That LBI and ICCG work together to lobby the Government to review the funding allocation formula for general practice to ensure funding adequately reflects the increased and complex needs of patients living in deprived areas, as well as the particular challenges facing general practice in London.

4. **Public awareness:** That a public awareness campaign be developed to promote treatment options on the basis of ‘The right care, in the right place, at the right time’, and also to increase awareness of alternative treatment options, such as the minor ailments scheme in pharmacies.

Membership of the Health and Care Scrutiny Committee – 2014/15

Councillors:
Councillor Martin Klute (Chair)
Councillor Raphael Andrews
Councillor Jilani Chowdhury
Councillor Osh Gantly
Councillor Mouna Hamitouche MBE
Councillor Gary Heather
Councillor Jean Roger Kaseki (Vice-Chair)
Councillor Kaya Makarau-Schwartz

Substitutes:
Councillor Alice Donovan
Councillor Nurullah Turan
Councillor Tim Nicholls

Co-opted Member:
Bob Dowd, Islington Healthwatch

Substitutes:
Olav Ernstzen, Islington Healthwatch
Phillip Watson, Islington Healthwatch

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Peter Moore, Rachel Stern, Mary Green, Philippa Murphy – Democratic Services
Lead officer – Alison Blair and Martin Machray, Islington CCG

Scrutiny Initiation Document and Framing of the Review

The Scrutiny Initiation Document (SID) for the review was first considered by the meeting of the Health Scrutiny Committee on 16 October 2012.

At that meeting the Committee resolved that the Chair and LINk member meet with the CCG to discuss how the scrutiny could effectively explore this area and requested any data available on GP performance by practice.

At their meeting on 6 November 2012 the Committee considered an initial presentation from Alison Blair, the Chief Operating Officer of the Clinical Commissioning Group (CCG) and Tony Hoolaghan, associate director of Primary Care at North Central London (NCL).

The Committee noted that the GP contract did not include a limit on list numbers and that the data on GP appointments for June showed significant variation from practice to practice and this should be reduced to ensure a positive experience for all patients. GPs could not turn away patients and data could be gathered from formal complaints and PALS on performance.

Members reported that phone consultations with GPs were helpful but services again varied from practice to practice. There were various myths about what GPs were required to do and how they were funded. It would be helpful if a factsheet was available detailing what recourse there was from GPs to commissioners and what happened if they were failing.

A number of initial points of interest were raised at this stage as follows -

- The myhealthlondon website was very helpful and included data about practice performance. It was seen as a useful resource and was likely to be rolled out nationally.
- Members requested a breakdown of GP practices detailing which were group practices and which were single handed and what services were provided from each site.
- The introduction of the 111 service would mean a more locally delivered service. There would be national publicity and Islington would start operating their service from April.
- There was an ongoing issue with GP time being taken up with patients needing referral letters for housing and benefits service. This was likely to increase with the new benefit changes.

Evidence from Islington LINk

In December 2012 the Committee called the Islington LINk to give evidence to the Committee. They were represented at that meeting by Gerry McMullen who outlined the work of the LINk with patients and the conclusions drawn from that research.

The LINk had conducted their research into this area in 2010 but there were still relevant themes that could be drawn out.

The report on the exercise presented a summary of key findings -

The LINk team interviewed 119 patients in the six practices visited in August 2010. Although there was a target to obtain twenty interviews at each practice and despite making more than one visit, it was not possible to reach this target at the smaller practices. The data obtained present a snapshot view of service users and their opinions. However, some common themes emerged from the interviews:

- *Making appointments by telephone or in person at the practice were identified as the two most common ways by which patients make an appointment.*
- *Only two of the practices visited had an online facility for patients to make an appointment and, even where that facility was available, it was only rarely used by those the LINk interviewed. Further information suggested that there may be low awareness of the online facility and/or accessing it to make an appointment may be complicated.*
- *The responses suggest that appointment systems need to offer flexibility, both in the method by which appointments are booked (phone, in person, online) and in the time of the appointments.*

One practice, Practice A, which offered all available methods of booking, monitored the appointments close enough to alter the pre-booked and walk-in appointments. This close monitoring and flexibility contributed to meeting the patients' needs.

The interviews, especially at one smaller practice, identified that the availability of appointments on a same day/walk-in basis is highly regarded by the patients at that practice.

From those the LINk interviewed at all the practices, most described the appointment systems in place as 'very easy' or 'easy' and rated them as 'good' or 'very good'. Only small numbers of those interviewed thought the appointment systems were 'difficult' and rated then as 'poor'. Negative responses were not recorded for all the practices visited but were more common in the interviews that we conducted at the medium-sized practices.

To reduce the rate of 'no shows' at booked appointments, one of the larger practices sent reminders as SMS text messages and this was welcomed by patients.

Some responses showed that some patients did not understand how the appointments system worked, for example that they could phone the practice later in the day to see if appointments had opened up. Or that, sometimes reception staff need to triage patients and so have to ask questions about their condition.

The Link had prepared key recommendations in the response to their research -

1. *Appointment systems should be flexible and closely monitored. Seasonal adjustments as well as daily adjustments (reflecting weather conditions or World Cup matches, for example) should be adapted to meet demand.*

2. *Extended hours should be offered when possible as these were valued by patients where finances permit.*

3. *Practices should produce clear, Plain English leaflets on how appointments can be made and the considerations of urgency. These should be available in a range of formats.*

4. *Patients should be made aware that if they request a specific GP an appointment on that day may not be available and should consider seeing another GP or waiting a bit longer for an advance booking.*

5. *Patients should be made aware that if they have more than one issue to discuss with a GP or need an interpreter, then they should try to book a double appointment.*

6. *Online appointment booking and online prescription ordering should be made easily accessible on websites, and its availability promoted to patients[1].*

The Committee noted that IPSOS MORI conducted research into this area and the new data would be available shortly. The new IPSOS Mori poll had changed its methodology from the previous poll so they could not be compared like for like. The poll data could be looked at and analysed to see if any relevant trends could be identified.

Access to GPs was regularly raised as an issue by patients and all GP practices should produce a practice leaflet detailing services but some practices' leaflets were not clear or were out of date. The variation in quality of GPs websites with some allowing online booking and some not was highlighted. All practices were upgrading to the EMIS system which should allow for improvements and practice managers were key to the services offered. All GPs should also have patient reference groups to gather views.

Timings for walk in appointments could also be misleading, for example at Bart's their clinic hours were stated as 8am-2pm but the last patient to be accepted would be at 12:45pm. For patients to make an informed choice they needed to have all the information about what services were available to them and the inconsistency of information was a major issue highlighted in the survey. It would be helpful to have a list of parameters for the services GPs were required to provide. Information should be sought on what was in the GP contracts and what financial incentives they would gain to provide additional services.

Evidence from NHS North Central London

At their meeting on 25 March 2013, the Chair welcomed Dr Henrietta Hughes, Acting Medical Director, NHS North Central London to the meeting to present her evidence. Dr Hughes explained her position in the new structures as Medical Director designate for the North East area of London where she would have responsibility for commissioning GPs after 1 April 2013.

Dr Hughes outlined the process of annual contract review. Each GP practice would complete a detailed document for submission to the contracts team, part of which would specify the clinic times offered to patients. The BMA recommended 4.6 appointments per patient per annum as a guide. Where it appeared that a practice had fallen below this guideline figure it would be asked to draw up an action plan which might propose an increase in the number of appointments per GP, the appointment of more GPs, or additional nursing time, or a combination of all of these inputs to ensure that more appointments were offered to patients.

Other options open to GP practices included the booking and cancellation of appointments on-line and text reminders to patients,

In the current system each PCT cluster had a complaints department. Under the new NHS structures complaints would be part of the responsibility of primary care development at Clinical Commissioning Group level.

In London patients could also use the My Health London website[2] to give feedback to their GPs.

[1] Extract taken from Islington LINk Enter and View Report: GP Services: Patient Experiences of Appointment Systems at Medical Centres in Islington

[2] www.myhealth.london.nhs.uk/

It appeared that there was evidence to suggest a large degree of inconsistency between GP practices. Also, it may be that some patients present at A&E instead of making an appointment with their GP. In the next stage of the review it would be useful to the Committee to have access to statistics from the acute hospitals showing which patients, and how many, presented at A&E and from which surgeries whether across the borough or from outside its boundaries.

The following points were made by Dr Hughes in response to questions from members of the Committee:

- There are a number of different approaches amongst GP practices, dictated in part by the size of the practice, the patient population, the range of options available for booking appointments e.g. online booking, book ahead, book on the day or the day before. The Committee might wish to look at demand trends and the flexible approaches to access the service.

- GP practices have different ways of handling appointments and dealing with emergencies. Some for example employed a telephone triage system; others might still rely on a telephone queuing system at the start of the working day. There were intelligent ways of planning demand: for example a practice could ask patient groups and vary the mix. This sort of approach would often be well received. The choice lay between book ahead and managing demand on the day.

- Telephone triage was a good way of managing demand on the day. To work effectively GPs needed to be at the front end of a telephone triage system. This could be very effective but depended on good telephone consultation skills and good safety netting. The criteria for a good triage system were good listening skills, and the ability to ask the right questions. Medicine was an art: it would always involve a judgement as it was partly about knowing when something was not right.

- A telephone triage system for managing ‘on the day’ appointments seemed to have much to commend it and the Committee would give further thought to including it as one of its recommendations.

- All patients should be able to register with their GP practice and all should have a standard experience. Patients’ lists were reviewed at regular (2/3 yearly) intervals. This was important as funding was geared to patient numbers and inactive ’ghost’ patients can misrepresent the size of the workload.

- Instant messaging was being trialled and there were experiments also involving tele-medicine, telecare and skype.

Evidence from GPs and GP representatives

At their meeting on 23 April 2014 the Committee heard evidence from Dr Robbie Bunt, Islington GP, Chair Islington LMC, Dr Katie Coleman, Islington GP, Joint Clinical Vice-Chair, Islington CCG, Dr Jo Sauvage, Islington GP, Joint Clinical Vice-Chair, Islington CCG, Dr Julie Sharman, LMC Secretary, Londonwide LMCs together with Alison Blair, Chief Officer, Islington CCG and Avni Shah, Head of Commissioning, Islington CCG.

In his introduction, Dr Robbie Bunt referred to the role of local medical committees as the statutory professional organisation elected by GPs to represent all NHS GPs and practice teams. In Islington

there were 37 practices, some of which were small single-handed practices whilst others had multiple partners, nurses and care assistants, and very large patient lists. GP practices were independent businesses.

London and Islington faced very real challenges: for many practices lists turned over by 30% a year and taking on new patients created a huge additional workload. There was also huge diversity in the local population: 42% of local people were born outside the UK; 20% did not speak English as a first language; and the borough had amongst the highest child poverty rates in the country. Islington was the 5th most deprived London borough and the 14th most deprived borough in England. This was surprising, given the high house prices in parts of the borough but many patients suffered from severe mental health problems, psychosis, and drug and alcohol-related conditions.

Dr Katie Coleman was a GP at the City Road Medical Centre which 14 years ago had taken over a depleted list comprising 2,800 patients, many of them elderly, which had since increased year on year to around 7,000. A 30% churn was typical and might involve registering 50 new patients in a week which understandably had a disruptive effect on the practice. Bunhill and Clerkenwell were amongst the most densely populated wards in the borough and a large number of patients had severe mental health issues and extreme levels of depression and anxiety. These issues could not easily be dealt with in 10 minute consultations.

The practice was juggling priorities. It was doing its best to manage demand, provide high quality services, and help patients to see their GP on demand. As an alternative approach it was piloting a new service called 'Dr First', the aim of which was to significantly improve patient access to GPs, and at the same time, reduce the demand on GPs, A&E and Walk-in clinics. Under 'Dr First', phone lines would be opened at 8.45am on weekdays, and patients would be called back by a senior doctor and a decision taken in each case either to invite the patient to come in to the surgery for a consultation, to book an appointment in advance, or to be dealt with there and then on the telephone. Out of 74 calls, ten patients needed to be seen by a doctor on the day, eight chose to make an advance booking and the rest were dealt with on the phone.

The pilot would run for a year and then be evaluated but the early signs were that this system was helping the practice to manage demand more effectively.

Dr Jo Sauvage confirmed this view and stressed that, as some patients were concerned about being dealt with over the phone, triage was always dealt with by a senior clinician who was able to apply clinical criteria and make a judgement in each case either to see the patient or deal with him or her over the phone. Invariably, lower thresholds would be applied for children, for the elderly and for those who did not speak English as a first language.

In response to the evidence the Committee raised various points:

Capacity was a concern. The perception locally was that patients were generally dissatisfied with the arrangements for accessing their GP. The impression was that the service was not as accessible as it should be and that people in work in particular found it difficult to make an appointment. It was this that had prompted the Committee to carry out a review with clear but tightly focused objectives. The intention was to make some best practice recommendations which added value and which made sense in practice. This was partly why the Committee had asked Dr Henrietta Hughes, as the Medical Director with responsibility for commissioning GPs in this part of London, to comment on the draft recommendations in due course. Against that background the Chair asked the following questions:

a) *To what extent was capacity an issue particularly in the south of the Borough?*

b) *Where does responsibility lie within the new NHS structures for strategic decisions such as when and where to provide a new health centre or practice as part of a new housing scheme?*

c) *Some practices operate 'walk-in', same day appointments but does this deter some patients who are not prepared to wait for an unscheduled appointment?*

d) *Who should make decisions on triaging patients, in the 'Dr First' pilot it's a senior doctor but for some out-of-hours consultations this would be done by an administrator?*

In response to the Chair's questions it was stated that senior clinicians should triage calls under 'Dr First' and it was very important that the same doctor saw those patients who came in for a face-to-face consultation as a result. As far as possible, the process from the call onwards must be managed from end-to-end by a senior clinician.

NHS England was the contractor for new GP services although Clinical Commissioning Groups also had responsibility for improving the quality of primary care and access.

Core hours in the GPs contract were from 8.30am to 6.30pm subject to variation by local agreement. In Islington 27 out of the 37 GP practices operated an enhanced service i.e. provided a service outside of the core contracted hours. As an example the City Road Medical Centre provided an extended hours service from 6.30pm to 8pm on two evenings each week. Although this was intended to help people in work, access at these times was not in any way restricted.

GP practices operated as individual businesses and developed services in line with patients' needs. There was no 'one size fits all' solution and the 'Dr First' pilot was one of a number of different approaches. Capacity was a major issue. Many patients had long-term conditions such as respiratory problems, heart disease and diabetes, all of which used to be dealt with in hospital. If they were to respond effectively and manage the increased demand, both volume and complexity of cases, GPs practices needed long-term continuity and certainty of funding for their business plans.

It was essential that patients understood that they had a responsibility to look after themselves. GP practices were struggling to manage demand, due partly to the size of the lists and partly to the complex nature of the conditions of some patients particularly those with significant mental health problems.

This situation was not helped by the numbers of patients presenting with minor ailments which might just as easily be dealt with by a visit to the local pharmacy, and by patients who made appointments simply to ask their doctor for a letter to assist them with a housing application, or those sent by a local school to get a doctor's sick note for their child when the proper course might have been for the parent to look after the child at home. The BMA had issued guidelines for the number of appointments per patient per annum which meant practices were under pressure to meet these targets.

The increasing complexity of patients' needs had created opportunities for cross-working. Every practice had a link person. There were links with councillors as well.

'Dr First 'was work in progress. It was being piloted alongside other different approaches which would be evaluated in 12 month's time including the impact on other surgeries in the vicinity. The practices involved were working closely with the Clinical Commissioning Group. Patients' surveys would also be

carried out. All GPs practices should have patient participation groups and wider groups to collect patient feedback.

The witnesses referenced the Islington LINk's research project in October 2010 'Patient Experiences of Appointment Systems at Medical Centres in Islington' which amongst other things had recommended that appointment systems should be flexible and also that practices should produce clear leaflets explaining how appointments could be made and what to do in cases of urgency. This was a contractual commitment.

In light of the evidence received the Committee resolved that they should review the final recommendations of the report with LMC, CSU and CCG prior to publication of the report.

Evidence from Patients

At their meeting on 23 May 2013 the Chair welcomed three patients to the meeting, Kay Dixon, Michael Rowlands and Rose McDonald, each of whom in turn gave their views in response to the following questions put by the Chair:

The appointments process

1. *How do you usually make an appointment with your GP e.g. by telephone, in person, on-line? Is it same day booking, advance booking, walk-in clinic etc.?*

2. *How is the booking of emergency appointments handled?*

3. *How satisfied are you with getting an appointment, the opening hours of your practice, and getting through on the telephone?*

4. *Are the arrangements clearly stated and clearly understood? (The practice must publish how patients can access a GP.)*

5. *Do you have to take time off work to attend a GP appointment? Does your GP practice offer extended hours e.g. before 8am, after 6.30pm, weekend opening*

Seeing the GP you want to see

6. *How satisfied are you that you can see your preferred doctor most or all of the time?*

Areas for improvement

7. *How could the appointments system be made easier for you/what improvements would you like to see?*

Responses from Patient 1 –

1. *By telephone for same day and advanced bookings. Ring on the day at 8am. It was also possible to book afternoon appoints by telephone during the lunchtime period before 1.30pm.*

2. *She was fortunate in that she had always been able to get a same day appointment.*

3. *The arrangements were clearly stated on the practice's website. Opening hours may differ from day to day.*

4. *This patient had retired. Extended hours were offered with two early morning consultations starting at 8.00am and two in the evenings at 6.30pm/7.00pm.*

5. *The patient was able to see her preferred doctor most of the time. (The practice normally had six GPs).*

6. *In her experience the appointments system worked fairly well. Appointments could be made via the website for the longer term but not for same day appointments. Some patients would prefer to make appointments on line.*

The following points were made in response to questions from other members of the Committee:

- The best advice was always to phone early before 8.am for a same day appointment.
- The patient would always prefer an appointment with her own GP: for reasons of continuity of care and also to build up a relationship between patient and doctor.
- Advance bookings were usually offered two weeks ahead.
- The practice tended to offer an appointment on the next available timeslot rather than offering a choice of time.

Responses from Patient 2 –

1. *By telephone or sometimes she would attend in person and queue for a same day appointment because it was so difficult to make an appointment otherwise. In her experience she was more likely to get an appointment by queuing. There was no walk-in clinic. She did sometimes make advance bookings: these were often 4/5 weeks in advance. Her GP was only in half a day a week and she needed to see this particular doctor as part of her post-surgery care.*

   An example was given of an instance where she had phoned at 1.40pm for an afternoon appointment and by the time her call was answered all of the appointments had gone and so she had attended in person at 1.15pm on the next day and queued for an appointment.

2. *Not satisfied. She would let the telephone ring for 5 minutes but often in her experience all of the appointments have gone – and so she prefers to queue in person. The surgery opened at 8am and closed at 7pm. Emergency appointments were available on Fridays for patients who chose to walk in and wait. The practice was not open at weekends.*

3. *She had found out about the arrangements by default, nothing was displayed on the notice board. The surgery was working with Harmoni. The patient outlined the circumstances which had led to her making a complaint against the practice.*

4. *As a carer, she preferred appointments during the daytime although occasional evening appointments would also help. She would prefer appointments at weekends or later in the evening. (7.30pm/8pm)*

5. *See 1. above.*

6. *The system would be easier if patients phoning early in the morning were offered afternoon appointments once all of the morning appointments had gone. She gave an example of an instance when the walk-in centre had not been prepared to see her because it was 10am. She felt that she was knocked back on a regular basis at a very busy surgery.*

The following points were made in response to questions from other members of the Committee:

- Patients were only allowed to present with one issue per appointment but what happens if they have related symptoms? There isn't enough time and while double appointments may be available in her experience there were never two vacant slots together.
- The practice had about five GPs, one or two of whom were new doctors.

Responses from Patient 3 –

1. *By telephone or advance booking. If a same day appointment were required he would have to phone and book an appointment with a GP who would call him back. The return call was made by a doctor mostly although on one occasion a receptionist had made the call.*
   This system was called 'Dr First'. He was extremely perturbed about how the system works. On one occasion, when suffering from a heart condition, he had walked in and ended up being taken to the Whittington by ambulance. Last year he had been told he couldn't be seen by walking in but if he had had a mobile phone he could have stepped outside and called for an appointment. Advanced appointments were usually made three weeks ahead if the patient wanted to see a specific GP and two weeks for any GP in the practice.

He believed that patients had a basic right to see a GP if they were not feeling well. He should not be put in a position of having to explain himself – of having to give a clinical justification to a doctor (or receptionist).

Under 'Dr First', a GP would call back within an hour and usually give him an appointment at a specified time. The elderly, infirm or confused, or those with language problems, might be put off. The system tended to favour those who were middle class, educated, self-confident and articulate, and relied on patients being able to give a clinical justification.

The practice had six GPs.

2. *Getting through on the phone was not difficult in his experience.*

3. *He had no idea what the opening hours were and did not recall seeing them on display at the surgery.*

4. *The patient was retired. He didn't know whether extended opening hours were available.*

5. *He didn't have a preferred GP - ten years ago he did, but not any longer.*

6. *He questioned the value of the triage system (Dr First). In his opinion this system doesn't work for the reasons given in answer to Question 1. above. It may be good for doctors and for reducing queues but now the practice was empty. He believed that patients who felt unwell should be allowed to go into their surgery and sit and wait to be seen by a doctor. This was an important part of their social wellbeing.*

The following points were made in response to questions from other members of the Committee:

- Six weeks ago the patient had gone direct to A&E after waiting for a letter from his GP and UCL had encouraged him to contact them directly and make appointments with them rather than through his GP.
- It may not be widely known that patients with long-term conditions may be able to make double appointments.
- The appointment system no longer works on the basis of a personalised doctor/patient relationship. The patient must take what is offered and can by-pass his GP if he has a serious condition. 'Dr First' had de-personalised the doctor/patient relationship.

The Chair thanked the patients for volunteering to answer questions from members of the Committee and for giving their own personal experience and stressed that the anecdotal evidence which the Committee had heard during the meeting had been very helpful in raising some issues that might usefully be followed up in the scrutiny review.

Evidence from Acute Hospital Trust

At the meeting of the Committee on 3 September 2013 evidence was heard from representatives of Whittington Health. By way of introduction the Chair explained that the Committee was trying to understand why A&E services were so overloaded at the present time and whether attendances at A&E varied from one GP practice to another. It was also trying to understand the underlying trends e.g. the numbers of patients who attend A&E from particular GP practices – whether there were there certain types of patient that present more frequently than others i.e. with particular types of complaints, and whether there were there any discernible trends related to particular practices.

Carol Gillen, Director of Operations, Integrated Care and Acute Medicine, Whittington Health and Humayun Mian, ED Operations Manager attended the meeting.

To give an impression of the size and scale of the Emergency Department's work:

- 90,000 patients per annum
- Mean daily arrivals 260 – (has been as high as 335 in recent weeks)
- 22% Paediatrics

- 2% Trauma & Resuscitation
- 46% Minor injuries / Primary Care
- 30% medical / surgical

An overview was given of the pathways for patients arriving by ambulance as well as for those who walk-in. A key feature was the urgent care centre, an integrated part of the Emergency Department which opened in April 2010. Open daily from 08:00am – 22:00pm, 7 days per week, 365 days per year, it was staffed with Emergency Nurse Practitioners & General Practitioners working as part of local GP Consortium, 'WISH.'

A breakdown was given of patients discharged from the urgent care centre and this showed that in July 2013 the vast majority of patients (numbering more than 2,000) were seen by a nurse practitioner or a GP at the centre. Most of the other patients were seen by doctors on a training programme.

An overview of departures (from the urgent care centre) showed that the vast majority (around 1,600) were discharged to their GP to follow up and over 900 'well' patients were discharged with no follow up required.

There were a number of reasons why some patients appeared to prefer the urgent care centre to their own GP, most of them related to access:

- Access: Lack of GP appointments on an evening – both actual and perceived
- Access: there seems to be a lack of available services at GP practices e.g. clinic for dressings
- Access: Unable to contact GP surgeries (or cannot book an appointment)
- Patient Choice: Convenience (attendance times were limited whereas the Emergency Department was open 24 hours a day.)
- Patient Choice: Perception of the Emergency Department being the safest place to be treated especially in the case of parents.
- A GP was based in the Emergency Department.

Recent trends showed:

- Higher number of attendances on an evening.
- Increased attendances on a weekend
- Introduction of 111 service i.e. this was a factor during the original roll out but no longer.
- High number of attendances upon initial launch (Majors and Urgent Care Centre).
- Referrals & Activity.

The statistics showed an increase of referrals during the months of April –July 2013 from both the 111 Service and Out-of Hours. A key factor however was that the Emergency Department had experienced a disproportionate increase in the numbers of patients presenting with minor complaints. One of the more significant factors that may account for this was the capacity of GP surgeries to cope with demand.

Variance by GP practice was usually dependent upon:

- Proximity to Emergency Department – if it was very local, patients may be making a choice
- Availability of appointments (emergency or at short notice)
- Accessibly of appointments (systems make a difference)

- Appointment booking facility – Some practices use automated service
- Services available at GP practice
- Demographic details of patient group

A number of points were raised in the discussion that followed. It appeared that 46% of attendances at the Emergency Department related to minor injuries although it was stressed that any cases where patients needed an X-Ray of any other form of diagnostic could only be dealt with in a hospital setting. Nevertheless, this posed a huge pressure on the Emergency Department.

In reply to questions from the Chair and other Members of the Committee, Mr Mian confirmed that information was collected on the reasons why patients presented at the Emergency Department and this could be made available on request. It could also be analysed by post code and presented by area or by GP practice. Repeat users of the service were also tracked. Records were kept of any patients who re-attended within seven days and 14 days.

Carol Gillen explained that the Whittington was already feeding back to GP practices where the evidence appeared to support local clinics being held to help patients manage particular conditions. In that sense the hospital's information was shared with other clinicians in the community. The hospital met primary care service providers, adult services and other partners on a regular basis to identify patients who may be presenting regularly at the Emergency Department in order to help them manage their condition. A lot of work was being done to help patients with long-term conditions. Many of these had alcohol-related problems and where appropriate patients would be referred to the drug and alcohol liaison team or other community-based services. She added that district nurses and social workers were also doing a lot of good work in the community.

