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ISLINGTON

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

AGENDA FOR THE HEALTH AND CARE SCRUTINY COMMITTEE

Members of the Health and Care Scrutiny Committee are summoned to a meeting, which will be held Committee Room 4, Town Hall, Upper Street, N1 2UD on, **17 November 2016 at 7.30 pm.**

Stephen Gerrard
Interim Director of Law and Governance

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Despatched	:	9 November 2016

Membership

Councillors:
Councillor Martin Klute (Chair)
Councillor Rakhia Ismail (Vice-Chair)
Councillor Jilani Chowdhury
Councillor Gary Heather
Councillor Michelline Safi Ngongo
Councillor Tim Nicholls
Councillor Una O'Halloran
Councillor Nurullah Turan

Co-opted Member:
Bob Dowd, Islington Healthwatch

Substitute Members

Substitutes:
Councillor Alice Perry
Councillor Dave Poyser
Councillor Clare Jeapes
Councillor Satnam Gill OBE
Councillor Angela Picknell
Councillor Marian Spall

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

Quorum: is 4 Councillors

1. Introductions

2. Apologies for Absence

3. Declaration of Substitute Members

4. 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** members present at the meeting.

5. Order of business

6. Confirmation of minutes of the previous meeting 1 - 4

7. Chair's Report

The Chair will update the Committee on recent events.

8. Public Questions

9.	Health and Wellbeing Board Update - Verbal	
A.	**Items for Decision/Discussion**	**Page**
10.	Scrutiny Review - IAPT - witness evidence	5 - 18
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The next meeting of the Health and Care Scrutiny Committee will be on 12 January 2017

Please note all committee agendas, reports and minutes are available on the council's website:

www.democracy.islington.gov.uk

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London Borough of Islington

Health and Care Scrutiny Committee - Thursday, 22 September 2016

Minutes of the meeting of the Health and Care Scrutiny Committee held at on Thursday, 22 September 2016 at 7.30 pm.

Present: **Councillors:** Klute (Chair), Heather, Nicholls, O'Halloran and Turan

Also Present: **Co-opted Member:** Bob Dowd – Islington Healthwatch

Councillor Martin Klute in the Chair

254 **INTRODUCTIONS (ITEM NO. 1)**

The Chair introduced Members and officers to the meeting

255 **APOLOGIES FOR ABSENCE (ITEM NO. 2)**

Councillors Chowdhury, Ismail and Safi Ngogo

256 **DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. 3)**

None

257 **DECLARATIONS OF INTEREST (ITEM NO. 4)**

None

258 **ORDER OF BUSINESS (ITEM NO. 5)**

The Chair stated that the order of business would be as per the agenda

259 **CONFIRMATION OF MINUTES OF THE PREVIOUS MEETING (ITEM NO. 6)**

RESOLVED:
That the minutes of the meeting of the Committee held on 19 July 2016 be confirmed as a correct record of the proceedings and the Chair be authorised to sign them

260 **CHAIR'S REPORT (ITEM NO. 7)**

None

261 **PUBLIC QUESTIONS (ITEM NO. 8)**

The Chair outlined the procedure for Public questions and filming and recording of meetings

262 HEALTH AND WELLBEING BOARD UPDATE (ITEM NO. 9)

None

263 LONDON AMBULANCE SERVICE - PERFORMANCE UPDATE (ITEM NO. 10)

Peter Rhodes of the London Ambulance Service, was present for discussion of this report and during discussion the following main points were made –

- Following the CQC inspection which placed the LAS in special measures work had been taking place to address areas of concern and it is hoped that when the LAS is reinspected in December/January it would come out of special measures
- The workforce is now fully staffed and an additional 717 frontline staff have been recruited in 2015/16
- In response to a question the LAS stated that they did not envisage the Brexit vote having too much of an impact on recruitment and retention
- The attrition rate of staff is roughly 10/20 per month which is good in a workforce of over 3000 staff
- Staff appraisals were taking place and there would be reviews during the year
- As part of the Quality Improvement Programme a review of the mental health act guidance is being issued to staff to ensure it is well understood. Training is also being strengthened to provide staff on the Mental Capacity Act and put in place a network for staff to ensure that they are confident in carrying out mental capacity assessments, and are able to seek guidance when require. In 2016/17 there will be a specific focus on the guidance associated with S136 in partnerships with the Police to ensure protocols and policies will be consistent and that calls will be appropriately triaged to enable a timely, safe and effective response
- In response to a question it was stated that the LAS were working hard to deliver a 35 working day response to complaints
- Work is going on with the CCG to look at data in relation to alcohol related calls
- Members stated that the next report submitted on performance to the Committee should include details of the experiences of front line staff working for the LAS and that a member of staff should attend the meeting

RESOLVED:
That the report be noted and the next time the performance report is submitted a front line member of staff be invited to attend

The Chair thanked Peter Rhodes for attending

264 ANNUAL ADULTS SAFEGUARDING REPORT (ITEM NO. 11)

Elaine Oxley, Head of Safeguarding, Housing and Adult Social Services Department was present and gave apologies for the Chair of the Safeguarding Board, Marion Harrington, as she was unable to be present at the meeting that evening. Members were informed that the Chair of the Safeguarding Board was standing down and Members stated that they wished to place on record their appreciation of her work.

During discussion of the report the following main points were made –

- Work is taking place on the issues of social isolation for carers and the stress involved in such isolation
- Reports of concerns on safeguarding had risen by 26% on the previous year but this did not mean that more abuse took place only that more concerns were reported. This may be due to people being made aware about the need to report abuse and neglect of adults
- More than half of all cases of abuse and neglect take place in the adults own home. The three most common types of abuse of safeguarding enquiries were physical abuse, financial abuse and neglect
- In the previous 12 months an additional 12 in house BIA's have been recruited and trained. This reduces the reliance on independent BIA's and reduces costs. Excellent working relationships have been developed with the best independent BIA's and Mental Health assessors who now prioritise referrals from Islington
- Regular multi-agency RADAR meetings to track trends and concerns about care providers in Islington. RADAR meetings are proving to be an effective way of monitoring how care providers are working to address concerns and improve standards and if problems are found support and an improvement plan is put in place

RESOLVED:
That the report be noted and the Committee record their thanks to Marion Harrington, outgoing Chair of the Safeguarding Board for her work

265 **SCRUTINY REVIEW - EFFECTIVENESS OF IAP - PRESENTATION AND SID (ITEM NO. 12)**

Jill Britten, Islington CCG was present and made a presentation to the Committee, copy interleaved, during which the following main points were made -

- The list of witnesses should include patients and their representatives
- In the objectives of the review awareness of the service should be included
- There should be demographics of those using the service included in the type of evidence to be assessed and additional patient outcomes measured and accessibility to the service
- Discussion took place in relation to getting people to an initial appointment and that this was a challenge

RESOLVED:
That, subject to the above amendments, the SID be approved

266 **SCRUTINY REVIEW - HEALTH IMPLICATIONS OF DAMP PROPERTIES - FINAL REPORT (ITEM NO. 13)**

The draft scrutiny review had been circulated and during discussion the following main points were made –

- Councillor Heather stated that he had some proposed amendments to the report and that he would notify these to the Chair and Democratic Services for consideration following the meeting
- The Chair stated that he would redraft the recommendations following comments and circulate them for consideration to Members of the Committee

RESOLVED:

That, subject to the following amendments –
Recommendation 1 – add the words 'can evidence related health issues' in line 2 and include reference to Partners, RSL's and private landlords
Recommendation 5 – Delete the word 'lifestyle' and insert the words' Building Fabric' in heading
And add the words in line 2, 'cold bridging, lack of insulation and any other building fabric issues'
Recommendation 7 – delete the word 'database' and insert the words 'share information'
Recommendation 8 – add the word 'internal' following the word'external' and add the words 'RSL's, Partners' in line 1 following the word 'Council'
Add additional recommendation – 'Public Health and Environmental Health are to work with the CCG to disseminate information to GP's on the extent and issues with damp properties and their perceived interaction with health issues, and to request GP's to return data to the CCG when they are seen by patients with health issues that appear to be living in a damp property'

the scrutiny report be agreed and forwarded to the Executive for consideration

267 **WORK PROGRAMME 2016/17 (ITEM NO. 14)**

MEETING CLOSED AT 9.35 p.m.

Chair

Islington Health Scrutiny Committee, 17 November 2016

Islington IAPT Services

1. Introduction

1.1. Improving Access to Psychological Therapies (IAPT) is a national programme, which aims to deliver NICE compliant treatments for adults suffering from depression and anxiety disorders (also described as 'common mental health problems').

1.2. The programme was rolled out nationally in 2010 to adults of all ages, with service provision commissioned by local Clinical Commissioning Groups (CCGs). In Islington, the service is delivered by Camden and Islington Foundation Trust (C&IFT), and is known locally as the iCope service. The service is open to all adults who live in Islington.

1.3. This report sets out the performance of the iCope service against national targets for the last three years, as well as current challenges for the service and areas of development for the future.

2. Background

2.1. IAPT services are based on three key criteria:

- **Evidence based psychological therapies**: delivered by fully trained and accredited practitioners, with type and level of treatment matched appropriately to the mental health problem
- **Routine outcome monitoring**: to enable both patient and clinician to have up-to-date information on progress made. Data is anonymised and published by NHS England to promote transparency and support service improvement
- **Regular, outcomes-focussed supervision**: to support clinicians to continuously improve and deliver high quality care

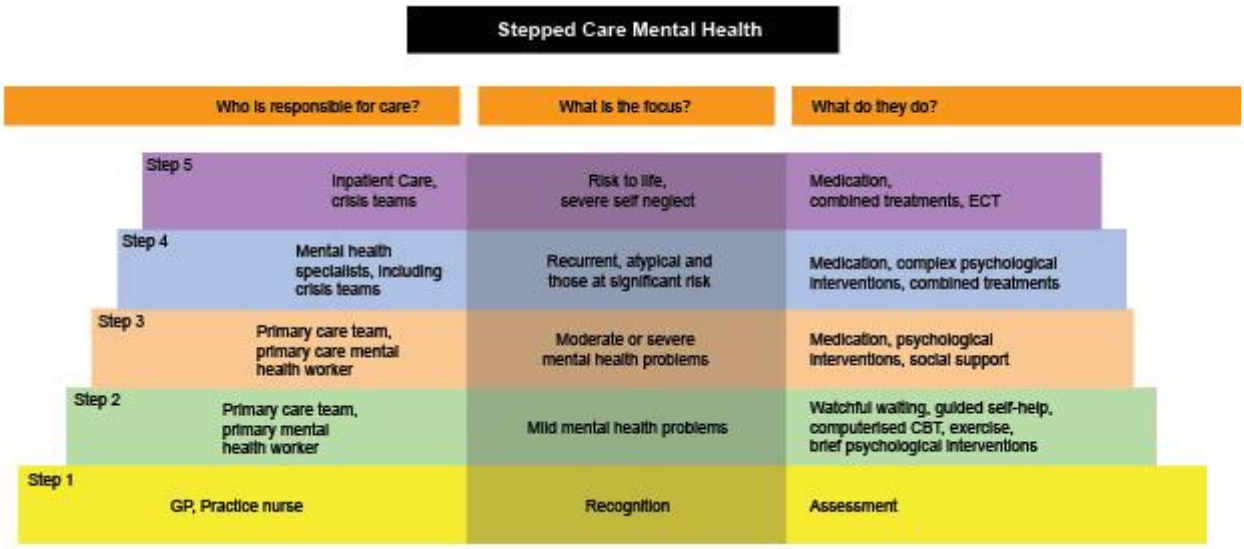
2.2. IAPT services are delivered using a 'Stepped care' model. This approach seeks to deliver the minimum amount of treatment required to deliver a positive outcome (so as not to 'burden' the patient), whilst ensuring that the intensity of treatment can be increased or decreased in line with people's need and progress towards recovery (i.e. stepped up or stepped down).

2.3. Examples of treatments available include:

- Cognitive Behavioural Therapy (CBT)
- Interpersonal Psychotherapy (IPT)
- Brief Dynamic Interpersonal Therapy (DIT)
- Couple Therapy for Depression
- Counselling for Depression

<u>Local Delivery Model</u>

2.4. Islington has one of the highest levels of mental health need in the country, with over 31,000 adults estimated to have depression and anxiety disorders, and higher rates of serious mental illness than the national average. The IAPT stepped care model is based on NICE guidance, and aims to support the majority of people suffering from depression and/or anxiety, whose needs fall within Step 2 or 3, as demonstrated in the diagram below:



2.5. In Islington:

- **Low intensity interventions (i.e. Step 2)** can include - guided self-help; computerised cognitive behavioural therapy (CCBT); advice and support in taking antidepressant or other psychotropic medication prescribed by GPs; psycho-educational groups; support with accessing local community resources including employment support and exercise on prescription; and pure self-help (Books on Prescription).
- **High intensity interventions** (i.e. Step 3) can include - cognitive behaviour therapy (CBT) (individual and group), interpersonal psychotherapy (IPT), behavioural couples therapy, and, for PTSD, eye movement desensitisation and reprocessing therapy (EMDR).

IAPT Plus

2.6. In addition, Islington CCG commissions C&IFT to deliver a 'Step 4a' service, known locally as 'IAPT Plus'. This service supports patients who present with longstanding complex problems of depression or anxiety, often associated with major adverse historical and/or current life circumstances, co-morbidities such as personality and relationship difficulties, long term physical health conditions and medically unexplained symptoms. This can include patients who are not able to yet engage elsewhere, have a lack of insight into their difficulties, are not currently motivated to engage with the 'treatment' model or who have had a significant history of previous treatment.

2.7. The aim of the intervention is to support the management of individuals within primary care and help people to feel more able to manage their problems and achieve personally defined goals, rather than anticipating significant clinical improvement on existing IAPT measures, i.e. many will not be expected to report having recovered, as per the clinical definition. Patients in these groups are offered a range of interventions appropriate for 'Step 4a' clients, to help support their management within primary care with additional psychological support. Interventions are offered in a variety of settings, including in a patient's home.

<u>Referral and Assessment</u>

2.8. IAPT services sit within Primary Care and can be accessed either through referral by a professional, or via self-referral, including online. Online self-referral consists of a simple form and requires minimal information i.e. GP surgery (if registered with a GP), name, date of birth, address, and information on the type of support required (if known). Individuals can also self-refer via telephone if they prefer.

2.9. Following referral to the service, initial assessment is carried out by a Psychological Wellbeing Practitioners (PWP), to determine whether the service is suitable for an individual. Where

possible, assessments will take place via telephone, however, face-to-face assessments are also available.

2.10. IAPT services have been developed to meet the needs of people with depression and/or anxiety – known as 'common mental health problems.' For those individuals assessed as having a level of need which exceeds that which can be met by the service, practitioners will seek to identify and refer onto a more appropriate service, including secondary care mental health services.

3. Performance

National Targets

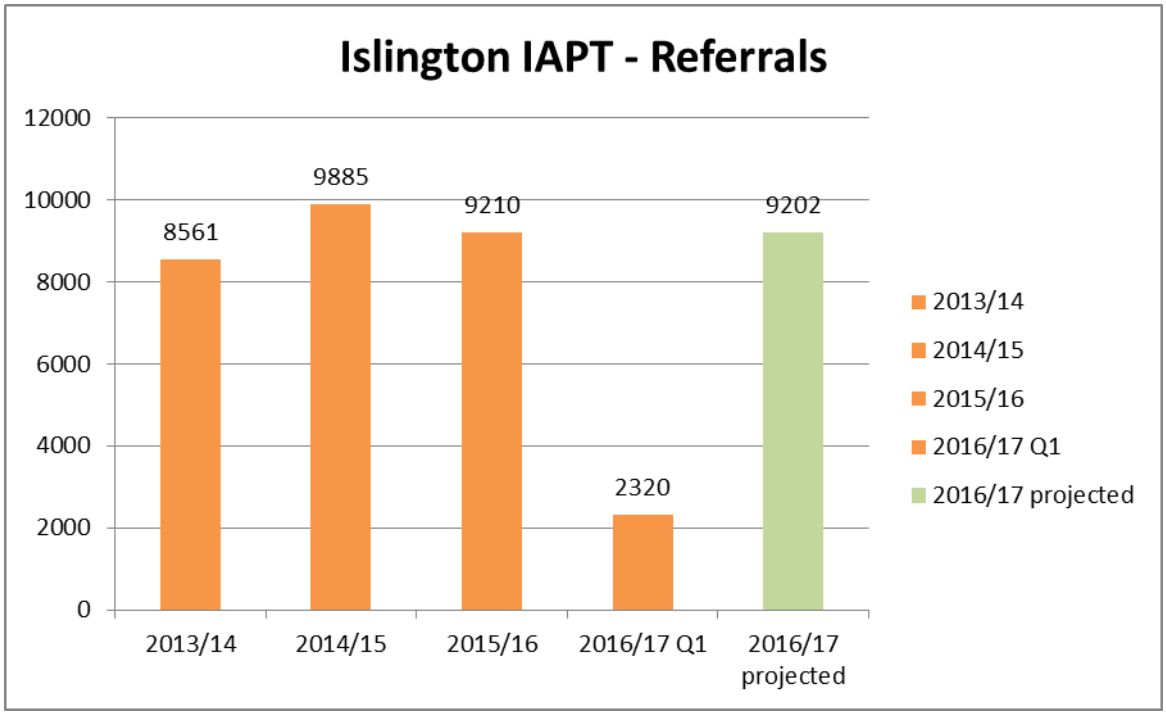
3.1. IAPT services are subject to national performance measures. For 2015/16 and 2016/17, the following targets have been set:

- **15%** of adults with relevant disorders will have timely access to IAPT services (Islington population = 31,031)
- **50%** of people accessing IAPT will recover
- **75%** of people referred to the IAPT programme begin treatment within 6 weeks of referral, and **95%** begin treatment within 18 weeks of referral.

3.2. The tables below show the performance of the Islington iCope service, and includes comparison with the other five boroughs within the North Central London footprint. The data provided is based on the nationally published data as reported by NHS Digital, which provides national information, data and IT systems for health and care services. Data published nationally differs from the data collected and reported locally up to 2015/16. The reasons for these discrepancies are addressed further under paragraphs 3.11 – 3.14.

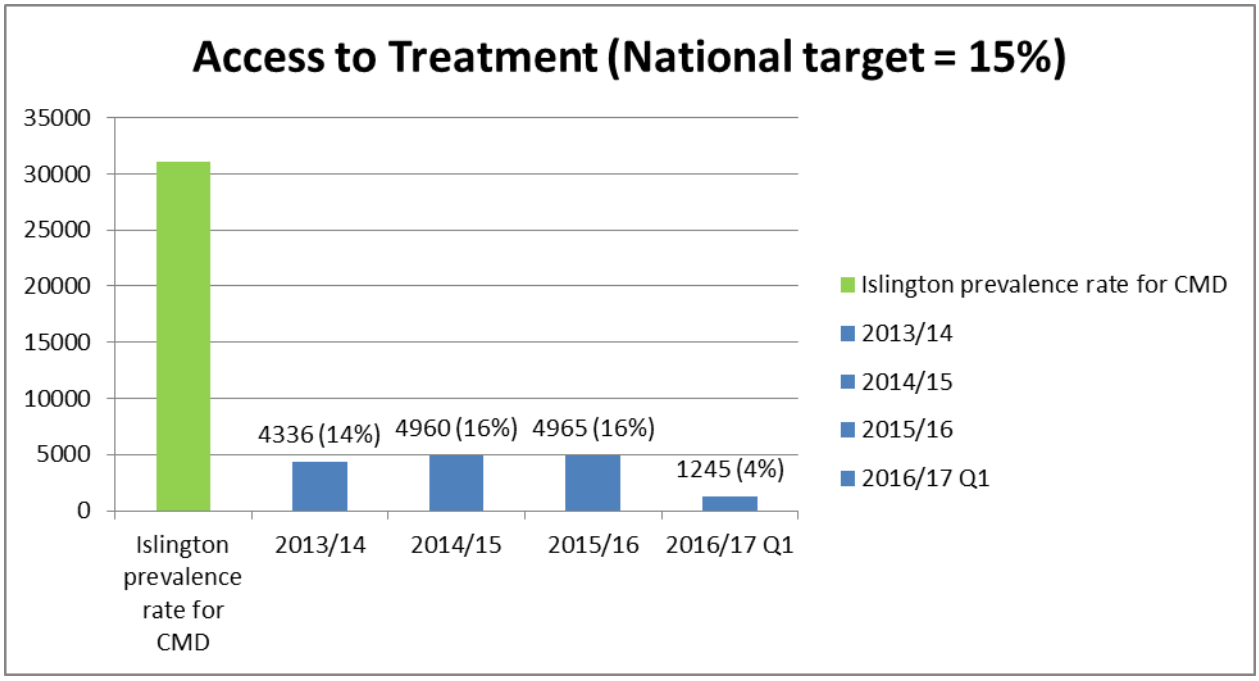
3.3. The rate of referrals to the service increased by 13% year-on-year between 2013/14 to 2014/15. The service employed a number of methods to promote the service amongst both professionals and the general public, and the increase in referrals is likely to be a result of this work. Although the number of referrals fell slightly in 2015/16, it is still noticeably higher than 2013/14. Similarly, projected figures for 2016/17 suggest referrals are expected to reach approximately 9,202.

Table 1: Referral data



3.4. Access to treatment is measured nationally, with a target of 15% of the prevalent population to access treatment each year. The access rate in Islington has gradually increased year-on-year, exceeding the target from 2014/15 onwards.

Table 2 – Access to treatment

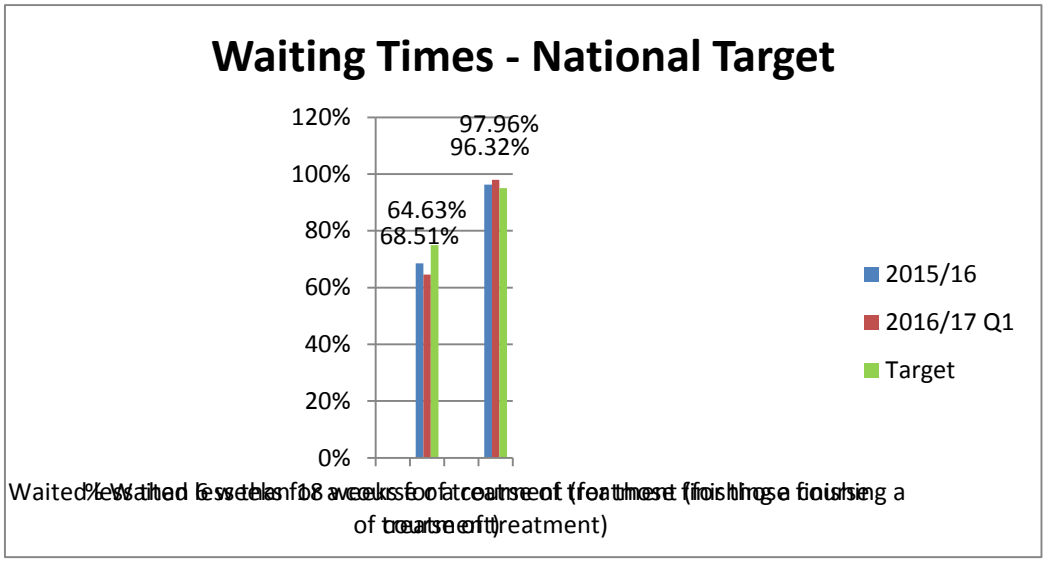


3.5. Waiting time targets are set nationally (as of 2015/16) against six weeks and 18 weeks as follows:

- 75% of people referred to the IAPT programme begin treatment within 6 weeks of referral
- 95% begin treatment within 18 weeks of referral.

Performance shows that waiting times against the 18 week target were exceeded in 2015/16, and have continued this trend into 2016/17. However, the proportion of people accessing treatment within six week of referral has fallen short of the target in 2015/16, with results for Q1 showing similar results.

Table 3: Waiting Times



3.6. Recovery rate targets are set nationally, with the expectation that 50% of people entering treatment will report to be 'in recovery' at the end of the treatment period. Recovery rates are defined by:

"the number of service users moving to below caseness on clinical outcome scores, as a proportion of the number of people ending contact with services and receiving at least two sessions of treatment."

3.7. IAPT services use a number of well-validated, patient completed questionnaires to measure change in a person's condition. Most of the questionnaires are administered at each appointment, making it possible to track improvement by comparing scores over time.

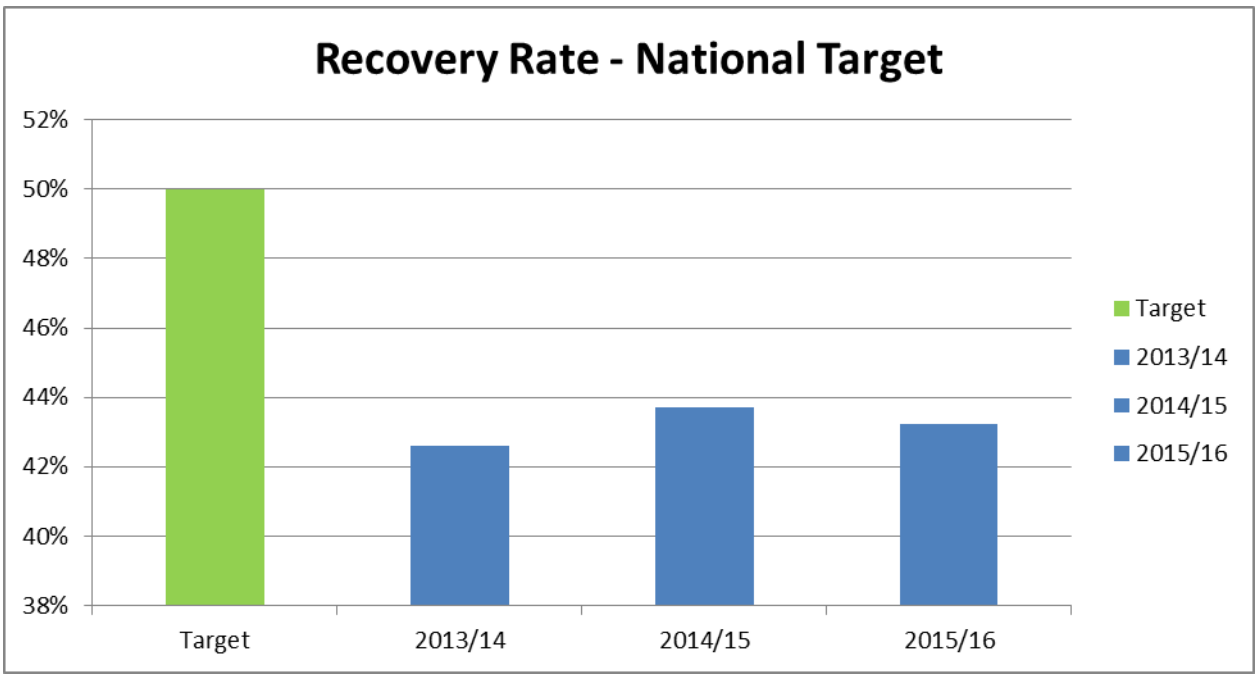
3.8. A number of factors can affect whether an individual meets the criteria of having recovered, including:

- Severity of need at the start of treatment
- Delayed discharge from treatment
- Clinical decisions
- Whether an individual has met the 'threshold' for recovery, prior to being discharged

The widening of the acceptance criteria for the iCope service (to include those whose needs fall within Step 4a) means that the service is more inclusive and supports a much broader range of patients within primary care. However, due to the way in which recovery is measured nationally, it is acknowledged by commissioners that this has an impact on the recovery rate.

3.9. The recovery rate for Islington iCope has risen each year, however, it is still below the target of 50%. In 2014/15, and action plan was put in place to address the poor performance against recovery levels, which delivered a small increase by the end of the year. However, it is recognised that this is a key area for improvement in 2016/17.

Table 4: Recovery



Local Comparison

3.10. The performance of the Islington IAPT service in 2015/16 is shown below, in comparison with other CCGs within North Central London. Although Islington has met the targets for access and 18-week waiting times, the performance of Haringey in particular exceeds Islington.

CCG	Access Rate (Target 15%)	Recovery Rate (Target 50%)	6-week waits (Target 75%)	18-week waits (Target 95%)
Islington	16%	44%	69%	96%
Camden	16%	44%	74%	93%
Barnet	11%	46%	72%	87%
Enfield	14%	46%	84%	96%
Haringey	17%	46%	92%	99%

Local Reporting Challenges

3.11. The IAPT service is subject to quarterly monitoring by Islington CCG as part of the wider NHS contract for mental health services in Islington.

3.12. National published performance data is generated through the reporting of local performance data. The data is ratified by NHS England, prior to being published.

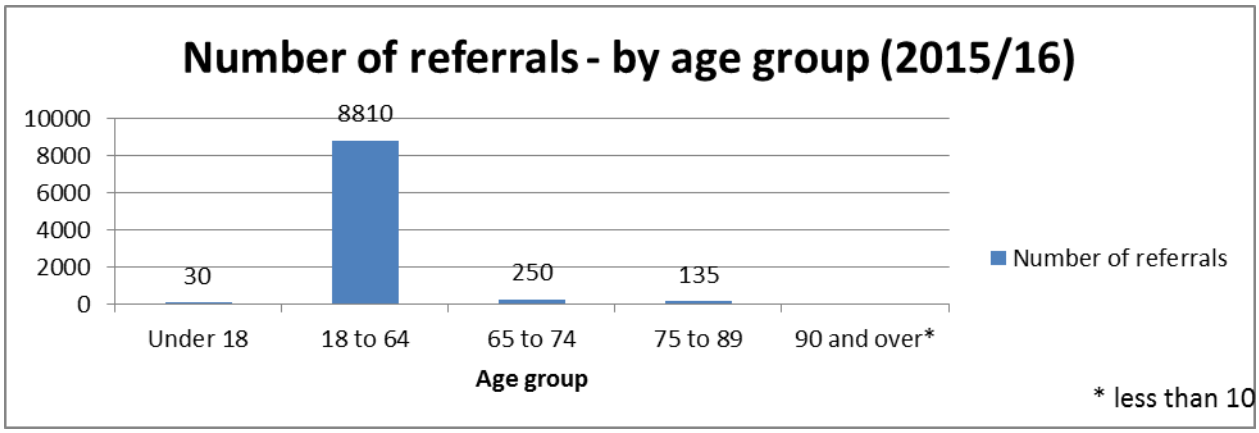
3.13. In early 2016/17, it was identified that there were significant discrepancies between the locally reported data and the national published data for 2015/16. Upon further investigation, it was identified that errors within the performance monitoring programme used by the IAPT service had led to these discrepancies.

3.14. It should therefore be noted that the published performance for the Islington IAPT service for 2015/16 does not fully reflect the work that was delivered. The service has taken steps to address the errors identified in the 2015/16 reporting process, and it is expected that reporting for 2016/17 will be much more accurate.

Demographics

3.15. The majority of adults accessing the service are between the ages of 18 and 64. Adults over the age of 64 are currently under-represented, and the service is working to identify ways to increase levels of engagement from this group.

Table 5: Age breakdown



3.16. Ethnicity data shows that 30% of all referrals were from adults who identified as White British, whilst 19% identified as being from non-white backgrounds. Both figures are below the Islington population, as determined by 2011 Census, which recoded 48% of the population as White British, and 32% from non-white backgrounds. However, the ethnicity data must be treated with caution for the following reasons:

- Census population data relates to all ages, not just adults. The younger population in Islington (under age 24) is significantly more ethnically diverse than the older population.
- Almost 40% of all adults referred to the service either chose not to state their ethnicity, or their ethnicity was not recorded. It is therefore possible that the ethnicity breakdown would look very different if the ethnicity of all referees was reported. Ethnicity reporting has improved in 2016/17, with 95% of ethnicity data recorded.

Table 6: Ethnicity (referrals)

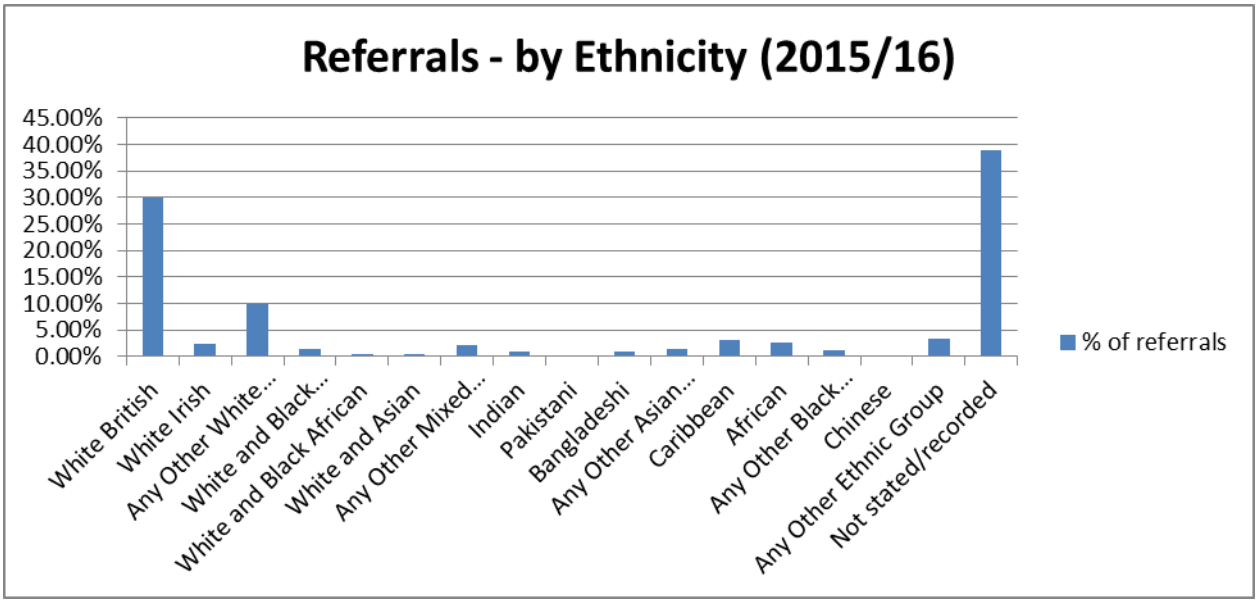
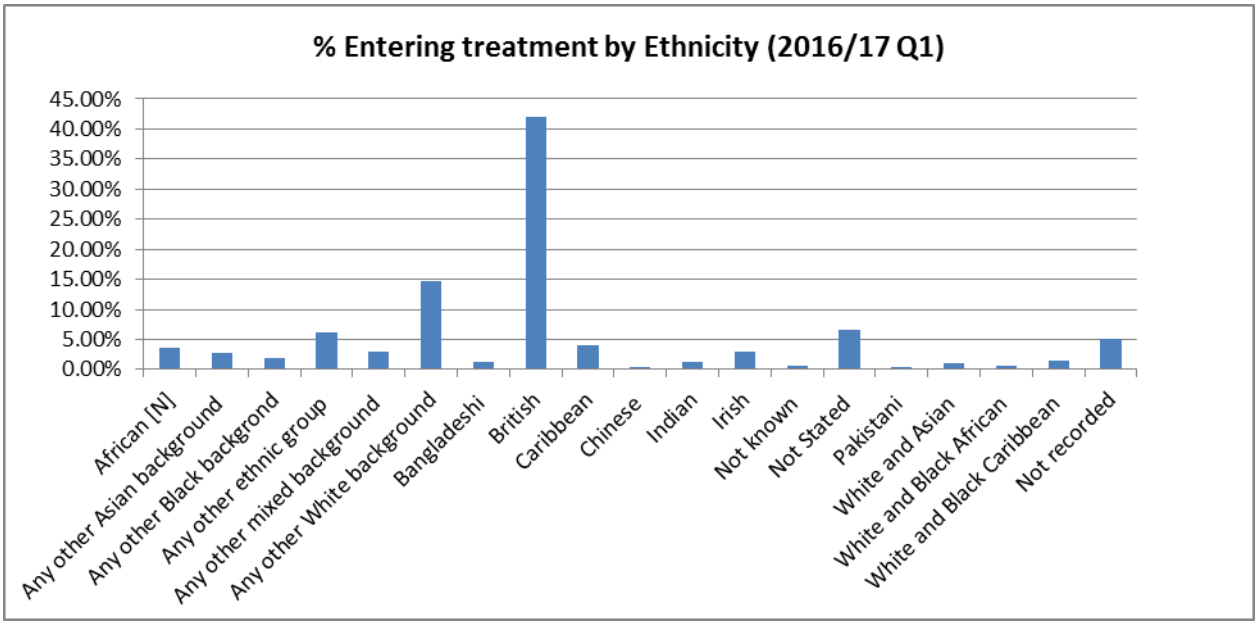


Table 7: Ethnicity breakdown (for those entering treatment – 2016/17 Q1)



Additional Outcome Measures

3.17. The IAPT service employs a variety of methods to measure outcomes and progress of individuals accessing the service. These include:

- Work and Social Adjustment measures
- Enablement Instrument (this tool has been adapted by the IAPT service to suit the client group)

3.18. These measurement tools allow the service to capture outcomes relating to a number of aspects of an individual's life, and progress made in these areas before, during and at the end of treatment. Examples of the areas measured include:

- Ability to understand and cope with problems
- Work
- Social Activities
- Family and relationships

3.19. Templates of the full set of measures are attached at Appendix 1.

Long-term physical health conditions

3.20. It is widely accepted that physical and mental health are closely linked; having a long term mental health condition can increase the likelihood of developing a physical health need, whilst people with long term physical health conditions can develop mental health problems. As part of the Five Year Forward View for Mental Health[1], IAPT services will be expected to increase their focus on supporting people with long-term physical health conditions (LTCs). Targets have not yet been set, however, the Islington IAPT service already reports this data locally. Reporting for 2015/16 and Quarter 1 2016/17 shows over one fifth of all adults who access treatment via the iCope service also have a long-term physical health condition:

[1] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Measure	2015/16	2016/17 Q1
Number of referrals with LTC	*Not collected*	411
Number who accessed service with LTC	980 (21%)	303 (24%)
Number who recovered with LTC	42%	47%

4. Service Promotion and Service User Engagement

4.1. The Islington iCope service promotes the service in a number of ways, including:

- Leaflets
- Posters
- Co-location in GP surgeries and other community settings to encourage ease of access
- Partnership working with local organisations and giving talks to members of those organisations

4.2. The iCope service has an established service user advisory group, which includes both current and former service users. The service consults the user group and seeks feedback in order to identify areas of the service that can be improved, and to support around developing new ideas to promote and deliver the service.

4.3. In addition to the group, all service users are encouraged to complete patient experience questionnaires, friends and family feedback; and there are suggestion boxes for anonymous feedback at our team bases.

4.4. The service is in the process of recruiting to peer mental health worker (paid) roles to co-facilitate treatment workshops and for other opportunities of supporting delivery.

5. Challenges and areas for improvement

5.1. There are a number of challenges facing the Islington IAPT service, alongside areas where commissioners expect performance to improve.

5.2. As shown by the performance data above, the current target for access to treatment is 15% of the prevalent population, and the service is this year on track to achieve 16-17% access. This was also achieved in 2015/16. As set out in the Five Year Forward View for Mental Health, access rates are expected to increase to 25% by 2020. Access targets for the next two years will be set at:

- 17% in 2017/18
- 19% in 2018/19

This will pose a significant challenge within current resources, and commissioners will be working with the service provider to identify how to address this.

5.3. In addition to increased access rates, as part of the Five Year Forward View for Mental Health, there will be an expectation that IAPT services will increase focus on supporting people with long term conditions or medically unexplained symptoms, as well as supporting more people into employment. The Islington service already works well with our local Mental Health Working (employment support) programme, and local reporting of long-term conditions is already underway.

5.4. The recovery rate for the service continues to be below target. Although local data for 2015/16 showed a recovery rate of 48%, once ratified at a national level, this fell to 43%. The service

provider has in place an action plan which seeks to address this challenge, and continues to work to identify areas of practice which may affect the final performance in this area.

