ISLINGTON
For a more equal future

Resources Department
Town Hall, Upper Street, London, N1 2UD

AGENDA FOR THE HEALTH AND WELLBEING BOARD

Members of Health and Wellbeing Board are summoned to a meeting, which will be held in Committee Room 1, Islington Town Hall, Upper Street, N1 2UD on **31 October 2023 at 1.00 pm.**

Enquiries to : Boshra Begum
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Despatched : 23 October 2023

Membership

Councillors:
Councillor Kaya Comer-Schwartz (Chair)
Councillor Nurullah Turan
Councillor Michelline Safi Ngongo

NHS Integrated Care Board:
Dr Clare O'Brien, Governing Body representative
Clare Henderson, Executive Director representative

Islington Healthwatch:
Emma Whitby (non-voting)

Other NHS Representatives:
Dr Helene Brown, NHS England (non-voting)
Darren Summers, C&I NHS Trust (non-voting)
Helen Brown, Whittington Health (non-voting)

Islington GP Federation:
Mike Clowes (non-voting)

Council Officers:
Jon Abbey, Corporate Director, Children & Young People
John Everson, Director of Adult Social Care
Jonathan O'Sullivan, Director of Public Health

Voluntary Sector Representative:
To be appointed

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

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

- if it is not yet on the council's register, you must declare both the existence and details of it at the start of the meeting or when it becomes apparent;
- you may choose to declare a Disclosable Pecuniary Interest that is already in the register in the interests of openness and transparency.

In both the above cases, you must leave the room without participating in discussion of the item.

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

*(a)Employment, etc - Any employment, office, trade, profession or vocation carried on for profit or gain.
(b)Sponsorship - Any payment or other financial benefit in respect of your expenses in carrying out duties as a member, or of your election; including from a trade union.
(c)Contracts - Any current contract for goods, services or works, between you or your partner (or a body in which one of you has a beneficial interest) and the council.
(d)Land - Any beneficial interest in land which is within the council's area.
(e)Licences- Any licence to occupy land in the council's area for a month or longer.
(f)Corporate tenancies - Any tenancy between the council and a body in which you or your partner have a beneficial interest.
(g)Securities - Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

This applies to all voting members present at the meeting.

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C. Questions from Members of the Public

To receive any questions from members of the public.
(Note: Advance notice is required for public questions).

D. Urgent Non-Exempt Matters

Any non-exempt items which the Chair agrees should be considered urgently by reason of special circumstances. The reasons for urgency will be agreed by the Chair and recorded in the minutes.

E. Exclusion of Press and Public

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

F. Urgent Exempt Matters

Any exempt items which the Chair agrees should be considered urgently by reason of special circumstances. The reasons for urgency will be agreed by the Chair and recorded in the minutes.

G. Confidential/Exempt Items for Information **Page**

The next meeting of the Health and Wellbeing Board will be on 12 March 2024

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www.democracy.islington.gov.uk

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London Borough of Islington

Health and Wellbeing Board - Tuesday, 4 July 2023

Minutes of the meeting of the Health and Wellbeing Board held at Council Chamber, Town Hall, Upper Street, N1 2UD on Tuesday, 4 July 2023 at 1.00 pm.

Present: Councillor Turan, Councillor Ngongo, Jon Abbey, John Everson, Jonathan O'Sullivan, Clare Henderson, Emma Whitby

Also Present: Emily Van Der Pol.

1 WELCOME AND INTRODUCTIONS (ITEM NO. A1)

It was agreed that Councillor Turan would Chair the meeting in Councillor Comer-Schwartz absence.

Everyone was welcomed to the meeting and introductions were made.

Councillor Turan in the Chair

2 APOLOGIES FOR ABSENCE (ITEM NO. A2)

Apologies for absence were received from Cllr Comer-Schwartz, Helene Brown, Michael Clowes and Darren Summers.

Emily Van Der Pol attended on behalf of Darren Summers.

3 DECLARATIONS OF INTEREST (ITEM NO. A3)

None.

4 ORDER OF BUSINESS (ITEM NO. A4)

Items were considered in the order they appeared on the agenda.

5 MINUTES OF THE PREVIOUS MEETING (ITEM NO. A5)

RESOLVED:

That the minutes of the meeting held on the 14th of March 2023 be agreed as an accurate record of the meeting.

6 DAMP, AND MOULD REPORT (ITEM NO. B1)

Ian Swift, the Director of Housing Needs and Strategy and Rebecca Nicholson Head of Integrated Services and programme manager for the damp and mould response at Islington Council introduced the item.

The following points were noted in the discussion:

- The report outlined the overview of the work since November 2022, this focused on the urgent response with tenants reporting damp and mould. Phase 2 work focused on reaching residents we were unable to contact, this work is underway, as well as analysis tenants linked to Children's and Adult Social Care services.
- Pilot work around tenancy and property visits were conducted, phase 2 of the pilot to reach other areas in the south and north of the borough.
- Work was underway to import property data into a dashboard to consider the risks of damp and mould. This would also consider vulnerabilities of residents where known.
- Islington Council was also liaising with housing associations around damp and mould issues. There were 17,000 housing association properties and 36,000 Islington Council properties in the borough. Four of the largest housing associations had attended the Housing Scrutiny Committee meeting in June to explain their work around damp and mould and reducing inequalities in their stock.
- The Council was working with health partners to fast-track cases where appropriate.
- The Board noted the council's enforcement powers in relation to private landlords. The council has a duty to make sure all types of housing are in a decent standard for residents.
- Some residents had raised concerns around damp and mould in temporary accommodation. Officers summarised the standards that private landlords had to meet to provide temporary accommodation, as well as the right to inspection and the safety rating system.
- The Director of Housing Needs and Strategy informed the Board that there was a meeting every eight weeks with key partners to discuss how to improve social housing for residents. A partnership agreement with housing associations was being developed and this would set expectations around health and wellbeing. It was commented that the council would work with residents to raise awareness about lifestyle factors that can increase instances of damp and mould.
- Officers were developing a referral mechanism which will be piloted with GPs to fast track action where damp and mould was having an impact on health. If successful, this could be rolled out to other agencies.
- Officers will be attending other board meetings as they recognised the need for critical appraisal of the work.
- It was suggested that a future Health and Wellbeing Board meeting could consider a deep-dive on this topic.

RESOLVED:

a) That the report on damp, condensation and mould in homes managed by Islington Council be noted, and phased progress to improve the situation be noted.

b) That consideration be given to other actions which health and social care services can make together with the Homes and Neighbourhoods

team to further tackle the issue of damp, condensation and mould and its effect on the quality of life and health and wellbeing of tenants.

c) That the Board schedule a wider and deeper dive into health and housing at a future Health and Wellbeing Board meeting, to assist with developing partnership approaches and working around this wider determinant of health and wellbeing, including other issues currently under review such as overcrowding.

7 INCLUSION HEALTH IN ISLINGTON AND NORTH CENTRAL LONDON (ITEM NO. B2)

Sarah D'Souza, Director of Communities, NHS North Central London ICB introduced the presentation on NCL Inclusion Health Needs Assessment alongside Alexandra Levitas from Public Health at Islington Council.

The following points were noted in the discussion:

- People in Inclusion Health groups face the most significant health inequalities of any group in our population; often compounded by the impact of intersectionality/multiple disadvantage. The average age at death was 46 years for people experiencing homelessness. This is 30 years below national average. There were high levels of early frailty across this group.
- Please in inclusion health groups also had a high level of complex health needs. This could be associated with childhood trauma, mental health issues, drug and alcohol use, sexual health, infectious diseases, poor perinatal outcomes, or the impact of violence.
- There could be complex barriers to accessing planned healthcare, including stigma and discrimination, lack of trust, trauma triggers, rigid appointment systems, digital exclusion, language barriers, and travel costs. These were compounded by lack of visibility within our system. Early intervention and joined up approaches were needed to support those with complex needs.
- The Inclusion Health Needs Assessment included three phases in the work which aimed to solidify our understanding of the inclusion health groups. Phase 1 included a rapid evidence review which reviewed over 100 local and national data sources and meetings and correspondence with 20 stakeholders. Phase 2 included a frontline staff survey and key stakeholder interviews. This considered overlaps of severe multiple disadvantages using existing data and lived experience interviews and considering service user journeys. Phase 3 involved the preparation of the final report to synthesise all evidence sources.
- There was a high prevalence of multiple disadvantages among those in inclusion health groups. The needs of the homeless community were well understood but there was a gap in understanding and service provision for sex workers and GRT communities.

- There were gaps in access and experience to services for those in inclusion health groups, including mainstream primary care, mental health services, and dental services. Experiences in hospitals and discharge pathways could be improved. Better coordination was needed around release from prison.
- There were pockets of excellent practice, including integrated working, collaboration, and partnership with mental health services.
- There was a need for greater education and awareness of inclusion health groups.
- The Board noted case studies of those in inclusion health groups experiencing multiple disadvantage.
- There was a need to consider how health partners worked together to address the issues raised in the report. It was recommended to consider how services are provided to inclusion health groups, particularly access to dental health and physiotherapy. There was a need to consider integrated approaches for sex workers and vulnerable women from inclusion health groups, as well as a coordinated approach to prison release and access to mainstream primary care.
- The proposed next steps included building on existing work with asylum seekers to develop an approach to inclusion health groups, to further consider co-production, to further develop services for sex worker and vulnerable women in light of the Violence Against Women and Girls work. On a system-wide level, there was a need a build an accountability network of inclusion health leadership and enable cross borough/system working on priorities.
- The Board considered the need for more information on looked after children and further information on financial resourcing and how this is allocated across the ICB and NCL, as well as the joining up of resources and the priorities. It was suggested that a business case could be developed by working with partners to set out priorities, pressures and set out financial investments.
- It was suggested that this work be taken to the Police, prisons and probation service for review.

RESOLVED:

a) That the scope and the Phase 2 report findings, and an overview for developing plans for taking forward recommendations and actions, be noted;

b) To consider the additional opportunities for Islington to use the insights from the Inclusion Health Needs Assessment to improve outcomes for inclusion health groups;

c) To consider how support from the wider North Central London system can assist with Inclusion Health within the borough.

8 HEALTH DETERMINANTS RESEARCH COLLABORATION (EVIDENCE ISLINGTON) UPDATE (ITEM NO. B3)

Jonathan O'Sullivan, the Director of Public Health introduced the report.

The following points were noted in the discussion:

- On the 8th November 2022 the committee received a paper detailing that Islington Council had been selected as one of thirteen successful sites across the UK to become a National Institute for Health Research (NIHR) Health Determinants Research Collaboration (HDRC), following a highly competitive process.
- Islington Council was awarded £233,553 for the period October 2022 to September 2023 to spend on developing foundations for research ahead of the award for the full HDRC. If successful, pending the outcome of the development year review, in attaining the Full-HDRC status, Islington Council would receive further 5-year funding.
- The report outlined various actions taken, including the governance strategic leadership and the operating model. A data and insights marketplace was being developed which sought to identify those most vulnerable and act on this to make a real difference for our residents.
- The main focus of the work so far had been on housing and debt and cost of living following feedback from residents. Public Health was working with Healthwatch Islington around these issues. Officers were also working with young people to develop an engagement strategy.
- The work would be co–designed with residents. It was important to prioritise the voice of our residents to ensure this is captured in the design phase and to create action plans together.
- Consideration was given to using data ethically and how data can be combined to address issues such as damp and mould.
- Officers had conducted audit exercises of the data we currently hold to ensure we can describe the inequalities in the borough accurately.

RESOLVED:

That the progress made against the development year activities be noted.

9 NCL DELIVERY PLANNING - POPULATION HEALTH STRATEGY (ITEM NO. B4)

Penny Mitchell, Director of Population Health Commissioning at NCL Integrated Care Board, the introduced the report.

The following points were noted in the discussion:

- This report outlined the emerging thinking regarding delivery planning for the Population Health & Integrated Care Strategy. System-ownership will be at the heart of this work therefore proposals should be seen as early-stage proposals with the aim to refine with partners from across the health and care system.
- The strategy had been considered by a range of partners and a more digestible version of the strategy would be prepared for residents too.
- The Population Health Strategy would focus on prevention, early intervention, tackling inequalities across communities, intersectionality

of equality, and putting communities' voices at the heart of the ongoing great work with partners.

- The Board asked how partners can continue to work together collaboratively to develop the plan locally, and also how to identify when it is appropriate to work more systematically across NCL. It was considered how a regional approach can be helpful in some cases, whereas other issues needed a more localised response. The Board considered the importance of continuing to have regular local conversations on the borough partnerships.
- A Board member commented that population health work can take a significant amount of time to come to fruition, especially when budgets are planned and executed on an annual basis. Continued investment in local services was key, and there was clarity around priorities locally, however it was thought there was a lack of detail on the implications of a system-wide approach to some issues and it was important to consider the differences between boroughs across the issues raised.
- It was commented that the language in the strategy could be revised for accessibility and to be jargon-free for residents.

RESOLVED:

To consider the approach to delivery planning in relation to the Population Health and Integrated Care Strategy.

The meeting finished at 2.30pm.

Chair

Islington Public Health
222 Upper Street, London N1 1XR

Report of: Director of Public Health

Meeting of: Health and Wellbeing Board

Date: 31st October 2023

Ward(s): All

Subject: Health Determinants Research Collaboration (Evidence Islington)

1. Synopsis

1.1. In 2022, the National Institute for Health Research (NIHR) conditionally approved Islington Council to become a National Institute for Health Research (NIHR) Health Determinants Research Collaboration (HDRC) – locally this has been called Evidence Islington. Funding was initially given for a pilot year, subject to delivering an agreed programme of development activities, NIHR would then fund Islington as an HDRC for five further years.