Progress of the Review

At the same meeting Alison Blair, Chief Officer of Islington Clinical Commissioning Group was invited to respond to the presentation from the Whittington, and explained that Islington and Camden CCGs had commissioned a one day audit/data collection exercise on Monday 9 September 2013 focusing on urgent care services at the Whittington, the Royal Free and UCLH together with walk-in centres and out of hours services. The aim was to identify the reasons why patients were presenting at A&E and how many of them had phoned in to their doctor's surgery on the day and were attending at A&E because they couldn't get an appointment. Any data that clarified this point would make an important contribution to the Committee's review. It was confirmed that the data analysis would be shared with the Committee.

Nationally, it was thought that around 20% of the patients who attended A&E should have gone to see their GP instead. Feedback from the one day audit would add to the body of knowledge locally. There was then a question of how this message should be communicated to the public and what more could be done to achieve a better outcome.

The Committee discussed the draft report with Alison Blair. She stressed that each GP practice worked differently, many of them had different appointments systems and some of these worked better than others. Different approaches offered patients choice and should be encouraged. It was suggested that the Committee could consider a recommendation which encouraged GP practices to offer to meet different demands from patients in different ways rather than offering one standard approach. Perhaps practices should employ a hybridised approach to appointments. It was questioned whether patients

knew what was available even though each practice was required to produce a leaflet and publicise their surgery arrangements on their websites.

Draft recommendations were discussed. Many of them related to procedural matters even though Islington faced considerable demographic challenges. The Chair emphasized that the Committee had agreed at the outset to a tight focus on appointments systems but the report could still identify further areas for investigation. One of the key areas was the challenge to primary care services posed by demographic change. Another was demand and capacity and the implications for primary care in the borough: this included aspects of demand which were development-related (particularly in the south of the borough) and also to the treatment of patients with long-term conditions. NHS England had strategic responsibility for providing additional GP practices to meet new and changing needs and for bringing interested parties together when necessary to discuss problems and devise solutions. With that in mind the Chair proposed that a meeting should be convened with a representative of NHS England together with Alison Blair and Julie Billett, Joint Director of Public Health to discuss issues arising from changing demand in the south of the borough.

Consideration of Draft Recommendations

At their meeting on 18 November 2013 the Committee considered an interim report from the Chair and draft recommendations:

Chair's Interim Report

This scrutiny was initiated as a result of anecdotal evidence put to members that there was considerable difficulty in obtaining appointments at some GP practices across the Borough. This scrutiny also takes place against the background of unparalleled and increasing pressure on hospital A&E departments, and with a secondary element of anecdotal evidence suggesting that some patients simply by-pass their local GP and instead, present at A&E as an alternative initial point of contact with the Health Service.

The scrutiny was agreed and initiated in January 2013, and it had been intended to issue a final report and recommendations towards the end of this year. However, in April 2013 the newly formed Islington Clinical Commissioning Group (ICCG) launched a funded initiative called 'Improved Access to GPs', which is investigating various improvements which could well interact with the objectives of this scrutiny. It therefore seemed best, in order not to lose the momentum gained from the scrutiny to date, to issue an interim set of recommendations from the committee to reflect our findings to date, covered by a brief commentary (this note) on progress. And for the committee to revisit its recommendations and link them wherever possible with the ICCG outcomes once the 'Improved Access' initiative is completed. It should also be noted that these recommendations have been shared with and commented on by ICCG, NHS England (London) and the LMC, with the intention being that if we can achieve broad agreement with stakeholders on the recommendations, or at least agreement to differ, the recommendations will be pertinent and relevant, and have a higher likelihood of implementation.

The scope of the scrutiny is actually quite narrow – The effectiveness of GP appointment systems. However, it has the potential to open up all sorts of supplementary lines of enquiry about staffing, NHS structures, and many other issues. We have resisted this temptation and stuck to the narrow focus of the terms of the scrutiny, in order to try and reach some meaningful conclusions.

Our early hope was that we could source some statistical evidence that would help demonstrate which practices were more effective at dealing with appointments, and where patients were preferring A&E

attendance. However, we found that the available statistics were too generalised to offer any dependable conclusions. This is not a fault of the data collection, but a measure of the complexity of the issue of when, where and how patients present themselves. What we have found is that subjective and anecdotal evidence of patients, doctors, practice managers, ICCG, and A&E staff offers far more revealing insight into the functioning of the system as a whole. In particular, we heard that different practices operate very different types of appointment systems, but equally successfully and effectively, that different cohorts of patients prefer different approaches to appointments, and that different patients of the same practice sometimes have very different experiences of the effectiveness or otherwise of the appointment system. It is therefore more or less impossible to recommend that one approach to appointments is more effective than another.

To my mind, the most fascinating evidence came from staff at Whittington A&E, who were briefed to present to the committee their (where necessary) subjective views on whether they see more patients from one practice or another, whether certain profiles of patients are more likely to present than others, and any other impressions they might have of where their patients are coming from and why. It was clear from this presentation that a significant number of patients that present at A&E are best seen by the Urgent Care Centre, and that at least 20% of these could have seen their GP instead. We heard that GPs with an online or 24hr phone appointments system generally seem to deliver fewer patients to A&E.

We heard that some parents take their children straight to A&E because they believe that hospital is the 'safest place'.

We heard that the implementation of the 111 service had not significantly increased attendances at A&E, once it had settled down. And most interestingly, we heard that the typical wait to see a doctor at the Urgent Care Centre (with no appointment) is 1.5 to 2 hours. This makes a striking contrast with GP surgeries, where a same-day appointment can mean waiting for up to 4 hours, sometimes at the surgery, to see a doctor, and where, if an appointment is not available on the day, the wait can often be 2 weeks for a 'bookable' appointment. This contrast in experiences can't help but suggest that there could, or even should, be a challenge to GPs to find ways of managing their appointment systems, to the point where patients no longer consider Urgent Care Centres as an easier alternative to an appointment with their GP.

Overall, whilst we have learned that it is very difficult to compare the appointment systems of different GP practices because they operate so differently, there remains anecdotal evidence that some GP practices continue to be more successful in operating their appointment systems than others. The challenge therefore, is to establish some kind of benchmarking system, that can achieve a consistent measure across practices of their effectiveness in delivering appointments to patients. It would be fair to say that the committee does not at the moment have a clear idea how this can be achieved, but we hope to achieve a consensus that this would be relevant and useful, and to secure agreement with GP practices across the Borough that they ought to be able to achieve broadly similar levels of performance in relation to appointments, whilst maintaining their individual approaches, and to find a consensual way of measuring this.

The one area where the Committee has allowed itself beyond the strict remit of the Scrutiny is the question of overall provision of GP surgeries. Again, anecdotal evidence suggests that GP surgeries in certain areas of the borough are currently over-stretched, and it is a matter of fact that in areas such as Bunhill and Clerkenwell, a number of high-volume residential developments have been or are currently being completed, with a corresponding increase in population, yet no increase in GP provision has

been initiated in response to these increases. What the committee has found, is that since the NHS reforms were introduced in April 2013, there is no established process or structure to both assess the need for additional GP provision, or to procure that provision. The Committee is very keen to help broker the establishment of such a process, and supplementary recommendation 1 attempts to capture this.

I am of the view that further constructive discussion is needed on both establishing workable benchmarking for the delivery of appointments, and also the establishment of a process to procure new GP provision. I am hopeful that the 'Improved Access' initiative will inform the former, and that ongoing discussions and meetings will help establish the latter. In the mean time, the draft recommendations are a summary of the committee's findings to date.

Cllr Martin Klute – Chair

Draft recommendations –

1. *Core and extended hours: That Islington CCG, working with NHS England, ensure that the availability of core and extended hours in Islington general practice is adequate and appropriate to meet patient's needs.*

2. *Performance benchmarking: That performance bench marks for GP appointments be established across the borough, in order that voluntary performance targets can be agreed with all Practices. (This recommendation seeks to drive up performance standards, where necessary, by the mechanism of peer pressure rather than a contractual approach, and to achieve a greater consistency of performance without challenging differing management approaches to appointments between individual practices.) The Committee note that NHS England are at present developing methods of benchmarking, and that following publication of proposals the Committee will review this again.*

3. *Patient feedback: That the committee, working with the CCG, review current approaches to patient feedback, in order to establish consensus on best (and most effective) practice, and drawing on the lead from acute hospitals in securing feedback on an individual appointments basis. The feedback to be used to inform under recommendations 1 and 2.*

4. *Long term conditions: That alternative appointment systems be established for patients with long term conditions that require regular appointments, in order to avoid the requirement to repeatedly re-book under the daily appointment system.*

5. *Social support functions: That GP practices, the Council and the CCG work jointly to establish an alternative approach to providing social support services currently provided by GPs, such as school sick notes and letters in support of housing applications, to enable GPs to concentrate on core medical responsibilities.*

6. *Practice information: That GP practices be required to fully publicise information regarding the availability and means of obtaining GP appointments at their practice. This information should be clear, available through all currently recognised channels of communication, and explain when and how appointments can be made, give clear information about Out of Hours Options, and the range of medical services on offer from the surgery in addition to basic appointments. The committee also strongly recommends the use by all practices of SMS text reminders for appointments to reduce*

DNAs.

7. *Telephone triage: That where telephone triage is used, this should be carried out in accordance with agreed protocols on best practice, to ensure that all patients have a positive experience, and that vulnerable patients are not challenged or distressed by their initial contact with the service.*

8. *Public awareness: That a public awareness campaign be developed to promote treatment options on the basis of 'The right care, in the right place, at the right time', and also to increase awareness of alternative treatment options, such as the minor ailments scheme in pharmacies.*

The Chair stated that given the trials currently being carried out supported by the Primary Care Foundation, were still ongoing that the Committee should only present interim recommendations at this stage and further recommendations and a final report should await the outcome of these trials. The Chair added that Martin Machray, the Director for Integrated Care and Governance at Islington CCG had written to him with details and he would arrange for this to be circulated to Members of the Committee.

The Chair also added that he was meeting Islington CCG and Neil Roberts of NHS England to discuss how best it could be planned to ensure that premises were procured in appropriate areas to meet the needs of the community in the borough given the changing demographic needs.

Martin Machray stated that he would try to submit the initial findings of the trials to Committee, including data sources, prior to April, so that their recommendations could inform the contract process. It was therefore resolved that the interim report and recommendations be noted and that further more detailed recommendations would be formulated once the results of the trials referred to above are known.

Healthwatch GP Mystery Shopping Exercise

Whilst waiting for the results of the trials the Committee heard evidence at their meeting on 25 February 2014 on the GP Mystery Shopping exercise Islington Healthwatch had carried out.

Bob Dowd introduced the findings of Healthwatch's mystery shopping exercise to investigate how GP practices in the borough responded to enquiries about complaints and what complaint information they displayed for patients.

The mystery shopping found that whilst a third of practices had leaflets that were easy to find, just under a third displayed no information about complaints at all. Some practices, but not all, had posters and some of these were out of date. The detailed findings are in section 3 of the report, but the main finding was that, as with GP appointment systems, there is no consistency across the borough, with surgeries apparently working in isolation and widely differing standards between them. There was no apparent explanation for this; the practices which scored well or badly did not appear to have any common characteristics. Bob Dowd noted that unlike appointments systems, there was a complaints procedure that all the surgeries should be following. Healthwatch had made a number of recommendations in the report. Alison Blair invited Bob Dowd to attend a forthcoming Practice Manager Forum to discuss these. Bob Dowd advised this survey would be followed up by a further mystery shopping exercise in a year's time.

Presentation of Draft recommendations to the Health and Wellbeing Board

The Chair attended the meeting of Islington's Health and Wellbeing Board on 12 March 2014 to present the draft recommendations of the Committee.

In discussion the following points were made:

- There should be standard expectations about access to GPs. However, there was also a need for flexibility in appointment systems to cater for the various needs of patients
- It was noted that NHSE had set up a project to look at services in the south of the Borough. It was also noted that three GP practices had been successful in bids to the Prime Minister's Challenge Fund to improve access.
- With regard to recommendation 8, relating to public awareness, the NHS had already produced public leaflets on "Choose the right treatment" to encourage people to choose the NHS service that could best treat their symptoms, rather than attending A&E
- That further multi-disciplinary work and communication be carried out on recommendation 5, relating to "Social support functions" and the inclusion of "school sick notes" provided by GPs. The Council's message to children and parents was that children must attend school. A multi-disciplinary approach would help to identify those seeking sick notes most frequently from a GP and any underlying issues.

Report from the Primary Care Foundation - "Improving Access and Urgent Care in General Practice"

At their meeting on 16 September 2014 Henry Clay, representing the Primary Care Foundation presented their report into "Improving Access and Urgent Care in General Practice" to the Committee.

Extract from "Improving Access and Urgent Care in General Practice" -

In March 2013 Islington Clinical Commissioning Group launched a Local Enhanced Service (LES) to improve access for patients to GP practices across the Borough. The initiative had two options:

Option A; the "Doctor First" approach, or

Option B; dedicated support to undertake a bespoke review of current systems and processes, through the Primary Care Foundation (PCF)

The report was designed to provide a summary of Option B, showing the differences on a practice by practice view.

2. Process

Initially 27 GP practices accepted the PCF option. The process is that GP practices capture data about their systems, processes, consultations, telephones and staffing for a sample week. This data is uploaded via a web portal to the PCF website, where it is checked, analysed and published in a practice specific report. The report includes a comparison of the practice's indicators against evidence based benchmarks, describing, amongst many other things, an optimum balance of:

- *Comparative activity of GPs and nurses, when looking at national indicators*

- *Available patient appointments for GPs, nurses and other health care professionals*
- *The split of appointment availability across the primary care team*
- *How soon patients can get an appointment and the availability of appointments they can book in advance*
- *How easy it is to get through on the phone and how often they are asked to call back*
- *What happens when patients request a home visit*
- *What patients say about access to routine and urgent appointments and their overall experience of making an appointment*
- *How consistent their reception staff are in dealing with a range of requests for urgent appointments, their level of confidence and how recently they have received training*

Within each practice report there are approximately nine pages of information that describe these findings. Included also is additional information describing the generic background, evidence and rational that underpins their report, together with suggestions about what GP practices find helpful in reviewing their systems and processes.

The PCF met with the GP practices to talk through the findings and offer any clarification or additional information necessary to help the GP practice move forward, together with any further support required to complete their changes (round 1). In addition there are a number of requirements within the LES that are not managed by the PCF.

An action plan was produced by each practice, with support from the PCF, to help them plan and implement any necessary changes.

The CCG commissioned a repeat of this process to help understand the impact of any changes made by the GP practice since round 1 (shown in round 2).

3. Status

The participating GP practices have completed their round 1 requirement, with most gathering their data during a period from March - May 2013. All GP practices received their reports and follow up visits during the summer of 2013. In addition to the original 27 practices, 1 further practice joined (for round 1 and 2) and a further practice more recently (for round 2 only).
All 29 GP practices completed their round 2 work, received their reports and have been offered further support and a follow up meeting.

Finally, practices received a second detailed report, based on round 2, and also a comparison summary to help show the differences identified between round 1 & 2.

4. Executive Summary

Many of the Islington GP practices have made significant efforts to understand and make appropriate changes to their systems and processes for access and urgent care. Some of these changes are already showing positive signs, although these changes can take time to be understood by patients and reflected in feedback.
It's also recognised that the dynamics can change for GP practices that have higher levels of patient deprivation or language problems; for instance, it's more likely that in these circumstances GP practices may need a higher proportion of same day appointments, compared to elsewhere. However, the principles are the same and it's good to hear from practices that experience these circumstances that they have been positive about the benefits these changes are bringing.

Like any other change, it's often a combination of processes that need review, across the whole GP practice system, and these will need ongoing monitoring and evaluation, rather than just a "quick fix".

During the discussion of the report there were several points of interest raised.

The Committee reported that it had been difficult to find threads of consistency across high and low performing practices and the widespread variation between practices was a big challenge.

. Although there was data on GP performance nationally there was no one solution for GP performance that would work for all practices. The Committee were aware that there was an expectation on practices that they would provide online access to patients from next year but there needed to be a balance of methods of access.

Henry Clay advised that locum issues were relevant when considering the data on GP performance and as part of the review process the Committee should look at how the CCG were helping practices to change the performance statistics as required.

There were draft access standards being prepared for London but they were not yet in place.

Occasionally reception staff felt that the surveys were invasive and it was important that practice managers explained how the surveys would help improve systems for the patients of the practice.

Support had to be given to receptionist teams to help with managing patients with English as a second language. There were existing translation services in place but the take up of these was low and did not seem to work well. Many patients chose to bring a family member or friend with them to translate.

Patients unable to get through to the surgery by phone to access appointments were a major issue. Aiming for targets of 90% of calls being answered in 30 seconds would often diminish complaints. When practices told patients to call back again at the same time tomorrow they were often perpetuating the pressure on phone lines at busy times of day. Resourcing on any given day could be an issue but there could also be more complicated underlying issues.

GP practices have different ways of handling appointments and dealing with emergencies. Some for example employ a telephone triage system, while others continue to rely on a telephone queuing system at the start of the working day. The choice lies between book ahead and managing demand on the day.

There are intelligent ways of planning demand: for example a practice could ask patient groups and vary the mix. This sort of approach may often be well received.

Telephone triage offers a relatively new approach to managing demand on the day. However, if it is to work GPs need to be at the front end of a telephone triage system, either taking or returning the patients calls. This depends on good telephone consultation skills and good safety netting. The criteria for a good triage system are good listening skills, and the ability to ask the right questions.

Instant messaging is being trialled in some practices and the Committee is aware that there are also experiments involving tele-medicine, telecare and skype. Other options open to GP practices include the booking and cancellation of appointments on-line and text reminders to patients. Some patients will always expect face-to-face contact but others may be prepared to consider a choice of telephone, skype or e-consultation.

Repeat appointments were a larger issue for availability. If patients were coming back seven times rather than five times then the practice needed to consider why the extra appointments were needed.

DNAs (did not attend) appointments were often higher when appointments were booked further in advance as the illness had improved by the time the appointment came around. If surgeries made better use of nursing staff so patients could be seen sooner the levels of DNA appointments could improve.

Walk in appointments could help with providing easier access to appointments, particularly to those with English as a second language but it was just one way of service delivery.

There was a drive towards extending access to primary care including into weekends. The shift was inevitable but it was possible that by working with other practices new service models could be developed. The difficulty with this was how to provide continuity of care as a patient's notes and clinical record would need to be accessible.

Continuity and having management plans in place that would explain what would happen when a situation arose were vital.

The Committee had heard evidence of many GPs performing a social support function and undertaking a significant amount of work on benefits assessments, housing applications and sick notes. It was suggested that giving other clinicians access to the system centrally would enable these patients to be seen elsewhere.

As practices grew they would need more resources. Allowing some staff to move round practices and out of hours services to gain experience could be beneficial.

Conclusion

Islington faces very real challenges, in common with many other inner London boroughs. To begin with, there is huge diversity in the local population: 42% of local people were born outside the UK; 20% do not speak English as a first language; and the borough has amongst the highest child poverty rates in the country.

Islington is the most densely populated borough in the UK and one of the five most deprived London boroughs. An average of 40.9% of children under 16 are living in poverty, and the rate of family homelessness is worse than the England average. Child obesity is higher than the national average; 25 % of children aged six are obese in Islington compared with 19 % nationally. The borough has the lowest life expectancy amongst men in London, and the fourth lowest for women.

But there are other significant issues. The GPs whom the Committee have met reported that many of their patients suffer from severe mental health problems, psychosis, and drug and alcohol-related conditions. People with serious psychological conditions such as psychosis represented 1.5% of the total registered population of Islington in 2010/11. This is the highest percentage in England. 10% of the total registered patient population in the borough have a recorded diagnosis of depression – the highest rate in London. Cardiovascular disease and cancer are major causes of early death.

Bunhill and Clerkenwell are amongst the most densely populated wards in the borough and a large number of patients have severe mental health issues and high levels of depression and anxiety. It is difficult to imagine that these issues could easily be dealt with by GPs in 10 minute consultations. The Committee note that a report was specifically commissioned to look at the issues of population increases in Bunhill and Clerkenwell and the impacts this will have on services.

Capacity appears to be a major issue for GP practices. The Committee heard that many patients have long-term conditions such as respiratory problems, heart disease and diabetes, all of which used to be dealt with in hospital. More than 35,000 people registered with a GP in the borough have one or more long-term conditions. If they are to respond effectively and manage the increased demand, both volume and complexity of cases, GPs have told the Committee that at the very least they need long-term continuity and certainty of funding for their business plans.

It seems that GP practices are struggling to manage demand, due partly to the size of their patient lists and partly to the complex nature of the conditions of some patients particularly those with significant mental health problems. This situation is not helped by the numbers of patients presenting with minor ailments which might just as easily be dealt with by a visit to the local pharmacy, and by patients who make appointments simply to ask their doctor for a letter to assist them with a housing application, or those sent by a local school to get a doctor's sick note for their child when the proper course might have been for the parent to look after the child at home.

All patients should be able to register with their GP practice and should have a standard experience. GP patient lists are reviewed at regular intervals, typically every two or three years. This is important bearing in mind that the funding of GP practices is geared to patient numbers and inactive 'ghost' patients can misrepresent the size of the workload.

The Committee has been advised that many practices' patient lists turn over by up to 30% a year. As an example the Committee heard that one local practice had taken over a depleted list comprising 2,800 patients 14 years ago, which had since increased year on year to around 7,000. A 30% churn is typical and might involve registering 50 new patients in a week which understandably would have a disruptive effect on any practice.

There is evidence to suggest a large degree of inconsistency between GP practices on their appointment systems. There are a number of different approaches amongst GP practices, dictated in part by the size of the practice, the patient population, and the range of options available for booking appointments e.g. online booking, book ahead, book on the day or the day before**.** The evidence we have heard has also shown little consistency between patient satisfaction and appointment systems. Two practices operating the same appointment systems can have vastly differing patient satisfaction rates and this makes it hard to identify one "best practice" approach. In the Committee's view there is not any one system that can operate for all practices to the satisfaction of all patients.

Core hours in the GPs contract are from 8.30am to 6.30pm subject to variation by local agreement. In Islington 27 out of the 37 GP practices operate an enhanced service i.e. provide a service outside of the core contracted hours. Although this is intended to help people in work, access at these times is not in any way restricted.

Many practices are juggling priorities. Some practices operate 'walk-in', same day appointments but this may deter those patients who are not prepared to wait for an unscheduled appointment.
The Committee heard from one practice which was doing its best to provide high quality services, and help patients to see their GP on demand.

The perception locally is that patients are generally dissatisfied with the arrangements for accessing their GP. The impression is that the service is not as accessible as it should be and that people in work in particular find it difficult to make an appointment. It was this that prompted the Committee to carry out a review with clear but tightly focused objectives. The intention is to make some best practice recommendations which add value and which make sense in practice.

The review has looked specifically at the demand for GP appointments in Islington which has 37 registered practices some of which are small single-handed practices whilst others have multiple partners, nurses and health care assistants, and very large patient lists. It has also looked at their capacity to meet demand, having regard to the challenges posed locally and wider considerations such as public expectations and the changing interface between acute and primary care, and the move towards integrated care which is being pursued by Whittington Health and others.

In light of the evidence received the Committee have formulated their key recommendations that they consider will help to improve access for patients and look to alleviate pressure on GPs.

APPENDIX 1 –

Access & Urgent Care in General Practice

Report prepared by the Primary Care Foundation, June 2014

Urgent Care in General Practice
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Improving Access and Urgent Care in General Practice
June 2014

1. Background

In March 2013 Islington Clinical Commissioning Group launched a Local Enhanced Service (LES) to improve access for patients to GP practices across the Borough. The initiative had two options:

Option A; the "Doctor First" approach, or

Option B; dedicated support to undertake a bespoke review of current systems and processes, through the Primary Care Foundation (PCF)

This report is designed to provide a summary of Option B, showing the differences on a practice by practice view.

2. Process

Initially 27 GP practices accepted the PCF option. The process is that GP practices capture data about their systems, processes, consultations, telephones and staffing for a sample week. This data is uploaded via a web portal to the PCF website, where it is checked, analysed and published in a practice specific report. The report includes a comparison of the practice's indicators against evidence based benchmarks, describing, amongst many other things, an optimum balance of:

- Available patient appointments for GPs, nurses and other health care professionals
- The split of appointment availability across the primary care team
- How soon patients can get an appointment and the availability of appointments they can book in advance
- Comparative activity of GPs and nurses, when looking at national indicators
- How easy it is to get through on the phone and how often they are asked to call back
- What happens when patients request a home visit
- What patients say about access to routine and urgent appointments and their overall experience of making an appointment
- How consistent their reception staff are in dealing with a range of requests for urgent appointments, their level of confidence and how recently they have received training

Within each practice report there are approximately nine pages of information that describe these findings. Included also is additional information describing the generic background, evidence and rational that underpins their report, together with suggestions about what GP practices find helpful in reviewing their systems and processes.

The PCF met with the GP practices to talk through the findings and offer any clarification or additional information necessary to help the GP practice move forward, together with any further support required to complete their changes (round 1). In addition there are a number of requirements within the LES that are not managed by the PCF.

An action plan was produced by each practice, with support from the PCF, to help them plan and implement any necessary changes.

The CCG commissioned a repeat of this process to help understand the impact of any changes made by the GP practice since round 1 (shown in round 2).

3. Status

The participating GP practices have completed their round 1 requirement, with most gathering their data during a period from March - May 2013. All GP practices received their reports and follow up visits during the summer of 2013. In addition to the original 27 practices, 1 further practice joined (for round 1 and 2) and a further practice more recently (for round 2 only).

All 29 GP practices completed their round 2 work, received their reports and have been offered further support and a follow up meeting.

Finally, practices received a second detailed report, based on round 2, and also a comparison summary to help show the differences identified between round 1 & 2. A summary report has been included.

A short commentary describing the overall impact across Islington and within their respective localities is included on pages 5 -10.

