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ISLINGTON

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

AGENDA FOR THE HEALTH AND WELLBEING BOARD

Members of Health and Wellbeing Board are summoned to a meeting, which will be held in Committee Room 1, Town Hall, Upper Street, N1 2UD on **20 April 2016 at 1.00 pm.**

John Lynch
Head of Democratic Services

Enquiries to	:	Jonathan Moore
Tel	:	020 7527 3308
E-mail	:	democracy@islington.gov.uk
Despatched	:	12 April 2016

Membership

Councillors:
Councillor Richard Watts (Chair)
Councillor Janet Burgess MBE
Councillor Joe Caluori

Local NHS Representatives:
Simon Pleydell, The Whittington Hospital NHS Trust
Wendy Wallace, Camden and Islington NHS Foundation Trust

Clinical Commissioning Group Representatives:
Alison Blair, Chief Executive, Islington Clinical Commissioning Group
Martin Machray, Director - Quality & Integrated Governance, Islington Clinical Commissioning Group
Dr. Gillian Greenhough, Chair, Islington Clinical Commissioning Group
Dr. Josephine Sauvage, Joint Vice Chair (Clinical), Islington Clinical Commissioning Group
Sorrel Brooks, Lay Vice-Chair, Islington Clinical Commissioning Group

Islington Healthwatch Representative:
Emma Whitby, Islington Healthwatch

NHS England:
Dr Henrietta Hughes, NHS England

Officers:
Julie Billett, Joint Director of Public Health
Sean McLaughlin, Corporate Director Housing and Adult Social Services
Cathy Blair, Director Targeted and Specialist Children, Family Services

A.	**Formal Matters**	**Page**
1.	Welcome and Introductions - Councillor Richard Watts	
2.	Apologies for Absence	
3.	Declarations of Interest	

If you have a Disclosable Pecuniary Interest* in an item of business:

- if it is not yet on the council's register, you must declare both the existence and details of it at the start of the meeting or when it becomes apparent;
- you may 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, you must leave the room without participating in discussion of the item.

If you have a personal interest in an item of business and you intend to speak or vote on the item you must declare both the existence and details of it at the start of the meeting or when it becomes apparent but you may participate in the discussion and vote on the item.

*(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 of your expenses in carrying out duties as a member, or of your election; including from a trade union.
(c)Contracts - Any current contract for goods, services or works, between you or your partner (or a body in which one of you 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 you or your 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.

This applies to all voting members present at the meeting.

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C.	Business items	Page
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D. Questions from Members of the Public

To receive any questions from members of the public.

E. 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.

F. Exclusion of Press and Public

To consider whether, in view of the nature of the remaining items on the agenda, any of them are likely to involve the disclosure of exempt or confidential information within the terms of Schedule 12A of the Local Government Act 1972 and, if so, whether to exclude the press and public during discussion thereof.

G. 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.

H. Confidential/Exempt Items for Information

I. Any other business

The next meeting of the Health and Wellbeing Board will be on 6 July 2016

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www.democracy.islington.gov.uk

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London Borough of Islington

Health and Wellbeing Board - Wednesday, 20 January 2016

Minutes of the meeting of the Health and Wellbeing Board held at Committee Room 1, Town Hall, Upper Street, N1 2UD on Wednesday, 20 January 2016 at 1.00 pm.

Present: **Councillors:** Richard Watts (Chair), Janet Burgess [in part] and Joe Caluori [in part].

Alison Blair, Chief Executive, Islington Clinical Commissioning Group
Martin Machray, Director - Quality & Integrated Governance, Islington Clinical Commissioning Group
Dr. Gillian Greenhough, Chair, Islington Clinical Commissioning Group
Sorrel Brooks, Lay Vice-Chair, Islington Clinical Commissioning Group
Wendy Wallace, Chief Executive, Camden and Islington NHS Foundation Trust
Simon Pleydell, Chief Executive, The Whittington Hospital NHS Trust
Emma Whitby, Chief Executive, Islington Healthwatch
Cathy Blair, Interim Corporate Director of Children's Services, Islington Council
Julie Billett, Director of Public Health, Islington council
Sean McLaughlin, Corporate Director of Housing and Adult Social Services, Islington Council

Councillor Richard Watts in the Chair

69 **WELCOME AND INTRODUCTIONS (ITEM NO. A1)**
Councillor Richard Watts welcomed everyone to the meeting.

70 **APOLOGIES FOR ABSENCE (ITEM NO. A2)**
Apologies for absence were received from Dr Henrietta Hughes, NHS England. Councillor Janet Burgess submitted apologies for having to leave the meeting early. Councillor Joe Caluori offered his apologies for lateness.

71 **DECLARATIONS OF INTEREST (ITEM NO. A3)**
None.

72 **ORDER OF BUSINESS (ITEM NO. A4)**
It was agreed that Item C1, Health and Work Programme – Update, would be considered prior to items B1 and B2.

73 **MINUTES OF THE PREVIOUS MEETING (ITEM NO. A5)**

RESOLVED:
That the minutes of the meeting held on 16 September 2015 be agreed as a correct record and the Chair be authorised to sign them.

74 **HEALTH AND WORK PROGRAMME - UPDATE (ITEM NO. C1)**
Lela Kogbara, Assistant Chief Executive (Strategy and Partnerships), and Graeme Cooke, Head of Strategic Change (Employment), introduced the report which provided an update on the Health and Work Programme agreed at the July 2015 meeting.

The following main points were noted during the discussion:

- It was reported that good progress had been made in developing the programme.
- Lela Kogbara was Chair of the Programme Board; however this responsibility was to pass to health colleagues. It was suggested that this would increase the Programme Board's emphasis on clinical matters.
- A multi-agency programme structure had been established by the council, CCG, JobcentrePlus and health colleagues. Objectives, outcomes and monitoring arrangements had been agreed. The programme had been implemented on a small scale, with the *Working Better* employment service operating from seven primary care settings. Although the small scale of this trial was recognised, it was commented that this was useful in resolving preliminary matters related to integration and data collection.
- It was commented that the CCG had been particularly helpful in liaising with health services and work was underway to develop joint training for health and employment professionals.
- A priority and challenge for 2016 was to procure a provider for the supported employment trial. It was reported that the trial would aim to work with 500 residents who were out of work with either a long-term condition or disability. It was intended for the trial to commence in summer 2016 and run for two years.
- The importance of engagement with residents was emphasised. Resident experts were being sought to participate in a steering group to help shape the design and delivery of the programme. To date 20 residents had been identified.
- The Board considered the national policy context of the programme and noted that the government had announced further support to those with long-term conditions in the 2015 spending review and autumn statement. In particular, £115 million funding had been announced for a Joint Work and Health Unit, which had been established by the Department for Work and Pensions and Department for Health.
- Whilst it was too early to evaluate the effectiveness of the programme, it was reported that the primary care services engaging with the *Working Better* employment programme had approached the programme with enthusiasm, recognised the benefits for patients and health and employment services and overall positive feedback had been received.
- Some initial feedback had been received which commented that agencies had to be careful in forming the narrative of the programme. The Board was keen to emphasise that the programme was not connected to national benefit cuts and was not seeking to "force" people back into work.
- A discussion was had on national health and work initiatives. It was reported that some Islington residents requiring health assessments by the Department for Work and Pensions had been contacted by the Health Assessment Advisory Service to advise that their assessment was in Milton Keynes. The Board noted that the nearest assessment centre was in Highgate and expressed concern at the impact that such administrative errors could have on vulnerable people.

RESOLVED:

1) That progress in developing the local Health and Work Programme be noted;
2) That future programme plans, including the procurement of a supported employment service trial in partnership with NHS England, be noted; and
3) That the issues, challenges, opportunities and wider policy context for the programme, as set out in the report submitted, be noted.

75 **A ROAD MAP FOR INTEGRATED HEALTH AND SOCIAL CARE (ITEM NO. B1)**

Alison Blair introduced the report which provided an update on proposals for greater integration between Islington Council, Islington Clinical Commission Group, their counterparts in Haringey, Whittington Health NHS Trust and Camden and Islington NHS Foundation Trust.

The following main points were noted during the discussion:

- The overall objective of integration was to improve health and care services for residents. It was thought that further integration of services would contribute to residents feeling supported and listened to and would mean that service users would only have to provide information once.
- In considering integration matters, partners would need to review how they communicate with each other and the public, the information they hold, how systems are managed and the changes required to achieve the best outcomes for residents. It was considered that further integration would improve efficiencies and the financial sustainability of services.
- The Board considered local services and initiatives which had benefitted from further integration, including the Integrated Community Ageing Team, iHub, locality networks and the integrated digital care record project. It was noted that there was national support for further integration of local services and, following small-scale successes, local agencies had to consider how services could be integrated further and at a greater pace.
- It was reported that discussions with Haringey had continued following the NHS Vanguard application in early 2015. Whilst there was a local and national appetite for integration, further consideration was required on how integration would impact on service providers, financial resources and the sustainability of services. The Board noted that it was crucial for local needs and priorities to be reflected in any integration arrangements.
- It was agreed that the Health and Wellbeing Boards of Islington and Haringey were best placed to lead on the integration of services and infrastructure. There was a need to move from integration on initiatives to integration at a strategic and governance level, although it was recognised that this was a greater challenge. The Board requested a further report on how integration with Haringey at a governance level could be achieved.
- To ensure integration achieved the desired outcomes, integration would need to be approached in a careful and targeted manner. All partners needed to further consider what was to be integrated and why. In addition, Islington Council would need to consider how integration with Haringey would interact with joint-working with Camden on Public Health functions. It was reported that CCG Chairs across London had recently discussed the benefits of collaboration and opportunities for shared learning.
- Although the Board recognised the potential efficiencies and benefits of integration, it was agreed that a detailed vision was required to shape the integration of local services. It was thought that once this vision was agreed the governance arrangements would follow. Partners would need to address the spatial scale of services; determining which services were best delivered at a sub-borough, borough, cross-borough, and cross-London scale.
- The importance of involving local people in developing integrated services was emphasised. In particular, it was commented that services had to reflect the differing levels of independence of service users; the level of professional involvement should be flexible to service user needs.
- It was suggested that naming the integration project would make it more tangible.
- It was hoped that integrated services would ease referral processes. It was emphasised that the focus of integration should be on securing the best

outcomes for patients and services and achieving economic benefits over a given timescale, as opposed to secondary concerns such as the management of buildings and facilities.

- It was suggested that integration could be assisted by mapping health and care pathways across boroughs; as although local agencies had similar processes to their counterparts in Haringey, these were not identical and integrated services would need to either resolve or recognise local differences.
- The Board requested that detailed proposals for integration, including an assessment of the optimal spatial scale of services and legal implications, be prepared and reported to the Board for discussion as soon as possible.

RESOLVED:

1) That the principle of further integration of local agencies in Islington and Haringey be supported;
2) That a further report on integration at a governance level be received to a future meeting; and
3) That detailed proposals for integration be prepared and reported to the Board for discussion as soon as possible.

76 SMOKEFREE CAMDEN AND ISLINGTON 2016 - 2021 (ITEM NO. B2)

Julie Billett and Liz Brutus, Assistant Director of Public Health, introduced the report which presented the Camden and Islington Smokefree Strategy 2016-21.

The following main points were noted during the discussion:

- The importance of smoking cessation initiatives was noted. Islington had the highest prevalence of smoking in London which represented the biggest preventable risk factor that contributed to premature death.
- It was commented that nicotine addiction was a long-term condition which often started in childhood and disproportionately affected those who were disadvantaged.
- The Board noted successes in smoking cessation, including positive work with schools and enforcement activities such as the smokefree playgrounds initiative.
- The Board considered the three objectives of the strategy; closing the gateways in to smoking for children and young people, helping people to quit smoking, and reducing related harm. It was commented that partnership work between Public Health, Adult Social Care and the NHS, amongst others, would be required to achieve these objectives.
- Specific recommendations for consideration included all members of the Board working towards training all resident-facing staff to provide advice on smoking cessation; all members of the Board to embed support with stopping smoking into their workplace wellbeing programmes; a coordinated approach to preventing and tackling smoking in children and young people; mainstreaming stop smoking activity across commissioned NHS secondary care services; and introducing further designated smokefree areas.
- It was commented that a detailed delivery plan would be developed to support the strategy.
- The Board considered that all partners needed to support the strategy for it to be successful. Although the mainstreaming of stop smoking activity across commissioned NHS secondary care services was supported, it was commented that NHS services could not take on the sole responsibility for such activity.
- In response to a query on how smoking cessation advice can be best provided to children and young people, it was commented that increasing the knowledge and confidence of those working with children and parents on a

regular basis was crucial. It was recognised that staff did not wish to appear judgemental; however services already working with families were well placed to have difficult conversations about smoking.

- The Board noted that those with vulnerabilities and long-term conditions, particularly mental health conditions, may require additional help to quit smoking.
- It was commented that providing resident-facing staff with the skills to deliver advice on smoking cessation could be a powerful tool, however sustained effort would be required to embed the giving of advice into working practices.
- The Board discussed the smoking of cannabis. It was noted that local agencies had focused on addressing cannabis use through drug services; however there was a need to raise public awareness of the overall health effects of smoking cannabis, particularly given its prevalence and the difficulties of enforcing its use. It was reported that up to 30% of respiratory patients at the Whittington Hospital were cannabis users. It was suggested that there can be a perception that smoking cannabis was somehow less harmful than smoking tobacco which needed to be addressed. The Board also noted the detrimental effect of cannabis use on mental health. The Board requested further information on the health effects of smoking cannabis and the work underway to reduce its use.
- It was confirmed that e-cigarettes were considered to be a legitimate tool in stopping smoking. Although e-cigarettes were not without harm, it was reported that they were significantly less harmful than smoking tobacco.

RESOLVED:

1) That the Strategy and its ambition for Islington to be smokefree by 2030 be endorsed and championed; and
2) Further information on the health effects of smoking cannabis and the work underway to reduce its use be submitted to the Board.

MEETING CLOSED AT 2.15 pm

Chair

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ISLINGTON

Report of: **Director of Commissioning, Islington CCG**

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	20 April 2016	B1	All

Delete as appropriate		Non-exempt

SUBJECT: Islington CCG Commissioning Intentions for 2016/17

1. Synopsis

The National Planning Guidance 2016/17 – 2020/21 for the NHS published on 22 December 2015 confirms that two plans are required to be delivered for 2016/17 onwards:

- A five year Sustainability and Transformation Plan (STP), driving delivery of the Five Year Forward View based on a Strategic Planning Group footprint (North Central London), for final submission late June 2016;
- A one year Operational Plan for 2016/17 for the CCG, as a milestone for delivering the STP, for final submission 11 April 2016.

This paper provides an overview of development of the Sustainability and Transformation Plan (STP) for North Central London and the Islington CCG Operating Plan for 2016/17.

2. Recommendations

To note and comment on the development of the Sustainability and Transformation Plan (STP) for North Central London and the Islington CCG Operating Plan for 2016/17.

3. Introduction

The National Planning Guidance 2016/17 – 2020/21 for the NHS published on 22 December 2015 confirms that we will be required to deliver two plans for 2016/17 onwards:

- A five year Sustainability and Transformation Plan (STP), driving delivery of the Five Year Forward View based on a Strategic Planning Group footprint (North Central London), for final submission late June 2016;

- A one year Operational Plan for 2016/17 for the CCG, as a milestone for delivering the STP, for final submission 11 April 2016.

These plans focus on delivery of the Five Year Forward View (FYFV) and an accelerated rate of service transformation as well as a shared approach to planning through system wide Strategic Planning Groups (SPG) including specialist commissioning, providers and local government. Therefore we must ensure our plans deliver:

- A radical upgrade in prevention and public health;
- A concerted effort to improve the quality of care, aligned to the introduction of new models of care;
- A focus on getting finances back in balance; and
- A place based system wide vision for transformational change to address local and national challenges and priorities.

The timetable for submission of Plans is summarised below:

	Operational Delivery Plan (ODP)	**Sustainability and Transformation Plan (STP)**
First cut	11 February 2016	31 March 2016
Second cut	2 March 2016	6 May 2016 (unconfirmed)
Final Version	11 April 2016	30 June 2016

4. The Sustainability and Transformation Plan (STP) 2016/17 – 2020/21

This plan will be developed collaboratively across our North Central London (NCL) Strategic Planning Group (SPG) for a five year period. This plan must address the priorities for change in a robust transformation plan that includes a clear vision, robust leadership and governance arrangements, milestones for delivery and agreed actions to achieve our vision. These plans need to be developed in collaboration with our whole health and care system (including local authorities and the third sector) with providers, commissioners and our population for a five year period.

The North Central London Strategic Planning Group in London) is to produce a multi-year Sustainability and Transformation Plan (STP) for the local healthcare system, outlining how local services will get from where it is now to where the Five Year Forward View requires them to be by 2020. STPs will therefore set out the strategic vision accounting for national and regional priorities which will be enabled through operating plans.

Guidance clearly highlights five elements that must be included in the STP:

- Local leaders working together as a team;
- Development of a shared vision with the local community and local government;
- Programming a clear plan of actions to deliver to the vision;
- Execution against this plan;
- An ability to learn and adapt to overcome challenges and meet our objectives.

In addition the STP must be developed openly and engage patients, carers, clinicians, citizens and local partners such as independent and voluntary sectors and Health and Wellbeing Boards. It will include activity for specialised services, primary medical care, prevention, social care and integration locally with local authority services.

The STP will need to demonstrate a system wide local sustainability plan for the local NHS system to balance its books across all organisations. The 'National Challenges' set out in three main questions to be answered by this plan are a core element but must not be considered as the only necessary answers to be provided by the plan:

1. How will you close the health and wellbeing gap?
2. How will you drive transformation to close the care and quality gap?
3. How will you close the finance and efficiency gap?

4.1 Sustainability and Transformation Plan Content

Each healthcare system will need to produce a Sustainability and Transformation Plan for the local healthcare system outlining how local services will get from where they are now to where the Five Year Forward View requires them to be by 2020. Plans should include:

4.1.1 Vision and strategic goals

- A multi-year, place based vision for the local population for each SPG;
- Alignment and consistency with organisational plans, outlining proposed changes to services and implications for each organisation;
- Vision that should be developed and tested with local stakeholders;
- Assurance that the SPG is financially sustainable post-implementation;
- A centralised financial, activity and capacity model that demonstrates triangulation of assumptions across all stakeholders;
- A demonstration of value for money using both financial and economic appraisal techniques.

4.1.2 Case for change

An overview of health needs of local population, areas for quality improvement, and local financial challenges facing the local health economy.

4.1.3 Priorities

A set of measurable (SMART) priorities for the next five years which build on plans submitted last year.

4.1.4 Enablers

An outline of the key enablers required to deliver the vision and priorities, including IT, workforce requirements, estates changes or utilisation.

4.1.5 Implementation plan

Detailed milestones, clear ownership, resourcing and risks for each priority area for action. A summary of progress to date in developing the Sustainability and Transformation Plan is appended for information.

4.2 Funding

The planning guidance confirms that financial resource will be provided for as follows:

- A new Transformation Fund held centrally by NHS England and awarded to systems and organisations who can demonstrate robust collaborative leadership supported by Sustainability and Transformation Plans with clear visions and plans;
- A Sustainability Fund of £1.8 billion from the Transformation fund distributed directly to provider trust organisations based on calculations trust by trust to return the NHS provider sector to financial balance. Recovery milestones will need to be met (deficit reductions, access standards and progress on transformation) as well as embedding a culture of 'relentless cost containment' in order for trusts to continue to receive funding.

5. Islington CCG Operating Plan for 2016/17

Commissioner and provider plans for 2016/17 will be submitted in April and need to be agreed by NHS England and NHS Improvement (who oversee NHS provider plans). Planning Guidance places great emphasis on the triangulation of plans across commissioners and providers in operating plans for 2016/17.

The plan must also deliver to year one milestones for seven day service priorities and a clear list of nine 'must dos' for 2016/17, set out in the guidance for all local systems.

5.1 Seven-day services

The priorities set out for 2016/17 reflect the NHS Mandate and Five year Forward View (FYFV) implementation. These priorities include partial roll out of seven day services delivering:

- **Access to acute services** complying with four of the ten **clinical standards** for seven-day services for 25% of the population (we already support Whittington Health to deliver seven day services through our current contract);
- **Enhanced access to primary care** for 20% of the population (we are already delivery enhanced access through primary care through the i:Hub service funded through the Prime Minister's Challenge Fund and locally commissioned services);
- **Consultant cover and diagnostic services** at weekends to reduce increased deaths compared to weekdays, as part of the seven-day service offer;
- **Better integration of 111, minor injuries, Urgent Care Centres, GP out of hours** to improve alternative out of hours service offers to patients (the new integrated 111 and out of hours service across North Central London (NCL) will commence in October 2016.

5.2 The nine 'must dos' for 2016/17:

1. **Develop our North Central London (NCL) Sustainability and Transformation Plan (STP)**, determining and delivering against our local critical milestones towards the triple aim within the Five Year Forward View. The triple aim relates to:
    - A radical upgrade in prevention and public health;
    - A concerted effort to improve the quality of care, aligned to the introduction of new models of care;
    - A focus on getting finances back in balance.

2. Deliver **system wide aggregate financial balance**, including productivity and workforce improvement programmes within providers and **Right-Care programmes** by commissioners, such as value based commissioning and population based outcomes;

3. Implement local plans to address **sustainability and quality of general practice**, including workforce and workload issues;

4. Achieve **access standards for A&E and ambulance waits** (category A 8 minute calls) including implementation of the Urgent and Emergency Care review through new networks;

5. Delivery of **18 week referral to treatment** standard, including offering patient choice;

6. Delivery of the 62 day, 2 week and 31 day **cancer standards** as well as ensuring **earlier diagnosis** to improve one year survival rates and reducing diagnosis on emergency admissions;

7. Achieve two **new mental health access standards**, for commencement of NICE approved care packages within 2 weeks (for 50%) of referrals for **First Episode Psychosis** and treatment within 6 weeks (for 75%) and 18 weeks (for 95%) of referrals for **IAPT**. This also includes maintaining diagnosis rate of at least two thirds for **dementia.** The CCG is achieving these standards in 2015/16;

8. Delivering **transformation of care for people with learning disabilities** including implementation of all elements of new published policy;

9. Implement plans for **affordable improvements in quality**, including provider publication of annual avoidable mortality rates.

These are not new to Islington CCG and we have already got clear programmes in place or in development for these priorities. Our plan will need to bring these priority programmes of work together, incorporate how they will link to the NCL Sustainability and Transformation Plan, ensure implementation delivers benefits across health and care in line with the ambitions of our local authority and ensure we have stretch milestones throughout the year that we can achieve and are agreed within our contracts with providers.

5.3 Islington CCG Plan

This section of the paper provides an overview of the first draft of the Islington CCG Operating Plan submitted to NHS England on 8 February 2016. On 8 February 2016 the CCG submitted:

- A summary financial plan for 2016/17;
- A summary activity plan for 2016/17 to deliver the NHS Constitution waiting time standards for A&E, cancer, and referral-to-treatment times.

A balanced budget has been produced for 2016/17, however risks around the values and assumptions with acute contracts along with the deliverability of savings plans need to be considered before a robust final position is presented.

The position within this report will form the basis of this submission with further reviews and submissions over the course of the next two months as contract negotiations with providers' progress.

5.3.1 Allocations

Islington CCG's programme allocation for 2016/17 has been confirmed as £326,996k. **This represents an increase of £6,947k or 2.17% to manage planning assumptions and commissioning pressures.** The £326,996k programme allocation includes section 256 funds (£5,894k), which are pooled into the Better Care Fund and £1,679k for winter pressures (the 2015/16 value rolled forward).

It should also be noted that of the 2.17% allocation growth, three specific items must be funded as a minimum. These are:

i). CAMHs transformational funding from 2015/16 - £450k;
ii). The provider cost increase of CNST and National Insurance contribution increases – no exact figure but assumed in the tariff changes, i.e. the net inflator (see section three) that will be applied to provider contracts to cover these costs;
iii). GP IT, which in the past has been funded separately. The core service cost was £599k in 2015/16. The assumption is that the transitional element (£180k) is discretionary and does not have to be funded by the CCG.

In summary, the CCG's core allocation before running costs for the next five years is set out in the table below. Details of the primary care and specialist commissioning allocations are also set at Appendix B.

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Allocation £k	**320,049**	**326,996**	**335,737**	**344,901**	**354,268**	**367,234**
Allocation per capita £		1,371	1,385	1,402	1,421	1,455
Growth		**2.2%**	**2.7%**	**2.7%**	**2.7%**	**3.7%**
per capita growth		0.4%	1.1%	1.2%	1.4%	2.4%
Target £k		308,479	317,818	326,987	336,383	351,381
Target per capita £		1,293	1,311	1,329	1,349	1,392
Opening Distance from target (DfT)		9.6%	6.7%	6.4%	6.2%	6.0%
Closing (DfT)	8.8%	6.0%	5.6%	5.5%	5.3%	4.5%

Note: DfT denotes distance from target.