5.5. The level of mental health need in Islington is high, both in comparison with other London boroughs, and nationally. The recent 'Healthy Lives, Healthy Minds' report by Camden and Islington Public Health Team identified that local data shows that approximately 29,900 adults in Islington have diagnosed, unresolved depression or anxiety (16% of residents aged18 and over), whilst an additional 15,897 adults are estimated to have a common mental health disorder which has not been diagnosed.

5.6. This high level of need, and the severity of those needs, presents a challenge for the IAPT service, not just in terms of capacity, but also with regards to being able to provide interventions that support people to move into a state of sustainable recovery. Where an individual's needs require more intensive support, the IAPT Plus service is available to provide a variety of interventions, however, it is recognised that many people accessing the IAPT Plus service will not meet the criteria for recovery.

Work and Social Adjustment

Common Fields
Stage: **Step 3 Assessment**

Score:
Comments:

Date completed:

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity.

1. **WORK** - if you are retired or choose not to have a job for reasons unrelated to your problem, please select N/A (not applicable)	0 Not at all 1 2 Slightly 3 4 Definitely 5 6 Markedly 7 8 Very severely, I cannot work N/A
2. **HOME MANAGEMENT** - Cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc	0 Not at all 1 2 Slightly 3 4 Definitely 5 6 Markedly 7 8 Very severely
3. **SOCIAL LEISURE ACTIVITIES** - With other people, e.g. parties, pubs, outings, entertaining etc	0 Not at all 1 2 Slightly 3 4 Definitely 5 6 Markedly 7 8 Very severely
4. **PRIVATE LEISURE ACTIVITIES** - Done alone, e.g. reading, gardening, sewing, hobbies, walking etc	0 Not at all 1 2 Slightly 3 4 Definitely 5 6 Markedly 7 8 Very severely
5. **FAMILY AND RELATIONSHIPS** - Form and maintain close relationships with others including the people that I live with	0 Not at all 1 2 Slightly 3 4 Definitely 5 6 Markedly 7 8 Very severely

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SCRUTINY REVIEW INTITATION DOCUMENT

Review: Improved Access to Psychological Therapies (IAPT)

Scrutiny Committee: Health Scrutiny Committee

Lead Officer: Simon Galczynski, Service Director Adult Social Care

Overall aim: To understand local arrangements for accessing IAPT services, and the effectiveness of these services in helping people recover from mental health conditions.

Objectives of the review:-

- To understand current arrangements and mechanisms for accessing IAPT service.
- To review waiting times for IAPT services.
- To assess the effectiveness of IAPT services
- To feedback the findings of the scrutiny to providers
- Publicity and awareness of the service

Duration: Approx. 6 months

How the review will be conducted

Scope: The services in scope of this time limited scrutiny review are NHS IAPT services commissioned from Camden and Islington Mental Health Trust (iCOPE).

Types of evidence to be assessed:

- Documentary evidence on demographics of those using the service and accessibility or reason adjustments made to ensure accessibility to the service

- Documentary evidence on national standards for access, waiting times and recovery rates; including any additional outcome measures collected.

- Witness evidence from a range of relevant individuals and organisations

    a. Patients and their representatives and consumer organisations
        i. Patients by experience
        ii. Patient representatives and groups e.g. Islington Borough User Group (IBUG)
    b. Commissioners
        i. Islington Joint Commissioning Team
    c. Providers
        i. Camden and Islington Foundation Trust

Additional information:
In addition to the statutory IAPT service Islington has recently commissioned 3rd sector organisations to provide Talking Therapies to meet specific needs as below (contract commences September 2016).

- Talking Therapy for people within Black, Minority Ethnics and Refugee (BMER) communities
- Talking Therapy for people who have suffered child sexual abuse and/or domestic violence
- Talking Therapy for people who have suffered bereavement

This is commissioned under a lead provider model, the following organisations are involved.

- Nafsiyat Intercultural Therapy Centre
- Women's Therapy Centre
- The Maya Centre
- Camden, City and Islington and Westminster Bereavement Service

Healthwatch Islington

Update and work planning

Health and Care Scrutiny, November 2016

2016/17

Home care (user stories), shared with LBI

Autism (how services make reasonable adjustments), ongoing – focus groups, surveys and interviews.

Accessible Information Standard, still scoping this

Social worker's phones (mystery shopping), round one complete,

Sustainability and Transformation Plans…

2016/17

Developing a more diverse ‘Patient Group’ with the CCG, Manor Gardens and Every Voice,

Supporting volunteers, new training courses,

Developing links with London Met,

Following up previous work – mental health now with the Health and Well-Being Board.

2017/18

- Sustainability and Transformation Plans,
- Gathering community views and providing information,
- Further themes to be agreed at a community meeting in February (21st).

Work Plan 2016 – 17

Healthwatch Islington's remit is to gather local evidence and engage local people in decision-making about health and care services in order to influence commissioning, provision and delivery of those services. We offer information about services to local residents. We work collaboratively with statutory partners to develop the best services for local needs, and we work closely with the voluntary sector. Our work is funded by the Local Authority and local health partners.

Aim	When		Notes
1. Report the views of home care service users	July 2016	G	We started to gather views in December 2015 and will report these in July 2016.
2. To assess provision of reasonable adjustments for patients with Autism and share good practice	March 2017	A	First phase – speak to patients and carers to devise a checklist Second phase – visit services, co-ordinate with Ambitious about Autism Third phase – report.
3. Gather and report views of extended hours GP practice model (IHUB)	June 2016	G	Interviews completed, report to follow.
4. Train parent researchers to carry out peer research (researchers will then carry out work for council's SEN services)	May 2016	G	Training developed and in the process of being delivered.
5. Support the engagement of a more diverse audience in the Pan Islington Patient Group	March 2017	G	Preparation is underway for a new model for the patient group. We will work with local partners to carry out additional discussion groups and a community-based meeting.
6. Work with London Metropolitan students to gather research to feed in to the Joint Strategic Needs Assessment	March 2018	G	Conversations with the university have started. They will now ensure that their health and social care course for 2016-17 includes 'Community Research' modules and HWI will provide students with the opportunity to practice these skills.
7. Continue to look for opportunities to work cross-borough with other local Healthwatch	Ongoing	A	Options are limited by resources and locally determined work plans. We are working together to represent local views at a regional level within health and will continue to seek out other opportunities to work together.

Aim	When		Notes
8. Gather views to inform the commissioning of mental health day services	Oct 2016	G	Phase one – service visits, to report by 1st July 2016 Phase two – community meetings with presentations from LBI Phase three – community involvement in specification and procurement.
9. Develop an auditing tool for new service 'Bright Beginnings' which will assess provision of services to pregnant women and new mothers from the BME community	March 2019	G	Phase one: Develop tool, Phase two: Measure progress and produce interim report (2017)
10. Accessible Information Standard – following the introduction of this standard we want to assess how local providers are making information more accessible	July 2016	A	Phase one – audit our own information, Phase two – focus on accessibility of information on key areas and advise on maximising accessibility
11. Keeping our local community informed of policy relating to local services	Ongoing	G	We will continue to host information stalls and workshops on key issues.
12. Offer a positive volunteering experience to our team of volunteers	Ongoing	G	Phase one: Volunteer's week conversations around Learning and Development – we have won an award for the work so far. Phase two: Implement learning from Volunteers Week. Adhere to the principles of Investors in Volunteers.
13. **NEW:** Mystery shopping the council's Advice and Access service and Social Workers' telephone lines.	March 2016	A	Phase one: Draft scenarios to test. Phase two: Mystery shopping the services in September/ October and again in February. Phase three: Reporting on findings with recommendations.

In addition, based on feedback from our local community, we will be scoping potential future work on:

- Obtaining referrals for secondary care services,
- Mental health and alcohol use for over 65s.

We will liaise closely with partners at the Islington Personal Budgets Network on the roll out of personal budgets in health and social care.

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healthwatch Islington

NHS Islington Clinical Commissioning Group

ISLINGTON Working in partnership

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

Draft for consultation

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FOREWORD

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

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

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

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

Cllr Richard Watts
Leader
Islington Council

Dr Jo Sauvage
Chair
Islington Clinical Commissioning Group

INTRODUCTION

What is this strategy?

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

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

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

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

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

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

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

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

How has the Joint Health and Wellbeing Strategy been developed?

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

What has informed the Joint Health and Wellbeing Strategy?

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

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

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

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

OUR VISION FOR ISLINGTON

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

A healthier, fairer and more resilient population

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

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

Our guiding principles

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

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

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

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

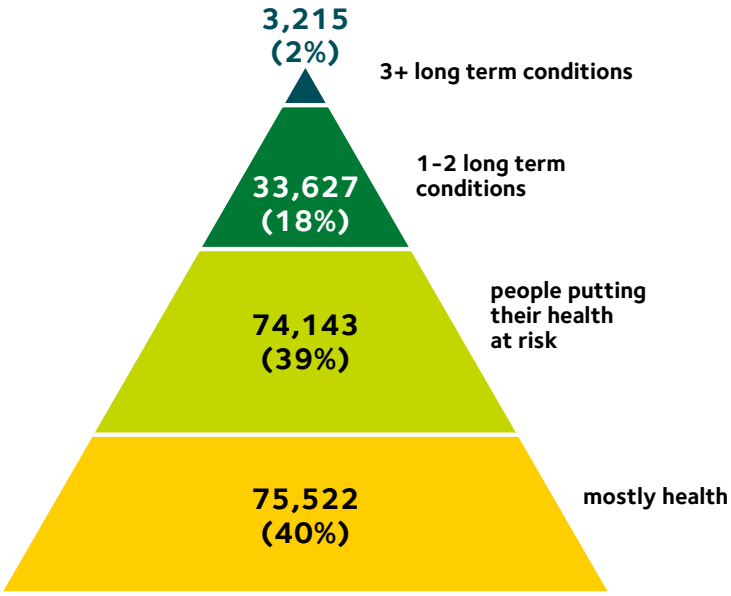
We will make Islington fairer and will focus on reducing inequalities in all that we do.

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

OUR POPULATION IN ISLINGTON

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

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



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

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

Household and families

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

23.6% are a couple with dependent children

20.8% are single-parent families with dependent children

36.0% are a couple without children

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

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

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

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

ISLINGTON'S HEALTH AND WELLBEING PRIORITIES

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

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

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

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

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

PRIORITY 1

Ensuring every child has the best start in life

Why is this important for Islington?

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

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

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

Where are we now?

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

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

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

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

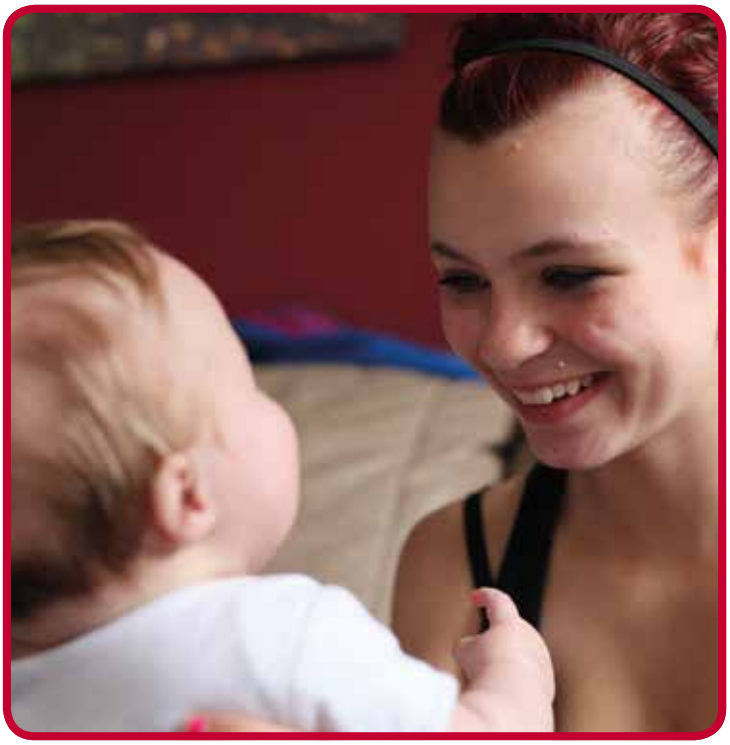
Immunisation rates for most of the major immunisation programmes have increased and are above London and national rates

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

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

What do we plan to do?

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



Improving outcomes for children and families

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

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

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

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

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

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

Driving integration across early childhood services

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

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

How will we know when we've achieved it?

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

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

PRIORITY 2

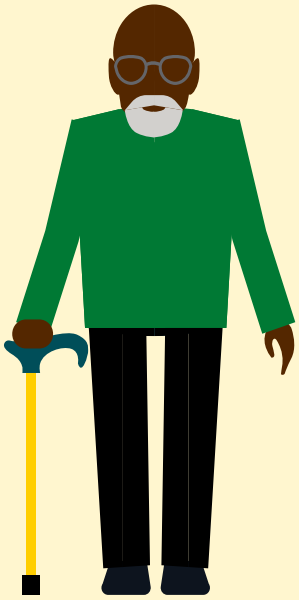
Preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities

Why is this important?

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

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

Where are we now?



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

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

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

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

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

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

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

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

What do we plan to do?

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

Embedding prevention and earlier intervention across the system

We will:

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

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

We will:

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

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

Promoting and enabling healthier lifestyles

We will:

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

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

We will:

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

How will we know when we've achieved it?

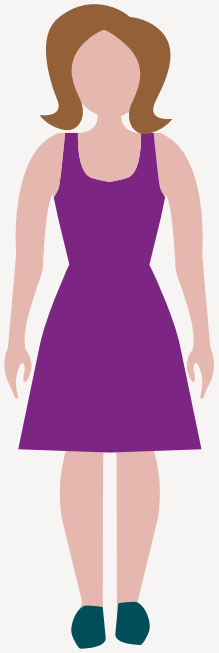
How will we know when we've achieved it?	How will we measure it?
More people living with long term conditions will report that they feel able and supported to manage their own care	➤ Percentage of people with a long term condition who have a care plan (GP Patient Survey) ➤ Percentage of people feeling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

PRIORITY 3

Improving mental health and wellbeing

Why is this important?

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



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

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

Where are we now?

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

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

Where are we now?

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

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

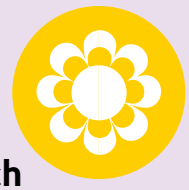
1 in 6 adults in Islington have at least one diagnosed mental health condition

Of children with a mental health condition in Islington,

more than half are undiagnosed

Between 2012-2014, there were

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



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

There is a

65% gap

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

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

mortality rate 3.6 times higher

than that of the general population in London and England

What do we plan to do?

Increasing focus on mental health and wellbeing for children and families

We will:

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

Increasing employment opportunities and workplace health

We will:

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

Working better as a system

We will:

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

Focusing on reducing violence and the harm it causes

We will:

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

Improving the physical health of people with mental health conditions

We will:

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

Supporting social connectedness

We will:

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

Preventing suicide

We will:

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

Increasing awareness and understanding

We will:

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

Focusing on dementia

We will:

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

Improving service access

We will:

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

How will we know when we've achieved it?

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

Islington's Draft Joint Health and Wellbeing Strategy Consultation

What do we want to consult on?

Islington's Health and Wellbeing Board (HWB) must set out a clear plan for how we will improve the health and wellbeing of people living in Islington over the coming years. This plan is the draft Islington Joint Health & Wellbeing Strategy 2017-20 (JHWS), and is jointly owned by the Council, Islington CCG and Islington HealthWatch.

Why do we want to engage with you?

Everyone has a role to play in improving the health and wellbeing of Islington's population. Therefore, everybody should be aware of this strategy, and have an opportunity to share their views on it.

We want your views

This consultation is about helping to shape the actions taken to achieve the three overarching health and wellbeing priorities agreed across Islington. The questions we would like you to respond to are detailed on the following page. In general terms we would like to hear your views on:

1. Do you agree that we have identified the right focus for improvement under each priority? Are there other areas of high priority that should also be included and, if so, why?
2. Have we selected the right measures to show improvement? Are there other ways to monitor and evaluate the outcomes that we should consider?
3. What role will you play in contributing to achieving the outcomes set out in this strategy?
4. Are there any other comments that you would like to make?

How to respond

The draft Joint Health and Wellbeing Strategy can be found on Islington Council consultation page. You can respond to the consultation through an online survey or by completing the form below. The online survey can be found here: https://www.surveymonkey.co.uk/r/T5YXFTK. The consultation form can also be found on the Islington Council consultation page.

If you wish to have this document in another format or language, please contact us at HWB@islington.gov.uk

The deadline to make a response to the consultation is: **7 December 2016**.

Consultation response form for Islington Draft Joint Health & Wellbeing Strategy 2017-20 (JHWS)

Name (organisation or individual):	
Priority outcome 1: Ensuring every child has the best start in life	
1. Do you agree that the actions under the "What do we plan to do?" section are right for ensuring every child has the best start in life?	
2. Are there any actions under the "What do we plan to do?" section that you feel should be included or excluded, and why?	
3. Do you think we have selected the right indicators to monitor and evaluate outcomes, under the "How will we know when we've achieved it?" section?	
Priority outcome 2: Preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities	
4. Do you agree that the actions under the "What do we plan to do?" section are right for preventing and managing long term conditions?	

5. Are there any actions under the “What do we plan to do?” section that you feel should be included or excluded, and why?	
6. Do you think we have selected the right indicators to monitor and evaluate outcomes, under the “How will we know when we’ve achieved it?” section?	
Priority outcome 3: Improving mental health and wellbeing	
7. Do you agree that the actions under the "What do we plan to do?" section are right to support improvements in mental health and wellbeing?	
8. Are there any actions under the “What do we plan to do?” section that you feel should be included or excluded, and why?	
9. Do you think we have selected the right indicators to monitor and evaluate outcomes, under the “How will we know when we’ve achieved it?” section?	

Further questions.	
10. What role will you play in contributing to achieving the priorities set out in this strategy?	
11. Are there any gaps in the Islington Joint Health and Wellbeing Strategy? What else should we include and why?	
12. Are there any other comments that you would like to make?	

Thank you for taking the time to take part in this consultation.

Please return your response to the consultation on the draft Joint Health and Wellbeing Strategy to: HWB@islington.gov.uk

Or

HWB consultation
Public Health
London Borough of Islington
3rd Floor
222 Upper Street
London, N1 1XR

By: **7 December 2016**

ISLINGTON

Chief Executive's Department
Town Hall, Upper Street, London N1 2UD

Report of: Executive Member for Health and Social Care

Meeting of	Date	Agenda Item	Ward(s)
Health and Social Care Scrutiny Committee	**17 November 2016**		**All**

Delete as appropriate	~~Exempt~~	Non-exempt

Report: Quarter 1 Performance Report

1. Synopsis

1.1 Each year the council agrees a set of performance indicators and targets which, collectively, help us to monitor progress in delivering corporate priorities and working towards our goal of making Islington a fairer place to live and work.

1.2 Progress is reported on a quarterly basis through the Council's Scrutiny function to challenge performance where necessary and to ensure accountability to residents.

1.3 This report sets out progress update for performance indicators related to Health and Social Care, over the first quarter of 2016-17 (i.e. 1 April to 30 June 2016).

2. Recommendations

2.1 To note progress to the end of Quarter 1 against key performance indicators falling within the remit of the Health and Social Care Scrutiny Committee.

3. Background

3.1 The council routinely monitors a wide range of performance measures to ensure that the services it delivers are effective, respond to the needs of residents and offer good quality and value for money. As part of this process, we report regularly on a suite of key performance indicators which collectively provide an indication of progress against the priorities which contribute towards making Islington a fairer place.

3.2 The full list of corporate performance indicators and targets for 2016-17 is set out in Appendix A.

3.3 This year, rather than Policy & Performance Scrutiny Committee (PPS) scrutinising all quarterly performance reporting, a new approach was agreed whereby each of the four theme based scrutiny committees – Children's Services, Health and Social Care, Environment & Regeneration, and Housing – will be responsible for monitoring performance in their own areas.

4. Quarter 1 update on Adult Social Care performance

4.1 This report contains an update on Adult Social Care indicators for Quarter 1.

Objective	PI No.	Indicator	Frequency	Actual Q1 Apr-Jun	Expected profile Q1	Target 2016-17	On/Off target (compared to profile)	Same period last year	Better than last year?
Support older and disabled adults to live independently	ASC1	Delayed transfers of care (delayed days) from hospital per 100,000 population aged 18+	Q	**620.7**	624.4	685.8	**On**	577.9	**No**
	ASC2	Percentage of people who have been discharged from hospital into enablement services that are at home or in a community setting 91 days after their discharge to these services	Q	**91%**	92%	92%	**On**	86.1%	**Yes**
	ASC3	Percentage of service users receiving services in the community through Direct Payments	M	**30.5%**	35%	35%	**Off**	30.3%	**Same**
Support those who are no longer able to live independently	ASC4	Number of new permanent admissions to residential and nursing care	M	**37**	N/A	105	**N/A**	34	**No**
Support carers	ASC5	Carers who say that they have some or all of their needs met (Score out of 12)	A	**7.3**	N/A	8	**N/A**	N/A	**N/A**
*Tackle social isolation faced by adult social care users **(E)***	ASC6	The percentage of working age adults known to Adult Social Care feeling that they have adequate or better social contact **(E)**	A	**64%**	N/A	70%	**N/A**	N/A	**N/A**

NB: Frequency (of data reporting): M = monthly; Q = quarterly; A = annual

Supporting independent living

4.2 Three measures are used to ensure that the Council is providing effective support to enable the most vulnerable to live independently for as long as possible.

4.3 The first, **delayed transfers of care from hospital**, has been introduced to the corporate PI suite this year and ensures that vulnerable residents are not left in hospital longer than they need to be, and that the Council and NHS work together to put in place adequate support arrangements to enable their release. The delayed days figure for Quarter 1 figures is 620.7 days, just ahead of the target of 624.4 days.

4.4 Delays at the Whittington, UCLH and St Pancras are monitored daily with a view to finding solutions for patients who are delayed in hospital, with action logs in place and updated regularly.

4.5 Islington is in the process of implementing a new initiative called the Single Health Resilience Early Warning Database (SHREWD) - an electronic monitoring system which allows key information to be shared electronically between health and social

care at the point when a patient is ready for discharge from hospital. This is a more efficient process than verbal and paper communication between staff involved in a patient's discharge. At present, we are the only council to adopt this technology but the Health and Social Care Information Centre is keen to roll this out nationally to improve communications between hospitals and local authorities.

4.6 A Rapid Response Service is being developed by the Islington Clinical Commissioning Group (CCG) to provide medical oversight of patients in their homes to prevent hospital admissions. Referrals will be made into the service by community GPs and Whittington Hospital's Enhanced Virtual Ward. The Reablement service will provide the social care element for those supported through the Rapid Response Service, through provision of short term carer support (up to 72 hours) to individuals in their homes.

4.7 On discharge from hospital, we've seen an improvement in the proportion who are **supported by our enablement service to return to the community within 91 days**. The Quarter 1 figure of 91% is better than the London average (85%) and an improvement on the end of year figure for 2015/16 (89%) and on the same period last year (86%). This is particularly impressive given the refocusing of our Reablement service upon those with the most complex support needs.

4.8 The third measure supporting this objective is the percentage of service users receiving services in the community through **Direct Payments**. These provide a budget directly to the service user to enable them to 'buy' their own package of support tailored to meet their needs.

4.9 The number of service users receiving Direct Payments is slowly increasing, and Islington has a higher proportion of Direct Payments compared to other London boroughs. However, the overall number of service users in receipt of care packages is also increasing, thus the proportion on Direct Payments has not increased and is below target.

4.10 In June 2016, there were 496 service users on Direct Payments, 1,243 on Virtually Managed Budgets (where the Council arranges the package of support) and 80 on a combination of DPs and VMBs.

Admissions into residential or nursing care

4.11 The Council provides residential or nursing care for those who are no longer able to live independently. The aim is to keep this number as low as possible, supporting more people to remain in the community. In Quarter 1, there were 37 **new permanent admissions to residential and nursing care for older adults** (aged 65 and over). This was higher than the number for the same period last year and, if this trend continues, we will exceed the target of 105 permanent admissions by the end of the year. This is due to the increasing age and complexity of needs of service users; they are typically older clients in their 80s and 90s whose needs are of such complexity that it is not always possible to support them to remain in a community setting. The Council needs to balance the benefits and costs of a community package of care against those of a residential care package.

4.12 A range of services exist to improve the quality of life for those who are admitted to permanent residential or nursing care. For example, a Lead Nurse works closely with eight nursing homes to support collaborative working into and across the homes. In recent inspections by the Care Quality Commission, quality of care in these homes was rated as 'outstanding' in one home and 'good' in the remaining seven.

4.13 Continuing professional development is provided for the care homes workforce. For example:

- Diabetes awareness sessions are currently being delivered by a Whittington Health Diabetes Specialist Nurse (DNS) and Dietician across care homes in the borough
- Chronic Obstructive Pulmonary Disease (COPD) awareness sessions are to commence in September 2016
- An inhaler workshop was delivered across all homes by pharmacists.
- Other training programmes such as the Cavendish Care Certificate and clinical supervision sessions facilitated by a link lecturer from Middlesex University

4.14 Other services provided within care homes include a Dysphagia pilot project and multi-disciplinary review meetings. The Integrated Community Ageing Team (iCAT) is in place to discuss cases and support understanding for improved decision making and learning.

4.15 To ensure service user safety, unannounced visits take place, led by the Lead Nurse and involving professionals from health and care services. Between January and June 2016, four quality assurance unannounced visits have taken place resulting in action plans to address gaps and identification of emerging themes to be addressed.

4.16 Nationally, Care Home Vanguards have been created with lessons learned from the six Vanguard areas. Good practice has been identified and shared with other local authorities. Islington is already demonstrating good practice in most of the themes identified, such as care homes having access to a consistent named GP, medicines reviews taking place, multi-disciplinary team support, and care homes having suitable networks to compare and share good practice.

Supporting carers

4.17 This is an annual indicator, measuring satisfaction of carers, so new data will not be available until next year. The Care Act puts a duty upon local authorities to meet the needs of carers. The Council has commissioned Age UK to engage and support more carers through the Islington Carers' Hub (ICH).

4.18 Data from the last quarter (April to June 2016) shows that there have been key improvements in the performance of the ICH, most notably:

- 12% quarter on quarter increase in new carers
- 3% quarter on quarter increase in carers accessing services (new and existing)
- 61% year on year increase in carers accessing services (new and existing)

4.19 Demographics of carers accessing support through ICH indicate that:

- 30% of new carers are in their 50s (comparable to the previous quarter and comparable to the total carers accessing support in the quarter)

- 46% of new carers are black and minority ethnic (BME) – an increase from 38% in the previous quarter. The BME Support Group remains our most well attended group and a valued resource to carers from the BME community
- 32% of all carers accessing support are male (an increase from 26% in the previous quarter)

4.20 There continue to be challenges in the implementation of the Carers Assessments across partners. At the request of Adult Social Care, the assessment forms have once again been modified and roll out of the new forms is underway.

4.21 The ICH undertakes its own annual survey of carers. The latest survey, undertaken in June 2016, directly reached all carers who had accessed support between 1 May 2015 and 30 April 2016 and was open to all carers via the ICH website. The survey highlighted some key findings:

- There is a diversity of routes by which carers find out about ICH support but friends and family and GPs remain the greatest source
- 89% would recommend ICH services to their friends and family
- The services have a strong record in meeting carers needs but it is harder for carers to understand the support in regards to 'outcomes'
- Carers remain digitally excluded with only 14% accessing the website, 7% accessing online advice and 11% accessing E-bulletins

4.22 Advice and Information remains our largest area of support provision with 60% of people accessing face to face support. Online advice through our website remains important but this is not the preferred method for carers. This is reflected in the percentage of respondents accessing the website and the E-bulletins suggesting a high level of digital exclusion for carers.

4.23 Of those accessing support, a high percentage agreed or strongly agreed that the support provided met their needs through the following services:

- Advice – 84% needs were met
- Information – 83% needs were met
- Support Services – 82% needs were met

4.24 While over 80% of carers felt their needs were met, when talking about meeting their outcomes this was more varied. For the majority of the outcomes listed, 30-40% were neutral (compared to 3% when looking at meeting needs) which could reflect a lack of understanding about the question or correlation between the support meeting their needs and the achievement of outcomes. Over the next 12 months we will be moving to monitoring outcomes with carers accessing case support and it is hoped that this will provide a greater clarity on the impact the support is having for carers.

Reducing social isolation

4.25 This is captured annually in the Adult Social Care Survey and the 2015/16 result is: 64.2%. The next update will be available in July 2017.

4.26 Reducing social isolation underpins much of the work commissioned by Adult Social Care. We continue to fund voluntary sector day care provision across the borough and are currently procuring a community enablement service. This service will

complement our mainstream reablement provision by providing short-term support to people to help reduce social isolation.

4.27 Our learning disability social inclusion service, seeks to reduce social isolation amongst people with learning disabilities by organising a range of leisure and social activities. Our new multi-disciplinary floating support service will commence in July 2016. This service will work with a range of clients to assist them in developing their independent living skills, to maintain their tenancies and to maximise their opportunities to become more socially included.

4.28 A number of our commissioned mental health services also help to reduce social isolation, for example through day service provision which encourages social inclusion through various creative group activities such as arts and crafts, cooking, creative writing, music and gardening.

5. Quarter 1 update on Public Health performance

Objective	PI No	Indicator	Frequency	Q1 Actual Apr-Jun	Q1 Target Apr-Jun	Target 2016-17	On/Off target	Same period last year	Better than last year?
Promote wellbeing in early years	PH1	Proportion of new births that received a face to face review within 14 days	Q	95%	90%	90%	**On**	new indicator	**new indicator**
	PH2	a) Proportion of children who have received the first dose of MMR vaccine by 2 years old	Q	93%	95%	95%	**Off**	92%	**Yes**
		b) Proportion of children who have received two doses of MMR vaccine by 5 years old	Q	89%	95%	95%	**Off**	88%	**Yes**
Reduce prevalence of smoking	PH3	a) Number of smokers accessing stop smoking services	Q	**332**	350	1,400	**Off**	649	**No**
		b) Percentage of smokers using stop smoking services who stop smoking (measured at four weeks after quit date)	Q	43%	54%	54%	**Off**	48%	**No**
Early detection of health risks	PH4	a) Percentage of eligible population (35-74) who have been offered an NHS Health Check	Q	10%	8.5%	20%	**On**	9%	**Yes**
		b) Percentage of those invited who take up the offer of an NHS Health Check	Q	35%	66%	66%	**Off**	46%	**No**
Tackle mental health issues	PH5	a) Number of people entering treatment with the IAPT service (Improving Access to Psychological Therapies) for depression or anxiety	Q	1,147	1,164	4,655	**On**	1,406	**No**
		b) Percentage of those entering IAPT treatment who recover	Q	52%	50%	50%	**On**	47%	**Yes**
Effective treatment for substance misuse	PH6	Percentage of drug users in drug treatment during the year, who successfully complete treatment and do not re-present within 6 months of treatment exit	Q	18%	20%	20%	**Off**	12%	**Yes**
	PH7	Percentage of alcohol users who successfully complete their treatment plan	Q	40%	42%	42%	**Off**	34%	**Yes**
Improve Sexual Health	PH8	Proportion of adults newly diagnosed with HIV with a late diagnosis (CD4 count less than 350 cells per mm).	Q	19%	25%	25%	**On**	new indicator	**new indicator**

Promote wellbeing in early years

5.1 In October 2015, responsibility for **health visiting** moved from the NHS to local authorities. A new corporate indicator has been added to enable us to monitor the service, using data on the proportion of births that receive a new birth visit within 14 days. Performance in the first quarter of 2016/17 exceeded the 90% *target.* We continue to move forward with the early years transformation work, developing the integration of health visiting and early years' services. A significant piece of work is underway reviewing how the Healthy Child Programme is being delivered to families and improving data collection.

5.2 Measles, mumps and rubella immunisation (MMR1) coverage for both two and five year olds has increased by 2 percentage point since quarter 4 2015/16 and has increased by 1 percentage point since the same quarter last year. While positive, rates remain under the target for population-level herd immunity of 95%. The Islington Childhood Immunisations Steering Group, a joint group of local and national public health and NHS partners, is working together to increase immunisations rates.

Reduce prevalence of smoking

5.3 Quarter 1 data on the number of people accessing **Stop Smoking Services** is just under target (332 people accessed the service compared to a target of 350 people). The percentage of service users who have stopped smoking is also below target – 43% of those who accessed the service quit compared to a target of 54%. A comprehensive review of the smoking cessation service, including residents from key target groups and stakeholders from partner organisations has been completed and a new service model to better meet the changing needs of the Islington population is being commissioned. This consists of a three tier model including self-support through an online and phone platform; engaging voluntary and community sector (VCS) and faith groups, alongside GPs and community pharmacies to deliver brief interventions and support; and a new tier 3 clinical service delivering support to entrenched smokers and harder-to-reach groups. Carbon monoxide (CO) monitoring was rolled out in the Whittington Trust maternity ward, as part of the support offer to pregnant smokers in quarter 1 2016/17.

Effective detection of health risks

5.4 A new service model for the community **NHS Health Checks** programme was introduced in quarter 1, bringing together pharmacy and outreach provision. Introduction of the new service, including implementation of a new booking system, has taken longer than anticipated resulting in a significant drop in the number of checks delivered. Nonetheless, the new service has been launched in seven Islington pharmacies and delivery of Health Checks is expected to improve in quarter 2.

Tackle mental health issues

5.5 More than 1,100 people with mental health issues were supported through our **Improving Access to Psychological Therapies (IAPT) programme** in quarter 1. Over half of those with initial problems severe enough to impact on their everyday functioning are moving towards recovery after treatment.

5.6 The Council has re-commissioned three mental health promotion services in Islington to support public mental health awareness and promote early access to treatment:

- The Mental Health Awareness training programme (Rethink) delivers training (including Mental Health First Aid) to frontline staff and the public
- The Direct Action Project (Peel Centre) develops mental health awareness and understanding amongst young people (age 11-24) through creative projects
- The Community Mental Health and Wellbeing Service (Manor Gardens) develops community mental health awareness through mental health champions and supports access to services for under-represented groups.

Effective treatment programmes to tackle substance abuse

5.7 There has been a small decrease in performance in quarter 1 compared to the previous quarter. This is likely to be attributable to the start of a new contract which saw the transfer of all prescribing (outside of primary care) to Camden and Islington NHS Foundation Trust. Performance is expected to improve in the coming quarters.

Improve sexual health

5.8 The proportion of adults newly diagnosed with HIV at a late stage of infection remains low, below the national upper limit of 25%, due to increasing awareness around sexually transmitted infections (STIs) and good access to testing in Islington. The data represents combined figures from Central and North West London (CNWL) NHS Trust as these data are not available at a borough level on a quarterly basis.

5.9 CNWL continues to deliver high quality HIV testing and met the target of 97% of sexual health service users offered HIV testing at first attendance during quarter 1 2016/17.

NB: Due to reporting limitations the above figures relate to both open access services, CNWL and cover a group of users wider than Islington residents.

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Final Report Clearance

Signed by …… …….
Date

Received by …… …….
Date

Appendix A

Corporate performance indicators and targets 2016-17

ADULT SOCIAL SERVICES							
Objective	**PI No.**	**Indicator**	**Frequency**	**2016/17 Target**	**2015/16 Actual**	**2014/15 Actual**	**Comments**
Support older and disabled adults to live independently	ASC1	**NEW:** Delayed transfers of care (delayed days) from hospital per 100,000 population aged 18+	Quarterly	685.8	N/A	N/A	Target set by Better Care Fund. This measures our ability to put in place support arrangements for vulnerable adults leaving hospital NB: Issues with data collection in previous years means that there are no reliable figures for 2014/15 and 15/16
	ASC2	Percentage of people who have been discharged from hospital into enablement services that are at home or in a community setting 91 days after their discharge to these services	Quarterly	92%	89.2%	84.7%	Target set by the Better Care Fund. This would put Islington in the top quartile for similar local authorities.
	ASC3	Percentage of service users receiving services in the community through Direct Payments	Monthly	40.0%	30.9%	31.4%	
Support those who are no longer able to live independently	ASC4	Number of new permanent admissions to residential and nursing care	Monthly	105	106	125	Target set by Better Care Fund.
Support carers	ASC5	Carers' reported quality of life	Annual (Survey July)	8	7.6	new indicator	Based on responses in Annual Carers Survey. Composite measure using responses to survey questions covering 6 domains: occupation, control, personal care, safety, social participation and encouragement and support. For each area, carers are asked to say whether they have all needs met, some needs met or no needs met. Max score for each domain 2. Max total score is 12.
*Tackle social isolation faced by disabled people and other vulnerable adults **(E)***	ASC6	The percentage of working age adults known to Adult Social Care feeling that they have adequate or better social contact. **(E)**	Annual (July survey)	70%	64.2%	N/A	

CHILDREN'S SERVICES							
Objective	**PI No.**	**Indicator**	**Frequency**	**2016/17 Target**	**2015/16 Actual**	**2014/15 Actual**	**Comments**
Improve access to and uptake of good quality Early Years provision	CS1	Percentage of 2 year old places taken up by low income families, children with Special Educational Needs or Disabilities (SEND) or who are looked after	Termly (July, November & March)	72%	63% (704)	55% (634)	The % is based on the number of children in funded places compared to the size of the list of eligible parents received from the DWP.
	CS2	Percentage of families with under-5s registered at a Children's Centre	Termly (July, November & March)	92%	91%	88%	The 97% target reflected the requirement for 'outstanding' in the Ofsted Children's Centre Inspection Framework. However, inspections under this framework are currently on hold. This is a stretch target, as our reach is already very high.
	CS3	Number of active childminders	Quarterly	195	187	191	
Support families facing multiple challenges and disadvantage	CS4	Number of families in Stronger Families programme with successful outcomes as measured by payment by results	2 claims a year - September and January for 15/16	100	30 families (4%) (Phase 2)	815 families (100%) (Phase 1 - cumulative over 4 years)	There are different criteria for Phase 1 and Phase 2 in this programme, so the numbers are not comparable.
Safeguard vulnerable children	CS5	Number of new mainstream foster carers recruited in Islington	Monthly	12	9	New indicator	
	CS6	Number of children missing from care	Monthly	10 or fewer	18	New indicator	
Ensure all pupils receive a good education in our schools	CS7	Percentage of primary school children who are persistently absent (defined as below 90% attendance)	Termly (July, November & March)	11% or below	9.5%	New indicator	The target reflects the government's new, stricter, definition of persistent absence
	CS8	Number of children in Alternative Provision	Quarterly	100 or fewer	127	153	
	CS9	Percentage of pupils achieving five or more A*-C grade GCSEs (including Maths and English)	Annual	At or above the inner London average	57.9%	59.9%	Inner London average for 2015/16 was 59.7%.
Ensure suitable pathways for all school leavers	CS10	Percentage of Islington school leavers in Year 11 who move into sustained education or training	Report after year end	98%	96.7%	94.4%	

CRIME & COMMUNITY SAFETY							
Objective	**PI No.**	**Indicator**	**Frequency**	**2016/17 Target**	**2015/16 Actual**	**2014/15 Actual**	**Comments**
Reduce youth crime and reoffending	CR1	**NEW:** Percentage of young people (aged 10-17) triaged that are diverted away from the criminal justice system	Quarterly	85%	80%	86%	MOPAC Target
	CR2	Number of first time entrants into Youth Justice System	Quarterly	95 or fewer	102	90	MOPAC Target
	CR3	Percentage of repeat young offenders (under 18s)	Quarterly	43% or below	48%	43%	MOPAC Target
	CR4	**NEW:** Number of custodial sentences for young offenders	Quarterly	35 or fewer	37	30	Islington has a relatively high rate compared to other areas. Our focus is on preventing young people receiving a custodial sentence as future outcomes are worse if they do
	CR5	Number of Islington residents under 25 who receive a substantive outcome (i.e. charge, caution etc.) after committing a violent offence	Quarterly	329	346	364	Target is based on a 5% decrease on 2015/16. This measure only captures those who have received an outcome
Increase the number of offenders into Education, Training & Employment	CR6	**NEW:** Number of Integrated Offender Management (IOM) cohort in employment	Quarterly	25	25	26	MOPAC Target NB: these will also be included in the Council's Employment support target
	CR7	**NEW:** Number of IOM cohort in education and training	Quarterly	25	57	32	MOPAC Target
Ensure an effective response for victims of crime and anti-social behaviour	CR8	**NEW:** Number of repeat ASB complainants to Police and Council	Quarterly	53	55	52	MOPAC Target – Repeat callers are those who call 10 + times, identified through analysis of police 101 & 999 and council ASB line calls
	CR9	Percentage of ASB reports which are responded to, verified and then repeat over the following three months	Quarterly	38%	40%	36%	
	CR10	Percentage of housing ASB cases that result in enforcement action	Quarterly	35%	36%	32%	Enforcement actions include use of Notices Serving Possession, Injunctions, Possession Orders and Eviction Orders as an appropriate action.