1.2. Following a review of the work delivered in the first year, NIHR have now confirmed that after a successful pilot year of Evidence Islington, we have been awarded full Health Determinants Research Collaboration (HDRC) status, starting on the 1 October 2023. There are only 13 local authority areas that have been awarded this status, which comes with £5million in funding to drive a culture of research, data and evidence-based policymaking in partnership with residents and our health and academic partners.

1.3. Following on from the update provided to the Board on 4th July 2023, this presentation provides an update on the progress to date and the plans going forward.

2. Recommendations

2.1 To note the NIHR's decision of approval for Islington Council to progress to full HDRC status on 01 October 2023.

2.2 To discuss and agree how the HDRC works with the Health and Wellbeing Board going forward, in particularly: opportunities to be involved in the work, sharing of findings and progress and priorities and themes of the HDRC.

3. Background

3.1. HDRCs are a new element of NIHR-funded research based in local government. Their purpose is to help enable local authorities to become more research-active, using evidence to inform their decision making by undertaking research and evaluation relating to their activities, including synthesising and mobilising existing evidence. NIHR HDRCs are nationally recognised centres of 'research excellence,' based in and led by local government, which receive core funding from the NIHR. Their focus is on building research capacity and capability between local government and the academic sector.

3.2. Islington Council has been awarded around £5million to take forward the HDRC work. This funding will mean we can lead a five-year programme to do this work with our resident co-design group, Healthwatch Islington and the Diverse Voices Health Network, our academic partners LSHTM, UCL, ARC North Thames among others – with three key workstreams:

1. Creating a sustainable research culture that places evidence at the heart of how we work with communities.
2. Strengthening and, maturing our data infrastructure to enable us to generate high quality insights and evaluate impact.
3. Building capacity and participation in research with our residents and voluntary and community organisations to drive change and make a positive difference, ensuring they are central to the design and delivery of the programme.

3.3. Islington's approach to HDRC, will act as a driver to Islington 2030, supporting the fundamental shifts needed to make a real impact on the core issues and inequalities our residents face.

3.4. In consultation with Islington communications department and Healthwatch Islington we created a more accessible brand and name for the HDRC, namely: Evidence Islington (EI), our working title for the HDRC.

Developmental year programme support and branding.

3.5. Evidence Islington's delivery over the 12-month pilot was focused around four key themes agreed with NIHR, namely:

- Further development of the strategic leadership, governance and operating model for the local HDRC
- Developing a monitoring framework
- Co-produce the community engagement and dissemination activities with residents and VCS groups and widen engagement and awareness from elected members.

- Undertake pilot work on the data challenges including the ethical and practical considerations.

3.6. Progress on these areas was reported to the Health and Wellbeing Board in detail at the July Board and a summary table is provided in appendix 1.

NIHR feedback

3.7. The NIHR Authority's decision of approval provided extremely positive feedback on the progress Islington had made during the pilot year. In particular, they highlighted the following:

- They liked the engagement with the senior leaders and elected members in the council and creative ways in which this was done. They were especially impressed with the early impact of this work with the engagement of the Director of Housing Needs and Strategy on supporting several of the directorates' workstreams.
- NIHR thought our approach to having housing as an area of particular focus was good and had helped focus the HDRC's attention rather than try and tackle every wider determinate at once.
- It was good to see a balanced level of PPI involvement in that the HDRC is aiming to integrate residents into decision making. They liked the discussion we had had around how evidence leads to action and who has power to influence change. They could see the impact from these questions in the change from the HDRC shifting from engagement and dissemination strategies to thinking about how evidence would influence change.
- They were impressed with the work done to ensure ethnic minorities and underserved groups are being engaged.
- They were pleased with the early wins that we had delivered such as the data linkage work identifying missing Unique Property Reference Numbers.

3.8. Today's presentation outlines Islington's strategic direction and plan as a full HDRC. Over the next 12 months our delivery is focused under the three core themes of our proposals (Strengthening collaborations and culture, data and infrastructure and capacity building). Some of the early priorities will be establishing the governance systems to oversee the programme and recruiting into the posts funded by NIHR. We will also need to ensure a robust baseline, so that we can effectively evaluate impact and define the actions needed to deliver the programme, this will include undertaking an Islington-wide needs assessment (this will include all LA staff including members, residents, and VCS partners) which focuses on training & organisational culture to support research. We will be continuing to develop the work underway to develop the housing and health linkage approach as well as identifying one or two areas of further focus.

4. Implications

4.1. **Financial Implications**

4.1.1. There are no financial implications arising from this report. The measures and recommendations proposed in this report are not currently quantifiable. Any recommendations from this report, if adopted, will need to be expanded upon and reviewed with the financial implications assessed.

4.2. **Legal Implications**

4.2.1. There are no legal implications.

4.3. **Environmental Implications and contribution to achieving a net zero carbon Islington by 2030**

4.3.1. There are no environmental implications that arise from this report.

4.4. **Equalities Impact Assessment**

4.4.1. 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.

4.4.2. An Equalities Impact Assessment is not required in relation to this report. It describes an overall research and development plan and a number of actions to develop the plan over the coming year. Actions that require an Equalities Impact Assessment will be assessed accordingly as part of their development and implementation.

5. Conclusion and reasons for recommendations

5.1 We are thrilled that after a successful pilot year of Evidence Islington, we have been awarded full Health Determinants Research Collaboration (HDRC) status. This is an exciting development and has been possible thanks to close collaborative working with our resident co-design group, Healthwatch Islington and the Diverse Voices Health Network, our academic partners LSHTM, UCL, ARC North Thames among others.

5.2 The award will see a five-year programme of investment funded by the National Institute for Health and Care Research (NIHR) to boost the local authority's capacity and capability to conduct high-quality research. The HDRC partnership will enable the local

authority to become more research-active, so we can collect and use evidence better to improve our services and reduce health inequalities, with a strong focus on engagement with the community. Islington's programme will focus on core issues that affect residents' health and wellbeing such as housing, employment, and the environment and align to the missions of our corporate plan.

5.3 We now need to build on the strong progress made through the development year pilot, taking this work much further through the full programme, working with colleagues across the council and in the community, supported by academic and other partners.

Final report clearance:

Signed by:

Jonathan O' Sullivan, Corporate Director of Public Health

Date: **13th September 2023**

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Appendices:

Appendix One

Appendix One: Progress made during Islington's HDRC Developmental year.

Development year goals	Progress (April to June 2023)
1. Further development of some aspects of strategic leadership, governance and operating model for the local HDRC	We have made significant progress in socialising the HDRC in the organisation over the past months. We have presented the purpose and aim of Islington HDRC to Islington's leadership network and conducted some targeted engagement with political members at a fresher's fair. We have also been working with senior members of the housing management team on developing further insight and research ideas on quality of housing, specifically looking at overcrowding and damp and mould. These engagement sessions have led to further planned sessions with members and the Housing Management team to have focused discussions about the HDRC. A paper to the Islington Together Board will be taken in July to discuss the governance of the HDRC and how we strengthen our approach to data and evidence. We are piloting different engagement mechanisms with partners/members through development year member events, activities and networks – to feed into developing the HDRC engagement and communication strategy so that it will have input from members, partners inside and outside of LBI. 1.1 Data & Insights Marketplace, 20th of April – n= 85. The event was attended by leaders (Heads of Services and above) across the organisation representing all departments. The event consisted of 2 keynote speeches, one of which was about the HDRC attendees were encouraged to visit the different stalls showcasing data and the HDRC in a "speed dating" style set up so that senior LBI leaders could engage with and learn how we are using data & evidence in many different ways. We also collected data on the day from participants on their thoughts around the use of data and evidence in the organisation and gaged interest from colleagues who would like to be involved/know more about the HDRC through a live Slido poll and evaluation of the event. 1.2 Freshers Fair (n= 20 attendees including ward councillors, members and executive members to provide them with a flavour of what directorates do and other capabilities in the organisation. Stall on data & insights with HDRC information, which gave us the opportunity to speak directly with councillors about their evidence needs and how HDRC could support their work. They asked questions about community safety, including differences between trends in reported crime and perceptions of safety, childhood obesity, air pollution, sustainability, exclusions, physical activity and social options for young people, including lively discussions about data availability and quality to inform resource allocation decisions (based on a current, high-profile consultation about changes to a local leisure centre). 1.3 Health & Wellbeing Board (scheduled 4 July 23) - chaired and supported by Executive Member for Health and Care and the Leader of the Council 1.4 Diverse Communities Health Voice (DCHV) meeting (19 June 2023). DCHV is a partnership of 12 organisations working with minoritised communities. They are seen as an intrinsic partner in supporting LBI-HDRC to reach inclusively out into our communities.

	1.5 Focus on housing and health research. We have had meaningful conversations with the Director of Housing Needs and Strategy on supporting several of the directorates' workstream using a data and evidence approach. These have resulted in support on the development of a questionnaire regarding overcrowding and some specific research on overcrowding and wellbeing alongside working with the NHS in developing a proposal for linking housing and health data. An internal communications plan is being developed to aid the organisation in understanding what the HDRC is and how it will help the organisation to deliver its ambitions on creating a fairer Islington.
2. Developing a monitoring framework	We have developed a monitoring plan and data collection form for the development year (interim 6-month report dated 31 March 2023 refers). Progress against objectives in the plan and data on engagement are discussed at fortnightly meetings. More detailed review of progress and strategic direction are conducted through in-person meetings held every 2 months. Once we have confirmation of full-HDRC, we intend to develop a five-year detailed project plan (Microsoft project) which will inform and refine our evaluation objectives and evaluation plan for the full HDRC. Our programme manager has explored various project management options for use in the full HDRC and their alignment with ways of working in Islington, including whether staff regularly use a particular PM methodology and software, whether they have the training and so on. She has identified the need for more sophisticated approaches to MS Excel, to one that will identify parallel and/or sequential workstreams (i.e. task dependencies), manage resource allocation (financial and HR for respective workstream) which will enable us to monitor the 'critical path' (the strategic critical tasks) to mitigate risks, track milestones and address arising issue(s) in a timely manner. We have concluded that Microsoft Project best meets our needs. We intend to develop the full HDRC monitoring framework using Microsoft Projects and populating this will begin once we are given the green light for progressing to a full HDRC.
3.Co-produce the community engagement and dissemination activities with residents and VCS groups and widen engagement and awareness from elected members	3.1 Established a mixed and engaged co-design panel with 12 residents. 3.2 Run the first three monthly sessions (17th April, 22nd May, 19th June), which have focused on the group getting to know each other and establishing ground rules for inclusive participation, understanding EI and explaining it in their own words, brainstorming ideas for ways in which residents can be involved in EI (based on resident-identified 'hot topics': housing, safety and parking), learning about the current composition of the borough (through a 'Who is Islington' quiz with updated demographics from the latest Census data), brainstorming ideas for way to reach subgroups who are underrepresented in previous council engagement and preparing for an upcoming discussion with council housing staff about how evidence is used to inform decision-making. Since June, several co-design members are helping to develop the agenda for the monthly group meetings, as we work towards co-production. Several recuring questions have been consistently raised by the co-design group i) what has been done with feedback they have provided in previous consultations, ii) how evidence leads to action and iii) who has the power to influence what types of change – for example, differences across council tenants, those living in housing associations and private renters. As a result, we are planning to test this out with housing colleagues (a topic the group frequently refer to) – to run a pilot 'evidence to action' discussion where residents can

interact directly with decision-makers about an issue that is important to them, hear first-hand what the council has more and less influence over, reflect on how evidence is used and advise how the council can better communicate with different groups of residents. We are thus testing out components of the strategy as we are developing the plan itself.

As a result of the initial three months with the co-design group, we have adapted our approach in 3 key ways:

I. Shifted the orientation of the strategy from engagement and dissemination to a much stronger emphasis on channels of influence and pathways from evidence to action.
II. Identified the need for both an overarching strategy and a more detailed action plan that is grounded in resident experiences of areas that are particularly important in their daily lives (e.g. housing, safety and transportation)
III. Identified the value of continuing a co-design group beyond the development year and the opportunity to work more closely with the umbrella VCS organisation in the borough: Voluntary Action Islington (VAI) as a way to reach more residents and VCS.

3.3 Convened a workshop (13th June) with members of the Diverse Communities Health Voice (DCHV) network (12 VCS organisations). In the development year we are seeking DCHV leads views on our wider engagement strategy. They will incorporate their ideas into the PPIE strategy, specifically feed in on how we can ensure that people from specific ethnic minorities and people with disabilities can be supported to be heard, involved and made aware of Evidence Islington.

3.4 Meet monthly with LBIs Engagement team to align their strategic ambitions with the HDRCs, and to enable learning to be shared across. For example, LBI are planning a Citizen Group to input into the Net Zero strategy, and they are using an independent organisation to recruit a representative sample. LBI have also launched an online consultation presence (https://www.letstalk.islington.gov.uk/), in which residents are asked if they would like to be contacted in the future for other consultation/engagement activities. To date 272 residents have consented into this process, and we will use this database with our EI recruitment for the 5-year HDRC PPIE plans.