5.3.2 Planning Assumptions for CCGs

The following planning assumptions have so far been confirmed and been applied to the initial operating plan for the CCG:

- A net uplift to provider contracts encompassing inflation, tariff changes, and efficiency requirements
- Demographic growth - 1.8% in line with population growth estimates used in the CCG allocation;
- Prescribing inflation assumed to be 4.9%,i.e. inflation plus demographic growth;
- Non-demographic – 1% at this stage on acute contracts only to allow for operating plan priorities including early detection of cancer;

- Unavoidable national cost pressures within the allocation uplift represent 1.4% of the 2.17%. CAMHs (£450k), GP IT (assumed core only £599k) and provider Trusts national insurance and CNST increases (assumed to in the net tariff inflator), have all been planned for.

The plans also include the assumptions that:

- Contributions to the national continuing care pool are not required in 2016/17 (£500k) so have been removed from plans. It is unclear whether the pool will be required in 2017/18;
- A 1% non-recurrent fund has been set aside to support provider deficits; as required;
- The CCG needs to find funds to meet planning requirements including support for the Healthy London Partnership (£490k) and the NCL transformation programme contributions previously funded

from the 1% fund now being held in case the local health economy needs it to balance the overall position. As a result, no funds are currently available for the NCL transformation fund;

- Mental Health expenditure and 'parity of esteem' requires the CCG to increase mental health commissioned service costs by a minimum uplift of 2.17%, i.e. the CCG's allocation growth.

5.3.3 Cost of Planning Assumptions

The values within the following table are only from applying business rules to NHS providers and the prescribing budget.

In summary, £12.6m is required to meet planning assumptions from a growth figure of £6.9m – **a pressure of £5.7m.**

	Demographic growth @ 1.8%	Non-Demographic growth @ 1%	Inflation 3.1%	Tariff efficiency @ 2%	ETO/DTR tariff impact	CQUINS @2.5% - net impact	Total
Acute	3,622,000	1,723,000	6,246,000	(4,028,000)	149,000	1,960,816	**9,672,816**
Non-Acute	1,432,000	0	2,463,000	(1,121,000)	0	157,995	**2,931,995**
TOTAL	**5,054,000**	**1,723,000**	**8,709,000**	**(5,149,000)**	**149,000**	**2,118,811**	**12,604,811**

NB: ETO tariff impact 0.7%, DTR (0.9)%

After reversing all non-recurrent items including metrics, challenges, readmissions and those agreed Whittington schemes and assuming and element of drawdown from the 2015/16 surplus (£2.95m from the £7.95m), a savings target of 3% is required.

This allows demand reserves of £3.7m to be established and meet the cost pressures associated with the Integrated Digital Care Record (IDCR) project (£583k) and the final quarter funding of i:Hub primary care service when funds from the Prime Minister's Challenge Fund end.

Although the planned surplus decreases to £5m, or 1.5% of resource allocation, this is still within the planning guidelines.

QIPP schemes of £5.7m (see table below) have been identified and the plan assumes the balance (£3.3m) will be identified before final submission. This will meet the 3% target and allow demand reserves of £3.7m to be set aside. If the QIPP balance is not found, demand reserves will fall - potentially as low as £0.4m.

Current QIPP scheme	Value (£'000)
Non-Elective admissions	800
Productivity metrics	1,650
Price changes (i.e. critical care)	670
Primary care (Gastroenterology & Anti-Coagulation)	175
Elective admissions (Kidney)	140
Other acute (IDCR, Meds & Challenges)	422
Continuing Care	250
Welfare Rights Service	30
Prescribing	600
Better Care Fund (duplication with primary care budgets)	750
Programme costs (administration & Interim)	50
Running Costs (reserve)	200
TOTAL	**5,737**

5.3.4 Activity planning assumptions

On 8 February the CCG submitted high-level activity plans for 2016/17. The table below provides a summary of the plans for 2016/17 submitted compared to forecast activity levels in 2015/16:

	Outpatient referrals	Outpatient First Attendances	Outpatient Follow-ups	Electives Daycase & Inpatient	Non-elective Admissions	A&E attendances
2015/16 outturn	**96,778**	**90,588**	**215,688**	**23,400**	**24,555**	**99,193**
Demographic growth	1,742	1,631	3,883	421	441	1,786
Non-demographic growth	2,517	2,354	5,608	187	196	1,489
National schemes	327	327				
QIPP	-79	-79	-265			
Better Care Fund					-679	-679
2016/17 baseline	**101,285**	**94,821**	**224,914**	**24,008**	**24,482**	**101,789**
Growth %	**+4.7%**	**+4.7%**	**+4.3%**	**+2.6%**	**-0.3%**	**+2.6%**

In summary our activity planning assumptions for 2016/17 are:

- Based on a start-point of forecast outturn for 2015/16 that is line with our year-end financial forecasts;
- Uplifted for demographic growth by 1.8% across all activity categories, with this being consistent with population assumptions underpinning the CCG's allocation;
- Uplifted for non-demographic growth in line with the financial assumptions in our plans for 1% to be applied to acute provider baselines. Uplifts vary by activity category but equate overall to the 1% financial uplift in the plans above:
  - 2.6% uplift for outpatient referrals and attendances;
  - 0.8% increase in elective procedures;

  - 1.5% increase in A&E attendances;
  - 0.8% increase in non-elective admissions.
- Increased for additional cancer outpatient activity, 5% over and above demographic and non-demographic uplifts, accruing from earlier detection initiatives. This is shown under "national schemes";
- Reduced for the impact of QIPP initiatives and admission avoidance schemes funded through the Better Care Fund. These deductions will increase as further QIPP schemes are identified for next year;
- The final row in the table above shows the net impact of applying growth (demographic, non-demographic, and for cancer) and deductions for the impact of QIPP initiatives and admission avoidance schemes funded through the Better Care Fund. The net impact by activity category are:
  - 4.7% increase in outpatient referrals and first attendances, with the increase designed to ensure delivery of waiting time standards for cancer and referral-to-treatment times;
  - 4.3% increase in outpatient follow-up attendances, with the uplift being 0.4% less than that for first attendances for the impact of productivity metrics (reduction in follow-up ratios and consultant-consultant referrals);
  - 2.6% increase in elective procedures, with the increase designed to ensure delivery of waiting time standards for cancer and referral-to-treatment times;
  - 2.6% increase in A&E attendances to reflect demand trends in 2015/16;
  - 0.3% decrease in non-elective admissions with growth being offset by the impact of admission avoidance schemes funded through the Better Care Fund including integrated networks (extended health and care teams aligned to practice networks), the integrated community ageing team, and work on supporting people with long-term conditions.

NHSE assurance that the CCG is commissioning sufficient activity to meet NHS Constitution targets in 2016/17 is to compare activity trends experienced in 2015/16 to those forecast for next year. The table below summarises those trends:

Net activity trends – including growth and QIPP	Outpatient referrals	Outpatient First Attendances	Outpatient Follow-ups	Electives Daycase & Inpatient	Non-elective Admissions	A&E attendances
Growth % 2015/16 to 2016/17	**-0.1%**	**+3.2%**	**+1.9%**	**+2.4%**	**-0.9%**	**+2.6%**
Growth % 2015/16 to 2016/17	**+4.7%**	**+4.7%**	**+4.3%**	**+2.6%**	**-0.3%**	**+2.6%**
Trend Comparison	**+4.8%**	**+1.5%**	**+2.4%**	**+0.2%**	**+0.6%**	**0**

In all activity categories, after applying growth (demographic and non-demographic) and QIPP offsets, net trends for 2016/17 match or exceed the trends experienced in 2016/17.

5.3.5 Delivery of NHS Constitution Targets

In the plan for 2016/17 submitted on 8 February 2016 the CCG declared compliance with NHS Constitution standards for next year. The table below, provided by NHS England summarises expected compliance in 2016/17 compared to performance in 2015/16. The Integrated Quality, Finance and Performance Report sets out a more detailed analysis of current performance:

Indicator Type	Current standards met (Y/N)	Plan standards met (Y/N)
Referral-to-Treatment – 92% open pathways less than18 weeks from GP referral	Y	Y
Diagnostics – 99% tests completed within 6 weeks of GP referral	N	Y
Cancer 62 day – 85% receive first treatment within 62 days of referral from GP or screening	N	Y
Cancer 2 Week Wait – 93% seen within 14 days of GP referral	N	Y
Dementia Diagnosis – 66.7% of expected dementia prevalence diagnosed	Y	Y
IAPT Access – 15% of people diagnosed with depression or anxiety have access to service	Y	Y
IAPT Recovery – 50% of people referred complete treatment and moving to recovery	N	Y
IAPT 6 Week Wait – 75% receive first treatment within 6 weeks of referral	N	Y
IAPT 18 Week Wait – 95% receive first treatment within 18 weeks of referral	N	Y
Urgent Care - A&E – 95% seen within 4 hours	N	Y

Performance against the NHS Constitution standards in 2016/17 is summarised below:

- 92% of people on incomplete referral-to-treatment pathways have been waiting for 18 weeks or less in line with performance in 2015/16. Waiting list backlogs and Whittington Health and Moorfields were removed in 2014/15 and at UCLH in the first quarter of 2015/16, and all three Trusts are currently meeting the standard as at December 2015;
- 99% of people will receive their diagnostic test within six weeks of GP referral from quarter two 2016/17 once the backlog of people waiting over six weeks at UCLH is removed by July 2016. Currently Whittington Health achieves the 99% standard for tests being carried out within six weeks of GP referral;
- Cancer 62-day waits will comply with the 85% standard from June 2016, in line with the recovery plan from UCLH. Performance from June onwards will ensure the standard is met for the year as a whole;
- Cancer two-week waits from GP referral to first attendance are expected to be met in 2016/17, with both Whittington Health and UCLH expecting to regain compliance in January 2016 and March 2106 respectively;
- Dementia diagnosis rates in Islington are the highest in England and at 83% in 2016/17 exceed the national standard of 66.7% diagnosis rate;
- In 2016/17 the CCG expects to meet the standards for access to psychological therapies (IAPT), with forecast based on:
    - More than 15% of people diagnosed as having depression with access to psychological therapy services;
    - The recovery rate for IAPT, 50% of people complete their treatment and are moving to recovery, is expected to be achieved in 2016/17, with the standard expected to be achieved for the first time in the final quarter of 2015/16;
    - The waiting time standard for IAPT (75% seen within six weeks and 95% seen within 18 weeks) with current performance, supported by an incentive scheme in the Camden and

Islington Foundation Trust contract, being 75% seen within six weeks and 95% seen within 18 weeks;

- The CCG is forecasting to meet the 95% standard for people being seen in A&E within four hours, with CCG performance measured through the emergency departments at Whittington Health and Moorfields Eye Hospital. Moorfields meet the A&E standard in 2015/16 whereas the Whittington Health and care economy does not. A recovery plan has been agreed with the Trust to deliver the 95% standard by July 2016.

6. Implications

6.1 Legal Implications

The CCG's commissioning intentions for 2016/17 in response to planning guidance are consistent with the operations of existing Section 75 Agreements between the CCG and Islington Council.

6.2 Financial Implications

As set out in the report.

6.3 Resident 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. No specific resident impact assessment is required in regards to this report.

6.4 Environmental Implications

The environmental implications of the Sustainability and Transformation plan will be assessed when the final draft is available.

As it stands, the Islington CCG Plan has some minor environmental implications, as the extended weekend hours will result in impacts associated with building usage, including energy and water use and waste generation. However, the better integration of 111, minor injuries, Urgent Care Centres, GP out of hours services may result in efficiencies that reduce the impacts of those services.

7. Conclusion and reasons for recommendations

The Health and Wellbeing Board is asked to note and comment on the development of the Sustainability and Transformation Plan (STP) for North Central London and the Islington CCG Operating Plan for 2016/17.

Background papers:
- None

Attachments:
- Appendix A: North Central London Sustainability and Transformation plan progress update March 2016
- Appendix B: Islington Allocation Summary

Final Report Clearance

Signed by		31 March 2016
	Director of Commissioning, Islington CCG	Date
		8 April 2016
Received by	……	……..
	Head of Democratic Services	Date

Report Author: Paul Sinden
Tel: 020 3688 2900
E-mail: p.sinden@nhs.net

North Central London
Sustainability and
Transformation Plan

North Central London Sustainability and Transformation plan Progress update

March 2016

There are a number of objectives for the NCL STP

Goals

The **goals** of our STP are:

- To improve the quality of care, wellbeing and outcomes for the NCL population
- To deliver a sustainable, transformed local health and care services
- To support a move towards place-based commissioning
- To gain access to a share of the national transformation funding which will ensure our hospitals get back to being viable, to support delivery of the Five Year Forward View, and to enable new investment in critical priorities such as primary care, mental health and cancer services

Outputs

The STP needs to deliver several **key outputs:**

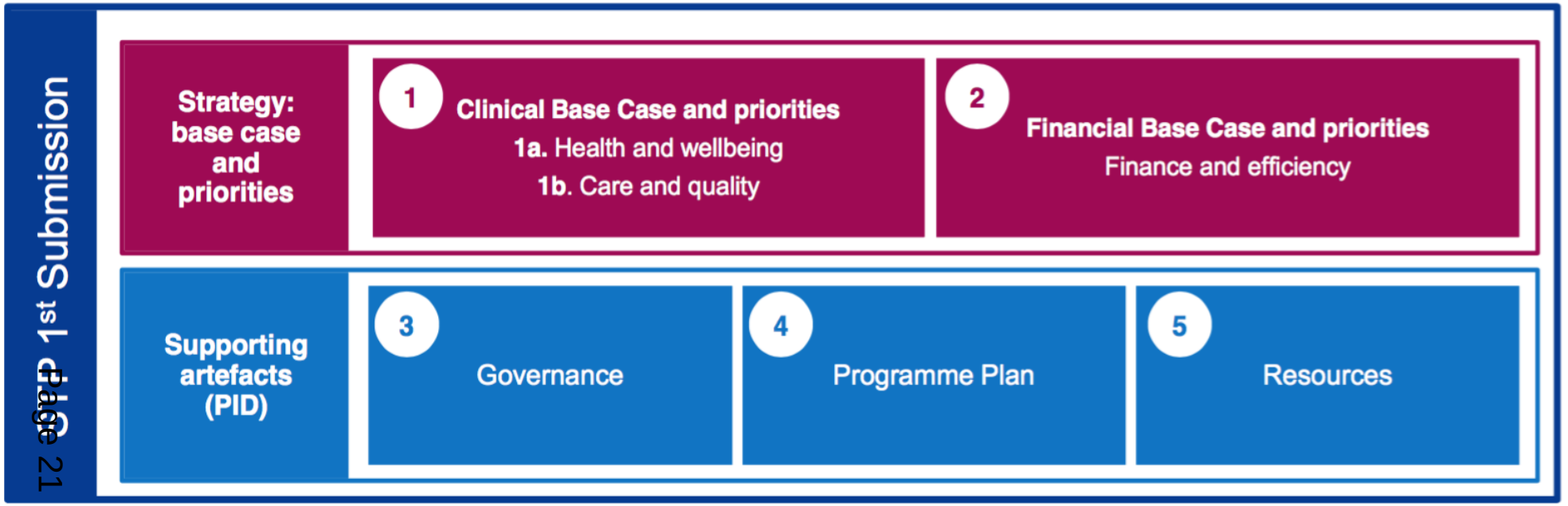
- A compelling clinical case for change that provides the foundation for the programme and is embedded across the work, and supports the identification of priorities to be addressed through the STP
- A single version of the truth financial 'do nothing' base case with quantified opportunity impacts based on the priorities identified
- A robust and credible plan for implementation and delivery over 5 years
- A governance framework that supports partnership working across the STP and collective decision making
- The resource in place to devliver transformation at scale and pace in the key areas identified

Process

The **process** to developing our STP needs to:

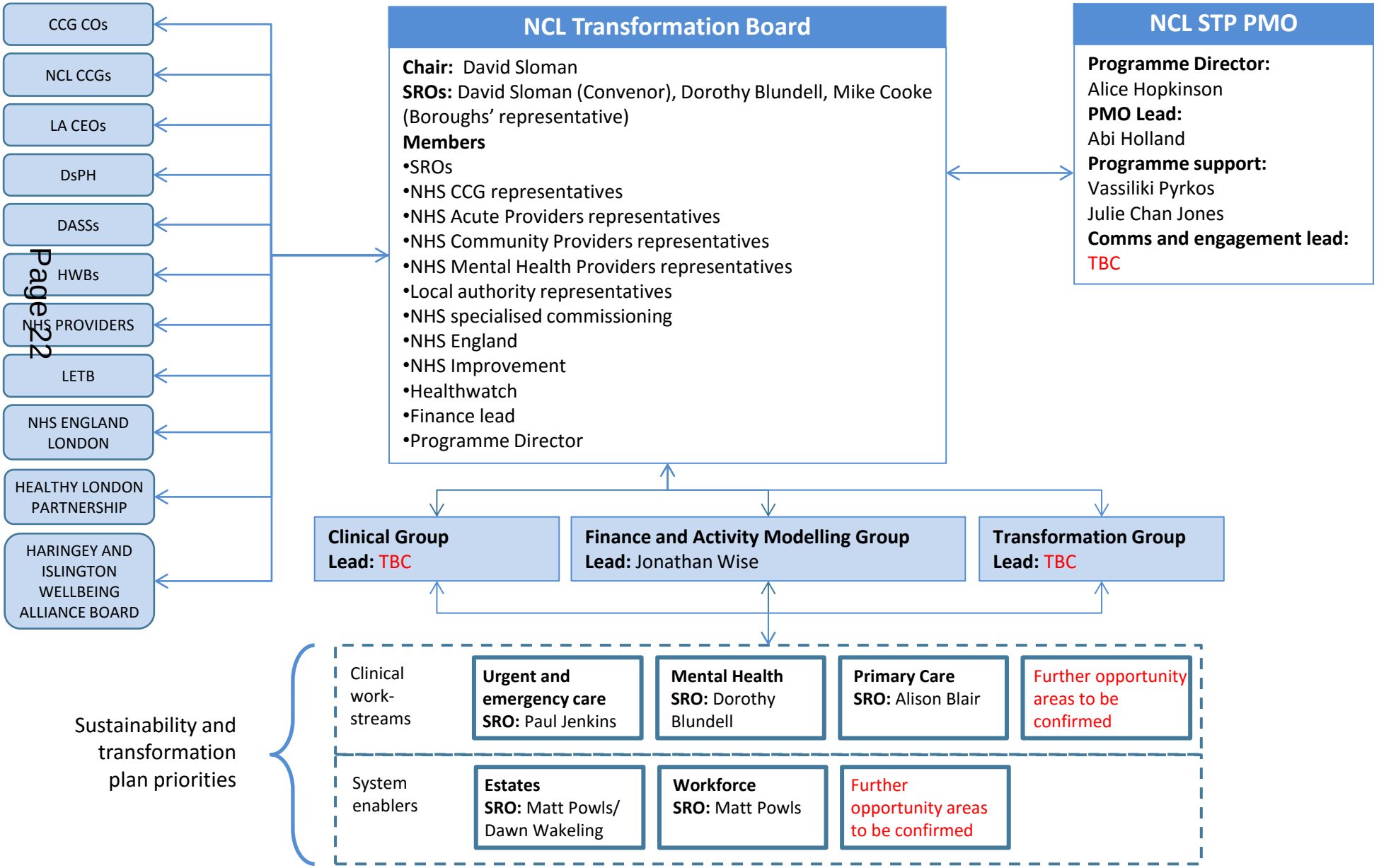
- Be collaborative, and owned by all programme partners in NCL
- Be structured and rigorous
- Move at pace, ensuring quick wins are implemented and transformation is prioritised
- Involve all areas of CCG, local authority and NHS England commissioned activity, including specialised services, primary care and reflecting local HWB strategies

The full STP needs to be submitted to NHS England on 30th June, but 5 key elements are required for the initial STP submission on 15th April

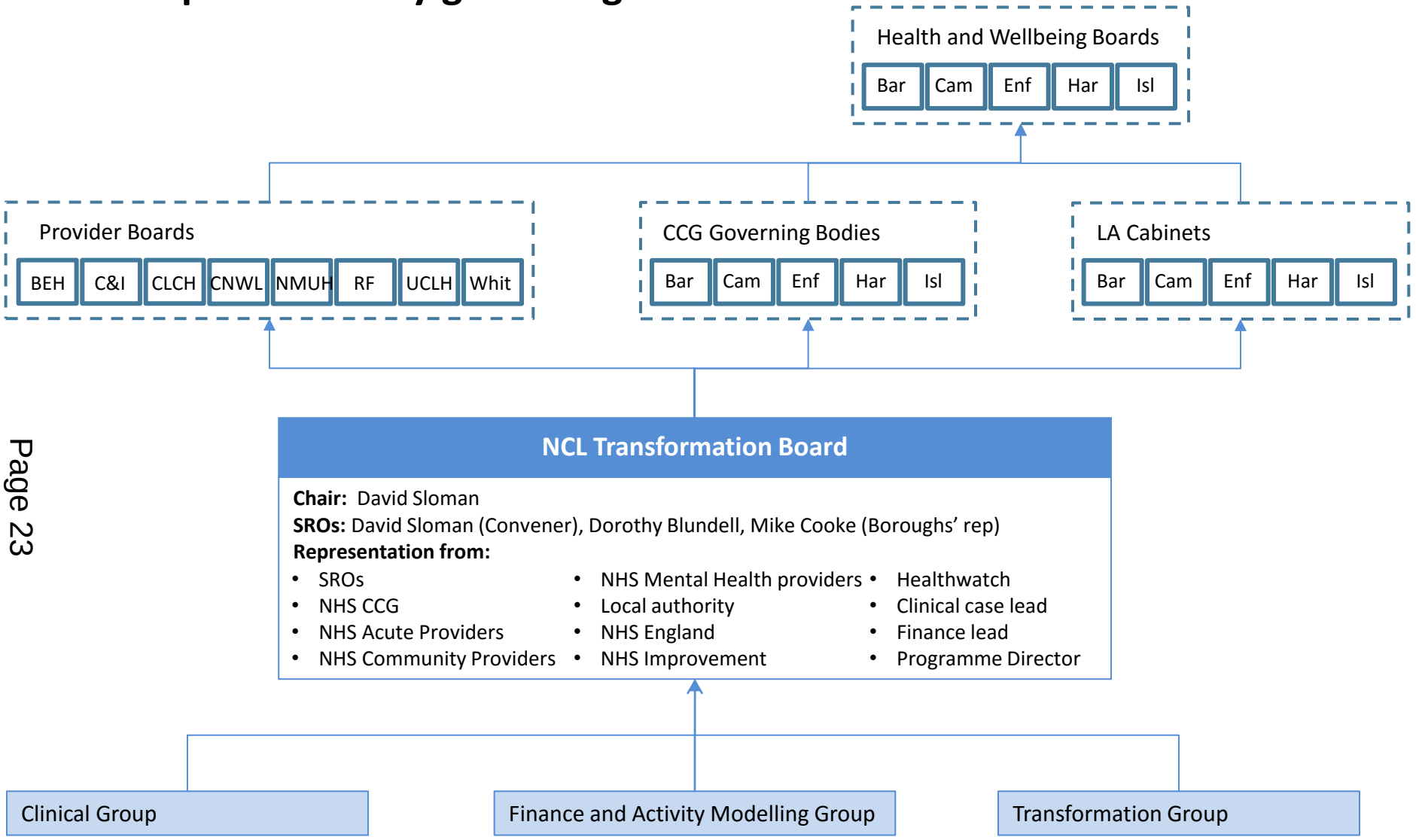


- A **base case**; both **financial** and **clinical** (i.e. the do nothing scenario)
- A number of supporting artefacts that enable development of the STP including:
  - A **programme plan** with clearly defined workstreams and milestones
  - **Governance arrangements** that provide appropriate leadership and control to STP development
  - **Resource agreements across the SPG** to support STP development
  - Interdependencies between both the financial and clinical base case have been considered and accounted for in designing and agreeing supporting artefacts

Current overarching governance framework for the STP



Relationship to statutory governing bodies



The Transformation Board has no formal decision making authority. The membership includes representatives from all statutory bodies (identified above) who will steer decision through their constituent boards for formal sign off.