CRIME & COMMUNITY SAFETY (continued)							
Objective	**PI No.**	**Indicator**	**Frequency**	**2016/17 Target**	**2015/16 Actual**	**2014/15 Actual**	**Comments**
Tackle Violence against Women and Girls (VAWG)	CR11	**NEW:** Percentage of repeat victims referred to the Domestic Violence MARAC	Quarterly	15%	10.6%	14.4%	MOPAC Target - linked to Domestic Violence MARAC (Multi-Agency Risk Assessment Conference)
	CR12	**NEW:** Number of young victims (aged 16 - 18) referred to the MARAC	Quarterly	10	4	6	MOPAC Target
	CR13	**NEW:** Number of domestic violence perpetrators with complex needs referred to the Domestic Violence MARAC	Quarterly	72	53	63	MOPAC Target
	CR14	**NEW:** Rate of domestic abuse sanction detections	Quarterly	40%	34%	39%	MOPAC Target
*Tackle hate crime through increased reporting and detection **(E)***	CR15	a) Number of Homophobic Offences reported to police **(E)**	Quarterly	96	87	86	In order to tackle hate crime, we need to encourage people to feel able to report it and, when they do, provide reassurance that more reports will actually result in a detection The targets set for 2016-17 aim for a 10% increase on 2015/16
		b) Number of Homophobic Offences detected by police (sanction detections) **(E)**	Quarterly	30	27	14	
	CR16	a) Number of Racist Offences reported to police **(E)**	Quarterly	638	580	517	
		b) Number of Racist Offences detected by police (sanction detections) **(E)**	Quarterly	210	191	179	
	CR17	a) Number of Disability Hate Offences reported to police **(E)**	Quarterly	19	17	10	
		b) Number of Disability Hate Offences detected by police (sanction detections) **(E)**	Quarterly	3	3	0	
	CR18	a) Number of Faith Hate Crime Offences reported to police **(E)**	Quarterly	77	70	53	
		b) Number of Faith Hate Crime Offences detected by police (sanction detections) **(E)**	Quarterly	19	17	9	

EMPLOYMENT							
Objective	**PI No.**	**Indicator**	**Frequency**	**2016/17 Target**	**2015/16 Actual**	**2014/15 Actual**	**Comments**
Support Islington residents with more complex needs into sustained employment	E1	a) Total number of people supported into paid work through council activity, with sub-targets for:	Quarterly	1,100	1,153	1,023	The target for 2016-17 is slightly below last year's achievement to reflect a decrease in resources together with a renewed focus on those who face significant barriers into employment. Individuals can be counted under more than one sub-target e.g. disabled and a parent, or young person and apprentice – but will only be counted once in the overall figure The overall target and the sub-targets include apprenticeships and offenders from the Integrated Offender Management (IOM) programme
		b) Islington parents of children aged 0-15	Quarterly	385	385	389	
		c) Young people aged 18-25	Quarterly	300	342	237	
		d) Disabled people / those with long term health conditions **(E)**	Quarterly	200	192	43	
	E2	Percentage of residents supported into paid work through council activity, who remain in employment for at least 26 weeks	Quarterly	55%	149	New indicator	Sustained employment will be measured by contacting clients six months after they've taken up their new job to see if they are still in employment (so anyone not yet in work for 6 months will not be counted in the figure)
*Increase proportion of disabled people in employment **(E)***	E3	Percentage gap between employment rate for residents with long term health conditions and overall Islington employment rate **(E)**	Annual (1year + data lag)	14.2%	tbc (data not yet released)	17.3%	Data source is the Annual Population Survey of the Labour Force Survey; with substantial lag in reporting. Target is to reduce the gap from 15.7% in 2013-14 to 13.2% by March 2019
	E4	Number of Islington working age residents claiming Employment Support Allowance or Incapacity Benefit **(E)**	Quarterly (6 months in arrears)	12,550 (Nov 16)	12,620 (Nov 15)	12,820 (Nov 14)	Equalities target. Aiming to reduce figures to 10,125 by 2019 This was calculated on the Inner London average ESA claimant rate at the time and the size of the reduction Islington would need to achieve to meet this (reduction of 2,695 by 2019)
Promote apprenticeships	E5	Number of people supported into an apprenticeship: a) Within the council b) With an external employer	Quarterly Quarterly	50 50	44 60	34 New indicator	These targets do not reflect the requirements under the Apprenticeships Levy. This comes into effect from April 2017 and targets for internal and external apprenticeships will reflect the new requirements NB: These figures are also included in the overall target of people supported into employment (above)

ENVIRONMENT & REGENERATION							
Objective	**PI No.**	**Indicator**	**Frequency**	**2016/17 Target**	**2015/16 Actual**	**2014/15 Actual**	**Comments**
Effective disposal of waste and recycling	ER1	Percentage of household waste recycled and composted	Monthly	35.2%	Tbc (mid-August)	32.8%	Target for 16/17 is a North London Waste Authority (NLWA) target.
	ER2	Number of missed waste collections - domestic and commercial (per calendar month)	Monthly	450	407	380	To put this in context, there are around 2.08 million waste collections each month
Deal promptly with planning applications	ER3	a) Percentage of planning applications determined within the target (majors)	Monthly	85%	82.5%	86.5%	For ”others” 85% would place Islington in the (top quartile in London)
		b) Percentage of planning applications determined within the target (minors)	Monthly	84%	83.7%	80.7%	
		c) Percentage of planning applications determined within the target (others)	Monthly	85%	86.0%	86.2%	
Promote and increase use of libraries and leisure centres	ER4	Number of leisure visits	Quarterly	2.145m	2.382m	2.062m	2% increase on 14/15 baseline and contractual with GLL for 15 years.
	ER5	Number of library visits	Quarterly	1.021m	1.021m	1.073m	16/17 target is to maintain 15/16 levels.
Tackle fuel poverty	ER6	Residents’ energy cost savings (annualised)	Quarterly	£223,500	£228,000	£269,770	The target for 2016/17 reflects an anticipated reduction in Energy Doctor visits (from 800 to 750), and Warm Home Discounts (from 1184 to 800) due to planned Government changes) Referrals to these services are made through SHINE - the Seasonal Health Intervention Network The costs savings are based on an average £90 per household from an Energy Doctor visit and £140 per household from Warm Homes Discount

RESOURCES: FINANCE, CUSTOMER SERVICES & HR							
Objective	**PI No.**	**Indicator**	**Frequency**	**2016/17 Target**	**2015/16 Actual**	**2014/15 Actual**	**Comments**
Optimise income collection	R1	Percentage of council tax collected in year	Monthly	96.5%	96.5%	96.3%	
	R2	Number of council tax payments collected by direct debit	Monthly	59,000	57,354	56,101	
	R3	Percentage of business rates collected in year	Monthly	99.0%	99.1%	99.0%	
Improve customer access and experience through appropriate channels	R4	Number of visits in person at Customer Contact Centre	Monthly	185,000	189,096	199,897	This target aims for a 2.5% reduction in visitor volumes as more residents are encouraged to go online
	R5	Number of telephone calls through Contact Islington call centre	Monthly	475,000	497,530	526,993	This target aims for a 4.5% reduction on 15/16, again reflecting a shift to online transactions
	R6	Number of online transactions	Monthly	165,000	147,159	119,267	The target for 16/17 is a 12% increase in online transactions. This includes transactions through My e-Account, the business portal, housing repairs and the 'Say I do' sites.
	R7	Percentage of calls into Contact Islington handled appropriately	Monthly	97.0%	98.0%	97.0%	'Appropriately' is based on 10 criteria including questioning skills, listening, being polite and friendly, offering the most appropriate solution, and clearly explaining next steps
Fair and effective management of council workforce	R8	Average number of days lost per year through sickness absence per employee	Quarterly	6.00	7.10	6.89	
	R9	Percentage of workforce who are agency staff	Quarterly	11.7%	13.2%	16.7%	Long term target is to reduce agency staff to 10% by March 2018
*Increased representation of BME / disabled staff at senior level **(E)***	R10	Percentage of BME staff within the top 5% of earners **(E)**	Quarterly	20.6%	19.6%	20.0%	Equalities target: Aim is to achieve even progression across all groups by 2019 and to increase the proportion of BME staff in senior management roles.
		Percentage of disabled staff within the top 5% of earners **(E)**	Quarterly	4.8%	3.5%	4.2%	

HOUSING							
Objective	**PI No.**	**Indicator**	**Frequency**	**2016/17 Target**	**2015/16 Actual**	**2014/15 Actual**	**Comments**
Increase the supply of and access to suitable affordable homes	H1	Number of affordable new council and housing association homes built	Quarterly	460	241	252	Four year target of 2,000 by end of Mar 2019.By affordable housing we mean Social Rented and Shared Ownership
	H2	Number of severely overcrowded households that have been assisted to relieve their overcrowding	Quarterly	78	78		This is the same as 2015-16's 'Actual' figure and will be extremely hard to achieve given the reduction in lettings from the forced sale of high value council homes.
	H3	Number of under-occupied households that have downsized	Quarterly	200	179	170	
Ensure effective management of council housing stock	H4	Percentage of LBI repairs fixed first time	Monthly	85.0%	84.5%	90.3%	'Fixed first time' puts the focus upon resolving repairs in a single visit.
	H5	Major works open over three months as a % of Partners' total completed major works repairs	Monthly	1.0%	1.6%	New indicator	We want this to be as near to 0% as possible. We are aiming for all major works by Partners to be completed in 3 months
	H6	a) Rent arrears as a proportion of the rent roll - LBI	Monthly	2.0%	1.7%	1.8%	
		b) Rent arrears as a proportion of the rent roll - Partners	Monthly	2.0%	2.2%	2.3%	
Reduce homelessness	H7	Number of households accepted as homeless	Monthly	400	375	396	
	H8	Number of households in nightly-booked temporary accommodation	Monthly	400	500	457	

PUBLIC HEALTH							
Objective	**PI No.**	**Indicator**	**Frequency**	**2016/17 Target**	**2015/16 Actual**	**2014/15 Actual**	**Comments**
Promote wellbeing in early years	PH1	**NEW:** Proportion of new births that received a health visit	Quarterly	90%	New indicator	New indicator	In 2016, responsibility for health visits moved from the NHS to local authorities
	PH2	a) Proportion of children who have received the first dose of MMR vaccine by 2 years old	Quarterly	95%	91%	93.6%	
		b) Proportion of children who have received two doses of MMR vaccine by 5 years old	Quarterly	95%	86%	89.7%	
Reduce prevalence of smoking	PH3	a) Number of smokers accessing stop smoking services	Quarterly	1,400	2,356	2,762	The lower target reflects the decrease of the value of the contract while new service is being shaped.
		b) Percentage of smokers using stop smoking services who stop smoking (measured at four weeks after quit date)	Quarterly	49%	48%	46%	The target is an average across different strands of the programme. The rate was reduced due to the decrease of the value of the contract while a new service offer is being shaped.
Early detection of health risks	PH4	a) Percentage of eligible population (35-74) who have been offered an NHS Health Check	Quarterly	20.0%	29.0%	22.5%	This is a five year rolling programme – aiming at 20% of the eligible population each year.
		b) Percentage of those invited who take up the offer of an NHS Health Check	Quarterly	66.0%	52.0%	66.9%	This is an aspirational target, set nationally.
Tackle mental health issues	PH5	a) Number of people entering treatment with the IAPT (Improving Access to Psychological Therapies) service	Quarterly	4,655	5,357	4,534	
		b) Percentage of those entering IAPT treatment who recover	Quarterly	50%	48%	New indicator	
Effective treatment for substance misuse	PH6	Percentage of drug users in drug treatment during the year, who successfully complete treatment and do not re-present within 6 months of treatment exit	Quarterly (with 6 month delay)	20%	18.1%	New indicator	
		Percentage of alcohol users who successfully complete the treatment plan	Quarterly	42%	40.1%	New indicator	
Improve sexual health	PH7	**NEW:** Proportion of adults with a late diagnosis of HIV	Quarterly	25%	N/A	N/A	This measures the success of our sexual health services in encouraging people to have HIV tests, to reduce late diagnosis for HIV.

ISLINGTON

Housing & Adult Social Services
7 Newington Barrow Way, N7 7EP

Report of: **Corporate Director of Housing and Adult Social Services**

Meeting of:	**Date**	**Ward(s)**
Health and Care Scrutiny	17 November 2016	All

Delete as appropriate	~~Exempt~~	Non-exempt

SUBJECT: Islington Adult Social Care Report and Local Account

1. Synopsis

1.1 The Islington Adult Social Care Report gives an overview of achievements for 2015/16 and areas of focus for the coming year.

1.2 The Local Account is an annual report for residents of Islington, which this year has been co-produced with experts by experience. It also includes aspects of the Islington Adult Social Care Report where relevant.

1.3 This paper provides some background information relating to the Islington Adult Social Care Report and the Local Account.

2. Recommendation

2.1 Health Scrutiny Committee are asked:

- **Note** the contents of the Islington Adult Social Care Report and the Local Account.

3. Background

3.1 The Islington Adult Social Care Report confirms a commitment to the principles described in the Corporate Plan.

3.2 One of these commitments is to support people into employment and this is a key focus for 2016/17 as we move forward with commissioning for prevention, as shown in the Adult Social Care Report. The Local Account provides an example of how we have worked through commissioned services to support someone into employment who has a mild learning disability. This honest account, written by the expert by experience, gives a unique viewpoint of someone who is satisfied with the services received, while demonstrating some of the challenges along the way. It is of interest to people with similar needs and also to professionals in this area of work. Housing and Adult Social Services is already making use of the story to further improve the experience of people with mild learning

disabilities.

3.3 Another principle of the Corporate Plan is that we provide people-centred services. The Moving Forward Programme, mentioned in the Islington Adult Social Care Report, continues to support this principle. For example, one of the workstreams within the programme covers improvements to disability services. The Local Account gives an example of personalisation within learning disability services, which is an account provided by the carer of a young person with learning disabilities in transition from Children's to Adults' Services. Again, it shows the experience of the parent and young person as services were developed over a period of time. It shows a high level of satisfaction with the services provided although the journey along the way was not as smooth as hoped. At a national level, the parents of young people leaving Children's Services often feel they are on the edge of a cliff as these services change or end. However, the account shows that services can be set up which meet the needs of the young person as they enter adulthood in a positive way. The experience shown in the account is now being used by Housing and Adult Social Services to learn and apply any lessons about communication with parent carers.

3.4 Co-production is a key principle of the Corporate Plan. The Islington Adult Social Care Report gives a number of examples of co-production in the page relating to co-production and qualitative research. One example of co-production is the method used to create the Local Account. This year it has been co-produced through a series of workshops with experts by experience. They were key to shaping the look and content of the document. Contributions from people who use our services were then gathered and anonymised. Contributors have signed accessible confidentiality agreements.

3.5 The experts by experience were keen to ensure that the Local Account was accessible to all residents of Islington, that it showed a variety of services, that it gave a balanced view of performance without complex charts and statistics and that it showed people who may be in similar circumstances how to gain access to services.

3.6 The rest of the Islington Adult Social Care Report includes statistics and information relating to characteristics of people receiving services, details of adult social care finances and Safeguarding.

4. Implications

4.1 **Financial implications**
None Identified

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.

4.2 **Legal Implications**
No legal implications for the local authority directly arise from the content of these reports.

4.3 **Environmental Implications**
There are no significant environmental implications resulting from these reports.

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.

A Resident Impact Assessment has not been completed because these are reports providing information about performance and services in 2015/16.

Signed by:

Corporate Director of Housing and Adult Social Services Date: 8 November 2016

Appendices

- Islington Adult Social Care Report

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ISLINGTON

HEALTH IN ISLINGTON: Key achievements

Cllr Janet Burgess

Presentation to Health Scrutiny
November 2016

Life expectancy

- Since 2000-02, life expectancy has **increased** in Islington for both men and women.
- Life expectancy at birth for men in Islington is now 79 years, an increase of 5.5 years since 2000. However life expectancy for men in Islington remains lower than London (80.3) and England (79.5) and is **the 8th lowest amongst all London boroughs**.
- For women in Islington life expectancy is 83.5 years and is similar to England (83.2).
- In Islington the **difference** in life expectancy between people in the **best-off** and **worst-off** areas of the borough is **6.5 years for men** and **2.0 years for women.**

Life expectancy at birth

Men	2000-02	2012-14	Percentage increase
Islington	**73.5**	**79.0**	**7.4%**
London	75.8	80.3	5.9%
England	76.0	79.5	4.6%

Women	2000-02	2012-14	Percentage increase
Islington	**79.1**	**83.5**	**5.6%**
London	80.8	84.2	4.2%
England	80.7	83.2	3.1%

Source: Public Health Outcomes Framework, 2016

Islington's Health and Wellbeing Board priorities (2017-2020)

Ensuring every child has the best start in life

- Improving outcomes for children and families
- Driving integration across early childhood services
- Remaining focused on prevention and early intervention.

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

- Addressing wider causes of poor health: particularly housing, employment and isolation
- Promoting and enabling healthier lifestyles
- Providing a collaborative, coordinated, and integrated care offer to residents

Improving mental health and wellbeing

- Increasing focus on mental health and wellbeing for children and families
- Increase employment opportunities and workplace health
- Focusing on reducing violence and the harm it causes
- Improving the physical health of people with mental health conditions
- Working better as a system to provide a better holistic service to people with multiple needs which include mental health
- Focusing on dementia
- Improving service access

ISLINGTON

ENSURING EVERY CHILD HAS THE BEST START IN LIFE

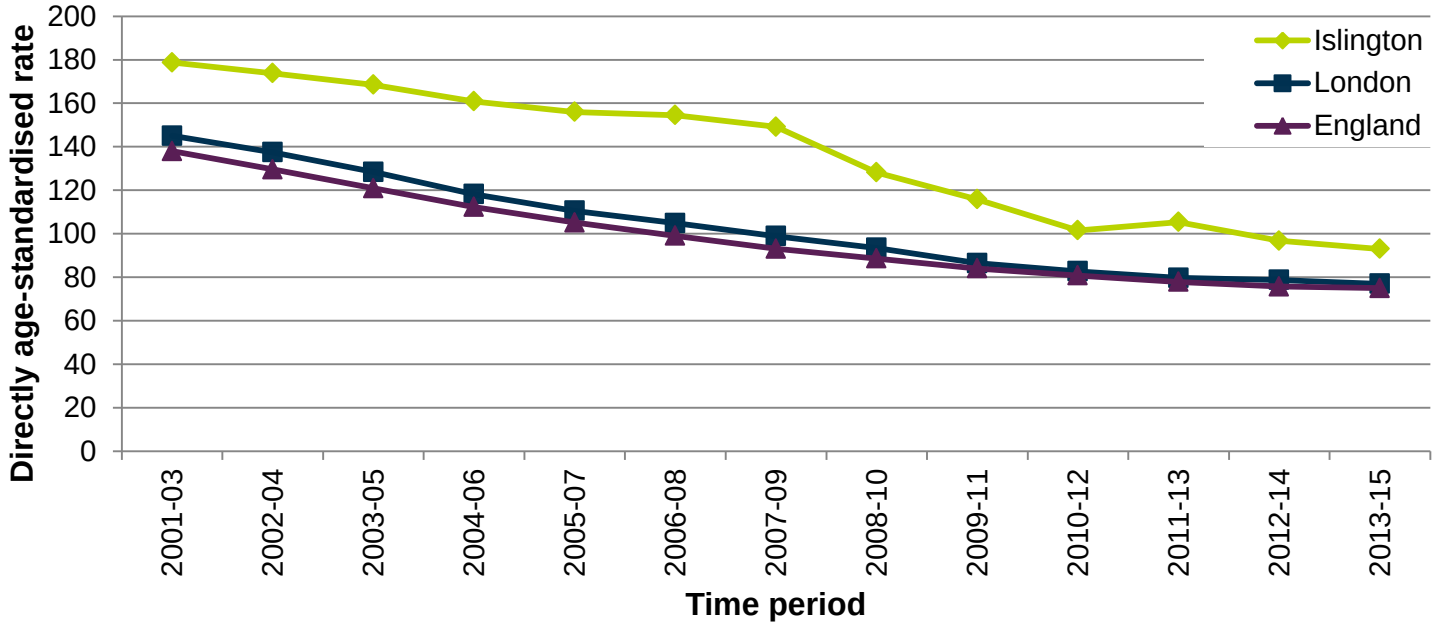
Key achievements – Best start in life

- Infant deaths have continued to reduce. Islington has the 5th **lowest rate of infant mortality** of all local authorities in England and a significantly lower rate compared to England (2.6 deaths per 1,000 live births versus 4 in England).
- The percentage of babies being **breastfed** at 6-8 weeks (88%) is better than England (74%).
- Islington has seen a **significant reduction in teenage pregnancy rates**, which have more than halved in five years.
- Islington continues to perform well in all childhood immunisations. 91.5% of children aged 2 years **immunised** against MMR, which the fifth highest rate in London. Significant improvement in the uptake of school aged immunisations in 2014/15, with Islington having one of the highest uptake rate of HPV immunisation in London.
- Joint **Child Health Strategy** focuses on implementation of an early intervention and prevention approach across all professionals and settings
- The percentage of children achieving a **good level of development** at reception year is improving but remains below the national average.
- **Children's oral health has improved.** The proportion of children aged 5 years old who experienced tooth decay has dropped from 30% in 2012 to 24% in 2015.
- In October 2015, responsibility for **health visiting** successfully moved from the NHS to local authorities. Over 90% of births receive a new birth visit within 14 days.

Key challenges – Best start in life

- **Childhood excess weight continues to be a challenge in Islington.**
- **In 2014/15 almost a quarter (22%) of children aged 4-5 years old had excess weight.** The rate has not changed significantly over the past 3 years and is currently similar to England and London.
- **Amongst children aged 10-11 years old more than a third (37%) had excess weight** in 2014/15. There has been a rise in the last two years and the rate is similar to London but higher than England.
- Referrals and uptake for the Tier 3 weight management programmes, tailored for children with additional needs, remain a challenge.
- To address obesity levels we need to take a systems-based perspective to tackling obesity – looking at every aspect of the local environment and collaborate with the community and voluntary sectors- youth clubs and independent housing/social care workers/troubled families to engage with the most vulnerable communities.
- Transformation of early years including integration of early year services and transformation of the early years workforce.

Directly age-standardised premature mortality rates attributable to CVD per 100,000 population, resident population aged <75 years old, Islington, London and England, 2001-03 to 2013-15



Source: Public Health Outcomes Framework, November 2016

What is being done locally?

ISLINGTON

- **Early years transformation:** building on the first 21 months programme we are aiming to improve early intervention in pregnancy and the first few years of life. The programme is driving key services to work in a more integrated way. This includes health visiting and family nurse partnership.
- **Islington Healthy Children's Centre and healthy early years programme:** Being recognised as a Healthy Children's Centre or other early years settings, e.g. nurseries and childminders means that the setting offers a good level of support for Islington's key health priorities for young children and families.
- Many policies and services in Islington help to **prevent childhood obesity** as they specifically improve healthy eating and increase physical activity, including **free school meals** for all primary school pupils, the **healthy schools programme**, and our new families for life offer.
- Islington aims to reduce oral health inequalities by **increasing knowledge of key oral health messages**, **increasing the availability of fluoride,** and **increasing access to local NHS dental services**. Key programmes include **Community-based fluoride varnish programme, the Brushing for Life scheme**, and **First tooth First Visit Dental Referral Initiative** and **Healthy Children's Centre Programme.**
- Islington has a strong **focus on promoting healthy relationships and reducing risk associated with sexual behaviour, including reducing teenage pregnancy prevention programme and sexually transmitted infections. This** encompasses sex and relationship education, advice and access to contraception services. Services provided are both universal and targeted to those young people who have particular vulnerabilities or needs.
- Islington is developing its approach to good mental health for children and young people through the mental health resilience and school (MHARS) programme.

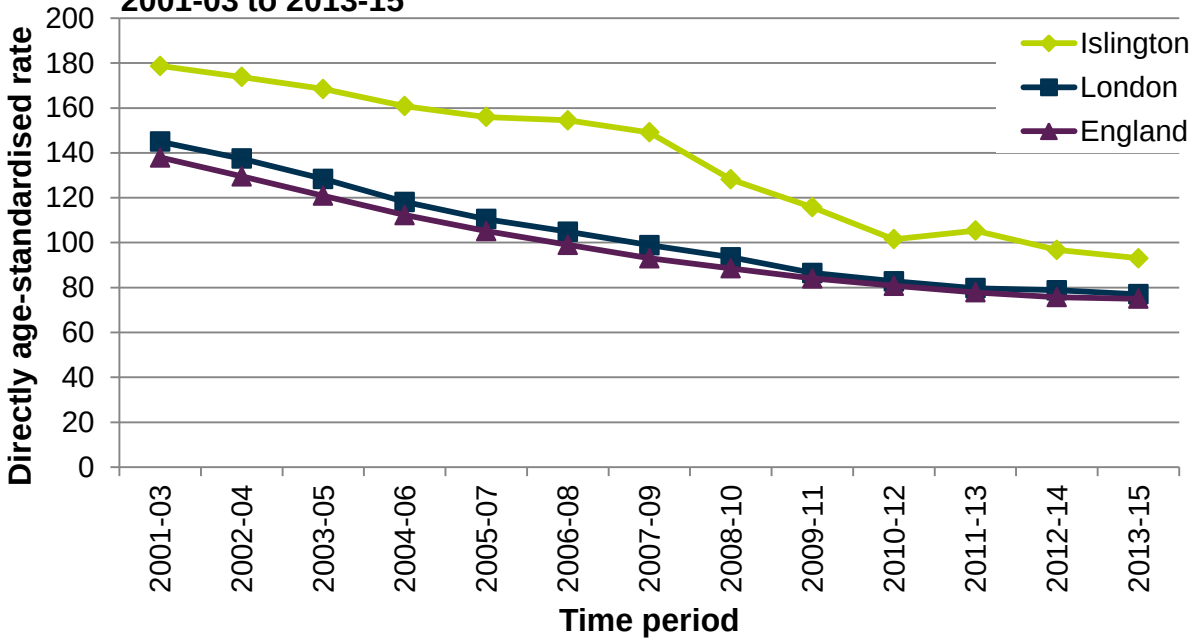
ISLINGTON

PREVENTING AND MANAGING LONG-TERM CONDITIONS (LTCS) TO ENHANCE BOTH LENGTH AND QUALITY OF LIFE AND REDUCE HEALTH INEQUALITIES

Key achievements - LTCs

- 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% reduction). However, the rates remain higher than the national and London averages.
- Since 2001-03, **premature cancer mortality has fallen** substantially but the rate is still **higher than England**.
- **Premature mortality from respiratory disease has fallen** and the rate is now similar to England and London.

Directly age-standardised premature mortality rates attributable to CVD per 100,000 population, resident population aged <75 years old, Islington, London and England, 2001-03 to 2013-15



Source: Public Health Outcomes Framework, November 2016

Key achievements – LTCs continued..

- Islington had the **lowest late diagnosis rate of HIV** amongst all London boroughs in 2012-14.
- **Over half** of adults in Islington are overweight or obese (52%). This percentage is **lower** than the London and England averages. 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
- The NHS Health Checks programme has continued to perform well. Islington yet again exceeded the national target for NHS Health Check offers. Almost 8,700 Health Checks were delivered to residents aged 35 to 74 in 2015/16.
- There has been a significant redesign of the **substance misuse treatment service** pathway in Islington to better meet changing local needs, whilst maximising value for money. Work will continue during 2016/17 to ensure that service users are discharged from treatment promptly but appropriately in order to maintain their recovery.

Key challenges - LTCs

- In 2014 Islington had the **highest** prevalence of smoking in London based on data from the Integrated Household Survey. Significantly 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.
- **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 all some of the worst in London**. Generally, in Islington, these rates have declined over the last five years, although these declines are not, statistically, significant.
- We continue to have **significantly worse admissions** to hospital as a result of alcohol, and the rates have increased in Islington over the last five years.
- There remain a significant number of people with undiagnosed COPD, diabetes, heart disease and hypertension. Case finding and earlier detection of these conditions are essential to ensure our residents can benefit from appropriate treatment and management of their conditions (including support for self care), to slow disease progression, and to improve health outcomes, missing opportunities for

What is being done locally?

- **NHS Health Checks programme:** designed to prevent heart disease, stroke, diabetes and kidney disease by identifying and treating people at high risk through targeting 35-74 year olds. During the Health Check individuals are also offered lifestyle advice.

- **Cancer screening** aims to detect early stage cancers or pre-malignant disease. Currently, three national cancer screening programmes for **breast, bowel and cervical cancer** are offered to eligible populations in Islington. Locally we have provided a locally focussed boost to the national "Be Clear on Cancer" Campaign.

- **Diabetes prevention programme** Islington is one of the first boroughs to roll out the national Diabetes Prevention Programme. The service supports people with pre-diabetes, preventing them from developing the condition

- GP and pharmacy local commissioned services focussing on early detection and management of long term conditions.

What is being done locally? (Lifestyles)

PHYSICAL ACTIVITY

- New service providing adult weight management and exercise on Referral (EOR) launched in April. Running jointly across Islington and Camden, the service provides a greater number of locations and activities for residents to access. Specific work is occurring to increase access to the services among those with a mental health conditions
- Specific projects to encourage residents with disabilities and women and girls to be more physically active have been developed using funding from Sport England.
- Continuing to encourage food businesses to sign up to the Healthy Catering Commitment award. Over 250 food businesses have achieved the Healthy Catering Commitment award.
- Completed an healthy weight self-assessment across the Council with a variety of partners including, 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 action plan to address this important issue over the next year.

SMOKING

- Healthier Futures (Formally Tobacco Free Futures) have completed an independent review of services using a resident inquiry approach and co-produced with residents a model for new services.
- Co-produced model includes 3 tiers: Tier 1 Self support, using a digital and phone platform; Tier 2 engaging VCS & faith groups, alongside existing GP and Pharmacy offering brief intervention and a new Tier 3 clinically based service to support entrenched and harder to reach groups.
- Tender opportunity to be advertised in late November for a new contract starting 1st April 2017.

What is being done locally? (Lifestyles)

ISLINGTON

ALCOHOL and DRUGS

Ensuring environments that promote lower risk drinking

- Reducing the Strength initiative aimed at reducing the availability of cheap high strength beer and cider
- 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.

Increasing awareness of the impacts of alcohol

- 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.

Ensuring drug treatment services meet the needs of local residents

- Successful procurement of a complex needs drug service: successful bidder was Camden and Islington NHS Foundation Trust are now providing a specialist treatment service for people with drug and/or alcohol problems who have additional complex needs around mental health, offending or other health issues.
- Remodelled primary care based alcohol and drug services (PCADS**)**

ISLINGTON

IMPROVING MENTAL HEALTH AND WELLBEING

Key achievements – Mental Health

- The number of people entering treatment with the **Improving Access to Psychological Therapies** (IAPT) services has continued to increase, and substantially exceeded targets. This means that over 17% of those estimated to have a common mental health problem within the borough have started treatment with the local IAPT service during the year. Nearly 50% of those who enter treatment recover after treatment.
- 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.
- Established Mental Health Promotion services include free **Mental Health awareness training**, **Mental Health First Aid training** and the **Community Mental Health and Wellbeing Promotion Service**. In 2015/16 there will have been over 450 participants in Mental Health First Aid Trainings, and 340 participants receiving one day Mental Health Awareness training.
- Islington had a **large decrease** in the suicide rate between 2001-03 and 2012-14: it is now not significantly different to London or England. There are, though, significant risk factors in the local population.
- Improved dementia care pathways and rates of diagnosis: Islington now has one of the highest rates of dementia diagnosis in the country, meaning more people with dementia are offered services and support.

What's being done locally?

Mental Health (MH) services in Islington cover services for children and young people (CAMHS), services for adults of working age, older people's MH services and alcohol and substance misuse. The national and local strategies of dealing with mental health inequalities aim to:

- **Raising awareness of Mental Health problems and services, including for postnatal depression, and tackling stigma and discrimination.**
- **The mental health and resilience in schools** (MHARS) is being rolled out to all schools in Islington.
- Programmes to **improve the physical health of those with mental health problems**
- **Mental health promotion** includes MH First Aid and Youth MH First Aid training (MHFA/YMHFA), the Mental Health Champions project, and the Direct Action project which focuses on children and young people
- **Primary care** (Improving Access to Psychological Therapies (IAPT).
- Development of a **local strategy to support suicide prevention** following a comprehensive review of suicide prevention pathways.

Cross council programmes

Housing and Health

ISLINGTON

- Evaluations of external wall insulation – Holly Park and High Rise Estates (ILEX/ Gambier/ Halliday House Insulation)
- Trialling innovative approaches to tackle fuel poverty through the Fuel Poverty and Health Booster Fund pilot.

•Andover and Cally Community Wellbeing pilots as a way of developing a sustainable model of community development and wellbeing.

- Ensuring the impact on health is central to our strategic response to the new housing act. Developing targeted health interventions, engaging residents and working with health professionals.

- Equipping all frontline staff with the skills and knowledge to support residents with housing, employment/finance and health and wellbeing issues through Making Every Contact Count training.

Employment and health

- Providing high quality, accessible employment support pathways.
- Trialling innovative approaches such as Individual Placement Support Services in GP practices to support people with LTC's to wor and improve their wellbeing.

- Developing better links between Fit Note and Work Capability assessments and employment support pathways

- Developing a strategic focus on employment in the health system and provider engagement and knowledge/skills in delivering employment outcomes

Engaging with employers to understand the business benefits of designing jobs and recruitment processes that work for people and to be able to access practical support

Making Every Contact Count (MECC)

- Making Every Contact Count (MECC) is about getting people early help and support, using the thousands of day-to-day interactions we have with residents to support them in making positive changes and improving their quality of life.
- The programme consists of an e-learning and a half-day face-to-face training which were launched in June 2016 covering
  - money matters
  - finding work
  - housing
  - health and wellbeing
- Staff and partners in frontline services gain skills, knowledge and confidence to deliver the right information to residents and signposting them to existing support avenues like SHINE, iWork and One You Islington.
- 440 staff and partners across Islington have completed the e-learning and 130 have done the face-to-face training. Many staff have included MECC into their performance appraisals.
- 20 MECC Champions will be recruited per year to take on additional specialist training and help embed MECC practice in the workplace and the community to have a lasting impact on residents' quality of life.

Public Health transformation programmes

Substance misuse

Adult lifestyles

Early years

Sexual health

Transformation programmes: Substance misuse

Aims:

- To commission a substance misuse integrated treatment and recovery service for Islington
- Improve outcomes in drug and alcohol services, deliver substantial efficiencies and maximise value for money
- Ensure effective, evidence-based treatment services available in Islington that can demonstrate value for money

Key actions for 2016/17:

- A review of integrated treatment models from elsewhere to identify examples of good practice and innovation that can inform local delivery
- Develop an engagement plan to ensure thorough stakeholder input to the refining of the proposed model. This will include efforts to seek the views of individuals not currently accessing services
- Creation of a service specification for the new treatment system incorporating outcomes based performance measures
- Market engagement to assess the viability of the specification and to prepare the market for procurement

Transformation programmes: Adult lifestyle programmes

Aims:

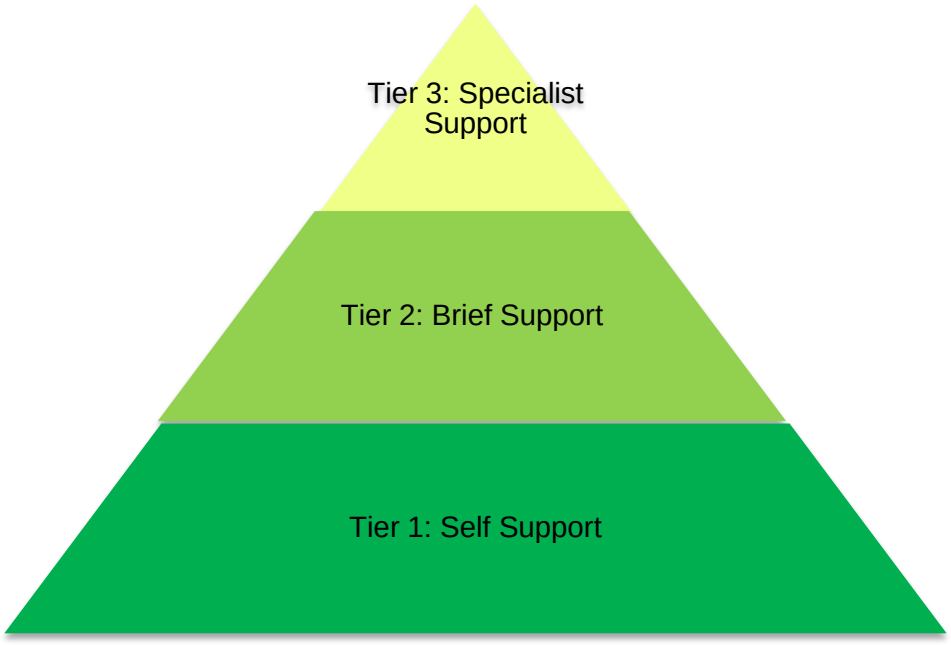
– Re-procurement of adult health improvement services to gain efficiencies and the development of a more integrated adult health improvement service offer.

Key actions for 2016/17:

– The majority of the programme has been delivered with new services designed and implemented, with the required savings generated

– Re-design and re-procurement of stop smoking services to better meet local need now occurring.

– The approach will result in the development of a three tiered model which will mean that those wanting to give up smoking find it easier to access the information and the most appropriate psychological, motivational, and prescribing support to help them quit.



Transformation programmes: Sexual health

Aims:

- To commission an integrated sexual health service across NCL, to meet the needs of a growing level of activity within a reduced budget, delivering substantial efficiencies and maximise value for money
- Ensure effective, evidence-based treatment services available in Islington and throughout NCL that can demonstrate value for money
- To meet the specific needs of Sex Workers, BME groups, Women, disadvantaged, high risk and underserved groups.

Key actions for 2016/17:

- Creation of a service specification for the new integrated sexual health system incorporating outcomes based performance measures
- Market engagement promote the tender opportunity
- Publish the tender opportunity - seek applications
- Currently scoring the applications – contract award January 2017.

Transformation programmes: Early years

Aim: With children's services development of an integrated early childhood services.

The new model will be based on:

- Three integrated early childhood areas which bring together health services, early years family support and children's centre activity, providing universal and targeted services, with clear pathways to specialist services, focused on our pregnancy to 5 vision
- Repurposing some children's centres as dedicated early years education settings thereby creating more early education spaces and increasing dedicated schools grant funding into the borough

The model will;

- ensure services are high quality, needs led, evidence based and have impact,
- target support to those with the greatest need,
- provide services which build resilience and reduce stressors for all families through pregnancy and with children under 5
- bring together the wider services for children under five and their partners currently funded through the Council or the CCG as part of the overall offer for children and families, Promote greater involvement of families in developing services.