4.Undertake pilot work on the data challenges including the ethical and practical considerations.	Review of ethical considerations: In February we received UCL Ethics Committee approval to conduct the review of ethics processes in approx.15 LAs. in collaboration with colleagues from Cornwall and Middlesborough Councils. Data collection is currently ongoing and planned to conclude in July, with preliminary findings due to be presented at the Research Ethics Association Conference in Bath, 7th July 2023, and discussed Local Authority Public Health Research Network 3 July. We have continued to strengthen cross council ethics review processes through periodic working group sessions with members from the Information Governance and Participation & Engagement teams and a series of dedicated sessions with Children's Services to discuss processes when other departments are engaging under 18s. We presented the ethics review process to an expanded council-wide engagement leads group on 6th June and are currently recruiting staff to serve on a peer review panel that will trial bimonthly meetings to provide joint review and feedback on new projects. This is a shift from the previous informal process, which only involved 1 reviewer, with review timelines dependent on that person's schedule. Alongside the council's IG lead, we will present and discuss data protection and ethics review processes at the next participation and engagement community of practice meeting to increase awareness across the council, particularly for staff whose roles are not dedicated to but involve resident engagement. Unique Property Reference Number: Digital services team have identified 49 applications that have people and/or address data. 12 have been identified as having no UPRN field and will be prioritised for improvement. These include systems related to children and adult social care. Data Linkages: We have agreed to prioritise the feasibility of linking data on quality of housing with health data. A proposal on this linkage was presented to the NCL population health management group on the 24th of May 2023 and supported by Islington Housing Management Team. The proposal is to link a set of housing data variables to health data in HealtheIntent, NCL's population health management system, to be able to discern prevalence of conditions exacerbated by damp and mould such as respiratory conditions, in LBI properties. Equality Characteristics: An audit of equality characteristics on the main council systems on completion of fields for ethnicity, disability and religion has been completed. A key finding is that where equality characteristics are mandated for a statutory return the field has a high rate of completion compared to very low completion rates for non-mandated collection. The next steps will be to prepare a report on how the collection of these protected characteristics could be improved. The report is likely to make recommendations on 1) training for frontline staff on the purpose and benefits of collecting these data 2) Annual audits on completion of equalities data from main people facing council systems/services and 3) Promoting the benefits and purposes of equality data collection amongst residents.

Public Health

4th Floor,

222 Upper Street, N1 1XR

Report of: Statutory Partners of Islington Safeguarding Children Partnership (Local Authority, Police and Health)

Meeting of: Health and Wellbeing Board

Date: 31st October 2023

Ward(s): all wards

Subject: Islington Safeguarding Children Partnership Annual Report 2021-2022

1. Synopsis

1.1 Over the past year, the partnership has made significant progress in addressing key challenges, notably through the establishment of two task and finish groups. The Transitional Safeguarding group showcased effective collaboration, while the group addressing disproportionality and inequality initiated crucial data analysis and action planning.

1.2 Despite our advancements, we understand that challenges, especially in neglect, remain. Recognizing this, we've emphasized the need for targeted training, auditing, and a detailed neglect strategy. Our audit activities have incorporated insights from both local and national reviews, including significant findings from the JTAI (Joint Targeted Area Inspection) in Solihull.

1.3 A hallmark achievement has been amplifying the voice of children in our initiatives. This is evident in our consistent commitment to placing them at the core of our decisions, as seen in collaborative projects like the Young Black Men and Mental Health initiative.

1.4 We've transitioned to daily safeguarding meetings (DSM), which have surpassed the efficiency of our earlier MARAC (Multi-Agency Risk Assessment Conference) meetings. Notably, the DSM has fostered improved feedback from women and girls impacted by domestic abuse, enhancing our services.

1.5 The annual report also highlights the success of our youth strategy, which has led to a decline in knife crime among youth and the inception of an action plan targeting disproportionality within the Youth Justice service.

1.6 While celebrating these successes, we're also mindful of areas that require improvement. One such area is the SEMH (Social, Emotional Mental Health) section, which has identified the challenge of prolonged waiting times for services. A strategic plan is in place to expedite these wait times.

1.7 The partnership's training on safeguarding and information sharing has been commended by delegates for its emphasis on collaboration and equipping professionals with vital knowledge. Daily safeguarding meetings (Violence Against Women & Girls) have significantly bolstered multi-agency collaboration in intervening in cases where domestic abuse is a risk, swiftly addressing emerging concerns and solidifying a united approach to child protection.

1.8 Overall, the Islington Safeguarding Children Partnership has displayed strong leadership, openness to feedback, and a balance of support and challenge. This annual report celebrates their exceptional work over the past year, and their dedication to the welfare of children is commendable. A heartfelt appreciation is extended to all entities and individuals in Islington who contribute to the safety and well-being of children and families.

2. Recommendations

2.1 The committee is asked to note this report and the future priorities for the ISCP.

3. Background

3.1 Safeguarding children partnerships in London (and throughout the UK) have a statutory obligation to produce an annual report based on legal frameworks and guidance primarily set out in the Children Act 1989 and 2004 and further detailed in the "Working Together to Safeguard Children" statutory guidance.

3.2 Aim of the Annual Report: The "Working Together to Safeguard Children" guidance details the core responsibilities and expectations for the safeguarding partners. One of these responsibilities is to publish an annual report. The report should:

- Provide Transparency: Detail what the partners have done as a result of the arrangements, including on child safeguarding practice reviews, and how effective these arrangements have been in practice.
- Highlight Learning: Include evidence of the effectiveness of local training, including multi-agency training, and how it is being evaluated.
- Ensure Accountability: Detail how findings from local reviews have influenced practice and informed their report.
- Assess Performance: Provide a robust and objective assessment of the performance and effectiveness of local services. This might include data on child health, the impact of domestic abuse, or outcomes for children in need.

- Voice of the Child: The report should also highlight how they have gathered and used the views of children and families to inform their work.

- Future Plans: Identify priorities for the coming year and how they propose to meet them.

3.3 The annual report encompasses the core responsibilities and expectations from the statutory partners and relevant agencies who conduct reports where needed to measure the effectiveness of safeguarding children within the ISCP. Relevant agencies who have shared and contributed their reports to the ISCP have made recommendations for their service and will give updates on how effective their actions have been in the next reporting cycle (next year).

4. Implications

4.1. **Financial Implications**

4.1.1 There are no financial implications arising from this report. The measures and recommendations proposed in this report are not currently quantifiable. Any recommendations from this report, if adopted, will need to be expanded upon and reviewed with the financial implications assessed.

4.2. **Legal Implications**

4.2.1 The Children Acts of 1989 and 2004 set out specific duties. Section 9a of the Children Act 2004 empowers the secretary of state to define criteria for targets for safeguarding in a local authority's area.

4.2.2 Section 17 of the Children Act 1989 puts a duty on the local authority to provide services to children in need in their area, Section 47 requires the investigation of potential significant harm to children in its area and Sections 31 and 38 permit the application to court for care or supervision orders to protect children.

4.2.3 In addition the Local Authority has a power to promote wellbeing in the community through itself and with its partners pursuant to Part 1 of the Local Government Act 2000 as amended.

4.2.4 The proposals in this report conform to these obligations.

4.3. **Environmental Implications and contribution to achieving a net zero carbon Islington by 2030**

4.3.1 There are no environmental implications that arise from this report.

4.4. **Equalities Impact Assessment**

4.4.1 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.

4.4.2 An Equalities Impact Assessment is not required in relation to this report. This is an update to the Health & Wellbeing Board on the already published annual report.

5. Conclusion and reasons for recommendations

5.1 The ISCP rightly places a high priority on safeguarding and promoting the welfare of vulnerable children in Islington. The annual report provides assurance about the quality and effectiveness of services provided. Through a range of scrutiny of services to Islington's most vulnerable children the ISCP ensures that children are as safe as they can be.

Appendices:

Islington Safeguarding Children Partnership Annual Report 2021-2022

Background papers:

As above.

Final report clearance:

Signed by:

Jon Abbey - Director of Children's Services People Directorate

Date: 29th September 2023.

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ISCP
Islington Safeguarding Children Partnership

Islington Safeguarding Children Partnership

Annual Report 2021-2022

ISCP ANNUAL REPORT 2021-2022

Content:

ISCP ANNUAL REPORT 2021-2022

Introduction by the Independent Chair and Scrutineer

The Islington Safeguarding Partners as part of their arrangements to safeguard children and promote their welfare are required to demonstrate that they are open to independent scrutiny.

I have been appointed to take on the role of independent chair and to offer independent scrutiny of the Islington safeguarding arrangements and this is my assessment of how effective these arrangements have been in practice over the past 12 months. I will highlight where I feel the arrangements are performing well and where I consider further development is required.

As an independent scrutineer, it is my role to review the annual report for the Islington Safeguarding Children Partnership. This report highlights the commendable work carried out by the partnership, reflecting its unwavering commitment to the safety, well-being, and development of children and young people in the borough.

A key focus of the partnership has been transitional safeguarding, ensuring a smooth and coherent journey for young people as they navigate the complexities of adolescence and transition to adulthood. The collaboration between agencies has been remarkable in this area, creating a strong safety net for these vulnerable young individuals. This continues to be complex and challenging work, particularly for those children who have been experiencing abuse and exploitation. As they reach 18, the services available to them are limited. Abuse and exploitation doesn't end at 18 years of age and yet many services for adults are designed only to support those people with ongoing care and support needs. This important work needs to continue to enable the partnership to develop effective 'Transitional Safeguarding' arrangements.

The partnership has successfully prioritized the voice of children, actively involving them in decision-making processes and leveraging their insights to improve coordinated service delivery. By placing children at the heart of their work, the partnership has demonstrated its dedication to understanding and addressing their unique needs.

The Disproportionality and Inequality Task and Finish Group has carried out excellent work in tackling disparities and promoting equity across the borough. Their efforts have played a crucial role in creating a more inclusive and supportive environment for all children.

The annual report from the Missing Children and Exploitation Subgroup showcases the partnership's unyielding determination to protect children from harm and support those who have been affected by these devastating experiences. Their work is a testament to the importance of a unified approach in tackling these complex issues. Whilst I was pleased to see the routine offer of return home interviews by the Exploitation and Missing Team, it was disappointing to see that only 18% of RHI's offered were successful. RHI's can provide the partnership with a rich picture of intelligence which highlights key themes or trends and assists with activities to prevent further missing episodes. Whilst this is challenging work, I would like to see an increase in the successful completion of RHI's.

The comprehensive Section 11 reports from relevant agencies and schools within the borough demonstrate a strong culture of safeguarding, accountability, and continuous improvement, essential in maintaining a high standard of child protection.

Introduction by the Independent Chair and Scrutineer

The partnership in Islington has displayed real vigour when it comes to learning from serious cases. The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Such reviews should seek to prevent or reduce the risk of recurrence of similar incidents. It is the responsibility of the Safeguarding Partners to identify serious safeguarding incidents at a local level and then to review them as appropriate so that improvements can be made.

This report includes the details of a number of reviews that were undertaken during this reporting period, along with highlighting how the partnership has learned lessons from high profile national reviews.

Islington Safeguarding Partners have a well organised group of multi-agency professionals that oversee reviews and ensure there is a culture of learning and continuous improvement. The group are very keen to see that the recommendations from reviews improve outcomes for children and that lessons learned are embedded into practice. Furthermore, the partners have created a robust audit regime which ensures that the learning is revisited and embedded. I will closely monitor the audit process to confirm that learning is indeed embedded, and practice is improved.

The partnership's safeguarding and information sharing training has received excellent feedback from delegates, highlighting its effectiveness in fostering a collaborative approach among professionals and empowering them with the knowledge and tools needed to safeguard children.

Lastly, the positive impact of the daily safeguarding meetings cannot be overstated. These meetings have facilitated excellent multi-agency working, enabling swift identification and response to emerging concerns, and fostering a truly united front in the quest to protect the children and young people of the borough.

There are many strengths to the safeguarding children arrangements across Islington. I have found a partnership that is open to scrutiny and challenge and one that strives to continually learn and improve practice.

There is strong leadership and a clear sense of joint and equal responsibility from the three safeguarding partners. The partnership is one that is built on high support, high challenge and where difficult conversations are encouraged.

In conclusion, this annual report showcases the outstanding work carried out by the Islington Safeguarding Children Partnership in the past year. Their dedication, collaborative spirit, and unwavering commitment to child protection have yielded remarkable results, and I am confident that they will continue to make a meaningful difference in the lives of the children and young people they serve.

Finally, may I take this opportunity to thank all of the organisations and individuals in the public, voluntary and private sectors who work tirelessly across Islington to improve the safety and quality of life of our children, young people, and families.

Alan C Caton OBE
ISCP Independent Chair/Scrutineer

ISCP ANNUAL REPORT 2021-2022

Introduction by Statutory Partners

It is with great pleasure that we present the annual report for the Islington Safeguarding Children Partnership (ISCP) for the reporting period (September 2021 to August 2022). The ISCP represents the collective efforts of our three statutory partners – the Metropolitan Police, NCL Integrated Care Board, and Islington Local Authority – all working tirelessly to promote the welfare and safeguard children and young people of Islington.

Over the past year, the partnership has made significant strides in addressing key challenges and priorities. We established two task and finish groups, which have made a substantial impact in their respective areas. The Transitional Safeguarding task and finish group successfully demonstrated the collaboration and hard work of all involved, providing a clear picture of the work carried out across the partnership. The second task and finish group, focused on tackling disproportionality and inequality, has begun the important process of understanding the data and formulating plans to address these issues.