Key messages emerging from the draft clinical case for change

Supporting fact base…

- People in NCL are living longer but are in poor health
- Widespread deprivation across NCL
- Differing levels of health and social care needs
- Challenges for primary care provision in some areas
- Lack of integrated care and support for those with LTCs
- Too many people in hospital beds who would be better treated at home or in the community
- Hospitals are finding it difficult to provide the most specialist care
- Challenges in mental health provision
- Workforce challenges
- Estates are not fit for purpose

…suggested priorities

- Mental illness
- Older people (particularly those with dementia)
- Long term conditions, including better integration of care and ensuring that suitable and sufficient social care is available
- Prevention
- Ensuring high quality services are available when required for the 78% of local people who are mostly healthy
- Primary care provision and reducing variation between practices, including a requirement for additional investment in primary care services
- Reducing the length of stay in acute hospitals, in partnership with social care
- Reducing delayed discharges in Haringey and Camden

There is scope to consider further opportunity areas in addition to the four priorities, and these will need to be reflected in the initial STP submission

- The NCL Collaboration Board identified the following priorities:
  1. **Acute services redesign:** with an immediate focus on urgent and emergency care
  2. **Mental health:** with an immediate focus on transforming inpatient care
  3. **Pathways:** with an immediate focus on primary care, having common standards and reducing variation
  4. **System wide enablers:** with an immediate focus on estates

- The cumulative challenge for CCGs along in NCL in 2020/21 is £460m
- The impact of the four collaboration priorities could address £135m of the financial gap
- Further opportunities need to be identified and analysed to close the key gaps identified in the clinical case and the finance base case

- We have discussed a number of principles in our approach to selecting additional priorities as part of the STP:
  - We should be **radical in our approach** and **not constrict ourselves** to opportunities available within the constraints of the current system
  - We should be considering **more effective vehicles for taking change forwards** including taking advantage of opportunities to **share resources**
  - We should be able to **articulate the opportunities to all audiences**, including patients, health commissioners and providers, local authorities and NHS England
  - We should be looking to **reduce demand** through new opportunities
  - New opportunities should be focused around **eliminating variation** and **adding value**

Next steps: priority actions prior to STP submission in June

- ☐ Hold formal launch / kick off for the STP to gain buy-in from across the system
- ☐ Agree additional priorities, overarching structure of programme and develop detailed workstream implementation plans
- ☐ Map out existing local work and ensure alignment with STP plans
- ☐ Quantify potential impact of agreed priorities
- ☐ Hold interdependencies workshop to identify key dependencies across the programme
- ☐ Agree programme budget and funding
- ☐ Fill resourcing gaps through external and internal roles
- ☐ Mobilise sub groups: draft ToRs, agree membership and establish key meeting dates
- ☐ Develop comms and engagement strategy and roll out across NCL

Appendix B Islington Allocations	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Allocation £k	**320,049**	**326,996**	**335,737**	**344,901**	**354,268**	**367,234**
Allocation per capita £		1,371	1,385	1,402	1,421	1,455
Growth		**2.2%**	**2.7%**	**2.7%**	**2.7%**	**3.7%**
per capita growth		0.4%	1.1%	1.2%	1.4%	2.4%
Target £k		308,479	317,818	326,987	336,383	351,381
Target per capita £		1,293	1,311	1,329	1,349	1,392
Opening DfT		9.6%	6.7%	6.4%	6.2%	6.0%
Closing DfT	8.8%	6.0%	5.6%	5.5%	5.3%	4.5%

Primary Medical	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Allocation £k	**28,294**	**31,687**	**35,408**	**37,165**	**38,657**	**40,490**
Allocation per capita £		133	146	151	155	160
Growth		**12.0%**	**11.7%**	**5.0%**	**4.0%**	**4.7%**
per capita growth		10.0%	10.0%	3.4%	2.6%	3.5%
Target £k		36,123	37,604	39,118	40,688	42,594
Target per capita £		151	155	159	163	169
Opening DfT		-17.3%	-11.7%	-5.2%	-4.3%	-4.3%
Closing DfT	-17.9%	-12.3%	-5.8%	-5.0%	-5.0%	-4.9%

Specialised	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Allocation £k	**81,354**	**88,518**	**93,545**	**98,499**	**103,553**	**109,364**
Allocation per capita £		371	386	400	415	433
Growth		**8.8%**	**5.7%**	**5.3%**	**5.1%**	**5.6%**
per capita growth		6.9%	4.0%	3.7%	3.7%	4.3%
Target £k		88,167	93,175	98,107	103,141	108,925
Target per capita £		370	384	399	414	432
Opening DfT		1.2%	1.1%	1.1%	1.1%	1.1%
Closing DfT	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%

Total	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Allocation £k	**429,697**	**447,201**	**464,690**	**480,565**	**496,478**	**517,088**
Allocation per capita £		1,875	1,918	1,954	1,992	2,049
Growth		**4.1%**	**3.9%**	**3.4%**	**3.3%**	**4.2%**
per capita growth		2.2%	2.3%	1.9%	1.9%	2.9%
Target £k		432,769	448,597	464,212	480,211	502,901
Target per capita £		1,814	1,851	1,887	1,926	1,992
Opening DfT		5.7%	4.1%	4.3%	4.2%	4.1%
Closing DfT	4.9%	3.3%	3.6%	3.5%	3.4%	2.8%

Population	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Population projection	234,315	238,558	242,341	245,999	249,298	252,409
Population growth		1.8%	1.6%	1.5%	1.3%	1.2%

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ISLINGTON
Public Health, 222 Upper Street, London, N1 1XR

Report of: Joint Director of Public Health

Meeting of	Date	**Agenda Item**	**Ward(s)**
Health and Wellbeing Board	20 April 2016	B2	All

Delete as appropriate		Non-exempt

SUBJECT: Refreshing Islington's Joint Health and Wellbeing Strategy (JHWS)

1. Synopsis

1.1 Islington's current Joint Health and Wellbeing Strategy (JHWS) (2013-2016) sets out the Health and Wellbeing Board's commitment and approach to tackling health inequalities and promoting health and wellbeing for the population of Islington. To build on the successes of this strategy and to provide a strategic framework and focus for the Board's work going forward, the JHWS and its priority outcomes need to be reviewed and refreshed.

Working with Islington residents and with key partners across the health and wellbeing system, the refresh of the JHWS provides the opportunity to set out a bold and ambitious vision and delivery plan for improving health and wellbeing in the borough, and tackling health inequalities.

1.2 This paper sets out the proposed approach to developing the new strategy ready for launch in January 2017.

2. Recommendations

2.1 To provide a strategic steer to the development of Islington's new Joint Health and Wellbeing Strategy, reflecting on achievements of the previous strategy and its focus on three high level priorities – giving every child the best start in life, preventing and managing long term conditions and improving mental health and wellbeing.

2.2 To discuss potential priorities, themes or areas of focus in order to provide a framework to the process of strategy refresh.

2.3 To agree the approach to refreshing the JHWS as set out in this report, subject to any changes discussed and agreed by the Board.

3. Background

3.1 The Islington JHWS 2013-2016 (see Appendix 1) was developed by Islington's Health and Wellbeing Board when the Board was operating in shadow form, prior to April 2013. It is the overarching plan to improve the health and wellbeing of children and adults in Islington and to reduce health inequalities.

3.2 The vision set out in the current strategy is to reduce health inequalities and improve the health and wellbeing of the local population, its communities and residents.

Three high level priority outcomes were identified in order to support delivery of this vision. They are:

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

3.3 The current strategy is predominantly focused on the health and social care related factors that influence health and wellbeing. The important underlying determinants of health and wellbeing, such as housing and employment, are addressed through other key strategies. The JHWS also emphasises the importance of partnership working, joint commissioning and integrated delivery of services to maximise value for money and cost effective use of system resources.

This strategy was informed by the Joint Strategic Needs Assessment (JSNA) and in consultation with residents and stakeholders.

4. JHWS 2013-16 - Summary of achievements and challenges

4.1 Over the past three years there has been significant progress with delivery under each of the three priorities. Section 4.2 below provides a short summary of the key achievements to date and ongoing challenges under each priority. It is not intended to provide a comprehensive overview of all work delivered across the borough over the past three years that has contributed towards improved outcomes under the three priorities, but instead highlights some of the recent, significant developments.

4.2 **Ensuring every child has the best start in life**

This priority has seen a number of successes:

- The percentage of babies being breastfed at 6-8 weeks (86.1%) is now better than the England average (73.9%).
- Islington has continued to see a significant reduction in teenage pregnancy rates; for the first time since the launch of the national teenage pregnancy strategy in 2000, Islington's teenage pregnancy rate is now lower than the London and England average.
- 53 Children's Centres have received Healthy Children's Centre status, as part of the local strategy to extend the reach of "healthy settings" approaches from schools to early years settings.
- A joint Child Health Strategy has been developed and adopted by Islington Council and Islington CCG, which focuses on implementation of an early intervention and prevention approach across all professionals and settings.
- Islington continues to perform well in all childhood immunisations. 91.5% of children aged 2 years are immunised against MMR, which is the fifth highest rate in London. There has also been significant improvements in the uptake of school aged immunisations, with Islington having one of the highest uptake rate of HPV immunisation in London in 14/15.
- School readiness is improving.

Continuing challenges in this area include:

- Rates of childhood obesity remain high but stable.
    - Almost 1 in 4 children aged 4-5 years old are overweight or obese, although the rate in Islington has continued to show a slight decrease and is currently similar to England and London levels.
    - 2 in 5 children aged 10-11 years old are overweight or obese. There has been a slight rise in the proportion of children in year 6 with excess weight in the past year, and the rate in Islington is now similar to London but higher than England.
- The number of children referred and assessed for autism has increased from 47 to 119 between 2012/13 and 2014/15 (+153%). This rise has significant implications across the range of health, care, and education services, as well as for adult services. In particular, from a Best Start in Life perspective, this increase in autism has significant implications for early intervention in support of parents and families.
- Children's oral health has started to improve, following significant oral investment in and focus on oral health, but there is still more work to be done to improve oral health outcomes for Islington children.

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

This priority has seen a number of successes:

- There has been a 46% reduction in early deaths from heart disease over the past 10 years. This is a faster reduction compared to London (40% reduction) and England (37%). However, local rates of premature death remain higher than the national and London averages.
- Since 2001-03, premature cancer mortality has fallen substantially but the rate still remains higher than England.
- Premature mortality from respiratory disease has fallen and the rate is now similar to England.
- Islington had the lowest rate of late HIV diagnosis in the country in 2011-13.
- The percentage of adults who are overweight or obese in Islington (65%) is lower than the London and England averages, and 62% of Islington residents participate in the recommended level of physical activity (over 150 minutes of physical activity per week). This percentage is significantly higher than the London and England averages
- Referrals into local adult weight management services are steadily increasing.
- In 2014 Islington was the top performing London Borough for the delivery of NHS Health Checks, and ranking 2nd out of 152 Local Authorities nationally in terms of the proportion of the population eligible for a health check who were offered and received a check.
- Islington was one of 14 areas awarded the national status of integrated care Pioneer, and health and wellbeing board partners continue to pursue an ambitious programme of health and care integration focused on improving resident's experience of care and population health and wellbeing outcomes.

Continuing challenges in this area include:

- In 2013 Islington had the 2nd highest prevalence of smoking in London, higher than both London and England. Despite Islington having a smoking quit rate (1,295 per 100,000) 1.5 times the national average (868 per 100,000), the number of smokers quitting is falling – reversing this trend is a key challenge for Islington.
- Cancer screening uptake in Islington is lower than the London and England averages and increasing uptake remains a challenge.
- Although statistically similar to England, Islington's rate of alcohol specific deaths, deaths from chronic liver disease and alcohol-related deaths are amongst some of the worst in London. Generally, local alcohol-related death rates have declined over the last five years, although these falls have not been statistically significant.
- Islington continues to have significantly higher rates of alcohol-specific admissions to hospital compared to the rest of London, and the rates have increased in Islington over

the last five years.

4.4 **Improving mental health (MH) and wellbeing**

This priority has seen a number of successes:

- An estimated 15% of 5-16yr olds experience MH conditions (higher than England), with higher levels of local investment than London or England. Child and adolescent mental health services (CAMHS) are now part of schools' pastoral care teams and, as a result of strong partnership working, schools are now one of the biggest referrers into the service.
- Mental health promotion services include free Mental Health awareness training, Mental Health First Aid training and the mental health champions programme. In 2014-15, 48 MH awareness workshops reached over 800 people and 32 new champions were recruited.
- The proportion of people with depression and/or anxiety accessing psychological therapies through IAPT (Improving Access to Psychological Therapies) reached the national target of 15% (4654 people) by March 2015. Within the service, approaching 50% of patients now move towards recovery, which is close to 'gold standard' outcomes for this type of service.
- Historically under-represented groups, such as men, people living in deprived communities and people from Black Caribbean groups, are now well represented amongst service users of iCope (Islington's IAPT service).
- Islington had a large decrease in the suicide rate between 2001-03 and 2011-13: it is now not significantly different to London or England. There remain significant risk factors for suicide in the local population.
- The 2015 Annual Public Health Report "Healthy Minds, Healthy Lives: Widening the Focus on Mental Health" emphasises the broad range of determinants and consequences of poor mental health in Camden and Islington. The report argues that mental health is everybody's business and summarises the high economic, personal and broader health benefits of achieving better mental health.

Continuing challenges include:

- Islington continues to have high rates of mental ill health, which are likely to increase over the coming years. Moreover, addressing the physical health needs of people with serious mental health problems continues to be a local priority. Prevention and early intervention are key to addressing this significant level of local need and improving outcomes.
- Increasing the number of people entering drug and alcohol treatment, and improving outcomes for these residents remains a significant local challenge.

5. The changing context for health and wellbeing

5.1 Although it has only been three years since the last JHWS, the wider policy context has moved on considerably since that time, with a number of major legislative changes and policy developments.

The **NHS Five Year Forward View**, published in October 2014 by the six leading national NHS organisations, sets out a vision for the future of the NHS in which services are organised around the needs of patients and users rather than organisations and professional boundaries. It calls for a 'radical upgrade' in the system's focus on prevention, and places significant emphasis on the need to stimulate and develop new models of care within health services and between health and care. The report articulates a number of new care models that NHS England will promote and work with local areas to develop over the next five years. Radically new contractual and organisational forms are expected to develop. Common to all these new models of care is the importance of expanding and strengthening primary care and 'out of hospital' care. The registered list-based model of general practice continues to be seen as fundamental to the provision of holistic, proactive, coordinated and long-term care at a population level.

The **integration** agenda in health and care is not new, and integration within health services and

between health and care has been a general policy goal for several decades. However, the focus on and momentum behind health and care integration has increased exponentially in recent years. The Health and Social Care Act 2012, the Children and Families Act 2014 and Care Act 2014 all enshrine statutory duties that promote greater integration.

The NHS and social care system is facing significant and growing pressure from rising demand and constrained resources. Demographic pressures from a growing and ageing population, increased complexity of needs, technological and medical advances, changing public and patient expectations and demands for a better standard of social care (and a better paid workforce) are key drivers of this pressure. In London alone, London Councils estimate the annual gap between available resources and need by 2020 to be £4.65 billion in health and £1.14 billion in adult social care, and more in children's social care.

Other key national initiatives designed to promote health and care integration "at scale and pace" and to tackle some of the barriers to integration are the integrated care pioneer programme (of which Islington is a 'first wave' pioneer site), the Better Care Fund and the New Models of Care (or 'vanguard') Programme. The **Better Care Fund** was developed to support joint working between health and social care to deliver better outcomes for local people. The Better Care Fund was first implemented in 2014/15 and the planning process for 2016/17 is currently in progress. Islington Clinical Commissioning Group (CCG) and Islington Council are continuing to work together to enable the Better Care Fund to:

- Underpin the work of the Islington Integrated Care Programme, including developing new models of care;
- Support the continued investment in social care services that benefit health; and
- Protect adult social care services and enable changes to be made required to maintain frontline provision while meeting the requirements of new legislation, such as the Care Act 2014.

5.2 Devolution of powers, responsibilities and budgets from the national level to the regional, sub-regional and local level in London is seen as an important part of the solution to the significant health, organisational and financial challenges facing the health and care system in London. During 2015, London Local Authorities, London CCGs, NHS England, the Mayor and Public Health England worked together to develop a proposition for **health and care devolution** and public service reform in the capital. In December 2015, these partners signed a Health and Care Collaboration Agreement, setting out their collective ambition to transform health and wellbeing outcomes, inequalities and services in London, alongside a shared set of objectives and principles for reform and devolution. Primary care, acute care, community services, mental health services, social care and public health are all in scope of the Agreement. Several devolution pilots were established across London, including an NCL-level pilot focused on estates, to test out the viability of health and care devolution in the London context.

5.3 The latest planning guidance for the NHS, issued in December 2015, sets out the requirement to develop five year **Sustainability and Transformation Plans (STPs)** for the period 2016/17 – 2020/21. The strategic planning footprint of which Islington is a part is North Central London (NCL). The intention is that these STPs will set out an integrated, system wide plan to deliver transformational change, improve quality and safety and achieve system wide financial balance, with an expectation that they will need to be agreed and developed across CCG commissioners, NHS providers, local authorities, the third sector, patients and the public.

5.4 Locally, the council approved its **Corporate Plan (2015 – 2019)** in 2015 which strives to ensure that Islington becomes a fairer place where everyone, whatever their background, has the same opportunity to reach their potential and enjoy a good quality of life. It aims to achieve this by:

- Providing more council housing and supporting private renters
- Helping residents who are out of work to find the right job
- Helping residents cope with the rising cost of living
- Making Islington a place where our residents have a good quality of life
- Providing residents with good services on a tight budget.

The Corporate Plan also commits the Council and its partners to work in new ways to reduce the scale of deeper social challenges that are fundamental to improving the quality of residents' lives and meet the significant financial challenge facing the Council and its partners across the public sector. The key social challenges identified by the plan are: mental ill health, domestic violence, long term conditions, substance misuse and long term unemployment.

5.6 Following an (unsuccessful) application to the nation Vanguard programme in early 2015, Islington and Haringey Councils, Islington and Haringey CCGs, Whittington Health and Camden and Islington Foundation Trust continue to work together to further develop and strengthen integrated health and care services, improve population health outcomes in Islington and Haringey, including a strong focus on prevention.

5.7 Although the new JHWS will necessarily focus on Islington-specific priorities, it will also need to complement and align with these other relevant strategies, plans and programmes at local, sub-regional and regional level . Furthermore the policy and financial context is likely to continue to change in the lifetime of the new strategy, so it will need to be sufficiently flexible in order to respond to this changing wider context.

6. Approach to reviewing the JHWS

6.1 This section sets out the proposed approach to reviewing and updating a new JHWS for the period 2017-2021. It is proposed that an officer task and finish group is established, with representatives from across the HWB member organisations, that will be responsible for delivering the refreshed strategy to the Board. The review process would involve looking at the:

- Impact of the current JHWS – asking what has been achieved so far, and what more there is to do (See Appendix 2).
- Needs and assets of the local population. The Joint Strategic Needs Assessment (JSNA), (for an overview, see Appendix 3) gives an overview of local needs and priorities, and this, alongside ongoing work to understand the changing population and demographics and its impact on future need and demand, will help us to develop priority areas of focus for future years.
- The current and future heath landscape within the context of local financial challenges, system transformation, integration and local devolution.

6.2 **Engagement with local residents and stakeholders**

The Health and Social Care Act (2012) places significant emphasis on capturing the views and experiences of the public in order to improve health and wellbeing and promote healthy behaviours. It recognises that the population has rights regarding involvement in their own health and social care. Over the past few years the Council, the CCG and HealthWatch have developed significant mechanisms, approaches and programmes of work focused on engaging residents and patients in the planning, development, delivery and evaluation of local health and care services. The findings from this ongoing work, further engagement work and a more formal period of consultation will be used to develop the new strategy and priorities.

6.3 **Proposed approach and timetable to refreshing Islington's JHWS**

Task	Lead	Date
Set up task and finish group to lead review and refresh of JHWS	Public Health	May 2016
Complete review of existing strategy, looking at the successes and outcomes, as well as outstanding issues	Current JHWS priority outcome leads	June 2016
HWB development session to present the findings from the review and discuss the approach to the new strategy	All board members	July 2016
Engage key stakeholders and residents in the process	Task and finish group/ Public Health	June – October 2016
Approval and adoption of Final JHWS	Health and Wellbeing Board	January 2017
Launch new JHWS	Health and Wellbeing Board	January 2017

7. Implications

Financial implications:

7.1 None identified. This paper provides an update across a wide range of programmes and services being delivered by various organisations including the Council and the CCG in support of the Health and Wellbeing Board strategy. Any plans or strategies derived or agreed in relation to this report should use existing available resources and therefore not create a budget pressure for the Council.

Legal Implications:

7.2 None identified.

Environmental Implications

7.3 There are no significant environmental implications resulting from this report's proposals. When finalised, the new Joint Health and Wellbeing Strategy will undergo an environmental assessment prior to it being brought to the Health and Wellbeing Board.

Resident Impact Assessment:

7.4 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.

A Resident Impact Assessment has not been completed because this work brings together different streams of work rather than being a new project. Equality Impact Assessments and public engagement are undertaken for programmes/services as and when need and will continue to be part of this process. The proposals outlined in this report should have an overall positive impact for the residents of Islington in terms of health and wellbeing.

8. Conclusion and reasons for recommendations:

8.1 The Board is asked to provide a strategic steer to the development of Islington's new Joint Health and Wellbeing Strategy, reflecting on achievements of the previous strategy and its focus on three high level priorities – giving every child the best start in life, preventing and managing long term conditions and improving mental health and wellbeing; discuss potential priorities, themes or areas of focus in order to provide a framework to the process of strategy refresh; and agree the approach to refreshing the JHWS set out in this report, subject to any changes discussed and agreed by the Board.

Appendices

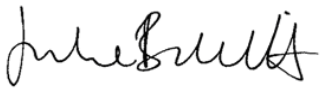
- Appendix 1 – Islington's Joint Health and Wellbeing Strategy (JHWS) 2013-2016
- Appendix 2 – Change in key indicators for the current JHWS
- Appendix 3 – Overview of progress and challenges of the current JHWS
- Appendix 4 – Joint Strategic Needs Assessment (JSNA) 2015 executive summary

Background papers:

- None.

Final report clearance:

Signed by:



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Joint Director Public Health — Date:

Received by:

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Head of Democratic Services — Date:

Report Author: Baljinder Heer-Matiana
Tel: 020 7527 1233
Email: Baljnder.Heer-Matiana@Islington.gov.uk

ISLINGTON

Islington's Joint Health and Wellbeing Strategy 2013-2016

January 2013

Executive Summary

This strategy has been developed by Islington's shadow Health and Wellbeing Board (sHWB). It is our overarching plan to improve the health and wellbeing of children and adults in our borough and to reduce health inequalities.

The vision of this strategy is to:

Reduce health inequalities and improve the health and wellbeing of the local population, its communities and residents.

We have identified three outcomes that will help deliver this vision. They are:

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

The focus for this strategy is predominantly on the health and social care related factors that influence health and wellbeing. The important underlying determinants of health and wellbeing are addressed through other key strategies which this document feeds into. This strategy emphasises the importance of partnership working and joint commissioning of services to achieve a more focused use of resources and better value for money.

This strategy has been informed by our Joint Strategic Needs Assessment (JSNA) and consultation with residents, strategic partners and other stakeholders.

We expect this strategy to be a "living document". As priorities change, our focus for action will need to change with it. We want to make sure that our planning stays in touch with the changing needs of Islington's people.

Islington's Joint Health and Wellbeing Strategy

Islington has a vision to:
Reduce health inequalities and improve the health and wellbeing of the local population, its communities and residents.

Introduction

The Health and Social Care Act requires Islington (London Borough of Islington) to set up a Health and Wellbeing Board to act as the principle structure responsible for improving the health and wellbeing of the local population through partnership working. In Islington, the Board's membership includes the Leader of the Council, local Councillors, Directors of Islington Council, the Chair of the Islington Clinical Commissioning Group, local GPs and representation from the Islington Local Involvement Network (the LINk), soon to be Healthwatch.

A requirement of the Health and Wellbeing Board is to produce a Joint Health and Wellbeing Strategy to steer the major strategic work on health and wellbeing in the borough. It will be the duty of the Health and Wellbeing Board to balance needs carefully and to make difficult decisions about strategic priorities given the resources available.

Purpose of Joint Health and Wellbeing Strategy

This Joint Health and Wellbeing Strategy (JHWS) will provide a focus for the board and assist in setting priorities locally.

It is not intended to be a detailed plan of action but instead sets out those areas that are of the greatest importance to the health and wellbeing of Islington's population and will be used to inform the setting of priorities including those within local commissioning processes.

Informed by our Joint Strategic Needs Assessment (JSNA), which describes Islington's population and the current and future health and wellbeing needs of residents, we have prioritised three outcomes to achieve our vision. These are:

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

The context

Islington is a borough with significant health challenges and stark health inequalities. This strategy sets out our approach to improving the health and wellbeing of children and adults in Islington, and reducing health inequalities.

Although the strategy predominantly focuses on the health and social care related factors that influence people's health and wellbeing, clear recognition is also given to the importance of addressing the wider determinants of health and wellbeing including: education, employment, poverty and welfare. These wider determinants can both impact on and be impacted by the health and wellbeing of an individual or population. For example, poverty and health are inextricably linked. Good physical and mental health equips individuals with the capacity to address difficulties that could lead to poverty and marginalisation. Poor health, alternatively, can deprive individuals of the capacity to cope with their problems. This strategy recognises that to improve the health and wellbeing of the population of Islington in the long-term, there must be a focus on tackling the wider determinants of health.