Areas of focus for the coming year

- Continue delivery of public health transformation programmes with specific focus on sexual health and substance misuse.
- Addressing the high levels of alcohol related harm in the borough.
- Renewing our approach to healthy weight in the borough, through Islington's physical activity (Proactive) and food strategies
- Improving the physical health of those with mental health problems
- Increasing the number of people with LTCs who are in employment
- Tackling social isolation in vulnerable groups, such as older people, MH and LD
- Addressing parental mental health in the early years and building resilience
- Continue to work with partners in Haringey on health and care system transformation.

ISLINGTON

Islington Adult Social Care

2016/17

The Adult Social Care Plan

- The Adult Social Care Plan 2015-2019 outlines how we will support the Council to deliver Corporate Plan *Towards a Fairer Islington.*

- We will make sure that our most vulnerable residents continue to receive good quality care and support. We will ensure that adults at risk are safeguarded from abuse and neglect.

- We will work to the principles that are described in the Corporate Plan, namely:
  - Early intervention and prevention: moving services to address problems before they become too ingrained to manage
  - People-centred services: we will develop person-centred policies and services, rather than systems or process-led approaches, with more multi-agency, multi-disciplinary teams, pooled budgets and joint working across Islington and within the Council.
  - Co-production: we will work together with service users as equals to develop policy and services and adopt the Co-production concordat approach used in “Making it Real”.
  - Strong partnerships: All public sector organisations in the borough are facing cuts and so the importance of working together in the interest of residents has never been greater.
  - Making every contact count: residents facing multiple disadvantages are in contact with many services, so it is essential that we make every contact with them count and avoid people having to negotiate their way through complex systems.
  - Employment focussed: Supporting people into employment should be at the heart of everything we do.

Social Care In Islington

In 2015/16 Islington offered 3792 residents a social care service (including both service users and carers). All data given is 2015/16 unless otherwise stated.

Headline demographics are:

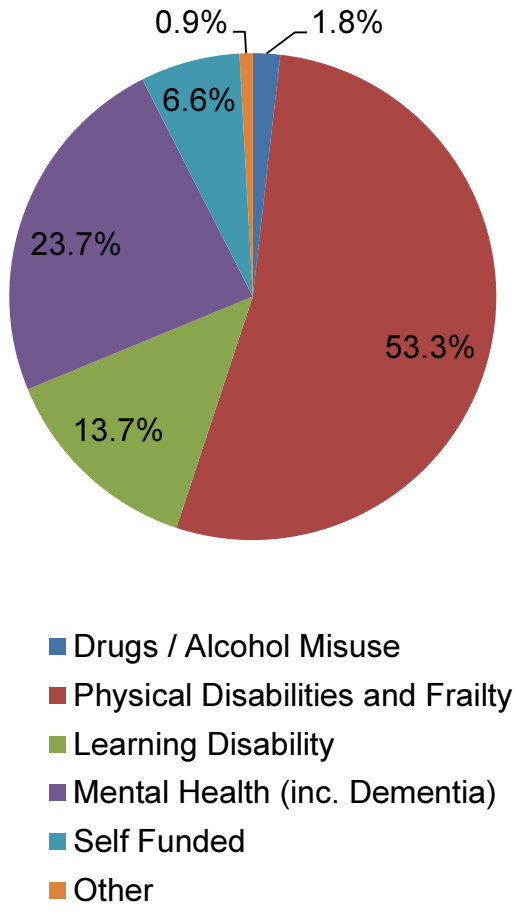
- 47% are male, 53% are female
- 44% are under 65, 20% are over 85.
- 39% are from BAME Groups.

The proportion of service users receiving a service to address a physical disability or frailty increases dramatically amongst the over 65s – however, it is the largest primary category for all service users aged over 40.

Islington has the highest diagnosis rate for Dementia in London and the 5th highest in England.

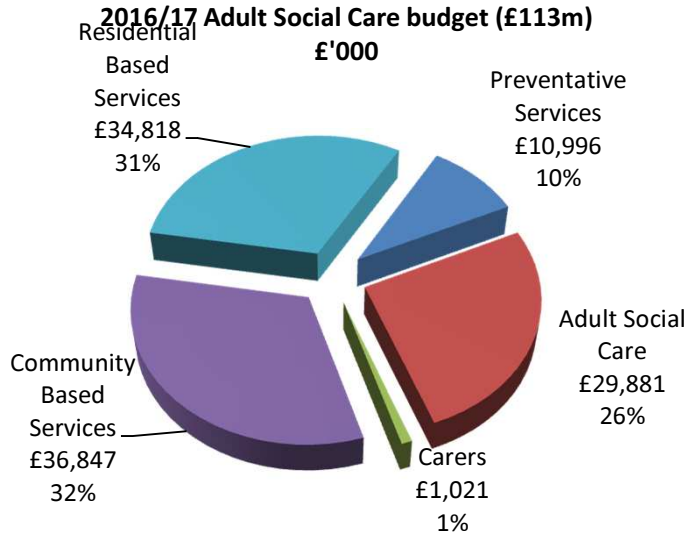
The numbers of adults with learning disabilities who require services is expected to increase as people transition from Children's Services.

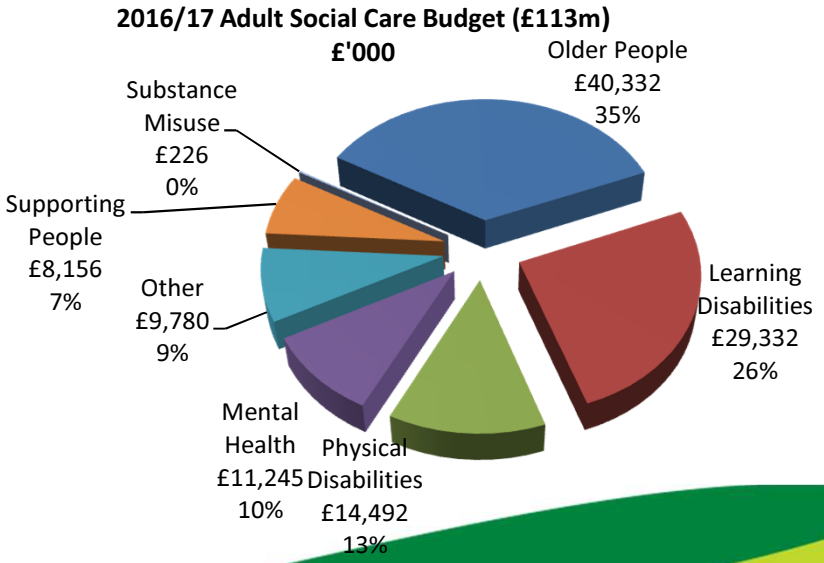
Service users by primary support reason



Adult Social Care Finances

- During the period 2011-2015 Islington Council has had to close a net budget gap of c£150m.
- Adult Social Care has contributed £31m to the £150m during this period.
- The department has made savings of £6.8m in 2014/15 and has plans in place to facilitate the delivery of £10.5m savings in 2015/16.
- Adult Social Services 2016/17 Gross Budget - £113m
  - 31% of the total budget is on residential and nursing care.
  - In 15/16 on average 729 people received this care – only 16% of those receiving an eligibility tested social care service
  - Very small proportion of the overall number of people receiving support from adult social care when preventative and community based services are also considered
- Estimated savings target of £20m approximately over the next 4 years.





THE MOVING FORWARD PROGRAMME

ISLINGTON

- Established in 2013 as the Adult Social Care Transformation Programme. There are currently 4 workstreams within the programme which are as follows;

  - **Improving Disability Services** - A series of projects and initiatives which aim to improve personalisation of learning disability services within LBI and ensure care is delivered closer to home
  - **Cross-cutting commissioning** – A review of some of our commissioned services to ensure they provide best value for money and are focused on delivering positive outcomes for service users
  - **Developing a new approach to care and support -** A number of initiatives focused around our operational services to ensure that people get the right support at the right time
  - **ICT Development** – Improved working with Partners to ensure that systems are joined up and we maximise technology to improve how we deliver care

The Moving Forward Programme vision is to 'revolutionise the way that we work, so that our residents can continue to be safe, well and independent in years to come.' By focusing on prevention, integrated care, personalisation and being more efficient, we can achieve better outcomes for service users and save money at the same time.

PROGRAMME APPROACH/DEPENDENCIES

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The Moving Forward Programme Approach:

- Managing demand
- Maintaining statutory services & preventative services
- Co-production
- Contract efficiencies
- Innovative commissioning approaches
- Promoting independence
- Integration
- Culture & Practice change

Dependencies across the council and partners:
Haringey and Islington – Wellbeing Programme
Cross cutting savings & public health savings
Health and Housing programme
Integrated Care Programme
Launch of new Shared IT service
Corporate Transformation programmes *e.g. Customer Transformation programme*

Reablement in Islington 2015/16

ISLINGTON

Reablement provides a short package of support for people who have recently had a period of illness, have come out of hospital and are having difficulty managing daily activities. The service supports users to develop the confidence and skills they need to live independently and safely at home.

Outcomes in 2015/16:

- 706 residents accessed the Islington reablement service in 2015/16
- 76.9% of service users left the service with no ongoing care needs
- 92% were still at home 91 days after their discharge from reablement.

Further strengthening these positive outcomes for people using the reablement service is a departmental priority for 2016/17.

The service improvements made in 2015/16:

- Development of monthly reablement strategic dashboard for performance monitoring
- Work undertaken with wider assessment and care management services to promote the role of reablement within the Islington social care system
- Training and development opportunities offered to reablement staff and managers to improve our systems and processes

Commissioning for Prevention: Our scope

Islington Council is committed to supporting our residents' wellbeing and independence so that they can be helped to avoid developing needs for care and support.

To reflect this commitment in our commissioning practice, a new prevention commissioning team was formed in January 2016, with the responsibility for commissioning a range of different preventative services, including:

- Advocacy and advice
- Lunch clubs and voluntary sector day provision
- Enablement services
- Accommodation and floating support services
- Employment support services

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Commissioning for Prevention: 2015-2016 Highlights

- **Co-developed a strategic advice partnership:** The prevention team contributed a to a review of information and advice services in Islington and worked closely with the VCS team to better coordinate the work of advice services across the Borough.

- **Developing a more coherent and easily accessible primary prevention offer:** We started to design a more collaborative and coordinated means of commissioning primary prevention services across the Borough.

- **Co-produced a prevention outcomes framework:** We worked in partnership with Age UK Islington to develop a co-produced prevention outcomes framework. This will enable us to measure the impact of preventative services across our commissioned providers.

- **Managed demand at our "front door":** We developed closer working relationships with our access and information team so that we can begin to increase early referrals to community based preventative services.

- **Developed a new single advocacy service:** We brought together several advocacy contracts into one single advocacy service. Going forward, this will enable us to maximise resources and better meet increasing demand.

Improved Mental Health Services

- *Primary Care Mental Health* was piloted in 9 practices to strengthen capacity and support a more sustainable mental health system. This includes embedding psychiatry, psychiatric nursing and psychology in GP practices evaluation suggests that reductions are achieved in secondary care and GP satisfaction is high.

- *Early Intervention Psychosis* service was extended to over 35 year olds. Islington was one of the first areas to achieve this.

- *Enhanced Psychiatric Liaison* continues to be available at the Whittington with significant impact on quality and length of stay, readmission rates and access to specialist intervention.

- *Perinatal service* provision was extended to provide a service at UCHL

- *Value Based Commissioning:* Collaborative working between service users, providers and commissioners to address the fact that people living with psychosis are dying up to 20 years younger than their peers, has developed a new model that puts users firmly at the centre of a system. Camden and Islington Mental Health Foundation Trust were awarded the contract as the lead provider. This contract shifts the emphasis to achieving better health outcomes for patients across both mental and physical health.

Safeguarding

- The Care Act 2014 came into effect. New categories of abuse have been recognised in the Act: modern slavery, domestic violence and self-neglect.

- Deprivation of Liberty Safeguards applications surged. In spite of this, the Safeguarding Adults Team managed to turn around most applications within timescales.

- The Safeguarding Adults team delivered training to more than 1600 people

Key statistics:

- 1464 concerns about possible adult abuse or neglect (an increase of 26% on last year)

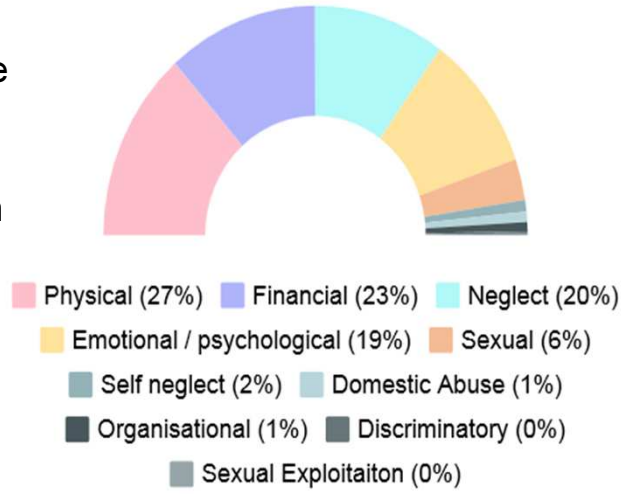
- 592 enquiries about suspected adult abuse (an increase of 4% on last year)

- 73% increase in deprivation of liberty safeguard applications

- In 100% of cases where we agreed abuse took place, we took action.

- Our actions either removed or reduced the risk of harm in 94% of cases

Safeguarding enquiries by type



Coproduction and qualitative research

Coproduction:

- Making It Real ended in March 2016. Work in its final year included:
  - Grant funded the Islington Personal Budgets Network (IPBN) to establish themselves as a Centre for Inclusive Living (CIL). The centre will promote inclusive living through peer support and assistance for personal budgets.
  - Developed the pre-paid direct payment card option, this is now available to all new people taking up direct payments and existing direct payments users.
  - Contributed to the work of the local Employment Commission to support more disabled people and carers into paid or voluntary work.

- Significant increase in service user and carer involvement and coproduction across adult social care and joint commissioning.
  - Service users and carers are consulted on the development of specifications, and also join the decision making panel that evaluates and awards the tender.
  - Service user feedback, either through commissioned service user research and representation groups, or direct engagement with service users informs all contract monitoring. We are working to make this more engaging and accessible, through the use of storyboards and case studies.
  - We consider this as vital to ensure effective service development and delivery.

- Islington's Framework for User Involvement, and its Reward and Recognition policy has been cited by the Social Care Institute for Excellence as a good practice example in their guide 'Co-Production – what is it and how to do it'.

Qualitative research:

- A test and learn Personal Health Budgets pilot with active service user engagement reviewed and improved the PHB offer to patients with long term conditions. This work will be continued as PHBs are rolled out to other client groups. (eg multiple sclerosis)

- The 2014/15 Statutory Service User Survey (fieldwork completed May 2015) asked additional questions about why people feel safe or unsafe. We found that fear of falls was a big concern for clients and so changed the falls assessments to reduce this risk and associated fear. We will research this again in the next service user survey (spring 2017)

- Restructure of Quality and Performance team aims to further increase reach and impact of service user and carer involvement across Adult Social Care and joint commissioned services, including greater use of qualitative research.

Areas of focus for the coming year

The challenge will be continuing to improve outcomes for residents in Islington who use adult social care in the context of a very difficult financial position. This involves:

Working with providers to develop a market of care in Islington that is best suited to the needs of our residents.

- Working with providers to develop a market of care in Islington that is best suited to the needs of our residents
- Enabling people to stay as well and independent in the community as possible, through the development and promotion of prevention services that are open to all.
- Delivering savings that have as low an impact on the quality of services delivered as possible, in line with the Council's budget plans.
- Scoping the market to ensure investments support emerging trends and is focused on minimising dependency on long-term services
- Continuing to develop joined-up health, care and support services with NHS partners, including the CCG, Whittington Health and Camden and Islington NHS Trust
- Ensuring that family carers are supported to continue in their caring role where they choose to do so, as well as improving outcomes for family carers in Islington.

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ISLINGTON

Our Real Story

The London Borough of Islington's Local Account for 2015/16

Co-produced with residents of Islington

If you would like this document in large print or Braille, audiotape or in another language, please telephone 020 7527 2000.

17th November 2016

My Story by Sean McLaughlin, Corporate Director of Housing and Adult Social Services.

As Corporate Director of Housing and Adult Social Services, I was keen to ensure that the Local Account was produced with local residents as the end users of our services. 2015/16 saw further spending cuts but it also yielded key successes including the successful conclusion of the Making It Real programme (see link to the report on our website).

http://www.thinklocalactpersonal.org.uk/_assets/Resources/MakingItReal/supportMaterials/Final%20Evaluation%20report%20FINAL%20(002).pdf

Over the past year we have seen improvements in the quality of life for people living in our borough and many of the people who used our services said these services made them feel safe and secure. It is the experience of people using our services that counts and we are privileged to share these experiences in 'Our Real Story'. I hope you find these accounts as useful and constructive as I have.

Need assistance with social care? Contact us on:

Access phone number: 0207 527 2299

Web link: https://www.islington.gov.uk/social-care-health/arrange-care/contact-adult-social-services

Email: access.service@islington.gov.uk

My Story by Dr Josephine Sauvage, Chair of NHS Islington CCG

As a practising GP, every day I see people with complex needs and very similar experiences to the people who have shared their stories here. In Islington, our residents are living longer but often in poorer health. We have some of the highest rates of mental illness and widespread deprivation in the country. Within this context, the CCG works closely with the council to plan joint services to address these issues. Some of the stories here tell the story of some of these services in action.

I hope these personal accounts are a useful resource to demonstrate the services that are available to the people of Islington.

Please note that names in these accounts have been changed to protect the privacy of individuals.

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My Story - Refugee

Yana fled Syria after the destruction of her home. She went to live in Jordan with relatives but life was tough without her close family. She was offered the chance to come to the UK and was 'so excited' at the prospect of coming to a country she had seen in films like, 'Harry Potter'.

Yana said: "hope came back to me, hope, I had lost hope, everything." Since coming to Islington, Yana has received services to help her live and study here. "I'm studying accountancy in college, I know this is my future I want to be an accountant." As well as working hard on her studies, Yana is trying to help and welcome other Syrian families who arrive. But life is hard for Yana as she worries every day about her parents (in Syria) and older brothers and sisters (scattered throughout Europe).

She is immensely grateful to the British public and the organisations that have welcomed and helped her since she arrived. Yana says: "All I can say is thank you. Thank you. I was lost and they helped me to find the way.'

Yana's story shows how Housing and Adult Social Services, Children's Services and GPs work together to help improve lives in a Fairer Islington.

Organisations involved in this type of work include:

Refugee Action Helping Refugees & Asylum Seekers - Refugee Action

Families First Families First | Islington Directory

Yana is part of the Government's Syrian Vulnerable Person's Resettlement scheme which will see 20,000 Syrians being resettled in the UK from Lebanon, Turkey, Jordan, Egypt and Iraq by 2020.

Islington has so far resettled 8 families since December 2015 when it was one of the first London boroughs to take part in the expanded scheme and has committed to welcoming a further 10 families.

Email:
access.service@islington.gov.uk

My Story – Homelessness and Mental Health

David was sleeping rough for some time before coming to a specialist supported housing scheme for single homeless people with additional complex needs. David had a support worker at the housing scheme but what he really wanted was a safe council flat. But the waiting lists were long.

David's mental health continued to suffer as he waited for a flat and he would drink heavily becoming abusive towards staff and tenants. After a serious incident, the mental health crisis team became involved and he was diagnosed with a personality disorder. He was accepted onto on a waiting list for a mental health co-ordinator. But this took time and David found it hard to cope becoming verbally abusive and hostile. His biggest fear was returning to the streets as a rough sleeper.

When the Mental Health Team became involved, David started to drink less, manage his emotions and gained confidence. The Housing Team agreed to consider him for housing depending on him achieving his personal development goals. He achieved these and moved with the help of floating support services who helped him to learn to live independently. David is now living well in his flat.

David's story shows how Housing and Adult Social Services and Mental Health Services work together to help improve lives in a Fairer Islington. Together, we continue to improve our Mental Health Services. In 2015/16:

- 9 GP Practices piloted Primary Care Mental Health to support a more sustainable mental health system. These practices now include Psychiatry, psychiatric nursing and psychology.
- The Early Intervention Psychosis service was extended to people aged over 35. Islington was one of the first areas to achieve this.

Web link: https://www.islington.gov.uk/social-care-health/arrange-care/contact-adult-social-services

Homelessness and Mental Health Statistics

Organisations involved in this type of work:
Single Homeless Project (SHP) provides supported accommodation and floating support to people with offending history and substance misuse issues.
St Mungo's provide our street based outreach service, advice services, day centres and hostels and support to people with mental health issues.
Hillside Clubhouse support people with mental health conditions into employment, volunteering or training, and with self-esteem.

In 2015/16:

- 158 people were sleeping rough in Islington in 2015/16.
- Most spent 1 to 2 nights on the street but some spent longer, with 13 spending more than 11 nights on the street. (Source: Mayor of London CHAIN Report Islington April 2015 to March 2016.)
- 76 of these were new to rough sleeping (37 of whom spent one night on the street) (Source: Mayor of London CHAIN Report Islington April 2015 to March 2016.)
- Most were dependent on alcohol or drugs. Substance misuse can be a way of coping with rough sleeping. (Source: Mayor of London CHAIN Report Islington April 2015 to March 2016.)
- Studies show that rough sleeping, substance misuse and mental ill health often go together. Mental illness can be the cause of rough sleeping and can cause people to remain homeless.
- Just over 1 in 3 people sleeping rough had a mental health condition compared with 1 in 6 in the general population in Islington. (Source: Mayor of London CHAIN Report Islington April 2015 to March 2016.)
- Islington has among the highest rates of mental illness in London.

Access phone number:
0207 527 2299

My Story – Care Worker

I worked as a Care Worker for an independent home care agency for roughly over a year after my Mum became ill and I wanted something to help me balance my work and home life. I really enjoyed my experience as a Care Worker. The office team was very helpful and understanding. I built an amazing relationship with the people I cared for ensuring I provided them with the best possible care whilst I was with them. Being a Care Worker was a very rewarding job and I enjoyed it every day.

I then got internally recruited to become a Co-ordinator for same company. I was very excited to start a new position but still working for the same company. I was a little nervous to start working as a Co-ordinator. The role is very different to the role I had as a Care Worker and it took me time to adjust to working under pressure and covering daily calls making sure the Customers got a quality service without having the hands-on approach I was used to. Having been a Care Worker before I think this has helped me in my new role and ensures I am realistic in my expectations and understanding of both Care Worker and Customer struggles. The team members in the office have always been so helpful and helped me whenever I was struggling.

We recently moved offices, since moving offices I must say it has become a very nice working environment, I have built amazing relationships with the Care Workers and work with the Care Workers on a daily basis to get the best for them and our Customers. I believe I am a contributing member of the team and bring a lively and bubbly dynamic to the workforce, without the help of the other Co-ordinators I wouldn't have been able to do it. The agency where I work is a very good company and I enjoy my position as a Co-ordinator.

Email:
access.service@islington.gov.uk

This story shows how Housing and Adult Social Services work with partner agencies to provide services for a Fairer Islington.

Home Care organisations involved in this type of work include:

Sevacare www.sevacare.org.uk

London Care www.londoncare.co.uk

Allied Healthcare www.alliedhealthcare.com

A full list of service providers can be found here: Adults - Search Results | Islington Directory

CQC assessments of service providers completed within the latest month can be found here: Search | Care Quality Commission

People's opinions of care organisations can be found here: https://www.careopinion.org.uk/

As at December 2015, in Islington there were an estimated 200 establishments and 5,700 jobs in adult social care, around 3,400 of these jobs were care workers. **Source: Skills for Care National Minimum Data Set for Social Care January 2016 Publication of Data**

The vacancy rate across the sector is 11.4%. **Source: Skills for Care National Minimum Data Set for Social Care January 2016 Publication of Data**

Around a third of care workers in Islington is aged 55 and over. This means that during the next 10 years these workers will reach the age of retirement. **Source: Skills for Care National Minimum Data Set for Social Care January 2016 Publication of Data**

Web link: https://www.islington.gov.uk/social-care-health/arrange-care/contact-adult-social-services

Access phone number:
0207 527 2299

My Story – Residential and Nursing Care

What was your situation when you decided to contact the London Borough of Islington (LBI) for information about services?

There are two separate cases. In January 2013 my father had a stroke and spent six months in various hospitals. First contact with LBI was at St Pancras. In 2014 my step-mother could no longer cope alone despite family and home carers and first contact with LBI was around that time.

What went well when LBI became involved?

Regarding my father, very little apart from the in house social worker, who was exemplary in fighting his case through the poor care planning for my father's future. Presently the support of the social services team is very good. Regarding my step-mother, things went much smoother and she is now as settled as can be expected considering her condition. Support from LBI is very good.

What didn't go so well?

Regarding my father I eventually engaged a solicitor in order to seek guidance to attain the correct level of care and to cut through the misinformation and reluctance of the authority to fulfil their legal obligations. Initially my step-mother was placed in a care home in another borough that was not what we expected and would not be our first choice though she was re-placed to a nearby location as soon as possible.

Have the services helped your situation?

Social services provide a valuable service to families who cannot be expected to cope with the upheaval of elderly relatives' failing health in old age.

This story shows how Housing and Adult Social Services work with partner agencies and health services when living independently at home is no longer an option.

Here are some of the organisations that help us support people with Nursing and Residential care needs:

1. St Annes nursing homes
2. Stacey St nursing home
3. Bridgeside Lodge nursing home

In 2015/16, 101 older people moved into specialist dementia nursing and residential care on a permanent basis. 50 of these people moved here between the ages of 85 and 94.

Islington works closely with our providers to improve the quality of life for people living in nursing and residential care. There is a programme of quality improvement that includes developing:

- A more skilled qualified and unqualified workforce in care homes .e.g. Diabetes awareness sessions programme
- Extended clinical skills e.g. management of syringe drivers
- Care closer to home for residents e.g. Advanced Care planning sessions
- A more positive resident experience e.g. Kissing it Better http://www.kissingitbetter.co.uk/about/

Email: access.service@islington.gov.uk

Web link: https://www.islington.gov.uk/social-care-health/arrange-care/contact-adult-social-services

My Story – Transitions

I'm a carer for my son who has Autism. I'd like to tell you about our experience of getting services for him as he moved into adulthood. When my son was 17 years old, a Transitions social worker got in touch with us. I must admit, I was so nervous. He had everything he needed in school and he was happy there and I, in turn, was happy he was getting everything he needed. I knew nothing about what he would be entitled to as he got older.

At first, things didn't go well with the Transitions service as there was a high turnover of social workers, so we would get used to one worker and then that worker would leave. We would start to plan my son's future and then it would stop again. It seemed like we were answering questions over and over again and not getting anywhere.

One of the first things the social worker did was an overview assessment. This had everything in it to do with the level of care Paul needed and also how caring for him impacted on his main carer (me). Then we did a Support plan. This was very stressful as I had never seen one of these before, and I didn't know what should go into this very important document, things like what Paul enjoyed doing outside of school, how to support him and how he communicates best. This plan lets support workers know more about the young person that they are going to be working with.

After this the school got in touch with me and we then had to do an Education Health Care Plan (EHCP) which was even more stressful as this document has everything from health conditions, educational needs and how to support Paul. This took almost a year to complete which felt like a long time. Thankfully, I was able to seek advice from Centre 404 who helped me to get everything I wanted in the document which meant that Paul was able to attend the college of his choice.

But when the document was with the college I felt as though it wasn't shared in full with the people who were supporting my son on a daily basis. So it seemed like the plan was worthless in the end.

In these early months of the transition planning, plus EHCP planning, I became very depressed and fearful. I was afraid that my son wouldn't have anywhere to go once he left school and that myself and Paul would be stuck in the house. He hates being at home for long periods of time and can get quite aggressive if he can't go out. It was a very worrying time.

I had a lot of negative thoughts about the future and kept seeing things in the news about parents of adult children with disabilities who couldn't cope once their son/daughter had turned 18, and who had committed suicide, I could see how without any support some people had become so distraught and alone that they felt they had to resort to such sad and desperate measures.

When my son's new social worker became involved, she was amazing. Everything started to click into place. She created the best Support Plan with me and gave me lots of advice. She was and is completely fair and impartial.

Thanks to her, Paul now has all the services he needs. He attends a day centre, has fantastic people working with him and is settled now in a routine that makes him happy.

I wish I had known before what sort of things I could have asked for. When Paul left school, I needed someone who could have told me what you can and can't have. I was not asking for the world and I do appreciate that there is only so much money to go around. But it's only through talking to other parents and Paul's new social worker that I got to know what's

possible. So, now I feel as though I'm becoming an expert in what you can have in a support plan. My son's social worker has been great at making sure we have what we need. She really looks after me so that I am in turn able to keep going and caring for my son. Otherwise, Paul might end up in residential care. I would hate that.

Something that I want people in my situation to know about is this. As soon as a transitions social worker becomes involved, keep your receipts. When Paul turned 18, the Council's finance officers got in touch and asked for all receipts to show how Paul's benefit/DLA money had been spent. This included everything from special food for special diets, clothes, equipment, cleaning materials, bedding, sensory equipment, and holidays. Basically, you need to keep everything.

They also need your/your son/daughter's bank statements. Basically, once you have a support plan/ overview assessment done by a transition social worker it will generate an amount of money for your son/daughter's care, which can be managed by you. Or you can have something called an ISF which stands for Individual Service Fund, which is an internal system of accounting that makes the personal budget transparent to the individual family and finance team.

If you don't provide these receipts your son/daughter will be asked to contribute from their benefits towards their own care. So, definitely keep all the receipts right from the time you hear from the Transitions Team.

This was another scary time for me as I didn't know how much my son would have to contribute to his care costs, the whole thing is very intrusive. But, in the end, because I'd kept all of my son's receipts, the financial assessment worked out fine.

My son's social worker is great and I feel lucky to have her supporting my son and me. But I live in fear of my social worker leaving one day as I know not everyone has such a wonderful social worker and because of the hard time we had at the beginning.

Everything works fine at the moment, but I always wonder about what's around the corner.

Parents could do with someone I'm going to call an Autism / learning disabilities navigator who tells you all about what's possible, so you know what you can ask for and just in case you are not fortunate enough to have support around you.

When you do get the right services, it's a great feeling and a massive weight off your shoulders.

This story shows how Housing and Adult Social Services work to ensure that young people have as smooth a transition from children's services to adults' services. It is a time of great anxiety for parents and this story shows we have some things to learn to help reduce these anxieties. We are now discussing how we can help in this important area so that we can work towards being an even Fairer Islington.

Islington Learning Disability Partnership (https://www.islington.gov.uk/social-care-health/disabled-people/ildp-about) refers clients to the Community Access Project which supports people with learning disabilities into employment.

Transitions Key Facts

- The timing of 'transition' from Children's to Adult Services takes place at different times for different people depending on their needs and situation.
- In 2015/16, 27 people with a global learning disability turned 18 with a need for Adult Services.

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0207 527 2299

My Story – Physical Disability and Mild Learning Disability

Tell us a little bit about yourself

I am a young 43 year old lady who has a mild, hidden learning disability. I also have Lupus, an auto-immune disorder which attacks the body. For example, someone without Lupus might get a cold and feel unwell for a week. If I get the same cold, I have it for 5 weeks and my lymph nodes swell up so bad that I can't move. But I still go to work, even so. I take medicine and am supposed to rest but I don't.

So, Lupus is an inflammation of the whole of your body (arms, legs, stomach, everywhere). People say that people with Lupus should also have a butterfly effect of spots on your face. But this isn't always the case. Everyone is different. People with Lupus also have anaemia (lack of iron). This is one of the first signs of Lupus. I would go home in the evening and fall asleep without eating, so my Mum took me to the doctor, as she was a qualified nurse, and that's how I was diagnosed in January 2008. The doctor did a special antibodies blood test. Lupus leaves you feeling tired, exhausted all the time, as if you're drunk. That's how it is for me.

I was diagnosed with my mild learning disability when I was 29 in June 2003. Knowing that I had a learning disability made me feel frustrated, angry and so alone. Because now I can see why I couldn't keep jobs and why I couldn't do tests. I was always below average. This would happen over and over again and I would cry. But then I became more aware of what I can and can't do. This is why I'm hard on myself. My Mum said, 'Evelyn, look at your hands, look at your fingers, do they look the same?'

'No,' I said.

'This is how things are,' Mum said, 'People are different. You need to do things for yourself.'

They diagnosed me with a mild learning disability in 2003. The way the psychologist explained the level of my learning disability to me was, 'Imagine there are 100 people queueing for the bus. Number 1 is standing at Finsbury Park and Number 100 is standing all the way back to Wood Green. Well you are person number 97.' That is, it's a mild learning disability. The test I took was a WASI® (Wechsler Abbreviated Scale of Intelligence®) test.

Before I was diagnosed, my Mum saw an article in the newspaper about an organisation called Elfrida. She told me, 'We're going to Elfrida.' There I saw a lovely lady who took me to see another lovely lady, who said that I might have a global learning disability. That's when they decided to send me to the psychologist who diagnosed me.

What good things have happened since being diagnosed?

It's such a good feeling that I was diagnosed with a mild learning disability. But I wanted to work. And one time, I applied for a post at Elfrida. This was a pilot in September 2006. I was out of work. My psychologist told me about it. They needed 6 people with a learning disability. It was only supposed to be for 6 months. I applied for it and I was selected for an interview. I nearly fell off my chair. I did very well at the interview. They let me know the same day that they wanted to give me the post. I was ecstatic as I was out of work and had just left a private sector job. I told Mum, my psychologist and everyone. I cried because for me someone believed in me and I could earn money. I like to be part of the working community so I can buy things like nice clothes.

That was 10 years ago and now I'm with Elfrida doing sessional, part-time work. I work on reception. Mary, the receptionist, wanted volunteers and I did 6 months of volunteering. I started this in 2012/13. Then one day, Mary said, 'I'm so glad I bumped into you. Because you did so well as a volunteer, we'd like to offer you a sessional, part-time position.' So, now I am working and earning.

I have done a Level 1 and 2 qualification in Admin. I do as many extra tasks as I can such as photocopying, postage, mailshots, inputting into databases, a lot more than reception work. Mary is astonished. On 26th October, she said to me, 'I just wanted to say a very big thank you for tidying the cupboard. You are doing such an amazing job in reception.' That gives me such encouragement that I can do things. I feel so valued in that post. If someone gives you a chance you can develop at your own pace. That's what Elfrida has done for me. I've done so many things. I've helped organise a sports conference. We had a database of people in sports and we rang them. I sent the letters out and I welcomed the people in at the main reception.

I have a lot of get up and go. I am hard on myself because of what I grew up with. My siblings all went to college and university. Even though I couldn't, I still develop and do what I want to do. It's how I was brought up. I've learned everything on the job. If you learn more, you develop more at your own pace.

I volunteer at Elfrida as a befriender. I go to see a service user in another local authority (I keep being head-hunted). It's called a Circle of Protection. I do a lot of interviewing at the London Borough of Islington and Elfrida. I was an expert by experience with the Making It Real Team. Lots of things are going well.

What hasn't gone so well?

I had a few bad experiences in the early days. At one point in the process, a professional said to me, 'If you want to work, you're more than capable because you don't look like someone with a learning disability.' I felt so angry, frustrated and really belittled because even though I don't 'look' like someone with a learning disability, my learning disability is hidden but it's still there. I wanted to say, 'How can you talk to me like that? You're the face of social services, you're meant to be professional. You're supposed to help me get a job.'

Why have you written this story?

I'm writing this for people with a mild learning disability. I'm also writing it for professionals so that they can improve how they work with or support people with a mild learning disability like me. Read my story. If a person tells me I can't do things, how do they know? I will try it and then I'll say if I can or can't do it. Don't tell me. I'll find out for myself.

I'm being head-hunted by Islington for projects. I am helping with co-production. Someone is giving me the chance. I have a lot to give. The more I do, the more I can put into my wedding savings.

You need a get up and go attitude, a positive mental attitude. Push yourself. I know I haven't been well. My physical disability makes me feel like I don't do enough. When my health declines, it stops me. But I get up again.

Here is an exercise for you. Just close your eyes and imagine you have a mild learning disability which is hidden. If you think about it, we may need a little or a lot of support, but we're not stupid. We're thoughtful, kind and we want to work.

As part of the celebrating 100 years of Elfrida Society, a lot of Elfrida staff will be attending the House of Lords on Monday 7th November 2016.

Last week on Friday the 28th October 2016, I took part in filming and telling my own personal achievements and how Elfrida have supported me through employment and meeting my current partner and now I am happy to say that I'm now engaged.

Getting the best out of paid employment and having a good employer is really important for all disabled staff, as it's very encouraging.

Evelyn's story shows how we support people with a mild learning disability. We work in partnership with voluntary and health services to ensure that there is equal access to employment and opportunities for all in a Fairer Islington. We have a new prevention commissioning team to commission prevention services, such as advocacy and advice, accommodation and floating support services

Learning Disability Providers

- **Islington Learning Disability Partnership** provides a range of social care and health- related services for young people and adults with learning disabilities - https://www.islington.gov.uk/social-care-health/disabled-people/ildp-about
- **The Consultation Project, run by The Elfrida Society** speaks up for people with Learning Disabilities in Islington and carries out user-led quality checks of learning disability services - http://www.elfrida.com/power.html
- **Islington Social Inclusion Project, run by Mencap** provides activities facilitating social inclusion and community participation - http://directory.islington.gov.uk/kb5/islington/directory/service.page

Learning Disability Key Facts

- In 2015/16, there were 945 individuals registered with Islington GPs flagged as having learning disabilities. 834 of this total were aged 18 years and over, 395 were female and 550 male.
- During this time period, ILDP provided long term support to **532** young people and adults with global learning disabilities and 18 people with a learning disability were supported into employment.

Email: access.service@islington.gov.uk

Web link: https://www.islington.gov.uk/social-care-health/arrange-care/contact-adult-social-services

Our collective story – facts from the Adult Social Care Survey and the Carer Survey

We have a survey of people who use our services once per year and a survey of carers every two years. These surveys tell us a lot about people's experience of their long-term health conditions and of carers' experience. Here are a few statistics from the latest surveys.

- Most people (over 80%) are extremely, very or quite satisfied with care and support services from the London Borough of Islington.
- Most people (well over 80%) say that the services they receive help them have a better quality of life.
- Over two thirds of people say their quality of life is excellent, very good or good. But this leaves around a third with a poor quality of life due to their long-term condition.
- Around 70% of respondents using services say their care and support services help them have control over their daily life but for carers only 28% feel they have control over their daily life.
- Over 70% of people responding to the survey feel they have as much social contact as they would like. But the picture is different for carers where only 29% said they had as much social contact as they would like.

So, it's possible to see that respondents using our services generally feel in control of their daily life and have a good quality of life but the picture for carers can be different.

Our Safeguarding Story

In 2015/16:

- 1464 concerns were raised about possible adult abuse or neglect
- 592 of these were dealt with as enquiries about suspected adult abuse
- In 100% of cases where we agreed abuse took place, we took action.
- In 94% of cases our actions either removed or reduced the risk of harm.

My Story by Cllr Janet Burgess, Executive Member for Health and Social Care

I hope you have enjoyed reading Our Real Story, which shows a selection of services to help you understand the work we do. We're committed to providing the best services to our residents with the resources that we have. We call this commitment, 'A Fairer Islington'. You can read all about 'A Fairer Islington' here: https://www.threeboroughdigital.com/storage/app/media/2015-10-27-islington-corporate-plan-oct-2015-resident.pdf

Our Real Story shows what we have done in 2015/16 to help create a Fairer Islington for people of all ages. The stories show how we help find jobs, improve the quality of life for residents and provide services with limited resources.