While we have made progress, we also recognise that there is still work to be done, particularly in the area of neglect. The partnership has acknowledged the need for more targeted training, auditing activity, and the development of a comprehensive neglect strategy to further address this priority. The ISCP has been proactive in learning from both local and national reviews. Our auditing activity has been responsive to findings from the Joint Targeted Area Inspection (JTAI) in Solihull, as well as local learning emerging from rapid reviews and Local Child Safeguarding Practice Reviews (LCSPRs).

A notable achievement during this reporting period has been the increased prominence of the voice of the child in our work. Their contributions to service delivery are evident throughout the report, demonstrating our commitment to placing children and young people at the centre of our decision-making processes. By showcasing the impact of each report from relevant agencies, we have evidenced collaboration in newly created initiatives, such as Young Black Men and Mental Health. We aim to illustrate the positive influence that our work has on the ISCP, relevant agencies, and, most importantly, the children and young people of Islington.

An essential component worth highlighting this year has been the implementation of daily safeguarding meetings (DSM), which have proven to be highly effective in comparison to our previous MARAC meetings. The DSM has not only outperformed previous targets, but has also established a valuable feedback loop with women and girls affected by domestic abuse, leading to the enhancement of our services. This progress reflects our commitment to continually adapt and improve our approaches to better serve those in need.

Another significant achievement highlighted in this annual report is the effectiveness of our youth strategy. Through targeted efforts, we have successfully reduced knife crime amongst young people and implemented an action plan to address disproportionality and inequality faced by the global majority within the Youth Justice service. These accomplishments demonstrate our dedication to creating a safer and more equitable environment for all young people in our community.

Furthermore, the Social Emotional Mental Health (SEMH) section of the report acknowledges the challenges faced in terms of increased waiting times for services. We recognise the importance of timely support for children and young people, and have outlined a plan to reduce these waiting times, ensuring that those in need receive the necessary assistance as promptly as possible.

Our partnership's focus on continuous improvement and innovation in all aspects of our work has been instrumental in driving the positive outcomes detailed in this annual report. We remain committed to enhancing our strategies and services to better safeguard and support the children and young people of Islington. As we move forward, we will continue to build on the successes and learnings of this year, striving to create a safer and more supportive environment for all children and young people in our community.

We invite you to explore this annual report and join us in our commitment to safeguarding the future of Islington's children and young people.

***David Pennington**—Director of Safeguarding, Chief Nurse's Directorate—NHS NCL ICB*

NHS North Central London Integrated Care Board

***Jon Abbey**—Director of Children's Services, Islington*

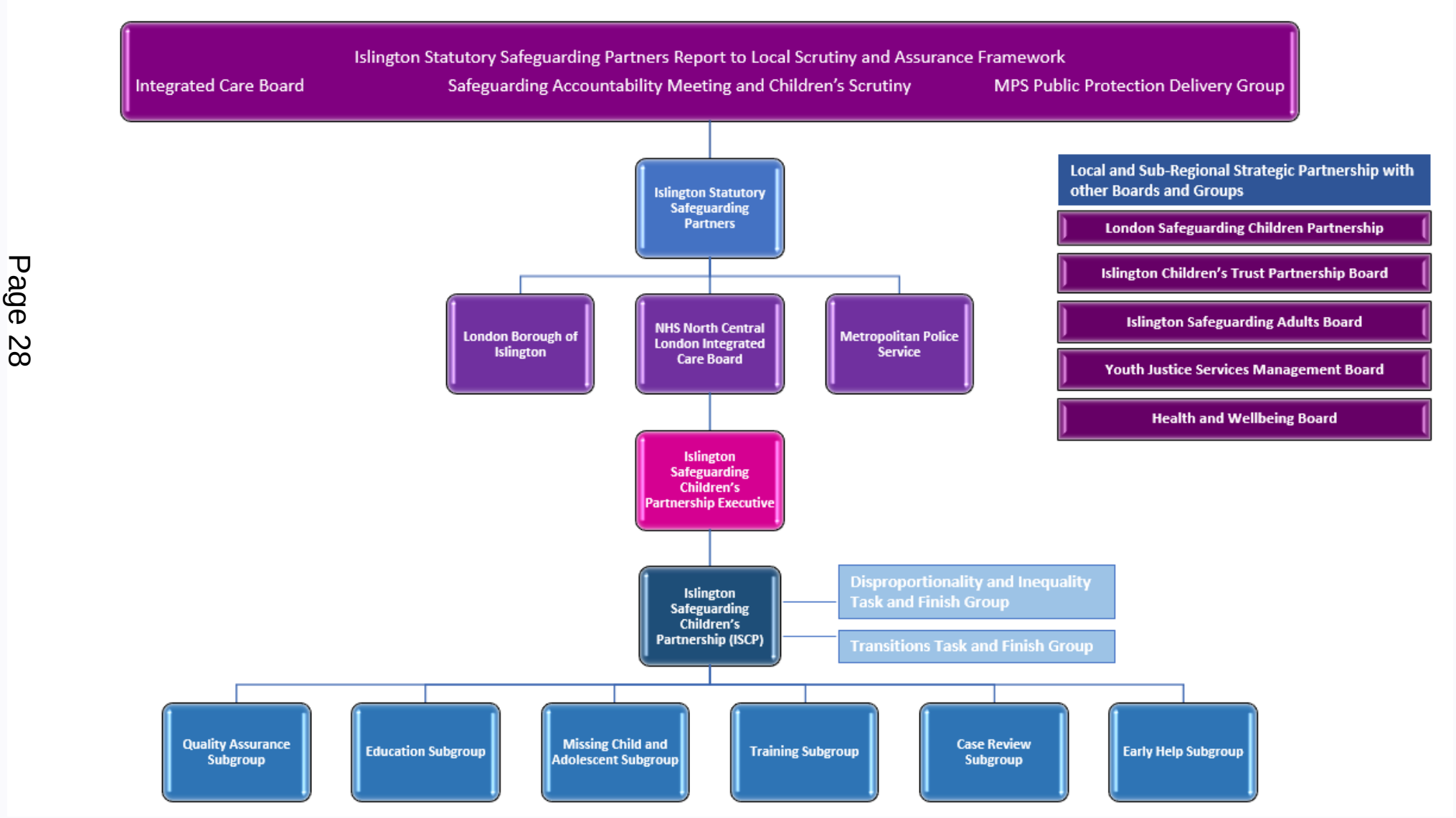
ISLINGTON

***Andy Carter**—Chief Superintendent, BCU Commander, CN Camden & Islington*

METROPOLITAN POLICE

ISCP ANNUAL REPORT 2021-2022

ISCP Structure Chart



Purpose of ISCP Annual Report

PURPOSE OF THIS REPORT

Legislation requires local safeguarding arrangements to ensure that local children are safe, and that agencies work together to promote children's welfare. The statutory safeguarding partners must publish a report at least once in every 12-month period. The report must set out what they have done as a result of the arrangements, including on child safeguarding practice reviews, and how effective these arrangements have been in practice. The report will also include:

• Evidence of the impact of safeguarding partners' and relevant agencies' work including training, on outcomes for children and families ranging from early help to looked after children and care experienced young people.

• An analysis of any areas where there has been little or no evidence of progress on agreed priorities, a record of decisions and actions taken by the partners in the reporting period, implementation of the recommendations of any local-and national child safeguarding practice reviews, including any resulting improvements.

• Ways in which the ISCP's partners and relevant agencies have sought and utilised feedback from children and families to inform their work and influence service provision.

AUDIENCE OF THIS REPORT

The report will be submitted to:

• The Local Authority's Chief Executive Officer and Leader of the Council.
• The Health and Wellbeing Board.
• The local Police and Crime Commissioner / MPS Borough Commander.
• ICB Governing Body.
• Child Safeguarding Practice Review Panel.
• What Works for Children Social Care.
• Children, Young People & Families.

Individuals and Boards are asked to note the findings of this report, and to inform the Independent Chair / Scrutineer and statutory partners of the actions they intend to take in relation to those findings.

REMIT OF THIS REPORT This report follows the ISCP Annual Report 2021/22 and covers the period from 1st September 2021 to 31st August 2022.

METHODOLOGY

In writing this report, contributions were sought directly from Partnership members, chairs of sub-groups and other relevant partnerships. The report draws heavily on numerous monitoring reports presented to the Partnership and its sub-groups during the year, such as Local Authority Designated Officer (LADO) Report, Private Fostering Report, Corporate Parenting Board report, Update to the SEMH Review and Survey from the Health and Wellbeing Board.

PUBLICATION

The report will be published as an electronic document on the Partnership's website.

ISCP PRIORITIES

These priorities reflect our desire to improve the collective effectiveness of agencies in four key areas. Partners and relevant agencies should:

• Address the impact of inequality and structural racism on vulnerable children and develop a better understanding of data across all of Islington Safeguarding Children Partnership.

• Address the impact of neglect on children and to help them become more resilient.

• Address the consequences of harm suffered by children because of domestic violence, parental mental ill health, and substance abuse, including helping children who have suffered harm to become more resilient.

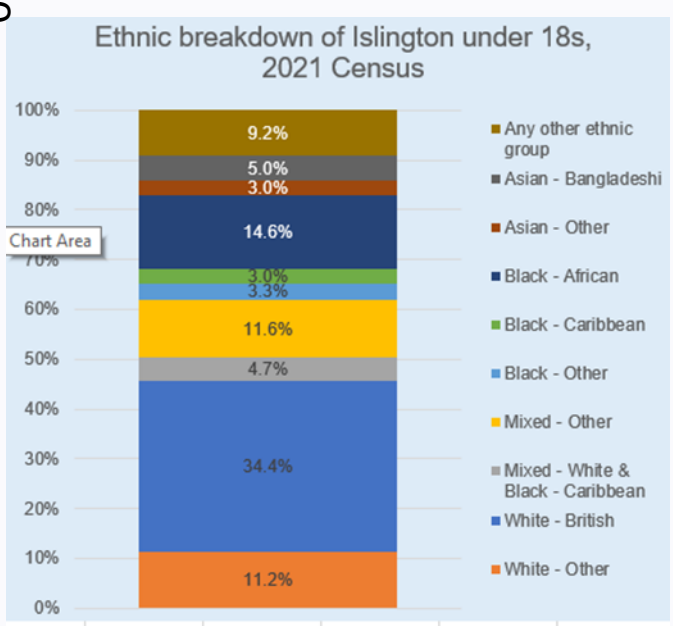
• Identify and help children who are vulnerable to sexual exploitation, criminal exploitation, and gangs.

London Borough of Islington

London Borough of Islington:

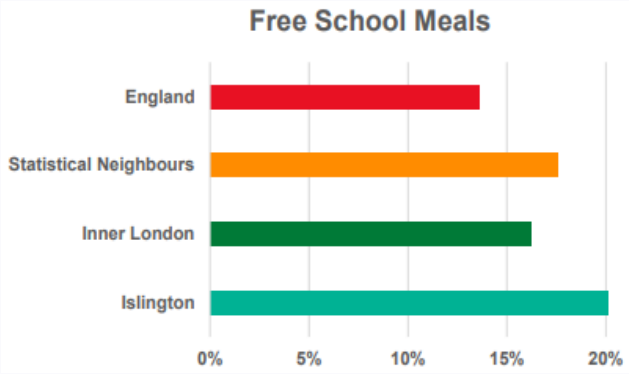
Islington is a small, densely populated inner London borough with a total population of **223,200**, which is estimated to increase by 1.2% by 2040. The borough is the second smallest in London in terms of area (after the City) and has the second highest population density.

The population age profile is on average younger than those for London and England, with 44% being young adults aged between 20 and 39 years. There are approximately **41,200 children** and young people aged 0-19 living in Islington, and around **67,600 0-25 year olds**. The proportion of children from the global majority is relatively high at **65.6%** and a significant proportion of children live in households where English is not the first language.



In terms of relative deprivation, Islington has been identified as one of the most deprived boroughs in London, with higher levels of poverty, unemployment, and inequality compared to other areas of the city. According to the latest Index of Multiple Deprivation (IMD) published by the UK government in 2019, Islington is ranked as the 16th most deprived local authority area in England, out of a total of 317 local authorities. The IMD takes into account a range of factors, including income, employment, health, education, crime, and housing, to provide a comprehensive picture of overall deprivation. While Islington is home to some affluent areas, such as Angel and Canonbury, there are also significant pockets of deprivation and inequality, particularly in parts of Holloway and Finsbury Park.

An example of the deprivation can be illustrated by the percentage of children in Islington on free school meals between **2021 to 2022 in comparison to statistical neighbours and England**:



The London Borough of Islington (LBI) has many positive aspects that contribute to its thriving and vibrant character. Some of the key positives about Islington include:

Culture and Creativity: Islington is home to a diverse range of arts and cultural institutions, including theatres, galleries, museums, and music venues. It is also known for its street art and has a thriving creative scene.

Green Spaces: Despite being a densely populated borough, Islington has many parks and green spaces, including Highbury Fields, Finsbury Park, and Gillespie Park. These spaces provide opportunities for outdoor recreation, community events, and leisure activities.

Community Spirit: Islington has a strong sense of community, with a range of local groups and organizations that bring people together for social, cultural, and civic activities. There is also a strong sense of activism in the borough, with residents actively engaged in campaigns and initiatives related to social justice, environmental sustainability, and other issues.

Diversity: Islington is a diverse borough with a rich mix of cultures, ethnicities, and nationalities. This diversity contributes to a vibrant and dynamic community, with a range of food, music, art, and other cultural offerings.

Transport: Islington has excellent transport links, with a number of tube and bus routes serving the area. This makes it easy to travel within the borough and to other parts of London, making it a convenient and accessible place to live and work.