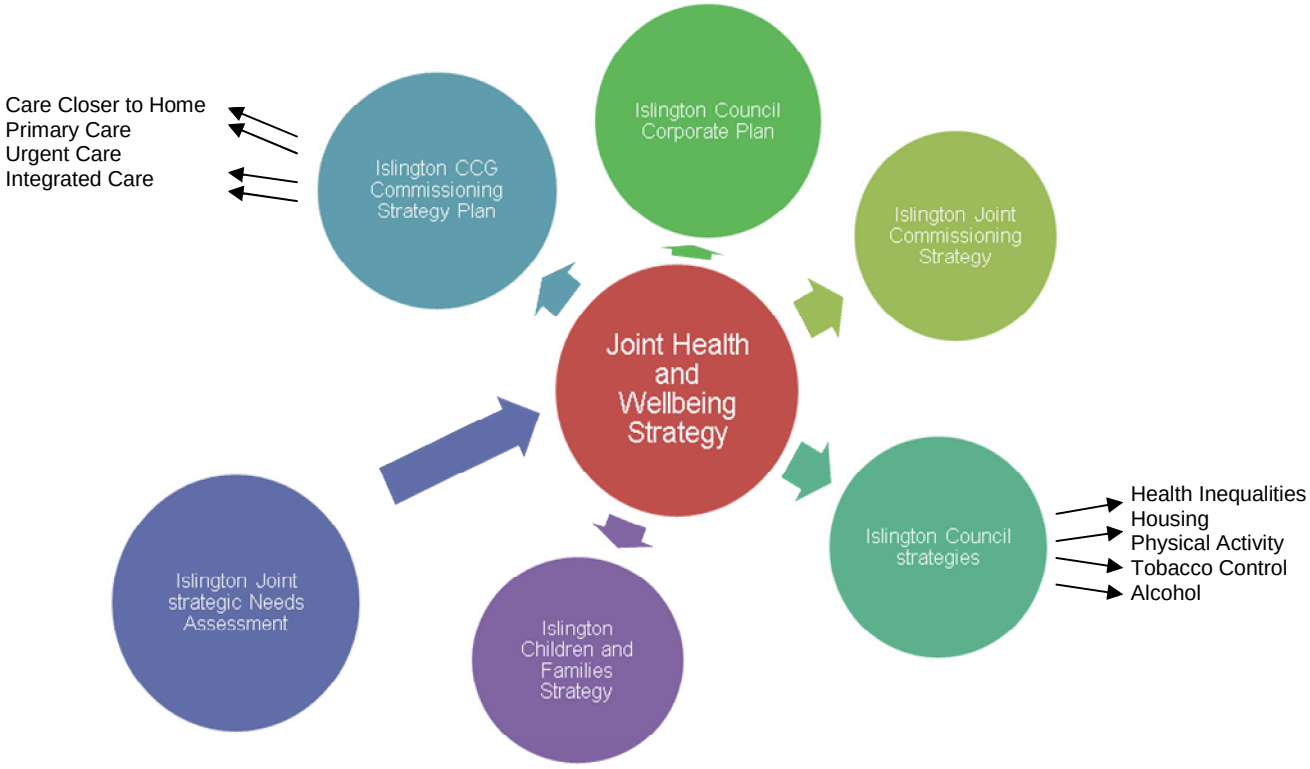
We recognise that influencing these key factors requires joined-up working, shared vision and effective collaboration across a range of partners including, but not restricted to, the NHS, local authority and community and voluntary organisations. The Health and Wellbeing Board brings together the key stakeholders for commissioning this strategy to enable action to be taken to address the underlying determinants of health and wellbeing.

This strategy will provide strategic direction to council strategies and action plans, including those on housing, regeneration and poverty.

A set of underlying principles has informed the development of the strategy. These include how to best meet need earlier, improve outcomes, and improve quality and equity, while making cost-effective use of limited resources at a time of rising demand, rising expectations and financial constraint. They directly inform those actions required to bring about change to the health and wellbeing of our local residents and communities.

Relationship with other strategies

The Joint Health and Wellbeing Strategy does not sit alone. The priorities set out in the strategy will inform related core strategic commissioning and delivery plans, helping to consolidate action on these areas of importance.



Monitoring and refresh process

The Joint Health and Wellbeing Strategy will be monitored through the Health and Wellbeing Board against the indicators outlined within this strategy. These outcome indicators align with those within the Public Health, Adult Social Care, NHS Commissioning and Children's outcome frameworks. The Health and Wellbeing Board will monitor delivery of the strategy every six months and refresh this three-year strategy on an annual basis.

Priorities, actions and measures

In order to achieve Islington's strategic vision and outcomes, it is necessary to identify those key priority actions needed to bring about the greatest change. This section briefly describes the key issues, where we are now, the gaps and challenges and outlines the priority actions required to improve the health and wellbeing of our residents and communities.

Different levels of support will be required of the Health and Wellbeing Board to ensure delivery of the actions outlined. Some of the actions require new ways of working - changing how local health and social care services work together to bring about change.

PRIORITY OUTCOME ONE: Ensuring every child has the best start in life

What is the issue?

Early influences on health and wellbeing affect lifelong outcomes and life chances. Children and young people in Islington experience significant disadvantage and poverty, with child poverty the second highest in the country. Poverty and education are two important wider determinants of health, and the priority actions for children and young people in this strategy are intended to complement and drive actions in support of these key areas.

Where are we now?

The proportion of women who have their first antenatal appointment by 12 weeks has significantly improved, but inequalities remain with some groups more likely to book late. Deaths in infancy in Islington are similar to London and national averages, but there are important risk factors including: levels of poverty, lone mother status, low birth weight, mothers born in countries which have high infant mortality rates, and smoking in pregnancy and within the household.

A range of factors that can impact on the health and wellbeing of children and young people are improving across Islington, notably in immunisations, breastfeeding, teenage pregnancy, physical activity and mental health and wellbeing. Children and young people's mental health and wellbeing is covered later under priority three which focuses on mental health.

Childhood **immunisations** at 12 months are among the highest in London, and compare favourably with other deprived boroughs. There is continuing need to improve uptake, particularly for Measles Mumps Rubella and booster immunisations.

Breastfeeding initiation and continuation at 6-8 weeks have continued to increase, with 76% (Q4 2011/12) of babies breastfeeding at 6-8 weeks. Local analysis shows that women aged under 25 and women from Asian communities are less likely to breastfeed than other groups.

National surveys on levels of **physical exercise** among children and young people show that a higher proportion of school children of all ages in Islington participate in at least three hours of physical exercise a week compared to London or nationally.

By the time children reach Reception class, more than one in ten are found to be **obese** (11.7% in 2010/11); by Year 6, this rises to more than 1 in 5 (21.7% in 2010/11), which is among the highest proportions in the country. Although the trend in increasing childhood obesity appears to have halted, high levels of childhood obesity represent serious long-term risks to health, as described under Priority 2.

Islington's **teenage pregnancy** rate has fallen significantly, currently below the London and England averages. However, Islington has the fifth highest rate of diagnosed sexually transmitted infections in London among young people, particularly linked to deprivation.

Dental health of young children in Islington is among the poorest in London, with a third of five year olds and 15% of 0-3 year olds experiencing tooth decay. Oral health is strongly

linked to deprivation, and the fact that oral diseases are largely preventable, makes oral health a particularly important public health issue in Islington.

Although Islington's uptake of **Vitamin D** supplementation in pregnancy and in younger children is above national averages, there is a need to improve uptake.

An estimated 500 Islington children and young people aged under 16 **smoke** regularly, equivalent to approximately 6% of all 11-15 year olds. Smoking during pregnancy in Islington has been between 7-9% over the last three years (7.3% in Q4 2011/12), although it remains significantly lower than national averages. Approximately 25% of under-1s in Islington are exposed to second hand smoke at home.

An estimated 9% of 11-17 year olds will have been drunk at least once in the last four weeks. The rate of alcohol admissions to hospital in the under-18s is the highest in London, although the actual number of young people admitted is small.

What are we doing?

Direct action by the Health and Wellbeing Board: The Health and Wellbeing Board have prioritised action on the First 21 Months – from conception to first birthday – which is designed to coordinate and improve outcomes in this crucial early period of development. It is a new initiative, but builds upon existing work and services. It needs the coordinated support of all members of the Health and Wellbeing Board, as well as other stakeholders, to bring about change.

The role of universal services / settings – including maternity, health visiting, primary care, and Children's Centres – are important in the first 21 months period. There is an active community and voluntary sector in Islington which provides services and support to many people during this period. Stakeholders, including maternity, health visiting, primary care, children's services, children's centres, parent representatives and public health have developed an action plan to facilitate increased delivery of maternity care in the community, and to develop the links and communication between services in order to promote better outcomes for children and families.

Examples of other programmes include:

- Islington's breastfeeding peer support programme provides advice and support to new mothers in Islington to enable them to initiate and maintain successful breastfeeding. It trains local volunteers as well as working with local services, community locations and businesses to ensure breastfeeding mothers are welcomed
- Healthy weight programmes for children and families, such as MEND (Mind, Exercise, Nutrition, Do It) for 2-4 year olds and 7-11 year olds, are offered locally
- Healthy Schools and Healthy Children's Centre programmes accreditation processes each include robust actions to address childhood obesity and improving diet. These issues are further addressed through the Islington Food Strategy and Proactive's Physical Activity Strategy
- Islington's community-based fluoride varnish programme is targeted to children aged 3-10 in children's centres, community nurseries and schools with a high uptake of free school meals to significantly reduce the risk of dental decay

- The Healthy Children's Centre and Healthy Schools programmes supports an active programme of health promotion in Islington, including areas such as smoking, alcohol and drug prevention in children and young people and sex and relationship education
- Children Centres actively promote opportunities for social contact and linkages with the aim of increasing social capacity and resilience and reducing social isolation. This work is being supported through the Healthy Children's Centres programme and the First 21 Months programme
- The teenage pregnancy programme has concentrated on both prevention (for example through sex and relationship education, availability and promotion of contraception, young people's services) and teenage parent support (for example through the Family Nurse Partnership and multi-agency coordination of support)
- The First 21 Months action plan recognises the importance of maternal (and parental) wellbeing, and the importance this plays in the child's own attachment and emotional development. It also includes a focus on making mental health services and pathways more accessible, especially in relation to postnatal depression; for example, raising awareness of postnatal depression and tackling the stigma and discrimination associated with it; improving links and communication between Children Centre's and Children Services, and adult mental health services including referral routes into the iCope (Islington's IAPT) service
- The Direct Action project delivered by Manor Gardens and the Peel Centre works with young people and parents of young children, particularly those from disadvantaged backgrounds, to raise awareness of mental health and wellbeing. It promotes messages for wellbeing and good mental health and raises awareness of mental health problems and where to access help if needed. It uses a variety of creative formats including music, spoken word, art and other approaches to engage hard-to-reach communities

Gaps and challenges

A focus on early years and pre-conception will improve outcomes in childhood and in later life. There is an overall need to support greater linkage, coordination and improved communication between services during this early period of life. There are important opportunities to detect risk and intervene in the development of problems earlier. Improving registration and use of Children's Centres can provide access to a variety of services designed to support needs in maternity and of families with children under 5. They also provide a place where children and families can be involved in social networks and mutual support to build strengths and reduce social isolation, and so help to promote better mental health and resilience.

Other challenges for improving outcomes in this area include the need to increase the uptake of vitamin D supplementation both during and after pregnancy, childhood immunisations, increasing breastfeeding, promoting physical activity and healthier diets, addressing and promoting mental health need, and achieving Healthy Children's Centre status.

As well as the focus on the early years we will continue to work on improving the health and wellbeing of children and young people to help ensure a good start in life for all. For example, there is a need to improve pathways for the prevention and management of obesity in children and young people and to work on the related wider determinants such as reducing the proliferation of fast food outlets near schools and increasing the opportunities for physical activity. Other areas of focus will include improving dental health, reducing teenage pregnancy and promoting good sexual health.

What is our focus for improvement?	What will we measure to show we have improved?	How will we make improvements?	Who will lead on this work?
Reduce infant mortality	Rate of infant deaths	First 21 Months programme is profiling current pathways, identifying best models of care through Children's Centres, and levers to improve outcomes across the first 21 months from conception	First 21 Months Advisory Group
Improve maternity and infant outcomes	Registration with Children's Centres	First 21 Months: Improve the offer for parents and children through better communication and links between services and developing how services work together to meet the needs of parents-to-be, children and families	First 21 Months Advisory Group
	% of women who accessed first booking appointment by 12 weeks + 6 days.	First 21 months: Promote early access to maternity services	First 21 Months Advisory Group
	Uptake of healthy start vitamins	First 21 months: Improve the uptake of Healthy Start vitamins, including vitamin D, starting with women in pregnancy and mothers of under-1s	First 21 Months Advisory Group
	Coverage of screening programmes	Ensure robust pathways for antenatal newborn screening.	Antenatal New Born Screening Committee
Increase childhood immunisation rates	Population vaccination coverage	Promote immunisations through schools and children's centres with a focus on MMR and booster vaccinations	Immunisation Steering Group
Reduce childhood obesity through increasing opportunities for healthy eating and physical activity	Excess weight in 4-5 and 10-11 year olds	Improve pathways for prevention and management of obesity in childhood and adolescence	Obesity care pathway working group
		Reduce the proliferation of fast food outlets near schools	LBI planning
	Breastfeeding initiation and prevalence	Sustain the breastfeeding peer support programme	Infant Feeding Group
	Initiative-specific.	Increase opportunities and avenues for physical activity	Pro-Active Islington
Improving the oral health of children and their families	Tooth decay in children aged five	Fluoride varnish programme Brushing for life scheme Improving access to dental care ("first tooth, first visit" programme, community engagement) Promoting healthy eating and reducing sugar consumption.	Oral Health Promotion steering group
Teenage pregnancy and sexual health	Under 18 conceptions Rates of Chlamydia diagnoses (15-24 year olds)	Continue to roll-out the healthy schools programme across the borough including the promotion of sex and relationship education.	Teenage Pregnancy Mainstream Group
		Improve access to contraception advice and services in a range of settings	Teenage Pregnancy Mainstream Group

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

What is the issue?

Employment, income, the environment and access to services such as good housing are all important wider determinants of health that impact on an individual's health and wellbeing. In Islington, poverty is the most profound factor contributing to poor health and wellbeing, with two-thirds of Islington's population within the most deprived fifth of the population nationally. Deprivation is an important predictor of whether a person is living with a diagnosed long-term condition: 31% more of those living in the poorest areas of Islington are living with a diagnosed long-term condition compared to those in the richest areas.

Where are we now?

Life expectancy has increased over time in Islington, but it remains low compared to other London boroughs and the country as a whole. Men in Islington have the lowest life expectancy in London, and women one of the lowest. Many other London boroughs with similar levels of deprivation have managed to successfully reduce the gap in life expectancy between their local area and the national average, but in Islington the gap has not closed.

The key cause of the inequalities gap in life expectancy between Islington and England is **premature or early death,** particularly amongst men living with long-term conditions such as cardiovascular disease, cancer and chronic obstructive pulmonary disease. Nearly half of all deaths in the borough are in people under the age of 75. People with mental health problems or learning disabilities have a higher prevalence of long-term conditions which highlights the need to ensure equitable access to services.

Around one in six adults in Islington has at least one diagnosed long-term condition. Overall, a third of adults with long-term conditions in Islington are living with **multiple conditions** and at relatively young ages. This highlights the need for planned and integrated care for people with multiple conditions to achieve optimal health outcomes. However, it should also be noted that a large proportion of the illness associated with long-term conditions occurs in older people (those aged 75 and over). The most prevalent condition is high blood pressure followed by type 2 diabetes, chronic depression, psychotic disorders, cancer, coronary heart disease and chronic obstructive pulmonary disease.

Lifestyle factors can contribute to the prevalence of long-term conditions. For example, in Islington, smoking contributes to around one-in-six early deaths and being overweight and obese contributes to about one-in ten. If the inequalities gap in ill health and early deaths between the most and least affluent is to be reduced, then success in tackling smoking and obesity among the boroughs poorest will need to be achieved.

Alcohol also plays a significant role in the burden of ill-health and death in adults. Islington has the highest rate of alcohol-attributable hospital admissions in London, whilst alcohol specific hospital admissions in men are the fourth highest in the capital. Islington also has the highest alcohol-attributable mortality rate for men and fourth highest for women in London.

Late presentation, under diagnosis and poor management of long term conditions can also contribute to early death. **Early diagnosis** is particularly important for cancers as there is a direct link between stage of disease at diagnosis and survival. Local information clearly illustrates that there is scope for significant improvement in ensuring people receive early diagnosis across different types of cancer. Earlier diagnosis of long-term conditions enables medical care to be offered at an earlier stage of disease, which may slow progression, prevent further complications and in many instances, be more cost effective. It also allows more time for individuals to be supported to adopt healthier behaviours to help prevent their condition from worsening.

What are we doing?

Islington currently provides a range of initiatives and approaches to supporting people to adopt healthier behaviours and manage their long-term conditions.

Direct action by the Health and Wellbeing Board: The Health and Wellbeing Board have prioritised the role of physical activity and improvements to finding and the management of long-term conditions in order to extend both length and quality of life in those with long-term conditions. Further action in these areas will build and strengthen work already underway.

ProActive Islington brings together the commissioners and providers of sports, leisure and physical activity in the borough. It is responsible for promoting physical activity and its benefits and works with partners to increase participation levels for all residents of Islington. This includes providing a strategic and co-ordinated lead for sport and physical activity and securing funding to expand the range of opportunities available. A physical activity strategy is currently being refreshed and builds on the achievements of the previous strategy, 2006-12. It sets out clear objectives for ensuring local people are aware of the benefits of physical activity, incorporating sport and physical activity into building design, increasing uptake of cycling, and targeting communities and groups at risk of poor health from sedentary lifestyles.

Individuals are supported in making behaviour changes through providing training to front-line staff on behaviour change techniques and risk factors for long-term conditions, including ‘Raising the Issue of Weight’ and Alcohol Brief Advice training. Further support is provided through services including the Stop Smoking Service, which supports over 2000 quitters annually across a number of settings including General Practice, pulmonary rehabilitation, mental health services and respiratory, surgical and medical departments at Whittington Health to stop smoking. The exercise on referral programme supports patients in Islington with specific low risk medical conditions to become more active.

The early diagnosis and care of people with long-term conditions further enhances length and quality of life and reduces health inequalities. Campaigns focusing on the signs and symptoms for lung and bowel cancers help to raise awareness of the conditions within the local population. These support key programmes of work that are making an impact locally, including the National Cancer Screening Programmes for bowel, breast and cervical cancers and the NHS Health Checks programme supported by an innovative and successful incentivisation agreement with local GPs.

Working closely with Islington's Clinical Commissioning Group CCG and colleagues in primary care, Islington is developing a number of new approaches to case finding undiagnosed disease, to complement the NHS Health Checks programme already in place for people aged 35-74. For older people in particular, these new approaches will help identify and address a range of issues and unmet needs, including social isolation, mental health problems and dementia, as well as case finding heart disease, diabetes, and kidney disease.

Local work has also focused on strengthening the promotion of self-management within people with a long-term condition. The Co-creating health model of self-management and cardiac and pulmonary rehabilitation programmes are available to eligible people who would benefit from these services.

For many people with a long-term condition a combination of lifestyle change and support in primary care will result in the greatest improvement. But high quality and integrated secondary care services are also essential for effective treatment, especially for people who present late with a condition or who have multiple long-term conditions. Locally, the Integrated Care Programme Board is developing an integrated care approach that involves the whole health and social care system. The aims are to include coordinating care around individual service users and carers, working jointly with social care, transforming communication and relationships between GPs and specialists and providing comprehensive disease management and preventive services to our population. Locally, four multi-disciplinary teams based in GP practices are being set up to better work with people at higher risk of deteriorating health and admission to hospital. Improved joint working, a single point of access and improved reablement services (services to help people regain independence) are all being rolled out.

Gaps and challenges

Providing programmes that are of sufficient scale and that are accessible is fundamental to addressing health inequalities. Increasing level one and level two stop smoking training in a range of settings will help to ensure smokers who do not visit their GP or Pharmacist can be reached. In addition, widening local training opportunities to a greater range of front-line staff in behaviour change skills and knowledge will help to promote healthier lifestyles to a wider audience.

As work progresses on the development of integrated care pathways, including those for COPD and diabetes in Islington, it is vital to ensure both primary prevention and early diagnosis/case finding are firmly embedded within these pathways. This will also help to address the variation in the control and management of long-term conditions seen across General Practices in Islington. Part of the package of care for patients with a long-term condition should, where appropriate, include the use of self-management techniques and programmes. Greater awareness and understanding of these programmes, alongside integration within care pathways for long-term conditions, will help to extend the benefits that can be gained from these programmes.

As well as work to identify people at risk of developing or already living with long term conditions, it is important to focus on the major lifestyle risk factors such as smoking, an unhealthy diet, a lack of physical activity, and alcohol consumption. Addressing these lifestyle factors will provide the greatest health gain. There are significant opportunities to promote healthier lifestyles more consistently. Options available to help people who are

obese, as part of local weight management pathways, include advice and support, weight loss programmes, exercise on referral, prescribing, and surgery. However, the costs of treating obesity and obesity-related conditions are very significant and much wider action on diet, physical activity and weight is needed across society and through the life course if the issue is to be successfully addressed in the long term. The Proactive Physical Activity Strategy provides more details of the actions that will be taken locally to increase levels of physical activity among all residents in Islington.

There is growing evidence of the effectiveness of how screening and brief interventions for identifying consumption of alcohol at above-low-risk levels in key settings and groups, including in general practice and A&E, and within the criminal justice system, can reduce drinking and the associated harms related to health, anti-social behaviour and reoffending.

There is a key need to develop the partnership response to alcohol harm, to ensure that priorities are aligned and that opportunities to reduce harm are maximised. Successful action on alcohol harm requires a shared programme of action between many different services, particularly between health services, adult social care, children's services, the police, emergency services and the community and voluntary sector. The Alcohol Summit which was held in September 2012 brought together the Council, NHS, Police, London Fire Brigade, community representatives and other partners to consider health impacts and other drink-related problems in Islington with the aim of identifying priorities and actions to reduce alcohol related harm in Islington. It is essential that the outputs from this event are turned into tangible actions.

What is our focus for improvement?	What will we measure to show we have improved?	How will we make improvements?	Who will lead on this work?
Close the prevalence gap in long-term conditions within the Islington population	Mortality rates from causes considered preventable	Improve case finding, treatment and management across long-term conditions including: high blood pressure, atrial fibrillation and early diabetes	Islington CCG and Public Health
		Work to further understand the variation in management of long-term conditions across GP practices	Islington CCG and Public Health
		Review availability, capacity and uptake of patient education and self-management programmes	Integrated Care Programme Board
		Achieve higher rates of seasonal flu vaccination coverage in younger people with a long-term condition	Islington CCG and Public Health
		Adopt and deliver an integrated care approach to the prevention of long-term conditions including COPD and diabetes	Integrated Care Board
Reduce early death from cardiovascular disease	Take up of the NHS Health Check Programme – by those eligible Mortality from cardiovascular disease	Increase uptake of the Islington NHS health checks programme within Islington's eligible population	Islington Public Health
Reduce early death from cancer	Mortality from cancer Cancer diagnosed at stage 1 and 2 Cancer screening coverage	Improve awareness of the signs and symptoms for breast, lung and bowel cancer	Islington Public Health
		Increase uptake of the national cancer screening programmes within Islington's eligible population	Islington CCG and Public Health
Reduce early deaths from COPD	Mortality from respiratory diseases	Sustain current improvements in the diagnosis and management of COPD in primary care	Islington CCG
Support people in making a behaviour change and to live a	Excess weight in adults Utilisation of green space for exercise/health reasons	Ensure health services are engaged in work around benefit maximisation and can signpost to relevant supporting services	Poverty Board

healthier life		Develop single point multi-agency hub to help professionals and the public to gain information to support lifestyle change and self-management.	Islington CCG and Public Health
		Provide training to frontline staff on promoting behaviour change and raising lifestyle issues	Islington Public Health
		Develop and implement integrated obesity care pathway including community-based programmes	Islington Public Health
Reduce smoking	Smoking prevalence – over 18s	Increase access to stop smoking services	Smokefree Alliance
		Increase the number of people trained to level one smoking cessation advice from BME communities and local businesses	
		Regulate Shisha and reduce illegal tobacco sales	
Increase physical activity	Proportion of physically active and inactive adults	Review the Islington Pro-Active Physical Activity Strategy	Pro-Active Islington
		Increase appropriate referrals and maintenance to local exercise referral programmes	
		Support development of physical-activity-friendly environment through the use of planning applications to encourage physical activity and active travel	
Reduce alcohol related harm*	Alcohol related admissions to hospital	Increase the number of those trained in providing brief advice for alcohol	Islington Public Health
		Develop a programme of wider partnership action to reduce alcohol harm	Health and Wellbeing Board
		Increase the provision of identification and brief advice for those drinking at increased or high-risk levels across a range of settings	Islington Public Health and Islington CCG
		Review the Islington Licensing Strategy	LBI
*Alcohol harm reduction cuts across two priority areas (improving mental health and wellbeing and preventing and managing long-term conditions); the actions included here should be looked at in conjunction with those under the improving mental health and well-being priority area			

PRIORITY OUTCOME THREE: Improving mental health and wellbeing

What is the issue?