In 2016/17, we are delivering savings that have as low an impact on the quality of services delivered. We're scoping the market to ensure investments support emerging trends with a focus on minimising dependency on long-term services. We are also ensuring that family carers are supported to continue in their caring role and we aim to improve outcomes for family carers. This is at a time of cuts where between 2010 and 2017 we will have lost over £1,000 per household.

I thank the people who have graciously shared their stories in this account and we hope to share more stories next year.

Need assistance with social care? Contact us on:

Access phone number: 0207 527 2299

Web link: https://www.islington.gov.uk/social-care-health/arrange-care/contact-adult-social-services

Email: access.service@islington.gov.uk

Your Story – Have Your Say

1) Did you find this document useful? Yes☐ No☐

2) What do you like about the services that Housing and Adult Social Services provide?

3) What don't you like about the services that Housing and Adult Social Services provide?

4) Have we missed something in telling Our Real Story?

Please send this form to michele.chew@islington.gov.uk

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North Central London Sustainability and Transformation Plan

North Central London Sustainability and Transformation Plan

21 October 2016

DRAFT

Key information
Name of footprint and number: North Central London, no. 28 **Nominated lead of the footprint:** David Sloman, Chief Executive, The Royal Free NHS FT **Organisations within footprint:** CCGs: Camden, Barnet, Islington, Haringey, Enfield LAs: Camden, Barnet, Islington, Haringey, Enfield Providers: Barnet, Enfield and Haringey Mental Health NHS Trust, Camden and Islington NHS FT, Central London Community Healthcare NHS Trust, Central and North West London NHS FT, Moorfields Eye Hospital NHS FT, North Middlesex University Hospital NHS Trust, Royal Free London NHS FT, Royal National Orthopaedic Hospital NHS Trust, Tavistock and Portman NHS FT, University College London Hospitals NHS FT, Whittington Health NHS Trust

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1 Foreword

Welcome to the Sustainability and Transformation Plan (STP) for the health and social care services that serve the population of North Central London (NCL). The aim of the STP is to ensure NCL is a place with the best possible health and wellbeing, where no one gets left behind.

This STP is a work in progress and we welcome your comments and input as we further develop the plans.

For the first time, we have come together as health and social care partners to plan how we will deliver excellent, future-proofed services for our local population over the next 5 years.

We know that the health and social care needs of our local people are changing, and that there are serious issues facing health and care services in NCL. People receive different care depending on where they go to obtain it: waiting times for services and health outcomes vary, and the quality of care and people's experience of health and social services is sometimes not as good as it could be.

On top of this, our financial situation remains challenging. Demand for health and social care continues to grow year on year and the growth in demand is running faster than the growth in funding. If we do nothing, we estimate that we would face an unprecedented financial gap in relation to health services alone of nearly £900m in NCL by 2020/21. In addition, as is well known, the trend is for people to live longer and in turn this is creating pressure on social care services and funding.

We believe the best approach to meeting these challenges is to work together to tackle them head on, working together to find solutions at scale and aligning as a system around the interests of local people rather than solely focusing on our individual organisations. It takes time to build relationships and trust in the context of a system that is fragmented and under increasing pressure, but we are committed to this joint endeavour across the whole partnership.

The STP sets out our commitment to transforming care to deliver the best possible health outcomes for our local population; shifting our model of care so that more people are cared for in out of hospital settings - through prevention, more proactive care, and new models of care delivery – and reducing reliance use of secondary care. We have made significant progress in developing our specific ideas for how we will achieve this. We have set up 13 different workstreams and have worked hard on these over the last few months to develop thinking, building on evidence and involving hundreds of members of staff drawn from every organisation in NCL. We have held public meetings in each of the boroughs to start to develop a dialogue with the local community, although we recognise there is much more to do on engagement in the months ahead.

The plan sets out a mixture of both radical service transformation and incremental improvements we believe we need to make in order to deliver real benefits for our population: increasing the emphasis on prevention; shifting care closer to home to reduce demand on hospitals; reducing variation in quality; improving productivity and reducing waste.

But the plan as it stands does not have all the answers. There are some parts of the plan which we have not had time to develop in detail that require significantly more work. We recognise the sheer scale of the changes that we set out currently in the plan will stretch our capacity to deliver, so we need to stress test the plan to ensure we focus on the most important improvement first. And fundamentally the plan does not yet balance the finances, either next year or by 2020/21. Unless we can do so, we will not be able to afford all of the investments and improvements we aspire to deliver. As a result we know that we may face some really tough decisions about where we can invest for improvement and where we will need to prioritise or make choices.

We need to resolve these questions between now and Christmas. We will ensure we are prioritising the areas which will add the most value (in terms of increasing health and wellbeing for people; improving the quality of care people receive; and ensuring value for tax payers' money) to focus our energies on achieving maximum benefit. This will include trying to attract as much investment into NCL as possible. We will continue to develop further ideas in the parts of the plan which are not fully developed. And we will review the phasing of our specific priorities for the first 2 years of our plan in the context of the significant financial challenge we face, seeking specifically to identify areas where we can go further and faster, and areas where we can defer our investment or effort.

We recognise there is much more work to do, and it is crucial that our local residents are involved in this. We are at the beginning of truly transforming care for our population, which will require significant input and contribution from the people who use services in NCL. We look forward to working with our local population to make designing and implementing the plan a success as it evolves.

2 Executive summary

There are some excellent health and care services in North Central London (NCL). However, services are not consistent and there are examples of poor practice. We also face significant challenges over the next five years and need to shift our model of care so that more people are cared for in out of hospital settings. This Sustainability and Transformation Plan (STP) has been produced by all the main healthcare organisations and local authorities within NCL. It sets out how we are planning to meet the challenges we face and deliver high quality and sustainable services in the years to come.

We know from our track record that we have the capability to deliver excellent services and to deliver significant change. However, we are not currently able to deliver services across NCL consistently to the standards we would like. We also face a number of significant challenges around the health and wellbeing of local people; and the care and quality of our services. Our current system is focussed on dealing with illness, rather than orientated to prevention and helping people to live well. There is a substantial financial challenge facing health organisations in NCL; the health system is already in deficit and, if nothing changes, this will worsen over the next 5 years meaning that by 2020/21 we estimate we will be c.£900m in deficit. Local authorities are also facing significant financial pressures due to demographic changes and policy inflation: by 2020/21 the combinations of pressures and continued loss of funding will result in a combined social care budget gap of c.£300m.

Our vision is for NCL to be a place with the best possible health and wellbeing, where no one gets left behind. To deliver on our vision, we have designed a programme of transformation with 4 fundamental aspects:

1. **Prevention:** We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population.

2. **Service transformation:** To meet the changing needs of our population we will transform the way that we deliver services.

3. **Productivity:** We will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies, including working together across organisations to identify opportunities to deliver better productivity at scale.

4. **Enablers:** We will build capacity in digital, workforce, estates and new commissioning and delivery models to enable transformation.

Delivering these plans will result in improved outcomes and experience for our local population, increased quality of services and significant savings.

Despite this, we currently expect that the overall financial position of NHS organisations will be a £75m deficit in 2020/21. We have identified a number of areas for further work between now and Christmas where we believe there may be additional savings to be found that would address this residual gap.

To ensure we are able to deliver as a system, building on the progress we have made to date we will develop a robust governance structure which enables NHS and local government partners to work together in new ways to drive implementation. We will put in place dedicated resources to support delivery. It is crucial that whole system is aligned around delivery of the STP and we will ensure that the development of the 2 year health contracts that are being put in place for 2017/18 - 2018/19 are consistent with the STP strategic framework.

We recognise there is more work to do to finalise the granular detail of our delivery plans and address the residual challenge we are forecasting. To develop our plans in more detail we want to fully engage people who use services and the public in our thinking to ensure they are reflective of their needs. We are committed to being radical in our approach, focusing on improving population health and delivering the best care in London. Our population deserves this, and we are confident that we can deliver it.

3 Context

North Central London (NCL) comprises five Clinical Commissioning Groups (CCGs): Barnet, Camden, Enfield, Haringey and Islington, each of which is coterminous with the local London Boroughs. Approximately 1.45m[1] live in the 5 boroughs. We spend c.£2.5bn on health and c.£800m[2] on adult and children's social care and public health. The population is diverse and highly mobile, with a large number of people living in deprivation[3].

There are four acute trusts within NCL: The Royal Free London NHS Foundation Trust (sites include Barnet Hospital, Chase Farm Hospital and the Royal Free Hospital in Hampstead), University College London Hospitals NHS Foundation Trust, North Middlesex University Hospital NHS Trust, and Whittington Health NHS Trust. There are two single specialist hospitals: Moorfields Eye Hospital NHS Foundation Trust and the Royal National Orthopaedic Hospital NHS Trust. Great Ormond Street Hospital for Children NHS Foundation Trust is within the NCL geography, but currently out of the scope of the STP. Community services are provided by Central and North West London NHS Foundation Trust, the Whittington Health NHS Trust, and Central London Community Healthcare NHS Trust.

Mental health services are provided by the Tavistock and Portman NHS Foundation Trust, Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health NHS Trust. There are 220[4] GP practices, and the out-of-hours services contract was recently awarded to the London Central and West Unscheduled Care Collaborative. There are 497 active social care sites registered across NCL, including 273 registered care homes (47 of which provide nursing)[5]. Care homes are particularly high in numbers in the north of NCL, for example in Enfield where there are 97 registered care homes (in contrast to the 12 care homes registered in Camden)[6]. In addition, there are 214 registered domiciliary care providers[7].

The organisation of services in NCL makes the area quite unique and this has ramifications for planning: there is a particularly high concentration of specialised services across multiple providers covering a small geographic area. This means many of the patients treated in NCL do not live in NCL and consequentially, a large proportion of the income paid to our providers comes from commissioners outside of the area.

As individual organisations in NCL, we have a history of working together in different ways to meet the needs of our population, and there are numerous excellent examples of collaboration as a result. However, working collectively across all organisations remains a relatively new endeavour and we continue to build the trust required to enable us to do so.

[1] ONS, Mid-year population estimates, 2015
[2] 2015/16
[3] Office for national statistics, IMD 2015
[4] Latest figures from NHS England, updated since publication of the NCL case for change
[5] Local Authority Care Quality Commission reports, 2016
[6] Local Authority Care Quality Commission reports, 2016
[7] Local Authority Care Quality Commission reports, 2016

We are home to 4 national Vanguards: The Royal Free London NHS Foundation Trust is developing a provider chain model; University College London Hospitals NHS Foundation Trust Vanguard is focused on what can be done to improve the end-to-end experience for people with cancer; Moorfields Eye Hospital NHS Foundation Trust is developing an ophthalmology specialty chain; and, the Royal National Orthopaedic Hospital NHS Trust is one of 13 partners developing a UK-wide chain of orthopaedic providers. NCL is also home to two devolution pilots: one seeking to optimise the use of health and social care estate, and another focused on prevention in Haringey. In primary care, GP practices are already working together in a number of GP Federations to provide extended services to our residents.

In NCL, every borough has its own unique identity and local assets we can build on. Many people lead healthy lives, but if they do get sick we can offer some of the best care in the country. We have a reputation for world class performance in research and the application of innovation and best practice, and we can harness the intellectual capacity of our workforce to ensure the best outcomes are delivered. There are many examples of excellent practice across health and social care in our area, which we intend to use to help ensure that excellent practice can be offered to all our residents.

Our track record demonstrates that we have the capability to deliver excellent services and also to significantly change our services when needed. Our ambition is that everyone is able to get the care they need when they need it. This means ensuring people have the best start in life, and supporting them to live healthy lives. When people do need specialist care, we want them to be able to access it quickly and in the most appropriate setting, and to be fully supported to recover in the setting most suited to their needs.

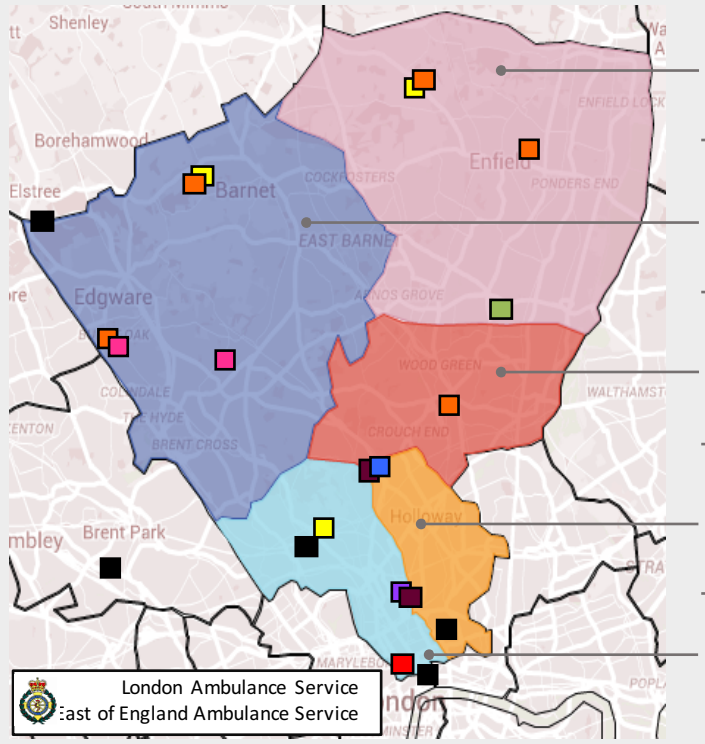
However, we are not consistently delivering our ambition to the standards we would like. We face significant challenges around the health and wellbeing outcomes for our population, the quality of our services and the financial sustainability of the health and care system. These are outlined in this document and set out in more detail in our case for change[8].

The national requirement to produce an STP is an opportunity for the NCL system to address these challenges together and widen the scope of our collaborative working. This document articulates:

- our collective understanding of the challenges we face
- our vision for health and care in NCL in 2020/21
- the plans to deliver on our vision and address the challenges
- the delivery framework which will enable us to implement our plan
- the impact we expect to achieve through the delivery of our plans
- our plans for securing broader public support and engagement with our proposals
- our next steps for further developing proposals and responding to our residual financial gap.

[8] https://www.uclh.nhs.uk/News/Documents/NCL%20case%20for%20change.September%202016.pdf

Exhibit 1: Overview of NCL



Enfield CCG/Enfield Council
~320k GP registered pop.
~324k resident pop.
49 GP practices

Barnet CCG/Barnet Council
~396k GP registered pop.
~375k resident pop.
62 GP practices

Haringey CCG/Haringey Council
~296k GP registered pop.
~267k resident pop.
45 GP practices

Islington CCG/Islington Council
~233k GP registered pop.
~221k resident pop.
34 GP practices

Camden CCG/Camden Council
~260k GP registered pop.
~235k resident pop.
35 GP practices

- Barnet, Enfield and Haringey Mental Health NHS Trust (main sites, incl Enfield Community)
- Camden and Islington NHS FT (and main sites)
- North Middlesex University Hospital NHS Trust
- The Royal Free London NHD FT
- University College London Hospitals NHS FT
- Whittington Health NHS Trust (incl Islington and Haringey Community)
- Central and North West London NHS FT (Camden Community)
- Central London Community Healthcare NHS Trust (Barnet Community)
- Specialist providers

Source: Population figures from 2014 ONS data.

4 Case for change: our challenges and priorities

In NCL we share many of the same challenges faced by health and care organisations across the UK (and indeed internationally). We have undertaken significant work to identify, articulate and quantify the specific gaps in health and wellbeing; care and quality; and our baseline financial position. Across the system we have aligned behind this work and we all agree on the nature and scale of the challenge, which we have described in our case for change which was published in September 2016.

4.1 Health and wellbeing gap

We have a diverse and highly mobile population. There are people from a range of Black and Minority Ethnic (BME) groups: these groups have differing health needs and health risks. A quarter of our local people do not have English as their main language[9], which creates challenges for the effective delivery of health and care services. The mobility of our population, with 8% of local people moving into or out of NCL each year[10], has a significant impact on access to services and delivery.

Poverty is a crucial determinant of health, and is widespread among both adults and children living in the boroughs that make up NCL[11]. Significant inequalities exist, which need to be addressed; for example, men in the most deprived areas of Camden live on average 10 years fewer than those in the least deprived areas[12]. We face challenges in addressing other wider determinants of health, for example, there are high levels of homelessness and households in temporary housing with all five boroughs in the top 10% for number of households in temporary accommodation[13]. Social isolation also remains a critical issue across the sub-region.

The children of NCL do not always get the best start to life. 30% of children grow up in child poverty and 6% live in households where no one works. 60 children take up smoking every day[14]. Although there have been some improvements recently, London as a whole has the highest rates of obesity nationally: 1 in 3 children are obese in Year 6 (age 11) and we need to do more to tackle this, particularly working with the schools in NCL[15]. Although many of our residents are healthy and people are living for longer, good health does not always persist into old age. Our older people are living the last 20 years of their life in worse health than the England average[16].

Almost half of people in NCL have at least one lifestyle-related clinical problem (e.g. high blood pressure) that is putting their health at risk[17]. However, they have not yet developed

[9] NCL case for change, 2016
[10] ONS mid-year population estimates 2014
[11] Census 2011
[12] IMD 2015, ONS
[13] https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness
[14] CENSUS 2011
[15] Public health outcomes framework tool, 2015
[16] Office for National Statistics, HSCIC CCG Indicators, 2014-15
[17] Camden and Islington GP Linked Dataset projected to NCL level

a long term health condition. Many of these lifestyle-related clinical problems are risk factors for NCL's biggest killers - circulatory diseases and cancer. These diseases are also the biggest contributors to the differences which exist in life expectancy.

There are high rates of mental illness amongst both adults and children in NCL[18], and many conditions go undiagnosed[19]. 50% of all mental illness in adults begins before 14 years of age and 75% by 18[20]. Children with mothers with mental ill health are much more likely to develop mental health issues themselves. Three of our boroughs have the highest rates of child mental health admissions in London[21] There are high rates of early death amongst those with mental health conditions[22], particularly in Haringey and Islington, and the rate of inpatient admissions amongst this population is above the national average. A strong focus on mental health is central to our approach with a clear aim of treating mental and physical ill health in a joined up way and with "parity of esteem."

4.2 Care and quality gap

Currently, our system does not sufficiently invest in those people with a life-style related clinical problem, which would help stop them from developing the long term conditions which in aggregate are a huge burden on our health and care system. Only 3% of health and social care funding is spent on public health in NCL[23], and that is despite evidence showing that between 2012 and 2014 around 20% (4,628) of deaths in NCL could have been prevented[24]. There is a large opportunity in refocusing our efforts towards prevention and making every contact count. This focus should also address the wider determinants of health such as poverty, housing and employment, all of which have a significant impact on individuals' health and wellbeing.

Disease and illness could be detected and managed much earlier, and managed better in community. It is thought that there are around 20,000 people in NCL who do not know they have diabetes, while 13% of the population are thought to be living with hypertension[25]. It is likely that people are being treated in hospital for long term conditions (LTCs) when they could be better managed by individuals themselves with the support of professionals in the community. Many people with LTCs – over 40% in Barnet, Haringey and Enfield – do not feel supported to manage their condition[26]. This would help avoid the high levels of hospitalisation we experience for the elderly and those with chronic conditions.

One of the disease specific challenges we face is in the provision of cancer care. Late diagnosis of cancers is a particular issue, alongside low levels of screening for cancer and low awareness of the symptoms of cancer in some minority ethnic groups. Waiting times to

[18] QOF data 2014/15
[19] NHS England Dementia Diagnosis Monthly Workbook, April 2016
[20] Dunedin Multidisciplinary Health & Development Research Unit. Welcome to the Dunedin Multidisciplinary Health and Development Research Unit (DMHDRU).
[21] Fingertips, 2014/15
[22] Healthy Lives, Healthy People 2010
[23] Based on 2015/16 public health budget of each NCL council
[24] Public Health Profiles Data Tool, PHE, 2012-14
[25] QOF 2014/15
[26] Office for National Statistics, HSCIC CCG Indicators, 2014-15

see a specialist are long, and so are waiting times for diagnostics. Additionally, referrals to specialists have almost doubled in five years. There is a huge shortfall in diagnostic equipment and workforce, and a lack of services in the community, particularly at weekends. A further issue is that some hospitals are seeing small numbers of patients with some types of cancer, in some cases less than two per week.

There are some challenges in primary care provision, however, this is a mixed picture which creates inequity. There are too few GPs in Barnet, Enfield and Haringey, and low numbers of registered practice nurses per person across all areas, but particularly in Camden and Haringey.

There are high levels of A&E attendances across NCL compared to national and peer averages[27], and very high levels of first outpatient attendances[28], which indicate potential gaps in primary care provision. Acute providers are not consistently meeting emergency standards.

In the acute setting there are differences in the way that planned care is delivered and this needs to be addressed, with variation based on differences in clinical practice rather than patient need. The number of people seen as outpatients in NCL is high and there is variation in the number of referrals between consultants in the same hospital, the number of follow-up outpatient appointments and the proportion of planned care that is done as a day case.

We are using hospital beds for people who could be cared for at home, or in alternative care settings. 59% of acute bed days are used by people with stays over 10 days, and the majority of these people are elderly. 85% of the mental health bed days in NCL are from patients staying over 30 days. Delayed discharges are also high in some hospitals. Staying longer than necessary in hospital is not good for people's health, especially the elderly whose health and wellbeing can deteriorate rapidly in an acute environment.[29]

We face challenges in mental health provision. People do not always have easy access to information and community based support, and community mental health services are under huge pressure. There is also no high quality health-based place of safety in NCL. Many people receive their first diagnosis of mental illness in Emergency Departments. High numbers of people are admitted to hospital – many under the Mental Health Act. There is variable access to liaison psychiatry, perinatal psychiatry and child and adolescent mental health services (CAMHS) within urgent care: most of the liaison psychiatry and CAMHS services in hospitals in NCL do not see children within one hour at weekends and overnight[30]. There is limited perinatal community service in NCL, in the northern boroughs there is no specialist team and in the southern boroughs the service does not meet national standards[31].

[27] RightCare Atlas of Variation in Healthcare, September 2015
[28] NHS England Activity Data 2014-15
[29] Philip et al. (2013) Reducing hospital bed use by frail older people: results from a systematic review of the literature. International Journal of integrated care.
[30] Mental health crisis care ED audit, NHS England (London), 2015
[31] Maternal Mental Health Everyone's Business

Our use of information and technology does not currently support integrated health and social care across NCL. There is a variable level of digital maturity across providers and most being below the national average for digital capabilities, particularly their capability to share information with others.

Some of our buildings are not fit for purpose and there are opportunities to use our estates better. 11 sites in NCL have facilitites management costs at least 10% more than the Carter benchmark (£319 p sq. m), with a further 3 sites within 10% of the benchmark. 8 sites have a higher proportion of unutilised space than the 2.5% benchmark contained within the Carter report, and over half of the sites analysed were found to have a higher proportion of non-clinical space than the Carter benchmark (35%).

We have significant workforce challenges across health and social care, including a high turnover across a range of professions, an over reliance on agency staff and HR policies which are not transferable across organisations.

There is consensus across the system that the current approach to commissioning and providing health and social care services across NCL could be better aligned to support the implementation of our emerging vision for the STP. In particular, the delivery of a population health approach and genuinely integrated care is significantly constrained by:

- the rigid separation of commissioning and providing responsibilities within the NHS
- the limited existing integration between health and social care
- the fragmentation of providers of health and care into many sovereign organisations
- increased financial risks across CCGs and providers
- stretched capacity and capability in the current organisational form.

We need to design new commissioning and delivery models that enable us to deliver transformed care in a way that is sustainable.

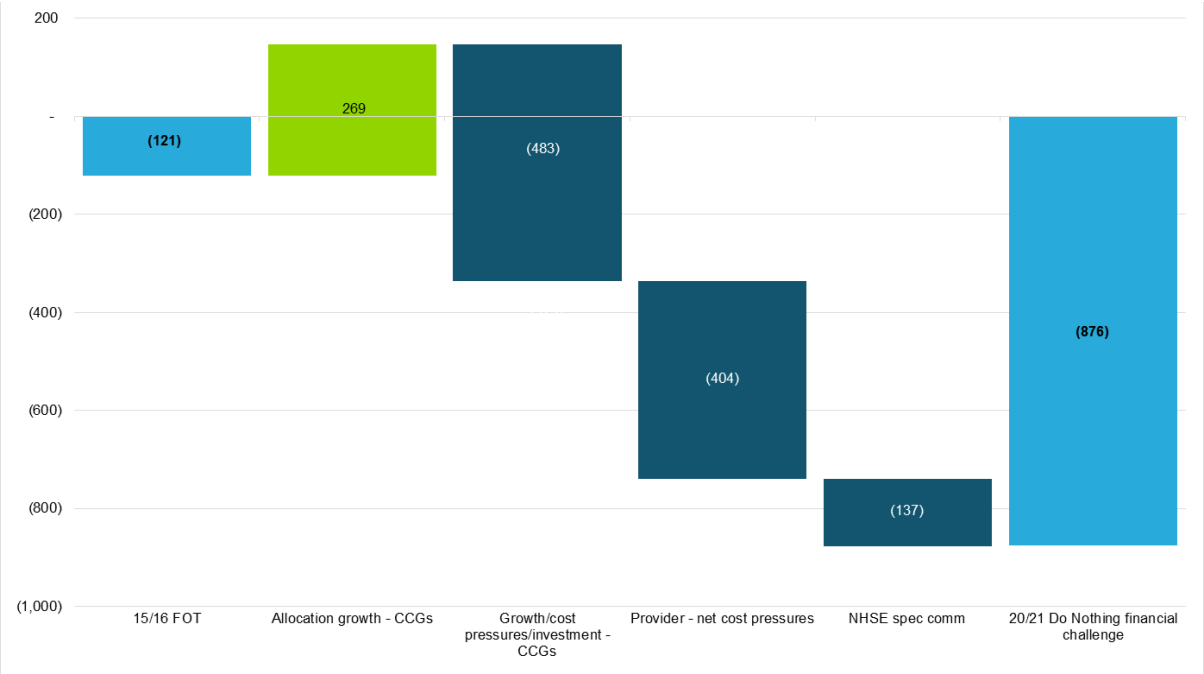
4.3 Baseline financial gap

Our population is growing and demand is rising: people access health care more often, and are – positively – living longer, but often with one or more long term conditions. Meanwhile, the NHS's costs are rising more than inflation across the UK economy (to which allocations are linked). The upshot of this is that not only is the system responding to greater demand, but also that the sum cost of activity is growing faster than allocations.

Put simply, funding increases in NCL of £269m over the next 5 years will not meet the likely increases in numbers of local people and growth in demand for health services of c.£483m, plus increases in the cost of delivering health care of c.£404m.

This means that there is a substantial financial challenge facing health organisations in NCL. Health commissioners and providers were already £121m in deficit in 2015/16 and, if nothing changes, this will grow to £876m in deficit by 2020/21.

Exhibit 2: The 'do nothing' financial gap for NCL



The 'do nothing' specialised commissioning financial challenge is estimated at £137m (this estimate is currently being validated). This excludes Great Ormond Street Hospital NHS Trust and the Royal National Orthopaedic Hospital NHS Foundation Trust which would add a further £49m and £10m respectively. The specialised commissioning challenge is driven by advances in science; an increasingly ageing population with LTCs; and rising public expectation and choice for specialised treatment. In addition there are increasing financial pressures for specialised services, including the increasing volume of expensive new drugs. Spending on specialised services has increased at much greater a rate than other parts of the NHS, and this is expected to continue.

The current combined net budgets for the 5 boroughs in NCL is £760m for Adults and Children's Social Care (CSC) and Public Health services. However, we know that between 2010/11 and 2020/21 the average reduction in borough spending power will be 35%. Adult Social Care (ASC) budget reductions during this period will total at least £154.5m. This reduction in funding requires that a significant savings programme be delivered.

The collective 2016/17 forecast budget pressures for the 5 boroughs in ASC and CSC is £39m (£26m ASC, £13m CSC). Both ASC and CSC will continue face considerable pressures from demographic growth, inflation and increasingly complex care needs. By 2020/21 the combinations of pressures and continued loss of funding will result in a combined social care budget gap of c.£308m, which is equivalent to a 28% reduction on the current Councils' total budget. Councils may have the option to raise a 2% precept for social care in future years, but this will be subject to political agreement and will not come close to closing the gap.

5 Vision

Our vision is for North Central London to be a place with the best possible health and wellbeing, where no-one gets left behind.

Developing our vision in NCL has taken time, and we have harnessed our high quality clinical and practitioner leadership at every stage of the process. The vision for NCL initially drew on existing local work which was underway before the STP process started. Leaders across the system then iterated the vision at an event in September 2016. This process, alongside the series of borough-based public engagement events in September and October, has ensured that our vision is collectively owned across the system. We are committed to fulfilling our vision through this plan, and have identified a set of core principles to support our ambition.

Our core principles

- We will work in a new way as a whole system; sharing risk, resources and reward.
- Health and social care will be integrated as a critical enabler to the delivery of seamless, joined up care.
- We will move from pilots and projects to interventions for whole populations built around communities, people and their needs. This will be underpinned by research based delivery models that move innovation in laboratories to frontline delivery as quickly as possible.
- We will make the best the standard for everyone, by reducing variation across NCL.
- In terms of health we will give children the best start in life, and work with people to help them remain independent and manage their own health and wellbeing.
- In terms of care we will work together to improve outcomes, provide care closer to home, and people will only need to go to hospital when it is clinically essential or economically sensible.
- We will ensure value for tax payers' money through increasing efficiency and productivity, and consolidating services where appropriate.
- To do all of this we will do things radically differently through optimising the use of technology.
- This will be delivered by a unified, high quality workforce for NCL.

6 Strategic framework

To deliver on our vision and achieve the triple aim as set out in the Five Year Forward View (to increase health and wellbeing; meet the highest standards of care and quality; and improve productivity and efficiency), we have designed a programme of transformation with 4 aspects:

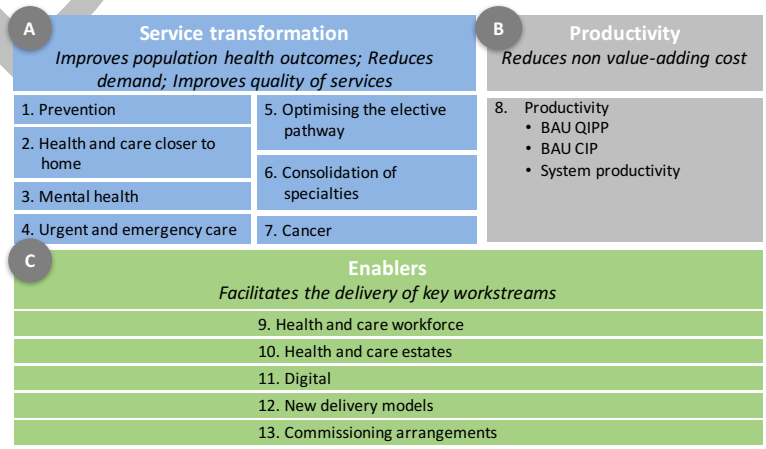
1. **Prevention:** Much of the burden of ill health, poor quality of life and health inequalities in NCL is preventable. We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population, which will reduce health inequalities, and help prevent demand for more expensive health and care services in the longer term.

2. **Service transformation:** To meet the changing needs of our population we will transform the way that we deliver services. This involves taking a "population health" approach: giving children the best possible start in life; strengthening the offers and provision in the local community to ensure that where possible care can be provided out of hospital and closer to home – reducing pressure on hospital services; rethinking the relationships between physical and mental health to ensure that mental health care is holistic and person-centred; and, reducing variation in services provided in hospital. Social care plays a key role in service transformation.

3. **Productivity:** In order to ensure sustainability, we will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies. For providers, this includes implementing recommendations from the Carter Review and working together across organisations to identify opportunities to deliver better productivity at scale.

4. **Enablers:** We will focus on delivering capacity in key areas that will support the delivery of transformed care across NCL. This includes digital, workforce, estates, and new commissioning and delivery models.

Exhibit 3: The NCL STP strategic framework



6.1 Prevention

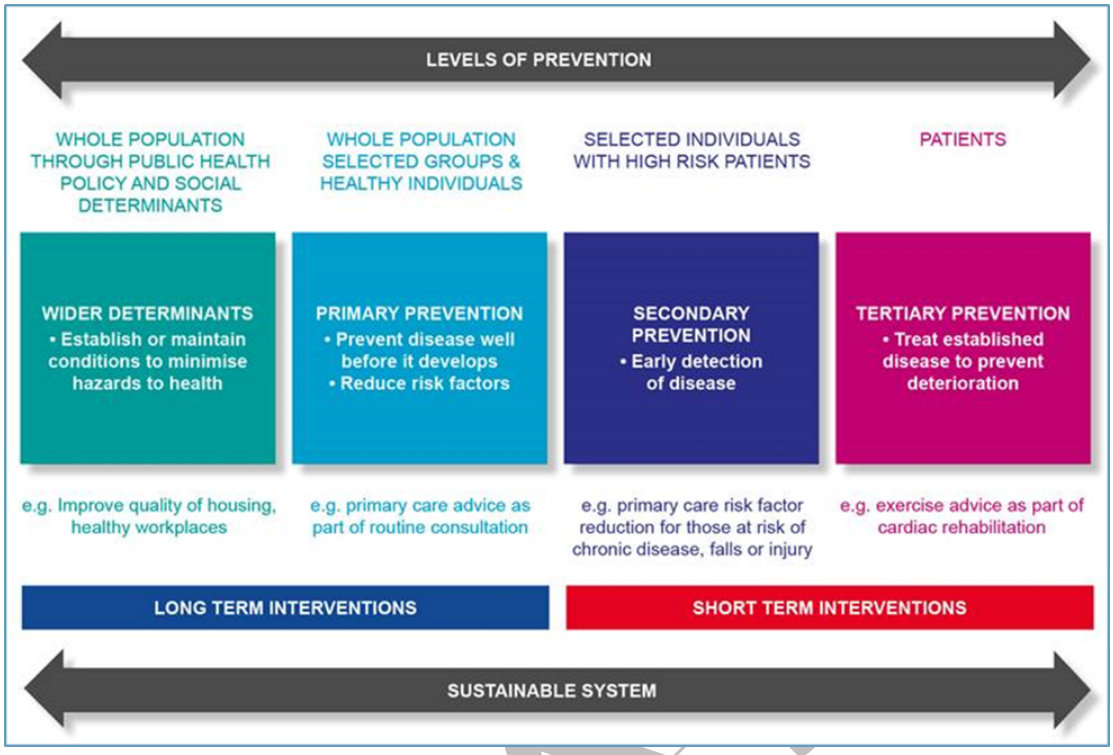
We will embed prevention and early intervention across the whole health and care system and deliver effective preventative interventions at scale. As a result, we will improve population health outcomes and reduce health inequalities by harnessing assets within and across communities for example, from Council services, including social care and the voluntary and community sector. This will positively impacting on the lives of residents, their families, and our communities.

Afrin lives in hostel accommodation and is dependent on alcohol. He experiences seizures almost daily. Afrin has in the past, with support from treatment, managed to gain abstinence but had a relapse which is due to depression brought on by unstable housing and economic circumstances. Afrin has had many unscheduled hospital admissions in the last 6 months. In future, on admission to hospital Afrin will be referred to an alcohol assertive outreach worker (AAOT) by the hospital alcohol liaison worker. This support will enable him to put in place foundations that will help him towards abstinence and recovery. Afrin will be supported to give up drinking, with input from an addictions doctor at a community alcohol service. A slow reduction plan, that is achievable and minimises the risk of seizures which in the past have led to hospital admission, will be put in place. Afrin will have regular 1-2-1 appointments with his AAOT, which will include psychological help.

Our prevention plans focus on interventions and system change across the whole spectrum of prevention (exhibit 4), where there is strong evidence of effectiveness and return on investment within the 5 year period of the STP[32]. In addition, we have identified opportunities where we could rapidly build upon successful local initiatives across NCL to achieve economies of scale.

[32] Interventions have been identified from the Public Health England (PHE) Supporting Pack for STPs and the return on investment work undertaken for Healthy London Partnerships by Optimity.

Exhibit 4: Approach to prevention



We will concentrate our efforts on:

- **Creating a 'workforce for prevention'** so that every member of the local public sector workforce in NCL is a champion for prevention.
  Specific interventions: Making Every Contact Count (MECC); Mental Health First Aid (MHFA); dementia awareness
- **Ensuring that the places where residents and employees live and work promote good health.** This will include: reversing the upwards trend in childhood obesity; supporting people with mental ill health and other long term conditions to stay in work; pioneering new approaches to tackling gambling, alcohol misuse and smoking; and supporting the workforce across NCL (including our own staff) to become healthier.
  Specific interventions: Haringey Devolution Pilot; improving employment opportunities for people with mental ill health through individual placement support (IPS); Healthy Workplace Charter; Healthy Early Years / Healthy Schools accreditation
- **Supporting residents, families and communities to look after their health: smoking and drinking less, eating more healthily, and being more active, as well as looking after their sexual health and mental health wellbeing.** This will all reduce hospital admissions from preventable causes such as smoking, alcohol, and falls, and reductions in associated ill health and early deaths. We will protect and ensure high quality universal services for vulnerable families by starting direct conversations with schools to proactively identify who these families are, and collaborating to map across primary care, social care, early years, therapies, paediatrics and secondary care. We will ensure that smoking cessation programmes are embedded across

maternity services and services for children and young people, targeting parents and older children. Drawing on the experience of our local authorities in running large scale campaigns, we will design and deliver a campaign across NCL to address a variety of wellbeing or long term conditions through a single preventative message with common NCL branding.
Specific interventions: smoking cessation; alcohol screening, liaison and outreach teams; weight management programmes; diabetes prevention programme; multifactorial falls intervention; long-acting reversible contraception; community resilience; increased access to mental health services for children and new mothers; London's digital mental health programme.

- **Diagnosing residents with clinical risk factors and long term conditions much earlier to increase life expectancy.** Once diagnosed, empowering them to manage their own condition(s) alongside proactive management by health professionals to prevent the development of further conditions and complications.
Specific interventions: increasing awareness and case finding (including national cancer screening and HIV testing) and appropriate medications to control conditions for people with high blood pressure, diabetes, atrial fibrillation; self-care and structured self-management for long term conditions; reablement offers in social care and care navigation.

We will build upon on the individual strengths that each part of the public sector in NCL can bring to preventing disease and ill health. As well as traditional 'health professionals' this also means working with local authority housing officers and the London Fire Brigade in, for example, preventing falls. We also recognise the key contribution that voluntary and community sector organisations can make in achieving disproportionately greater improvements in health for residents with mental ill health and learning disabilities, specific BME groups, and those in the most deprived communities, and we are committed to working more collaboratively with these organisations.

6.2 Service transformation

To meet the changing needs of our population we will transform the way that we deliver services, shifting the balance of care from reactive to proactive. This will be through ensuring people achieve the best start in life, developing our care closer to home model, creating a holistic approach to mental health services, improving urgent and emergency care, optimising the elective pathway, consolidating of specialties where appropriate and transforming cancer services to improve the end-to-end experience. Social care plays a key role in all aspects of service transformation.

6.2.1 Achieving the best start in life

Children make up between 25% and 30% of the population across the NCL footprint which means that service transformation must include a specific focus on our children and young people. We recognise that providing children with the best start in life is critical for their development and health long term. We have identified interventions across the pathway,

from prevention to acute care, that are focussed specifically on improving health and outcomes for children and young people.

In the context of a considerable body of research suggesting that fetal exposure to an adverse environment in-utero sets the trajectory for child and adult health in terms of congenital malformations, obesity, diabetes and cardiovascular disease, we will explore ways to link primary care, public health and maternity services to optimise maternal health before, during and after pregnancy. In particular, smoking cessation, weight reduction, optimisation of blood sugar control in diabetics and improvement of diet in women of reproductive age has the potential to reduce the health needs of children. We will leverage the work of our NCL Maternity Network to ensure that our local maternity system implements the findings of the national Maternity review: Better Births. We are keen to take part in the National Maternity Transformation programme as an Early Adopter.