Overall, these factors contribute to a positive and thriving community in Islington, making it an attractive place to live, work, and visit.

Effectiveness of Children Services Contact / Referral Team

Effectiveness of Islington's Children Services Contact Team

Islington received **12,199 contacts** requesting a service for children in 2021/22, a **9.4% increase** from numbers in 2020/21. The most common source of contacts was from the **police - 30%,** followed by **schools - 15.0%, Hospitals (not A&E) -7%** and **Family members/ Relative and Carer -6%**

Top 7 Contact Reasons in 2021/2022

Contact Reason	#	%
Domestic Violence (Physical/Emotional/Financial/Sexual)	1766	14.4%
Parenting Capacity Difficulties	1329	10.8%
Information Requests (Other Agencies)	1027	8.4%
Child Mental Health	1014	8.3%
Specific concerns regarding a sibling	781	6.4%
Physical Abuse	742	6.1%
Parental Mental Health	689	5.6%

• **4,724 (38.5%)** of contacts were progressed to receive an **early help service, 2,325 (19.0%)** received a **statutory social care service, 3997 (32.6%)** received **no further action and 1073 (8.8%)** received **information and advice.** ***NFA Audit.***

• Islington had the **22nd highest rate** of children assessed as Children in Need in the country in 2021/22.

• Compared with statistical neighbours, **Islington had a higher rate of children subject to a child protection plan** (at any point during the year): the rate for 2021-22 was 84 per 10,000 for Islington, versus 79 per 10,000 for the statistical neighbours.

• **Islington also had a higher rate of Section 47s** than the statistical neighbours: the rate per 10,000 children was 196 for Islington, compared with 177 per 10,000 children for the statistical neighbours.

• Islington had **a higher proportion of repeat child protection plans** (24%) compared to statistical neighbours (20%), auditing activity have explored this on page 13

• Overall, the length of child protection plans was slightly longer in 2021-22 than the previous year: in 2021-22 58% of plans ended within a year, compared with 64% in the previous year.

• **Islington** continues to have **more children looked after** per 10,000 than its statistical neighbours – 105 children per 10,000, compared with 69 per 10,000. This is also a noticeable rise for Islington since 2020-21, when the rate was 86 per 10,000. This is likely attributed to a larger cohort of CIN children as well as an influx of Unaccompanied and Separated Children (UASC). The **Corporate Parenting Board** demonstrates their plan to reduce this number (page 17).

• Islington's proportion of looked after children with three of more placements during a year is on a par with the proportion for the statistical neighbours, at **11%**.

Joint Area SEND Inspection in Islington

Joint area SEND inspection in Islington (Ofsted.gov.uk)

Between 8 November 2021 and 12 November 2021, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Islington to judge the effectiveness of the area in implementing the special educational needs and/or disabilities (SEND) reforms as set out in the Children and Families Act 2014.

Inspectors spoke with children and young people with SEND, parents and carers, local authority staff and National Health Service (NHS) officers. They visited a range of providers and spoke to leaders, staff and governors about how they were implementing the SEND reforms. Inspectors looked at a range of information about the performance of the area's self-evaluation. They reviewed performance data and evidence about the local offer and joint commissioning.

Their findings demonstrate a dedicated and ambitious leadership, committed to continuing to improve services that provide the very best for children and young people with SEND.

Evidence and impact of strengths in effectiveness of local area identifying and meeting the needs of children and young people's SEND:

- Strong strategic leadership and well-established teams
- Strong and well-established joint working relationships
- Very effective use of data
- The ability to identify children's' needs in the early years are very well embedded with a strong focus on staff developing staff knowledge and expertise through the Disabled Children's Advice Team offering guidance and consultations to health practitioners. This is also evidenced in babies and young children being able to access nursery provision from 6 months of age as part of the "early opportunities scheme"
- The team of educational psychologists provides timely and effective support to schools in identifying pupils' needs and training staff.
- Robust and integrated approach to supporting children and young people with complex medical and physical needs
- Adhering to the voice of young people in the form of the Young People's Panel producing resources to help children and young people with SEND in acute health settings.
- Parents and school leaders holding specialist services in high regard.
- Education, Health and Care Plans are consistently of high quality and that partnerships with parents and young people are meaningful and effective
- Case officers know young people and their families very well
- Transition planning is strong

Joint Area SEND Inspection in Islington

Areas for development:

- Noted that some schools might not be as inclusive and are slower to identify and meet the needs of pupils who need SEND support.
- Parents noted that at time communication with school can be inconsistent.
- Children and young people wait too long for specialist Autism Spectrum Disorder and mental health interventions
- Due to recruitment issues, some direct speech and language therapy has stopped
- The proportion of fixed-term exclusions for children and young people with SEND is too high in secondary schools.
- The variety of post-16 options for those with the most complex needs is limited and there lacks a systemic and coordinated approach to this.

SEND Strategy 2022 to 2027

Purpose of this strategy is to outline the vision, aspirations, and priorities in Islington for developing support and provision for children and young people with SEND and their families for the next five years. It applies to all partner agencies in Islington who are responsible for commissioning and providing services and view this as a high priority.

- Ambition One: Fully inclusive education for all: They intend to support all schools and settings in Islington to be inclusive and welcome children and young people with SEND
- Ambition Two: Right support in the right place at the right time for parents and carers: They intend to transform parents' parents experience of the SEND system by delivering the right support in the right place at the right time
- Ambition Three: Equity and excellent education provision: They will deliver new, ambitious and innovative provision that enables children and young people with SEND to receive excellent education in their local community
- Ambition Four: All young people are well prepared for adulthood: They will enable all young people to achieve independence, build good relationships and have a meaningful occupation

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Annual Reports from Partners Agencies: LADO

Assurances of effectiveness from Partner Agencies: Safer Workforce: Local Authority Designated Officer Report

There is a statutory expectation that relevant agencies recruit staff safely, however, there are occasions where allegations are made against staff or volunteers working with children. Relevant agencies should have in place clear procedures to explain what to do when allegations are raised. The LADO should be contacted when there is an allegation that any person who works with children has:

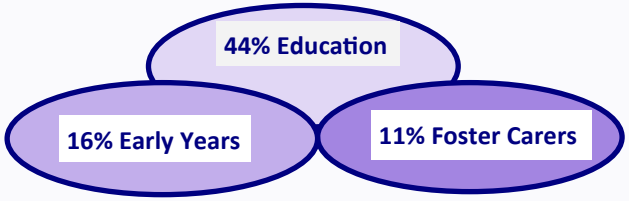
- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child;
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children;
- Behaved or may have behaved in a way that indicates they may not be suitable to work with children.

The ISCP have arrangements in place for monitoring and evaluating the effectiveness of arrangements to manage allegations across the partnership. The ISCP received the 2021/22 LADO Annual Report for scrutiny covering the period from 1st April 2021 to 31st March 2022 and it concerns :

230 Contacts

This is a noticeable increase from last year's 156 contacts and is the highest recorded contacts for Islington for a reporting year.

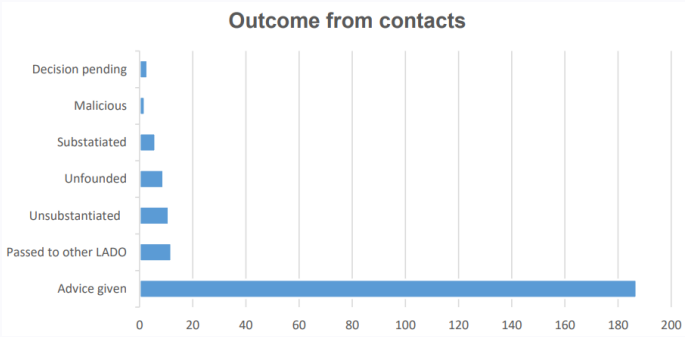
Sources of referrals:



These were the top three work setting where staff were subjected to an allegation being made against them. These figures are consistent with previous years figures and are expected given education is the biggest employer in the children's workforce.

73% of contacts were related to an allegation in the workplace (77% in 2020-21). 16% of contacts were related to an issue in member of staff's private life that raised concern about their suitability to work with children (23% in 2020-21). 11% were unrelated to concerns about harm, such as general complaints (3% in 2020/21).

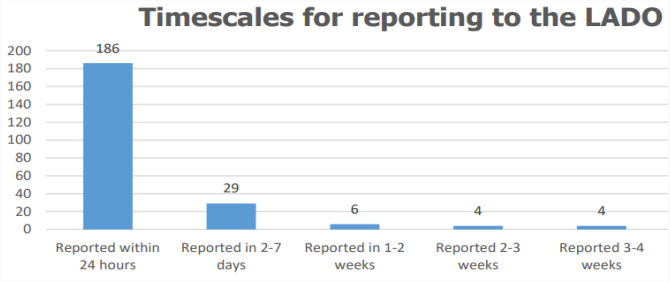
Only 6 cases out of all referrals ended up being substantiated



Nature of concern with referrals:

As in previous years, the majority of contacts related to concerns about physical abuse **123 (53%)** incidents, mainly in relation to use of physical intervention in schools. This is a stark increase from the previous year of 49 contacts, accounting for 31%, which is likely to be attributed to schools re-opening following the Covid 19 lockdowns. The second and third highest number of contacts relate to private life matters 37 (16%) and sexual abuse 34 (15%) respectively.

Partner agencies remain dedicated to managing allegations and attending ASV (Allegations against Staff/ Volunteers) meetings, even on short notice. The shift to virtual meetings during the pandemic has made it easier for agencies to convene meetings promptly, this practice will be maintained going forward.



The LADO has managed to complete actions from previous annual report such as: **1.** Reconvene the ASV steering group once a term with Police, Children's Social Care, Fostering, Early Years and Education. **2.** Transfer of the LADO data to SharePoint to allow greater stability and access to partners. **3.** Continue to host ASV meetings via MS Teams to allow easier participation of partners, with the option of face to face.

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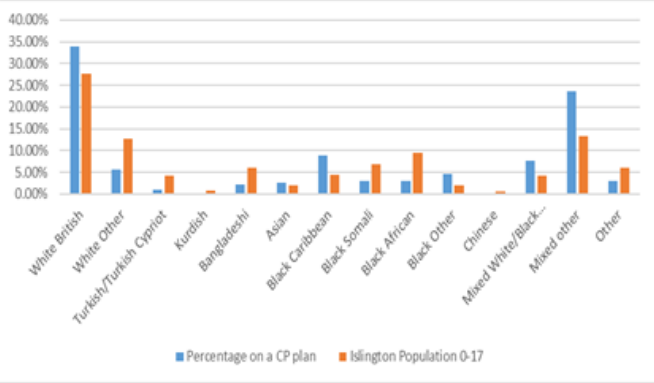
Annual Reports from Partners Agencies: Child Protection Annual Report

LBI Children Services Safeguarding and Quality Assurance Child Protection Annual Report

In 2021/2022, 172 new child protections plans were made, the lowest number of new child protection (CP) plans since 2013/14 and an 18% decrease from the previous year (209). The breakdown of category of abuse is as follows: **Emotional Abuse:** 95 (55%), **Neglect:** 48 (28%), **Physical Abuse:** 15 (9%) **& Sexual Abuse:** 14 (8%) The factors impacting parenting capacity for children subject to child protection plans include: domestic violence and abuse, adult mental health and adult substance misuse.

Based on the ethnicity breakdown of child protection plans we can see significant over-representation for Mixed other, Mixed White and Black, Black Caribbean and a under representation for Black African, Black Somali, White Other and Bangladeshi children.

This overrepresentation has been previously been observed by the ISCP and as a result, have set up the Disproportionality and Inequality Task and Finish Group.



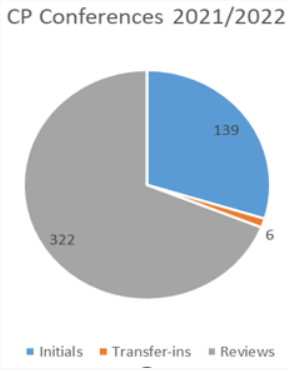
In 2021/22, 23.8% of new child protection plans were repeat plans. This means that out of the 172 children made subject of a child protection plan, 41 children from 23 families became subject to a repeat plan. This is an increase from 10.5% in 2020/2021 (although as stated in the annual report for 2020/21, this was an unusually low figure for Islington).

An audit was undertaken of all the **23 repeat CP plans** (for 41 children from 23 families), looking at the time lapse between plans, risk factors and decision making. Most plans were repeated after a time gap of over two years. 13% were repeated within a two-year period – a smaller percentage to last year's 41%. Like previous years, the most common risk factor in repeat plans was domestic violence and abuse. Following the making of a repeat CP plan, 58% (24 children from 10 families) escalated to a parallel legal framework. This demonstrates that LBI CSC are able to identify themes and explore explanations by means of auditing.

To mitigate against repeat plans LBI CSC have made recommendations such as:

- To ensure the right decision is made regarding repeat plans, the CP Coordinator and Service Manager are alerted, and a consultation is sought to confirm the sustainability of positive changes for children's outcomes.
-The Practice and Outcomes Board will conduct more frequent scrutiny due to Islington's vulnerability to repeat plans.
-Ongoing learning for CP Coordinators and Team Managers will focus on the length and quality of CP plan interventions, sustainability of change, and decision-making.

391 child protection conferences were chaired by Islington Child Protection Coordinators in the period between April 2021 and March 2022 (a decrease from 467 the previous year).