4. Executive Summary

Many of the Islington GP practices have made significant efforts to understand and make appropriate changes to their systems and processes for access and urgent care. Some of these changes are already showing positive signs, although these changes can take time to be understood by patients and reflected in feedback.

It's also recognised that the dynamics can change for GP practices that have higher levels of patient deprivation or language problems; for instance, it's more likely that in these circumstances GP practices may need a higher proportion of same day appointments, compared to elsewhere. However, the principles are the same and it's good to hear from practices that experience these circumstances that they have been positive about the benefits these changes are bringing.

Like any other change, it's often a combination of processes that need review, across the whole GP practice system, and these will need ongoing monitoring and evaluation, rather than just a "quick fix".

The following pages set out information to demonstrate progress being made across the Borough.

Simon Lawrence
Primary Care Foundation, June 2014

Participating GP practices by locality

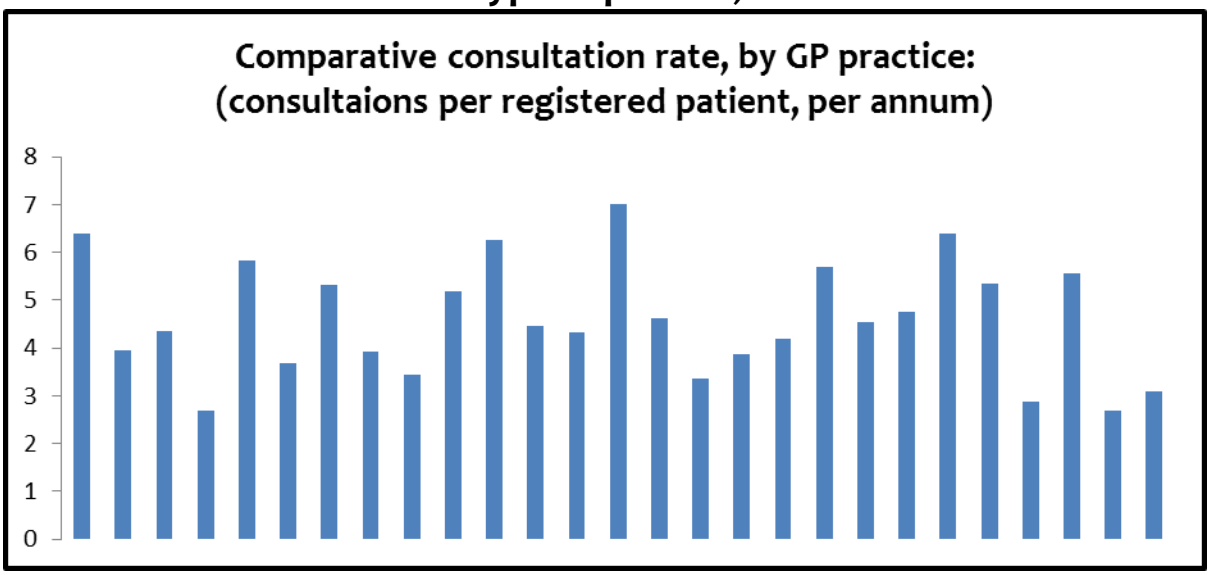
Goodinge Group Practice
Highbury Grange Medical Centre
Holloway Medical Clinic
Dr Ko's and Partner
The Miller Practice
Sobell Medical Centre
Andover Medical Centre
Archway Medical Centre
The Beaumont Practice
Dartmouth Park Practice
The Northern Medical Centre
The Rise Group Practice
St John's Way Medical Centre
Hanley Primary Care Centre
Stroud Green Medical Clinic
The Village Practice
Elizabeth Avenue Group Practice
The Family Practice
Islington Central Medical Centre
Mitchison Road Surgery
New North Health Centre
River Place Health Centre
Roman Way Medical Centre
St Peter's Street Medical Practice
The Amwell Group Practice
Clerkenwell Medical Practice
Bingfield Street Surgery
Killick Street Health Centre
Pine Street Medical Practice
Ritchie Street Group Practice

29 participating practices

What was the picture after round 1?

- Strong correlation with General Practice Patient Survey in many areas
- Some complex systems designed to "manage" demand; e.g. embargo's, which drive "phone/call early" culture
- Widespread variation in reception quiz results
- Continuity of care varied; part time GPs, popular GPs and duty GP systems can cause this
- Out of balance split between same day and book ahead availability (usually too high same day)
- High % of occasions when patients are asked to ring back (when appointments are all gone) in some practices, prompting pressure on staff and phones and inconvenience for patients
- Book ahead period too short (some concern about DNAs)
- Long wait for next routine appointment
- Mixed picture for home visiting; some assessments and visiting late in the day
- Skill mix quite varied; GPs, nurses, HCAs
- Few practices had consistent scripts for reception staff; quite a bit of variation and defaulting to next appointment rather than offering a choice
- Some variability of clinical practice e.g. consistency of care

But a typical picture; not unusual!



This chart, from round 1, demonstrates the differences between GP practice consultation rates.

Some of the important factors within GP practice control

Consultation rate, appointment availability and skill mix: why is this important?

Making sure GP practices have sufficient clinical consultations is obviously important; so we demonstrate how close to the expected number of consultations, weighted for the age and sex of their population, each practice is delivering.

However, it's not just the total number; the split of how consultations are shared across the healthcare team, the split between appointments booked for the same day and those booked in advance, as well as how soon the next routine appointment is available are also important indicators.

We sometimes find GP practices have far more appointments than we might expect; this can be for a variety of reasons. Whilst being higher or lower than average does not necessarily mean something is wrong, it can help to identify where some changes might be helpful; not just for the benefit of patients, but also the workload of the team.

When we meet with GP practices, we discuss this and some potential reasons why this might be, together with ideas that might help improve the balance. From this they can decide how they might adjust their systems and processes.

Please see the summary on page 7 which describes how GP practices have changed these arrangements to improve access and urgent care.

Telephone systems, capacity and demand: what makes the difference?

In our work with a large number of practices we have found that the patient survey result is normally a good reflection of the actual experience of accessing the practice on the phone. If the result is good in the survey (average or above average) then GP practices can be reassured that patients do not experience difficulty in getting through on the phone. If however the result is below average then it is likely they have issues that could be addressed.

There are four variables which will impact on the ability of patients to get through on the phone.

- Volume of incoming calls
- Number of lines
- Number of people answering
- Call lengths

The table we include in the GP practice report uses the Erlang formula to calculate the number of staff required to answer the phone in each hour to ensure that 90% of calls are answered promptly, based on the reported call volumes and length of the average call.

When we meet with the GP practice, we look at all of these factors and discuss how they might want to use this information to improve their systems and processes.

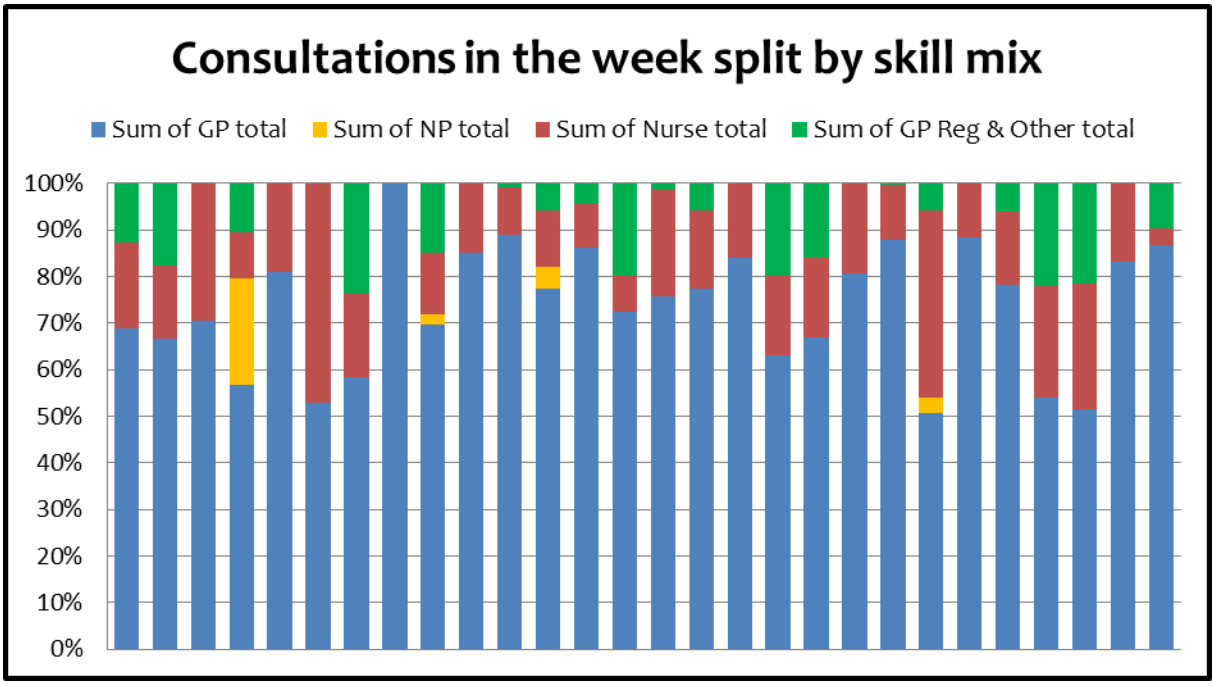
Please see the summary on page 9 which describes how GP practices have changed these arrangements to improve access and urgent care.

What did we find after round 2, compared to round 1?

Consultation arrangements

Central Locality	• 3 of 6 practices had a consultation rate closer to that expected • 3 of 6 practices had an improved same day/advance appointment ratio • 3 of 6 practices had a better balance of activity skill mix (GPs, nurses, HCAs) • 6 of 6 practices had increased their book ahead appointment window in line with the recommended length (usually about 6 weeks) • 5 of 6 practices had reduced the wait for the next routine book ahead appointment • 3 of 6 practices reduced the occasions when patients are asked to call back (when appointments run out)
Northern Locality	• 4 of 9 practices had a consultation rate closer to that expected • 5 of 9 practices had an improved same day/advance appointment ratio • 3 of 9 practices had a better balance of activity skill mix (GPs, nurses, HCAs) • 8 of 9 practices had increased their book ahead appointment window in line with the recommended length (usually about 6 weeks) • 4 of 9 practices had reduced the wait for the next routine book ahead appointment • 4 of 9 practices reduced the occasions when patients are asked to call back (when appointments run out)
South East Locality	• 3 of 8 practices had a consultation rate closer to that expected • 5 of 8 practices had an improved same day/advance appointment ratio • 5 of 8 practices had a better balance of activity skill mix (GPs, nurses, HCAs) • 4 of 8 practices had increased their book ahead appointment window in line with the recommended length (usually about 6 weeks) • 2 of 8 practices had reduced the wait for the next routine book ahead appointment • 5 of 8 practices reduced the occasions when patients are asked to call back (when appointments run out)
South West Locality	• 3 of 6 practices had a consultation rate closer to that expected • 3 of 6 practices had an improved same day/advance appointment ratio • 3 of 6 practices had a better balance of activity skill mix (GPs, nurses, HCAs) • 6 of 6 practices had increased their book ahead appointment window in line with the recommended length (usually about 6 weeks) • 3 of 6 practices had reduced the wait for the next routine book ahead appointment • 3 of 6 practices reduced the occasions when patients are asked to call back (when appointments run out)

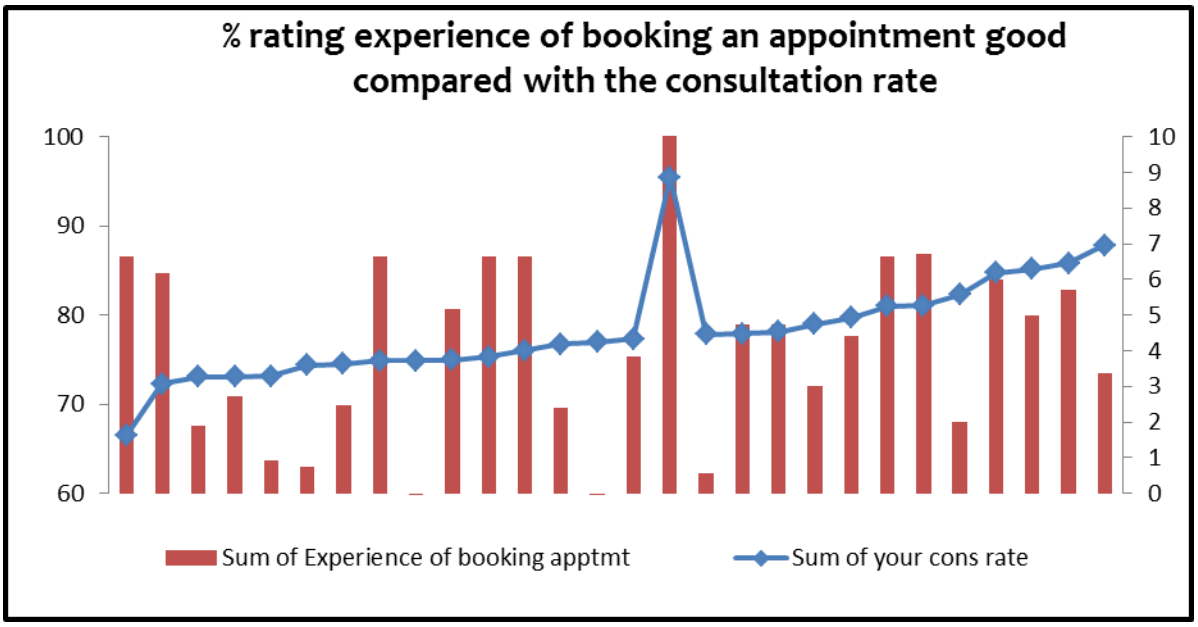
The majority of GP Practices have adjusted their systems and processes to deliver services more responsive to their patient's needs but these changes can also improve the work balance and experience of their staff.



This chart, taken from the round 2 data, shows the variation of clinical staffing across GP practices in Islington.

We know that the typical average workload in general practice is split, with about two thirds of consultations undertaken by GPs.

But the size of the GP Practice and the ability to recruit and train the right clinical staff can affect the skill mix.



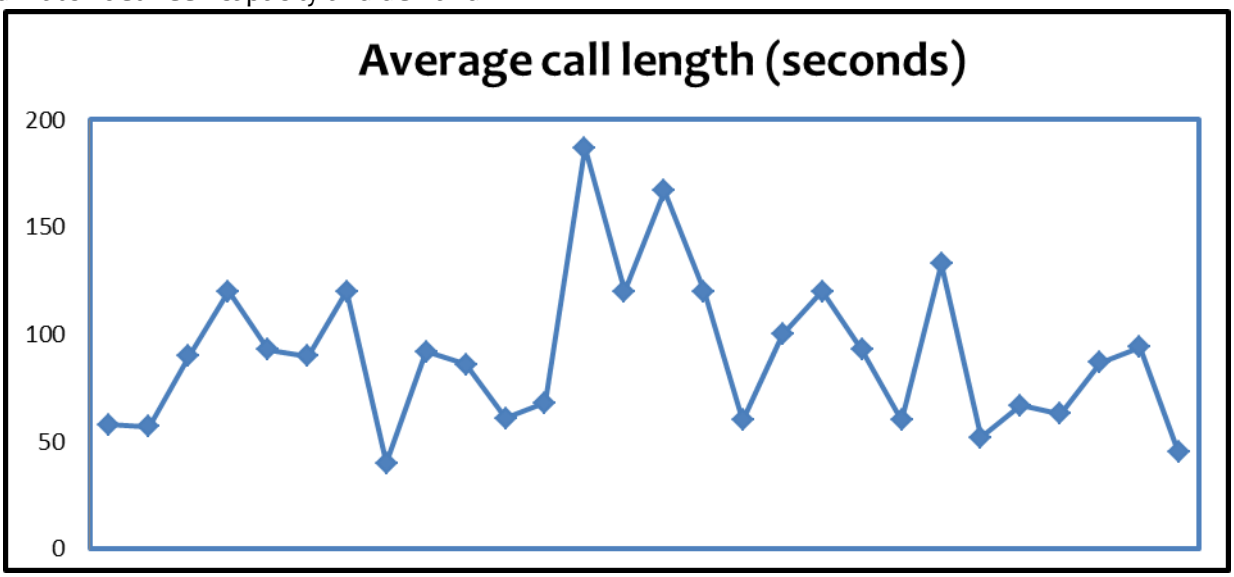
This chart, taken from the round 2 data, shows that a higher consultation rate does not necessarily improve patient satisfaction with booking an appointment; other factors such as continuity of care, ease of getting through on the phone and the availability of an appointment within the next few days will affect patient's experiences.

What did we find after round 2, compared to round 1?

Telephone arrangements

Central Locality	• 4 of 6 practices had reduced the time to complete calls resulting in better telephone staff capacity • 3 of 6 practices had improved their capacity overall, with better cover and response across the day
Northern Locality	• 3 of 9 practices had reduced the time to complete calls resulting in better telephone staff capacity • 5 of 9 practices had improved their capacity overall, with better cover and response across the day
South East Locality	• 5 of 8 practices had reduced the time to complete calls resulting in better telephone staff capacity • 5 of 8 practices had improved their capacity overall, with better cover and response across the day
South West Locality	• 4 of 6 practices had reduced the time to complete calls resulting in better telephone staff capacity • 4 of 6 practices had improved their capacity overall, with better cover and response across the day

This shows some good progress with many GP practices improving their systems and processes to ensure a good match between capacity and demand.



This chart, from round 2 data, demonstrates the variability between GP practices in how quickly they complete a call. This affects their overall capacity on the telephones.

Reception Staff Training; following up the reception quiz results

The purpose of the reception quiz is to check on the overall consistency or variation in managing patient calls or queries. The first part looks at practice protocols and training, as well as exploring staff confidence in recognising potentially life threatening conditions. The second part presents 13 different scenarios where patients call describing a particular health problem and the receptionist has to decide how they would respond, from calling an ambulance, through to getting immediate help from a doctor, to booking the patient for an appointment. This is less about whether the response is right or wrong (although with more serious conditions you will be looking for rapid intervention) but the level of consistency across the team. If there is substantial variation across the team the GP Practice may want to run a training session across the reception team, led by a clinician, to explore why there is variation, how much is acceptable, and how it can be reduced.

What did we find after round 2, compared to round 1?

Reception Quiz results

Central Locality	• 4 of 6 practices still had some variation in results across the reception team's answers
Northern Locality	• 6 of 9 practices still had some variation in results across the reception team's answers
South East Locality	• 3 of 8 practices still had some variation in results across the reception team's answers
South West Locality	• 3 of 6 practices still had some variation in results across the reception team's answers

This shows GP practices still need to offer ongoing support to their reception team; we have found this works particularly well where clinicians lead this process, perhaps using the scenarios from with the reception quiz or other typical local experiences.

Individual Practice Summaries

The following pages show samples of the brief summary shared with each GP practice, comparing round 1 to round 2 outcomes.

Anonymous 1

Summary of Key Points

March 2013; round 1	March 2014; round 2
• Consultation rate 4.47 against expected 5.1	• Consultation rate 4.92 against expected 5.15
• Same day appointments 53.5% (about 1/3 same day would be expected)	• Same day appointments 34.9% (more book ahead appointments available)
• GPs undertake approximately 84.9% of appointments (about 66% would be expected)	• GPs undertaking 77.4% of appointments
• Next routine book ahead appointment 7 days	• Next routine book ahead appointment 1 day
• Book ahead window 2-4 weeks	• Book ahead window 4 weeks
• Average call length; 91 seconds	• Average call length; 68 seconds
• Phone demand and capacity; under pressure	• Phone demand and capacity; good cover across the day
• 15-30% of time patients asked to call back	• 15-30% of time patients asked to call back
• 6 reception staff not trained in last 2 years	• 0 staff not trained in last 2 years (all trained in last 2 years)

Practice action plan from round 1

• Increase clinical sessions (issues with recruiting nurses) • Re-dress same day/book ahead balance • Review GP practice in follow up appointments, etc	• Increase receptionist cover dedicated to answering phone • Training of receptionists in urgent care decisions

Commentary

The practice has made remarkable progress and improved against the indicators in most areas. The consultation rate has increased in line with need; same day appointments are in better balance and book-ahead appointments more readily available. The practice have clearly worked hard in reviewing systems and processes in reception with better cover dedicated to answering the phone, training and quicker call handling. Average weekly workload on GPs has reduced, although still higher than average.

The throughput of nurse practitioners has remained lower than expected.

Recommendations

It's recommended that the practice continues to review the availability of appointments, recommendations within the reports and their action plan. Areas for continued attention could include reducing the number of times patients are asked to call back for an appointment (this remains high) and maintaining support for reception staff with clinical leaders providing training. We have not considered the GPPS survey results from

the second report (as the period is too short, data from before the first round is still included and it will take time for the changes to filter through to patients completing the survey).

Anonymous 2

Summary of Key Points

May 2013; round 1	April 2014; round 2
• Consultation rate 3.43 against expected (4.9)	• Consultation rate 3.27 against expected (4.63)
• Same day appointments 50.6% (about 1/3 same day would be expected)	• Same day appointments 62.7% (17% of patient's indicate they are looking for a same day appointment)
• GPs undertake approximately 81.3% of appointments (about 66% would be expected)	• GPs undertaking 83.1% of appointments
• Next routine book ahead appointment 2 days	• Next routine book ahead appointment 1 days
• Book ahead window 2 weeks	• Book ahead window 2 weeks + (unlimited reported)
• Average call length; 127 seconds	• Average call length; 94 seconds
• Phone demand and capacity; under pressure all day	• Phone demand and capacity; under pressure in the morning
• Less than 5% of time patients asked to call back	• We rarely ask patients asked to call back
• DNA rate 1.3%	• DNA rate 6.3%
• Only 1 member of staff completed the quiz	• Only 1 member of staff completed the quiz

Practice action plan from round 1

• Extend book ahead window • Train staff on telephone	• Increase nurse sessions • Text patients with appointment reminders to reduce DNAs

Commentary

The practice has made good progress in reducing call completion times and there is less pressure on phones during the afternoon. The book-ahead window has been extended for some appointments and the wait for a book-ahead appointment is low. Patients are less likely to be asked to call back for an appointment.

Whilst the GP and nurse are carrying out the average number of consultations per w.t.e, overall the availability of appointments is lower than expected. Same day appointments appear far higher than required. The percentage of GP consultations across the team is higher than average.

Recommendations

It's recommended that the practice continues to review the availability of appointments, recommendations within the reports and their action plan. Reviewing the availability of clinical consultations and skill mix might be worthwhile, as is the split between book ahead and same day appointments. We have not considered

the GPPS survey results from the second report (as the period is too short, data from before the first round is still included and it will take time for the changes to filter through to patients completing the survey).

Bunhill Development Options Appraisal Paper

March 2014

NHS England

NHS England

First published:

Updated: (only if this is applicable)

Prepared by

Trina Draper

Maria Rodrigues

Contents

1. Executive summary

1.1 The latest population estimates suggest that Islington's population will increase by 37% between 2011 and 2026. An additional 41,000 people will be living in the borough. A significant part of this growth will be focused upon Bunhill ward in the south of the borough where a range of major developments are taking place. The most recent estimates project an additional 4,000 will be living in Bunhill ward by 2026. Bunhill's growing population may place increasing pressure on the existing GP facilities. The capacity analysis carried out by NHS England in partnership with Islington CCG and Islington Council demonstrates that there will be a clear need to assess and plan the requirements for additional healthcare provision by 2020.

1.2 Finding a suitable site in this area of Islington is challenging both due to the high land values and lack of available sites. Islington Council have been in discussions with Berkeley Homes about the redevelopment of the City Forum site (250 City Road) and other planned developments in Bunhill ward. The proposed development may provide 995 new residential units along with a range of commercial uses and 1.4 acres of public realm. As part of the discussions, Berkeley Homes proposed to provide a small healthcare facility on site (242sqm). In light of this proposal, NHS England agreed to assess the need and demand for new healthcare facilities within the Bunhill ward.

1.3 The City Forum is likely to have a significant impact on local health care services. Along with other developments taking place in Bunhill ward, development proposes to provide up to 995 apartments, and therefore with population increase into the Bunhill South-eastern ward; consideration must be given to how the potential growth in population will impact local primary medical services. In addition to the increased occupancy (generated from the new development), it is worth giving consideration to the overall increase in the demand on primary medical services due to the forecast population growth within the area over the next few years including another 350 residential units in Bunhill ward and an estimated 1,500 residential units currently being built in the adjacent Hoxton Ward in Hackney.

1.4 The proposal of the City Forum development and the proposed use of a healthcare unit resulted in discussions between NHS England and the London Borough of Islington Planning Department, and subsequently a Task and Finish Group was set up to facilitate the involvement and collaborative working between representatives from the Islington & Camden CCG, NHS Property Services, Public Health, NHS England, the North East London Commissioning Support Unit (NELCSU) and the London Borough of Islington Planning Department to discuss the possible impact that the population growth, including that resulting from new developments such as City Forum and other developments may have on healthcare services in the Bunhill Ward. Currently City Forum is one of the larger planned developments. This group identified 12 GP Practices within a 1 mile radius of the proposed new development (and thus the most likely to be affected by the growth in population) and subsequently collated together and discussed in detail all the relevant information on the following:

- Population and forecast growth in and around Islington and in particular the Bunhill Ward;
- Current Primary Medical Services provision;

- Current & forecast GP Capacity (based on current and projected patient list forecasts);
- Current condition of GP Premises;
- Expression of interest from GPs to relocate;
- Distance between each practice and the City Forum Development and the current transport links.

1.5 Following collaborative discussions and a consideration of all of the evidence; our findings suggest that by 2020 that there will be a significant case for additional infrastructure based on projections to include the City Forum Development and natural growth to the Bunhill ward (which add up to an increase of around 4000 in population growth). This will result in an increased pressure on the capacity of the 12 GP Practices surrounding the development. However it has been identified that at present, there is adequate capacity for growth across the 12 GP Practices to absorb a steady increase in the population forecast over the next few years.