We will promote active travel, sport and play for children in schools, for example involving schools to deliver the *Take 10, Active 15, Walk a daily mile* initiatives that other parts of the country have adopted to support this. By 2020/21, our aim is that 4 out of 5 early years' settings and schools in NCL will be accredited as part of the healthy schools, healthy early years or similarly accredited programme for promoting healthy lives.

Tai, 14, suffers from severe depression. With the involvement of Tai, his family, and his CAMHS practitioners, Tai has been admitted into a Tier 4 unit on a planner basis. Previously, it was likely that Tai would have been placed far from home. In future, with the local commissioning of Tier 4 he will be able to be placed close to home. This will enable better linkage with the local CAMHS community team, which will have also been enhanced. Together, these factors will mean Tai has a better experience of care and stays in hospital for a shorter length of time. When Tai is discharged back into the community, he will have an enhanced care plan to support him to keep well.

We will address mental ill health in children as early as possible: developing antenatal and postnatal interventions for mothers with mental ill health; improving services for parenting support, health visiting, and signposting; and creating targeted services that focus on vulnerable high risk families. We will capitalise on the universal services of MIND, Place2Be and voluntary sector initiatives like *Hope Tottenham* that are already established and working directly with families and young people. As part of our Child and Adolescent Mental Health Services (CAMHS) and perinatal initiative led through the mental health workstream, we will:

1. **Develop a shared dataset for CAMHS** to enable comparison and shared learning across the 5 boroughs
2. **Tackle eating disorders** by establishing dedicated eating disorder teams in line with the waiting time standard, service model and guidance
3. **Upskill our workforce** to meet the mental health and psychological wellbeing needs of children and young people, including developing a children and young people's IAPT workforce capability programme

4. **Build on our Transforming Care initiative** by supporting children and young people with challenging behaviour in the community in order to prevent the need for residential admission
5. **Improve perinatal mental health services** by developing a specialist community perinatal mental health team that serves the NCL population and the physical health acute trusts within NCL
6. **Implement a Child House model** following best practice to support abused children
7. **Create a 24/7 crisis pathway for children and young people**, including local commissioning of Tier 4 CAMHS to eliminate out of area placements for non-specialist acute care by 2020/21; and review of S136
8. **Develop a co-commissioning model for youth justice** working with NHS England.

The principles of THRIVE will be used as an overarching approach to our CAMHS work, with the aim that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019 as set out in the Mental Health Taskforce.

6.2.2 Health and care closer to home

Health and care will be available closer to home for all, ensuring that people receive care in the best possible setting at a local level and with local accountability. We already have many high quality services outside acute settings across NCL, but our health and care closer to home model will focus on scaling these services up, reducing variation and making this the default approach to care. Social care will play a key role in the design, development and expansion of the future model.

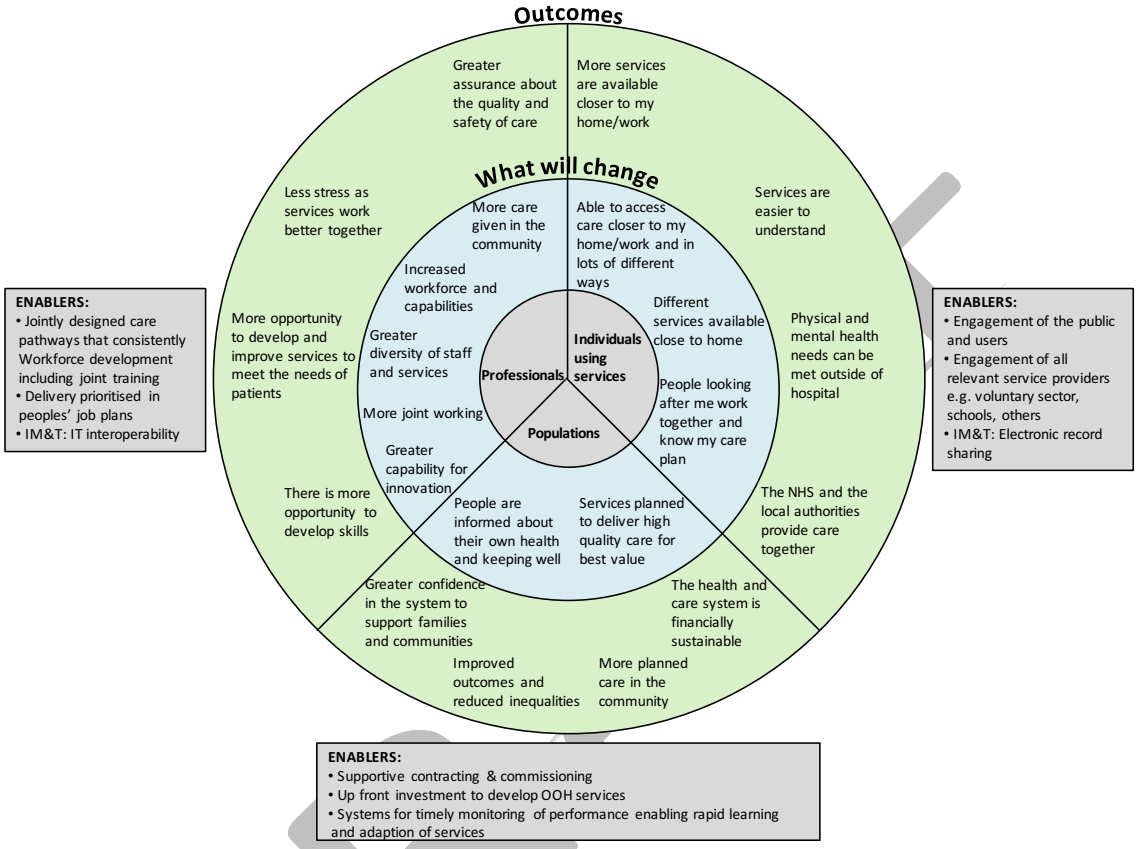
> Ms Sahni is 87 and has four chronic health problems. Previously, she had to book separate appointments with different primary care professionals to have all of the relevant check-ups and appointments that she required. In future, Ms Sahni will be in a special "stream" of patients who will have all of their care co-ordinated by a very experienced GP. This will allow her to see the specialist heart or diabetic nurses at the Integrated Care Centre located at her GP surgery. There will also be a care navigator in the team who can help to sort things out for her at home, including community support when she needs it.

We will address the sustainability and quality of general practice, including workforce and workload issues. It is recognised that for some people, health and care being delivered closer to their home is not always the best choice, and therefore high quality hospital-based and care home services will continue to be available when needed.

At the heart of the care closer to home model is a 'place-based' population health system of care delivery which draws together social, community, primary and specialist services. This will be underpinned by a systematic focus on prevention and supported self-care, with the aim of reducing demand on the system over time. We will deliver the right care at the right time to the whole population. The care closer to home model is one of the key vehicles by

which we will contribute towards the overall delivery of the Better Health for London outcomes.

Exhibit 5: Delivery of the Better Health for London outcomes through the health and care closer to home model



Specific interventions that make up the scope of the care closer to home model include:

- **Developing 'Care Closer to Home Integrated Networks' (CHINs):** CHINs may be virtual or physical, and will most likely cover a population of c.50,000 people. They will be home to a number of services including the voluntary and community sector to provide a more integrated and holistic, person-centred community model, including health and social care integrated multi-disciplinary teams (MDTs), care planning and care coordination for identified patients. Interventions focussed on the strengths of residents, families and communities; improving quality in primary care; and reducing unwarranted variation will also operate from CHINs, including Quality Improvement Support Teams (QIST) to provide hands-on practical help for individual GP practices to ensure a consistent quality standard and offer to all patients. This will include support for case finding and proactive management of high blood pressure, atrial fibrillation and diabetes. We have already piloted CHINs, for example the Barnet Integrated Local Team (BILT)[33] hub which provides coordinated care for older residents with complex medical and social care needs, as well as providing support

[33] Barnet integrated Care Locality Team, 2016

to carers. The BILT hub has been open since April 2016 and is a joint funded health and social care pilot.

- **Extending access to primary care:** patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week.
- **Supporting healthier choices:** in line with our prevention agenda, the care closer to home model will include upscaling our smoking cessation activities by 9-fold to reduce prevalence and hospital admissions; increasing alcohol screening and the capacity of alcohol liaison services and alcohol assertive outreach teams across NCL; scaling up weight management programmes with integrated physical and wellbeing activities; and reducing unplanned pregnancies by increasing the offer and uptake of long acting reversible contraception.
- **Improving access through technology and pathways:** telephone triage, virtual consultations and online booking systems will be available for all patients.
- **Supporting patients through social prescribing and patient education:** the care closer to home model will include a greater emphasis on social prescribing and patient education. Support will be available for patients, carers and professionals to be confident users of information and IT solutions that enable self-management and care, as well as care navigation support to direct patients to the right services.
- **24/7 access to specialist opinion in primary care:** primary care will be able to provide more complex patients with a number of options for specialist opinion outside of the hospital itself. These range from: 1) advice only 2) an urgent 'hot clinic' appointment in an out-patient clinic 3) assessment in an ambulatory emergency care facility and 4) admission to an acute assessment unit. In addition, consultant-led clinical assessment and treatment services offered in CHINs will enable more patients to be managed in the primary care setting. Specialties to be considered include gynaecology; ENT; urology; dermatology; musculo-skeletal; and ophthalmology.
- **GP front door model in Emergency Departments:** we will review the existing provision across NCL of GP led triage, treatment and streaming for all ambulatory patients will be provided at the front door of Emergency Departments. GPs and nurses on the door make decisions about where the patient is best treated – which could be in the urgent care centre or emergency department, or redirection to alternative services.
- **Falls emergency response team and multifactorial intervention:** multifactorial interventions combining regular exercise, modifications to people's homes and regular review of medications will prevent people from falling in the first place. If they do fall, falls partnership ambulance vehicles will be available with advanced, multi-disciplinary practitioners. In addition, a specific falls service will support patients to remain at home after a fall.
- **Enhanced rapid response (ERR):** a rapid response team will prevent an admission to hospital for those in crisis, providing enhanced therapy, nursing and social work support to support people to stay in their own home.

- **Acute care at home:** where there is a medical need, acute clinical care will be provided at home by a MDT to provide the best possible patient experience and outcomes, and enable the patient to benefit from holistic integrated care.
- **Frailty units:** a dedicated service, such as that already in place at the Whittington, that will be focussed on rapid assessment, treatment and rapid discharge of frail older people that could potentially be co-located within the Emergency Department. This will enable ambulatory care for people aged over 65. These would be rolled out across NCL.
- **Enhanced care home support:** provided to stabilise and / or treat residents in the care home where appropriate thereby reducing the level of conveyances, unplanned attendances and admissions to secondary care. The care closer to home model will prevent emergency readmissions from care homes through development of a care home bundle, including a proactive approach to prevention and early identification of complications.
- **End of life care:** we will support people at the end of life to receive the care that they need to enable them to die in their place of choice via rolling out the Co-ordinate My Care (CMC) care planning programme, and ensuring the new Integrated Urgent Care service (see section 6.2.4) has access to CMC plans.

Acheiving care closer to home will need to be underpinned by strong resilient communities that are able to support residents live independently at home, where that support is needed. The support may be needed from families, carers, neighbours or from voluntary and community groups all of whom have central roles to play.

We plan to bring together the funding currently used for Locally Commissioned Services (LCS) and the premium spent on Personal Medical Services (over and above GMS) and establish one LCS contract framework for the whole of NCL. This LCS contract will have agreed outcomes which are shared with the Health And Care Closer to Home Networks (CHINs) and the Quality Improvement Support Teams (QISTs) so that all local GPs are provided with the necessary funding and incentives to fully engage with these vital components of the health and care closer to home work. Delivery of this whole system alignment is partly dependent on NHS England (London) delegating commissioning of the PMS premium to the CCGs which is currently under discussion with all key parties.

In support of delivering our health and care closer to home model, Islington CCG has expressed an interest in becoming an Integrated Personal Commissioning (IPC) site in order to improve health and wellbeing outcomes through personalised commissioning, improved care and support planning and developing an asset based approach to support solutions.

The IPC site will:

- improve outcomes for patients with care delivered closer to home, and aim to reduce unplanned admissions
- realign service provision in light of new service developments related to IPC and Personal Health Budgets
- review existing contracts to assess impact and identify opportunities for realignment based on a number of other developments such as New Care Models and IPC.

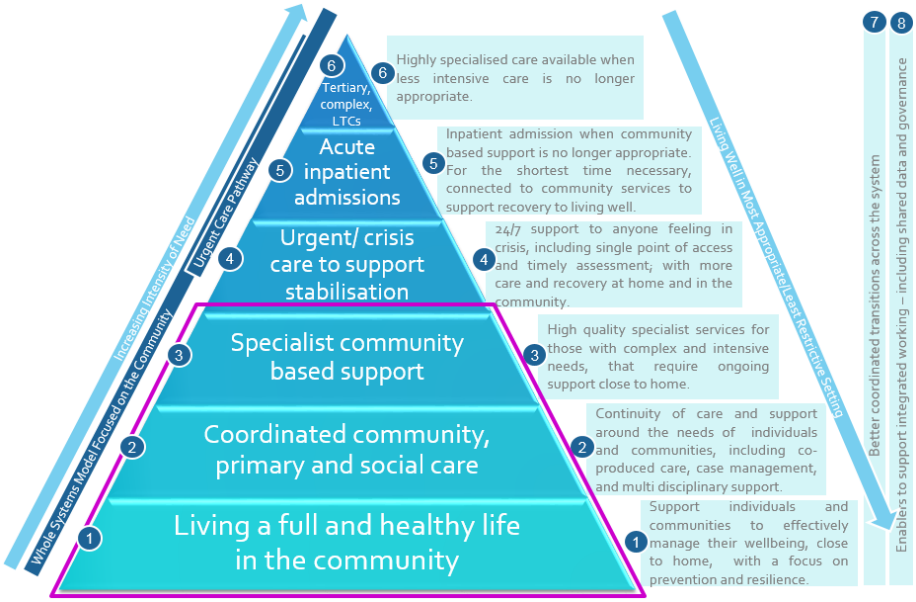
Improving outcomes will be the crucial measure of success of the care closer to home model. Using national and international evidence, we have estimated that some of the outcomes that our health and care closer to home model could potentially deliver are:

- 70% of people at the end of their life will have a care plan to support them to die in their place of choice
- 4% decrease in unplanned pregnancies
- a reduction in alcohol consumption with 10% fewer alcohol-related hospital admissions
- up to 150,000 fewer emergency department attendances
- 63,000 fewer non-elective admissions
- 35,000 fewer outpatient attendances
- 10% reduction in falls-related hospital admissions
- a halving of the numbers of late HIV diagnoses
- 50,000 weight management referrals leading to a reduction in excess weight
- 66% of people with high blood pressure have it diagnosed and controlled
- 55% of people with atrial fibrillation are receiving anti-coagulants
- 69% of people with diabetes have controlled blood glucose.

6.2.3 Mental health

We will develop a 'stepped' model of care (see exhibit 6) supporting people with mental ill health to live well, enabling them to receive care in the least restrictive setting for their needs.[34] We recognise the key role and accountabilities of social care for people with long-standing mental ill health and drawing on this will be central to the success of the stepped model.

Exhibit 6: The mental health 'stepped' model of care



[34] As identified in the Mental Health Taskforce Report

We aim to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds. This will improve overall mental health outcomes across NCL, reduce inequalities for those with mental ill health, enable more people to live well and receive services closer to home and ensure that we are treating both physical and mental ill health equally. We will achieve the key mental health access standards:

- more than 50% of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within 2 weeks of referral
- 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within 6 weeks of referral, with 95% treated within 18 weeks.

Maisie suffers from dementia, and is cared for by her husband Albert. Previously, after falling at home, Maisie was admitted to hospital. Due to the accident and change of surroundings, Maisie was agitated and more confused than normal. In future, the hospital will have Core 24 liasion psychiatry meaning that the liaison team will be able to help the hospital support both Maisie's physical and mental health needs. As Maisie will receive holistic care it will mean that she is ready to be discharged sooner than if only her physical health needs were supported. Maisie's husband Albert will also be supported by the dementia service, allowing him to continue to care for Maisie at home.

Initiatives will cover mental health support for all age groups and include:

- **Improving community resilience:** both for the general population, and those at risk of developing mental ill health or of it becoming more severe. For the general population this includes a promotional drive aimed at increasing basic mental health awareness including self-awareness, normalising mental health needs and reducing stigma. For the at risk population focus will be given to improving access and support through training of non-mental health specialists to recognise mental ill health symptoms, improving service navigation, development of open resources, and provision of individual and group therapies; employment support to help people to maintain and get back into work including through Individual Placement Support[35]; and suicide prevention work to strengthen referral pathways for those in crisis, linked to the local multiagency suicide prevention strategies.[36] This will be delivered in conjunction with other regional and national schemes such as the London digital wellbeing platform. We will continue to build upon current work; for example Barnet CCG and local authority are already working towards a dementia friendly borough by providing lunch clubs, reminiscent therapy and engaging with local shops to raise awareness.
- **Increasing access to primary care mental health services:** ensuring more accessible mental health support is delivered locally within primary care services, developed as part of the CHINs; enabling both physical health and mental health needs to be

[35] Five Year Forward View - 29,000 more people living with mental ill health should be supported to find or stay in work (~725 within NCL)
[36] Five Year Forward View - Reduce suicide by 10%

supported together[37]. We will offer support directly to patients and support to GPs and other professionals; enabling more people to access evidenced based mental health services[38], and more care to be offered through CHINs rather than requiring referral to secondary care mental health services. Services will include increasing the IAPT offer to reach 25% of need.[39]

- **Improving the acute mental health pathway:** building community capacity to enable people to stay well and reduce acute presentations. This includes developing alternatives to admission by strengthening crisis and home treatment teams; reviewing Health Based Place of Safety (HBPoS) provision with the view to reduce the number of units and to have a sector wide provision that meets all requirements; and investing in longer term supported living arrangements to ensure effective discharge, enabling more people to live well in the community.
- **Developing a Female Psychiatric Intensive Care Unit (PICU):** we will ensure local provision of inpatient services to female patients requiring psychiatric intensive care, where currently there is none. This will enable patients to remain close to their communities, with a more streamlined and effective pathway ensuring a focus on recovery.[40]
- **Investing in mental health liaison services:** scaling up 24/7 all-age comprehensive liaison to more wards and Emergency Departments, ensuring that more people in Emergency Departments and on inpatient wards with physical health problems have their mental health needs assessed and supported.
- **CAMHS and perinatal:** initiatives as set out in section 6.2.1.
- **Investing in a dementia friendly NCL:** looking at prevention and early intervention, supporting people to remain at home longer and supporting carers to ensure that we meet national standards around dementia, including a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

An important enabler of a number our initiatives is the redevelopment of both the Barnet, Enfield and Haringey Mental Health Trust St Ann's site and the Camden and Islington Foundation Trust St Pancras site (in conjunction with the proposed relocation of Moorfields Eye Hospital Foundation Trust to the St Pancras site).

The proposed developments of the St Ann's and St Pancras sites would:

- transform the current inadequate acute mental health inpatient environments on both sites
- provide more therapeutic and recovery focussed surroundings for patients and staff
- improve clinical efficiency and greater integration of physical and mental health care
- release estate across the trusts, to enable development of community-based integrated physical and mental health facilities
- develop world class research facilities for mental health and ophthalmology enabling practice to reflect the best evidence

[37] FYFV – at least 280,000 people with severe mental ill health have their physical health needs met (~7,000 within NCL)
[38] Five Year Forward View - more adults with anxiety and depression have access to evidence based psychological therapies (~15,000 within NCL)
[39] Five Year Forward View
[40] Five Year Forward View - inappropriate out of area treatments for acute mental health care should be eliminated in all areas by 2020/21.

- provide land for both private and affordable housing, as well as supported housing for service users and housing for key workers.

6.2.4 Urgent and emergency care[41]

Over the next five years, we will deliver urgent and emergency care (UEC) services that are reliable, work well together and are easily understood. Our services will be consistent and inspire confidence in patients and professionals; supported by the use of an integrated digital care record that can be accessed across organisations. The first 2 years will focus on reducing variation in our services and the latter years will focus on transformation of the urgent and emergency care system, aligning closely with the care closer to home model.

Mary is 83 years old and lives at home with her husband. Mary had a fall at home and injured her ankle. Her husband was unable to help her get up so he called 999 for an ambulance. Mary was taken to the nearest A&E and admitted to hospital, where she is diagnosed with a urinary tract infection (UTI). She was reviewed by the consultant: a plan was put in place for treatment of her UTI and physiotherapy was recommended for her ankle. Over the weekend, Mary's UTI improved, but there was no consultant to review her condition or physiotherapist to provide her care, so Mary was unable to go home. When going to the toilet in the night, Mary fell again and stayed in hospital for a further 2 weeks. Mary became increasingly less mobile and more frail and dependent.

In future when Mary falls, her husband will dial 999, and a paramedic will be dispatched. When the clinical assessment does not suggest any fractures, the crew will access the local directory of services whilst on scene and electronically refer Mary to the Acute Care at Home service with request for a 12 hour response. Mary will then be visited at home by the falls team the next day who will design a package of care for Mary including reablement, allowing Mary to stay at home. The falls team will be able to detect if there is anything unusual about Mary's behaviour, and make a rapid appointment with her GP if they suspect a UTI. Mary will then get the antibiotics she needs to resolve this at an early stage.

Our aims are to:

- **Create a consistent UEC service across NCL:** all UEC services in NCL will meet National and London-wide quality standards[42] which will promote consistency in clinical assessment and the adoption of best practice. Patients will be seen by the most appropriate professional for their needs, which may include directing them to an alternative emergency or urgent care service.
- **Develop and implement a high quality integrated UEC service:** all urgent care services across NCL (including NHS 111, GP out of hours, Urgent Care Centres) will work together to offer consistent care. These services will be renamed 'Integrated

[41] This workstream includes all aspects of Urgent and Emergency Care provision delivered in the acute setting, including support for people to leave hospital. Also in scope is the development of a high quality, integrated urgent care system.
[42] As defined by the NHS E UEC designation process

Urgent Care'. We have commissioned a joined up new Integrated Urgent Care service provided by one provider, LCW, which goes live in October 2016. This service combines the NHS 111 and GP Out-of-Hours (OOH) services, and allows patients to access a wider skill mix of specialised clinicians in a new NHS 111 clinical hub.

- **Develop high quality, responsive 7-day hospital UEC services:** people will be supported to leave hospital as quickly as possible through building close links between acute care providers and social care. We will support shorter hospital stays by operating a simplified discharge or integrated 'discharge to assess' model: planning post-acute care in the community, as soon as the acute episode is complete, rather than in hospital before discharge. This will be the default pathway, with non-acute bedded alternatives for the very few patients who cannot manage this.
- **Develop high quality, responsive 7-day community services:** where possible, people will be supported and treated at home by community and ambulance services. For those people who do require ambulance transfer, the ambulance services will be able to use any UEC services that meets the patient's need.
- **Develop high quality ambulatory care services across NCL:** we will develop a service that reduces avoidable, unplanned admissions to hospital, such as that already in place at the Whittington. All UEC services will create consistent ambulatory care pathways that support people to have their care on a planned basis, wherever possible. This will provide same day emergency care to support patients to be assessed, diagnosed, treated and able to go home the same day without an overnight admission. This model will be rolled out across NCL.

The focus on urgent and emergency care services will reduce the number of unplanned admissions to hospital and support people to go home from hospital as soon as possible. This will improve patient experience, improve outcomes and make sure that people have their care on a planned basis wherever possible.

6.2.5 Social care

Social care is a crucial part of many of our workstreams, particularly care closer to home, Transforming Care, and mental health, as well as children's and public health interventions. We are considering how local authorities can work with the workforce leads across NCL to design and develop proposals specifically for social care, including a focus on the sustainability of provider workforce, the sustainability of the registered workforce and stimulating the personal assistant workforce. We will ensure that our plans factor in practical steps that we can take as partners to address provider failure and the huge risks around capacity and quality in the domiciliary market.

The role of social workers will be essential to delivering on our model for health and care closer to home, in addition to the role of home care workers, personal assistants, blended role between district nurses and care workers. The workforce workstream will consider these career pathways, making careers in these areas more attractive to support increased sustainability of the workforce. We will quantify any investment that might be needed in workforce from a social care point of view e.g. increasing numbers of domiciliary care

workers and, drawing on learning from elsewhere, we will quantify the return on investment.

Social care is also built into our mental health model, including a broader dimension of public service support such as employment support workers. Learning disabilities is a key area of focus given that half of social care spend is on this group, and that children with special educational needs and learning disabilities have worse long term outcomes in both health and education. We need to start supporting those with learning disabilities from early childhood to ensure early detection and appropriate intervention. Many of our interventions, including health visiting, early years, community paediatrics, CAMHS, and working directly with schools will ensure that we better support these children. We plan to scale up our Transforming Care work to implement enhanced community provision; reduce inpatient capacity; upgrade accommodation and support for those with learning disabilities; and roll out care and treatment reviews in line with published policy to reduce long lengths of stay in hospitals and improve independence.

As part of our STP we will explore collaboration and consolidation opportunities between local authorities in areas such as the hospital discharge pathway and the mental health enablement process. We will consider what can be commissioned differently and/or at scale - particularly across health and social care, for example nursing homes. We will focus on ramping up the use of data analysis and risk stratification; working cohesively with public health across the patch; leveraging telecare; and sharing of ideas and learning about best practice in terms of health and social care integration. Our pan-NCL bed state analysis will consider non-health beds, including the 6,440 care home beds in NCL, so that we gain an in-depth understanding of why people end up in these beds and how best their needs could be met elsewhere (as well as the resources it would take to do this).

We recognise the co-dependencies between health and social care: any change in either sector may have a significant impact on the other. As we continue to develop our plans, we will ensure local authorities are involved throughout so that we can mitigate any risks around this together, and transform the system so that it is truly integrated.

6.2.6 Optimising the elective (planned care) pathway

Building on the opportunities identified through RightCare, we will reduce unwarranted variation in elective (planned) care across providers in NCL. This will include reducing variation in the length of stay in hospital and the number of outpatient appointments received by patients with similar needs. Optimised pathways will ensure patient safety, quality and outcomes, and efficient care delivery.

Previously, John (who is 75 and has pain in his knee) made an appointment with his GP. The GP referred him to the hospital where he was seen in outpatients and sent for an MRI scan. A consultant established that John needed a knee replacement. John was about to go on a trip to visit family in the USA for 2 months, so the consultant sent him back to his GP. When he returned John saw the GP again as well as the consultant, who sent him to preoperative assessment. He was found to have high blood pressure, and was sent back to the GP for treatment. Once his blood pressure was under control, John was listed and then admitted for surgery. He spent about 5 days in hospital, and then returned home.

In the future, John will see an extended scope physiotherapist at the GP surgery for his knee pain. The physio will arrange the MRI, and discuss the results with John. The physio will identify that John has raised blood pressure while completing his electronic referral template to the consultant at the hospital, and liaise with the GP to make sure this is treated before he is referred. John will have his hospital appointment and pre-operative assessment on the same day, and will be given all the information he needs to prepare for after the operation.

We will draw on local examples of best practice, such as the South West London Elective Orthopaedic Centre; and international best practice, such as Intermountain's hip replacement pathway redesign, which reduced the cost of total hip replacement by a quarter.[43] Building on the evidence, we will redesign pathways with local clinicians, responding to local needs and opportunities. We will initially focus on areas with high volume or high variability, where there is opportunity to achieve high impact by making changes, such as orthopaedics.

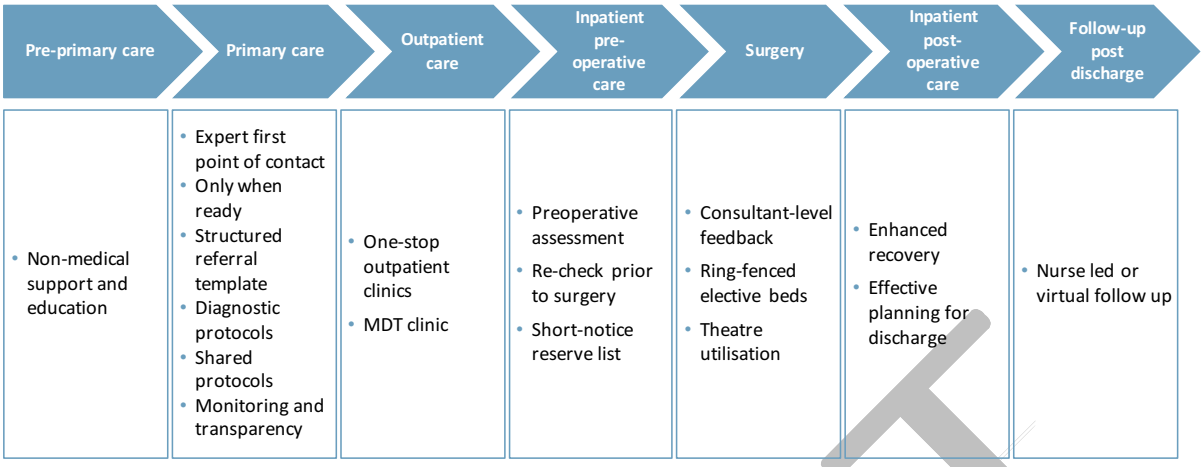
We will leverage the following opportunities for improvement to elective pathways:

- expert first point of contact: making sure people have access to the right expertise from their first appointment in primary care
- one-stop services: so that people do not need to attend multiple outpatient appointments before their procedure
- efficient surgical pathways: to ensure maximum use of staff and theatres
- timely discharge planning: to reduce unnecessary time in hospital.

To deliver on the above, a series of interventions will be put in place at each stage of the elective pathway. These are illustrated in exhibit 7.

[43] James and Savitz (2011). How Intermountain Trimmed Health Care Costs Through Robust Quality Improvement Efforts . Health Affairs

Exhibit 7: Interventions that support optimised elective pathways



For orthopaedics, implementation of these high level interventions includes: interventions includes:

- **Better use of non-medical support and education:** promoting non-medical support staff as the first line for minor concerns (e.g. at gyms), greater use of pharmacists, and giving patients access to more information online.
- **Expert first point of contact:** the first person the patient comes into contact with would be a GP with special interest or experienced physiotherapist, who would know the full range of treatment options available. As a consequence of this, more outpatient referrals would have diagnostics already performed and patients would be supported by the right information when they are making decisions about onward treatment.
- **Use of a structured referral template:** allowing all information to be available at the first clinic appointment. Ideally, this would be an electronic form which would reduce the risk of unnecessary follow up appointments as all relevant diagnostics and information are readily available to clinicans at the initial appointment. Structured referral templates are currently used by some providers and commissoners in NCL to good effect, but would be used more widely as part of the optimised elective pathway.
- **Improved diagnostic protocols:** administrative protocols would be ordered to ensure that the appropriate tests are being conducted to diagnose patients. This would limit repetitive tests being ordered, which is better for patients and optimises resource use.
- **Use of NCL-wide shared protocols:** would ensure that patients are being managed in a consistent way. It would build relationships and teams across the whole system, fostering trust and reducing duplication in tests, appointments and treatements as a result.
- **Only when ready:** patients are only referred when they are ready and available for treatment. This avoids a second GP appointment and re-referral.
- **Better monitoring and transparency:** peer review and support would be established to ensure referrals are appropriate, enabling clinicians to have an open dialogue

regarding the quality of referrals and continuously improve their own referral practices.

- **One-stop outpatient clinics:** access to simultaneous pre-assessment and additional diagnostics in a single place, reducing the need for unnecessary follow ups.
- **Multi-disciplinary team (MDT) clinics:** clinics which consist of multiple different people working together to triage to the most appropriate clinician. Consultants, extended scope physios and GPs with special interests would all working together in a single setting to form the MDT.
- **Pre-operative assessments conducted at the first outpatient appointment:** if patients are not found to be fit, then their plan is reviewed the same day. This would be supported by greater use of e-self assessment by patients in their home. Rehab and post-operative packages of care would be arranged prior to referral, enabling patients who are at risk of staying for long lengths of time in hospital to be proactively identified.
- **Re-check prior to surgery:** patients will be contacted 48-72 hours before their surgery to reduce the risk of late cancellations. This check will ensure patients are still well enough for surgery, and want to go ahead with the planned procedure.
- **Short-notice reserve list:** to ensure that gaps caused by late cancellation can be filled by patients who are ready for treatment which allows theatres to be used most efficiently.
- **Consultant-level feedback:** transparency of list utilisation and case volumes per list. This allows for peer challenge to take place between consultants, to ensure the highest quality and most efficient practices are being maintained.
- **More effective planning for discharge:** discharge planning services will be offered earlier in the process, before patients are admitted to hospital. This will give greater access to community support services, and reduce delays in discharge.
- **Enhanced recovery pathways will be consistently applied**: patients will have a greater understanding of their expected length of stay when they are admitted, and be advised on the best course of action to avoid staying for longer.
- **Ring fenced elective beds will be available:** to reduce wasted theatre time, and diminish the risk of infection for elective patients.
- **Theatre utilisation will be optimised:** by scheduling cases and ensuring that critical equipment is properly scheduled to maintain the order and running of lists.

In addition to the improvements being worked through for orthopaedics, further specialties have been identified for focused pathway design. These are:

- Urology
- General surgery
- Colorectal surgery
- Hepatobiliary and pancreatic surgery
- Upper gastrointestinal surgery
- Gynaecology
- Gynaecological oncology
- Ear, Nose and Throat (ENT)

- Vascular surgery
- Breast surgery
- Musculoskeletal (MSK)
- Ophthalmology
- General medicine
- Gastroenterology
- Endocrinology

As well as delivering efficiency savings, reducing variation in planned care will improve patient outcomes and experience through:

- improved access to information and support to help people manage conditions without surgical intervention
- support for people to access to the right professional expertise the first time, rather than being referred between several different professionals
- improved access to surgical interventions as capacity will be freed up
- patients receive a single outpatient appointment rather than needing to make several attendances
- less time spent in hospital, meaning less chance of acquiring infections and reducing the risk of lost independence
- ensuring access to the right post-operative support, helping patients get back to normal life more quickly.

Reducing variation will also improve staff experience, including ensuring access to the right professional expertise when needed, better access to high quality diagnostics, improved relationships between professionals in different care settings and increasing sharing and learning from best practice across the local professional communities.

6.2.7 Consolidation of specialties

We will identify clinical areas that might benefit from being organised differently (e.g. managing multiple services as a single service), networking across providers, or providers collaborating and / or configuring in a new way in order to deliver high impact changes to major services. While changes of this sort can be challenging to implement and controversial with the public, we should not shy away from considering making changes

In London, two thirds of early deaths in people under 75 are from cancer and heart disease, there is a high risk of heart disease among the local population and the number of people diagnosed with cancer is growing. Specialists, technology and research are spread across too many hospitals to provide the best round-the-clock care to all patients. If we were to improve local survival rates for heart disease and all cancers in line with at least the rate for England, over 1,200 lives could be saved each year. (Source: UCLH news, 14 March 2014)

UCLH, Barts Health, the Royal Free and a number of other north London trusts implemented a significant service reconfiguration to address these issues. Cardiovascular care services provided at The Heart Hospital, The London Chest Hospital and St Bartholomew's Hospital were combined to create an integrated cardiovascular centre in the new building at St Bartholomew's. For 5 complex or rare cancers, specialist treatment is provided in centres of excellence across the area. Services for other types of cancer and general cancer services, including most diagnostics and chemotherapy, continued to be provided locally.

where we are sure that significant improvements in the quality of care can be achieved.

We are not starting from scratch in this area: considerable service consolidation and specialisation has already taken place in NCL. Recent examples where we have successfully done this include:

- Cardiac / cancer (see case example box)
- Neurosurgery
- Pathology Joint Venture
- Renal medicine
- Hepatology and hepatobiliary surgery
- Neurosurgery
- Vascular surgery
- Ear, Nose and Throat (ENT)
- Bone Marrow transplantation
- Upper gastrointestinal
- Malignant gynaecology
- Cardiology
- Major trauma services
- Stroke services
- Plastic surgery
- Respiratory sub-specialties
- Cancer services including: pancreatic cancer, renal cancer, skin cancer, prostate cancer, head and neck cancer

However, we recognise that there may be other service areas which are or will become vulnerable in the future. There are many reasons why consolidation of services might be considered as a possible opportunity for improvement. First and foremost, we agree that improving quality should be the key driver for exploring consolidation, particularly where there is clear evidence of patients achieving better outcomes. Where there is a 'burning platform' and it is widely accepted that a service needs urgent attention (for example, in addressing issues of workforce sustainability), consolidation will be explored as an option. Releasing cost savings to support overall system sustainability is another driver for exploring potential consolidation opportunities.

This work is at an early stage. No decisions have been made, but we have identified services where we will review whether some form of consolidation may be worth consideration. It is recognised that fundamental, large scale reorganisation may take longer than the 5 year strategic horizon of the STP. As such, we have made no assumptions of financial benefit from this work.

To understand where we should focus further work, senior clinicians have systematically assessed services based on whether consolidation or alternative networking is required and / or could be beneficial. This has enabled us to identify a long list of services potentially in scope for further work over the 5 year period, for example:

- Emergency surgery (out of hours)
- Maternity services, in the context of the Better Births initiative (see section 6.2.1)
- Elective orthopaedics
- Mental health crisis care and place of safety
- Mental health acute inpatient services
- Histopathology
- General dermatology services

Over the next year each of these services will be reviewed in light of whether they would benefit from consolidation or networking. We are in the process of developing proposals to bring together some mental health inpatient services in order to drive significant improvements in quality and patient experience as set out in the mental health workstream (see section 6.2.3). In addition, work is under way to understand potential opportunities for consolidation of mental health places of safety.

6.2.8 Cancer

We will save lives and improve patient experience for those with cancer in NCL and beyond. Commissioners and providers across NCL joined together to form our Cancer Vanguard, in partnership with Manchester Cancer and Royal Marsden Partners, with the aim of achieving earlier cancer diagnosis, ensuring effective use of cancer outcomes information and adoption of recognised best practice across the full spectrum of cancer pathways.

Previously Margaret, aged 60, went to see her GP with persistent epigastric pain for several weeks. She was otherwise well, and did not have reflux, diarrhoea, vomiting or weight loss. Over the course of next 3 weeks, Margaret's GP organised tests and ruled out any inflammation, heart problem, or gallstones that could cause the pain. He also started Margaret on a tablet (lansoprazole) to try to reduce inflammation from the acid on her stomach lining. However, Margaret's pain was more persistent this time and she was still worried.

In the new system, Margaret's GP will be able to refer her to the Multidisciplinary Diagnostic Centre at UCLH despite the fact that her symptoms are not considered "red flag". Here, Margaret will be assessed for vague abdominal symptoms. A clinical nurse specialist will see her 4 days after referral. The team will identify that Margaret has early stage pancreatic cancer and because it is picked up early she will be able to access potentially curative keyhole surgery.

Our cancer workstream is derived from the Vanguard agenda and encompasses a range of improvements to current practice. The key areas of focus include:

- **Early diagnosis:** to address impact of late diagnosis on survival outcomes across NCL, we will target specific causes of late diagnosis and poor detection rates. Targeting colorectal and lung pathways are a particular focus given the high percentage of patients receiving late stage diagnoses, often in Emergency Departments. We will roll out the Multi-disciplinary Diagnostic Clinic model for vague abdominal symptoms, promote adoption of straight to test models and deliver a programme to

improve awareness of cancer symptoms in primary care.