Life experiences and circumstances, including bereavement, pregnancy and parenthood, exams, difficulties at work and unemployment, may increase vulnerability to mental health problems across all groups in society. People with long-term mental health problems are at increased risk of long-term social exclusion, including worklessness, poor housing, isolation and poverty. Alcohol and drug use are associated with a wide range of harms, including important links to levels of crime and anti-social behaviour, as well as wider negative health and social impacts.

Where are we now?

Estimates suggest that there are more than 30,000 adults in Islington experiencing **mental health problems** during any one week. Mental ill health among 5-17 year olds is estimated to be 36% higher in Islington than the national average with around 3,200 (or more than 1 in 8) children and young people in the borough experiencing mental health problems at any one time.

Mental health needs vary according to gender, ethnicity and age and are influenced by family, social and environmental determinants. Some groups have higher levels of mental health problems or evidence of differential access and outcomes. These include:

- Children and young people experiencing deprivation and poverty. Parental mental ill health or substance misuse is also a significant risk factor for children and young people
- Depression and anxiety are much more common in women than men, and women are also at higher risk of self-harm. Men are at greater risk of suicide, particularly younger unemployed men, and psychotic disorders, such as schizophrenia or bipolar disorder
- Men and women from some Black and Minority Ethnic (BME) communities, including Caribbean, African and Black British and Irish communities are over-represented in secondary care services and on primary care registers for serious mental illness
- People with disabilities or long-term physical conditions, such as diabetes or heart disease, are at greater risk of depression

There were an estimated 2,100 opiate and/or crack **drug users** in Islington in 2009/10, equivalent to 14.4 per 1,000 residents, third highest in London. Estimates of local **alcohol use** indicate around 7% of the population drink at high risk levels and a further fifth drink at increasing risk levels that may be harmful to their health and impact upon wider local services. Although alcohol has an important and positive role in social and family life and is an important part of Islington's thriving night-time economy, increasingly alcohol is becoming a significant cause of personal, social and economic harm. Islington has the highest rate of alcohol-related hospital admissions; the highest rate of alcohol-specific mortality in men; and the third highest rate of incapacity claimants whose main medical reason is alcoholism.

Islington's prevalence of **dementia** is lower than national rates due to a significantly lower percentage of the population aged over 65. In 2010/11, there were an estimated 1,088 people with dementia, compared to 759 on primary care registers, indicating that 70% of the expected number of cases of dementia were diagnosed in Islington, well above the London and England

averages (44%). Although treatment and support does not extend life expectancy, it can lead to an important improvement in quality of life for patients and their carers and families. The major area to focus on now is to improve community-based care that reduces or avoids the need for hospitalisation or other institutional care and crisis response in late diagnosis.

What are we doing?

Direct action by the Health and Wellbeing Board: The Health and Wellbeing Board have prioritised improvements to the dementia care pathway as well as addressing the negative impacts on physical and mental health caused by alcohol use as areas for early action.

There has been an increasing shift locally towards prevention, earlier intervention and recovery designed to improve outcomes, quality of life and reduce inequalities. NHS Islington Public Health, in partnership with key stakeholders and commissioners, has been working hard to increase the capacity and capability of communities to help themselves and others when experiencing mental health distress and to tackle stigma and discrimination around mental health. Working to raise awareness around mental health issues and mental health services will help to encourage more people to access support for mental health problems in primary care, particularly Improving Access to Psychological Therapies (IAPT) services and help prevent suicides. The programme of activities encourages earlier identification of mental health problems and help-seeking behaviour. Other initiatives include Mental Health First Aid and Youth Mental Health First Aid training, the Direct Action Project for children, young people, parents and families and the Mental Health Champions project.

- Mental Health First Aid and Youth Mental Health First Aid Training (MHFA/YMHFA) are internationally recognised programmes that are licensed to national organisations for instructor training in each of the four UK countries. They are two day evidence-based courses with the aim of improving the general public's and workforce's awareness and understanding of mental health and increasing skills and competencies in mental health so that help can be given to others in mental health distress or need, including suicidality. YMHFA is designed to be delivered to those working with, living with or caring for young people aged 11-18.
- The Mental Health Champions (MHC) project is a local initiative which aims to take the messages and skills of MHFA out to hard-to-reach communities in Islington, with a particular focus on groups overrepresented in secondary mental health services and those underrepresented in primary mental health services. The champions are volunteers who are supported and trained to work with their local communities and organisations to increase knowledge of mental health, address the myths, stigma and discrimination which can act as barriers to seeking or offering help, and signpost people to appropriate services.
- The Direct Action Project targets young people (aged 12-24) and parents of young children across Islington and delivers a range of evidence-based interventions in partnership with CAMHS, schools, and youth hubs to increase early identification and diagnosis of mental health problems, self-help strategies and skills in recognising and supporting mental health distress in others, including suicide risk.

Islington's Child and Adolescent Mental Health Services, through innovative work in a range of non-health settings, including Children's Centres and schools, have improved access and equity, particularly for children and young people from BME communities.

Camden and Islington Foundation Trust is introducing a new single point of contact to improve access to timely assessment and advice. The trust's community focus supports recovery and inclusion, with care and support for the majority of patients based in the community and their own homes, together with community and voluntary sector support for people with serious mental health problems.

Implementation of the dementia care pathway, with Memory Assessment Services and dementia support, have encouraged earlier recognition and diagnosis and provision of earlier intervention, treatment and planning. Dementia liaison services within hospital settings, to support better diagnosis and care on wards, have also been implemented.

The physical health needs of people with serious mental illness have been increasingly recognised with, for example, the use of health checks to detect cardiovascular risk in primary care and work with the mental health trust on smoking and co-management of physical conditions in inpatients.

There is growing evidence of the effectiveness of a range of interventions to reduce alcohol harm in key settings and groups, including in general practice and A&E (also see Priority Outcome Two) when implemented together with greater access to treatment services, including hospital-based liaison services and community treatment services. Recent assessments of the needs of people with drug and alcohol misuse problems have illustrated the importance of ensuring local treatment services are accessible and that service users complete the treatment provided.

Gaps and challenges

The above represent important strategic directions of travel that we need to continue to develop in order to reduce long-term harms and improve outcomes. The shift towards earlier diagnosis and intervention in the community re-emphasises the importance of primary care and links into other early intervention or support services, e.g. Children's Services or employment advice services.

Ongoing challenges include continuing to increase the proportion of people accessing Improving Access to Psychological Therapies services, recovery rates and equity of access across the population. In conjunction with this, there is a need to continue the development of mental health screening and treatment as part of long-term physical conditions management and within drug and alcohol services to tackle dual diagnosis. People with drug or alcohol misuse problems need to be identified and supported in services to ensure successful completion of treatment.

As discussed previously (see Priority Two), partnership working is essential to ensure effective alcohol harm reduction occurs and that opportunities are maximised.

Dementia services have seen a significant shift towards earlier diagnosis and support, designed to help improve quality of life for people with the disease and their carers. This has the potential to support a significant shift from institutionalised care in later disease, particularly in response to late diagnosis and crisis, to more community-based forms of support and care, and there is a key need to review and develop pathways that support this change.

What is our focus for improvement?	What will we measure to show we have improved?	How will we make improvements?	Who will lead on this work?
Support the shift towards prevention, earlier intervention and recovery	Rates of people accessing services for mental health problems	Increase uptake of the Islington Psychological Therapies Service – iCope	Mental Health Advisory Group
		Improve links and communication between Children's Centres and Children's Services, and adult mental health services including referral routes into iCope to promote good maternal and paternal mental health	Islington Public Health
		Raise awareness of mental health problems and services, including for postnatal depression, and tackling the stigma and discrimination associated with it	Islington Public Health
		Promote Mental Health First Aid training and increase numbers being trained in the borough	Islington Public Health
		Promote Mental Health Champions programme and increase numbers of Champions recruited into programme	Islington Public Health
Reduce alcohol related harm*	Number of people entering treatment	Improve the number of people entering treatment and the subsequent recovery rates within alcohol treatment services	Joint Commissioning Group
Reduce prevalence of substance misuse within the local population	Number of successful completions of drug treatment	Improve recovery rates within drug treatment services	Joint Commissioning Group
Improve Dementia care pathways	Rates of diagnosis Numbers of advanced care plans	Improve rates of diagnosis through the Memory Assessment Service, the new CQUIN (an incentive scheme) for dementia in hospitals and Health Checks for over 75s	Older Adults Integrated Care Group
		Support more people with dementia through Intermediate Care, particularly the Enhanced Reablement service, and increase referrals to	Older Adults Integrated Care Group

		the Dementia Advisors	
		Support service user groups through the Dementia Advisor service to lead on this work	Older Adults Integrated Care Group
		Offer increased access to end-of-life care planning to people with dementia	Older Adults Integrated Care Group
		Deliver more START courses (Strategies for Relatives) to help carers in their role	Older Adults Integrated Care Group
*Alcohol harm reduction cuts across two priority areas (improving mental health and wellbeing and preventing and managing long term conditions); the actions included here should be looked at in conjunction with those under the managing long term conditions priority area			

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Islington Joint Health and Wellbeing Strategy key indicators

Key for RAG rating (current value):		Key for arrows (progress):	
	Better than comparator		Significantly improved
	No significant difference		No significant change
	Worse than comparator		Significantly worsened
	Not applicable		Not applicable

PRIORITY OUTCOME ONE: Ensuring every child has the best start in life

Indicator	Description	Baseline		Current						Progress
		Time period	Value	Time period	Value	London	vs London	England	vs England	
Reduce infanct mortality										
Rate of infant deaths	Rate of deaths in under 1 year of age per 1,000 live births	2007-09	4.5	2011-13	2.3	3.8		4.0		
Improve maternity and infant outcomes										
Registration with Children's Centres	Percentage of children registered with a Children's Centre, local data	2010/11	65%	2014/15	88%	-	-	-	-	-
Antenatal assessments within 13 weeks	Percentage of women who have seen a midwife or a maternity healthcare professional by 12 weeks and 6 days of pregnancy	2013/14 Q3	92%	2014/15 Q3	103% [1]	-	-	-	-	-
Uptake of healthy start vitamins drops among children 6 months - 4 years	Percentage of eligible children taking healthy start vitamin drops, an estimate based on 8 weekly uptake	2013/14	7%	2014/15	8%	-	-	-	-	
Uptake of healthy start vitamin tablets among pregnant or breastfeeding women	Percentage of eligible women taking healthy start vitamin tablets, an estimate based on 8 weekly uptake	2013/14	12%	2014/15	12%	-	-	-	-	
Newborn bloodspot screening	Percentage of babies registered within the local authority who have a conclusive result recorded on the Child Health Information System	-	-	2013/14 [2]	98%	96%		94%		-
Newborn hearing screening	Percentage of babies eligible for newborn hearing screening for whom the screening process is complete	-	-	2013/14	99%	98%		98%		-

[1] Two possible reasons for greater than 100% recording; i) the indicator compares bookings for mothers having assessments at a trust to the number of maternities at the point of delivery at that trust two quarters later. However the maternity at the point of delivery figure may be lower than the number of mothers having assessments due to mothers suffering miscarriage, women choosing to undergo a termination or women transferring to another hospital. ii) women who live in urban areas where there are multiple hospitals they could choose to deliver at, often choose to undergo assessments at more than one hospital to enable them to compare maternity service provision. As a result women may be double counted, leading to a higher ratio of assessments to deliveries.

[2] 2014/15 data for Islington was not published as values are missing in the source data. Therefore the 2013/14 data is presented as the current value.

Indicator	Description	Baseline		Current						Progress
		Time period	Value	Time period	Value	London	vs London	England	vs England	
Increase childhood immunisation rates										
DTaP/IPV/Hib coverage in 1 year olds	Percentage of children who received 3 doses of DTaP/IPV/Hib vaccine by their first birthday	2010/11	92%	2014/15	96%	91%	🟢	94%	🟢	↑
MMR1 coverage in 2 year olds	Percentage of children who received one dose of MMR vaccine by their second birthday	2010/11	85%	2014/15	94%	87%	🟢	92%	🟢	↑
Hib/MenC coverage in 2 year olds	Percentage of children who received one booster dose of Hib/MenC vaccine by their second birthday	2010/11	86%	2014/15	94%	87%	🟢	92%	🟢	↑
PCV booster coverage in 2 year olds	Percentage of children who received one booster dose of PCV vaccine by their second birthday	2010/11	82%	2014/15	94%	86%	🟢	92%	🟢	↑
MMR2 coverage in 5 year olds	Percentage of children who received two doses of MMR vaccine by their fifth birthday	2010/11	75%	2014/15	90%	81%	🟢	89%	🟡	↑
Preschool booster (DTaP/IPV) coverage in 5 year olds	Percentage of children who received one booster dose of DTaP/IPV vaccine by their fifth birthday	2010/11	78%	2014/15	90%	79%	🟢	89%	🟢	↑

Indicator	Description	Baseline		Current						Progress
		Time period	Value	Time period	Value	London	vs London	England	vs England	
Reduce childhood obesity through increasing opportunities for healthy eating and physical activity										
Excess weight in 4-5 year olds	Percentage of overweight or obese children aged 4-5 years	2010/11	26%	2014/15	22%	22%	🟡	22%	🟡	🡻
Excess weight in 10-11 year olds	Percentage of overweight or obese children aged 10-11 years	2010/11	39%	2014/15	38%	37%	🟡	33%	🔴	🡒
Breastfeeding initiation	Percentage of mothers who give their babies breast milk in the first 48 hours after delivery	2010/11	88%	2014/15	88%	86%	🟢	74%	🟢	🡒
Breastfeeding prevalence	Percentage of infants that are totally or partially breastfed at age 6-8 weeks	2010/11	73%	2014/15	72%	-	-	44%	🟢	🡒
Number of children completing child weight management programmes	Children living in Islington, registered with an Islington GP practice or attending a school in Islignton, aged 4-18 years, who were overweight or obese and completed a child weight management programme	2013/14	224	2014/15	227	-	-	-	-	-
Improving the oral health of chilren and their families										
Tooth decay in children aged five	Average number of obviously Decayed, Missing (due to decay) and Filled Teeth per child	2007/08	1.5	2011/12	1.3	1.2	🟡	0.9	🟡	🡒
Teenage pregnancy and sexual health										
Under 18 conceptions	Rate of under 18 conceptions per 1,000 female population aged 15-17, 3-year average	2007-09	47	2011-13	28	25	🟡	28	🟡	🡻
Rates of Chlamydia diagnoses (15-24 year olds) [3]	Number of people diagnosed with Chlamydia per 100,000 population aged 15-24 years	2012	2,084	2014	1,948	2,178	🟢	2,012	🟡	🡒

[3] Previously data from the PHE was used, for which the numerator was the number of new chlamydia diagnoses. Now data from the Public Health Outcomes Framework (PHOF) is presented instead as the PHE doesn't publish the local level data anymore. Here the numerator is the number of people diagnosed with chlamydia within the year.

PRIORITY OUTCOME TWO: Preventing and managing long-term conditions to enhance both length and quality of life and reduce health inequalities

Indicator	Description	Baseline		Current						Progress
		Time period	Value	Time period	Value	London	vs London	England	vs England	
Close the prevalence gap in long-term conditions within the Islington population										
Mortality rate from causes considered preventable	Directly age-standardised rate of mortality from causes considered preventable per 100,000 population									
- Persons		2008-10	264	2012-14	203	169	🔴	183	🔴	↓
- Male		2008-10	351	2012-14	263	219	🔴	230	🔴	↓
- Female		2008-10	186	2012-14	145	125	🔴	138	🟡	↓
Reduce early deaths from cardiovascular disease										
Take up of the NHS Health Check Programme	Percentage of those invited who take up the offer of an NHS Health Check	2011/12	69%	2014/15	67%	49%	-	49%	-	-
Premature mortality from cardiovascular disease	Directly age-standardised rate of mortality from all cardiovacular diseases in persons less than 75 years per 100,000 population									
- Persons		2008-10	128	2012-14	97	79	🔴	76	🔴	↓
- Male		2008-10	185	2012-14	143	111	🔴	106	🔴	→
- Female		2008-10	76	2012-14	54	49	🟡	47	🟡	→
Premature mortality from cardiovascular disease considered preventable	Directly age-standardised rate of mortality that is considered preventable from all cardiovacular diseases in persons less than 75 years per 100,000 population									
- Persons		2008-10	85	2012-14	60	50	🔴	49	🔴	↓
- Male		2008-10	128	2012-14	94	75	🔴	74	🔴	→
- Female		2008-10	46	2012-14	29	27	🟡	26	🟡	→

Indicator	Description	Baseline		Current						Progress
		Time period	Value	Time period	Value	London	vs London	England	vs England	
Reduce early deaths from cancer										
Premature mortality from cancer	Directly age-standardised rate of mortality from all cancers in persons less than 75 years per 100,000 population									
- Persons		2008-10	173	2012-14	150	133	🔴	142	🟡	→
- Male		2008-10	197	2012-14	186	152	🔴	158	🔴	→
- Female		2008-10	151	2012-14	117	116	🟡	127	🟡	→
Premature mortality from cancer considered preventable	Directly age-standardised rate of mortality that is considered preventable from all cancers in persons less than 75 years per 100,000 population									
- Persons		2008-10	108	2012-14	93	78	🔴	83	🟡	→
- Male		2008-10	125	2012-14	112	87.5	🔴	90	🔴	→
- Female		2008-10	93	2012-14	75	70.0	🟡	76	🟡	→
Cancer diagnosed at stage 1 and 2 [4]	New cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed	2012	38%	2013	39%	43%	🟡	46%	🔴	→
Cancer screening coverage - breast cancer	Percentage of women aged 53-70 years eligible for breast screening who were screened adequately within the previous three years	2011	67%	2015	63%	68%	🔴	75%	🔴	↓
Cancer screening coverage - cervical cancer	Percentage of women eligible for cervical screening who were screened adequately within the previous 3.5 years (for women aged 25-49) or 5.5 years (for women aged 50-64)	2011	69%	2015	67%	68%	🔴	73%	🔴	↓
Cancer screening coverage - bowel cancer [5]	Percentage of people aged 60-69 years eligible for bowel cancer screening who were screened adequately within the previous 2½ years	2010	40%	2014	49%	-	-	58%	-	-

[4] Experimental statistics because of the variation in data quality: the indicator values primarily represent variation in completeness of staging information.
[5] This data is from the Cancer Commissioning Toolkit, and the age range of eligible population is 60-69 years, while it is 69-74 years for the bowel cancer screening coverage data from the PHOF by the PHE.

Indicator	Description	Baseline		Current						Progress
		Time period	Value	Time period	Value	London	vs London	England	vs England	
Reduce early deaths from COPD										
Premature mortality from respiratory diseases	Directly age-standardised rate of mortality from respiratory disease in persons less than 75 years per 100,000 population									
- Persons		2008-10	44	2012-14	38	31	🟡	33	🟡	➔
- Male		2008-10	56	2012-14	50	39	🟡	38	🔴	➔
- Female		2008-10	33	2012-14	27	24	🟡	27	🟡	➔
Premature mortality from respiratory diseases considered preventable	Directly age-standardised rate of mortality that is considered preventable from respiratory disease in persons less than 75 years per 100,000 population									
- Persons		2008-10	25	2012-14	20	17	🟡	18	🟡	➔
- Male		2008-10	29	2012-14	25	21	🟡	20	🟡	➔
- Female		2007-09	22	2011-13 [6]	17	13	🟡	16	🟡	➔
Support people in making a behaviour change and to live a healthier life										
Excess weight in adults	Percentage of adults (16 and over) classified as overweight or obese	-	-	2012-14	52%	58%	🟢	65%	🟢	-
Utilisation of green space for exercise/health reasons [7]	Weighted estimate of the percentage of residents (16 and over) taking a visit to the natural environment for health or exercise purposes	Mar 2011 - Feb 2012	4%	Mar 2013 - Feb 2014	12%	12%	🟡	17%	🟡	➔
Reduce smoking										
Prevalence of smoking among persons aged 18 years and over	Weighted percentage of self-reported smokers aged 18 and over, Integrated Household Survey	2010	21%	2014	22%	17%	🔴	18%	🔴	➔

[6] The 2012-14 figure for females was not published for Islington due to the small number of cases, therefore the 2011-13 figure was used as the current value.
[7] As the effective sample size is small (<100), the estimate may not be precise.

Indicator	Description	Baseline		Current						Progress
		Time period	Value	Time period	Value	London	vs London	England	vs England	
Increase physical activity										
Proportion of physically active adults	Percentage of respondents aged 16 and over doing at least 150 minutes of at least moderate intensity physical activity per week in the previous 28 days, Active People Survey	2012	62%	2014	66%	58%	🟢	57%	🟢	→
Proportion of physically inactive adults	Percentage of respondents aged 16 and over doing less than 30 minutes of at least moderate intensity physical activity per week in the previous 28 days, Active People Survey	2012	20%	2014	20%	27%	🟢	28%	🟢	→
Reduce alcohol-related harm										
Alcohol-related admissions to hospita (narrow definition)	Directly age-standirdised rate of admission episodes for alcohol-related conditions per 100,000 population									
- Persons		2009/10	846	2013/14	801	541	🔴	645	🔴	→
- Male		2009/10	1,207	2013/14	1,088	743	🔴	835	🔴	→
- Female		2009/10	524	2013/14	545	363	🔴	475	🔴	→
Protect the elderly population from infectious diseases that can lead to long-term complications										
Flu vaccination coverage in people aged 65 and over	Percentage of adults aged 65 and over who received the flu vaccination between 1st September to 31st January in a primary care setting (GPs)	2010/11	73%	2014/15	68%	69%	🔴	73%	🔴	↓
Pneumococcal polysaccharides vaccine (PPV) uptake in people aged 65 and over	Percentage of adults aged 65 and over who received the pneumococcal polysaccharide vaccination in the year	2010/11	64%	2014/15	61%	65%	🔴	70%	🔴	↓

PRIORITY OUTCOME THREE: Improving mental health and wellbeing

Indicator	Description	Baseline		Current						Progress
		Time period	Value	Time period	Value	London	vs London	England	vs England	
Support the shift towards prevention, earlier intervention and recovery										
People in contact with mental health services [8]	Rate of people admitted to secondary mental health services per 100,000 aged 18 and over	-	-	2013/14 Q1	2,908	2,143	-	2,160	🔴	-
iCope treatment recovery rate	Proportion of people who complete iCope treatment and are above clinical caseness who are moving to recovery	2013/14	38%	2014/15	42%	-	-	-	-	↑
Reduce alcohol-realted harm										
Number of people entering alcohol treatment	Number of clients with a new presentation to treatment where alcohol is the primary drug	2012/13	501	2014/15	521	-	-	-	-	-
Reduce prevalence of substance misuse within the local population										
Successful completions of drug treatment	Percentage of drug users that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months									
- Opiate		2010	6%	2014	6%	8%	🟡	7%	🟡	→
- Non-opiate		2010	31%	2014	34%	39%	🟡	39%	🔴	→
Improve Dementia care pathways										
Rate of dementia diagnosis	The number of people diagnosed with dementia as a percentage of estimated number of people with dementia	2009/10	53%	2013/14	69%	53%	🟢	52%	🟢	↑
Care reviews for dementia patients [9]	Percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months	2013/14	85%	2014/15	84%	85%	🟡	84%	🟡	→
Comprehensive care for dementia patients [9]	Percentage of patients with a new diagnosis of dementia with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 6 months before or after entering on to the register	2011/12	91%	2014/15	88%	80%	🟢	82%	🟢	→

[8] Proxy data for the original indicator "Rates of people accessing services for mental health problems". As the data used here is the rate of people admitted to secondary mental health services, a higher rate was conisdered to be worse in respect of prevention and early intervention. The figure for London is an estimate aggregated from all known lower geography values.
[9] Proxy data for the original indicator "Numbers of advanced care plans"

Islington Joint Health and Wellbeing (JHWS) Strategy: Review and refresh

Appendix 3: Overview of progress with delivery (JHWS 2013-16) and key challenges

Priority 1: Ensuring every child has the best start in life

Achievements	Challenges
a) Reduce infant mortality and improve maternity and infant outcomes A number of outcomes in this area have improved: - Infant deaths have continued to reduce - Timely booking with maternity services - Registration with children's centres - Uptake of healthy start vitamins - Newborn screening is better or equal to the national average. • Islington Children and Families Prevention and Early Intervention Strategy 2015-2025 has been published. • The First 21 Months is resulting in key services working in a more integrated way. **b) Child Immunisations** • Child immunisation rates have continued to rise and our rates are above average for both London and England as a whole. • In 2014/15 Islington was the top performing local authority in London for all routine vaccinations. However, coverage for 5 year old immunisations, although higher than London and similar to England, is still below the 95% WHO recommended levels to achieve herd immunity. **c) Breastfeeding** Breast feeding rates have remained stable throughout the strategy and they are higher than London and England. **d) Oral health** • Rates of dental decay have been falling in Islington. • In 2014/15, the Islington community-based fluoride varnish programme delivered a total of 13,223 fluoride varnish applications to 3-10 year olds • However, there are still far too high rates of oral health decay which is entirely preventable.	**a) Overweight and obesity** • Childhood overweight and obesity continues to be a challenge in Islington. • In 2014/15 almost a quarter of reception year pupils (22%) were overweight or obese. • Among Year 6 pupils, the equivalent figure was more than a third (37%). The proportion of Year 6 pupils who are overweight (including those who are obese) is higher than the national average (33%) although has declined slightly since 2013/14. • In 2014/15 More Life received 290 referrals and had 236 children start a programme. Of these 176 completed. • Referrals and uptake for the Tier 3 programmes (for children with additional needs) remain a challenge

e) Teenage pregnancy • The rate of teenage pregnancy in Islington has continued to fall and is now below the rates for both London and Islington as a whole. • Chlamydia diagnoses remain high compared to national averages and while this is indicative of infection in the community Islington's rates are considered good as we are identifying and therefore treating infections. • In April 2015 launched a new Young People's Sexual Health Network across Camden and Islington.	