1.6 In view of the evidence the following options have been identified:

- Option 1 – Do nothing;
- Option 2 - Grow existing Practices within their current premises;
- Option 3 - Develop and improve of one or more existing practices premises;
- Option 4 - Relocate an existing GP Practice into the City Forum Development;
- Option 5- Commission new premises and a new contract.

2. Purpose of the Paper

2.1 This paper provides a background to aid the decision making in relation to Primary Medical Services in the Bunhill ward. This paper will detail the options appraisal that has taken place in relation to utilising the proposed healthcare unit at City Forum and describes the process used to make a recommendation to the decision making body at NHS England outlining the associated risks and options going forward.

3. Case for Change

3.1 Urban development, particularly large schemes, can lead to rapid population growth and subsequent additional demand on health services at the local level. Legislation allows local authorities and developers to agree planning obligations to provide and support healthcare services to cope with population growth and change. More recently, the new Community Infrastructure Levy, once adopted in Islington, will replaces tariff-style infrastructure planning obligations for new healthcare facilities.

3.2 According to the paper 'Estimating population growth from urban development in and around Islington' (produced by Camden and Islington Public Health) the total population of Islington is projected to increase by 41,500 people by 2026. The evidence within this paper also suggests that there are a number of planned new developments (before 2026) being developed within the Southern-east Bunhill ward and by 2021 this ward will experience an estimated growth of 1341 households totalling an approximate 2,740 additional residents. However, the total estimated population growth from all sources is expected to be an increase of around 4000 additional residents.

3.3 An estimated 1,500 homes are currently being built in Hoxton ward (Hackney), which lies adjacent to Bunhill ward on the north eastern side of City Road. This is likely to result in excess of a further 3000 residents in the immediate area. There is a likelihood that a significant number of these residents will use Islington GP practices and in particular City Road Practice. At present, 18% of City Road Practice's patients live in Hackney.

3.4 Currently, four out of the twelve Practices located within one mile of the City Forum site have expressed their interest in relocating from their current practice to larger premises. These Practices are:

- City Road Medical Centre
- St Peters Street Medical Practice
- Clerkenwell Medical Centre
- Elizabeth Avenue Group Practice

3.5 The City Forum development is offering a space of 242sqm. to be occupied as a health unit in a prime location, which will become available in 2021. However it was identified that this space is considerably small when compared to what the above practices are currently occupying and taking into account additional space that would be needed to cater for the predicted growth in population. It is therefore recommended that the space requirements for a new health unit would be a minimum of 600sqm.

3.6 At present, the City Forum development is limited yet has potential opportunity to meet the needs of a growing population in Bunhill ward. It is limited for a number of reasons. Firstly, the decision is with the Mayor of London and not with the Council, smaller space being offered by Berkeley (the developer) and there is still uncertainty over when and if it will go ahead. If this opportunity does not come to fruition, there will be a need for all partners to work together to identify alternative locations.

4. Current Service Provision

4.1 Practices

4.1.1 There are twelve GP Practices each located within a 1 mile radius of the proposed City Forum development; four of these are located in the City & Hackney and eight in Islington. The smallest GP Practice has an approximate patient list size of 1,802, and the largest Practice holds an approximately 12,994.

4.1.2 The City Road Practice is likely to absorb a significant amount of the growth of the City Forum Development as it sits just 0.2 miles *(See distance table below)* from the new development; however there are 11 other practices within a 20 minute walking distance.

4.1.3 The next three nearest practices to City Forum are all located within the borough of Hackney (in the same building) and currently do not cover residents from the borough of Islington under their practice boundary therefore residents from City Forum may be declined registration on this basis until practice boundaries are abolished in line with national guidance.

4.1.4 The New North Health Centre is a Single Handed GP Practice (with the smallest list size of 1,802) which currently holds the most capacity to absorb this level of growth however this practice is situated 0.9 miles** away from City Forum and has poor direct transport links.

4.1.5 The following table outlines the distance between each Practice within a 1 mile radius of the City Forum Development in order of shortest distance in miles, walking and by public transport.

4.1.6 The practices below have expressed an interest in relocating should there be new premises available at City Forum:

- City Road Medical Centre
- St Peters Street Medical Practice
- Clerkenwell Medical Centre
- Elizabeth Avenue Group Practice

GP Practice	List Size	Borough	Practice Status (Group/ single hander)	Miles to 250 City Road, EC1V 2PU	Walking distance to EC1V 2PU (minutes)	Distance Transport - Bus (minutes)
City Road Medical Centre*	6, 843	Islington	Group	0.2	4	4
Pitfield Medical Practice – Branch Practice	3, 545	City & Hackney	Group	0.7	14	9
Shoreditch Park Surgery	7, 272	City & Hackney	Group	0.7	14	9
Hoxton Surgery	5, 853	City & Hackney	Group	0.7	14	9
St Peter Street Medical Practice	9, 740	Islington	Group	0.7	14	14
Clerkenwell Medical Centre	9, 409	Islington	Group	0.7	16	19
Pine Street Medical Centre	2, 477	Islington	Single Handed	0.8	16	19
Amwell Group Practice	8, 151	Islington	Group	0.8	17	17
Ritchie Street	12, 994	Islington	Group	0.8	17	12
The Neaman Practice	8, 487	City & Hackney	Group	0.9	18	14
New North Health Centre	1, 802	Islington	Single Handed	0.9**	18	12
Elizabeth Avenue Group Practice	7, 028	Islington	Group	1	21	14

Table 1: Distance from City Forum to various GP Practices

4.2 Quality of Service

4.2.1 In order to assess the level of quality on services provided, we have used the GP High Level Indicators (GPHI) which comprises of a national set of indicators that is used for quality assurance and the GP Outcomes Standards which is a London wide tool used to measure quality improvement. *See Appendix 1*

4.2.2 There is considerable variability in quality and standards of the facilities offered across the twelve local practices.

4.3 Premises

4.3.1 Using the data provided by the Practices and NHS Property Services *Appendix 2* provides details of all the practices' premises including the

length of lease and current condition. Majority of the practices are tied up in long term leases.

4.3.2 Five (including City Road Practice which is nearest in proximity to City Forum) of the twelve practices do not have room for expansion therefore if they were to reach maximum capacity they would need to seek larger premises.

4.3.3 The Gross Internal Area GIA has been measured for each of the Practices. The building's area is measured to the internal face of the perimeter walls at each floor level. The Net Internal Area has been measured from the usable area within a building measured to the face of the internal finish of perimeter or party walls ignoring skirting boards and taking each floor into account

4.4 **Capacity**

4.4.1 Capacity has been measured in terms of the number of consulting and treatment rooms (clinical space) available and required for the practices' list of registered patients.

4.4.2 In order to work out whether the existing twelve practices have the capacity to absorb the predicted growth in population, a national guidance tool, the Health Building Note Design Manual guidance was used to determine current capacity; (See *Appendix 3* for all calculations).

4.4.3 The Design Manual guidance has been written with the provision of new-build facilities in mind, however the principles described apply equally to refurbishments and extensions of existing buildings. The design manual was used to calculate the practices current room capacity based on their list size combined with the following criteria:

- Number of weeks the building will be open each year;
- Opening hours each week;
- Average duration of each appointment by service and room type;
- Average room utilisation rate.

4.4.4 The practice's patient appointment times per week (in hours) is divided by the number of rooms available each week (in hours). This calculation determines the required number of rooms necessary to provide sufficient access to the total patient list size.

4.4.5 It is difficult to anticipate what proportion of the additional 4000 residents will be absorbed by each practice. As a result, capacity of the twelve practices was measured individually and then added up to gage the total number of consulting rooms that are currently available. This was then compared to the cumulative number of consulting rooms that

would be required based on the cumulative list size for all twelve practices plus the full growth of 4000 residents.

4.4.6 Appendix 3 shows that 35/70 (50%) consulting rooms are being utilised for GP appointment which leaves a surplus of half the capacity under utilised. 20 out of the 22 available treatment rooms are being utilised which demonstrates very limited capacity for growth.

4.4.7 Using the same formula, future room capacity based on the cumulative projected list sizes for all practices (83,600 patients) plus the forecast growth of 4000 residents (2740 from the development plus 1,260 natural population growth) was calculated to determine the capacity required by 2020. The results for this showed that collectively all practices use a total of 35 out of the available 70 consulting rooms for clinical appointments. By 2020, when it is estimated that there will be a total registered population of 87,600, there will be a need for 62 consulting rooms. This means that there will be a surplus of 8 consulting rooms collectively.

4.4.8 Although the above demonstrates that there will be capacity for absorption of the growth in population by 2020, there are limitations to using this method of calculation. One of the limitations is that it assumes that the clinical rooms are purely available for GP appointments and does not take into account other service provision such as community services.

4.4.9 The above methodology of calculating room capacity has not been shared with any of the twelve practices therefore it or difficult to say whether this is a reliable means of measuring capacity or not.

4.5.0 It is also assumed that the growth of 4000 residents can be absorbed equally by the twelve practices however factors such as patient choice, distance and quality of services will play a key role in where these residents choose to register with the GP practice.

5. Options appraised for the future service provision

Having reviewed the information in Section 4 which was compiled based on information provided by the GP practices concerned and expert advice from members of the Task and Finish Group, the following 5 options have been identified as the most feasible solutions to the predicted growth in population within the Bunhill ward.

A benefits and risk analysis has been carried out on all the proposed options to determine their viability. *See Appendix 4*

5.1 Option 1- Do nothing

5.1.1 This option entails no change in current service provision or infrastructure. Doing nothing will cause a significant pressure on GP capacity within the Bunhill Ward by 2020, and subsequently will create a significant pressure on GP Access which is likely to result in a strain on other service providers such as Acute and Emergency care (e.g. an increase in patient admissions to A&E departments and the use of the Ambulance service). The result of doing nothing is likely to cause significant indirect financial implications to the NHS.

5.2 Option 2- Grow existing Practices within current premises

5.2.1 The result of this option will be that existing practices will be required to absorb the increase in population as a result of the developments in Bunhill ward. There will be no additional cost to NHS England and this will provide an opportunity for existing practices to grow their lists, thereby increasing capitation.

5.2.2 There is reliance upon local practices being able to absorb the additional patients as the potential growth in population may put additional pressure on existing GP premises.

5.2.3 Drawing from the information provided on the analysis of the forecast room capacity table (Appendix 3), the data demonstrates that all practices have some capacity to absorb more patients in terms of consulting rooms required however there is a deficiency in treatment rooms (used by Nurses, HCAs) available and required. The following practices in Islington have the most scope to cope with the additional patient capacity within the current provision they have or will be able to acquire (additional rooms currently available for rent) within their current premises:

- Ritchie Street
- New North Health Centre
- Elizabeth Avenue Group Practice

5.2.4 However, if the development at City Forum does go ahead, the above three practices not the nearest to the new site.

5.2.5 City Road Practice, which is the GP Practice within closest proximity to the City Forum development (and therefore the most likely to absorb the increased population growth from the new development), does not have sufficient room capacity to facilitate this growth.

5.3 Option 3- Develop and improve one or more existing practices

5.3.1 This option will allow willing GP practices the opportunity to increase their list size and subsequent capitation payments; resulting in the continuation of the provision of Primary Medical Services and continuity of

care to patients within their existing premises with limited disruption. However a decision to invest in the development and improvement of existing practices will be dependent on room availability for expansion and any Practice with a desire to expand or improve their existing premises will be required to submit a Business Case for such improvements.

5.3.2 An overview of the current premises (see Appendix 2) demonstrates that there are only 2 Practices (Elizabeth Avenue and St Peters Street) whereby an extension to the current premises to facilitate further capacity is possible; however both of these Practices currently have high risk statutory compliance issues and therefore this is unlikely to be a viable option.

5.4 Option 4- Relocate an existing GP Practice into a larger premises to absorb the additional population growth

5.4.1 Relocation of an existing practice would involve selection of an existing practice to relocate into new, larger premises to allow for expansion of list size and service provision.

5.4.2 The chosen GP Practice to relocate into this new health suite will be a Practice:

- Within a 1 mile radius of this new development
- A practice that has expressed their interest in relocating
- A Practice that has demonstrated a case for change to relocate showing a legitimate need for relocation which has been demonstrated by means of a business plan/evidence based document outlining how the Practice plans to utilise the additional space, optimise capacity and engage with the developer/NHS England to provide high quality Primary Care Services

5.4.3 The relocation of an existing GP Primary Medical Service contract into this development will minimise the financial risk that may incur if a new contract is procured with a zero patient list whereby the uptake of new patient registrations may be too gradual or less than anticipated, thus resulting in no value for money.

5.6 Option 5- Commission new premises and a new contract

5.6.1 This entails the procurement of a new APMS contract with new premises and could allow for local collaborative working via the option of GP networks bidding for the contract.

5.6.2 Commissioning a new contract has high cost implications for NHS England in that funding will be required for the value of a new contract, procurement costs and the costs of new premises (could include high service charges as well).

5.6.3 The contract will commence with a zero list size which tends to lack cost efficiency due to the lack of financial viability in the first year or two whilst the new provider is trying to build the list size from zero patients. In situations like this NHS England would need to mitigate the risks to the provider for this period by subsidising their contract value therefore would prove more expensive than relocating an existing practice into this space.

6. Further Consideration

6.1 Concerns from constituents via the Counsellors office over poor access to appointments with GPs have been considered and noted, however it was acknowledged that the solution to this does not necessarily lie in commissioning a new GP practice but to focus on what the problems and look at different ways of working. Islington CCG has on-going work to deal with access within the boroughs.

6.2 Although the Health Building Note 11-01 Facilities for Primary and Community Care Services guidance was used to calculate capacity within the practices, it is important to note that this was not shared with the practices therefore lacks user in put. There will therefore need to be further engagement with the twelve practices that will be affected.

6.3 The capacity analysis demonstrated in Appendix 3 shows that at the moment only half (35/70) the consulting rooms being utilised for clinical consultations however this does not mean that the rooms are not being used for other purposes such as community services.

6.4 There has been limited engagement with City & Hackney CCG and Council. There are a number of developments proposed in the neighbouring wards (in City & Hackney) to Bunhill which will have a significant impact on the four City & Hackney practices. More details will be required on this for analysis of the impact.

7. Recommendation

7.1.1 It light of the findings discussed in the paper, it is proposed that NHS England endorse the following recommendations:

- It is anticipated that the most significant impact on the local practices will be from 2020 onwards when the City Forum development is currently scheduled for completion (if planning permission is successful) therefore it is recommended that **Option 4** is then implemented to allow for absorption growth in population. This will mean that new premises will need to be sought as soon as possible. There is a proposal to secure purpose build premises within the City Forum development however the space offered (242sqm) is unacceptable and will therefore either need to be

increased to approx. 600sqm. And if not alternative premises will need to be sourced.

- **Option 2** to be implemented in the mean time i.e. up until 2020 as there is currently capacity to absorb the initial slow growth in the ward until the developments are realised.

8. Conclusion

8.1 Premises for healthcare within London are a rare commodity and therefore the proposed opportunity to acquire a healthcare unit within the City Road Development of the Bunhill Ward of Islington creates a unique opportunity for the commissioners of Primary Medical Services.

8.2 The findings within this paper suggest that eight of the twelve GP Practices will reach capacity following the absorption of the forecast population growth to their current list size. Evidence therefore concludes that there is capacity for growth amongst *some* of the GP Practices; however these GP Practices within the capacity range are not within close proximity to the new development, hence patient distribution will become a factor.

Appendix 1: Quality of Services

Practice Code	GP Practice	Contract Type	GP High Level Indicators (GPHI)		GPOS
			No of Triggers	Indicators Triggered	
F83064	City Road Practice	GMS	2	Domain 3 = 1 (recovery from illness/injury) diabetes retinal screening 67.7% NAT AVG 91.45%. Domain 4 (patient exp) 69.43% NAT AVG 87.4%	Level 1 = 9 level 2 = 0 Review identified
F84038	Pitfield Medical Practice	GMS	1	Domain 3 (recovery from illness/injury) diabetes retinal screening 77.2% NAT AVG 91.45	Level 1 = 8 Level 2 = 1 Review identified
F84635	Shoreditch Park Surgery	GMS	1	Domain 3 = 1 (recovery from illness/injury) Antibacterial Prescribing 0.52 NAT AVG 2.2	Level 1 = 4 Level 2 = 0 Achieving practice
F84692	Hoxton Surgery	PMS	1	Domain 3 = 1 (recovery from illness/injury) Antibacterial Prescribing 0.55 NAT AVG 2.2	Level 1 = 4 Level 2 = 2 Approaching review
F83032	St Peter Street Medical Practice	GMS	1 (note this practice has outlying data points which are counted in more than one domain, but only trigger once. This number is less than the sum for the domain totals)	Domain 1 = (Premature mortality) flu vaccs at risk 33.99% NAT AVG 51.99%. Domain 3 = 1 (recovery from illness) Flu vaccs at risk 33.99% NAT AVG 51.99.	Level 1 = 3 Level 2 = 0 Achieving Practice

Practice Code	GP Practice	Contract Type	GP High Level Indicators (GPHI)		GPOS
			No of Triggers	Indicators Triggered	
F83624	Clerkenwell Medical Centre	GMS	0		Level 1 = 3 Level 2 = 0 Achieving Practice
F83678	Pine Street Medical Centre	GMS	1	Domain 2 = 1 (Long term conditions) Diabetes admissions 0.18 NAT AVG 0.03	Level 1 = 3 Level 2 = 0 Achieving Practice
F83652	Amwell Group Practice	GMS	0		Level 1 = 6 Level 2 = 0 Approaching review
F83021	Ritchie Street	GMS	1	Domain 4 = 1 (patient experience) 69.96% NAT AVG 87.4%	Level 1 = 4 Level 2 = 2 Approaching review
F84640	The Neaman Practice	GMS	4 (note this practice has outlying data points which are counted in more than one domain, but only trigger once. This number is less than the sum for the domain totals)	Domain 1 = 3 (Premature mortality) emergency admissions 0.62 NAT AVG 0.28, Cervical smears 62.78% NAT AVG 77.42, Asthma prevalence 0.39 NAT AVG 0.65. Domain 2 (long term conditions) Asthma prevalence 0.39 NAT AVG 0.65. CHD cholesterol monitoring 64.85% NAT AVG 80.14. Domain 5 (Patient Safety) = 1 emergency cancer admissions 0.62 NAT AVG 0.28	Level 1 = 3 Level 2 = 0 Achieving Practice

Practice Code	GP Practice	Contract Type	GP High Level Indicators (GPHI)		GPOS
			No of Triggers	Indicators Triggered	
F83034	New North Health Centre	GMS	0		Level 1 = 5 Level 2 = 2 Approaching review
F83012	Elizabeth Avenue Practice	GMS	1 (note this practice has outlying data points which are counted in more than one domain, but only trigger once. This number is less than the sum for the domain totals)	Domain 1 = 1 (Premature mortality) CHD prevalence 0.45% NAT AVG 0.72%. Domain 2 = 1 (long term conditions) CHD prevalence 0.45% NAT AVG 0.72%	Level 1 = 8 Level 2 = 1 Review identified

Appendix 2: Premises **Key:** GIA: Gross internal ar**ea** **NIA:** Net Internal Area

GP Practice	Length of Current Lease	Expiry date of lease	Premises data	Expansion proposals
City Road Practice	25yrs	2024	561.10m2GIA	Purpose built in 1999. Ground floor level. No scope for expansion. High risk statutory compliance issues - No asbestos survey and legionella risk assessment carried out. CQC compliance issues.
Pitfield Medical Practice	22yrs	2026	GIA = NK. Combined NIA 219.88m2 17.10% of the building acc. to MiCAD	Branch surgery in NHS Building. Practice is located in the same building as the Hoxton Surgery and the Shoreditch Park Surgery.
Shoreditch Park Surgery	Undocumented		GIA= 495m2 Combined NIA 392.42m2, 30.52% of the building acc to MiCAD	NHS Building .Practice is located in the same building as the Hoxton Surgery and the Pitfield practice.
Hoxton Surgery	16yrs	2026	GIA = 574m2 Combined NIA 436.09m2, 33.92% of the building acc to MiCAD	NHS Building .Practice is located in the same building as the Shoreditch Park Surgery and the Pitfield practice.
St Peter Street Medical Practice	No Lease. GP owned		GIA /NIA not known	Converted residential property consisting of ground and upper floors with ground floor extension. Potential for extension on first floor level but the premises do not meet minimum standards. High risk statutory compliance issues - No asbestos survey or legionella risk assessment carried out. CQC compliance issues
Clerkenwell Medical Centre	No signed lease		NIA = 250.93m2	No scope for expansion - Finsbury Health Centre is a Grade 1 listed building
Pine Street Medical Centre	No signed lease		NIA = 207.30m2	No scope for expansion - Finsbury Health Centre is a Grade 1 listed building
Amwell Group Practice	25yrs	2028	GIA/NIA not known	Purpose built in 2003. Ground and first floor. Part of mixed used residential development. No scope for extend the premises. Rooms occupied by community attached staff and could potentially be ‘freed

GP Practice	Length of Current Lease	Expiry date of lease	Premises data	Expansion proposals
				up' in preference for GP/Nurse consulting sessions if the practice list size were to increase significantly. High risk statutory compliance issues - No legionella risk assessment carried out.
Ritchie Street	25yrs	2021	576m2 but not sure of GIA/NIA	Purpose built in late 1990's. No scope to extend the premises. There are 16 clinical rooms in total 2 of these are used every day for the urgent walk-in Centre. High Risk statutory compliance issues - No asbestos survey or legionella risk assessment. CQC compliance issues.
The Neaman Practice	25yrs	2030	GIA as per the drawings on MICAD = 827.06m2	Information not available
New North Health Centre	25yrs	2035	Total size of building 157m2 NIA.GP space occupancy 117.8m2 NIA. Vacant space consists of 3 consulting rooms, GP wishes to expand into some of this space.	Purpose built in 2011. Ground floor accommodation. Part of a mixed use residential and pharmacy development. There is no potential to extend the premises but there are 3 clinical rooms are currently vacant in this building. High risk statutory compliance issue - No legionella risk assessment.
Elizabeth Avenue Practice	20yrs	2020	GIA /NIA not known	Purpose built in 1986 ground and first floor. The premises could be extended. The practice carried out a feasibility to extend their premises in 2012. High risk statutory compliance issues - no asbestos survey or legionella risk assessment.

Appendix 3: Capacity

	A	B	C	D	E	F	G	H	I	J	K
Practice (based on actual practice data)	List Size as at 1/10/13	Consultation : Patient appointment time per week in hrs:	Consultation: Rooms available in hrs:	Number of C/E rooms required:	C/E rooms currently available	No. of C/E rooms available to absorb additional growth	Treatment Room: Patient appointment time per week:	Treatment Rooms: Rooms available:	Number of treatment rooms required:	Treatment Rooms currently available	No. of addTreatment rooms available to absorb additional growth
City Road	6843	86	28	3	4	1	45	28	2	2	0
Pitfield Medical Practice	3545	60	36	2	2	1	25	36	1	2	1
Shoreditch Park Surgery	7272	60	28	2	9	7	28	28	1	3	2
Hoxton Surgery	5853	58	34	2	3	1	83	34	2	3	1
St Peter Street Medical Practice	9740	77	29	3	5	2	68	29	2	2	0
Clerkenwell Medical Centre	9409	85	29	3	7	4	66	29	2	3	1
Pine Street Medical Centre	2477	46	25	2	3	1	16	25	1	1	0
Amwell Group Practice	8151	97	28	3	7	4	65	28	2	1	0
Ritchie Street	12994	176	31	6	14	9	82	31	3	0	0
The Neaman Practtice	8487	94	32	3	6	3	53	32	2	2	0
New North Health Centre	1802	27	30	1	4	3	20	30	1	1	0
Elizabeth Avenue Group Practice	7028	153	28	5	6	1	83	28	3	2	0
Total:	**83,601**	**1019**	**358**	**35**	**70**	**37**	**634**	**358**	**21**	**22**	**6**
Total list increase pop. growth	**87,601**	**1958**	**32**	**62**	**70**	**8**	**614**	**32**	**20**	**22**	**2**

Notes:

Figures within Column B, C, D & I & J are provided by the Practices and indicate current availability and usage

Figures within Column E & K are taken from the Oakleaf survey or other similar property survey's of rooms available. Where the Oakleaf Survey was not available Practice provided data was used

Figures in red are based on exisitng list sizes plus forecast growth of 4000 therfore indicates future requirements

Appendix 4: Options Risk and Benefits Analysis

	Option	Benefits	Risks
1.	Do nothing	• No additional cost to NHS England (with the exception of increased capitation payments associated with an increased list). • No disruption for the Practice (i.e. no moving premises)	• Current infrastructure may not be able to cope with additional list size. • Expected growth of population may put additional pressure on existing GP premises. • Indirect financial implications to the NHS via increased access to acute and emergency services.
2.	Grow existing Practices within current premises.	• Provides an opportunity for existing practices to grow their list thereby increasing capitation • No additional cost to NHS England (with the exception of increased capitation payments associated with an increased list). • Less disruption for the Practice (i.e. no moving premises)	• Loss of opportunity to develop a new GP Practice or improve upon current existing GP premises within a new residential development amongst and already ever growing population • Expected growth of population may put additional pressure on existing GP premises. • Reliant on local practices being willing and able to absorb the additional patients. • Current infrastructure may not be able to cope with additional list size.