- **New models of care:** we are developing the case for a single provider model for radiotherapy in NCL, to help achieve financial sustainability, reduce variation in clinical protocols and improve patient access to research and clinical innovations. This is being explored between the North Middlesex University Hospitals NHS Trust, the Royal Free NHS Foundation Trust and University College London Hospitals NHS Foundation Trust and also links with the hospital chains Vanguard led by the Royal Free. We will increase provision of chemotherapy closer to home, establishing a quality kitemark for chemotherapy and supporting self-management. The first patient treatment in the home for breast cancer will be available by the end of September 2016.
- **Centre for Cancer Outcomes (CCO):** to deliver robust outcomes data, improve pathway intelligence and address important population health research questions we will produce balanced scorecards which can made available to MDTs, providers and commissioners through a free to access web based platform.
- **Research and commercialisation:** we will leverage our unique position nationally in cancer to improve care for people with cancer, generate additional revenues across the system, and generate efficiencies by avoiding unnecessary interventions.

6.2.9 Specialised commissioning

Specialised services are those provided in relatively few hospitals / providers, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to develop their skills. In NCL, the main providers of specialised acute services are University College London Hospitals NHS Foundation Trust (with income totaling £317m) and the Royal Free London NHS Foundation Trust (with income totaling £273m). A further 10 providers receive an additional £128m in income for the delivery of specialised services. This includes three specialist hospitals: Royal National Orthopaedic Hospital NHS Trust, Moorfields Eye Hospital NHS Foundation Trust, and Great Ormond Street Hospital NHS Trust. Barnet, Enfield and Haringey Mental Health NHS Trust and the Tavistock and Portman NHS Foundation Trust provides specialised mental health services. As well as caring for the local population, the specialised services provided by hospitals in north central London are also accessed by a population from outside of NCL.

We recognise that planning for specialised services can have an impact across the region (and potentially nationally), and are therefore working closely with NHS England, London region to develop plans in this area. At a pan-London level, 11 priority transformation initiatives for specialised services have been identified. These are:

- Paediatrics
- Cardiovascular
- Neuroscience and stroke
- Renal
- Cancer

- Adult mental health
- Child and Adolescent Mental Health Services (CAMHS)
- Trauma
- Women and children
- Blood and infection
- Medicines optimisation

On review of these pan-London initiatives, our clinical leadership identified 5 areas which resonated strongly as opportunities where we could lead the way in transforming specialised services. We are in the process of progressing plans in the following 5 areas:

- **High cost drugs:** this involves reviewing and strengthening adherence to starting and stopping rules for all high cost drugs. There is already work ongoing in NCL in this area, which has revealed that clinicians are good at starting people on these drugs but poor at stopping them. We will set clear criteria around the use of high cost drugs at an NCL level. In addition, we will reduce the spend on cancer drugs through the Cancer Vanguard Pharma Challenge process, which includes programmes on biosimilars, home administration and system intelligence.
- **Elective spinal surgery:** we will rapidly progress work on assessment, pre-surgical pathways and stratification to ensure patients are directed to the best possible place. This will help us balance demand and capacity more effectively.
- **End of life chemotherapy:** we will undertake a comprehensive review of chemotherapy usage close to the end of life. Using the evidence on when to stop end of life chemotherapy, we will develop protocols around this. We will work across the whole pathway on this issue, and link stopping acute chemotherapy to end of life discussions in primary care, working closely with the Cancer Vanguard to deliver this.
- **Imaging:** we will contain growth in imaging costs by eliminating the need for re-acquisition due to inadequate or unavailable scans. For patients, this will increase the speed of diagnosis and result in a reduction in duplicated contrast or radiation exposure. Implementing a networking approach to imaging will help us to deliver on this, as well as use of information management and technology to enable providers to share information on the scans which have already taken place.
- **Spinal cord injury:** we will redesign the pathway locally to address patients are currently waiting in Intensive Care Unit (ICU) beds to access specialist spinal cord injury rehabilitation services. Waiting in ICU beds can cause the onset of other symptoms leading to worse outcomes for patients and high costs for the system.

We recognise that our planning on specialised services is less developed than many other parts of the STP. We will continue to work with the specialised commissioning team in NHS England, London Region to develop more detailed plans in this area.

6.3 Productivity

6.3.1 Commissioner productivity (BAU QIPP)

We will continue to deliver significant “business as usual” efficiencies throughout the 5 year period. Business as usual (BAU) QIPP (Quality, Innovation, Productivity and Prevention)

comprises savings commissioners expect to deliver as part of their normal activities. These are efficiencies in areas of CCG spend not covered by our other workstreams and include opportunities in the following areas:

- **Mental health:** this includes ongoing non-transformational efficiencies, consistent with parity of esteem requirements. Examples of mental health QIPP are the management of out of sector placements and streamlining the pathways with specialist commissioning across forensic and mental health services.
- **Community:** spend on community services was c.£133m in 2015/16. There is an assumption of increased efficiency equivalent to 1.5% per annum supported by benchmarking work and transition to new models of care.
- **Continuing care:** spend on continuing care was c.£90m in 2015/16. There is an assumption of increased efficiency equivalent to 2.1% per annum supported by existing framework agreements.
- **Primary care prescribing:** spend on primary care prescribing was c.£205m in 15/16. There is an assumption of increased efficiency equivalent to 2.5% per annum including the adoption of generic drugs where possible, the adoption of local quality schemes to improve consistency and effectiveness. This is in the context of assumed growth of 5-7% per annum.
- **Programme costs (including estates):** this includes measures to reduce void costs and better alignment of health and care services to reduce the overall estate footprint whilst maintaining and improving service quality.

6.3.2 Provider productivity (BAU CIP) and system productivity

Significantly improving provider productivity is an essential part of the work to address our financial challenge. Our plans assume significant delivery of CIP (Cost Improvement Programmes), improving provider productivity.

We have identified opportunities for system productivity (defined as those areas where CIP delivery is dependent on trusts working together) to deliver financial savings whilst maintaining or improving quality. Our plans also assume savings from improvements to contracting between CCGs and trusts which will be realised system wide.

Specific initiatives to improve productivity include:

- **Workforce:** we will establish a shared recruitment and bank function across providers meaning that staff can be deployed between providers in the system; as well as improving retention of current staff and upskilling the health and social care workforce to enable delivery of new models of care. We commit to complying with the maximum total agency spend and hourly rates set out by NHS Improvement.
- **Procurement:** we will reduce purchasing unit costs with increased volume and scale across all providers by reducing clinical variation in product choice and undertaking joint action on drugs and medicines management.
- **Back office:** we will create centralised functions for payroll and pensions, finance and estates in order to reduce our overheads and improve service resilience. In addition we will:

    - Consolidate IT services to reduce costs whilst improving the resilience and quality of services
    - Enhance the existing share procurement arrangements to reduce non-pay costs
    - Pool our legal budgets and resources, considering options to consolidate outsourced resources or appoint an in-house legal team.
- **Operational and clinical variation:** we will collectively reduce average length of stay, maximise theatre utilisation and streamline clinical processes, in addition to the changes proposed through the elective workstream.
- **Contract and transaction costs:** Releasing savings from streamlining transactions and contracting. This will be delivered through implementing new commissioning arrangements (which may facilitate joint procurement of services from the Commissioning Support Unit (CSU), for example) and leveraging the opportunities associated with joint commissioning between local authorities and CCGs.
- **Other:** Additional existing provider productivity schemes: estates, clinical admin redesign, service transformation, income etc.

6.4 Enablers

6.4.1 Digital

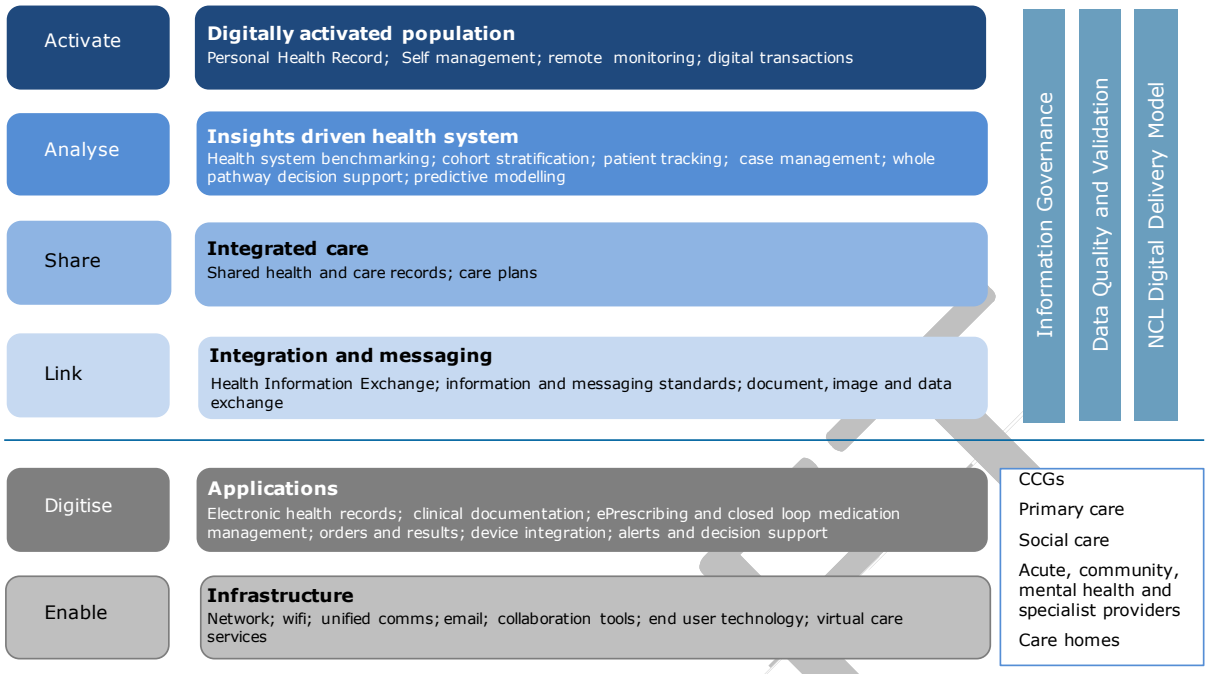
We will use digital technologies and information to move from our current models of care to deliver proactive, predictive, participatory, person-centred care for the population we serve.

There is significant and immediate opportunity for digital to transform our current delivery models and seed completely new, integrated models of health and social care. We recognise the strength of both the clinical and financial case for digital and its potential impact in strengthening productivity, providing ease of access to our services, minimising waste and improving care. Our ambition is to become a national leader in population health management enabled by informatics, to reduce variation and cost and improve care.

We will prioritise and increase pace of appropriate digital technology adoption within our organisations, realigning the demand on our services by reducing the emphasis on traditional face to face care models. In addition, we will explore new digital alternatives that will transform our services, with the aim of moving care closer to home, enabling virtual consultations and providing our patients with the information and resources to self-manage effectively, facilitating co-ordinated and effective out of hospital care. We will utilise opportunities for real-time, fully interoperable information exchanges to provide new, flexible and responsive digital services that deliver integrated, proactive care that improves outcomes for our patients.

Our digital programme proposes the creation of an NCL Population Health Management System (exhibit 8), which supports prevention, service transformation and productivity, and would enable us to meet the national mandate of operating paper free at the point of care by 2020. Through this system we will move from a landscape of diversity and variation to one of shared principles, consolidation and joint working for the benefit of the population.

Exhibit 8: NCL Population Health System Management



The 6 workstreams that make up our digital strategy are:

- **Activate**: We will provide our citizens with the ability to transact with healthcare services digitally, giving them access to their personal health and care information and equipping them with tools which enable them to actively manage their own health and wellbeing.
- **Analyse**: We will use data collected at the point of care to identify populations at risk, monitor the effectiveness of interventions on patients with established disease and deliver whole systems intelligence so that the needs of our entire population can be predicted and met.
- **Link**: We will enable information to be shared across the health and care systems seamlessly.
- **Share**: We will create and share care records and plans that enable integrated care delivery across organisations.
- **Digitise:** We will support our providers to move away from paper to fully digital care processes; including documentation, ordering, prescribing and decision support tools that help to make care safer.
- **Enable**: We will provide infrastructure which enables our care professionals to work and communicate effectively, anywhere at any time, and facilitate new and enhanced models of care closer to home.

To deliver on our digital strategy we will need to invest £159m, with a further £21m in 2020/21 (see section 8.3).

6.4.2 Estates

Our vision is to provide a fit for purpose, cost-effective, integrated, accessible estate which enables the delivery of high quality health and social care services for our local population. The priorities for development of our estates strategy are:

- to respond to clinical requirements and changes in demand by putting in place a fit for purpose estate
- to increase the operational efficiency of the estate
- to enhance delivery capability
- to enable the delivery of a portfolio of estates transformation projects.

There a number of barriers to achieving this, including:

- the complexity of the estates system in NCL, including the number of organisations and the differences in governance, objectives and incentives between each organisation, which often results in organisations working in silos
- misaligned incentives, which do not encourage optimal behaviour
- lack of affordability, specifically the inability for trusts to retain capital receipts, budget "annuality" and the difficulty of accessing capital investment for re-provision
- the complexity of developing business cases in terms of getting the right balance of speed and rigour, and the different approvals processes facing different organisation types (for example, there are different capital approval regimes operating across the NHS and local government).

We are working as part of the London devolution programme to pilot devolved powers in relation to the health and care estate. As part of this, we are asking for:

- local prioritisation and investment of capital receipts, including those that would otherwise be retained nationally
- NHS capital business case approval to be accelerated and consolidated through the implementation of a jointly owned and collaborative NCL / national process (or devolved to sub-regional or London-level)
- development of enhanced and revised definitions of value for money, which consider social value, wider community benefit and system sustainability at the sub-regional level
- new approaches for the accounting treatment of multi-year projects for non-foundation trust providers, in support of our plans
- developing local flexibilities in terms and conditions for the primary and community health estate to improve quality and utilisation
- support to agree the London-level and NCL delivery options to enhance our work
- ability to pay off PFIs using money raised from capital sales and/or a commitment by national partners to renegotiation of such agreements, where they have been identified as a significant barrier to financial sustainability and/or the facility is less than 50% utilised and no other utilisation solution will address the issue.

We anticipate the following benefits:

- a whole system approach to estates development across NCL, with different partners working together on projects and developing a shared view of the required investment and development to support clinical change
- the ability to undertake better local health economy planning, including establishing estates requirements
- increased affordability of estates change across NCL
- greater incentives to dispose of surplus property, releasing land for housing
- focused action on the development of the estates requirements to deliver care closer to home
- greater efficiency and flexibility in the estate, reducing voids and improving utilisation and co-location which will support financial savings

Across the sites of Moorfields, St Pancras, St Ann's we are beginning to evidence qualitative benefits of working together to deliver estates value and improvement. The sector for a number of years has had unresolved estates issues relating to poor mental health inpatient accommodation and potentially saleable and high value estate at St Pancras Hospital. The 3 providers are working together on this strategic estates project which aligns estates priorities between all 3 trusts.

The proposed programme, which is still subject to consultation, would see sales proceeds from surplus assets used to deliver new purpose built mental health accommodation, and the eventual relocation of Moorfields Eye Hospital to the St Pancras site. Clinical improvements would be prioritised through the building of a new Institute of Mental Health and an integrated Eye Hospital and Institute of Ophthalmology at the current St Pancras Hospital site.

The three trusts are currently refining their outline business cases, with Board decisions due in late 2016 and early 2017. Subject to consultation, further testing of economic viability and planning permission, the specific benefits of the work will include:

- development of a new world class research, education and clinical care facility housing an integrated Moorfields Eye Hospital and UCLH's Institute of Ophthalmology, transforming ophthalmology facilities that are at present a constraint on continuous improvement
- improvements to the estate to meet CQC "must dos" including new mental health inpatients facilities for Camden and Islington NHS Foundation Trust (including the integration of physical and mental health and social care through an integrated practice unit at St Pancras). Also, new facilities for Barnet, Enfield & Haringey Mental Health Trust at St Ann's Hospital, Tottenham
- a world class UCLH Institute of Mental Health and associated patient care and educational facilities at St Pancras Hospital
- potential to deliver c.1,500 new housing units in London, significantly contributing to the NHS target for release of land for residential development
- improvements to environmental sustainability, as the new builds will deliver a balance between BREEAM ratings for 'green' initiatives, the cost of the capital build requirements to deliver them and the whole life cycle benefits in terms of costs and

a more sustainable future for our planet. We will design, build and operate in a manner that supports recycling and use of low carbon technology.

The schemes are planned at a total capital cost of c.£400m (see section 8.3) with joint provider engagement under the umbrella of the estates devolution pilot driving completion of the final scheme by 2023. It is planned that £326m of this is financed by sale proceeds with the remainder funded from a variety of sources, including philanthropy.

Progressing this scheme may lead to a platform for sector wide capital prioritisation and create an improved incentive framework for asset disposal and enhanced utilisation, which will give rise to a locally originated capital funding stream.

In line with the findings of Healthcare for London in 2014, our analysis shows that significant capital work is required across NCL to improve the primary care estate. The primary and community estate needs improvement in a number of areas:

- development of CHINs to enable the delivery of the care closer to home model
- expansion and development of primary care facilities to ensure registration for a significantly expanding population and extended hours access
- whilst some capital to enable delivery may be available through the estates technology and transformation fund (ETTF), it is unlikely that this will cover the full set of requirements of £111m. Devolved powers will enable us to secure capital to deliver these much needed improvements and reduce the running costs of this estate.

Exhibit 9: NCL CHIN estate planning

NCL CCG CHIN current locational planning (NB Early stage and subject to full consultation)		
Barnet CCG	North	Vale Drive Health Centre: The site identified is a LIFT building and hence it will improve utilisation
	East	Finchley Memorial Hospital: A LIFT building which is a natural hub and this will improve utilisation
	South	Grove Mead and/or new Colindale HC: A new health centre/CHIN is planned for Colindale (ETTF & S106)
	West	Edgware Community Hospital: ECH is another natural activity hub and also an underutilised site at present
Camden CCG	North	Hampstead Group: An extension to an existing practice is planned to create a health centre/CHIN (ETTF)
	North East	Kentish Town Health Centre: A LIFT building which is a natural hub and this will improve utilisation
	South	Somers Town: An existing practice that is well placed to serve as a CHIN
	West	West Hampstead: An existing practice that is well placed to serve as a CHIN
Enfield CCG	North East	Freezy Water/Ordnance Community Centre: Existing practices that perform and are well placed (CHIN TBD)
	South East	Forest Road HC and Evergreen HC: LIFT buildings in Edmonton and this will improve their utilisation
	South West	Winchmore Hill: An ETTF scheme aims to extend an existing practice to develop a health centre/CHIN hub
	North West	Chase Farm/Cockfosters (Holbrook House): Either on the Royal Free hospital site or within a new mixed-use
Haringey CCG	North East	Somerset Gardens: An ETTF scheme aims to extend an existing practice in the White Hart Lane re-gen area
	South East	Tynemouth: A well placed existing practice currently providing extended access
	South West	Hornsey Central (Queenswood): A LIFT building which is a natural hub and this will improve utilisation
	North West	Bounds Green: A well placed existing practice currently providing extended access
Islington CCG	North	Archway: An ETTF scheme to develop a new build health centre/CHIN
	Central	Islington Central: A well placed and effective existing practice which can serve as a CHIN
	South	Ritchie Street: A well placed and effective existing practice which is able to serve as a CHIN

6.4.3 Workforce

We aim to ensure that NCL becomes the place of choice to train, work and live healthy lives. This includes co-creating, communicating and collaboratively delivering a compelling offer to attract, develop retain and sustain a community of people who work in health and care in NCL. Our workforce needs to move further towards a person-centred approach and this means developing a whole range of new skills, training modalities and new roles.

Our vision is for staff to be part of the wider NCL workforce, not just part of a single organisation. Through this we will achieve efficiencies in employment by managing services collectively across the footprint. We will create sustainable career pathways to attract, develop and support a workforce fit for purpose in the changing health and care landscape. We will work with NCL organisations across all care settings (including social care) to support their collaborative efforts to be excellent employers – employers of choice, committed to looking after the wellbeing of staff whilst also preparing them to begin delivering the new care models. This will support NCL organisations to recruit and retain staff, particularly where employee turnover rates are high or where there are staff shortages. Career pathways will not be limited to a single care setting and will offer our staff opportunities to experience a wide range of different opportunities which fit their own aspirations. This process will allow us to work towards the development of an integrated employment model and a personal career passport for staff to develop their career over the long-term within NCL.

We aim to improve employee wellbeing and reduce avoidable sickness absence cost-effectively, therefore increasing lifetime productivity. We will focus on implementing the healthy workplace charter in NHS organisations, local authorities and in small and medium sized businesses.

Through equipping the existing workforce with new skills and ways of working, we will both ensure that our people are working to the best of their ability as well as adapting roles to meet the changing requirements of our services. We will support some of those people currently working in hospital settings with the skills and confidence to work across the care pathway, reaching out into community care settings and delivering the care closer to home model. We will similarly enhance the capabilities of those currently working in social, community and primary care. We will equip all our existing and future staff with motivational and coaching skills, competence in promoting self-care and prevention, and the enhancement of emotional resilience in themselves, their teams and their patients. All frontline NHS and local authority staff will be trained online in Making Every Contact Count (MECC), with key frontline staff also receiving face-to-face training. All non-medical frontline staff will receive training in Mental Health First Aid (MHFA). All NHS and social care staff will be trained in basic dementia awareness, with more advanced training for frontline staff who are more likely to encounter people living with dementia.

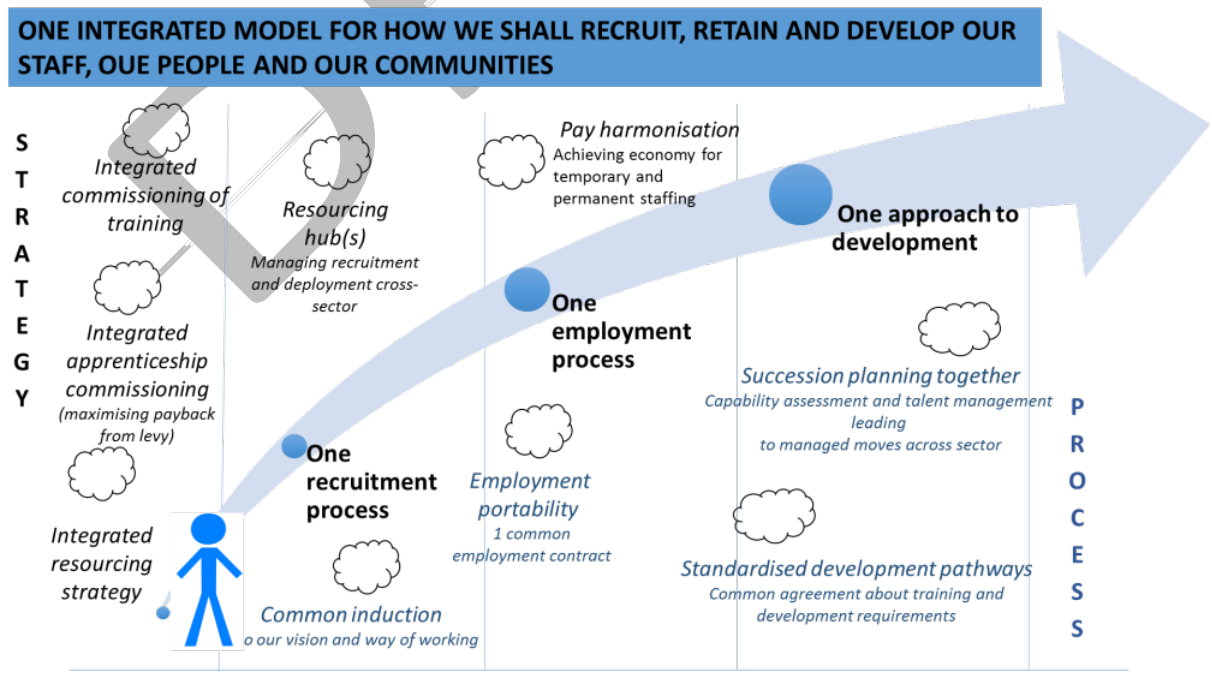
While most of the people who will be engaged in delivering the NCL vision are already with us, working in roles which will need to adapt or change in some way, we will also support the establishment of a small number of new roles, such as physician's associates, care

navigators and advanced clinical practitioners. We will undertake expert strategic workforce planning and redesign, and commission training for skill enhancement, role diversification and new role implementation.

To enable transformation, we will deliver system-level organisational development, supporting system leaders as individuals and as teams through the transformation journey to enable personal resilience and courageous action. In addition, we will train everyone in a single approach to continuous quality improvement to create a culture of continuous improvement to deliver clinical excellence and quality care.

Health, social care and public health delivery is not limited to employees of our traditional employers, and our notion of working with the 'wider workforce' extends to the numerous carers, volunteers and citizens who improve the life of our population. In order to improve the general wellbeing of our population and make use of the substantial social capital across our footprint, we will educate and support patients, carers and those in their communities in areas such as self-care, self-management, dementia and mental health awareness. Building on our 'wider workforce' vision and aligning with initiatives such as the Alzheimer's Society ambition for London to be a dementia friendly city by 2020, we will support the training of groups such as barbers, hairdressers, librarians and teachers to gather a better understanding of dementia and other long term conditions. Across NCL, we have already built five strong Community Education Provider Networks (CEPNs), and these will provide an effective vehicle for delivery of this aim. We will review the provision of learning and development across NCL to ensure we make the best use of existing assets to encompass the wider healthcare community including patients and carers. Our immediate aims will be to standardise and streamline statutory and mandatory training, align induction and share in-house learning and development capacity.

Exhibit 10: Integrated workforce model



6.4.4 New commissioning and delivery models

As part of the STP development process, and in response to the changing healthcare landscape in NCL, the 5 CCGs have been exploring ways of working more collaboratively together whilst also seeking to strengthen joint commissioning with local authorities. We have concluded that a more formalised degree of cooperation between the 5 CCGs will improve health commissioning, particularly in response to:

- the development of new models of care, including larger provider organisations such the Royal Free Vanguard.
- increasing financial risk
- stretched capability and capacity.

Our work has covered the development of a proposal for joint governance of strategic commissioning decisions (see section 9.2.1); the development of a common commissioning strategy and financial strategy; and, a review of CCG management arrangements, with a view to shaping new ways of commissioning. With a focus on population health systems and outcomes and the transition to new models to deliver these, our objective is to further strengthen strategic commissioning over the next 2 years. We have agreed that any new commissioning arrangements need to balance the importance of local relationships and existing programmes of work with the need to commission at scale.

The governing bodies of each of the CCGs have agreed to the need for new executive management arrangements including shared roles across the CCGs: an Accountable Officer; a Chief Finance Officer; a Director of Strategy; and, a Director of Performance. Additionally, in order to ensure the continued role of each CCG in respect to its local commissioning and joint work with local government, local Directors with responsibility for local functions and services have been proposed.

These new leadership positions will work with each of the CCGs, as well as the new shared governance structure described in section 9.2.1, to ensure that health commissioning in NCL delivers the best possible health and wellbeing for the local population whilst ensuring value for money. The arrangements will be further considered by governing bodies in November with the expectation that the new leadership will be in place no later than 1 April 2017.

In parallel, commissioners and providers across the system have been working together to define our direction of travel in terms of new delivery models. We already have significant work we can build on relating to this, including the Royal Free London's provider chain model; the UCLH Cancer Vanguard; the Moorfields Eye Hospital ophthalmology specialty chain; and, the Royal National Orthopaedic Hospital NHS Trust chain of orthopaedic providers.

We have consulted with the leaders of all organisations across the system to get views on the different options for new delivery models, and the broad consensus includes moving towards:

- whole system working with a population rather than individual organisational focus
- a deeper level of provider collaboration, including collaboration between primary care, community services, acute services, mental health services and social care services.
- the establishment of some form of 'new delivery vehicle' or 'new delivery system' to support this provider collaboration.
- a transfer over time of some elements of what we currently consider commissioning functions (for example, pathway redesign) into these new delivery vehicles.
- a move towards some sort of population based capitated budget for the new delivery vehicles.
- the retention of a strategic commissioning function responsible for holding the delivery vehicles to account, with accountability for outcomes rather than inputs based on principles of commissioning for value.

Further work needs to be done to resolve issues and differences of view around the following:

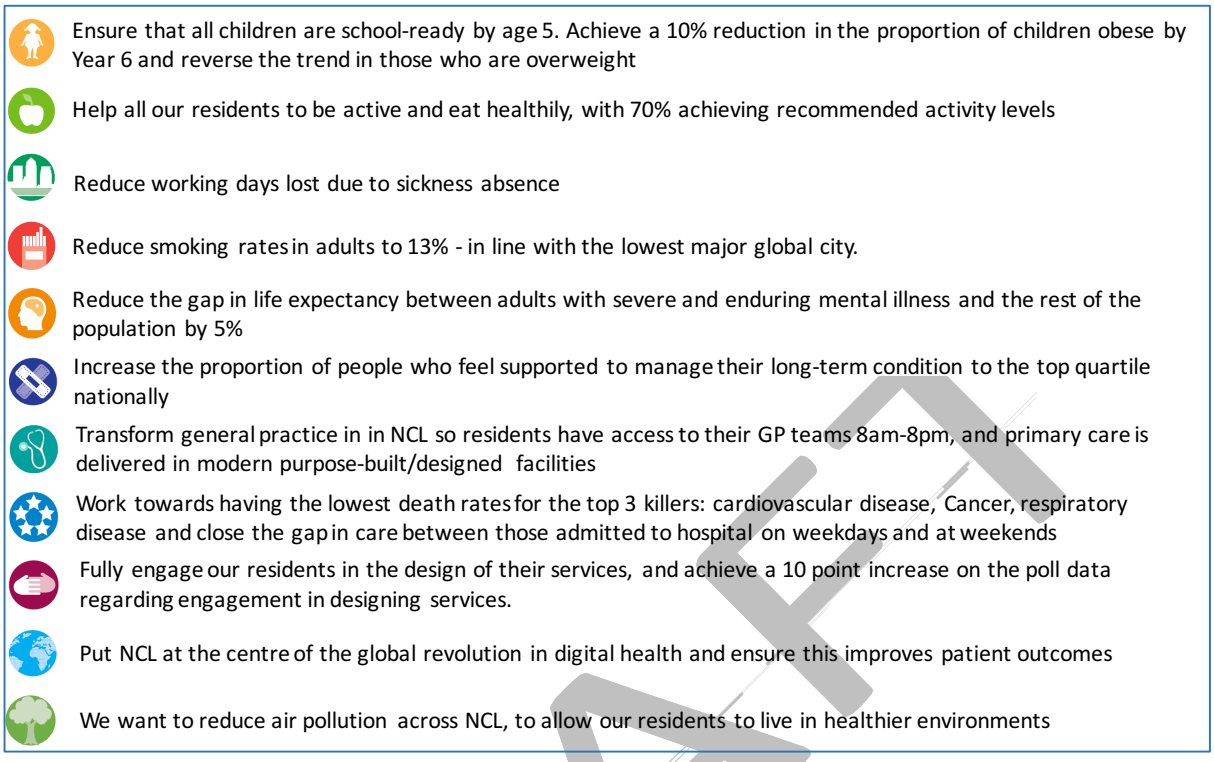
- the organisational form for the new delivery vehicles
- the optimal population size for population health management
- the geography over which new delivery vehicles should operate
- the form and governance of the strategic commissioning function
- which commissioning functions should remain with the strategic commissioning function and which should be undertaken through the new delivery vehicle.
- the scope of the new delivery vehicles
- unresolved issues such as how to manage patient choice, specialised services and other flows outside of the delivery vehicle and a full understanding of the legal framework which might impact on implementation
- speed of implementation.

Discussions continue across health and care commissioners and providers in NCL to establish agreement about the nature and scale of new delivery vehicles. Different care models are still being considered, and this work is being steered through the STP governance framework.

6.5 Measuring our success

We have established the anticipated impact of each of our workstreams to ensure we remain on track to close the key gaps as set out in our case for change. However, to ensure that the breadth of our workstreams collectively meet the scale of our ambition, 11 overarching outcomes have been developed by the London Health Commission for the Better Health for London strategy. These have been adapted for NCL and endorsed by the clinical cabinet for our STP. We will know if we have been successful by measuring impact against these outcomes over the next 4 years.

Exhibit 11: NCL STP outcomes



7 Delivery plans

A delivery plan has been developed for each of our workstreams, setting out the scope; objectives; financial and non-financial impact with trajectories; any investment requirements and the key risks to successful delivery. We will finalise the details of the delivery plans over the next few months as we agree the detailed phasing and investment timetables.

The delivery plans will be live documents and will continue to be iterated as the programme develops. In addition, each workstream is required to develop a full programme initiation document which will provide a reference point for every workstream to ensure planned delivery is on track, and to support the effective management of interdependencies between workstreams.

8 Bridging the financial gap

The financial analysis that we have undertaken (see exhibit 2) shows the significant gap between anticipated growth in demand (and therefore cost growth) for the NHS in NCL and the growth in funding that the NHS expects to receive over the 5 years of the STP. Without changing the way that we work together as a system to provide a more efficient, joined up service across organisations, this would leave us with an estimated £876m deficit in 2020/2021.

The STP in NCL has brought together organisations across health and social care to jointly discuss how we can address this financial challenge as well as making progress in improving the quality of, and access, to services. Based on the plans and analysis set out in this STP, which have been developed with and by local clinical experts, we will reduce the annual deficit over the next five years to £75m (exhibit 12) – whilst this addresses more than 90% of the financial gap, we recognise that further work is needed.

The key elements of the plan are set out in detail elsewhere in this document. Exhibit 12 shows how these contribute to the improvement in the annual financial position of the NCL system over 5 years. The key areas of work are:

- **Care closer to home:** savings of £114m have been estimated from improving access to primary care; proactively identifying need and early intervention to avoid crisis; rapid response to urgent needs to prevent hospital admissions; providing community-based and ambulatory-based care; and reducing delays to discharge.
- **Prevention and the support of healthier choices:** this is estimated to result in savings of £10m.
- **Mental health outreach and liaison:** this is estimated to result in savings of £6m.
- **Optimising the elective pathway**: savings of £55m have been estimated from benchmarking against best practice; working closely with clinicians; optimising flow through theatres (increasing throughput); and reducing length of stay - in addition to the excellent work that our hospitals and other providers do to improve productivity each year.
- Additional plans are being developed relating to the **UCLH Cancer Vanguard** scheme and **Royal Free Hospital Chain Vanguard** which are estimated to deliver £35m.
- **System level productivity** savings of £98m are planned to be achieved alongside the 'business as usual' cost improvements across providers in NCL of £218m and local commissioner business as usual efficiencies (QIPP) of £57m.
- We have identified a potential saving of £24m per year through 'buying out' a number of **Private Finance Initiative** hospitals, bringing management of these facilities back within the public sector. We will continue to work with the Department of Health and others to develop these plans, recognising that there are a number of constraints.
- Although detailed plans have not yet been developed, we have been advised by NHS England to assume that the NCL proportion of the **London Ambulance Service (LAS)** financial gap of £10m and the estimated **specialised commissioning** pressure of £137m will be fully addressed by LAS and NHS England respectively. NCL hospitals provide a very significant amount of specialist care and it is therefore essential that NHS England works together with the STP on how these services can flourish whilst

also addressing the financial pressures associated with the growth in specialist activity (which in most developed economies is higher than growth in other services due to new technologies, drugs and clinical interventions).

- Further work is ongoing in relation to developing a fuller understanding of the social care financial position and pressures. At present no financial values have been included as advised by NHS England, but this has not prevented the STP from working very closely across both health and social care. In particular the NHS within NCL is seeking to learn from local authority colleagues best practice in relation to reducing cost whilst improving the experience of people who use services and the public.

These improvements cannot be achieved without investment. The plan is based on investment of £64m in prevention and care closer to home, and £4m in elective care. We have also assumed that £31m of our indicative £105m share of the Sustainability and Transformation Fund will be required to fund national policy priorities over and above these investments, in addition to that already assumed within the 'do nothing' scenario.

The savings set out above are predicated strongly upon reducing significant activity in acute hospitals, in particular reducing demand for inpatient care. We know that realising such savings can be difficult in practice and are contingent upon removing or re-purposing capacity within acute hospitals. As such, through working with the clinical cabinet of clinical leaders within NCL we have assumed that the cost savings that will be realised from each avoided day of acute hospital care will be significantly lower than the average tariff that is currently paid to providers by commissioners for this care. This is reflected in a £53m 'risk adjustment' in the financial analysis.

8.1 Normalised forecast outturn by year

Each year there will be a number of one-off costs and income streams to the commissioners and providers within NCL. Our 5 year financial analysis is initially based upon the "normalised" (or underlying) financial position in 2016/17 which is then projected forward. We estimate that 2016/17 outturn will be a normalised deficit of £216m (£101m on an in-year basis). Significant one-off figures within this include UCLH's transitional funding that it is receiving to compensate for the financial impact of moving cardiac services to the new, world class centre at Barts hospital, and the Royal Free's transitional funding in relation to the merger with Barnet and Chase Farm. The underlying figure also includes a £40m adjustment which is an estimate of the combined risk to the NHS provider and commissioner forecast outturn. This has arisen as a result of potentially different assumptions between NHS commissioners and providers about the value of work undertaken by the end of 2016/17. We have reached an agreed view on forecast outturn activity and will continue to work urgently to ensure consistency of payment assumptions between different parts of the NHS within NCL. All parties have agreed a more 'open book' approach to contract agreements that will ensure a consistent, system-based approach.

The STP plan shows a gradual improvement in the financial position over the 5 years of the STP (exhibit 13). The normalised position improves year on year. This pattern is in part caused by the requirement for majority of the investment in the early years of the STP, with benefits accruing in the later years.

8.2 2017/18 forecast operating plan

In 2017/18 we estimate that our in-year position will be a £95m deficit for NCL against a draft system control total of £13m surplus (which we anticipate will change over the coming weeks due to a number of technical issues). This incorporates significant investment during the year on service transformation and delivery of the Five Year Forward View:

- investment in service transformation: £25m. This relates to the care closer to home (£23.5m), elective (£0.8m)and outpatient (£0.4m) workstreams
- other recurrent investment by CCGs and trusts – included within the CCG and trust cost movements it is estimated at £25m in 17/18 to deliver elements of the 5YFV priorities
- other non-recurrent costs (estimated at £20m in 17/18) for investment in Vanguard costs, IT digital costs, and STP programme costs.

In line with NHSE guidance we have also assumed that we will receive our 'fair share' of the national Sustainability and Transformation Fund (£105m) in 2017/18. This compares to the £52m currently notified to NHS providers, and additional a further £53m improves our revised forecast operating plan position to a deficit of £62m – see exhibit 14.

8.3 Capital expenditure

We recognise that the national capital budget for the NHS is highly constrained over the course of this parliament, and will continue to work hard to minimise the need for significant capital investment unless there is a strong return on investment. NCL also has a number of creative proposals that will seek to maximise disposal proceeds from sites no longer required, and use these to reinvest in the priority areas of the STP as well as the potential to provide additional, much-needed housing for the residents of NCL.

There are a number of large capital schemes that are already approved and underway within the STP and, whilst far from being 'business as usual' these are included in the 'do nothing' scenario as their approval pre-dates the STP work. Total capital, before specific STP-related investment, is £1.2bn over the 5 years. This includes:

- **UCLH new clinical facilities:** haematology-oncology and short stay surgery – (£137m); Proton-beam therapy (£130m), ENT and dental facility to consolidate two existing hospitals onto the main University College Hospital campus (£98m) and other more minor schemes. UCLH have approved DH funding of £278m (£51m public dividend capital (PDC) and £227m DH Loan) as well as anticipated, ring-fenced disposal proceeds to finance these developments
- **Royal Free - Chase Farm redevelopment:** (£183m), which includes £93m of approved DH funding (£80m PDC and £13m DH Loan).