Areas for future focus

a) Obesity

The future approach to tackling childhood obesity has an increased focus on prevention and ensuring all children in Islington can eat well and stay active. This will include an increased role for the health and wellbeing team, expanding healthy schools to a wider range of settings and developing the training offer and build the capacity of all professionals working with children and families to support healthy living. They will work closely with the Healthy Living school nurse.

The importance of taking a systems-based perspective to tackling obesity – looking at every aspect of the local environment and how this drives obesity – is also increasingly recognised. We need to collaborate more with the Voluntary and Community Sector (VCS), including youth clubs and independent housing/social care workers/troubled families to engage with the most vulnerable communities, as well as building on our work with colleagues across the council and local NHS to support this.

b) Parental mental health

There is an increasing recognition of the importance of parental mental health in the early years – both antenally and postnatally, and this is an area for future focus.

c) Autistic spectrum disorder (ASD)

In recent years there has been in an increase in the number of children under 5 being referred for assessments and then diagnosed with Autistic Spectrum Disorders, across the full spectrum of severity. The number of referrals for under 5s assessment has increased from 47 to 119 between 2012/13 and 2014/15 (an increase of 153%). The number of assessments has increased to lesser extent, from 59 to 79 children (+34%) reflecting capacity limitations of the team. Most additional assessments over time have resulted in ASD diagnoses. The implications across the range of health, care, education and adult services are very significant and we need to address this.

Priority 2: Preventing and managing long-term conditions (LTCs) to enhance both length and quality of life and reduce health inequalities

Achievements	Challenges
a) Closing the prevalence gap • Mortality rates from causes considered preventable have fallen. • Islington has been recognised as an Integrated Care Pioneer. • A chronic kidney disease (CKD) pathway workstream has commenced with targeted areas to include: case finding, early intervention, improved coding and chronic disease management. • The Joint Liver Working Group for Camden and Islington is working to address the increasing issue of liver disease through improved patient pathways, treatments, and knowledge. **b) Reduce early deaths from cardiovascular disease** • There has been a reduction in early deaths from cardiovascular disease (CVD). However, rates remain higher than the national and London averages, and it is still the biggest contributor to premature mortality. • The NHS Health Checks programme has continued to perform very well in Islington. Between Q1 2013-14 to Q2 2015-16 37% of Islington eligible population received NHS Health Check. As a result Islington ranked as the 4th best performing London Borough for delivering Health Checks and 12th out of 152 Local Authorities in England. **c) Mortality from cancer** Premature cancer mortality has fallen but the rate is still higher than England and London. **d) Mortality from respiratory diseases** Premature mortality from respiratory disease has fallen and the rate is now similar to England. **e) Excess weight in adults** • Over half of adults in Islington are overweight or obese (52%). This percentage is lower than the London and England averages. • The Adult Weight Management (AWM) has delivered a consistent number of referrals, initiators and completers into the service over last couple of years. • In 2015 Islington jointly topped the Good Food for London league table, reflecting the borough's high level of participation in key healthy and sustainable food initiatives. • To date over 250 food businesses have achieved the Healthy Catering Commitment award.	**a) Cancer screening** Cancer screening uptake in Islington is lower than the London and England averages and increasing uptake remains a challenge. There are a number of programmes addressing this: • Public Health have been providing a locally focussed boost to the national 'Be Clear on Cancer' (BCOC) campaigns • NHS England is responsible for delivering cancer screening programmes in England; however, Public Health have established a group to monitor and scrutinise local screening data, and improve local screening performance. **b) Smoking** In 2013 Islington had the 2nd highest prevalence of smoking in London, with higher than London and England. A decreasing number of people are accessing stop smoking services and there is an ongoing challenge to increase the numbers of people accessing support and quitting smoking. **c) Alcohol** Despite a range of work to tackle alcohol related harm, the harm to health remains significant in Islington. Islington has some of the highest levels of harm in London, with significantly worse admissions to hospital as a result of alcohol, these rates have increased over the last five years. Significant work has occurred to tackle the harm caused by alcohol in Islington: • Developing and implementing the licensing strategy. • Reducing the Strength initiative aimed at reducing the availability of cheap high strength beer and cider • The Late Night Levy aims to recoup some of the cost of policing the night time economy from those profiting from it • Proactively reviewing and making representations against potentially harmful alcohol licences. Islington's approach to proactive licensing management and ensuring health are active partners in licensing has been identified as an example of good practice in this area. • Public Health has commissioned HAGA, an alcohol charity, to raise awareness of the impacts of alcohol and how residents can self-moderate their drinking or seek help from the services provided by the Council. Training in Identification and Brief Advice is provided free of charge to 180 staff a year.

- The Islington Food Strategy was re-launched in November 2014 involving over 25 local partners and stakeholders. The vision for the action plan was agreed as 'Eating Well Together: Making Healthy Choices the Easy Choices'.

f) Reduce smoking

- In 2012/13 Islington had a 1.5 times higher smoking quit rate (1,295 per 100,000) than the national average (868 per 100,000).
- The stop smoking service has maintained a stable quit rate, which remains higher than the Department of Health recommended rate of 35%, but is still below the target of 54%.
- The Islington Smokefree Alliance has brought together a wide range of organisations that have a common aim in reducing smoking prevalence.

g) Physical activity

- 66% of over 16s participate in the recommended level of physical activity (over 150 minutes of physical activity per week), this is higher than the national and London average.
- Islington ProActive have developed a strategy and action plan to support improvements in physical activity.
- Exercise on Referral (EOR) has achieved an increasing number of referrals (2,000 per annum), initiators (70% of referrals) and completers (70%) over the last couple of years.
- The EoR provider has worked closely with iCope over the last two years to encourage more service users with a mental health condition to access EoR
- Planning applications have been used to support the development of physical activity friendly environments in Islington, through Section 106 investments.
- Funding from Islington Clinical commissioning Group (CCG) has created 12 'Active Spaces' in schools and residential.
- External funding has been won from Sport England for two three year projects in Islington; one to encourage residents with disabilities to be more physically active, and the other one will encourage women and girls to be more physically active.

Areas of future focus

a) Alcohol

The approach we have is grounded in the evidence of what works. We need to continue with this approach, also looking at:

- **Minimum unit price.**

There is a clear evidence base that implementation of a minimum unit price would effectively reduce alcohol related harm and as such Public Health and licensing are advocates for this; however we feel this would be hard to implement as an individual borough. The Health and Well-Being board should use it power to lobby for implementation at least at a regional level or ideally at a national level.

- **Licensing**

Locally public health are using the powers of being a Responsible Authority to support our partners in police and licensing. However despite a clear recognition of the impacts of alcohol on health and a local commitment to using health evidence in licensing decisions, our ability to do this is limited due to national legislation around licensing. It is essential that a wider range of health data be taken into account as part of licensing as currently our potential impact in this area is limited by health not being included as a specific objective of the licensing policy. A fifth objective focused on health would enable us to put together more rigorous joint objections to premises in problem areas. The Health and Well-Being Board are an important role in lobbying for national change in this area.

- **Population perceptions and attitudes towards alcohol**

Evidence shows building a healthy and sensible relationship with alcohol is essential in successfully reducing alcohol related harm. We need to help and support people to make better choices about alcohol. As such it is important that this remains an area for focus for the Health and Well-Being Board. In particular we need to focus on the following:

- Increasing awareness, skills and attitudes: changing attitudes to alcohol is an ongoing process
- Ensuring Islington is a safe drinking environment: we need to ensure that we promote a safe night-time economy
- Support for families: the impacts of alcohol are often felt by those not drinking, whilst there is a clear evidence base that shows children of high risk drinkers are more likely to become high drinkers themselves
- Facilitating access to support and treatment: treatment services need to be easy to access, we are currently redeveloping our drug and alcohol treatment to ensure those who need help are supported effectively and appropriately
- Reducing availability and affordability
- Collaborative approach; alcohol harm is cross cutting, in a time of reducing resource we must ensure we together to be tackle alcohol harm

b) Physical activity

Although Islington has increased the proportion of residents that are active, there is still some way to go until all of the population is classified as active. The evidence highlighting physical inactivity as a leading factor in health and well-being continues to grow, particularly the contribution it has to the burden of non-communicable diseases. In particular we need to focus on:

- Creating active environments to encourage residents to be active
- Implementing the Public Health England Everybody Active, Every Day strategy
- Decreasing residents sedentary behaviour
- Increasing active travel.

c) Obesity

Islington public health have completed a self –assessment across the Council with a variety of partners including Council, Voluntary and community sectors to scope what is currently being done to prevent obesity and to evaluate where the gaps are. This will inform the development of an obesity strategy through the life course for 2016.

d) Mental health and physical health

Physical health and mental health are inextricably linked. Life expectancy is lower among people with some mental health conditions, and this is largely attributed to long term physical conditions. The relationship between physical and mental health is complex and two-directional; people living with a long term physical condition are more likely to experience common mental health disorders as a result, and some lifestyle risk factors are more common among people with mental health conditions, increasing their risk of developing physical health problems, such as heart or respiratory disease. These associations are becoming more recognised, and there are more interventions available to meet the mental health needs of those with physical health conditions, and vice versa. Locally, this is reflected in care planning and self-management programmes for people with physical health conditions. We need to increase our focus on physical health of people with severe mental health conditions in particular (case finding, diagnosis and management). We also need to improve case finding of depression in people with physical LTCs. Additionally, developing pathways of care for people with all mental health conditions, which include prevention and management of long term conditions, will contribute to better overall health outcomes.

Priority 3: Improving mental health and wellbeing

Achievements	Challenges
a) Support the shift towards prevention, early intervention and recovery • Increased numbers of people accessing iCope services. The percentage of those entering IAPT treatment who recover is now just above the national (and local) target of 50%, an Improvement on the previous year. Waiting list targets have been introduced this year (offering parity with physical health services) and the service is achieving these targets. • Children's Centres across Islington have been key to raising awareness of mental health problems and services available. • The Whittington Hospital has developed a good psychology/psychiatry offer in maternity. • Growing Together is part of both CAMHS and iCope and works with both parents and children aged between 1 and 5 years old, in families where both the adult and child are having difficulties with emotions, behaviours or relationships. • All Islington schools have a named CAMHS practitioner, with some schools purchasing additional input. **b) Raise awareness of MH problems and services, including for postnatal depression, and tackling stigma and discrimination** • A pilot in Canonbury Children's Centre has built in an additional home visit undertaken by a maternity support worker and a family support worker, which helps with earlier identification of mental health problems. • Holloway Children's Centre has developed a drop-in focused on post-natal depression and other stressors for all parents, and offers appropriate support. • The Islington Mental Health and Resilience in	**a) Mental health** The prevalence of diagnosed mental health conditions is high in Islington. Depression and psychotic conditions, in particular, are greater here than in most parts of London or England. Over the coming years, it is likely that the prevalence of mental health conditions–especially dementia–will rise, due to a growing and ageing population. **b) Reduce alcohol related harm and substance misuse** • The numbers of people accessing treatment has remained quite stable, with a slight drop for opiate, and a slight increase for non-opiate and alcohol. • In Q1 of 2015/16, the percentage of drug users in drug treatment during the year, who successfully completed treatment and did not re-present within 6 months of treatment exit increased to 11.8% from the previous quarter although this is still below the annual target of 15%. • The percentage of alcohol users who successfully complete their treatment plan remained stable at 34% below the annual target of 40%. There are a number of service improvements / developments which are intended to improve both numbers in treatment and outcomes: • Work with services providing outreach to ensure that they are working effectively with each other • Drug and alcohol services within GP practices are being developed alongside the new primary care mental health teams in order to broaden the reach of these services • Redesigning the treatment pathway for both drugs and alcohol.

Schools (I-MHARS) framework sets out the components of whole school practice and ethos that effectively develop resilience, promote positive mental health and support children at risk of, or experiencing, mental health problems. This is being rolled out to all schools. • The PICTS team (Psychology Informed Consultation and Training) provides training for GPs, councillors, etc. on working with people with personality disorder, who may otherwise be more challenging to manage. **c) Promote Mental Health First Aid training and increase numbers trained in the borough.** • In 2015/16 there will have been over 450 participants in Mental Health First Aid or Youth Mental Health First Aid trainings, and 340 participants receiving one day Mental Health Awareness training. • The Direct Action Project targets young people (aged 12 - 24) and parents of young children across Islington and delivers a range of evidence based interventions in partnership with CAMHS, Children's Centres, schools, and youth hubs to increase early identification and diagnosis of mental health problems, self-protection strategies and skills in recognising and supporting mental health distress in others. **d) Promote Mental Health Champions programme and increase numbers of champions recruited into the programme** • The new Community Mental Health and Wellbeing Promotion Service (from 1st June 2016), will aim to promote awareness of mental health and mental wellbeing, challenge the stigma associated with mental illness, and increase access to mental health services across all Islington communities, and particularly within identified excluded communities. This new service replaces the existing Mental Health Champions (MHC) project and Community Development Worker (CDW) service.	• Increasing awareness of the services available to support not only those misusing drugs and alcohol but also those affected by someone else substance misuse

e) Improve dementia care pathways • Increased rates of dementia diagnoses is seen as a big success and Islington now has one of the highest rates in the country, meaning more people with dementia are offered services and support. • Rates of dementia diagnosis have been improved through a Directly Enhanced Service in Primary Care and a Commissioning for Quality and Innovation (CQUIN) scheme at the Whittington and UCLH, although key strengths locally include the good relationship between GPs and the Memory Service, with GPs confident that good services are available to support people after diagnosis. A strong GP lead for dementia is also seen as a key factor. • The Dementia Navigators service was re-commissioned in 2013/14, moving from an advice/signposting service to one offering much greater support based on needs. • The Enhanced Reablement Service provides intensive support packages to people who would otherwise be at high risk of admission to residential or nursing home (typically due to dementia). • START, a manual based, eight session intervention, promoting the development of coping strategies amongst carers, works with carers to identify individual difficulties and implement strategies. The START programme is very popular with patients and carers.	

Areas of future focus

- Addressing prevention and earlier intervention is key to improving MH and will be a focus for the coming years.
- Tackling social isolation in vulnerable groups, such as older people, people with MH problems and people with learning disabilities is another priority area for future work.
- A comprehensive review of suicide prevention pathways in Camden and Islington was carried out during 2015. The findings of this review pave the way for the further development of a local strategy to support suicide prevention. Developing and implementing the main recommendations of the review with local partners will be a focus through 2016.
- Improved data sharing is key to improving services – particularly between hospitals and Health Visitors/Children's Centres. This is also an issue for GPs and dementia services- if GPs could share diagnoses with the Memory Service/Dementia Navigators, the service could actively follow them up.

Appendix 4: JSNA recommendations:

Children and young people

- A strong preventive and early intervention offer in pregnancy and the early years is important to reduce long term health impacts and inequalities.
- Promoting breast feeding, healthy eating, physical activity and access to weight management support to children and their families continues to be important to reduce high levels of obesity and excess weight.
- All staff across Children's Services, schools and health partners who work with children and young need to work in an integrated way.
- Access to effective services for conditions such as asthma or mental health problems in community and primary care settings will help to improve outcomes.

Preventing ill health

- A large scale, systematic and co-ordinated approach to reducing health inequality is needed that involves all partners and focuses on the wider socio-economic and environmental determinants and on family and individuals.
- Poverty is one of the greatest threats to health and wellbeing in the borough. Getting people into work and particularly those population groups that face persistent barriers to moving into work, should be a focus.
- Support local business to create healthier workplaces for their staff to improve staff wellbeing and ultimately reduce sickness absence and absenteeism
- Work with local communities/specific population groups to improve understanding about how to improve the accessibility and reach of services.
- Programmes and services to support people to adopt healthier lifestyles should be delivered at sufficient scale and appropriately targeted

Overweight and obesity

- To continue to commission and evaluate interventions that promote physical activity, both universal services and those targeted at population groups most in need e.g. people on low incomes, people with disability

Tobacco

- Educate and prevent young people from starting smoking
- Ensure smoking cessation services target high risk populations to quit.
- Regulate and enforce the laws on sale and display of tobacco products

Alcohol

- Building on exiting work, ensure there is a strong partnership approach to minimise alcohol harm, including enforcement of licensing regulations, identification and brief advice and high quality treatment services

Physical and mental health

- There are a significant number of people living with a long term condition but who have not yet been diagnosed. There is an increasing need for health and care services to identify and manage these long term conditions earlier and more effectively to improve health outcomes and quality of life
- Programmes raising awareness of signs and symptoms of long term conditions including cancers and COPD should be targeted at deprived communities.
- Implement strategies and programmes that encourage people with long term conditions to self-manage and stay independent.
- The strong link between physical health and mental health underlines the importance of the movement towards models of care that address both mental and physical health together.
- All those with a physical long term condition should be offered screening and help for depression.

Vulnerable groups

- Ensuring prevention and treatment services are accessible and able to meet the needs of people with disabilities in order to improve outcomes and reduce inequalities.
- Continue to ensure there are targeted health interventions for vulnerable children and adults
- The increase in the older adult population will mean an increasing number of people with dementia,
- With the increase in the over 80s, an increasing number of people will also be physically frail
- Raise awareness of the needs of carers and improve access to support and training for carers

ISLINGTON

Report of: Director of Commissioning, Islington CCG

Meeting of	Date	**Agenda Item**	**Ward(s)**
Health and Wellbeing Board	20 April 2016	B3	All

Delete as appropriate		Non-exempt

SUBJECT: Better Care Fund 2016/17: Planning Update

1. Synopsis

1.1 The Better Care Fund was developed to support joint working between health and social care to deliver outcomes for local people. The Better Care Fund was implemented in 2014/15 and the planning process for 2016/17 is currently in progress. Islington Clinical Commissioning Group (CCG) and Islington Council are continuing to work together to enable the Better Care Fund to:

- Underpin the work of the Islington Integrated Care Programme including developing new models of care;
- To support the continued investment in social care services that benefit health;
- To protect adult social care services and enable changes to be made required to maintain frontline provision while meeting the requirements of new legislation such as the Care Act 2014.

The aim of this report is to summarise the implementation journey of 2015/16 and the plans for 2016/17.

2. Recommendations

2.1 That the integrated working in 2015/16 and key achievements for local people be noted.

2.2 That the planning assumptions for 2016/17 be reviewed and agreed in principle.

3. Background

3.1. Nationally, the Better Care Fund is the biggest ever financial incentive for the integration of health and social care. The fund has required Clinical Commissioning Groups and local authorities in every single area to pool budgets and to agree an integrated spending plan. In 2015-16, the Government committed

£3.8 billion to the Better Care Fund. In 2016-17, the Better Care Fund has increased to a mandated minimum of £3.9 billion to be deployed locally on health and social care. From 2017-18, the government will make funding available to local authorities, worth £1.5 billion by 2019-20, to be included in the Better Care Fund.

The aim of the Better Care Fund is to promote joint working between health and social care. In Islington, the Better Care Fund has been an extension of the integrated working which is established in the borough. In addition to the Better Care Fund, Islington has over £50 million in pooled budgets across health and social care for adults and children.

Islington has utilised the Better Care Fund to further enable and support the joint work in progress through the Integrated Care Programme. The Better Care Fund priorities locally are:

- Locality Offer across community, social care and mental health services to support primary care capacity;
- Enhancing primary care capacity;
- IT and inter-operability to ensure patient information can be shared across integrated services and along care pathways;
- To meet demographic pressures in social care, and across health and care services for older people and people with learning disabilities;
- To maintain social care eligibility;
- To incentivise providers to support integrated care.

3.2 The funding for the Better Care Fund are enabled through national funding allocations and set out through national guidance including the 2016/17 Better Care Fund Policy Framework. Nationally the local funding amounts are reviewed annually on a national basis. The Better Care Fund for 2015/16 pooled budget between Islington Clinical Commissioning Group and Islington Council was £18.388m. In 2016/17 this has increased to £18.410m. This includes funding streams such as the Disabled Facility Grant of £1.318m which is an existing national scheme providing home adaptations to support independent living. For Islington the allocations provided are set out in the table below.

Year	Total Better Care Fund (BCF)	LBI Funding Contribution	Islington CCG Funding Contribution	BCF CCG funding ring-fenced for NHS out of hospital commissioned services [1]	Comments [2]
	£000s	£000s	£000s	£000s	
2014/15	5,894	0	5,894	n/a	Includes existing NHS England grant of £4,822 for transfer to Local Authority via Section 256
2015/16	18,390	1,409	16,981	n/a	LBI funding £693k Disabled Facilities Grant (DFG) + £716k Social Care Capital Grant
2016/17	18,411	1,318	17,093	4,857	LBI funding is from £1.318m DFG which has subsumed Social Care Capital Grant funding in 16/17

Note 1: New requirement in 16/17 for BCF partners to ""fund NHS commissioned out-of-hospital services, that demonstrably lead to off-setting reductions in other NHS costs against the 2014-15 baseline
Note 2: Social Care Capital Grant funding has now been rolled in to Disabled Facilities Grant in 2016/17

Based on these allocations planning for 2016/17 is currently in progress. The Islington plan for 2016/17 is in line with the 2015/16 plan. The 2016/17 plan has been further developed due to changes in the national requirements and learning from 2015/16.

A key component of the 2015/16 Better Care Fund was a pay for performance requirement for the reduction in non-elective emergency admissions. In 2016/17, this requirement has been replaced by two new requirements nationally.

There are new requirements for local areas to fund NHS commissioned out-of-hospital services and to develop a clear, focused action plan for managing delayed transfers of care (DTOC), including locally agreed targets. The aim of these new requirements are to ensure people are enabled to live in the community where possible and return in a timely way to their place of residence following time in hospital.

Locally, the number of reported schemes in the Better Care Fund has been consolidated to ensure emphasis on delivery and clearer reporting mechanisms on performance. In addition, the Integrated Care Programme is to have a renewed focus on linking together mental health with physical health services and on prevention alongside the existing priorities for integration to enable whole system working. This will include reviewing plans drawn up with Public Health, the Local Authority and the CCG to focus on the wider preventative strategies across the core partners to focus on existing and innovative preventative services which delay and reduce demand on more intensive health and social care interventions.

Islington Clinical Commissioning Group and Islington Council have submitted two joined up and agreed planning submissions to NHS England with the final submission to be made on 25th April 2016.

3.3 **Key achievements** in 2015/16 that were enabled by the Better Care Fund include:

- **Protection of Adult Social Care:**
  The Better Care Fund supported the realisation of the Moving Forward programme in Adult Social Care. The Better Care Fund, alongside existing pooled budgets between health and social care, has supported investment into frontline services such as social care services that benefit health (core social care offer of assessment, care management and reablement); carers funding (carers funding, assessment and carers breaks) and disabled facilities grant (home adaptations for independent living). The fund has also been used to support demographic pressures and substantial growth in NHS funded Continuing Healthcare for people with Learning Disabilities and older people. This resourcing has enabled local people to live more independently, and return to the community in a timely way when accessing hospital services;

- **Roll out of Locality Integrated Health and Social Care Networks:**
  Islington CCG and the Council, alongside GP practices, developed in 2015/16 extended health and care teams to support networks of practices, to provide an integrated response to those patients most at risk of admission and other people who would benefit from a more joined up response. The trial covered eight practices and 25% of the Islington population. This model of integrated care teams is currently in progress of roll out for universal coverage;

- **Enabling IT solution:**
  Islington has commissioned BT to develop an Integrated Digital Care Record and a Person Held Record. These solutions are in the process of being tailored and refined to meet the needs of the local population and to bring together the data requirements across health and social care.

- **Incentivising acutes to deliver change:**
  An incentive scheme was included in the Whittington Health contract for 2015/16 to facilitate the delivery of service changes to support systems resilience and to support the introduction of value based commissioning and payment by outcomes.

- **Workforce to join up health and social care:**
  The Islington Community Education Provider Network was established and developed an integrated care training programme to enable a skilled workforce that delivers care with dignity and compassion, is motivated to make a difference and is rewarded for its efforts.

- **Delivery of Patient Outcomes:**
  Islington is one of the six sites that Health Foundation/NHS England are using to evaluate the value of implementing the Patient Activation Measure in the UK to assess patient outcomes. Islington has undertaken the survey; of the 37,995 questionnaires sent out, 10,354 were returned (27% response rate). Results of the survey are currently being evaluated.