	Option	Benefits	Risks
3.	Develop & improve existing Practices	• Provides an opportunity for existing practices to grow their list thereby increasing capitation • This provides continuity to the current registered patients i.e. their care provision will continue at the existing locality. • Less disruption for the Practice (i.e. no moving premises	• The current premises may not allow for expansion due to size limitation or building restrictions • Any development or improvement funding is reliant on the approval of an adequate Business Case being put forward by the GP Practice • Additional premises costs to NHS England based on increased space occupancy
4.	Relocate an existing GP Practice into the City Forum Development	• The existing provider will benefit from a new fit for purpose building, thus being able to absorb additional capacity • A more cost effective approach in comparison to procuring a new contract. • NHS England can continue to monitor and maintain the already established Primary Care Service Contract thus eliminating the time and costs associated with procuring and establishing a new contract with a zero patient list.	• Administration & moving costs • Anticipated disruption associated with relocating an existing practice. • Increased premises cost associated with a new building (rent & rates) • Additional purchasing of new or replacement equipment costs (Clinical, Office and IT)
5.	Commission new premises and a new Practice	• A new GP Practice will absorb the patient increase of a new residential development • A new GP Practice fit for purpose • A new GP Practice will generate recruitment and possibly attract potential residents to the development and thus	• Costs associated with the procurement process • Additional cost to NHSE associated with a new contract • Additional contract and monitoring costs • Additional premises costs • Not cost effective due to the financial risks

	Option	Benefits	Risks
		boost morale within the community.	associated with a 'zero patient' list which may take time to build however financial viability is likely be dependent on an estimated patient capitation.

APPENDIX 3 –

SCRUTINY REVIEW INITIATION DOCUMENT (SID)
Review: GP Appointment Systems
Scrutiny Review Committee: Heath Scrutiny Committee
Director leading the Review: Director of Public Health
Lead Officer: Alison Blair, Islington CCG
Overall aim: To assess the performance of GP appointment systems and the service provided to residents.
Objectives of the review: To assess how effective urgent and non-urgent appointment systems are and how these vary across the borough. To examine GP appointments against current targets and identify any under-performing areas. To collect evidence of patient experiences and assess any unmet needs.
How is the review to be carried out: (Use separate sheets as necessary for 1-4 below) Scope of the Review Types of evidence will be assessed by the review: (add additional categories as needed) Documentary submissions: It is proposed that witness evidence be taken from: GPs Patient Groups ii) Commissioners Visits
Additional Information:
Extract from Minutes of HSC held on 16/10/2012 In the discussion the following points were made:
Objective one should be amended to read “to assess how effective urgent and non-urgent appointment systems”. Objective two be amended to read “To examine GP appointments against”. That the Chair and LINk member meet with the CCG to discuss how the scrutiny could effectively explore this area. The Committee requested any data available on GP performance by practice.

APPENDIX 4 –

Background

Roles and Responsibilities

NHS England is responsible for commissioning GP, dental, pharmacy and optometry services and for carrying out contractual compliance and performance monitoring.

It is however a jointly agreed objective of the Clinical Commissioning Group and the NHS Commissioning Board that local patients should have easy access to safe, high quality and accessible services.

The Clinical Commissioning Group (CCG) commissions the majority of health services for patients in the local area. This includes acute care, mental health services and community services but not GP services or specialist services such as heart transplants. CCGs do however have a role in driving up the quality of primary care in their area, and a duty to collaborate with NHS England to improve the quality of services.

GP practices operate as independent businesses and develop services in line with patients' needs. Their interests are represented to the NHS by local committees of NHS GPs, known as local medical committees.

The GP contract was determined nationally in 2004. The important points relating to GP appointments and access to GPs by patients may be summarised as follows:

(a) All practices must publish details of how patients can access a GP for a consultation. Many practices produce a leaflet.
(b) The number of appointments that should be offered is not specified, nor is the type of appointments system.
(c) Practices are required to 'meet reasonable needs of patients'. There are no limits on the number of patients that may be taken on by any one practice, nor on how many staff (doctors, nurses, receptionists) a practice may employ.
(d) The targets on speed of access were removed in 2010. It is no longer a requirement that a patient must be able to see a GP within 48 hours.

As part of the process of annual contract review, each GP practice is required to complete a detailed document for submission to the NHS contracts team, part of which specifies the clinic times offered to patients. The BMA recommends 4.6 appointments per patient per annum as a guide. Where it appears that a practice has fallen below this guideline figure it is asked to draw up an action plan which might propose an increase in the number of appointments per GP, the appointment of more GPs, or additional nursing time, or a combination of all of these inputs to ensure that more appointments are offered to patients.

The Committee has examined a number of factors which have a bearing on access to GP appointments and the patient experience. These include:

(a) Demand and GP Appointments and the capacity of GP practices to respond

- The number of patients registered with each practice;
- The number of GPs and other staff (i.e. practice nurses and receptionists);
- The number of appointments offered;
- Opening hours;
- The appointments system (e.g. same day booking, advance booking)

- The telephone system;
- Do not attend patients;
- The extended hours offered by each practice.

(b) Patient feedback on Access to GPs and Appointments

In London patients can also use the My Health London website to give feedback to their GPs www.myhealth.london.nhs.uk/.

(c) Patients' Complaints related to GPs Appointments

Under the new NHS structures complaints are part of the responsibility of primary care development at Clinical Commissioning Group level. All GP practices have patient participation groups and wider groups to collect patient feedback. GPs cannot turn away patients and data could be gathered from formal complaints.

The data on GP appointments for June 2012 shows significant variations from practice to practice and this should, as far as possible be reduced to ensure a positive experience for all patients.

STRATEGIC RESPONSIBILITY FOR COMMISSIONING

NHS England has responsibility for strategic decisions on the provision of additional GP practices and improvements to premises etc. and for bringing interested parties together as part of the decision-making.

NHS 111 SERVICE

It may be necessary to factor in NHS 111 which has recently replaced NHS Direct as the single number for urgent care advice. (The Service is provided locally by London Central & West Unscheduled Care Collaborative (LCW).) If the review wants to look at the entrance points to medical advice and health care, NHS 111 is one of them, alongside GPs and A&E.

Can NHS 111 cope with demand at peak periods? Is it contributing to the increased demand at A&E (too wide a subject for our review?)

To date there has been no evidence to suggest that NHS 111 has contributed to any increase demand in A&E attendances. Islington CCG are carefully monitoring LCW's ability to deal with peaks and troughs in activity. They receive weekly reports on this and are working with LCW on their plans for the winter period when they can expect to get more calls. NHS 111 also provides a directory of services whereby patients are signposted to the most appropriate services based on the need including primary care – GPs, community pharmacy, community services where appropriate etc.

A&E

It has been suggested that some patients present at A&E instead of making an appointment with their GP. See Tables 1 and 2 below. These six practices were selected because between them they account for the highest numbers of patients reporting to A&E at either Whittington or UCLH during the six month period from September 2012 to February 2013. It should be stressed however that these

practices have the largest patient lists in Islington and between them have more than 60,000 registered patients.

Table 1Whittington Hospital

GP Practice	Whittington	% of Total
Goodinge Group Practice	933	5.8
Northern Medical Centre	1,029	6.4
St John's Way Medical Centre	1,684	10.5
Total	**3,646**	**23**

Table 2 University College London Hospitals

GP Practice	UCLH	% of Total
Killick Street Health Centre	1,020	9.1
Ritchie Street Group Practice	1,106	9.8
St Peter's Medical Practice	743	6.6
Total	**2,869**	**25**

Sources: NHS Choices and Islington CCG Database

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ISLINGTON

Environment and Regeneration
222 Upper Street
London N1 1XR

Report of: Executive Member for Environment

Meeting of:	Date	Ward(s)
Executive	15.1.15	All

Non-exempt

SUBJECT: Diesel Surcharge on Permits

1. Synopsis

1.1 The Council's Sustainable Transport Strategy aims to reduce traffic volumes, traffic congestion, and the negative environmental impacts of unnecessary car use within Islington.

1.2 This report considers the particular adverse health impacts of diesel vehicles and proposes a levy on resident permit holders with diesel/heavy oil vehicles in order to reduce the harmful emissions from these types of vehicles.

2. Recommendations

2.1 To agree to introduce a surcharge on diesel and heavy oil emission pricing for resident parking permits, as set out in paragraph 3.9 below and with effect from April 2015.

2.2 To agree to exemptions from the surcharge for carers, taxis (black cabs) and trades people, as set out in paragraph 3.13, 3.14 and 3.16 below, with effect from April 2015 and until the introduction of the Mayor's Ultra Emission Zone.

3. Background

3.1 Through its Sustainable Transport Strategy, the Council supports and encourages resident good

health and good air quality by reducing harmful vehicle emissions and reducing unnecessary vehicle trips.

3.2 Emission based resident parking policies were introduced in 2008 (revised in 2010), in order to reduce carbon dioxide emissions (CO2). This initiative aimed at reducing greenhouse gas emissions by encouraging a move towards cleaner, lower emission vehicles. However, the initiative did not consider other vehicle emissions from diesel vehicles which are injurious to health.

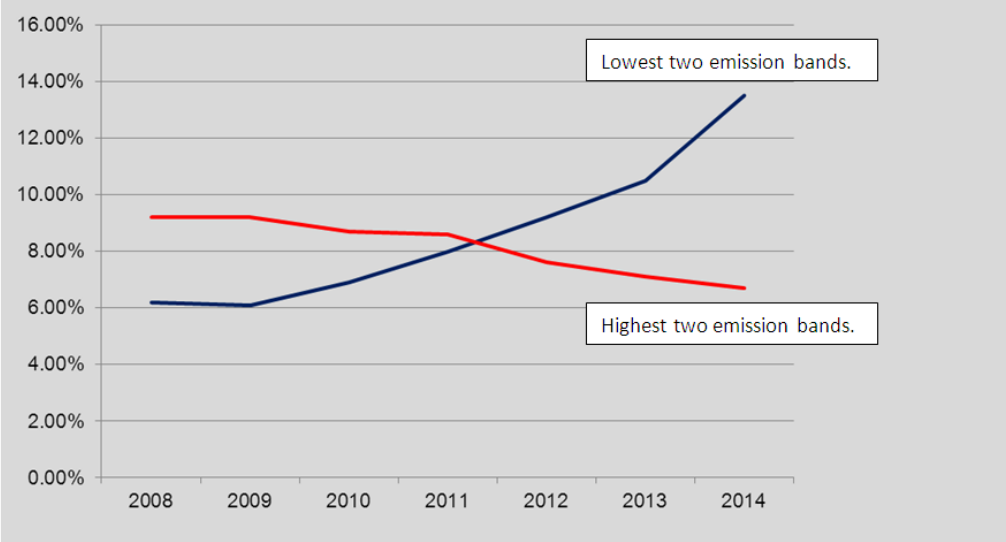
3.3 **Emission Based Parking**

Following a borough wide referendum in 2007, in 2008 Islington implemented seven price bandings for resident parking permits in support of the aims of Sustainable Transport Strategy. The purpose was to reduce CO2 emissions across all modes of vehicles and incentivise car ownership reduction.

3.4 In 2010 Islington reviewed this price banding and brought them in line with the DVLA's thirteen CO2 emissions bands. This was considered appropriate as the primary source of pollution/emissions data for vehicles was the DVLA website. It was accepted that the changes would require a number of years to take full effect. The current banding structure is at **Appendix A**.

3.5 Since 2008, there has been a progressive move from higher emission bands towards lower emission bands, as shown in **Figure 1.**

Figure 1.



3.6 Over the last seven years, the two lowest polluting bands have increased from 6.2% to 13.5% of all permits issued. The two highest polluting bands have reduced from 9.2% to 6.7% of all permits issued. However the present policy has not directly discouraged the use of diesel/heavy oil vehicles, the emissions of which (including particulates), are harmful to health.

3.7 **Diesel and Heavy Oil Emissions Pricing**

Diesel engine exhaust includes soot, aerosols such as ash particulates, metallic abrasion particles, sulphates, silicates and nitrogen oxides. The black carbon element of diesel emissions has a particularly adverse effect on human health. Diesel exhaust also contains nanoparticles, which have additional health impacts, though not fully understood. The adverse health effects of diesel particulates are linked to cancer, heart and lung damage, and mental functioning. Exposure has also been linked

with acute short-term symptoms such as headache, nausea, coughing, difficult or laboured breathing, irritation of the eyes, nose and throat and the onset of asthma in vulnerable individuals.

Diesel fuelled vehicles can emit up to four times more nitrogen oxides and up to more than twenty times more particulate matter than petrol fuelled vehicles. This has significant adverse health impacts and including for drivers who are particularly exposed to air pollution whilst in their vehicles. The most heavily polluted areas in Islington are also the most deprived wards, making reducing the health inequalities gap even more difficult. Whilst we can support residents to change lifestyle factors such as smoking and obesity, further interventions are still required to address environmental factors.

The sixth Environmental Audit Select Committee report on Air quality published in December 2014 identified that diesel vehicles are the most significant driver of air pollution in our cities. The growth in the number of such vehicles has in the past mainly been due to the financial incentives provided by the EU in order to reduce CO_2 emissions but newer petrol vehicle are now equal to diesel in terms of CO_2 emissions. Therefore a move away from diesel towards low emission petrol vehicles will now give greater benefits to both public health and the environment.

In 2012 the International Agency for Research on Cancer (IARC) (part of the World Health Organisation (WHO)) classified diesel engine emissions as “carcinogenic to humans”. This decision was made after a review of scientific evidence gathered from international experts. Their research showed that exposure to diesel engine exhaust causes lung cancer. Many studies have also found a firm link between traffic related air pollution and the risk of cardiovascular disease.

The biggest health inequalities issue in Islington is the large numbers of deaths from long-term conditions at relatively young ages. This accounts for the bulk of the gap in life expectancy between Islington and England. The main causes of death across all ages in Islington are cardiovascular disease, cancer and respiratory diseases (accounting for 33%, 28% and 13% of deaths in Islington respectively). Exposure to high levels of air pollution, particularly diesel emissions, is known to exacerbate these existing health conditions.

3.8 Other ill health effects of diesel originate with the high Nitrogen Oxides (NOx) emissions, though there is no available data that would allow a diesel banding structure. The Mayor’s Ultra Low Emission Zones (ULEZ) proposals focus on the need to reduce Nitrogen Oxide emissions from 2020, based on the notion that all cars registered after 2014/15 will produce low levels of NOx and CO2. However, there are no more imminent plans to address either Nitrogen Oxide or particulates emitted from diesel vehicles.

3.9 It is estimated that there are over 9,000 diesel/heavy oil vehicles currently with resident permits in Islington. In light of the above evidence, the Council strongly believes that action should be taken to reduce the harmful emissions of diesel vehicles sooner than 2020. It is therefore proposed to levy on top of the current pricing structure, a yearly surcharge of £96 each time a resident parking permit for a diesel or heavy oil vehicle is renewed or a new permit purchased unless the applicant is within one of the proposed exempted categories in paragraphs 3.13 to 3.15 below. This is equivalent to £8 per month or around £1.85 per week. The proposed charge is set at a level significant enough to encourage a move away from diesel/heavy oil vehicles, in a similar manner to the policy adopted for CO2 reduction. This proposal will also apply to all Estate Housing resident permit charges for diesel/heavy oil vehicles.

3.10 Other permit types may in future be subjected to the diesel surcharge including Business Permits, Universal Permits, Teachers Permits, Hire Car Permits, and Car Club Permits. It is proposed that these may be considered as part of an overall diesel surcharge policy.

3.11 **Exemptions**
The Council has implemented various existing concessions for different types of users of parking permits, as shown in **Appendix B**.

3.12 It is acknowledged that the proposed changes may cause some concern for those who depend on the use of their vehicle for mobility or employment purposes. It is proposed that exemptions be in place, for certain resident permit holders of diesel/heavy oil vehicles, until the introduction of the Mayors Ultra Low Emission Zone (which if approved is expected to commence in 2020, with resident exemptions living within the zone coming into force in 2023). In addition, the Council will work with TfL to seek a 'Euro VI heavy duty vehicle regulation' exemption.

3.13 **Carers**
This would be achieved on the basis that a carer would already have a carers permit or that a new carer could apply for one. As there is an existing process and eligibility criteria, it is recommended that this exemption be taken forward.

3.14 **Taxis (black cabs)**
This is considered straight forward, as these vehicles are readily identifiable and it is recommended that this exemption also be taken forward.

3.15 **Trades People**
There are three DVLA categories for vehicles, M (for carriage of passengers), N (for carriage of goods) and O (for trailers). Categories M and N are broken down further into three sub-groups, depending on size and mass (weight) of the vehicle. Vehicles such as typical cars are generally categorised as M, whilst vehicles used for trade, such as transit vans, are generally categorised as N.

3.16 It is proposed that the categorisation in paragraph 3.15 above be utilised through the use of the DVLA database to provide an exemption to all vehicles categorised specifically as N1 (vehicles designed and constructed for the carriage of goods and having a maximum mass not exceeding 3.5 tonnes), which are considered most likely to be used by local trades people. In addition, it is recognised that a portion of trades people may use category M vehicles. It is therefore further proposed that those who through the permit/renewal process self-declare as a trades person will be considered for an exemption on a case by case basis.

4. Implications

4.1 Financial implications:

4.1.1 The parking account is a ring-fenced account with any surplus generated from its activities invested in highways and transport related activities. Additional income received from the diesel surcharge will be allocated to the ring-fenced parking account, with the level of income dependent upon the extent of exemptions and the success of the surcharge in encouraging a move away from diesel/heavy oil vehicles. The impact of this will be modelled as part of the medium term financial planning process.

4.2 Legal Implications:

4.2.1. Sections 45 and 46 of the Road Traffic Regulation Act 1984 (the Act) enables the Council to designate parking places on the highway, to charge for parking in these places and to make a charge for parking permits for their use. The Council may differentiate in its permit charges between vehicles of different classes, including by reference to their level and type of emissions. An exemption may be granted to diesel taxis and vehicles used by carers and tradespeople for the purpose of their business from the proposed higher charge for diesel vehicles.

The function of setting charges for permits and vouchers must, like the other functions in the 1984 Act, be exercised to "secure the expeditious, convenient and safe movement of vehicular and other traffic (including pedestrians) and the provision of suitable and adequate parking on and off the highway…" so far as practicable having regard to:

(a) the desirability of securing and maintaining reasonable access to premises;
(b) the effect on the amenities of any locality affected and …..;
(bb) the strategy prepared under section 80 of the Environment Act 1995 (national air quality strategy);
(c) the importance of facilitating the passage of public service vehicles and of securing the safety and convenience of persons using or desiring to use such vehicles; and
(d) any other matters appearing to the local authority to be relevant [to the over-arching purpose].
(section 122 of the 1984 Act)

Further, in setting charges the Council must have regard to the Mayor of London's Transport Strategy (sections 142 and 144(1)(a) Greater London Authority Act 1999). That strategy emphasises the importance of reducing emissions and improving air quality.

The Secretary of State's non statutory Operational Guidance on Parking recommends that authorities set charges which are consistent with the aims of their transport strategy including road safety and traffic management strategies.

The Executive is reminded that it is unlawful for the Council to set or increases charges for parking permits for the purpose of generating additional income to fund its traffic management functions.

In the event that the impact of the proposed new charges generates a surplus over and above the cost of the on street parking scheme and its administration and enforcement, the Act requires that surplus to be paid at the end of the year into the Special Parking Account and spent on the wider transport purposes listed in section 55(4). Any shortfall is required to be made good from the general fund.

4.3 Environmental Implications:

The proposals will reduce harmful emissions from vehicle traffic within the Borough, particularly Nitrogen Oxide, particulates and Carbon Dioxide.

4.4 Residents Impact Assessment:

These proposals will mainly impact on those with resident permits who own diesel and heavy oil vehicles. All residents will benefit from better air quality and better health outcomes, especially older and young people. However a surcharge may affect some of these residents on low incomes.

The Council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good

relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The Council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The Council must have due regard to the need to tackle prejudice and promote understanding.

5. Conclusion and reason for recommendations

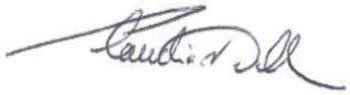
5.1 The proposals in this report will reduce harmful emissions within the borough and thereby mitigate their adverse impact on the health of residents.

Appendices – Appendix A – Current Resident Permit Pricing Structure
Appendix B - Existing Permit Concessions

Background papers - none

Final report clearance:

Signed by:



23.12.14

Executive Member for Environment Date

Received by:

Head of Democratic Services Date

Report Author: Zahur Khan
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Appendix A – Current Resident Permit Pricing Structure

Currently, there are 13 bandings for resident permits, and the prices are as below:

Band	Pre-2001 (cc)	Post-2001 (CO2g/km)	12 months	6 months	3 months	1 month
A	Electric	0-100	Free	Free	Free	Free
B	1-900	101-110	£15.50	£7.75	£5.75	£5.75
C	901-1100	111-120	£28	£14	£7	£5.75
D	1101-1200	121-130	£74	£37	£18.50	£6.25
E	1201-1300	131-140	£90	£45	£22.50	£7.50
F	1301-1399	141-150	£97	£48.50	£24.25	£8.25
G	1400-1500	151-165	£121	£60.50	£30.25	£10
H	1501-1650	166-175	£139	£69.50	£34.75	£11.50
I	1651-1850	176-185	£163	£81.50	£40.75	£14
J	1851-2100	186-200	£206	£103	£51.50	£17.50
K	2101-2500	201-225	£240	£120	£60	£20
L	2501-2750	226-255	£336	£168	£84	£28
M	2751 and above	256 and above	£434	£217	£108.50	£36.50

For **black taxi drivers**, there is an added price discount of one band, dependent on the given emissions data.

Appendix B – Existing Permit Concessions

Carers Permits, These allow those carers who meet the eligibility criteria to purchase permits despite not being resident in the CPZ of the cared-for person.
Visitor Vouchers, All purchases of these permits are unlimited, but for those over 60, and those on Disability Living Allowance, we offer vouchers at a 50% price discount.
Blue Badges, Islington was one of the first councils to use an independent mobility assessment service (which is now recommended nationally), to ensure that only those who are entitled to the Badge get one. The Council also allow those residents with Blue Badges to apply for a free residents permit, which then allows them to park outside their home without having to display the Blue Badge, deterring (and distressing) casual car crime.
New Parents, Islington provide 40 hours of free vouchers when they register the birth of their child, to cover the burst of parking activity that comes from having a new baby.
Suspensions, Islington offer residents a discount to the standard suspension admin charge (£88 as opposed to £180), when suspensions are chargeable.
Funerals, Islington offer a free waiver service for funerals, to assist in the bereavement process.
Vouchers for faith organisations, Faith organisations in Islington are entitled to apply for 200 hours of free visitor vouchers per year to facilitate parking for visitors to places of worship. A place of worship will be defined as a building that has a long established use as a place of worship, or have planning consent for use as a place of worship. These vouchers can be used to park vehicles in resident, or resident/shared use bays in the controlled parking zone in which the place of worship is located.
Universal permit, This is an annual permit aimed businesses that have a requirement to park across the borough on a regular basis. There is a 33% discount available for any registered charity who may require such permits.
Debt consideration, Islington has established a corporate team that will consider debts of the less well-off, which may be due to more than one Department. This includes residents who incur large Penalty Charge Notices (PCN) debts and face enforcement agent action, where we try and manage their debt according to their means.

ISLINGTON

Public Health Department
3rd Floor, Turbine Wing
222 Upper Street
London N1 1XR

Report of: Janet Burgess, Executive Member for Health and Wellbeing

Meeting of:	**Date**	**Ward(s)**
Executive	15 January 2015	All

Delete as appropriate	~~Exempt~~	Non-exempt

SUBJECT: Approval of the Procurement Strategy for Universal Child Health Services, including a request to award a two year extension to the School Nursing contract.

1. Synopsis

1.1 This report seeks pre-tender approval for the procurement strategy for Universal Child Health Services in accordance with Rule 2.5 of the Council's Procurement Rules.

1.2 The two services included in this procurement strategy are Health Visiting Services for children aged 0-5, and the School Nursing Service for children aged 5-19. Approval for a contract award for a two year extension to the current School Nursing Service contract is sought as part of this procurement strategy.

2. Recommendations

2.1 To approve the procurement strategy for Universal Child Health Services 0-19. This strategy recommends the procurement of health visiting and school nursing services together from April 2017.

2.2 To approve a contract award for a two year extension to Whittington Health for the School Nursing Service contract (contract No. WH-sub-1007), as part of this procurement strategy, to allow time to conduct a review of both services and design the new service model.

2.3 A future pre-procurement strategy report will be presented to the Executive following the health

visiting service transfer to the council in October 2015 and once the health visiting and school health reviews are completed. The report will contain further details about the new service model for Universal Child Health Services 0-19, as well as its estimated value, the procurement timetable and the evaluation criteria.

3. Background

3.1 Nature of the service

This report outlines the procurement strategy for universal child health services 0-19. The two services included in this procurement strategy are the health visiting service (for children aged 0-5) and the school nursing service (for children aged 5-19). Responsibility for commissioning health visiting services currently sits with NHS England but will be transferred to the local authority in October 2015. There will be a 12-18 months "safe landing" clause attached to the transfer, meaning that the earliest that the local authority will be able to recommision the contract will be between October 2016 and March 2017, depending on the terms of the service transfer. The health visiting service also includes the Family Nurse Partnership (FNP), which is a targeted health visiting service for pregnant teenagers and teenage mothers. Health visiting in Islington is currently provided by Whittington Health, which also provides the health visiting service for Haringey, although there are separate service arrangements for each borough.

Recently, the Government has announced that certain elements of the health visiting service will be mandated in regulations for local authorities when the service is transferred, specifically: the antenatal health promotion review; the new baby review, which is the first health visitor check after the birth; the 6-8 week assessment; the 1 year old assessment; and the 2 to 2 ½ year-old review. These are key milestones for targeted evidence-based assessment and support during the early years.

Responsibility for commissioning School Nursing Services was transferred to the local authority on the 1st of April 2013. The current service is also provided by Whittington Health. School nurses focus on the delivery of the national Health Child Programme (5-19), which offers school aged children a schedule of health and development reviews, screening tests, immunisations and health promotion, as well as tailored support for children and families. School nurses also deliver the National Child Weight Measurement Programme (NCMP), which is a mandated public health programme for the Local Authority.

The service was subject to a major review by NHS Islington in 2011/12 as part of the then PCT savings programme, and the budget for the service was reduced by 35%. It has been acknowledged there are a number of long standing gaps and challenges in the current school nursing service model, in particular around providing more targeted support to school children with health problems and long term conditions, including mental health, and hence a review of the current model in the context of the wider school health offer is underway.