Timeliness of CP Conferences:
In 2021/22, 63% of initial conferences were held within this statutory timescale, a slight decrease from 66% the previous year. This means that 39 conferences concerning 82 children were held later than 15 working days from the strategy discussion. Reasons for the delay have been demonstrated, such as: school holiday preventing quoracy or assessments not being completed on time. To mitigate this, their team have recommended that: ICPCs should be scheduled on the same day as the strategy discussion when a team manager anticipates the need for one. Practice/ team managers must receive briefings on timescales and develop strategies to improve ICPC planning for families facing chronic issues.

Recommendations made for this CP annual report:

1.Hybrid model of chairing child protection conferences to move to including all core group members physically in the room by September 2022
2.Promotion of child and family advocacy with FGC manager reviewing up coming conferences to identify opportunities for children to participate more
3.3-month trial of streamlining model of recording review child protection conferences
4.Briefing to teams around strategies to improve strategy discussion to ICPC timescales
5.Briefing to teams to reduce risk of repeat child protection plans such as ensuring there is a consult prior to convening a repeat ICPC.

Annual Reports from Partners Agencies: Whittington and CANDI

Whittington Hospital Adult and Children's Safeguarding six monthly report

March 2022 to September 2022

The report provides assurance around responding to and learning from safeguarding concerns raised from internal incidents and serious incidents; Local Child Safeguarding Practice Reviews.

- Since introducing Elev8, safeguarding training compliance has significantly improved, with Level 1 at 88%, Level 2 at 87%, and Level 3 at 81%. The Elev8 online learning platform is expected to enhance compliance recording.
- Safeguarding cases have become more complex, with increased mental health, substance misuse, and domestic abuse incidents in referrals. Notably, prebirth referrals have risen.
- Adolescent mental health remains a key safeguarding issue. Limited national specialist provision and more complex mental health issues arising at younger ages consistently challenge the safeguarding team.
- Although domestic abuse cases (presenting at health settings as this is contrary to the increase in Islington's DSM) have stabilized across boroughs, they remain the primary reason for social care referrals. More men are reporting themselves as domestic abuse victims.
- In 2021, changes to domestic abuse legislation recognized children living with domestic abuse as victims, significantly impacting safeguarding professionals.
- Under new legislation, Local Safeguarding Practice Reviews (LSPRs), formerly known as Serious Case Reviews (SCRs), currently have nine active reviews (across several boroughs). Whittington Health has a robust action plan addressing SCR learning, with most actions completed before SCR/SPR publication.
- Staff supervision compliance remains high, and ad hoc sessions for discussing complex cases are beneficial for staff.

Acknowledging the needs of the local area is in integral part of collaborative working. As such the Whittington ensures that Trauma Informed Practice (TIP) remains a key focus across practice and TIPS training has been rolled out across the workforce. Supervision models also focus on trauma and the impact this will have on behaviour and emotional wellbeing in both adults and children.

Camden and Islington (Candi) NHS Foundation Trust: Contribution to the ISCP's Priorities

They have been able to demonstrate how they have worked towards to the ISCP's priorities (page 7).

- Candi provide training to their staff discussing the impact parental mental ill health can have on a child's wellbeing. Their 'Think Family' approach towards training aims to promote a holistic risk assessment of cases to ensure that they are able to alert the appropriate professionals should any concerns arise from parental mental ill health.
- They have incorporated the Quality Improvement project that was undertaken by a Domestic Abuse Practitioner which focussed on the challenges practitioners faced pertaining to asking the right questions—allowing them to think about the bigger picture. For example asking questions specific to children being in the family home, the impact of domestic abuse on children and the confidence to conduct multi agency working with seeking advice from relevant agencies. Candi plan to extend the QI project to other teams across the Trust.

Annual Reports from Partners Agencies: Moorfields Eye Hospital

Moorfields Eye Hospital
Safeguarding Children and Young People
Annual Report

Prioritizing the protection of children and young people (CYP)(C&YP) is essential at Moorfields Eye Hospital NHS Foundation Trust, as they continuously promote safeguarding as a core practice component while focusing on the child or young person in decision-making processes and upholding the Trust's legal obligations. This summary offers an overview of C&YP safeguarding activities from April 1, 2021, to March 31, 2022.

During the reporting period, the following learning and improvement outcomes have been achieved:
• The SGC&YP team addressed 549 queries and concerns, an 8% rise from 2020-2021, with 38% open cases in children's social care and 16% from external agencies regarding known Moorfields patients.

• Children's social care referrals increased by 7%, with a potential 27% rise in new referrals had children directly presented to Moorfields. 18% of referrals were related to "Think Family / Child Behind The Adult."

• No child safeguarding serious incidents occurred; 74 incidents were reported, revealing areas for learning in information sharing with external safeguarding services.

• The team helped review 22 complaints (a 17% increase), including four involving vulnerable children, ensuring high-quality responses and adherence to safeguarding obligations.
• Nine Trust documents were reviewed and updated, considering Covid-19 recovery for staff adherence to best practice policies and processes.

• Mandatory child safeguarding training compliance met or exceeded the 80% target for Levels 1, 2, and 4. Level 3 compliance improved in January 2022, while honorary staff compliance is still being addressed.

• Systemic learning is supported through various activities, including training, meetings, briefings, SGC&YP group dissemination, supervision, and the distribution of internal resources, among other methods.

Evidence of their impact to safeguard and promote the wellbeing of children in Islington:

Key achievements during this reporting period we have:
• Continued to respond to safeguarding themes emerging during recovery from the Covid-19 global pandemic.
• Provided a safe and effective service during Team vacancies including provision to covering the Safeguarding Adults agenda during long term sickness.
• Developed a safeguarding children and young people module for the UCL Moorfields MSc Orthoptics.
• Presented three completed audits to the Islington Safeguarding Children's Partnership subgroups.
• Signed Moorfields up to the Islington Safeguarding Children Partnership Children Looked After Pledge.
• Developed a staff myth busting guide to support best practice: "Asking safeguarding questions is it dangerous?"
• Presented an overview of Moorfields approach to addressing the PREVENT Agenda to the Islington Borough PREVENT Board.

Moorfields Hospital evidencing the ISCP's priorities in the following ways:

Neglect:

Released quarterly internal Safeguarding Nuggets Newsletters in 2021-2022. • Created a staff myth-busting guide for safeguarding best practices. • Developed a safeguarding module for UCL/Moorfields MSc Orthoptics with a focus on ophthalmic medical neglect. • Enhanced the "was not brought" procedure flowchart. • Raised awareness of neglect on the safeguarding notice board, including missed appointments and leaving children home alone.

Parental factors:

• Raised awareness of the national Ask for Ani domestic violence codeword across the Trust via intranet and notice boards. • Improved the process for identifying and addressing domestic violence in patients using the Attend Anywhere platform by developing a staff guide based on the 2020 procedure flowchart.

Annual Reports from Partners Agencies: NCL Integrated Care Board

North Central London Integrated Care Board
Contributions to the ISCP Annual Report:

The NCL ICB collaborates with commissioned health providers to ensure service quality and improvements that cater to local needs. Robust safeguarding quality assurance processes are in place, demonstrating effective protection for vulnerable children and young people at risk of or experiencing neglect.

Following the passage of the Health and Care Bill in April 2022, Clinical Commissioning Groups (CCG's) were disbanded with the transfer of statutory safeguarding responsibilities into the newly established North Central London Integrated Care System (NCL ICS) on the 1st July 2022.

The NCL ICB is responsible for ensuring that it, and the services it commissions comply with statutory safeguarding obligations. During the transition from CCG to ICB, due diligence work initiated in April 2022 focuses on maintaining adherence to statutory safeguarding requirements. Over the next year, efforts will continue to develop and strengthen the ICB/ICS Health Safeguarding System Assurance.

The NCL ICB is able to demonstrate how it collaborates with partners to meet the ISCP's priorities, with examples of this highlighted below:

Addressing Neglect

The Children's Joint Commissioning Team leads the Social and Emotional Development work based on the THRIVE Framework, promoting early intervention and prevention for children and young people. They contribute to the commissioning of the IMHARS (Islington Mental Health and Resilience in Schools) program, which adopts a whole-school approach to mental health and resilience, using evidence-based methods. This work is complemented by the well-established Schools Well Being Service (NHSE/I Trailblazer program), across all primary and secondary schools in Islington. The team aims to develop a wave 9 proposal for 2023, further embedding this work and increasing capacity.

Addressing domestic violence, parental mental ill-health and substance abuse

Designated Professionals collaborated with health providers to enhance the health contribution to the ISCP dashboard, incorporating additional data on domestic abuse, substance misuse, and self-harm. This improvement will offer a more comprehensive understanding of the health system response and facilitate a better partnership comprehension of safeguarding challenges and necessary responses.

Identification of children who are vulnerable to sexual exploitation and holding perpetrators to account

In 2021, the Home Office chose 10 pilot sites for devolved decision-making regarding child victims of modern slavery through the National Referral Mechanism (NRM). The Designated Nurse Safeguarding Children ensures health representation with binding decisions, there is a requirement for health representation provided by the Designated Nurse Safeguarding Children. Throughout the pilot, health representation has been consistent, leading to robust and timely decisions for affected children and young people. By the end of March 2022, 39 cases were heard at the NRM pilot, with all but one reaching a decision within the expected 45-day timeframe.

Addressing the impact of inequality and structural racism on vulnerable children

The ICB and Designated Safeguarding Professionals play a system leadership role in addressing disproportionality and inequality affecting ethnic groups within health and multi-agency partnerships. The Designated Nurse for Safeguarding Children will co-lead the data workstream of the Disproportionality Task and Finish group, helping to better understand the effectiveness and impact of safeguarding and related systems in addressing this priority.

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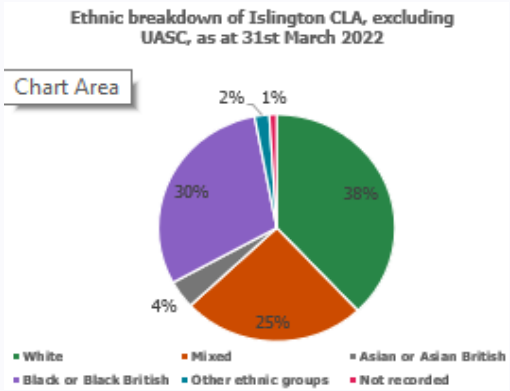
Annual Reports from Partners Agencies: Corporate Parenting Report

Corporate Parenting Board Annual Report

The Corporate Parenting Board (CPD) annual report provides an overview of the achievements, progress and challenges regarding Islington's Children Looked after (CLA), and Care Experienced Young People (CEYP) from 1 April 2020 to 31 March 2022.

As mentioned on page 9, LBI has more children looked after than its statistical neighbours. It is evident that LBI acknowledges so as a result conducted an audit to look at care proceedings to ascertain whether the proportionate decision was taken see page 49. It is likely that the high rates of children looked after, correlates with higher rates of children in CIN and CP.

The CPB annual report also highlights the disproportionality in the global majority being overrepresented which is a theme consistent with previous year.



The report also highlights positives such the CPB's priorities for CYP and the positive impact they are able to evidence. For example , their priority to:

Challenge inequalities by developing life long corporate parenting duties across and beyond the Council

- They offer lifelong corporate parenting, where a task and finish group chaired by Chief Executive to develop and implement this vision.

Plans to prepare CYP for targeted work experience

Impact: Several council departments, including Environment, Public Health, and Community Wealth Building, provide work experience, shadowing opportunities, and employment support advice to young people. One young person was employed full-time after completing work experience with the council's Finance department.

- Islington's protocol for the unnecessary criminalisation of CLA and care-experienced young people formalising Islington's Trauma Informed Practice across ISCP and YJSMB.

Impact: Remand to custody dropped from 28 in 2017/18 to 12 in 2021/22. The reoffending rate for CLA is on par with peers at 33% in 2021/22.

Ensure our children and young people are in safe and stable homes

Impact: The House Project helps 24 young people annually to transition towards independence. Out of the 67 young people who have participated since August 2018, 36 have moved into their own homes and 9 are in the process of doing so, indicating the program's success. The majority of these individuals are managing their tenancies well, and there have been no reported breakdowns.

Children and young people receive excellent support for their health and wellbeing

- CAMHS service embedded within the CLA, Fostering and IF teams

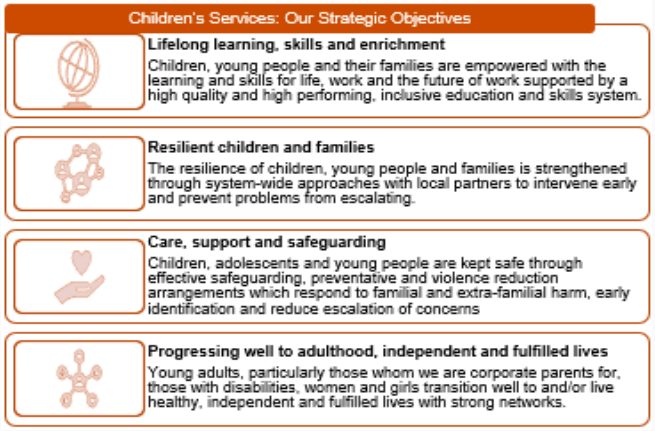
Impact: 115 clients seen by CAMHS with 94% attendance

Ensure children and young people's views and experiences influence how we plan and deliver our services and that our young people receive help in a way that they feel listened to, loved and is accessible to them

- The Children's Active Involvement Service (CAIS) consults with young people, provides activities, and conducts training for foster carers. They also play a key role in staff recruitment. CAIS attends the Corporate Parenting Board and strongly advocates for the views of children and young people.