In addition to these major developments there is of course significant business as usual capital investment such as equipment replacement and building maintenance, funded through depreciation, cash reserves and other sources of funding (including disposals).

The additional gross capital requirements to implement the transformation programme set out in the STP totals £542m, with a much smaller net investment requirement after taking into account disposals, donations and grants:

- **Estates redevelopment:** relating to our St Pancras/St Anns/Moorfields proposals: £404m, assumed to be funded through disposals £326m), DH loans (£39m) and Donations (£37m), of which **£272m** (including short term bridging loans and repayments) occur within the period covered by this STP (i.e. before 2020/21) and is included above. This scheme, including an assumption of DH loan funding, has yet to be agreed, and will be subject to normal Business Case processes through NHS Improvement.
- **Primary Care for Care Closer to Home and 5YFV investment: £111m** assumed to be funded predominantly through ETTF (£60m – all bids submitted), s106/CIL/GP contributions (£26m), grants and other sources.
- **IT investment: £159m** with a further £21m in 2021/22. All assumed to be funded by ETTF (circa £10m – bids submitted for the Person Held Record/IDCR) or through the central Digital Transformation Fund.

We recognise that further work is needed to develop full business cases for the above, and at present these figures are estimated - particularly in relation to primary care and digital investment. In developing these schemes we will seek to maximise the use of existing buildings and other assets, and minimise the need for new capital investment, together with applying a robust requirement for return on investment for each scheme. However, we fundamentally believe that investment in primary care and digital technology is central to the transformation of services that is needed in NCL to address the gaps in service quality, access and finance, and wholly consistent with the Five Year Forward View and requirement to be paper-free at the point of care by 2023. It would be wrong to assume that such investment is not required and will not deliver value simply because of the stage in development of these plans that NCL is currently in.

The estates redevelopment relating to St Pancras, St Ann's and Moorfields, and the estates devolution work, offers an exciting and compelling vision as to how existing assets, disposals, redevelopment and construction of new facilities can be financially efficient as well as delivering significant benefits to patients, service users and the wider population.

In addition, we will continue to engage as an STP with the work being led by Sir Robert Naylor in relation to property strategy across the NHS, to further understand how being a pilot area in this can help NCL make best use of its current assets to support the delivery of our STP vision.

8.4 Next steps to address the financial gap

We are very clear that we have more to do to close the financial gaps for the remainder of 2016/17 and across the next 4 years of the STP.

We will therefore undertake a period of further intensive work over the next 8 weeks both to improve confidence in delivery of current estimates, whilst concurrently working on other areas to further improve the position. As far as possible we will aim to do this by

Christmas, so that our operating plan submission improves on this submission. However, we do believe that there is a risk that the gap will not be fully closed in every year whilst ensuring that we continue to prioritise quality of and access to services, particularly as we balance the need to invest in the early years to deliver transformational benefits in later years. It is also essential that STPs and their constituent organisations and leadership are given the regulatory headroom to develop longer term plans, and that the 'new models of care' being developed give clarity of financial accountability to support the financial challenges that the STP faces.

We have identified a number of immediate actions to improve our current financial position, which include:

- early delivery of high impact care closer to home interventions
- accelerated delivery of stretch targets for high impact elective pathways
- increased effort in terms of delivering efficiencies through provider productivity schemes
- reducing any non-value added contracting costs
- implementation of pay harmonisation and shared principles around usage of bank and agency staff
- leveraging existing capacity in NHS providers to reduce outsourcing of activity to the independent sector
- other non-recurrent savings measures
- assessing and incorporating the impact of 2017/18 tariff changes.

There are also a number of areas that we will explore further as we believe there may be significant savings to be found. These include:

- maximising clinical productivity across providers, for example introducing shared clinical rotas
- developing alternative pathways for the London Ambulance Service to avoid conveyance to Emergency Departments
- rolling out standardised pathways to all specialities
- identifying opportunities to reduce the length of stay for patients receiving specialist services
- reviewing any plans that require capital and have not yet been agreed to establish the most cost effective way to deliver agreed outcomes
- rapid implementation of cancer initiatives, including early diagnosis, new models of care, end of life interventions and research and innovation
- re-providing cost effective services for the c.20% of people we estimate are currently in hospital beds but are medically fit to leave
- putting in place a peer review challenge approach across all areas of spend to identify further opportunities to reduce or avoid spend, and to aid collective delivery of plans.

Exhibit 12: Bridging the financial gap to 2020/21

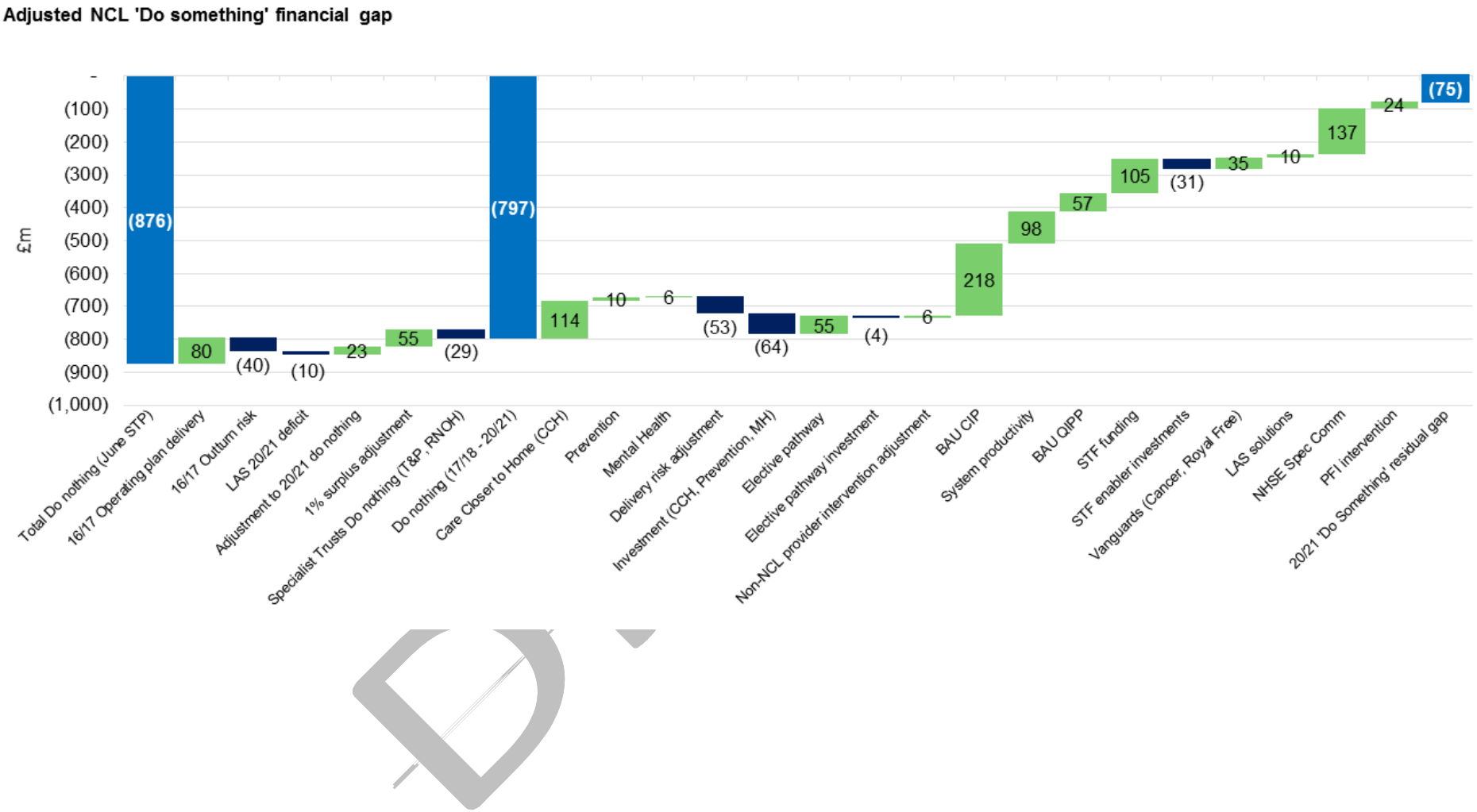


Exhibit 13: Normalised forecast outturn by year

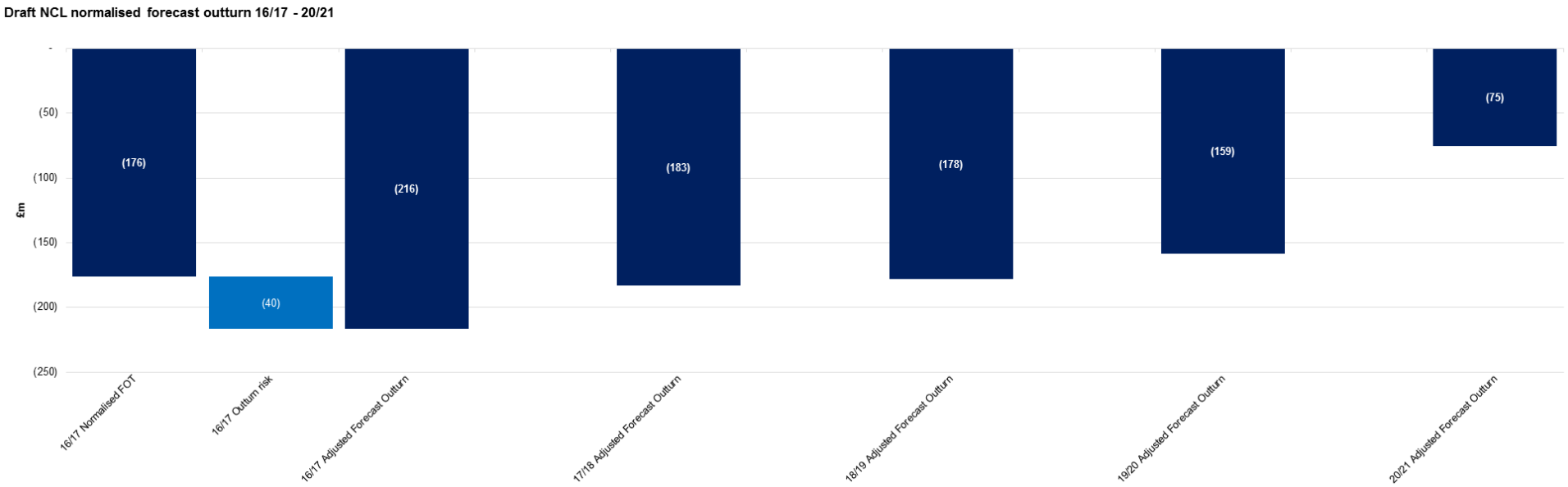
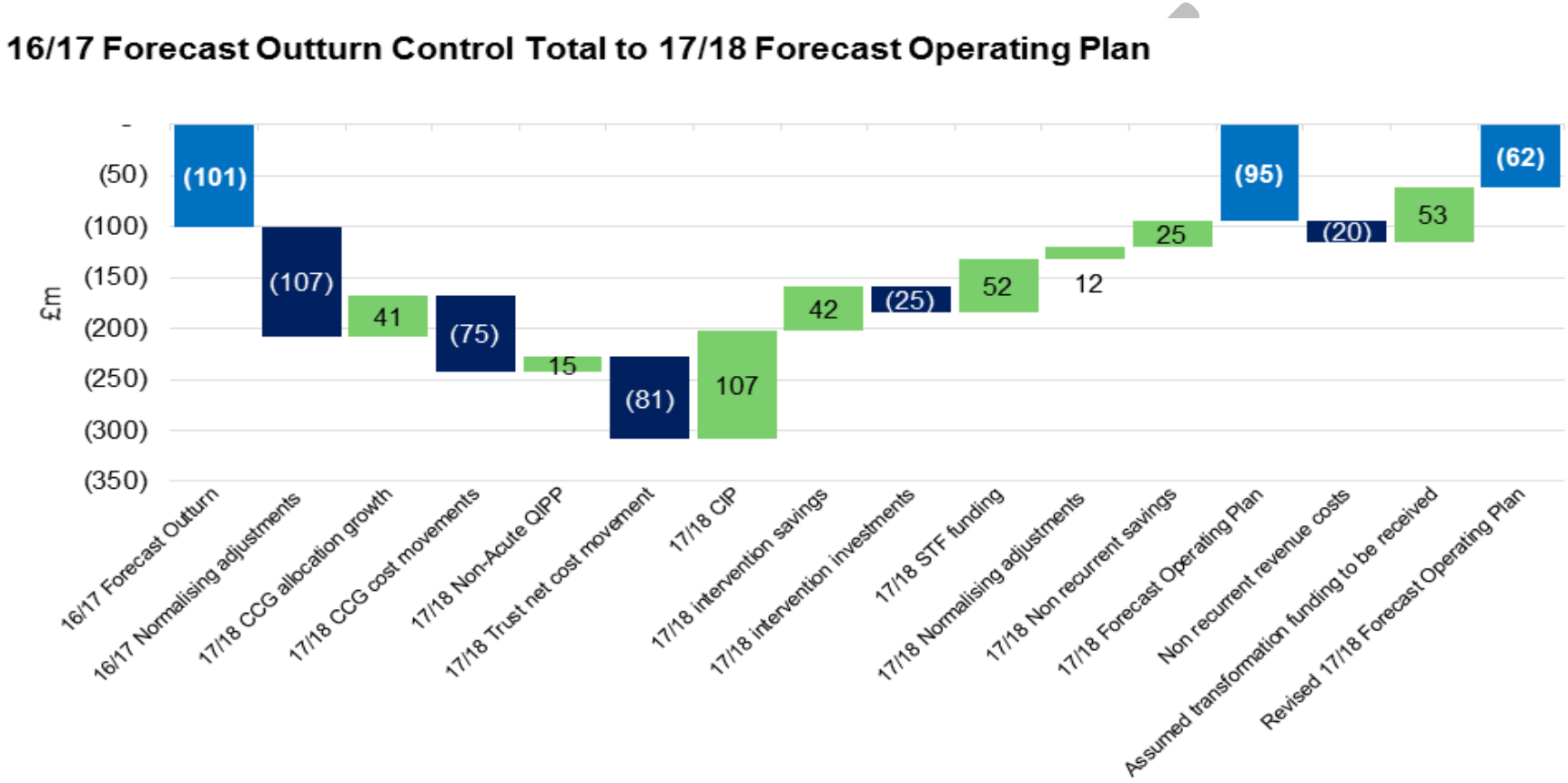


Exhibit 14: Forecast 2016/17 outturn control total to 2017/18 forecast operating plan



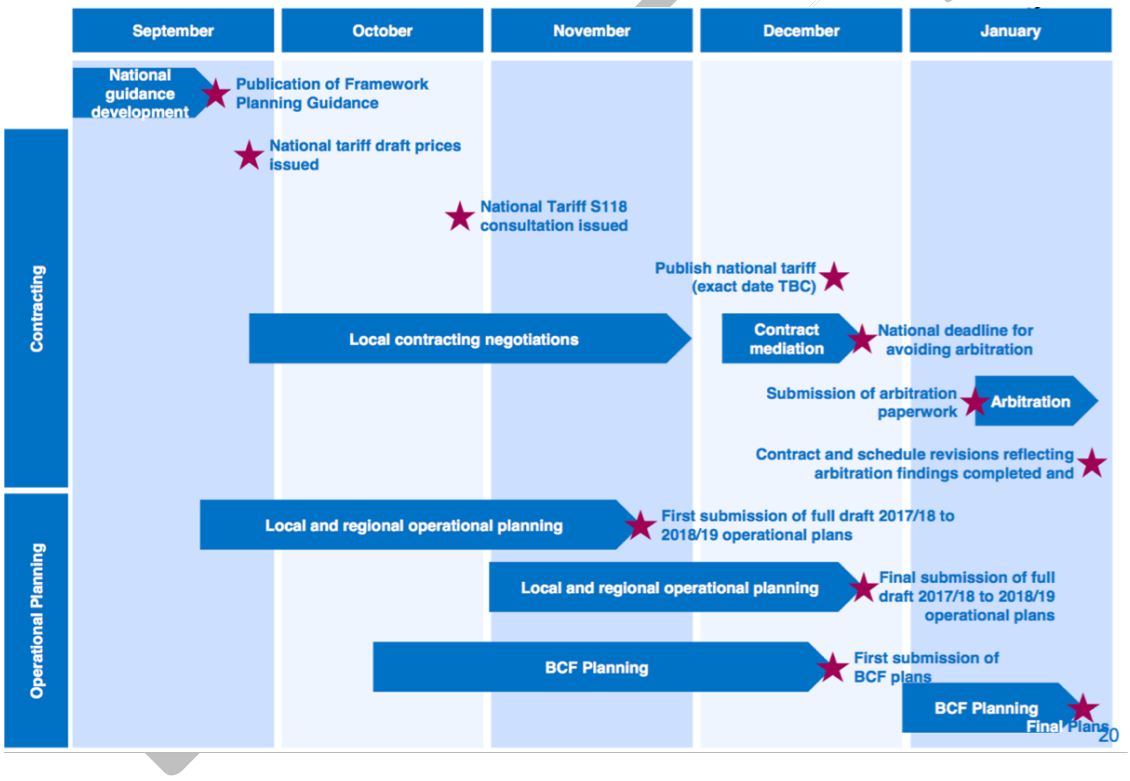
Note: The 16/17 in year FOT of £101m together with the £107m 16/17 normalizing adjustments represents the normalized 16/17 position excluding the specialist trusts (RNOH, T&P). Including the specialist trusts normalised 16/17 position (£8m) brings the combined 16/17 normalised deficit to £216m (shown in exhibit 13).

9 How we will deliver our plan

9.1 Delivery through 2 year contracts in NCL

Delivering the STP is a priority for health and care commissioners and providers in NCL - therefore it is essential that commissioning intentions and contracts reflect this. In line with national guidance, we are entering into a planning round for 2 year contracts covering 2017/18 and 2018/19. We will use this opportunity to ensure all contracts are strategically aligned to the STP, thus enabling its delivery. Whilst we recognise that implementation might look different in different local areas, we know that it will only be possible to deliver on the STP if we are all pulling in the same direction. Setting up 2 year contracts based around our STP delivery plans will both enable rapid implementation and support a longer term move to new relationships between commissioners and providers, reducing transactional costs and building the foundation for the development of new commissioning and delivery arrangements.

Exhibit 15: High level plan for 2 year planning round to support delivery of the STP



We have developed a proposed process and a set of draft principles for managing the contract negotiations that will take place over the next couple of months. Our leadership group will meet regularly (every 2 to 3 weeks) to ensure leadership alignment, assess progress on operating plans, and to ensure that the behaviours of teams reflect the agreed NCL approach.

We have agreed that operating plans and contracts will need to be strategically consistent with the STP. To achieve this, all finance and activity alignment will be overseen by the STP finance and activity modelling group, with overall plan alignment to be overseen by the NCL wide planning group led by the CCGs. All interim finance and activity submissions by CCGs and trusts between 21 October and 23 December should therefore be aligned across NCL

before submission. Whilst organisations will individually follow up queries with NHS England or NHS Improvement on 2017/18 control totals, no organisation will agree their individual target unless and until there is a pan-NCL plan agreed.

The risks of delivery of operating plans will be identified and jointly owned and managed, with the following principles:

- simplicity
- reducing transaction costs
- incentivising the changes in care delivery as set out in the STP
- incentivising the delivery in improved productivity as set out in the STP
- locating risk where it can best be managed
- an open book approach
- use of agreed sources of data.

In the current context of the financial position and management capacity across the system, we will ensure in the first 2 years of the STP that we are prioritising our efforts in the areas which will add the most value in terms of increasing health and wellbeing for people; improving the quality of care people receive; and ensuring value for tax payers' money. We will focus our energies on achieving maximum benefit and we will seek to identify areas where we can further and faster to build confidence and momentum.

We will identify resources to take forward areas of further potential benefit. In addition, we will set up a process for independent peer review challenge of all areas of discretionary spend in providers and CCGs to identify further opportunities to reduce or avoid spend and to aid the collective delivery of plans.

9.2 Decision making in the programme

The STP is a collaboration between a range of sovereign organisations in NCL, each with its own governance and decision-making structures. We have not to date introduced any collective decision-making structures. However we have worked together to produce both the Case for Change and the STP.

The STP is a work in progress and therefore has not been signed off by any of the organisations within the STP. We will take this STP through the public sessions of each of the NHS provider boards, CCG governing bodies and Local Authorities for their support and input into the next steps.

9.2.1 Collective governance arrangements for CCGs

Going forward, in order to support a more collaborative commissioning approach across NCL, the 5 CCGs will need a mechanism for collective decision making. Governing Bodies have recognised this requirement and have agreed the principle of establishing a joint NCL-wide governance structure for some elements of commissioning.

Further work is being done on the details of the proposed joint governance structure. Engagement on the design has been ongoing during October 2016 and will continue with further details to be presented at Governing Body meetings in November 2016.

9.3 Programme architecture

In coming together as an STP footprint, we have developed a governance structure, which enables NHS and local government STP partners to work together in new ways. The NCL STP Transformation Board brings together executives from all programme partners monthly to oversee the development of the programme. It has no formal decision making authority, but members are committed to steering decisions through their constituent boards and governing bodies. Three subgroups feed into the Transformation Board: the Clinical Cabinet, the Finance and Activity Modelling Group and the Transformation Group.

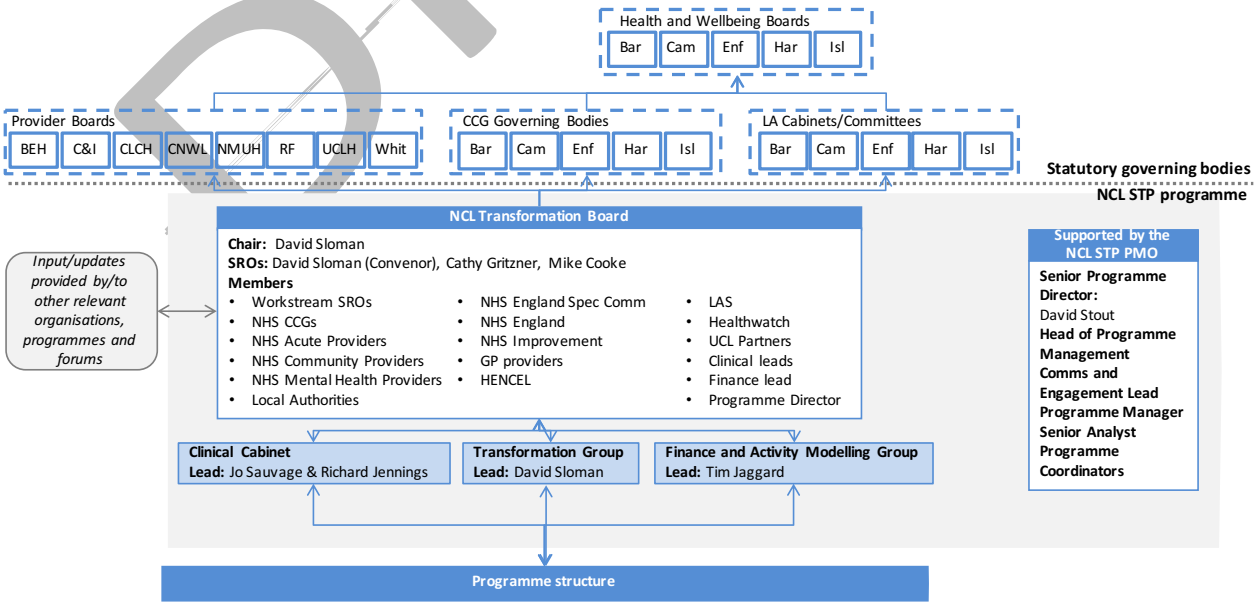
The Clinical Cabinet meets fortnightly to provide clinical and professional steer, input and challenge to all the workstreams as they develop. Membership consists of the 5 CCG Chairs, the 8 Medical Directors, clinical leads from across the workstreams, 3 nursing representatives from across the footprint, a representative for the Directors of Public Health and representatives for the Directors of Adult Social Services and the Directors of Children's Services respectively.

The Finance and Activity Modelling Group is attended by the Finance Directors from all organisations (commissioners and providers). This group also meets fortnightly, to oversee the finance and activity modelling of the workstream plans as they develop.

The Transformation Group is an executive steering group made up of a cross section of representatives from all organisations and roles. This group is specifically responsible for driving progress between meetings of the Transformation Board, and meets fortnightly to do so. Membership includes the SROs of all workstreams.

Additionally, the NCL STP has a full time PMO which facilitates and coordinates the meetings of the main governance groups, as well as delivering communications and engagement support to the programme.

Exhibit 16: NCL STP current governance structure



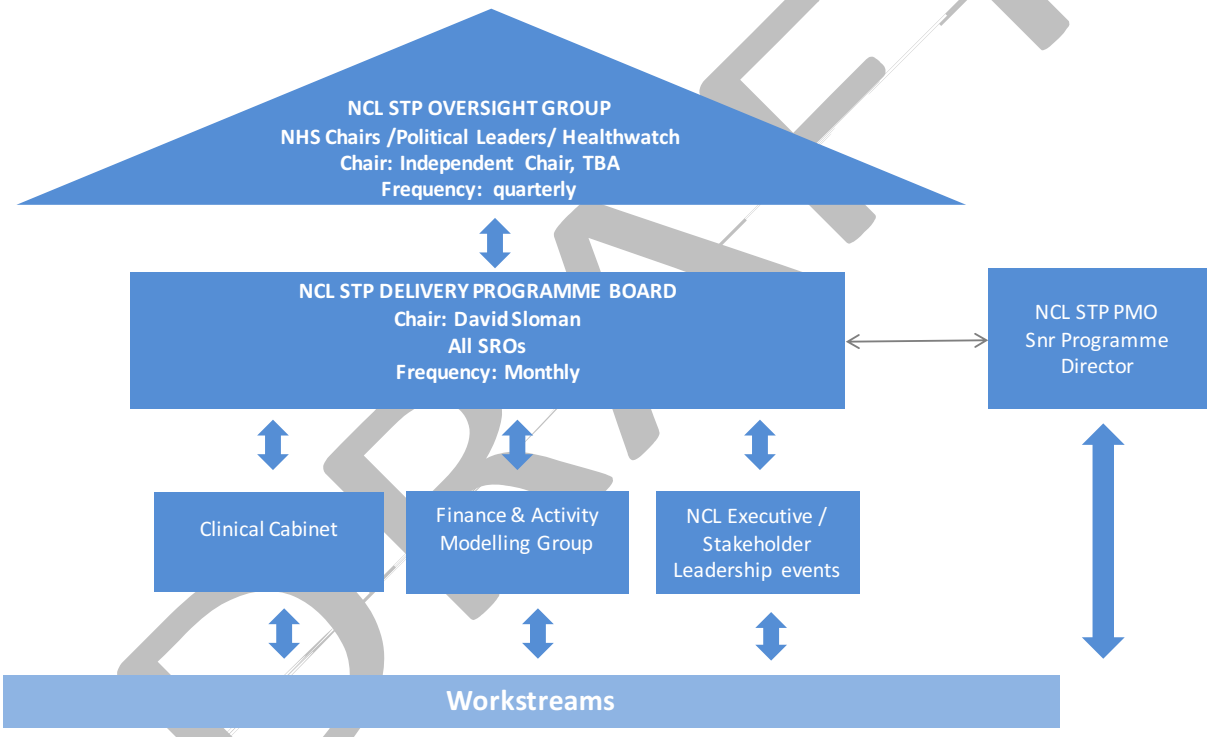
The component workstreams of the NCL STP feed into the overarching governance framework. The workstreams are responsible for developing proposals and delivery plans in the core priority areas. Every workstream has its own governance arrangements and meeting cycles which have been designed to meet their respective specific requirements, depending on the core stakeholders involved.

9.3.1 Future programme architecture

We recognise that as we move from planning to implementation that we will need to amend our programme architecture to ensure that it is fit for purpose. We will work with the Transformation Board to agree any required changes to the programme architecture so that we are ready to move forward with implementation from the new year.

Our initial proposal for discussion is set out in exhibit 17.

Exhibit 17: Proposed future programme architecture



This structure would comprise the following new groups:

- **STP Oversight Group:** This oversight group would be made up of Chairs and political leaders and would go some way to address the current 'democratic deficit' and representation of views of the local population. It is proposed that this group meet quarterly and might benefit from an appointed Independent Chair. Membership of this group would ensure scrutiny of the delivery of STP delivery and ensure a better connection with the NHS boards, governing bodies and local authority leadership.
- **STP Delivery Programme Board:** To drive and oversee the progression and delivery of the STP. It is proposed that the delivery board meet monthly. This would replace the Transformation Group.

- **Executive leadership events:** CEOs and other relevant executive directors and stakeholder representatives would meet periodically as requested by the Delivery Board in order to resolve delivery issues.

9.3.2 Health and wellbeing boards

CCGs are required to involve their local Health and Wellbeing Board (HWB) when preparing their commissioning plan so that HWBs can consider whether their draft plans take proper account of the local health and wellbeing strategy. As CCG commissioning plans will be set within the context of the STP, it will be important that we engage with HWBs as we develop the STP. Engagement of HWBs will also be an important means of ensuring engagement of local political leadership in the STP process.

9.3.3 Overview and scrutiny committees

Local authorities have a role in reviewing and scrutinising matters relating to the planning, provision and operation of health services in their local area. Commissioners and providers of NHS services (including NHS England, CCGs, NHS trusts, NHS foundation trusts and private providers) must consult the local authority where they are considering any proposal for a substantial development or variation of the health service in the area. Ordinarily, where the services in question are commissioned by NHS England or CCGs (as the case may be), the commissioners carry out this exercise on behalf of providers. Providers of public health services commissioned by the local authority are also required to consult the local authority in the same way as commissioners and providers of NHS services.

The local authority may scrutinise such proposals and make reports and recommendations to NHS England and the Secretary of State for Health. Legislation provides for exemptions from the duty to consult in certain circumstances, for example where the decision must be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff. As part of the overview and scrutiny process, the local authority will invite comment from interested parties and take into account relevant information available, including that from Healthwatch.

We have a Joint Health Overview and Scrutiny Committee (JHOSC) in place across NCL which has already put the STP on its agenda as a standing item. We will ensure that we liaise closely with the JHOSC as the STP plans develop so that we can plan ahead for any likely need for public consultation. In addition, we will discuss plans with any relevant local authority overview and scrutiny committees as we move towards local implementation.

9.4 Programme resourcing

We have dedicated resources in place to support the delivery of the STP, with an agreed overall programme budget of £5m in 2016/17. Each workstream has a Senior Responsible Officer (SRO). Some workstreams have shared leadership, where a mixed skillset is required. All of these individuals are senior Executive level - Chief Executives, Medical Directors or Finance Directors - ensuring leadership of the highest quality. Each SRO is supported by a dedicated programme manager, and in some cases a broader team of support. A programme budget for 2016/17 has been allocated to each of the workstreams based on

their proposed requirements. STP partner organisations are also giving in kind to each of the workstreams to ensure high quality plans can be delivered at pace.

We will review the requirements for 2017/18 and beyond as we finalise the delivery plans and phasing of implementation. A £10m resource requirement to deliver the plan has been factored into our financial modelling.

10 Engagement

We have come a long way since being asked to come together as 22 health and social care organisations with disparate views last December. It takes time to build trust and develop shared a shared vision of the future between people and organisations, and to get everyone working towards the same goals. We are now all aligned behind a collective agenda and are ready to share it more widely, seeking input and feedback on our draft plans to date.

The most important people we need to engage with are those who use our services – the residents of NCL. We have specifically created a shared core narrative for this purpose – ensuring it is in patient-focused and accessible in language to begin to involve people in the process. Now that we are in a position to communicate our collective thoughts effectively, our intention is to engage residents, local Councillors, our workforce and other key stakeholders to get feedback on our plans. We have held initial public meetings in each of the 5 boroughs to begin the process of co-design with patients, people who use services, carers, families and Healthwatch.

Our approach going forward will be to collaborate more extensively with people who use services and carers, local political stakeholders as well as members of the public, to ensure that our residents help inform our decisions. This approach is guided by the following core principles (often called the "Ladder of Citizen Participation"). We will undertake different types of engagement as set out on the ladder as appropriate:

1. 'inform' stakeholders
2. 'engage' with stakeholders in open discussions
3. 'co-design/ co-produce' services with stakeholders

Feedback from our local residents will be fundamental to our decision making and will help us shape the way the final plan is implemented.

10.1 Our future plans

We will now build on the success of our initial public engagement events by:

- holding a quarterly forum in each borough
- holding pan-NCL events on specific issues that may arise in support of the borough level events
- hosting meetings with the public on focussed topics such as urgent and emergency care, primary care, and mental health to get in-depth input from the community
- organising 'Tweet chats' on specific areas of interest
- developing a designated YouTube channel and populating it with relevant resources.
- using partner digital media channels – Twitter, Facebook, Instagram – to promote our public engagement programmes and information. We will also use these channels to test ideas and progress on local priorities which will help us develop our plans further.

To do this, we will:

- use Healthwatch, other patient representative groups and resident's associations, local authority engagement networks and the range of other networks available to reach out to the public and share our draft plans
- work in partnership with communications teams across NCL organisations and use their wide range of community channels to socialise the STP, for example Camden CCG's citizens' panel and Enfield's Patient Participation Groups Network.
- use existing online engagement tools that CCGs, local authorities and providers have to engage specific audiences and reach those who may be unable to attend our events.

We recognise it is crucial to ensure our local political stakeholders are actively involved in the oversight of the plans as they develop. We are planning on doing this by:

- planning regular face to face meetings between the STP leadership team and local councillors and MPs, along with Ministers in the Department for Health if required to seek their regular advice on all proposed changes
- continuing to share progress updates of the STP at all meetings at the Joint Health Overview and Scrutiny Committee (JHOSC)ensuring that all political channels through CCGs, local authorities and providers are kept fully briefed on the STP as it develops and any public concerns for the regular engagement they undertake with elected leaders
- logging all media stories and regularly updating the Transformation Board and those meeting with elected members on the STP as it develops, media development and any public concerns.

There is also a need to engage more of our own workforce in the planning process. We will do this via:

- the weekly STP newsletter that we have set up for those working within the organisations of the STP
- providing people working within our organisations with regular updates on progress through internal newsletters and bulletins, weekly / monthly updates from Chief Executives
- hosting sessions with a wider set of clinicians and social care practitioners to get their input into the priorities and delivery areas. This will include working with our GP Federations to engage primary care providers to ensure our workforce is a driver and owner of change
- running events within our membership organisations to showcase the range of work which is happening across NCL and to ensure staff understand the current plans, and how they may affect them as we progress into implementation.

We will continue to build our communications and engagement capabilities across the system. We are planning to host a workshop with communications leads from across sectors to co-design the future engagement strategy, having now identified the key audiences that we need to engage with across the 5 boroughs. The strategy will include the design of a programme of deliberative-style events which will bring together different groups to more

directly shape our plans. We will establish a designated communications and engagement workstream to oversee delivery of the strategy, with a Senior Responsible Officer for engagement.

10.2 Public consultation

A formal public consultation is not needed for every service change. However, it is likely to be needed should substantial changes to the configuration of health services in a local area be proposed as our plans develop and we are committed to ensuring we consult widely and effectively.

We are already beginning to develop a comprehensive picture of local views and concerns through our early engagement, building an extensive stakeholder and community database and contacts which will enable us to develop a detailed plan of those affected by any proposed changes.

We also have an existing relationship with both general and specialist media outlets (including digital). We are already working on STP stories with these stakeholders and will continue to do so whether formal consultation is required or not.

10.3 Equalities analysis and impact assessment

Under the Equality Act 2010, we are required to analyse the effect and impact of the NCL STP in relation to equality. We are committed to carrying out an equality impact assessment to ensure our plan does not discriminate against disadvantaged or vulnerable people, or other protected groups.

Our equality analysis will consider the effect on different groups protected from discrimination by the Equality Act to ensure any changes are fully effective for all target groups and mitigate against any unintended consequences for some groups. We are committed to undertaking an Equalities Impact Assessment as our plans become more fully developed.

We already have a good overview and analysis of equality information from across the NCL footprint through our existing and ongoing partnership work with the 5 local authorities, CCGs, providers and other representative organisations. We are building on local regular equality audits of residents, patients and staff to ensure good engagement with protected groups and others, so that we can better understand the actual or potential effect of changes to functions, policies or decisions through the STP. This will help us to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Throughout our engagement to date, and building on the insight above, we have taken advice on best practice to ensure that all our public facing work is as fully accessible as possible, including sharing information in a variety of formats to ensure our we are able to engage all our residents, using interpreters or Easy Read material where required. We will continue to hold events and meetings in accessible locations (accessible for people with disabilities and easily reached on public transport, with adaptations made for attendees'

communication needs). Our aim is to enable different groups to be fully involved as the STP progresses.

11 Conclusion and next steps

The STP is work in progress and we recognise that we have much more work to do to deliver the vision we have set out.

The immediate next steps between now and Christmas are to:

- to take steps to stabilise our financial position, developing more detailed ideas in the areas we have not yet fully explored
- agree the priorities for implementation in the first 2 years of the STP to ensure that we focus initially on the improvements which will make the most impact on our triple aims most quickly.

At the same time, we are clear that we will not lose focus on the longer term transformation that will support sustainability.

There remain many issues to resolve and we know we do not have all the answers. But we are determined to succeed and will continue to work with people who use services, the public and our staff to find solutions in the months and years ahead.

HEALTH SCRUTINY COMMITTEE
WORK PROGRAMME 2016/17

16 MAY 2016

1. Membership, Terms of Reference and Dates of Meetings
2. Work Programme 2016/17 and prioritisation of scrutiny topics
3. 111/Out of Hours service specification –update from Chair
4. Islington CCG Annual report
5. Margaret Pyle update – Results of consultation/Progress on transformation
6. Health and Wellbeing Board – update

09 JUNE 2016

1. Drug and alcohol misuse – Annual Update
2. Camden and Islington Mental Health Trust Quality Account
3. Scrutiny Review – Health Implications of Damp Properties – witness evidence
4. New Scrutiny topic
5. Work Programme 2016/17
6. Health and Wellbeing Board – update

19 JULY 2016

1. NHS Trust – Whittington Hospital – Performance update
2. Scrutiny Review – Health Implications of Damp Properties – Draft recommendations/Hyde Housing Association
3. Work Programme 2016/17
4. Whittington Hospital – Governance arrangements
5. Healthwatch Annual Report
6. Health and Wellbeing Board – update

22 SEPTEMBER 2016

1. London Ambulance Service – Performance update
2. Scrutiny Review – Effectiveness of IAP – Presentation and SID
3. Annual Adults Safeguarding report
4. Work Programme 2016/17
5. Health and Wellbeing Board – update
6. Scrutiny Review – Health implications of Damp Properties – Final report

17 NOVEMBER 2016

1. Scrutiny Review – New Topic – witness evidence
2. Health and Well Being Board – update
3. Work Programme 2016/17
4. Performance statistics
5. Healthwatch work programme
6. Health and Wellbeing Strategy
7. Presentation Executive Member Health and Social Care
8. Sustainability and Transformation Plan – NC London

12 JANUARY 2017

1. NHS Trust – UCLH – Performance update
2. Scrutiny Review – New topic – Witness evidence
3. Work Programme 2015/16
4. Health and Wellbeing Board – update
5. Scrutiny Review – 12 month progress report – Patient Feedback
6. Performance statistics

06 MARCH 2017

1. Scrutiny Review – New topic– witness evidence

2. NHS Trust – Moorfields – Performance update
3. Work Programme 2015/16
4. Health and Wellbeing Board – update
5. Whittington Estates Strategy

22 MAY 2017

1. Scrutiny Review – New topic– witness evidence
2. Work Programme 2016/17
3. Health and Wellbeing Board – update
4. Scrutiny Review – Topics 2017/18
5. Membership, Terms of Reference etc.
6. Performance statistics

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