3.2 Rationale

Ensuring the best start in life for Islington's children and young people is a joint priority for Islington's Health and Wellbeing Board and Clinical Commissioning Group. The Healthy Child Programme (HCP) is the universal public health programme for children and families from pregnancy to 19 years of age. The HCP is evidence-based, available to all children and aims to ensure that every child gets the best start they need to lay the foundations for a healthy life. It aims to offer every child and family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support positive parenting and healthy choices – all

services that children and families need to receive if they are to achieve their optimum health and wellbeing, and more targeted support to children and families where there are vulnerabilities and risks.

Procurement of these two services is necessary for Islington Council to deliver the core elements of the Healthy Child Programme (HCP). Universal and targeted public health services provided by health visiting and school nursing teams are crucial to improving health and wellbeing of children and young people, underpinned by a strong evidence base for child health promotion interventions. Both services also play an important role in the safeguarding of children and young people.

As responsibility for commissioning health visiting services will transfer to the Council from October 2015, there is a strong rationale for procuring both services together as part of a procurement strategy for the provision of universal child health services in Islington (0-19) from 2017.

Some of the potential benefits of a 0-19 approach include:

- Enable us to review and design the delivery model for these two services more efficiently and effectively, leading to improved quality of services and ensuring they provide best value for money.
- Allow for stronger integration of the two services, including the creation of a seamless pathway of support for children from birth to age 19.
- Ensure there is continuity in the support given to children and their families through key transition points (i.e. from early years to school).
- Allow for integration of the support provided around the whole family, i.e. there could be a single link for parents who have children both in early years and in schools.
- Supporting the development of a single child health information record for all children 0-19.
- Allow for a shared management structure for both services and increased opportunities for professional development for both the health visiting and school nursing workforce, through collaboration in the provision of key services.

In order to support this procurement option, an extension is being sought for the Islington School Nursing Service for two years until March 2017.

An extension for school nursing will enable us to align the procurement with health visiting. In addition, it will allow us to consider the potential benefits of commissioning these two services with other boroughs, or via integrated arrangements with other local NHS services for children and families commissioned by Islington CCG.

The recommendations of the school nursing review will feed into the procurement strategy to ensure the re-procured and re-specified school nursing service best meets the needs of school aged children in Islington. A review of the health visiting service is also planned as part of the commissioning transition arrangements for Islington, which will similarly inform the future reprocurement of universal child health services.

3.3 Estimated Value

The current value of the school nursing contract is £677,000 per year. The value of the two year extension of this contract is therefore £1,354,000.

We are currently working to estimates of what financial resources will be transferred to the local authority to commission Health Visiting and the Family Nurse Partnership (FNP). The most recent estimates from the incumbent provider of current combined employee and non-employee costs for

health visiting and the Family Nurse Partnership programme are £4,132,000 for health visiting and £373,000 for the FNP per annum. The costs are based on the size of the health visiting service reaching the target set in the national 'Call to Action' for increasing the health visiting workforce. NHS England has committed to funding the full trajectory for health visitors, irrespective of whether the provider has managed to fill all vacant posts at the time of transfer to local authorities.

The reviews of these services are intended to identify options for increasing efficiencies and effectiveness and improving outcomes, including commissioning school nursing and health visiting services jointly; opportunities for encouraging investment from the NHS or schools in selected functions/ interventions; and the pros and cons of joint commissioning with other boroughs or the NHS.

The mix of universal and targeted services provided through Health Visiting and School Nursing is important in driving improvements in children's health, particularly in the early years. This is an area of priority because of the high levels of vulnerability and disadvantage experienced by children and families in the borough. There is therefore an important need to drive transformation and improvement in our child health services, and this will be a major focus of the reprocurement of health visiting and school nursing as part of the achievement of Best Value and improved outcomes in services. The re-procured service is proposed to run for a period of 3 years, starting from April 2017, with an optional extension of 2 years.

3.4 Timetable

The contract for health visiting will be transferred from NHS England to Local Authorities in October 2015. There is a 12-18 months "safe landing" clause attached to the transfer, meaning that the earliest that the Council will be able to reprocure these services is between October 2016 and March 2017.

The School Nursing Contract was transferred to the Local Authority in April 2013. The current contract expires on 31 March 2015. A two year extension is requested to align re-commissioning of this service with health visiting.

3.5 Options appraisal

At this stage the two main procurement routes considered are the following:

Option 1: Re-procure school nursing in 2015/16 following completion of the current review of the service. This option would require shorter one year extension to the School Nursing contracts.

Option 2: Request a two-year extension for the school nursing contract to align contract end points with Health Visiting, and to procure both services together, including other options for other local integration, for example with other boroughs such as Camden and/or local NHS services.

Option 2 is the preferred option, as it will allow us to align the procurement of school nursing with health visiting, and increases the opportunities for commissioning jointly. It will also allow completion of the review of school health in Islington to identify gaps and areas for development and ensure the reprocured school nursing service best meets the needs of school aged children in Islington.

3.6 Key Considerations – social value

The vast majority of the resource for these two services is spent on the school nursing and health visiting workforce. In terms of the school nursing service contract extension, we will work with the provider to seek to identify local opportunities for apprenticeships, training and recruitment for Islington residents.

A requirement for the payment of LLW will be included as a condition of the contract extension. All staff currently employed to provide this service are already above the LLW, so there we do not anticipate any implications for the current provider.

3.7 Evaluation

If the proposed procurement strategy and extension are agreed, we will then conduct a full appraisal of the options available for the future commissioning of these two services. Once an option has been agreed, a procurement project group will be set up involving key representatives from relevant departments (and with other councils if applicable).

The evaluation criteria for the tender will be decided by a procurement project group, but it is expected to include the following:

- Quality and outcomes of service provision.
- Best value.
- Monitoring and transparency.
- Improving partnerships and collaboration.
- Improving governance and budget accountability.
- Allowing for innovation within the agreed framework.

The detailed evaluation criteria will need to be developed by the procurement project group, and reviewed and agreed as part of the re-procurement proposals. A future report will be presented to Executive after the health visiting service has been transferred to the council and the school health review completed, with detailed information about the new service model to be procured and the evaluation criteria that will be used as part of the procurement.

3.8 Key risks

The key business risks associated with this procurement strategy are related to delays or other issues with the transfer of health visiting contracts to the council, as well as the financial allocation to the Council to support the future commissioning of the health visiting service. To capture and mitigate all these risks, a robust project plan for the transition of Health Visiting is in place with clear objectives, deliverables and timescales, and an Integrated Governance Framework has been agreed with NHS England which allows Islington Council to be co-commissioners of the service in the period leading up to the transition. A due diligence process relating to the financial aspects of the transfer is currently being carried out. The commissioning budget for health visiting and the FNP programme that will be allocated to Islington Council as part of its ring-fenced public health grant was due to be confirmed in December 2015. Announcement of these allocations has been delayed and is now expected in early 2015.

3.9

Set out below is a summary of the key information contained in this report:

Relevant information	**Information/section in report**
1 Nature of the service	This report outlines the procurement strategy for universal child health services 0-19. The two services included in this procurement strategy are the health visiting service (for children aged 0-5) and the school nursing service (for children aged 5-19). The responsibility for commissioning health visiting services currently sits with NHS England but will be

	transferred to the local authority in October 2015. This strategy would allow for the Council to commission these two services together, and also allow consideration of joint commissioning with other boroughs such as Camden, as well as jointly with the local NHS. This paper also states the case for a two year extension for School Nursing until March 2017, so that the procurement of the two services can be aligned from April 2017. See paragraphs 3.1 and 3.2 for more details.
2 Estimated value	The estimated value for the two services per year is £5,182,000, of which £677,000 is currently in the Council's Public Health grant for school nursing. The re-procured service is proposed to run for a period of 3 years, starting from April 2017, with an optional extension of 2 years.. The value of the two-year extension for the School Nursing contract requested is £677,000 per year. The total value is £1,354,000. See paragraph 3.3
3 Timetable	The contract for health visiting will be transferred from NHS England to Local Authorities in October 2015. There is a 12-18 months "safe landing" clause attached to the transfer, meaning that the earliest that local authority will be able to recommision the contract is between October 2016 and March 2017. The School Nursing Contract was transferred to the Local Authority in April 2013. The current contract expires on 31 March 2015. A two year extension is requested to align re-commissioning this service with health visiting. The new contract for the Health Visiting and School nursing services will start from April 2017. The detailed timetable for the procurement process will be established by the procurement project group. See paragraph 3.4
4 Options appraisal for tender procedure including consideration of collaboration opportunities	Two options were considered: a. Reprocuring school nursing in 2015/16, following the current review, which would require an extension for the school nursing current contract of up to one year. b. Request a two-year extension for the school

	nursing contract to align contract end points with Health Visiting in order to procure both services together as part of the Procurement strategy for Universal Child Health services (0-19), as well as considering options for commissioning with other boroughs such as Camden or with local NHS services. Option b is the preferred option, as it would enable us to align the procurement of both services and jointly commission both services; it would also give us time to conduct a review of school nursing service and implement changes ahead of reprocurement. When we appraise options for re-procuring both services, we will explore opportunities for developing integrated commissioning arrangements with Camden, as well as with Islington CCG. See paragraph 3.5.
5 Consideration of: Social benefit clauses; London Living Wage; Best value; TUPE, pensions and other staffing implications	Consideration will be given to social benefit clauses in terms of local opportunities for apprenticeships, training and recruitment for Islington residents as part of the reprocurement. A requirement for the payment of LLW will be included as a condition of the contract extension. All staff currently employed to provide this service are already above the LLW, so there we do not anticipate any implications for the current provider. See paragraph 3.6
6 Evaluation criteria	The evaluation criteria will be decided as part of the procurement process, but it is expected to include the following: - Quality and outcomes of service provision. - Best value. - Monitoring and transparency. - Improving partnerships and collaboration. - Improving governance and budget accountability - Allowing for innovation within the agreed framework. A future report will be presented to Executive once the new service model has been designed and prior to procurement, with details of the evaluation criteria to be used. See paragraph 3.7
7 Any business risks associated with entering the contract	The main business risks are:

	- Delays/ issues with the transfer of health visiting contracts to the Council, including financial allocations. To avoid this, a project plan is in place with clear objectives and timescales, and an Integrated Governance Framework has been agreed with NHS England which allows us to be co-commissioners in the period leading up to the transition. A due diligence process in relation to the indicative financial allocation is being conducted.
8 Any other relevant financial, legal or other considerations.	Implications are described in section 4

4. Implications

4.1 Financial implications

Islington Council receives a ring-fenced Public Health grant from the Department of Health to fund the cost of its Public Health service. The total funding for 2014/15 is £25.429m and will remain at that level for 2015/16.

The responsibility around commissioning of health visiting services will pass from NHS England to the Council in October 2015. This should come with budget and should not create a pressure for the Council.

The amount expected to transfer in relation to health visiting (including the Family Nurse Partnership) is £4.5m. There is a risk that the values identified are insufficient to provide the current level or expected level of service.

There is currently a budget of £677k available for School Nursing meaning a potential total budget (incl. health visiting money) of £5.177m for Universal Child Health Services. This figure is however subject to change due to the allocation for the health visiting transfer not yet being confirmed.

The Council's Public Health expenditure must be contained entirely within the grant funded cash limit indicated above. If any additional pressures are incurred management actions will need to be identified to cover these.

To avoid a potential future financial pressure for the Council, any contracts should have a termination clause which allows them to end if they become unaffordable.

4.2 Legal Implications

The council has a duty to improve public health under the Health and Social Care Act 2012, section 12. The council must take such steps as it considers appropriate for improving the health of the people in its area including providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way) as well as providing services or facilities for the prevention, diagnosis or treatment of illness (National Health Service Act 2006, section 2B, as amended by Health and Social Care Act 2012, section 12 and Regulation 2013/351 made under the National Health Service Act 2006, section

6C).

Therefore the council may provide universal child services as proposed in this report. The council may enter into contracts with providers of such services under section 1 of the Local Government (Contracts) Act 1997.

The threshold for application of the Public Contracts Regulations 2006 is currently £172,514. The value the proposed contract is above this threshold. These services fall within Part B of the Regulations. Although Part B services do not need to strictly comply with the provisions of the Regulations, there is a requirement under EU rules for part B services to comply with the principles of equal treatment, non-discrimination and fair competition. The council's Procurement Rules require contracts over the value of £100,000 to be subject to competitive tender. On completion of the procurement process the contract may be awarded to the highest scoring tenderer.

In relation to extending without transparency or competition the existing contract with Whittington Health for the school nursing service, there is a potential risk of procurement challenge. This is because the value of the extension is significant, being £1,354,000 over two years. However the market for the provision of these services is currently thought to be very restricted, which is likely to minimise the risk. The benefit of extending the existing contract in order to carry out a single procurement for the combined services for health visiting and school nursing, as proposed in the report, is likely to outweigh the risk associated with extending the existing contract.

4.3 Environmental Implications

An environmental impact assessment will be conducted as part of the procurement process.

4.4 Resident Impact Assessment (incorporating the Equalities Impact Assessment):

The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

Neither the initial screening for a Resident Impact Assessment nor a full RIA has been completed because the services proposed in this procurement strategy are to be provided from April 2017 and hence it is still too early to conduct a RIA. A full RIA will be carried out prior to the procurement process.

5. Conclusion and reasons for recommendations

5.1 This paper presents the procurement strategy for Universal Health Services for children aged 0-19, which includes the following two services:

- The Health Visiting Service (for children aged 0-5). The responsibility for commissioning health visiting services currently sits with NHS England but will be transferred to Islington Council in October 2015. The earliest Islington Council will be able to re-commission this service is 12-18 months after transition, i.e. from October 2016 to March 2017. The service is currently provided by Whittington Health. This also includes the Family Nurse Partnership service, which is a targeted health visiting service for teenage mothers.

The School Nursing Service (for children aged 5-19). The responsibility for commissioning this service was transferred to Islington Council on the 1st of April 2013. The current contract with Whittington Health (provider) expires in March 2015.

As it will be the Council's responsibility to commission both services from October 2015, there is a strong rationale for considering procuring both services together as part of a procurement strategy for the provision of universal child health services in Islington (0-19) from 2017. In addition, there may be options to jointly commission with other, or to jointly commission with other NHS children services.

This will require an extension for the Islington School Nursing Service for two years until March 2017. A two-year extension of the school nursing contracts will enable us to align the procurement of school nursing with health visiting. It will also enable time to complete reviews of health visiting and of school health in Islington to identify gaps and areas for development to improve value and quality. The recommendations of these reviews will feed into a more detailed procurement strategy, new service model and service specification for the service to ensure the provision of a high quality service which best meets the needs of children and young people in Islington.

5.2 A future pre-procurement strategy report will be presented to the Executive once the health visiting service has been transferred to the council in October 2015 and once the health visiting and school health reviews are completed. This future report will contain further details about the new service model, the estimated value, the procurement timetable and the evaluation criteria.

Final report clearance:

Signed by:

Janet Burgess

17 December 2014

Janet Burgess
Executive Member for Health and Wellbeing

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ISLINGTON

Public Health
Municipal Offices, 222 Upper Street, London, N1 1YR

Report of: **Director of Public Health**

Meeting of:	**Date**	**Ward(s)**
Executive	15 January 2015	ALL

Delete as appropriate		Non exempt

THE APPENDIX TO THIS REPORT IS NOT FOR PUBLICATION

Subject: Contract award report for 1314- 164 - The Camden and Islington's Young People's Sexual Health and Contraceptive Service

1. Synopsis

1.1 This report summarises the outcome of the procurement process in respect of a managed network of younger people's sexual health services and seeks approval to award the contracts for Lot 1 to Brook, Lot 2 to Brandon Centre and Lot 3 to the Homerton NHS Trust. This report also summarises the status of the procurement with regards to Lot 4.

2. Recommendations

2.1 To approve the award of the contracts for younger people's sexual health services to

Lot 1 - Core Offer + **Specialism (Targeted and Vulnerable Groups Sexual Health and Relationships Support Service; Brook

Lot 2 - Core Offer + **Specialism (C-Card Coordination PLUS Workforce development); The Brandon Centre

Lot 3 - Core Offer + **Specialism (Clinical Outreach Service); Homerton NHS Trust

2.2 To grant delegated authority to the Director of Public Health for the award of Lot 4.

2.3 To note the contents of Exempt Appendix A.

3. Background

3.1 The aim of the procurement is to offer a managed network of Care Quality Commission (CQC) registered sexual health services for younger people (up to 25 years of age, but mainly focused on under 21s). It includes younger people sexual and reproductive health clinics, clinical outreach, targeted youth outreach, in-reach to education facilities, psychotherapy, chlamydia screening and a condom distribution scheme. The contract will commence on 1st April 2015. This procurement was undertaken in collaboration with Camden Council.

3.2 The service will support delivery against the three main sexual health Public Health Outcomes Framework measures for younger people up to the age of 25 years:

- Reduced Under 18 conceptions
- Improved Chlamydia diagnoses (15-24 year olds)
- Reductions in people presenting with HIV at a late stage of infection

The services meet a wide range of other important objectives while providing easy access to 'one stop shops' in services with extended opening hours and accessible locations.

3.3 The young people's network will deliver the following outcomes to improve the sexual health in the local population as a whole:

- Increase access to services whether clinic based or through outreach for young people with the highest levels of risk
- Increase access to HIV and viral hepatitis testing for young people at risk
- Provide services in a way that is appropriate to young people in accordance with You're Welcome principles
- Provide services at locations and times which meet the needs for young people from across Camden and Islington
- Reduce the need for young people to access specialist Level 3 GUM and contraception services unless clinically indicated

3.4 Specific performance indicators have been developed to measure the achievement of these outcomes. Bidders were invited to make proposals against these indicators which were assessed as part of the tender process

3.5 The new managed network will enable commissioners to:

- Provide transparent lead accountability, pathways and budget lines for all elements of young people's sexual health provision.
- Examine ways in which the best elements/practice in Camden and Islington can be incorporated into a jointly commissioned young people's sexual health service across both boroughs.
- Develop a stronger link between sexual health services and safeguarding & improve systems to identify risks for young people.
- Use the commissioning process to achieve value for money and economies of scale.
- Use the commissioning process in achieving the right balance of service provision between client groups.

3.6 This tender exercise was undertaken as the existing contracts end on 31 March 2015. It provided an opportunity to review the service and to demonstrate effectiveness and added value for the new services.

3.7 The Camden and Islington Young People's Sexual Health and Contraceptive service was offered to the market on the basis of LOTs, with each Specialism being required to operate across both boroughs and co-locate with services within the network wherever possible.

3.8 The model:

Lot 1 Southern Border - *Core Offer (plus) - **Specialism (Targeted and Vulnerable Groups Sexual Health & Relationships Support Service)
Lot 2 Mid Camden - *Core Offer (plus) - **Specialism (C-Card Coordination and Workforce development)
Lot 3 Mid Islington - *Core Offer (plus) - **Specialism (Clinical Outreach services)
Lot 4 Camden & Islington - Network coordination

The Core Offer includes provision of:
- A Level 1&2 Sexual Reproductive Health (SRH) Clinic
- Sex and Relationship Education (SRE) support to local schools
- Sex and Relationships Counselling

The aim of Lot 4 is to create an effective managed network across all the sexual health services. This includes simplifying and streamlining the outward face of the services for service users, working to ensure vulnerable young people are identified within the network, such as those at risk of sexual exploitation and maintaining equitable and high standards of provision across the borough. In addition the network will provide the specialist medical input across the network.

3.9 Bidders had to be successful on any of the Lots 1, 2 and 3 to be able for their bid to be considered for Lot 4

.

3.10 The procurement process followed was a restricted procedure. This is a two stage procedure. Expressions of interests in bidding for this contract were sought. Providers expressing an interest were then asked to complete a Pre-qualification Questionnaire (PQQ). The PQQ stage involved selecting a maximum of up to 5 highest scoring submissions per Lot. All submissions were subject to minimum requirements set out in the PQQ.

3.11 The tender evaluation panel assessing the pre-qualification questionnaire and bids consisted of Managers from Public Health and Commissioning across Camden and Islington, finance colleagues and 5 young people for the Young Peoples Presentation.

3.12 A total of 31 expressions of interest were made. The six completed questionnaires were submitted in total for all 4 Lots. Details of providers are attached in Appendix A

3.13 The Pre-Qualification Questionnaire (PQQ) assessed whether bidders had suitable levels of experience. All compliance questions had to be answered, met and evidenced as necessary. 6 organisations submitted pre-qualification questionnaires. 5 organisations met the minimum requirement and were invited to submit a tender

3.14 All organisations invited to tender were required to submit an application form which included method statement questions addressing each of the Quality Criteria and pricing schedule per

Lot. Invitation to Tenders were assessed as most economically advantages against the following criteria

Quality Criteria		(60%)
•	Mobilisation/Implementation/Change Management	5%
•	Service Model and delivery – core	10%
•	Service Model and delivery – Specialism	7%
•	Management/Staff/Recruitment and business continuity	10%
•	Partnership Working	8%
•	Performance and Outcomes – core	5%
•	Performance and Outcomes – Specialism	5%
•	Client Engagement & Involvement	5%
•	Young People's presentation	5%
Cost		(40%)

3.15 Tender submissions where subject to minimum quality thresholds, with organisations needing to score a minimum of 3 to each quality requirements in the invitation to tender to be considered.

3.16 Four tender submissions were received (see table below and further details in appendix A).

Lot 1	Brook
Lot 2	Brandon centre
Lot 3	Homerton University Hospital NHS Trust Central and North West London NHS TRUST (CNWL)
Lot 4	CNWL

Whittington Health Trust did not submit a bid.

3.17 The panel carried out site visits for information purposes only and they did not form part of the evaluation. Clarifications were emailed via the e-tendering system, to providers and scores were confirmed following a response from bidders. The panel were able to award for Lots 1, 2 and 3.

3.18 The procurement panel were not able to recommend an award for Lot 4 as the only bid for this lot came from an organisation that were not successful in Lots 1, 2 or 3. Lot 4 will be negotiated directly with the successful providers after contract award.

3.19 Efficiencies have been made from this contract with a reduction of £188,883 to Islington's annual contribution, increasing the expected level of service across all providers, widening the services geographical remits and increasing the upper age limited

3.20 The contract is being awarded at total combined annual value of £1,660,000 across Camden and Islington which at the maximum life of the contract would equate to a total contract value of £11,620,000. This contract contains clauses that allow the contract to be varied or terminated. There is 5% performance related to be retained for shared outcomes across the network.

3.21 Islington's annual contribution is £823,117 with a total contract value of £5,761,819 including extensions.

3.22 The estimated total value for Lot 4 is £1,050,000 over the maximum 7 years (84 months) term of the contract. This is based on £150,000 per annum. The Islington share of this is £525,000 or £75,000 per annum. This includes a 5% performance related payment to be retained for shared outcomes across the network.

4. Proposed Decision

4.1 Based on the results of the tender, the tender evaluation panel recommends the awards of contracts for lots 1, 2, and 3 to Brook, the Brandon Centre and Homerton NHS Trusts

4.2 For the Director of Public Health to award the contract for Lot 4 through a process of direct negotiation with the three successful providers for Lots 1-3 under delegated authority in consultation with the Lead Member for Health and Wellbeing.

5. Implications

5.1 Financial Implications include reference to LLW, TUPE/Pensions Implications

Islington Council receives a ring-fenced Public Health grant from the Department of Health to fund the cost of its Public Health service. The total funding for 2014/15 is £25.429m and will remain at that level for 2015/16.

The Council is entering into a procurement collaboratively with Camden Council in order to provide sexual health services to younger people.

The current budget earmarked by Islington for this procurement is £823,117 per annum, this will result in a total contract value over the 3 year life of £2,469,351 and £5,761,819 with extensions. The result of this procurement is a saving of 20% (£188k) on Islington's current annual contribution.

The Council's Public Health expenditure must be contained entirely within the grant funded cash limit indicated above. If any additional pressures are incurred management actions will need to be identified to cover this.

Payment of London Living Wage is a requirement of the contract and will not result in any additional costs.

Any TUPE cost implications that may arise from this tender will have to be met by existing resources outlined above.

To avoid a potential future financial pressure for the Council, any future contracts should have a termination clause which allows them to end if they become unaffordable.

5.2 Legal Implications

The council has a duty to improve public health under the Health and Social Care Act 2012, section 12. The council must take such steps as it considers appropriate for improving the health of the people in its area including providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to

health or in any other way) as well as providing services or facilities for the prevention, diagnosis or treatment of illness (National Health Service Act 2006, section 2B, as amended by Health and Social Care Act 2012, section 12).

Therefore the council may provide services in relation to sexual health as proposed in this report. The Council has power to enter into contracts under section 1 of the Local Government (Contracts) Act 1997 on the basis that such services are properly required for the discharge of the Council's functions.

The threshold for application of the Public Contracts Regulations 2006 (the Regulations) is currently £173,934. The value of the proposed framework agreement to be established is above this threshold. These services fall within Part B of the Regulations. Although Part B services do not need to strictly comply with the provisions of the Regulations, there is a requirement under EU rules for part B services to be procured in compliance with the principles of equal treatment, non-discrimination and fair competition. The council's Procurement Rules require contracts over the value of £100,000 to be subject to competitive tender.

In compliance with the principles underpinning the Regulations and the council's Procurement Rules a competitive tendering procedure with advertisement has been used.

Bids were subject to evaluation in accordance with the tender evaluation model and Brook, the Brandon Centre and Homerton NHS Trust may be awarded the contracts for Lot 1, 2 and 3 respectively as recommended.

In deciding whether to award the contract to the recommended providers the Executive should be satisfied as to the competence of the suppliers to provide the services and that the tender prices represent value for money for the Council. In considering the recommendations in this report members must take into account the information contained in the exempt appendix to the report.

5.3 Environment Impact Assessment

There are no major Environmental Implications in the proposed procurement. The main areas of environmental impact of the contract would be the travel of outreach workers, who should be encouraged to travel by foot or public transport where possible, and the energy performance of the buildings from which services are delivered.

5.4 Resident Impact Assessment

An Equality Impact Assessment (EIA) was completed on 5th November 2013.