- **Non Elective Emergency Admissions:**
  Non-Elective Emergency Admissions are a key metric monitored by NHS England. In Q2 and Q3 2015/16, Islington showed a better performance than planned in this area. This means that less people were admitted to hospital than anticipated which supports the work completed in the community to support people at home where possible and appropriate.

Baseline				
Q4 13/14	**Q1 14/15**	**Q2 14/15**	**Q3 14/15**	**Total**
4,570	4,532	4,261	4,421	**17,784**
Plan				
Q4 14/15	**Q1 15/16**	**Q2 15/16**	**Q3 15/16**	**Total**
4,322	4,588	4,640	4,640	**18,190**
Actual				
Q4 14/15	**Q1 15/16**	**Q2 15/16**	**Q3 15/16**	**Total**
4,460	4,702	4,466	4,371	**17,999**

Source data: Islington CCG, Secondary Uses Service (SUS) data, non-elective admissions (EC4). SUS data is the NHS data source providing activity and cost information.
Note: Islington will report on Q4 15/16 performance to NHS England in May 2016.

4. Implications

Financial implications:

4.1 The Better Care Fund for 2015/16 pooled budget between Islington Clinical Commissioning Group and Islington Council was £18.388m. In 2016/17 this has increased to £18.410m. This includes funding streams such as the Disabled Facility Grant of £1.318m which is an existing national scheme providing home adaptations to support independent living.

Scheme Name	**Financial Investment**
16.01 Protection of Adult Social Services	£5,995,000
16.01 Protection of Adult Social Services	£1,807,000
16.02 Reablement	£1,200,000
16.03 Carers	£246,000
16.04 Care Act	£663,000
16.06 Risk Pool	£1,200,000
16.07 IT	£600,000
16.08 Out of Hospital Services	£5,382,000
16.09 Disabled Facilities Grant	£1,318,000
TOTAL 16/17 BCF	**£18,411,000**

Legal Implications:

4.2 Section 121 of the Care Act makes provision for a fund for the integration of care and support with health services to be known as the “Better Care Fund”. This provision is a mechanism which allows the sharing of NHS funding with local authorities to be made mandatory. Section 121(1) of the Care Act 2014 amends section 223 (B) of the National Health Service Act 2006 (funding of the National Health Service Commissioning Board) to allow the Secretary of State to specify in the mandate to NHS England a sum which the Board must use for objectives relating to integration. The mandate is given to the Board by the Secretary of State under section 13A of the National Health Service Act 2006.

Section 121(2) of the Care Act 2014 inserts a new section 223GA into the National Health Service Act 2006 which allows the Board to direct clinical commissioning groups (CCGs) to use a designated amount of their financial allocation for purposes relating to service integration. It also makes provision for how the designated amount is to be determined. Payment of the designated amount must be subject to a condition that the CCG pays the money into a pooled fund established under arrangements made with a local authority under section 75 of the National Health Service Act 2006. In exercising its powers in relation to the Better Care Fund, the Board must have regard to the need for provision of health services, health-related and social care services.

The BCF provides for £3.9 billion worth of funding to be spent locally on health and care to facilitate closer integration and improve outcomes for patients, service users and carers. A condition of accessing the money in the BCF is that CCGs and local authorities must jointly agree plans setting out how the money will be spent and these plans must meet certain requirements.

Environmental Implications:

4.3 The Better Care fund work has some minor environmental implications; the extended evening and weekend hours at three medical practices will result in an increase in energy usage, whilst the new primary care rapid response service will result in extra journeys, contributing towards emissions and congestion. However, the digitisation of care records will reduce the need for physical paper copies.

Resident Impact Assessment:

4.4 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. No specific RIA has been carried out in relation to this report; impacts on residents will be assessed in relation to specific schemes.

5. Reasons for the recommendations / decision:

5.1 The Health and Wellbeing Board is asked to note the joint work across health and care services in Islington to develop integrated care for local people through the Better Care Fund, note the performance against plan assumptions for non-elective admissions and carers reported quality of life, and note financial expenditure against plans.

Appendices: None

Background papers: None

Final report clearance:

Signed by:

1 April 2016

Director of Commissioning. Islington CCG — Date

Received by:

8 April 2016

Head of Democratic Services — Date

Report Author: Marisa Rose, Integrated Care Programme Director
Tel: 020 3816 2923
Email: marisa.rose1@nhs.net

ISLINGTON

Report of: **Chief Executive, Healthwatch Islington**

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	20 April 2016	B4	All

Delete as appropriate		Non-exempt

SUBJECT: Review of Mental Health Services for Young Adults by Healthwatch Islington

1. Synopsis

Healthwatch Islington undertook qualitative surveys with young adults (18-32) to find out more about their experiences of accessing healthcare services. The full report of the review is set out at Appendix A.

2. Recommendations

That the findings and recommendations of the Healthwatch Islington review of mental health services for young adults be noted.

3. Background

Access to mental health support is an issue that residents regularly raise with Healthwatch Islington. Healthwatch liaised with local commissioners to ensure that what we gathered could add value to existing work.

Some of the recommendations of the report are being met by work being implemented by the CCG and the council. The Board is asked to consider how Board partners ensure that the findings and recommendations from this report are acted upon locally.

There is an urgent need to address issues of worklessness, a lack of accommodation and social isolation amongst many of the respondents. It is therefore recommended that a holistic approach to mental health

services is considered, one which draws together a number of practical, clinical and well-being services. These services should include social activities, advice, guidance, advocacy and psychological services.

It is recommended that the services referred to above are delivered in a range of community based settings to create a more flexible approach to the delivery of mental health services. This will broaden the scope of services available and provide a range of familial and socially connected environments for vulnerable young adults.

It is also recommended that community based organisations working with young adults with mental health needs should be provided with financial support and professional expertise to:

- Actively engage in processes and fora associated with co-commissioning. This should relate directly to the design of local services,
- be equipped to refer effectively to mental health services, and
- measure organisational activities to assess their impact on young adults with mental health needs. It is suggested that an organisational toolkit is co-produced, with commissioners and clinical staff to equip organisations to begin to undertake these developments. Healthwatch recognises the problematic nature of the current funding climate and will therefore actively pursue funding sources to support this suggestion.

4. Implications

4.1. Financial implications

There are no financial implications arising as a direct result of this report. Any plans or strategies derived or agreed in relation to this report should use existing available resources and therefore not create a budget pressure for the Islington Council, CCG or other partners.

4.2. Legal implications

None identified.

4.3. Environmental Implications

There are no significant environmental implications related to the recommendations in this report.

4.4. Resident 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 RIA is not required to be completed in relation to this report, however as already identified by the Board there is the potential to increase prevention and early intervention work in the area of mental health support. Increasing the accessibility of services to young adults would have a positive impact for residents.

5. Conclusion and reasons for recommendations

The themes raised in the review were not new. Stigma alongside a lack of trust in mental services was a dominant theme and therefore an area requiring additional focus. There was evidence of persistent levels of lack of access to mental health services for those facing multiple vulnerabilities, which suggests there may be a need to equip organisations not funded to deliver mental health services to offer more support.

The role the family plays in supporting those with mental health needs amongst particular communities was a key theme. Although there is recognition from many respondents that this support has played a key role in their ability to manage their mental health, in some cases family could be blocking those living with mental health needs from accessing appropriate mental health services.

A lack of adequate accommodation, worklessness, and social isolation were dominant themes throughout the consultation.

Attachments: Appendix A – Healthwatch Islington: Mental Health Services for Young Adults in Islington

Background papers: None.

Final Report Clearance

Signed by		
	Chief Executive, Healthwatch Islington	16 March 2016 Date
Received by	…….	8 April 2016 …….
	Head of Democratic Services	Date

Report author: Sarah Lee
Tel: 020 7832 5828
E-mail: sarah@healthwatchislington.co.uk

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healthwatch Islington

Mental health services for young adults in Islington

Front cover image: A woman consoled by her friend.
Photographer: Newscast Online
Credit: Newscast Online

Healthwatch Islington

Healthwatch Islington is an independent organisation led by volunteers from the local community. It is part of a national network of Healthwatch organisations that involve people of all ages and from all sections of the community.

Healthwatch Islington gathers local people's views on the health and social care services that they use. We make sure those views are taken into account when decisions are taken on how services will look in the future, and how they can be improved.

www.healthwatchislington.co.uk

Contents

Why we looked at mental health services for young adults

Mental Illness is the single largest cause of disability in the United Kingdom, contributing up to 22.8 per cent of the total burden, compared to 15.9 per cent for cancer and 16.2 per cent for cardiovascular disease. According to the Kings Fund 'no other set of conditions matches the combined extent of prevalence, persistence and breadth of impact'.

(Transforming Mental Health: a plan of action for London - September 2014)

Following a call from community members present at our last Healthwatch conference and discussions with local providers servicing individuals with mental health needs, Healthwatch Islington approached Islington commissioners of mental health services and public health with the aim of identifying how and in what ways Healthwatch could begin to influence the commissioning of local mental health services.

Commissioners suggested that an area where more data was needed was within the young adult population (18-32 years).

The commissioners' specific interest was in identifying the needs of those who are unable to draw on strong family networks and/or find it difficult to develop and establish themselves economically and socially in a borough like Islington. They were also interested in knowing the impact these needs have on young adults and why they are under-represented as users of mental health services.

Based on these conversations and current population trends in Islington for those most affected by mental health, we targeted a number of key groups. These included members of the Asian community due to their under-representation in primary care mental health services and Black African and Black African Caribbean men who are over represented in in-patient psychiatric services. We targeted young adults dealing with a range of multiple vulnerabilities such as homelessness, leaving care, social isolation and members of the LBGT community.

Examples of these types of multiple-vulnerability are described here by a respondent:

I became homeless and had a nervous breakdown. I got a place at University outside London but I became home sick and wanted to come home. I went to my GP who diagnosed me. Finding accommodation was really hard on a low income. I couldn't afford a deposit and I was street homeless for a while. I had no family or friends and no help from anyone. I felt lost.

As I am under 35 I was not eligible for single accommodation and had to take shared accommodation. I wanted independence and that was one of the reasons I went to university, but when I had to leave I became frustrated. I felt I had failed. I don't feel ready to start anything.

I am on the waiting list for psychological services and I attend a support group, which does drama, therapies, organises trips, you can share with people and join in. I feel things might have been better if the Local Authority could have found me a home or a social worker, maybe something customised to my needs and not generic or maybe I could have seen a psychiatrist, but I was told I wasn't severe enough.

I am under 25 so I get £115 every 2 weeks. Before coming to the…I didn't know where to go and my housing situation was awful. I am now engaging with voluntary services. The services have helped break my social isolation.

Due to the focus on the 18-32 age group for the consultation, Islington Child and Mental Health Services (CAMHS) were not a target organisation. However issues did emerge on the impact CAMHS service delivery can have on access to adult mental health services. It was suggested that the transition from CAMHS to adult mental health services was at times problematic for the individual and following consultation on the draft report, that communication channels between the two services could be improved through an integrated approach to service delivery.

Demographics and Trends

Islington has high rates of common mental health problems such as depression and anxiety as well as the highest rates of serious mental illness in London. 28,500 people in Islington are estimated to be experiencing depression and anxiety in any one week and 20 suicides are reported per year. (Islington Evidence Hub October 2013)

Further evidence suggests there will be no change in the underlying prevalence of mental ill-health in the borough but that an increase in Islington's population will lead to an increase in the number of people with depression, psychotic disorders and dementia. (Islington's Adult Joint Clinical Commissioning Strategy 2012-2017).

Like other areas of health, mental health treatment can be most effective if provided early on. Islington's population is relatively young but predictions in population growth indicate that the population group aged 40-74 is increasing significantly which could further impact on mental health need.

Increases in levels of mental health need amongst some Black and Minority Ethnic (BME) communities has implications for projected increases in mental health conditions in the borough as population trends show larger proportions of ethnic minority representation amongst younger age groups, with the 0-19 age group representing the highest group. (Camden and Islington Public Health 2014)

There is growing recognition for improvements in the design of mental health services for young adults (McGorry et al 2013). Youthspace created by Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) is a good example of a service striving to address some of the mental health needs experienced by this group, in particular those who by the age of 25 are not in employment education and training.

In addition the links between poverty, economic insecurity and mental health are presented in a report commissioned by the Cripplegate Foundation. The report suggests that:

Mental ill health is closely associated with low incomes, unemployment and precarious working conditions, unmanageable debts, housing issues, social isolation, and poor physical health. At the same time financial insecurity can adversely affect people's well-being and resilience; it can increase stress, anxiety and depression; and it can exacerbate relationship breakdown, social isolation and physical health.

(Distant Neighbours: poverty and inequality in Islington - New Economic Foundation 2013)

The report argues that the negative impact poverty has on individual's mental health in Islington will increase with the deepening of austerity measures, which it is anticipated, will now be exacerbated through the imposition of Universal Credit and the new Welfare and Work Reform Bill (2015-16).

- **Healthwatch Islington Services**

Data from Healthwatch Islington shows that almost 10% of all queries made to our signposting service are recorded as directly relating to an individual's mental health. (July 2015) In addition to these numbers of direct mental health queries, over 20% of queries for support with health and social care are from those living in the most deprived areas of Islington, whilst significant numbers of calls to Healthwatch Islington for support with access to health and social care services are from distressed and/or confused callers.

Methodology

The method for the consultation exercise was finalised at the end of 2014, following a meeting with local stakeholders interested in the development and design of mental health services and a training workshop for peer interviewers.

The stakeholder meeting was attended by a broad range of organisations (these are listed as appendix a). Stakeholders were asked to comment on the questionnaire design for the consultation and to identify specific areas they felt were important for the client group. These were noted as a need:

1. For more information on local well-being and psychological services

2. To support local organisations to refer young adults effectively to psychological services

3. For organisations to begin to measure the impact of well-being services for young adults – focussing on early intervention

4. For increased levels of mental health and well-being provision

5. To learn more about young people's experience of mental health

The peer interviewer training workshop focussed on equipping young adults to interview young adults in the community about their personal experiences of mental health and the types of interventions they felt would help either themselves or their peers in addressing their feelings and aiding their recovery. A total of 21 young adults attended the training workshop.

Of key importance for the peer interviewers were definitions of mental health and how these were used during the interviewing process: the interviewers were keen to encourage engagement from interviewees and not use language and definitions that could potentially alienate those agreeing to participate.

Following this stage of the consultation design Healthwatch designed a semi-structured questionnaire. The questionnaire aimed to encourage a flexible conversation between interviewer and interviewee.(the questionnaire is attached as appendix b).

Interviews were undertaken on a one to one and group basis.

Interviewee referral organisations

Healthwatch worked with organisations that could access particular demographics amongst the young adult population in Islington. This included those from the Asian and African and African Caribbean community and those with multiple vulnerabilities. Additionally and within these groups we spoke to members of the Lesbian, Gay, Bisexual and Transgender (LGBT) community, members of the homeless population as well as those struggling to secure permanent accommodation, those who were socially isolated and those living in poverty.

The following organisations helped with interviewee recruitment (see appendix c for details):

- The Lift Centre,
- Street League,
- Pilion Trust,
- Only Connect,
- Stonewall Housing,
- Islington Bangladesh Association,
- Islington Somali Community

We collected 50 responses of whom three were 15, 42 were between 18 and 32 and five were between the ages of 40 and 60 but who talked about the experiences of their children who were in the target age range. 35 were male and 15 female. Interviewees reside in Islington, apart from 1 who made use of Only Connect London on a daily basis. Of those who responded to a request for ethnicity monitoring date; individuals were from the backgrounds indicated in Table 1 (overleaf).

All of the young adults interviewed were receiving some form of help from the referring organisations. This help included practical, social and emotional support.

The data reveals a high proportion of individuals from BME backgrounds. Healthwatch did not use a sampling method due to the target number of responses gathered, however those interviewed were representative of these groups. This may indicate that higher proportions of young adults from these groups are not accessing adult mental health services.

Table 1: Ethnicity of young adults interviewed

Ethnicity	Number of responses
Mixed Caribbean and White	2
Indian	1
Bangladeshi	14
African	2
Ethiopian	1
Arabic	1
Irish	1
Pakistani	1
Nigerian	1
Mixed African and White	1
White British	2
Mixed	1
Sudanese	1
Black British	2
Jamaican	1
Ugandan	1
Colombian	1
Chinese	1
Somali	9

Responses from professionals

We gathered comments from individual workers based in the organisations that helped with interviewee recruitment and from other professionals concerned with improving the mental health of young adults in the borough. For the purposes of the report we were interested in gaining a 'picture' of the types of services provided to young adults in Islington with mental health needs, the needs of the young adults and any perceived gaps in services.

Other professional organisations that supported the peer interviewer recruitment and/or were interviewed included:

- The 18-24 Islington Gangs Transition Service.
- Targeted Youth Support & Youth Offending Services London Borough of Islington Children's Services.
- Islington Public Health
- Islington Mental Health Joint Commissioning Team
- ICope: Islington Improving Access to Psychological Services (IAPT)
- BetKnowMore (social enterprise tackling gambling and addiction)
- Islington's Community Wellbeing Development Service
- Islington Somali Community
- Islington Mind
- Alone in London
- YMCA

Key themes emerging from these interviews included:

- **The need for services to be more accessible**

There is a need for services to be more accessible – meeting people in familiar surroundings – young people need to know they can talk about anything. They want to talk about what life is like for them and about their families. Some young people need a service that offers a totally different experience of the health service. Young people want to know are they going to section me? Am I mad?

Counselling/psychotherapeutic interventions need you to have the ability to be with someone, you need inter-personal skills, warmth and to have a positive regard for the individual you are working with, it could almost be called be-friending/mentoring/advocacy. A service needs to be multi-faceted and to work for the individual: a pick and mix idea.

- **Professionals also felt there is a need to understand how to work with challenging young adults and implement this in local provision.**

The challenge is to manage risk, whilst at the same time holding in mind the emotional, and providing a therapeutic service.

Additional themes were recorded as:

- **An absence of a solution from professionals**
- **A need for open ended support, and**
- **A dependency, particularly amongst some BME communities, of young adults on the family unit**
- **Fear and lack of understanding of mental health support**

A lot of the time mothers won't talk to doctors about problems in the family. They fear their children will be taken away from them.

Referring to the mental health team is difficult, the community need to trust the referral, there is a need to break down isolation and there is a resistance to medication, not sure that professionals always know what is needed.

- **A recognition that existing services can be too clinical**

They can be too clinical, and not so people friendly, they can work from the position of institutional stereotypes. A service should address the stigma and be more about engagement in counselling. A clinical approach can be about something being done to you and is favoured as other forms of intervention are hard to measure. Clinical interventions are about cognitive change and people being sent away to do 'homework'. It's a clinical/scientific process. Some people however want a diagnosis, the stigma needs breaking down.

I feel psychologists open wounds and make you feel worse, they chuck labels at you – borderline disorders, depression, anxiety and not explaining what any of them mean. I have been involved in mental health services since I was 7 I am now 18. I would not recommend people seeing counsellors they will label you. (Homeless Female 18)

- **There was also an acknowledgement of the contribution the voluntary sector can make to improving mental health for young adults.**

Mind is a good service. It is neutral and you don't always have to fit into a box.

There was consideration of the impact CAMHS services can have on access to adult mental health services, and finally an important issue was raised on the potential for misdiagnosis of young adults with special needs. There was evidence of young adults with ADHD being diagnosed as disruptive and being treated for mental health.

In addition to these themed responses Healthwatch held detailed exchanges with Islington's Assistant Director of Public Health, senior members of Islington's Joint Mental Health Commissioning Team and senior members of the clinical team at ICope.

These exchanges were invaluable in framing the reports final recommendations and in considering how and in what ways community and voluntary organisations can begin to work together with local authorities, commissioning teams and clinical services to improve access and retention of members of the young adult population in Islington in psychological services.

Islington Public Health emphasised the need for us to clearly identify links between multiple vulnerability, mental health and access and the commissioning team emphasised the need for services and commissioners to continue to develop and improve approaches to ongoing engagement with young adult users of mental health services.

ICope reported 9,000 referrals over the last 12 month period, which apart from the 18-25 and over 65 age group were reported as evenly spread across ages. Self-referral was reported as an increasing source of referrals to the service: There has been an increase from 11% to 35% over the previous period. The service also reported a need to reach out further to particular communities and to adapt services to appeal to younger adults. ICope outlined a range of services from 16 week psychological interventions for people with depression and anxiety to one off workshops, work in GP surgeries and at other local organisations working with the unemployed such as Job Centre Plus and Remploy. ICope noted flexibility as an area that needed further consideration for types and methods of service delivery particularly in the context of current targets and comments from users of the services and there was recognition that more work could be done with local communities to improve access for individuals facing multiple levels of vulnerability. Working with ICope's team of Psychological Well-Being Practitioners was felt to be a potential area for exploring these changes.

Interviews with young people

Young people were asked three main questions:

1. What is your experience of mental health?

2. Have you or any young adults you know had support for their mental health?

3. What kind of help do you think you and/or other young adults need to support their mental health?

The data below provides information drawn from the responses gathered.

1. What is your experience of mental health?

Examples of the relationship between mental health and other practical and social issues were recorded as:

I wasn't good at managing money which was hard. I felt abandoned and confused, people are being left out, they are not accessing services to meet their needs, the benefit caps are also having an impact, until you are over 35 there is not much accommodation and what there is, is temporary. I don't claim JSA, I am not ready, I have made a claim for ESA. Things have got lost in the post due to my change of addresses. I hope they will back date the money I want to establish myself.

I had a flat but I lost it. I was 19 and moved to a flat from leaving care. I wasn't able to look after myself properly and budget, it got to the point where I wasn't even opening letters. I feel I wasn't given the right kind of help.

I was homeless when I got out of prison. I got kicked out of home I thought no one cared about me. I couldn't get a job for money, I couldn't see anyone like my friends because I was barred from my local area, I couldn't even steal to get food. I got caught trying to kill myself and got sent to hospital. Money is a big source of stress. Society pressures you to perform well, to spend money. Cost of education is too high you start life after university with debts. The cost of living in London is higher than what you get at minimum wage.

Other mental health experiences were varied but the following themes were identified:

- **Stigma was discussed in number of contexts, including trust of local services**

Yes in my family, my aunties and uncles, I think it's generational because they're the only ones that are like that. They hoard and don't communicate much they hold things to themselves. If there's something wrong they wouldn't tell anyone they'd keep it to themselves.

I think people trust authority, or senior people who have dealt with a similar problem. The community is quite close people usually would go to their local imam.

My dad has dementia and only close members of the family can look after him, he doesn't trust/feel safe with others.

There is a silent suffering from the parents. They always try to hide family problems.

I wanted to see a psychologist to help me finish school and cope with the pressure but my parents didn't want me to see one. They said, they will send me to mental hospital and give me drugs and that I should talk to a friend if I have difficulties in school. They also said it is too expensive.

She starts things and then gets kicked out, she writes on her social media page about killing herself and saying if she did she would be dead now, her family don't really know how to support her. The family unit is too busy and is trying to accept her as she is. She needs a lot of attention. I have known her for 6 years and she is getting worse. The family are not telling people as they think she might get taken away.
(Young woman aged 22 talking about her friend)

- **There was also evidence of differing views on the causes of mental health**

I believe spirits and black magic can affect people's minds. My nephew is not suffering from a mental illness but sometimes he changes. He gets angry. He snaps. He gets into fights. He didn't use to. Maybe someone did some black magic on him to make him mad.

- **Shame and the social isolation this can lead to was highlighted by a number of respondents.**

I felt guilty and stupid and ashamed on my daily routine and my physical well-being. I feel useless at times as I could not do anything for myself. I feel isolated as I do not want to have any contact with other people.

I always avoid people who I might think will talk back about history and the situation in my country. I consequently avoid socialising with people from my community and I feel very alone. I am suffering with post-traumatic stress disorder as result of my experience and the subsequent incident of violence and hardship.

- **The impact of recreational drugs was also mentioned**

It comes from a lot of stress, and can also come from family and the world. You also have mental issues that come from drugs. You don't know what's going on in people's lives until you talk to them – I have a friend he went to prison and a mental institute.

Anxiety can be caused by drugs, alcohol, etc. MDMA is a friendly drug but the side effects are tremendously negative.

Drugs are filled with chemicals that cause more harm than good, chemical-free cannabis is not that bad. The problem is that you don't know what chemicals they put in the drugs. You think you take one thing but you are actually taking something else.

- **Discussions on drugs also revealed confusion on the impact some drugs can have on a person's mental health.**

They said I had psychosis but I don't think I did. I had insomnia. I knew what was wrong with me. One time I took MDMA, it messed up my head (hallucinations), cannabis doesn't do that.

There is a history of mental illness in my family – psychosis, schizophrenia, "madness". Cannabis is medical e.g. cancer. It's different than other drugs. You can't overdose

- **Some felt that the prescription of medication had been unnecessary.**

Yes I have been sectioned and started using medication. After a while I stopped taking medication. I do not trust medication. Now I use supplements instead (Feed your brain).