Impact: Last year, CAIS participated in 46 projects. They developed an app for young people in response to requests from care-experienced individuals.

Young commissioners are shaping future plans for regulating providers.



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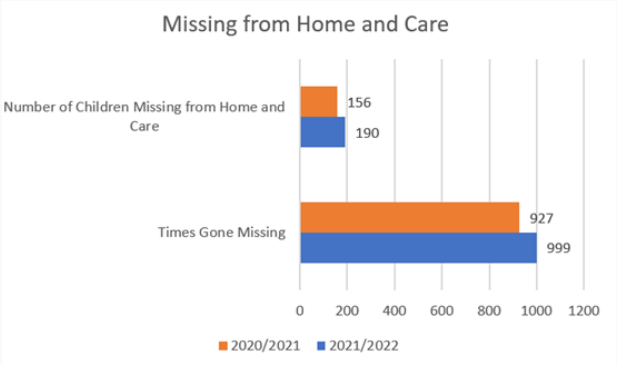
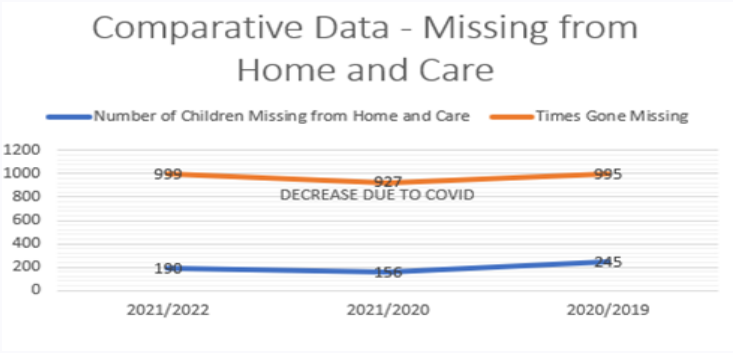
MCAE Annual Report Breakdown - Missing from Care, Home and Education

Missing from home:

103 children went missing from home 257 times. 10% of children accounted for 49% of total missing from home episodes (126). 54% of the episodes the child returned within 24 hrs and 24% returned the following day. Last year: 74 children went missing from home 151 times. In total 54% of the missing episodes from home involved young people returning in less than 24 hours and 24% of episodes related to young people returning the following day.



Of the 10 young people who went missing most frequently, all were considered at risk of exploitation or serious youth violence at some point during the year. The majority (7 out of 10) were boys, while all 3 girls were at risk of sexual exploitation. Notably, 7 out of these 10 most frequently missing children were looked after, indicating that exploitation risks may persist even after a child enters care.



Missing from care:

91 children went missing from care 648 times. 11% of children accounted for 46% of the total of missing from care episodes (304)
53% of the episodes the child returned within 24 hrs and 24% of children returned the following day. Last year: 86 children went missing from care 649 times.
33% of the young people who have gone missing from care are Black. This correlates with an exact match to the ethnicity break down of young people who are looked after by the London Borough of Islington, meaning there is not an over-representation of Black children Looked After going missing. In total 77% of the missing episodes involved young people returning the next day or earlier, an increase of 2% from last year and 5% on 2019-20

There has been a 50% increase in the number of White British young people who have gone missing from care last year and they have gone missing 118% more times. Which means that children with white ethnicity have also increased significantly as a proportion of all children in care who have gone missing.

Return Home Interviews (RHI's)

The Return Home Interview (RHI) process is provided by the Exploitation and missing team, this includes a specialist missing and engagement worker and the four ASIP workers who also carry out RHI's alongside their other duties.

Between April 2021 and March 2022, there were 999 missing episodes and 719 Return Home Interviews were offered. Engaging children and young people in meaningful RHI's remains a challenge, either because the child refuses or it is not possible to contact the young person (phone calls and texts going unanswered after several attempts).

72% RHI were offered for the 999 missing episodes

18% (131) RHI's were successful, meaning the child spoke to a professional about when they were missing and 15% (105) refused the interview.

29% (208), it was not possible to make contact with the child for the interview to go ahead after several attempts

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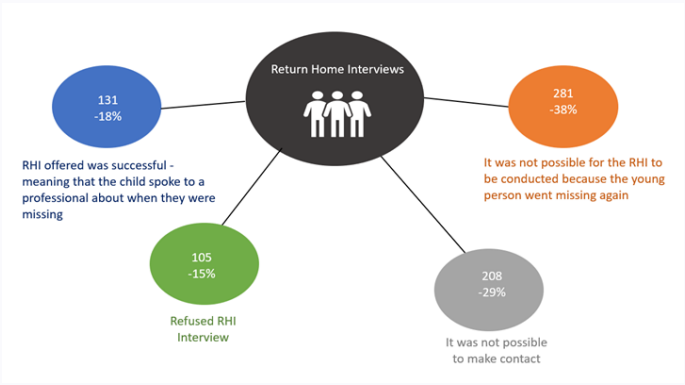
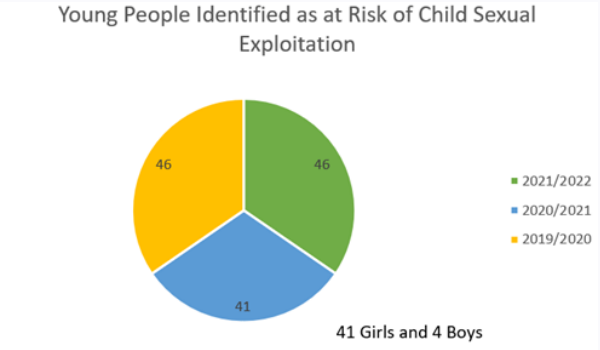
MCAE Annual Report Breakdown - Return Home Interviews RHIs and Child Sexual Exploitation

Impact:

One area that has also emerged as very beneficial is if a child goes missing but isn't open to any service the Engagement worker offers the parent some sessions regarding their potential concerns or possible mild escalation of difficult behaviour at home. This work means the parent either receives the support and some tools to manage the issues themselves or the Engagement worker can recommend appropriate early help support.



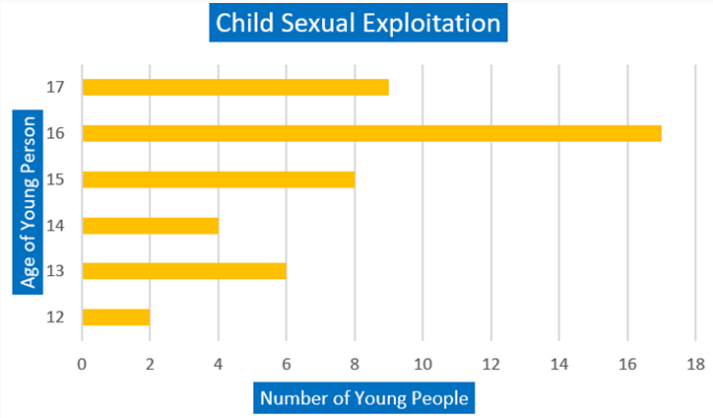
Child Sexual Exploitation



The slight decrease in numbers last year was likely due to the lockdown, and less children being out of the home. Although we are aware that children are often groomed online, but again due to children and parents having less contact with professionals during this time, incidents of online grooming and child sexual exploitation may have been under-reported.

This year, 50% of children identified as being at risk of Child Sexual Exploitation (CSE) were white, while 23% were Black. The number of Asian children identified as being at risk remains consistently low, and it is unclear whether this is because sexual exploitation is not happening within Asian communities or because it is going undetected. It is important to note that while white young females make up the majority of children identified as being at risk, this does not mean that young people of other ethnicities are not also at risk.

There is a noted theme that girls of a younger age are coming to the attention of Police and LBI Children Services for concerns around child sexual exploitation and are going missing more frequently. Young people being groomed and exploited via the internet has remained a significant issue and the way children and young people are exploited online is always evolving. It is an ongoing challenge to safety plan against adolescents need to seek out sexual contact, respond to attention and express their sexuality. This has brought up concerns regarding Online Safety and as a result ISCP have sought more voices of children and families regarding this theme and have also devised a plan to implement more Online Safety sessions for parents and school staff.

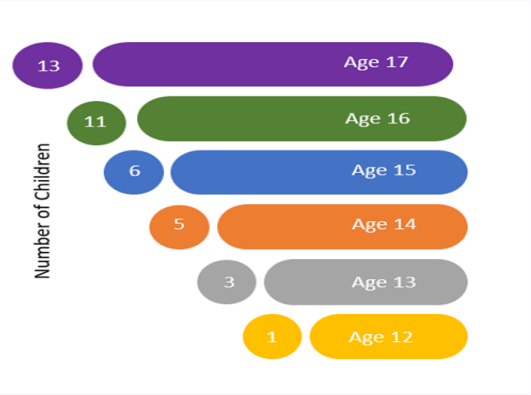


MCAE Annual Report Breakdown - Child Criminal Exploitation, Borough Briefings & MACE

Child Criminal Exploitation:

Between April 2021 and March 2022 51 young people, under the age of 18, were identified as being at risk of Child Criminal Exploitation this is a small decrease on the year before when the number was 55, 11 out of those 51 were female. In 2020/2021 the number was 5 and in 2019/20 there was 1 female identified as at risk of CCE, therefore the significant increase We are seeing more females coming to police attention for criminal activity.

Older children may be stopped and searched by police more and therefore more likely to be found in possession of drugs, indicating they are being exploited to deal or run county lines. The selected month's data shows similar percentages of White and Black young people at risk of CCE, unlike the previous two years which consistently showed overrepresentation of Black males. The data was verified over different time periods and indicates a decline in the numbers of identified Black young people at risk of CCE over the last six months, with a slight increase in mixed heritage young people. The data suggests that the action plans and interventions
put in place by CSC and Young Islington may have contributed to this decline.



Borough Briefings:

An action stemming from the Missing and Child & Adolescent sub-group was to find a way to disseminate pertinent information (informed by Police, CSE team, Gangs Analyst, Integrated Gangs Team, Community Safety Team and YJS) to our partners to raise awareness of activities that occurs throughout the borough that supports the identification of potential and current risks relating to child exploitation. In January 2022 the Exploitation and Missing Team commenced Borough Briefings. The briefings are attended by partners from across the borough who may come into contact with children who are at risk of exploitation, but do not attend MACE or other forums where relevant information can be shared with them, for e.g. General Practitioners, or Youth Workers.

Impact

The briefings have been well attended by partner agencies and the feedback has been positive and therefore they will be continued. Some agencies have reported that it gives them scope on what is happening in the borough so they are able to inform their staff of recent incidents to ensure they are able to keep children safe and promote their welfare. Going forward it would be beneficial to reach out to partners for a more formal evaluation of the briefings to assess any changes needed to the format or content that may be required.

Multi Agency Child Exploitation (MACE):

Established robust process around involving other local authorities in the Pre-MACE/MACE Discussion

Several of the young people who are considered at risk of Exploitation are placed outside of the borough. The Exploitation and Missing team will be in communication with the local exploitation police for the young person and request intel and updates for Pre-MACE. However, over this year it has been discussed that a more formal process around sharing information between different Pre-MACE and MACE panels across the country needs to be established. This is also to make sure that other key agencies such as Health services in different locations are also aware of the exploitation concerns.

Impact:

This piece of work is ongoing, we have strengthened our partnerships with our neighbours such as Camden and Lambeth where and there has been reciprocal information sharing. Over next year The Exploitation and Missing Safeguarding Manager will reach out to their equivalents in other London Boroughs to discuss how more formal information sharing process can be put in place. The London Child Protection Procedures will also be updated shortly to include working with Children Moving Across Boundaries/Boroughs.

MCAE Annual Report Breakdown - ASIP

Adolescent Support Intervention Project (ASIP)

The ASIP pilot project from the LA Children Services started in May 2021. Their aim is to mitigate the risks of contextual harm (extra familial harm) towards young people by providing an intensive wrap-around service. The service incorporated feedback from 16 and 17 year olds who had been subject to exploitation to inform the design of ASIP.

Between September 2021 to August 2022 ASIP had received a total of 25 referrals, of which 13 received ASIP intervention. Some Interventions have included providing respite trips out of London for families; one to one parenting support; support during times of crisis; home improvements; activities to manage trauma which manifests in aggression; daily support to attend school; reflective spaces for professional networks; formulation workshops with schools; creating bespoke work experience opportunities. ASIP practitioners will also attend strategy meetings to provide input and expertise around contextual risks to the network. ASIP is a trauma informed service, and consists of four Case Managers, a CAMHS Psychologist and a Contextual Safeguarding & Education Lead and the Practice Manager.