The EIA identified that there would be no differential impacts. This decision was made because this proposed procurement would have no disproportionate impact on any of the equality groups accessing the services.

6 Conclusion and reasons for recommendations

6.1 The recommended providers have agree as part of the tender process to work in collaborative to provide a managed network of sexual health services

6.2 The managed network model is considered to provide better value for money across Camden and Islington

6.3 The recommended providers are those that scored the highest through the evaluation process based on the most economically advantages against the criteria.

6.4 Decision on award for Lot 4 can now be best made through a process of direct negotiation with the providers.

Final report clearance:

Signed by:		Date:
	Executive Member for Health and Wellbeing	5 January 2015

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ISLINGTON

Housing & Adult Social Services
7 Newington Barrow Way, London, N7 7EP

Report of: Executive Member for Housing and Development

Meeting of:	Date	Ward(s)
Executive	15 January 2015	Tollington

THE APPENDIX TO THIS REPORT IS NOT FOR PUBLICATION

SUBJECT: CONTRACT AWARD FOR THE CONSTRUCTION OF 23 NEW COUNCIL HOMES AND A COMMUNITY CENTRE AT IVY HALL, HOLLY PARK, N4 4BN

1. SYNOPSIS

1.1 Through building new council homes we can help tackle the cost of living crisis faced by many of our residents by creating more jobs that pay the London Living Wage (LLW) and training opportunities, including apprenticeships, for local people and help increase the supply of decent, genuinely affordable homes

1.2 This report seeks approval to award a construction contract for a development of 23 new council homes for social rent and a new community centre on the site of the existing Ivy Hall Community Centre and covered car parking areas at Holly Park, N4 4BN. A robust procurement process has been undertaken in accordance with policies and procedures adopted by the Council and the New Build Contractor Framework. This has resulted in a direct negotiation process with a contractor who has a good track record of delivering new homes in Islington to the required quality standards and achieving value for money (VFM) for the council.

2. RECOMMENDATION

2.1 To approve the award of a contract to Higgins Construction PLC for the construction of 23 new homes and a new community centre.

3. BACKGROUND

3.1 The site comprises of an existing concrete structure that is used in part as a car park which then extends to form a raised plinth around Ilex House which is an existing 17 storey residential tower block that was built in the 1970s. The base of the car park contains the Ivy Hall

Community Centre. The perimeter of the site is lined with grassed verges containing several mature trees.

3.2 It is anticipated that the development will make a positive contribution to the borough through the delivery of much needed new council homes and social infrastructure in the form of a new improved community centre at the site. The new community centre will enable the relocation of Hanley Crouch (The Laundry) Community Centre to this site along with the existing management arrangements to ensure that the community will continue to benefit from the excellent service provided in a new and improved setting.

3.3 A review of five initial massing options for the development of the site was undertaken from 2012 and a thorough and inclusive consultation process was undertaken to establish a form of development that would respond to the surrounding built context, protect neighbouring residential amenity and provide high quality new homes and a new community centre.

3.4 Following resident consultation a planning application in respect of the proposed scheme was submitted in December 2013 and received the necessary consents at Planning Committee on 03 April 2014 (Planning Ref: P2013/4952/FUL).

3.5 The approved proposals include the following mix of new homes:

	Social Rent	
Property type	Units.	Hab rooms
1 bed	8	16
2 bed	11	33
3 bed	4	20
Totals	**23**	**69**

4. THE PROCUREMENT PROCESS

4.1 The early involvement of a contractor provides valuable input at the design stages and this reduces the risks around scheme delivery.

4.2 Following evaluation of the scheme and the procurement options, it was agreed to enter into a direct negotiation with Higgins Construction PLC through the former New Build Contractor Framework 2010-14.

4.3 All contractors appointed to the replacement Framework 2014-18, including Higgins Construction PLC, have been required to sign up to paying their own employees, and those employed by their sub-contractors, the LLW.

4.4 Further, all Framework contractors have signed a declaration to confirm that they have not and/or will not participate in the blacklisting of trade union members or activists contrary to the Employment Relations Act 1999 (Blacklisting) Regulations 2010 and the Data Protection Act 1998.

Value for Money

4.5 More details of the tender evaluation process and value for money assessment can be found in the exempt Appendix 1 to this report.

Quality Assessment

4.6 As this is a negotiated contract, there have been extensive discussions with Higgins Construction PLC regarding the preparation of their price and further investigative works were undertaken to remove conditions, provisional sums and caveats. There are no immediate concerns as to their capability of undertaking the works from a technical and resourcing point of view.

4.7 Additionally council officers and the Employer's Agent have met with Higgins Construction PLC in order to confirm the acceptability of their approach, both in terms of pricing, construction methods and on-site management.

6. IMPLICATIONS

6.1 Financial Implications

6.1.1 The Council's approved 3 year (2014-15 to 2016-17) new build programme totals £95.2m. The latest indicative 7 year (2014-15 to 2020-21) new build programme totals £173.049m.

6.1.2 The construction contract value in relation to the Ivy Hall scheme which comprises 23 homes for social rent and a new community centre is included in the Council's latest 7-year new build programme. The on-going revenue costs of managing and maintaining the new homes are included in the HRA's medium-term financial strategy.

6.1.3 The scheme will be funded from the combination of resources i.e., RTB 1-4-1 receipts and some internal resources e.g. borrowing, RCCO and other capital receipts.

6.2 Legal Implications

6.2.1 Under Section 9 of the Housing Act 1985 the Council has the power to provide housing accommodation by building houses on land acquired for that purpose or by converting buildings into houses and to sell part of that accommodation. Under section 7 of the Public Libraries and Museums Act 1964, the Council has a duty to provide a comprehensive and efficient library service. Accordingly the council may enter into a contract for the proposed works (section 1 Local Government Contracts Act 1997).

6.2.2 Higgins Construction PLC have been appointed to the Council's New Build Contractor Development Frameworks (2010-14 and 2014-18) following competitive tendering exercises in accordance with EU Procurement Legislation. Under the Framework Agreement a new build works contract may be awarded to a Framework Constructor either following a mini competition or by direct selection. Higgins Construction PLC was selected to take this scheme forward under the 2010-14 Framework and have now submitted their tender price for construction of the proposed development of new homes and community centre.

6.2.3 In these circumstances it would be reasonable for the construction contract to be awarded to Higgins Construction PLC provided that the Executive are satisfied that their price represents value for money. In reaching that decision the Executive should take into account the information contained in the exempt appendix 1.

6.3 Environmental Implications

6.3.1 It will be essential during both the demolition and construction periods to ensure the contractor adheres to environmental legislation particularly around waste regulations.

6.3.2 Clearly defined roles on who is responsible for waste management and disposal, obtaining licences and permits and liability will be essential before work commences. Appropriate legislation will be applied rigorously and full method statements for all activities will be required from the contractor before commencement in order to mitigate these risks.

6.3.3 The new homes will be built to high standards in terms of environmental sustainability, meeting at least Level 4 of the Code for Sustainable Homes. They will be very energy efficient which means they will be cheaper to run for the residents who live in them, helping to keep down the cost of living.

6.4 Resident Impact Assessment

6.4.1 A Resident Impact Assessment (RIA) was completed on 19 August 2014 which identified that there may be an impact on older people and/or people with a physical or sensory disability with regards to the added walking distance to the temporary community centre during the building of the new centre and that this will be monitored to ascertain if it is an issue and, where possible, mitigating actions will be identified. Overall, however, the new build proposals should have a positive impact through provision of much needed affordable homes and enhanced community centre facilities for the benefit of all residents, including those with protected characteristics.

6.4.2 A copy of the RIA is available from the author of this report upon request.

7.0 Conclusions and Reasons for Recommendations

7.1 In conclusion, and based on the outcome of the direct negotiation process outlined in this report, Higgins Construction PLC has offered a contract price that has been shown to be financially competitive with their quality proposals deemed to meet the required standards.

7.2 It is, therefore, recommended that a contract be awarded to Higgins Construction PLC for the construction of 23 new homes for social rent and a new community centre as their tendered price forms an acceptable basis for agreeing the final contract sum.

Appendices:
Exempt Appendix 1: Tender evaluation and value for money assessment

Background papers: None

Final report clearance:

Signed by:

15 December 2015

Executive Member for Housing and Development

Date

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ISLINGTON

Public Health
Municipal Offices, 222 Upper Street, London N1 1YR

Report of: Director of Public Health

Meeting of:	**Date**	**Ward(s)**
Executive	15 January 2015	ALL

Delete as appropriate		Non exempt

SUBJECT: PROCUREMENT STRATEGY APPROVAL FOR THE TRANSFORMATION OF SEXUAL HEALTH SERVICES

1. Synopsis

This report seeks approval for a procurement strategy for open access sexual health services, which forms a key part of the public health transformation programme in Islington.

Open access sexual health services are mandated as part of the conditions of the Public Health Grant. The open access nature of sexual health services means that there are significant cross-boundary flows of residents using services, particularly across central London boroughs. The contracts for local Genito-Urinary Medicine (GUM) and Sexual and Reproductive Health (SRH) community contraceptive services provided by Central and North West London NHS Foundation Trust (CNWL) were waived for two years on the transition of Public Health to the council. This means that contracts will expire in March 2015.

Islington is participating in two major programmes with other London councils, which are designed to help deliver Best Value and improved quality for open access sexual health services. The first programme is about developing a new payment approach (an integrated sexual health tariff) and the second is a wider programme of transformation to develop proposals for future service models.

There are important benefits which can be achieved through collaborative working between councils which would otherwise be difficult to realise in an open access system. However, developing, consulting and engaging, agreeing and implementing the programmes across London councils and a large number of services in an open access system with significant cross-boundary activity is complex and will require considerable coordination. In order to complete this work, and implement the programmes co-

terminously with other London councils, a waiver of Procurement Rules for the local open access sexual health services is requested for April 2015 – March 2017.

2. Recommendations

2.1 To approve this procurement strategy, setting out the approach to the transformation of open access sexual health services over the next two years.

2.2 To agree Islington Council's continued participation in an Alliance of London councils for the purposes of (i) a collaborative commissioning approach to open access Genito-Urinary Medicine (GUM) services for 2015/16 and 2016/17; and (ii) gaining access to the terms and standards negotiated by other London councils participating in the Alliance with other open access GUM services over that period.

2.3 To agree to waive the council's Procurement Rules in order for Islington Council to contract with the existing local service provider, Central and North West London NHS Foundation Trust (CNWL), in 2015/16 and 2016/17 for (i) the provision of open access GUM services, acting as the host local authority on behalf of the councils participating in the Alliance, and (ii) open access Sexual and Reproductive Health (SRH) community contraceptive services, commissioned jointly with Camden.

2.4 To agree that the Director of Public Health is granted delegated authority to approve the contracts with Central and North West London NHS Foundation Trust for GUM and SRH services on behalf of the London Borough of Islington for 2015/16 and 2016/17.

3. Background

3.1 Sexual and reproductive health needs

3.1.1 London has very high levels of sexual health needs, particularly in inner London. Good sexual health is important to individuals and impacts on their wider health and wellbeing, and life opportunities. National studies point to long term changes in sexual attitudes and lifestyles and sexual health needs across the general population. There are significant inequalities in sexual health, including: gay, bisexual and other men who have sex with men; some BME communities, including Caribbean and African communities; younger adults, particularly young women; people experiencing socio-economic disadvantage; among others. London is made up of a highly mobile and multi-cultural population who frequently access care outside of their Borough of residence, which significantly affects the care pathways and therefore the inter-dependencies between Boroughs.

3.1.2 Islington is particularly vulnerable in terms of sexual health needs, linked to a mix of population and deprivation factors. Overall, residents have the fifth highest rate of sexually transmitted infections and of diagnosed HIV in the capital, significantly above both the London and England averages. In 2013, there were at least 32,000 attendances at open access sexual health services by residents. Against these high levels of need, Islington has achieved a significant and sustained reduction in teenage conceptions and has a much lower proportion of HIV infections diagnosed at later stages than London or England, which helps improve long term outcomes for individuals and reduces the risk of further infections. Terminations of pregnancy are above the England average but below the London average and significantly lower than in most other deprived London boroughs.

3.1.3 Sexual health therefore represents one of the most significant local public health challenges. Effective programmes of sexual health promotion and HIV prevention, including sex and relationship education and targeted work with key risk groups, together with access to contraception and sexual health services for the detection and treatment of sexually transmitted infections represent central pillars of the approach to improving sexual health. This procurement strategy relates to the last two of these: Sexual and Reproductive Health (SRH) community contraceptive services and Genito-Urinary Medicine (GUM) services, both of which are open access.

3.2 Current arrangements for open access sexual health services

3.2.1. GUM and SRH services are open access services which Local Authorities are mandated to provide for the benefit of all people present in their area[1]. In other words, anyone who is in an area is entitled to use the services provided in that area; services cannot be restricted only to people who can prove that they live in the area, or who are registered or referred by a local GP.

3.2.2. Islington's major provider of sexual health services is Central and North West London (CNWL) NHS Foundation Trust. Open access GUM services are provided at The Archway Centre in Islington and the Mortimer Market Centre in Camden. The two sites account for around 60% of GUM attendances by Islington residents, however the service, which is one of the largest in the country, sees significant numbers of patients from all over London as well as from outside London. About 40% of Islington residents access services outside Islington or Camden, usually in nearby boroughs. Major 'out of area' providers used by Islington residents include Chelsea and Westminster (which operates three clinics, including one in Soho), Barts Health (with clinics in The City of London and Whitechapel) and Guy's and St Thomas'. Therefore, collaborative commissioning and cross-charging (so that Islington is only responsible for funding GUM attendances for its own residents) is an essential component of maintaining open access GUM services for Islington. Islington's overall budget for use of GUM services by residents this year is £5.1 million, of which £3.3 million is the budget allocated for CNWL.

3.2.3. CNWL also provide the open access SRH (contraceptive) service for Camden and Islington. The SRH services have continued to be funded on a block contract basis since transition from the NHS, jointly commissioned between Islington and Camden, albeit with both councils retaining full budgetary responsibility and control for their share of the service. Islington's budget for the service in 2014/15 is £1.259 million. Most activity takes place within the Margaret Pyke Centre, which has recently relocated to new premises near King's Cross, on the border with Islington. Additionally, some activity takes place within the GUM clinics, and at clinic sessions provided at Finsbury Health Centre.

3.2.4. Sexual Health services as currently configured have evolved from within the NHS environment and have transitioned to the responsibility of local authorities with relatively little change in terms of providers or service models to date. The major change post-transition has been on the commissioning side, with the end of the 'host' NHS commissioner arrangement that existed for cross-charging GUM services, whereby the local NHS commissioned the service on behalf of all other NHS commissioners who paid a centrally mandated tariff for the open access GUM services used by their patients. This change created considerable challenge for both commissioners and service providers following transition during 2013/14 in agreeing and managing payments across the open

[1] See Reg 6: Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives Regulations) 2012

access system.

3.2.5. To help address this, Islington joined an alliance of 12 London councils to negotiate contracts with major and other local GUM providers this year, with Islington negotiating this year's GUM agreement with CNWL on behalf of all 12 London councils. Similarly, other councils negotiated agreements with their local GUM services on behalf of the alliance of councils. Camden and Islington Public Health played a further role across the 12 London councils, developing a new clinical service specification together with evidence-based key performance and quality indicators, designed to improve monitoring and insight into the performance and quality of GUM services. Subsequently, the specification and indicators have been adopted by a number of other London councils outside the Alliance.

3.3 Sexual health transformation

3.3.1. Islington's central geographic position within London, with significant flows of patients travelling in and out of the borough to use sexual health services, means working together with other London councils provides increased opportunities for commissioning and transforming sexual health services to achieve best value and assure and improve quality for services received by residents. There are currently two important London-wide initiatives being developed which, if agreed, will be important for Islington's future commissioning of open access sexual health services.

- The first is a programme focused on moving to a different payments system. This would more closely relate payment to level of clinical need than the current system inherited from the NHS. This would involve implementing a new integrated sexual health tariff.

- The second is a programme to develop proposals for a new service model, intended to take account of changing patterns of need and use of services.

3.4 Changing how councils pay for open access sexual health services in London: a new integrated sexual health tariff

3.4.1. Changing the way Islington pays for sexual health services has the potential to generate significant efficiencies and savings for commissioners by more closely relating payment to the level of service needed and provided to residents. This builds on work previously carried out in the NHS, now being refreshed, and based on previous estimates could generate £1.5 million savings for Islington (across all provider services, not just local services). The proposal involves implementing a comprehensively different tariff system derived from clinical pathways based on need, for the screening, diagnosis, treatment and follow-up of sexually transmitted infections and including contraceptive needs.

- At the moment, there is a simple first and follow up tariff paid for GUM attendances which does not distinguish between levels of patient need.
    - So for example, the tariff payment does not differentiate between a patient presenting with a significant history of risk and a complex sexually transmitted infection compared to a patient with little risk seeking an HIV test for reassurance or peace of mind.
    - This is the payment system that was in place in the NHS at the point at which commissioning responsibility transferred to local authorities.
    - Community contraception services are covered in 'block' contract arrangements.
- The new tariff system being developed proposes to more closely relate payment to

the level of clinical service needed by patients.

- The new tariffs would be based on clinical pathways set out in clinical guidelines, developed and agreed with sexual health clinicians – currently being updated to take account of recent major changes in clinical guidelines.
- The level of new tariff payment would be based on an analysis of the NHS provider costs necessary to deliver the care pathway efficiently.

3.4.2. The integrated sexual health tariff was first developed and tested in London in 2011/12. Financial analysis at that time found that the level of commissioner payment for sexual health services across London as a whole was significantly in excess of what it cost trusts to provide. There was variation, but in some instances the difference between the income that trusts received and what it was estimated it cost to provide services was 30% or more, meaning many commissioners were paying significantly more than it cost providers to deliver services. With changes happening in the NHS at that time, the work was not further advanced.

3.4.3. Following transition of public health responsibilities to councils, London Directors of Public Health agreed to update the work on the integrated sexual health tariff at the start of this financial year. As part of this programme, Islington is currently working with the other London councils to re-run the analyses based on this year's GUM and SRH activity levels and to refresh tariff pathways in the light of new clinical guidelines. Islington's sexual health providers, and other providers across London, are currently collecting and submitting detailed data on activity and case mix of their patients enabling commissioners to re-model the financial impacts, opportunities and risks of proposals for moving towards a new integrated tariff-based funding arrangement. It is expected that the updated work will show significant savings for commissioners if the new tariffs are introduced, however activity levels and rates of sexually transmitted infections have changed considerably since 2011/12 and this may affect estimates of local potential savings.

3.4.4. The updated work will include a thorough risk and sensitivity analysis of the impact of potential tariff changes for both commissioners and service providers. This work is expected to produce a first phase report in March/April 2015 at which time London councils will need to take stock of the analysis, what it is likely to mean for both commissioners and services, and determine next steps.

3.4.5. Given the scale of the potential change – with several services potentially seeing reductions of 30% or more in income for their GUM services – as well as the current complexity of commissioning open access GUM and sexual health services in London, the introduction of the new tariff, should it be agreed, will need careful coordination across London councils to implement, allowing reasonable time for commissioners and clinical services to prepare for the change. At this stage, an implementation date at the start of 2016/17 would be expected if the new tariffs are agreed.

3.5 Transforming open access GUM services

3.5.1. Changing payments represents one important proposal for more cost-effective commissioning of services, but particularly with high and changing levels of sexual health needs and increasing levels of activity, system-wide changes will be needed to better address needs in the future. Therefore, as well as the change in tariff, Islington is working in a collaboration of 19 London boroughs and The City of London to develop future service model options focused on open access GUM services.

3.5.2. This is a phased programme of work, led by Camden Council's Chief Executive on

behalf of the participating councils. The first phase of this transformation work has concentrated on developing the case for change and developing options for change – including:

- a thorough analysis of need, including inequalities, and overview of services across the participating councils;
- modelling cross-boundary patient flows and access;
- extensive engagement with commissioners across London;
- development of potential options for collaborative commissioning and contracting approaches between the participating councils; and
- evidence review of service models and interventions, based on clinical and quality standards, including innovations such as emerging digital/on-line and home testing/sampling systems.

3.5.3. This first phase completed at the end of October 2014. The second phase of the work is intended to develop proposals for a future model and specification of services, with a programme for engagement with clinical, service user, residents and other stakeholders, including commissioners of other sexual health services.

3.5.4. The focus of the London councils' collaborative work is on open access (Level 3) GUM services. However, the integrated tariff work will include SRH and any proposed models will have a place in the wider sexual health pathway, linking to other aspects of sexual health services. Many of these are commissioned by the council, including sexual health promotion and HIV prevention, GP practice and community pharmacy sexual health services, community contraceptive clinics and young people's sexual health services. However, the pathway also needs to take account of and link with sexual health services commissioned by CCGs, such as abortion services, and by NHS England, including HIV treatment and care services. The importance of ensuring that sexual health services for residents are coordinated is therefore a key part of the work.

3.5.5. Supporting this service transformation work, it is envisaged that the new tariff system described in the previous section, will help to provide additional tools for commissioners to implement changes and help encourage innovation.

3.5.6. This is an ambitious programme developing proposals for change across a complex geographic, commissioning and service environment, which if agreed, will require substantial development and engagement to agree and implement a model that will be able to better meet high and increasing levels of sexual health needs and service use in a more cost-effective way. An implementation date starting 2017/18 for re-specifying and re-commissioning new service models would be expected.

3.5.7. Camden and Islington Public Health are playing a key role in the programme and the project team, providing analysis, needs assessment and input into the options development, ensuring close local involvement in the programme as it develops.

3.6 Commissioning open access sexual health services in 2015/16 and 2016/17

3.6.1. Islington entered into a collaborative agreement of 12 west and north central London local authorities in 2014/15 to commission open access GUM services, via an Alliance described earlier in this report. This brought a greater strength to contract negotiations and consistency of approach in prices and terms agreed by commissioners, including efficiencies and moving from the previous NHS contracts into local authority contracts. It also provided benefits for trusts, for example in terms of greater certainty over financial flows and common terms and requirements. Extending participation in the

collaborative commissioning agreement into 2015/16 and in 2016/17, during the proposed period of the waiver for open access sexual health services, will help to realise further benefits and efficiencies for commissioners as well as providing a more coordinated base for the proposal to implement a new integrated tariff in 2016/17. In 2015/16, a number of other London councils will also work collaboratively with the Alliance, which should further enhance its negotiating position.

3.6.2. Since transition in April 2013, commissioners have made significant progress on managing costs in the context of increasing levels of activity, by keeping the tariff at the rate at which it was prior to transition in 2012/13, agreeing efficiencies, introducing an in-year reduced tariff for activity over and above expected growth and removing additional performance related NHS payments. Taking all these factors into account, in the local context, we have a crude estimate that average unit costs are around 12% lower than they would be under the current non-mandatory tariff issued by the Department of Health.

3.8.3. In order to provide the time necessary for the development and agreement and of the programmes described above, and to support co-terminous commissioning of new open access sexual health service models with other London councils in order to realise greater value and quality, this paper requests approval of a waiver to contract standing orders for the open access services for GUM and SRH provided by CNWL to cover the period April 2015 to March 2017. It also seeks agreement to continued collaborative commissioning with other London councils in order for Islington to benefit from the advantages of a collaborative commissioning approach over the same period April 2015 to March 2017, in line with the GUM collaborative agreement described in the report Procurement Strategy for Open Access Genito-Urinary Medicine (GUM) 2014/15 agreed by the Executive in March 2014.

4. Implications

4.1 Financial implications

Islington Council receives a ring-fenced Public Health grant from the Department of Health to fund the cost of its Public Health service. The total funding for 2014/15 is £25.429m.

GUM services are mandatory open access services within Sexual Health that are demand-led with increasing levels of activity. Islington has an obligation to pay for activity irrespective of whether a contract is in place or not and tariffs exist for these purposes. This contract should not create a budget pressure for the Council. Although there is a contract in place there is still a risk of a pressure based on an increase in activity.

The current budget earmarked for the Sexual and Reproductive Health service is £1,259,800 per annum. The proposed contract value of £1,255,412 per annum equates to £2,510,824 over the two (2) year period and should not create a budget pressure for the Council.

The Council's Public Health expenditure must be contained entirely within the grant funded cash limit indicated above. If any additional pressures are incurred management actions will need to be identified to cover this.

4.2 Legal Implications

The threshold for application of the Public Contracts Regulations 2006 (the Regulations) is currently £172,514. The value of the contract to be let is significantly above this

threshold. These services fall within Part B of the Regulations. Although Part B services do not need to strictly comply with the provisions of the Regulations, there is a requirement under EU rules for Part B services to be procured in compliance with the principles of equal treatment, non-discrimination and fair competition. The Council's Procurement Rules require contracts over the value of £100,000 to be subject to competitive tender.

It is not clear at this stage whether there is a market for the provision of these services. If there is such a market there would be potential for procurement challenge on the basis of noncompliance with the requirements of the Regulations and the Council's Procurement Rules. However the fact that a proper procurement is being planned following the development of new service models from 2017/18 and the need for such contracts to be coterminous across London is likely to mitigate this.

As a result of the value of these contracts the decision on the waiver (Procurement Rule 3.6) as well as the contract award decision (Procurement Rule 14.1.1) needs to be made by the Executive.

4.3 **Environmental Implications**

There are no direct environmental implications expected at this stage. It is unlikely that the integrated tariff would have environmental implications. There is a possibility that the transformation programme might have implications, but this would need to be assessed as part of the development of more detailed service model options.

4.4 **Equality Impact Assessment**

Resident and equality impact assessments will need to be carried out as the proposals on the integrated tariff and the transformation programme are developed.

5. Conclusion and reasons for recommendations

5.1. Islington has high levels of sexual health needs among local residents. Open access services for GUM and SRH are important parts of effective action to improve sexual health, mandated in the Public Health Grant conditions. Commissioning open access services in London, with significant cross-boundary flows of patients, presents particular challenges for commissioners around coordination and implementation of changes.