They would give me stuff I didn't need. They gave me a sleeping pill for insomnia (When I could have bought sleeping pills myself at the shops) When the mind has got nothing to do, that's bad.

- **Impact of unemployment was another theme**

When you're unemployed you're on a downer, you've got low self-esteem and low confidence

I am always at home and I do not see my friends, I need help with employment or training.

- **Family dependence was another dominant theme especially amongst those interviewed from particular BME communities**

I have experienced mental illness myself. When I am getting hyper, I cannot take care of myself. I cannot dress myself, I cannot wash myself... My husband is my primary carer. I am very grateful to him. In my case, it is my past that affects my present. And sometimes, I cannot deal with the emotions. It is overwhelming.

2. **Have you or any young adults you know had support for their mental health?**

In response to this question many respondents spoke about how people just seemed to manage.

If people don't take care of themselves, depression can settle in. When I think too much, that leads me to think: "what if I am getting depressed?" That scares me, I don't want that. So I try not to think too much.

If someone has a problem he gets used to it and adjusts to it and then it becomes normal. I don't know if it is a mental health problem.

- **Again people spoke about relying on friends or their families**

I think friends generally. Most people who have depression won't talk to a lot of people this is why is good to have friends that you can talk with.

My parents and my husband are a great source of help. My mother takes care of me, she handles my medication. I take it constantly.

When you have problems you want to talk with a friend. Cry on his/her shoulder.

Usually, I talk to my friends, or my family, or my neighbours. Every time, they tell me "Don't worry, you'll be fine". And I follow their advice and most of the time I feel better for a short while. I never sit down at home. If I stop doing things it leads to thinking and that leads to depressive thoughts.

Only the family cares about the mentally ill individuals. The mental health care team do not care they only give medications. I make sure that he takes his medications. He has only the medication.

- **And some didn't know where to go, highlighting a lack of information on local services**

I have no idea where I would go. I would have probably looked online.

I wouldn't go to my GP to talk about stuff that is not physical. I don't think they deal with these things.

- **And others didn't feel they got the help they needed, highlighting also a potential need for one point of contact for the individual**

If I go to the GP and share my problem, he would have directed me to someone else. I was annoyed. It's like they are avoiding. If they can't help me on the spot so I'm wasting my time. It is hard to open up and share these things anyway so you want to talk to one person.

- **A lack of trust of counselling services was also a dominant theme**

In some cases you have to inform someone of their or their loved ones' psychological disorder. People don't believe you. And after stress comes depression. It is a sensitive issue. It can pass over, it trickles down, it spreads to other people. There isn't a lot of help out there. There are trust issues to consider. It is difficult to open up to strangers.

It is not common that people go to counseling because it always very personal issues. If they have problems they will talk to their friends and not to a counsellor, to people they don't know. It's a matter of trust. I wouldn't go to counseling but to a good friend because this is what I feel comfortable with.

I don't trust these doctors, I don't talk to them I'm scared they will put me in a home.

- **However for some who did get help the outcome was positive**

I spent 3.5 weeks in a mental hospital. The help I got was talking to someone. I didn't get drugs. I much prefer someone listening to me, listening to what I want to say. That's what prevented me from trying to kill myself again. I wanted to kill myself, I told them I had nothing to live for, so they showed me something to live for, gave me support. They got me to realise I had people out there to support me, who cared for me. When I got out, people showed positive and unbiased support .The support you need is someone ask how do you feel and truly care about you and not feel sorry for you. People being nice and normal helps - not feeling sorry for you.

I like it here at the Pilion Trust it's like a family.

Before coming to Stonewall I didn't know where to go and my housing situation was awful. I am now engaging with Mind and I also accessed help from London Friend.

The services have helped. Yeah my friend is getting help now, at first I think she was too scared to ask for help but after talking to someone they got help, they're fine now.

Now I feel much better. I take two tablets in the morning and one at night for three years. At the moment I don't know what is available for me.

Currently I have a support worker. She is helping me to do a course. I want to train to have some direction and a purpose.

Football is a good stress release it definitely helps.

I'm on placement now it's good.

3. **What kind of help do you think you and/or other young adults need to support their mental health?**

I think working with parents would help but only if they want to listen and more funding for mental health awareness and specialist accommodation to cater to specific needs. People need to be more compassionate and need to know how to signpost people to the right kind of services, we need more campaigns and maybe other therapies I think charities and churches have more compassion, they can be more flexible, they run food banks, shelters etc like meditation.

- **The need to have someone to talk to was a strong theme**

For me the services I would like would be someone who could advocate for me on day to day issues and stresses in life. I would really like to be able to speak to someone on the phone and discuss my problems when I need to.

Help to take medication, counselling, someone to help me collect prescriptions, help with loneliness, budgeting, activities, employment.

I feel a much more impassioned approach and a genuine display of caring could really help young people feel appreciated and that they are considered as part of a bigger society. Empathy and inclusion would go a long way.

I would like to be told a list of people I can talk to when I feel like talking.

I would like a social worker or a someone to check in on me regularly. I would like to be monitored. I used to have a social worker fortnightly but they are not coming round anymore. They say I seem to be doing fine.

A person with mental illness can feel hurt, pain, frustration, anger, just like anyone else and wants to be treated as an individual. Mental health problems can affect people in different ways, and they need different kind of help with their difficulties. They need counselling and

psychotherapy, medication and maybe admission to hospital.

- **Others felt services were too slow to respond**

It is important that the mental health care team give help as soon as the person presents with a mental health illnesses. The service is very slow and this has worsened my sister's condition. She is getting better but needs to go through a long process. We feel she will get better but only with a combination of solutions and swiftness of action.

- **Whilst others felt too much fell onto the family**

I have experienced mental illness myself. When I am getting hyper, I cannot take care of myself, I cannot wash myself. My husband is my primary carer. I am very grateful to him. In my case, it is my past that affects my present. And sometimes, I cannot deal with emotions.

My parents and my husband are a great source of help. My mother takes care of me, she handles my medication. I take it constantly.

- **And others felt there should be tailored support**

There should be more information available specifically for young adults

Young adults should help others in the same situation to understand mental health, because they're young you can relate more, go into schools, colleges etc.

It should be promoted as much as contraception is promoted in school.

The support in schools should be the same as college.

- **And that early intervention would be useful**

Start from young, year 7 is ok, then they'll understand when they're growing up what to look out for and who can help.

Conclusions

This consultation exercise has provided us with an in-depth insight into the mental health needs of young adults facing multiple vulnerabilities and suggests there is likely to be an increase in the number of young adults in Islington facing mental health problems now and in the future. It provides a body of evidence from young adults experiencing poor mental health and professionals working with individuals with mental health needs that current services are having a limited impact on engaging with and sustaining positive relationships with those who are vulnerable. Within this report vulnerable respondents were predominantly from: Asian and African backgrounds, those struggling to secure accommodation, the homeless, socially isolated, individuals from LBGT backgrounds and those who are living in poverty. This respondent profile was not based on a sample but rather, reflected individuals who were prepared to talk to us from the referring organisations. This may have implications for the demographic of young adults accessing adult mental health services.

However for those who did receive help, most reported positive experiences and a sense that they were more able to cope and manage a variety of practical, social and psychological problems.

We would also like to mention that young people (under 18) were not a target group however interviews with young adults and professionals did suggest that young adults who had experience of using CAMHS services did not have a successful transition to adult mental health services.

Key themes:

1. Stigma alongside a lack of trust in mental services was a dominant theme and therefore an area requiring additional focus. It could be useful to review the impact of existing services commissioned to reduce stigma, and how stigma and a lack of trust of mental health services; ensuring there is a focus on how and in what ways stigma is played out amongst community members in Islington and how it impacts on young adult's access to mental health services. These services include those delivered in both clinical and non-clinical settings including practical, social and psychological services.

2. There was evidence of persistent levels of lack of access to mental health services for those facing multiple vulnerabilities, which suggests there may be a need to equip organisations not funded to deliver mental health services, but who are working with individuals experiencing mental health to:

   - improve their knowledge of how and in what ways their existing services are impacting on individual and community mental health,
   - increase their knowledge of local mental health services; and their potential benefits to the community,
   - refer effectively to mental health services.

3. The role the family plays in supporting those with mental health needs amongst particular communities was a key theme. Although there is recognition from many respondents that this support has played a key role in their ability to manage their mental health, in some cases family could be blocking those living with mental health needs from accessing appropriate mental health services.

4. A lack of adequate accommodation, worklessness, and social isolation were dominant themes throughout the consultation. It is therefore suggested that a more holistic approach to mental health service delivery is considered through the integration of advice, guidance and advocacy services with psychological services; in particular for those adversely affected by Universal Credit and the Welfare and Work Bill.

Recommendations

1	There is an urgent need to address issues of worklessness, a lack of accommodation and social isolation amongst many of the respondents. It is therefore recommended that a holistic approach to mental health services is considered, one which draws together a number of practical, clinical and well-being services. These services should include social activities, advice, guidance, advocacy and psychological services.
2	We recommend that the services referred to in our first recommendation above are delivered in a range of community based settings to create a more flexible approach to the delivery of mental health services. This will broaden the scope of services available and provide a range of familial and socially connected environments for vulnerable young adults.
3	We recommend that community based organisations working with young adults with mental health needs should be provided with financial support and professional expertise to: ▸ Actively engage in processes and fora associated with co-commissioning. This should relate directly to the design of local services, ▸ be equipped to refer effectively to mental health services, and ▸ measure organisational activities to assess their impact on young adults with mental health needs. It is suggested that an organisational toolkit is co-produced, with commissioners and clinical staff to equip organisations to begin to undertake these developments. Healthwatch recognises the problematic nature of the current funding climate and will therefore actively pursue funding sources to support this suggestion.

References

1. ‘Designing youth mental health services for the 21st Century, examples from Australia, Ireland and the UK’, McGorry et al, published in the British Journal of Psychiatry, Volume 202, Issue 54, Jan 2013.

2. ‘Distant Neighbours: Poverty and Inequality in Islington’, New Economics Foundation and Cripplegate Foundation 2013.

3. Islington’s Adult Joint Clinical Commissioning Strategy, Islington Clinical Commissioning Group, 2012 – 2017.

4. Islington Evidence Hub, October 2013 http://www.islington.gov.uk/publicrecords/library/Public-health/Information/Factsheets/2013-2014/(2013-10-11)-Mental-health-fact-sheet-(2).pdf

5. ‘Transforming Mental Health: A Plan of Action for London’, Guilburt, H, Edwards, N, Murray, R, The Kings Fund, 2014.

6. Widening the Focus: Tackling health inequalities in Camden and Islington, Annual Public Health Report, Camden and Islington 2013/14.

Appendices

a) Stakeholder meeting attendees

- Alone in London
- The Peel Centre (Direct Action Project)
- Islington Youth Counselling Service
- Iranian and Kurdish Women's Rights Organisation
- Islington Carers Hub
- Caxton House (Community Hub)
- Octopus Communities (Community Hub)
- Only Connect London
- Hanley Crouch Community Association (Community Hub)
- Jobs in Mind
- Latin American Women's Rights Association
- Islington Bangladesh Association
- Finsbury Park Trust
- Islington South Community Counselling
- Scope
- Hillside Clubhouse
- Voluntary Action Islington
- Department of Work and Pensions

b) Young person questionnaire

Age:
Gender:
Post code:

1. What is your experience of mental health? This could relate to your personal experience or the experience of your peers?

2. Have you or any young people you know had support for their mental health?
   Prompts: if yes did it help and in what ways? if no, why not?
   As part of this question people may want to provide an example
   You can also ask do people know what's available and where to go for help

3. What kind of help do you think you and/or other young people need to support their mental health?
   You could ask here about anything specific

4. Is there anything else you would like to add?
   Could ask here about improvements to services

c) Interviewee referral organisations

Lift is Islington Council's healthy living hub for young people. It houses a 30-station, cafe, media and computer suite, meeting rooms, kitchen and a large dance studio. Young people can come for personal help with apprenticeships, college applications, CVs, looking for work, volunteering or developing projects. Lift also supports young people with advice and guidance on personal issues, lifestyle decisions and sexual health. Pulse is also available to help with young people's health queries in fully-equipped clinical facilities.

Street League specialises in changing the lives of young people from disadvantaged backgrounds through the power of football. Originally founded as an organisation working with homeless people in 2001, they now work with 16 to 25-year-olds who are not in employment, education and training (NEET). Street League engages with young people in a structured football and education 'Academy' programme, with two hours in the classroom and two hours on the pitch each day. The intensive 10-week programme develops vital employability skills such as communication, teamwork and goal-setting. It also offers nationally-recognised qualifications.

Pilion Trust is a charity who works with people who have been affected by drugs, alcohol and mental health. They are a non-profit charity working with the community to support the community. We interviewed young people at one of their 'crash pads' situated in the basement of Cally Methodist Church.

Only Connect is a creative criminal justice charity. They work in schools, prisons and on the streets to deliver projects that build relationships. The focus of their work is innovation to prevent first-time offending and reduce re-offending. Members are enabled to design and deliver solutions to their own problems and problems faced by other members and peers across London. They provide clubs that offer training, support and creative opportunities, deliver creative criminal justice projects in the community and advocate for young people at risk.

Stonewall Housing is the specialist lesbian, gay, bisexual and transgender (LGBT) housing advice and support provider in England. They provide housing support for LGBT people in their own homes, supported housing for young LGBT people, as well as free, confidential housing advice for LGBT people of all ages. They also research and lobby for LGBT housing rights, so that all LGBT people can feel safe and secure in their homes.

Islington Bangladesh Association established totackle poverty, deprivation and the isolation being experience by a marginalised Bangladeshi community in the borough. It has a long standing reputation within the community in terms of service provision in addressing the social, cultural, welfare and economic needs of the Bangladeshi community.

Islington Somali Community works with Somalis of all ages in Islington and neighbouring London boroughs. Their aim is to improve the wellbeing of the Somali population and to work towards the full integration of refugees in the local community. Much of their work focuses on providing advice and information about housing, education, employment, health and other essential services. ISC also refers and signposts to connect clients to other services available. A key strand of work is Islington Links - an innovative youth work project engaging young people at risk of involvement in crime and drugs. Throughout the year ISC organises cultural events, mother tongue and supplementary classes, outings for children and adults, interpreting and translation services.

healthwatch Islington

200a Pentonville Road
London N1 9JP

0207 832 5814
info@healthwatchislington.co.uk
www.healthwatchislington.co.uk
@hwislington

ISLINGTON
Public Health, 222 Upper Street
London, N1 1XR

Report of: Joint Director of Public Health

Meeting of	Date	**Agenda Item**	**Ward(s)**
Health and Wellbeing Board	20 April 2016	C1	All

Delete as appropriate		Non-exempt

SUBJECT: Work Programme 2016/17

1. Synopsis

1.1 This report introduces the work programme for discussion and approval by the Health and Wellbeing Board.

2. Recommendations

2.1 That the work programme for 2016/17 be approved, subject to any amendments of the Board.

3. Strategic Context

3.1 The focus of the Health and Wellbeing Board is on responding to the needs identified by the Joint Strategic Needs Assessment (JSNA) and on the delivery of the priorities identified in Islington's Joint Health and Wellbeing Strategy (JHWS).

3.2 The Board is responsible, on behalf of the council and CCG, for promoting the health and wellbeing of local residents and it must encourage integrated working and commissioning between health and social care services in order to secure the best possible health outcomes for all local people and reducing health inequalities, based upon the JSNA and JHWS.

4. Background

4.1 The work programme is a key document for the Health and Wellbeing Board. It has the dual function of directing the focus of the formal meetings of the Board for the present year and enables the public and wider stakeholders to understand the Board's planned activity.

4.2 Forward planning is necessary to ensure issues of strategic importance are responded to in an appropriate and timely fashion and to enable the Board to achieve its strategic objectives and the transformational changes necessary for both the council and the CCG.

4.3 The present Work Programme covers both the statutory duties of the Health and Wellbeing Board and the key projects that have been identified as priorities by the Board. It covers the period until Spring 2017.

4.4 The Board should seek to align its work programme with the strategic work programmes of other relevant boards and committees of the CCG and council as appropriate.

4.5 It is intended for the HWB to consider and approve the work programme at each meeting. When proposing items to the work programme, Board members should specify the information and analysis required and who will author the report/s in question.

4.6 The Health and Wellbeing Board Agenda Setting Group will meet periodically and will have the right to amend or propose items for inclusion on the work programme as appropriate.

4.7 The Work Programme is attached at Appendix A.

5. Implications

Financial implications:

5.1 There are no financial implications arising directly from this report.

Legal Implications:

5.2 The Health and Social Care Act 2012 states that every local authority must establish a Health and Wellbeing Board for its area. The Islington Health and Wellbeing Board is responsible, on behalf of the council, for promoting the health and wellbeing of local residents. It must encourage integrated working and commissioning between health and social care services in order to secure the best possible health outcomes for all local people and reducing health inequalities, based upon the joint strategic needs assessment and the joint health and wellbeing strategies. Health and Wellbeing Boards have a number of statutory duties designated through the Health and Social Care Act (2012) that will inform what items should be taken to the Health and Wellbeing Board meetings.

Environmental Implications

5.3 There are no significant environmental implications arising directly from this report

Resident Impact Assessment:

5.4 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 RIA has not been completed because an assessment is not necessary in this instance

6. Reasons for the recommendations / decision:

5.1 The Health and Wellbeing Board is asked to note the Work Programme; approve the work programme for the next meeting of the Board; and propose additions and amendments to the Work Programme for 2016/17.

Appendices

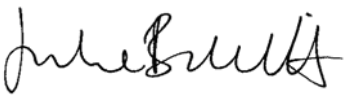
- Appendix A: Draft Work Programme 2016/17

Background papers:

- None.

Final report clearance:

Signed by:



8 April 2016

Joint Director Public Health — Date

Signed by:

11 April 2016

Head of Democratic Services — Date

Report Author: Baljinder Heer-Matiana
Tel: 020 7527 1233
Email: Baljnder.Heer-Matiana@Islington.gov.uk

Islington Health and Wellbeing Board
DRAFT Work Programme 2016/17

April 20th 2016, 13:00 - 15:00 Town Hall, Upper Street, N1 2UD		
Item	Purpose/ Decision	Responsible officer
For Discussion/comment		
1. CCG's Commissioning plan for 16/17 and update on the NCL Sustainability and Transformation Plan (STP)	• Overview of CCG commissioning plans and strategic priorities for 16/17 • Update on the development of the Sustainability and Transformation Plan (STP) for North Central London, in line with NHS Planning Guidance, which sets out how NHS organisations (CCGs and providers) will work with local authorities to improve health and wellbeing outcomes, care quality and financial sustainability. The presentation will include emerging strategic plans for system transformation and reform, as well as the timetable and process for sign off of the plan. • The Board is asked to: (1) NOTE the commissioning plans and (2) AGREE whether commissioning plans take proper account of the JSNA and JHWS • The Board is asked to (3) NOTE progress on the development of the Sustainability and Transformation Plan (STP) for North Central London	Chief Officer, ICCG
2. Joint Health and Wellbeing Strategy Refresh	• This paper sets out a proposed process and timetable for refreshing the Islington JHWS, and seeks an initial steer from the Board on key priorities and areas of focus as we start to develop the new strategy. • The Board is asked to; (1) PROVIDE a strategic steer to the development of Islington's new Joint Health and Wellbeing Strategy, reflecting on achievements of the previous strategy and its focus on three high level priorities – giving every child the best start in life, preventing and managing long term conditions and improving mental health and wellbeing; (2) DISCUSS potential priorities, themes or areas of focus in order to provide a framework to the process of strategy refresh; (3) AGREE the approach to refreshing the JHWS set out in this report, subject to any changes discussed and agreed by the Board.	Director of Public Health, LBI
3. Islington's Better Care Fund – progress report	• Islington's HWB provides oversight of Islington's Better Care Fund programme delivery. This paper will provide the Board with an update on progress and plans for 16/17. • The Board is asked to; (1) NOTE and (2) COMMENT on the integrated working	Director of Housing and Adult Social Care, LBI

	in 2015/16 and key achievements for local people • The Board is asked to REVIEW and AGREE in principle the planning assumptions for 2016/17 be reviewed and agreed.	
4. Mental Health services for young adults in Islington. A consultation by HealthWatch Islington	• HealthWatch Islington carried out a consultation with young adults on their experiences of using local mental health services and have used the findings to make recommendations for key local partners. • The Board is asked to: (1) NOTE and (2) DISCUSS the recommendations set out in the HealthWatch report.	HealthWatch Islington
5. Work programme	• Islington's Health and Wellbeing Board's work programme is developed by partners with oversight from the Chair of the Board. This draft programme for 2016/17 is intended to be a working document due to the fast pace of change and will be reviewed and agreed by the Board at every meeting. • The Board is asked to: (1) NOTE the draft work programme for 2016/17 and (2) CONSIDER any additional items to inclusion in the work programme.	HWB Chair
For information (Discussion by exception)		

July 6th 2016, 13:00 - 15:00 Town Hall, Upper Street, N1 2UD		
Item	Purpose/Decision	Responsible officer
For Discussion/comment		
1. Joint Health and Wellbeing Strategy refresh update	• The Board is asked to: (1) NOTE progress on the development of the draft Joint Health and Wellbeing Strategy; (2) IDENTIFY potential areas for improvement to inform the final version for public consultation; (3) APPROVE the draft strategy for a period of public consultation to take place between August and October 2016, subject to any agreed changes	Director of Public Health
2. Update on workforce training and development to support integrated care	• This paper highlights the work of Islington's Community Education Provider's Network (CEPN), setting out what it is trying to achieve, some of the key workforce challenges and opportunities nationally and locally in relation to supporting future models of integrated care, the development of a cross organisational / disciplinary training faculty and to describe how this work sits under the integration programme locally and could/should relate to the HWB.	Jo Sauvage, ICCG

	• The Board is asked to: (1) NOTE and (2) DISCUSS Islington CEPN's plans for 2016/17	
3. Safeguarding adults and safeguarding children in Islington in 2015/16 – a review of key achievements and priorities going forward	• There is a statutory duty for the annual safeguarding reports to be presented to the chair of the HWB. Annual children and adults safeguarding reports are also presented to Islington's CCG's Governing Body. In previous years, full annual reports have also been presented to and discussed by the HWB. • The board may wish to propose that both independent Chairs of the safeguarding boards present a paper (as opposed to their full annual reports) setting out key issues and achievements over the past year, and priorities going forward, drawing out how these priorities align with the strategic priorities of the HWB and how the HWB can champion and support action across the system to address these safeguarding priorities.	Corporate Director of Housing and Adult Social Services Corporate Director of Children's Services
4. Learning Disabilities and Autism Self-Assessment Frameworks	• Joint commissioners are required to submit the Learning Disabilities Self-Assessment Framework (SAF) on an annual basis to NHS England. It covers a range of topics regarding services to people with learning disabilities. NHS England requires the report to be submitted into Health and Wellbeing Boards for approval.	Corporate Director of Housing and Adult Social Services
5. Work programme	• The Board is asked to: (1) NOTE the draft work programme for 2016/17 and (2) CONSIDER any additional items to inclusion in the work programme.	HWB Chair
For information (Discussion by exception)		

October 19th 2016, 13:00 - 15:00 Town Hall, Upper Street, N1 2UD		
Item	Purpose/Decision	Responsible officer
For Discussion/comment		
1. Joint Health and Wellbeing Strategy Consultation findings	• The Board is asked to: (1) NOTE the findings from the public consultation; (2) CONSIDER the findings when finalising the strategy and agreeing its priority areas of focus.	Director of Public Health
2. CCG and Council Commissioning Intentions 2017/18	• Overview of CCG and council commissioning intentions and strategic priorities for 17/18 • The Board is asked: (1) NOTE joint commissioning plans; and (2) AGREE whether commissioning plans take proper account of the JSNA and JHWS	CCG Chair Director of Public Health Corporate Director of Housing and Adult Social Services Corporate Director of Children's Services
3. HealthWatch Islington's Strategic Plans for 2017/18	• HealthWatch's strategic plans and priorities for 17/18 • The Board is asked: (1) NOTE and (2) DISCUSS HealthWatch plans for 2017/18	HealthWatch Islington
4. JHWS Priorities Update (April 2016 to present)	• For information. Updates come periodically (every 6 months)	Director of Public Health
5. Work programme	• The Board is asked to: (1) NOTE the draft work programme for 2016/17 and (2) CONSIDER any additional items to inclusion in the work programme.	HWB Chair
For information (Discussion by exception)		

January 25th 2017, 13:00 - 15:00 Town Hall, Upper Street, N1 2UD		
Item	Purpose/Decision	Responsible officer
For Discussion/comment		
1. Joint Health and Wellbeing Strategy – final version	• The Board will be asked to: (1) APPROVE and ADOPT the strategy for 2017 - ??	Director of Public Health
2. CCG's Commissioning plan for 17/18 and update on NCL's Sustainability and Transformation Plan (STP)	• Overview of CCG commissioning plans and strategic priorities for 16/17 • Update on the development of the Sustainability and Transformation Plan (STP) for North Central London,	Chief Officer, ICCG
For information (Discussion by exception)		