5.2. There are significant opportunities to improve value and quality through changing the payments system and transformation of open access sexual health services. Islington is only likely to fully realise the benefits of these proposals by working in collaboration with other London councils, so it is important that local commissioning changes are co-terminous with other commissioners in order to fully realise efficiencies and benefits.

5.3. Working collaboratively with other London councils, will enable Islington and other participating councils to draw on talent from across the councils in developing and implementing effective solutions in the context of a complex sexual health system, and increases the potential to gain greater efficiencies and better outcomes from provider services. Significantly this collaborative approach also increases the scope for greater market management as part of the transformation of open access sexual health services to deliver improved outcomes for sexual health for residents, subject to the development and agreement of programme proposals.

5.4. In order to allow time to fully develop, agree and deliver these programmes of change

working with other London councils, this paper requests that the procurement rules for open access GUM and SRH community contraceptive services provided by CNWL are waived from April 2015 until March 2017 (please see attached waiver documents) and that Islington's participation in the collaborative agreement between London councils for commissioning open access GUM services developed in 2014/15 is extended to cover 2015/16 and 2016/17.

Background papers:
None

Final report clearance:

Janet Burgess 5 January 2015

Signed by:

Executive Member for Health and Wellbeing Date:

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ISLINGTON

Housing & Adult Social Services
7 Newington Barrow Way, London N7 7EP

Report of: Executive Member for Health and Wellbeing

Meeting of:	**Date**	**Ward(s)**
Executive	15 January 2015	All

Delete as appropriate	~~Exempt~~	Non-exempt

SUBJECT: APPROVAL OF THE PROCUREMENT STRATEGY FOR CONTRACT EXTRA CARE SHELTERED HOUSING

1. Synopsis

1.1 This report seeks pre-tender approval for the procurement strategy in respect of Extra Care Sheltered Housing Services in accordance with Rule 2.5 of the Council's Procurement Rules.

1.2 The contract will provide at least 99 units of Extra Care, Intermediate Care and Housing Support services to individuals with complex needs across a range of client groups including Older People, those with Physical and Sensory Disabilities and Global Learning Disabilities.

2. Recommendation

2.1 To approve the procurement strategy as outlined in this report, to enter into a new maximum sixteen (16) year contract to provide Extra Care Services. This procurement strategy will secure continuity of care for very vulnerable residents, continuity of supply of specialist resources and continued value for money for the Council. The initial contract term will be for four (4) years with an option for break and extension for a further four (4), plus four (4), plus four (4) years, providing a maximum contract length of sixteen (16) years.

3. Background

3.1 **Nature of the service**

3.2 Housing and Adult Social Services (HASS) Commissioning wishes to procure a block contract for the provision of a minimum of 99 units of Extra Care and Intermediate care accommodation within the borough of Islington. The contract will secure units that are built to extra care sheltered housing standards, closely grouped geographically to enable the cost efficient and safe delivery of support and care services to tenants. The requirement is for units that are available for immediate occupation by our

existing extra care tenants from the start of the contract term.

3.3 Extra Care sheltered housing provides vulnerable people with access to on-site 24/7 personal care, community health and housing support services. The service is targeted at those with complex needs, usually aged 55+, and is provided for those who have been assessed by care managers as needing this level of support. People in Extra Care hold an assured tenancy and live in a self- contained flat with their own front door. The service provides a range of activities to improve quality of life and reduce isolation, including access to a meals service for tenants wishing to eat together. Tenants can contact staff outside of their planned care times through an on-site alarm service.

3.4 Intermediate Care services deliver a structured time-limited rehabilitation service to enable people who have experienced deterioration in their health through illness or injury to regain as much control over their own lives as possible, The service is targeted at older people who would otherwise face unnecessary prolonged hospital stays or inappropriate admission to acute in-patient care, long term residential or nursing home care or continuing NHS health care.

4. Current Commissioning Arrangements

4.1 The Council currently commissions extra care, intermediate care and housing support services from Notting Hill Housing Trust. Arrangements are spread across 3 sites within Islington, collectively referred to as 'The Mildmays'. The existing contract expires 30 June 2015. The procurement strategy seeks to secure a contract with a provider for the continued delivery of services whilst fulfilling the Council's procurement duties.

See Appendix 1. Point 1 Nature of the Service for further details of the Council's current commissioning arrangements for Extra Care Services in the borough.

5. Need for Extra Care Services in Islington

5.1 Numbers of older people living in the borough are set to increase. The number of older people living alone is relatively high, and many are doing so without the support of extended families due to the high cost of housing in the borough. In this environment referral into Extra Care is the default position when service users are assessed by care managers as no longer able to manage at home. This has resulted in high occupancy rates for the service. See Appendix 1, Point 2 for further information about the ongoing need for the service.

6. Estimated Value

6.1 The arrangement will be funded from existing Adult Social Services resources (base budget) and initially continued annual funding of £60K from Health and Supporting People.

6.2 The value of the procurement is £2,223,804 per annum. The initial contract term will be for four (4) years with an option for break and extension for a further four (4), plus four (4), plus four (4) years, providing a maximum contract length of sixteen (16) years There is no suitable existing framework that could be utilised for this contract.

6.3 The spend on this service for the last two years is:

2012/13 - £2,223,804; 2013/14 - £2,223,804.

7. Value for Money

7.1 The service represents good value for money as the default accommodation based provision for those assessed as no longer being able to cope at home. The alternative would be provision of large, costly and extensive domiciliary care packages, including night time and weekend care, to keep people at home, or the more likely option of placing more people into residential care. The unit cost for LBI of placing somebody in extra care is £400.92 per week compared to a unit cost of £593 per week for

residential care and £683 per week for residential dementia care in Islington. See Appendix 1, point 3 for further Value for Money information.

8. Procurement Timetable

8.1 See Appendix 2, point 1 for Procurement timetable. The current contract expires 30 June 2015.

9. Procurement Options

9.1 The following procurement routes have been considered:

- Direct Negotiation route
- Competitive Tender route (restricted procedure).
- Delivery of the service in-house. This would require finding an appropriately sized site, and a development partner to build extra care sheltered housing units. This process would take several years to complete and is therefore not a viable option to meet existing demand.

10. Options Appraisal

10.1 The preferred option is a direct negotiation route. Options appraisal assesses direct negotiation as the best option to secure the continued supply of extra care services in the borough at current volume and price. See Appendix 2, point 2 for an outline of rationale for choosing this procurement route.

11. Key Considerations

11.1 The potential social benefits to be realised through this procurement are:

- the lowering of unemployment – any new contract will encourage the provider to source local employees and volunteers
- the provision of good quality jobs and payment of the London Living Wage (LLW) – payment of LLW will be a requirement of any new contract Staff employed under the current contract are paid at or above the LLW rate.

11.2 Any new contract will require the provider to deliver value for money services and continuous improvement of those services. Compliance in both areas will be monitored once the contract is operational. Continuous improvement will be achieved chiefly through greater partnership working with community and acute health care services with the aims of:

- extending the length of time people live in extra care
- enabling more people to die at home, if that is their preferred place to die
- reducing the amount of time tenants spend in hospital
- avoiding unplanned hospital admissions
- extending independent living through use of reablement services.

Delivering improved last years of life care and advance care planning will enable tenants to remain in extra care for longer and increasingly until the end of their lives, reducing the need to move onto more expensive nursing home care.

11.3 The contract specification for the service is outcomes based ensuring the provider works with tenants to promote choice about the service that are received, support independence, deliver quality of life and enable social inclusion.

12. Evaluation

12.1 The contract is based on an outcome specification. The award of the contract will only be made once the commissioning team are satisfied that they can ensure best value based on quality and cost and negotiations will be framed around quality assurance and continuous improvement; workforce development; customer care and service user involvement and participation.

13. Business Risks and Business Opportunities

13.1 The options appraisal in Appendix Two, point 2 outlines the benefits and risks associated with different procurement options. The greatest risks are associated with following a competitive tendering process which, if it failed as it is likely to do through lack of competition, would result in either:

- The Mildmays being lost as an extra care resource and the source of the 12 remaining residential intermediate care beds in borough, leaving the Council to support an additional 87 vulnerable older people in general needs housing with high support needs or
- The need to engage in post procurement direct negotiation with the current provider and the likelihood that essentially the same service is secured but at an enhanced contract value.

13.2 If the Mildmay units were lost as extra care the risks would be managed by:

- Reviewing existing tenants to assess how best to meet their needs
- Decanting into more appropriate accommodation, including residential care – likely result for the majority of current tenants. Research indicates that such moves can result in poor outcomes for those involved.
- Introducing large and costly care packages including night time and weekend services to support people at home
- Spot placing people out of borough for intermediate care. Evidence indicates that spot placements for intermediate care out of borough are much more likely to turn into permanent residential care placements, since the placements cannot be closely managed by Islington health and social care staff.

The costs associated with all 4 elements above will present a significant cost pressure for the Council.

See Appendix 2, points 7, 8 and 9 for a full analysis of business risks and opportunities.

13.3 The Employment Relations Act 1999 (Blacklist) Regulations 2010 explicitly prohibit the compilation, use, sale or supply of blacklists containing details of trade union members and their activities. Following a motion to full Council on 26 March 2013, all tenderers will be required to sign the Council's anti-blacklisting declaration. Where an organisation is unable to declare that they have never blacklisted, they will be required to evidence that they have 'self-cleansed'. The Council will not award a contract to organisations found guilty of blacklisting unless they have demonstrated 'self-cleansing' and taken adequate measures to remedy past actions and prevent re-occurrences. The adequacy of these measures will initially be assessed by officers and the outcome of that assessment will be reviewed by the Council's Procurement Board

13.4 The following relevant information is required to be specifically approved by the Executive in accordance with rule 2.6 of the Procurement Rules:

Relevant information	**Information/section in report**
1 Nature of the service	The contract will deliver at least 99 units of Extra Care, Intermediate Care and Housing Support services to individuals with complex needs across a range of client groups including Older People, those with Physical and Sensory Disabilities and Global Learning Disabilities.

<table>
<tr><td></td><td>See paragraph [3]</td></tr>
<tr><td>2 Estimated value</td><td>The estimated value per year is £2,223,804.

The agreement is proposed to run for a period of 4 years with an optional extension of 4 + 4 + 4 years, making a total contract period of up to sixteen (16) years.</td></tr>
<tr><td>3 Timetable</td><td><table>
<tr><td>Pre-tender consideration report for Procurement Board</td><td>15/10/14</td></tr>
<tr><td>Procurement Board Meeting</td><td>30/10/2014</td></tr>
<tr><td>Procurement Strategy Report for Joint Board</td><td>28/11/2014</td></tr>
<tr><td>Joint Board Meeting</td><td>9/12/2014</td></tr>
<tr><td>Procurement Strategy Report for Councillors</td><td>6/11/2014</td></tr>
<tr><td>Procurement Strategy Report for Executive</td><td>12/12/2014</td></tr>
<tr><td>Executive Meeting</td><td>15/01/2015</td></tr>
<tr><td>Contract Start:</td><td>01/07/2015</td></tr>
</table></td></tr>
<tr><td>4 Options appraisal for tender procedure including consideration of collaboration opportunities</td><td>Options appraisal assesses direct negotiation as the best option to secure the continued supply of extra care services in the borough at current volume and price.

See paragraph 10.1 above and Appendix 2, point 2</td></tr>
<tr><td>5 Consideration of:
Social benefit clauses;
London Living Wage;
Best value;
TUPE, pensions and other staffing implications</td><td>Application of LLW and the project’s considerations to workforce and volunteering development will contribute to both economic and social sustainability.

The contract specification for the service is outcomes based ensuring the provider works with tenants to promote choice about the service that are received, support independence, deliver quality of life and enable social inclusion

TUPE will only apply if there is a service provision change (i.e. the service is transferred to a new organisation).

See paragraph [11]</td></tr>
<tr><td>6 Evaluation criteria</td><td>See paragraph [12]</td></tr>
<tr><td>7 Any business risks associated with entering the contract</td><td>By following the Direct Negotiation route, the Council will be not be able to review the market through a competitive tender process to determine whether there will be a suitable number of organisations who are competent and capable of providing the service they will be invited to tender.

However, there is no anticipated competition for the provision of current services, namely due to the volume of service and building requirements necessary for the delivery of extra care services. A Prior Information Notice</td></tr>
</table>

	(PIN) is being drafted in December 2014 to test the market in the short to medium term for potential additional supply in borough or nearby to satisfy procurement requirements. See Appendix 2, points 7, 8 and 9.
8 Any other relevant financial, legal or other considerations.	See paragraph [14.1]

14. Implications

14.1 **Financial Implications**

The procurement strategy will be funded from existing Adult Social Services resources (base budget) and initially continued funding from Health and Supporting People. The total contract value is £2,223,804 per annum with the breakdown as follows:

HASS	£1,753,761
Supporting People	£60,000
NHS	£410,043
Total	£2,223,804

The service represents good value for money as the default accommodation based provision for those assessed as no longer being able to cope at home. The alternative would be provision of large, costly and extensive domiciliary care packages, including night time and weekend care, to keep people at home, or the more likely option of placing more people into residential care. The unit cost for LBI of placing somebody in extra care is £400.92 per week compared to a unit cost of £593 per week for residential care and £683 per week for residential dementia care in Islington.

By 2020 the Islington population aged over 65 is projected to rise by 9% to over 19,000 people and the over 85's from 2,200 to 2,660 people. 62% of our older residents live in social housing, 42% live on their own. The cost of housing means many family members move away as they can't afford to stay in the area. This affects the extent to which older people can be cared for at home when they become very frail and is likely therefore to impact on the demand for extra care provision going forward. Extra care sheltered housing is a significantly cheaper option than residential care.

14.2 **Legal Implications**

The Council has a duty to make arrangements for providing residential accommodation and care for persons who by reason of illness and disability are in need of care and attention which is not otherwise available to them (section 21 National Assistance Act 1948 (as amended). The Council may discharge that duty by making arrangements with private providers of residential accommodation for those assessed to need it (section 26 of the 1948 Act). Accordingly the council may enter into a contract with a provider to secure the supply of extra care sheltered housing services (section 1 of the Local Government (Contracts) Act 1997).

The threshold for application of the Public Contracts Regulations 2006 is currently £172,514. The value of the contract to be let is above this threshold. However the provision of extra care sheltered housing services is a Part B service within the Regulations. Part B services do not need to comply with the full requirements of the Regulations including publication of an advertisement in OJEU. However, there is a requirement under EU rules for part B services to be procured in compliance with the principles of equal treatment, non-discrimination and fair competition which, according to EU case law can only be satisfied by sufficient advertising. The council's Procurement Rules require contracts over the value of £100,000 to be subject to competitive tendering.

There is some risk of procurement challenge in entering into a new contract arrangement with the existing provider, Notting Hill Housing Trust without conducting a transparent procurement process,

including the publication of a contract notice. However this risk may not be significant if, as stated in the report, there are no other suitable providers for this service based in Islington who would be interested in bidding for the contract. The risk will be mitigated if a prior information notice is published to test the market.

14.3 **Environmental Implications**

An environmental impact assessment has been carried out and it was identified that the proposals in this report would have no significant environmental impact.

14.4 **Resident Impact Assessment (incorporating the Equalities Impact Assessment)**

The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

An Equality Impact Assessment will be completed during the preparation stage in November 2014. The EIA identified that there would be no differential impacts. The EIA will be published and available upon request.

15. Conclusion and reasons for recommendations

15.1 The report has outlined the rationale for a procurement strategy of direct negotiation and details the significant risks associated with a competitive tender for both current users of Extra Care services and the Council.

This report recommends that a new contract term should be directly negotiated with the current provider, Notting Hill Housing Trust. This procurement strategy will secure continuity of care for very vulnerable residents, continuity of supply of specialist resources and continued value for money for the Council.

Appendices

- Appendix 1: Background Information to Key Areas of Main Report
- Appendix 2: Procurement and Business Options/Risks Analysis for Main Report

Background papers: None

Final report clearance:

Janet Burgess

Signed by: Executive Member for Health and Wellbeing **Date:** 9 December 2014

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Appendix 1

Background Information to Key Areas of Main Report: Approval of the Procurement Strategy for Contract Extra Care Sheltered Housing

1 Nature of the service

1.1 Current commissioning arrangements

1.2 The Council currently commissions extra care, intermediate care and housing support services from Notting Hill Housing Trust (NHHT). Arrangements are spread across 3 sites within Islington, collectively referred to as 'The Mildmays'.

1.3 NHHT owns the 3 Mildmay properties and under the terms and conditions of the existing contract, they provide housing support, domiciliary care and intermediate care services to individuals placed in the schemes by the Council and the CCG. As the property owners NHHT also provide the landlord and housing management function. The Council has 100% nomination rights to the units.

1.4

Scheme	Units	User Group
6 Mildmay Park	10	Physical and Sensory Disability
20-26 Mildmay Park	40	Older People and Global Learning Disability
	12	Intermediate Care
73 Mildmay Street	37	Older People
Total	**99**	

The scheme configuration is shown in the table above.

1.5 An analysis of usage and profile of current need has been carried out indicating that the number of support hours specified for delivery within the contract may need to be increased during the contract period. This is because those within the service are developing more complex needs and those being referred into the service often have a higher level of need at entry than would have been the case 5 or 10 years ago. The number of contract hours has not previously been increased to reflect this change. This increase in complexity of need is replicated in care homes and home care services.

2. Need for Extra Care Services

2.1 By 2020 the Islington population aged over 65 is projected to rise by 9% to over 19,000 people and the over 85's from 2,200 to 2,660 people. 62% of our older residents live in social housing, 42% live on their own. The cost of housing means many family members move away as they can't afford to stay in the area. This affects the extent to which older people can be cared for at home when they become very frail and is likely therefore to impact on the demand for extra care provision going forward.

2.2 A local policy change in February 2014 was introduced with the aim of reducing the number of residential care placements, making extra care the default position when service users are assessed by care managers as no longer able to manage at home. This action has resulted in high occupancy rates for Extra Care and it is anticipated that the policy is likely to result in an increase in demand for extra care units in borough. Potential sources of, and options for, securing additional supply within existing housing stock in borough have been investigated indicating there is limited supply and significant operational barriers to using it.

3 Value for Money

3.1 The service represents good value for money. There is no planned percentage reduction for this service as the Council secured significant efficiencies in 2012/13 at the same time as negotiating a zero percent annual uplift in the new contract.

3.2 Any reduction in budget would need to consider the long term impact on spend in other more expensive service areas, since Extra Care is used as part of our preventative strategy, maintaining people in the community, and reducing the numbers going into more expensive residential care.

3.3 Benchmarking of extra care services has proven to be difficult to assess. It has been difficult to compare other areas prices because of variation in service criteria, service user groups, and specification of services across local authorities.

3.4 The service represents good value for money as the default accommodation based provision for those assessed as no longer being able to cope at home. The alternative would be provision of large, costly and extensive domiciliary care packages, including night time and weekend care, to keep people at home, or the more likely option of placing more people into residential care. The unit cost for LBI of placing somebody in extra care is £400.92 per week compared to a unit cost of £593 per week for residential care and £683 per week for residential dementia care in Islington.

3.5 A predicted increase of 9% in the number of older people living in the borough by 2020 suggests an increase in demand for accommodation based support services, and as indicated above extra care sheltered is a significantly cheaper option than residential care.

3.6 This procurement exercise should be achieved through available resources and as such should not create a pressure to the Council initially, but as mentioned elsewhere there may be an increase in the number of care hours required to support tenants over the lifetime of the contract as existing tenants develop more complex needs, and those entering the service do so with a higher level of need from the onset.

Appendix 2

Procurement and Business Options/Risks Analysis for Main Report: Approval of the Procurement Strategy for Contract Extra Care Sheltered Housing

1. Procurement Timetable

Pre-tender consideration report for Procurement Board	15/10/14
Procurement Board Meeting	30/10/2014
Procurement Strategy Report for Joint Board	28/11/2014
Joint Board Meeting	2/12/2014
Procurement Strategy Report for Councillors	6/11/2014
Procurement Strategy Report for Executive	12/12/2014
Executive Meeting	15/01/2015
Contract Start:	01/07/2015

2 Procurement Options Appraisal Key Points

2.1 The key rationale for direct negotiation is that there is no anticipated competition for the provision of current services. Any new provider would be required to have 99 units of extra care sheltered housing ready and available for occupancy from 1 July 2015. Investigations undertaken by commissioners in 2013, when seeking to secure additional local sources of supply, indicated that there is no such stock available in Islington.

2.2 Commissioners are concerned that should services be competitively tendered there is a real risk that there will be no competitive response. In such circumstances the Council may fail to secure ongoing supply for existing service users, and as a result would incur significant additional costs to ensure service users remain appropriately supported. See point 3.1 below for further information.

2.3 A Prior Information Notice (PIN) is being drafted in December 2014 to formally test the market in the short to medium term for potential additional supply in borough or nearby.

2.4 Collaboration with other boroughs to secure extra care services is a restricted option as the borough wishes to retain 100% nomination rights to extra care services within the borough. Collaboration was considered with the London Borough of Camden for joint procurement arrangements but contract end dates were not co-terminus. Camden procured extra care services on a long term contract during 2012/13.

3 Option Benefits – direct negotiation

3.1 A key benefit to this approach would be preventing disruption for existing extra care tenants who would be able to remain living in their current homes. Notting Hill Housing Trust (NHHT) owns the Mildmay buildings. If NHHT failed to win the contract to provide care services at the Mildmays the units there would revert to general needs housing and the majority of current tenants would have to move out as

they could not be appropriately supported without access to 24/7 on-site care services. The Council would incur additional financial costs for reviewing all tenants, supporting any decants, and providing alternative more expensive residential care. There would be a further risk as research suggests that moving frail older people often results in poor outcomes for them.

3.2 As noted at 2.1 above commissioners anticipate a lack of competition should the Council decide to undertake a competitive tendering process and are concerned that there are unlikely to be many, if any, providers other than NHHT who will be able to meet the service requirement. Any other provider seeking to secure this contract would be required to have 99 units of extra care housing standing empty and ready for tenants to move into from July 2015. Commissioners are not aware that any such large vacant premises exist in borough.

3.3 The Council has a positive commercial relationship with the provider who is a valued delivery partner. There is a proven track record of securing value for money whist maintaining high quality service with this provider through negotiation.

4 Option Benefits – competitive tender (Restricted procedure)

4.1 By following a restricted procedure, the Council will be able to review the market during the selection stage (PQQ). Should there be a suitable number of organisations who are competent and capable of providing the service they will be invited to tender.

5 Option Drawbacks – direct negotiation

5.1 Although it is anticipated that there is either no market or a very limited market of suitable providers, by directly negotiating with the current provider suitable providers who are unknown to the Council will not be identified.

6 Option Drawbacks – competitive tender

6.1 If the Council decides to pursue a competitive tender route and does not secure a new contract for the provision of extra care either with NHHT or another provider, there will be a significant risk to manage in terms of continuity of care for service users and substantially increased financial pressure for the Council – see 3.1 above for details.

6.7 Any current local service provider will know when there is likely to be limited or no competition for their services, and in that knowledge may decide not to bid for their service themselves, allowing the procurement to fail, and then seeking to directly negotiate new terms. This strategy would carry some limited risk for any current provider but if successful would place them in a strong negotiating position, with the result that the Council may be under pressure to negotiate a new contract term at significantly enhanced rates.

7 Business Risks

7.1 Risks associated with Competitive Tender

7.2 As outlined in the options appraisal an unsuccessful competitive tender would result in either:

- The Mildmays being lost as an extra care resource and the source of the 12 remaining residential intermediate care beds in borough
- A significant risk to manage 87 vulnerable people living in general needs housing with high support needs
- Post tender direct negotiation with the current provider and the possibility that essentially the same service is secured but at an enhanced contract value.

7.3 If the 99 units were lost as extra care, and intermediate care, the risks would be managed by:

- Reviewing existing tenants to assess how best to meet their needs
- Decanting into more appropriate accommodation, including residential care – the likely result for the majority of current tenants. Research indicates that such moves can result in poor outcomes for those involved.
- Introducing large and costly care packages including night time and weekend services to support people at home
- Spot placing people out of borough for intermediate care. Evidence indicates that spot placements for intermediate care out of borough are much more likely to turn into permanent residential care placements, since the placements cannot be closely managed by Islington health and social care staff.

7.4 The costs associated with all 4 elements above will present a significant cost pressure for the Council.

7.5 The loss of the Mildmays will result in the Council having reduced capacity to fulfil the following corporate objectives:

- To maintain Islington residents in their own homes for longer
- To reduce isolation
- To improve prevention and early intervention
- To reduce hospital admissions and reduce the number of people entering into residential care services
- To develop an integrated care model.

7.6 The Council will lose a long standing, beneficial commercial relationship with a valued partner and successful provider of care services.

8 Risks associated with Direct Negotiation

8.1 By following the Direct Negotiation route, the Council will be not be able to formally review the market through a competitive tender process to determine whether there

will be a suitable number of organisations who are competent and capable of providing the service they will be invited to tender.

8.2 However, as already stated there is no anticipated competition for the provision of current services. To mitigate this risk a Prior Information Notice (PIN) is being drafted in December 2014 to test the market in the short to medium term for potential additional supply in borough or nearby.

9 Business Opportunities

9.1 The procurement strategy will secure continuity of care for tenants, continuity of supply and continued value for money.

9.2 Extra care provides the opportunity to deliver a truly integrated service across housing, social care and health, delivering:

- improved quality of life and wellbeing
- reduced need for more intensive and expensive services
- opportunities to reduce unplanned hospital admissions through effective partnership working
- managed last years of life.

9.3 Improving prevention and early intervention
Commissioners will use the procurement to ensure that services are responsive to changing pressures and demands and maintain a preventative approach, enabling tenants to live in the community for as long as possible, enjoying improved quality of life and avoiding the poor outcomes associated with social isolation.

9.4 The new specification will increase the requirement for the provider to engage in and support end of life planning, working more closely with community and primary health services to:

- reduce unplanned hospital admissions
- reduce unnecessary London Ambulance Service call-outs
- increase the number of people dying in their preferred place
- reduce the number of tenants moving into more costly nursing care or delay the point at which they do so.

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