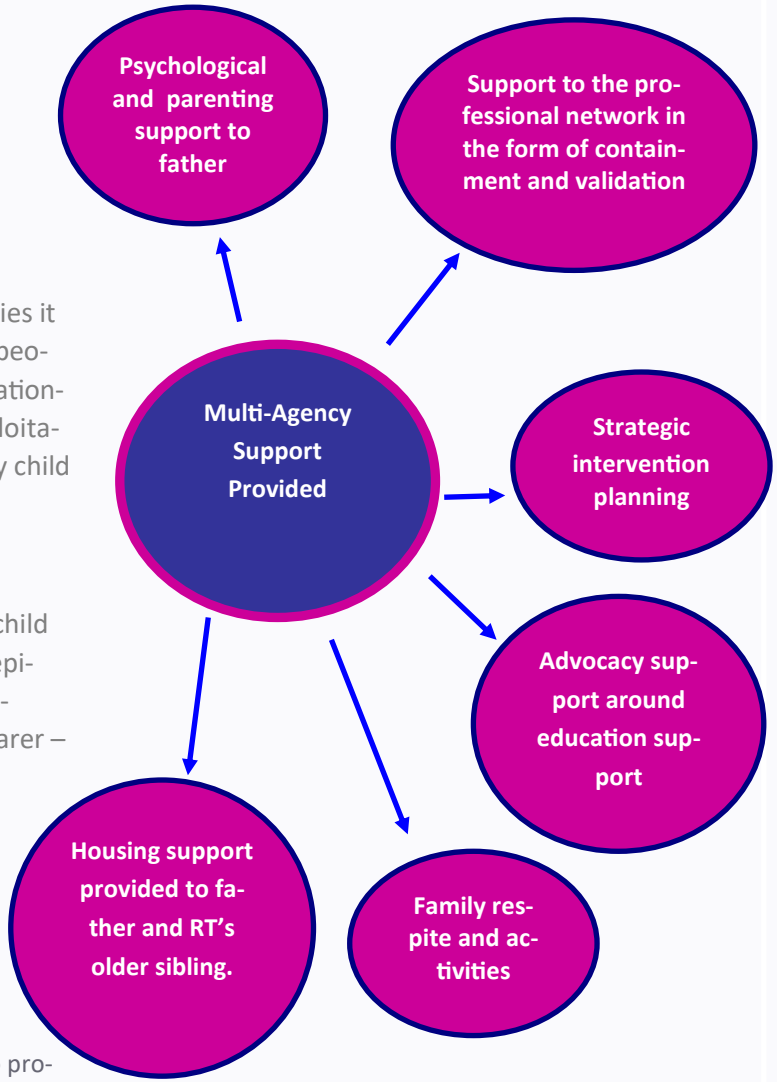
Given the intense service that ASIP provides families it has demonstrated impact on children and young peoples' lives through its intervention. Given its operational role functions and serves children at risk of exploitation it is able to function as an add-on to statutory child in need or child protection intervention.

Evidence of impact on multi-agency working

Child RT was referred to ASIP due to concerns of child sexual and criminal exploitation, regular missing episodes, low school attendance, low emotional well-being and relationship breakdown with primary carer – father.

ASIP Impact continued:

Reduced from Child Protection to Child in Need plan - RT stayed in the family home – Noted improvement in relationship between RT and father – Father had increased ability to mentalise RT's lived experiences. The intervention demonstrated effective partnership working with other relevant agencies and the family to produce a desired outcome.



MCAE Annual Report Breakdown - Serious Youth Violence (SYV) and Harmful Sexual Behaviour

Serious Youth Violence (SYV):

From April 2021– March 2022 39 children have been identified as being at risk of SYV and 47 individuals over the age of 18. It is important to note these are the ages of the young people in March 2022 so when they were identified as at risk of SYV some of those 47 young adults may have been under 18. Out of the 86 young people identified as being at risk of being affected by SYV 1 was female.

Collaborating with IGT and Gangs police, proactive peer mapping remains a challenge due to a younger cohort of mobile children and youth moving between groups and areas. The partnership with Community Safety team has been strengthened, and Community Safety Officers now provide valuable intelligence about gang locations at Pre-MACE and MACE meetings which demonstrates multi-agency working

Evidence of impact is an example of A space underneath a block of flats potentially used by gangs was reported with evidence of drug use and sexual activity. Community Safety collaborated with Parkguard to increase patrols and obtain details of young people stopped for mapping exercises and interventions. The space was closed and is no longer accessible to young people.

Harmful Sexual Behaviour:

Over the last year, 46 HSB consultations were held which is a reduction from the previous year. When the Exploitation and Missing team was created the aim of the HSB branch was to explore child on child sexual abuse and the culture of abuse within gang settings. This remit has expanded and showed a need and gap in the service for support around all types of sexualised behaviour.

Evidence of impact:

The Protocol for Schools for Managing Child-On-Child Sexual Abuse, Violence and Harassment was completed in November 2021. As a result, the Principal Officer Safeguarding in Education along with the ISCP and Health and Well-Being Board organised the delivery of Child on Child Sexual abuse workshops for school to ensure that the protocol is embedded into their policies and practice and they are complying with Ofsted recommendations. This has had positive feedback from schools especially when it relates to real case examples.

MCAE

Analysing and addressing the overrepresentation of Black teenage boys identified as at risk of being involved in serious youth violence.

Further analysis is needed regarding the over representation of black teenage boys at risk of being affected by serious youth violence within Islington. This work will need to be completed in conjunction with the Youth Offending Service and Young Islington Teams with an aim of looking at how young people are identified to services, as well as how and when they are offered intervention and support.

The multi-agency approach to address the over representation needs to be agreed and actioned by the Missing and Child & Adolescent Exploitation Subgroup.

Update:

The Exploitation and Missing Team continue to work with YJS, IGT, TYS and Community Safety Teams to address the over-representation. We continue to ensure that we are sharing information with key agencies via strategy meetings, daily tasking meetings with IGT, and attendance at Islington Group Offending Partnership Panel state in full to ensure we are intervening appropriately. As mentioned earlier in this report there are projects being piloted within the borough which aims to intervene with young black males before they experience or become involved in serous youth violence. The Missing and Child & Adolescent Exploitation Subgroup will also agree what more actions they can take to address this concern.

Contextual Safeguarding:

Contextual Safeguarding will continue to be a priority of The Missing and Child & Adolescent Exploitation Subgroup in 2022/2023, over the last year they have strengthened the partnership work with the Community Safety Team, and they now attend MACE and Pre-MACE and highlight spaces in the borough that require intervention and will provide support and action. For example, several complaints were made about a particular walkway in one of the borough's estates, the Community Safety Service was able to arrange to block one of the entrances so it could no longer be used as a cut through, they stepped up the patrols by Parkguard and sent pictures of the young people to the Exploitation Team and IGT to see if we recognised any of the children to provide support and intervention to them.

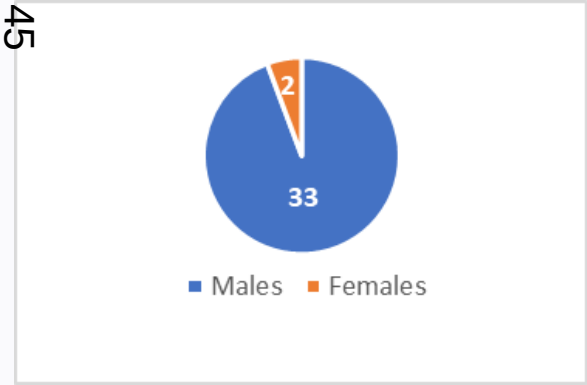
An action plan and proposal for the implementation of a Contextual Safeguarding policy will be presented to the Subgroup in October 2022 with the aim of rolling out the recommended changes in April 2023. It is acknowledged that the existing teams across the borough have good systems of communication in place for responding to incidents, sharing intelligence and exploring contextual risk/harm and not just focussing on individual cases separately. However, the next step forward is implementing how to formalise, record and measure the impact of this work.

National Referral Mechanism

National Referral Mechanism

LBI CSC and London Borough of Camden CSC have undertaken a pilot programme with the Home Office's National Referral Mechanism (NRM). The NRM is a government-led process for identifying and supporting victims of modern slavery and human trafficking in the UK. The NRM provides a framework for the identification of potential victims and ensures they receive appropriate care and support.

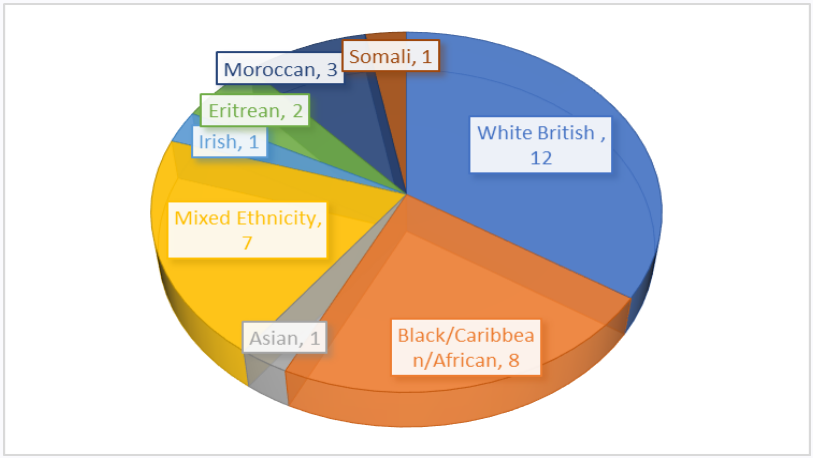
LBI CSC made 23 referrals and LBC CSC made 12 referrals to the pilot panel (35). The demographics of the referrals received thus far are between the ages of 12 and 17.

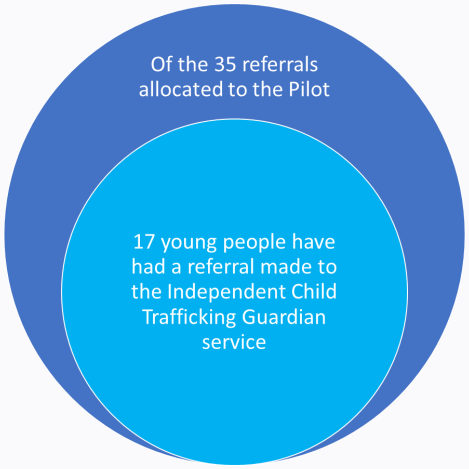


Of the 35 referrals, there have been 20 Positive Reasonable Grounds and Conclusive Grounds decisions made at the first meeting where the cases were heard. 13 referrals were deferred to the following panel meeting where a Positive Reasonable Grounds decision was made at the first meeting and at the second meeting Positive Conclusive Grounds decisions were made.

The remaining cases the first responder/social worker have been asked to make a referral immediately.

The ethnicities of the young people have been recorded as follows:





It has been agreed that, as 5 of the cases raised concerns about exploitation that took place in another country and no concerns around exploitation in the UK were raised, these 5 cases did not require a referral to the Independent Child Trafficking Guarding service.

Impact:

The positive results has enabled the LBI CSC to prevent further harm to vulnerable children by removing them from situations of exploitation, with a plan to provide them with a safer environment. It also supports their recovery and rehabilitation, helping them to overcome the trauma and effects of exploitation and empowering them to move forward with their lives.

Missing from Education : Elective Home Education

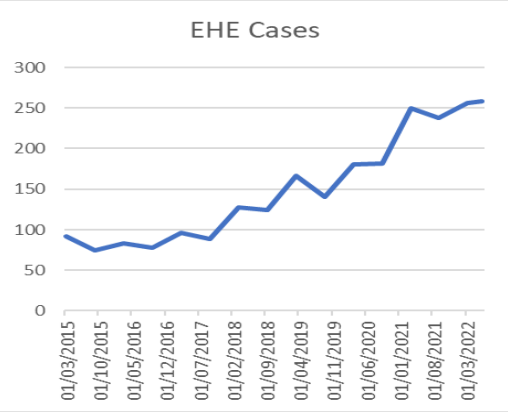
Elective Home Education (EHE)

The access and engagement Team with Pupil Services for the LBI has presented to the ISCP Education subgroup. They reported that there were 250 EHE children since the pandemic (75% increase). As a result of the Covid 19 pandemic their team were not able to visit children in their home, therefore much of the visits relating to 2021 were virtual visits.

EHE Advisor Visits (Including Virtual)	
Calendar Year of Visit	Total
2018	77
2019	116
2020	153
2021	205
2022 (to date)	74

The access and engagement team writes comprehensive reports based on their visit with families who home educate their children. However, there has been a rise in parents wanting their children to return to school as Covid restrictions have lessened.

Sample Date	# of EHE Cases
05/03/2015	92
05/09/2015	75
05/03/2016	83
05/09/2016	78
05/03/2017	96
05/09/2017	89
05/03/2018	128
05/09/2018	124
05/03/2019	167
05/09/2019	141
05/03/2020	180
05/09/2020	182
05/03/2021	250
05/09/2021	238
05/03/2022	256
07/06/2022	258



Although there are currently no specific statutory duties placed on the LBI in relation to this group, the potential safeguarding risks present a moral imperative. Pupil Services' overarching commitment to ensure that every child can be the best they can be, also places a responsibility on them to ensure, as far as the current framework allows, that each child has an at least 'satisfactory' offer. This is an area of work that is always picked up during Ofsted inspection (and mentioned explicitly in the Local Area SEND Inspection framework) and they report regularly to the Islington Safeguarding Children Partnership (ISCP).

In the year 2020, majority of parents reported Covid 19 was there reason for EHE. Furthermore in 2021, this trend continued, however, we believe this may have included parents having a positive experience of home educating during the pandemic and wishing to continue. More recently we have seen a shift back to parents choosing to home educate due to their own cultural or philosophical reason.

Impact

Given the increase in EHE pupils overtime, Pupil Services reported to looking into securing funding to resource staff to visit and advise families who are electively home educating. One of their aims involves targeting new EHE families more quickly to explain the responsibilities they will be taking on and try to resolve any schooling issues, so that the number of EHE reduces over time to numbers closer to pre-epidemic levels.

New Incoming Legislation:

The Schools Bill, published on 12 May 2022, will introduce new legislation establishing an LA administered registration system for children not in school i.e., children not registered at a relevant school (e.g., due to being electively home educated).

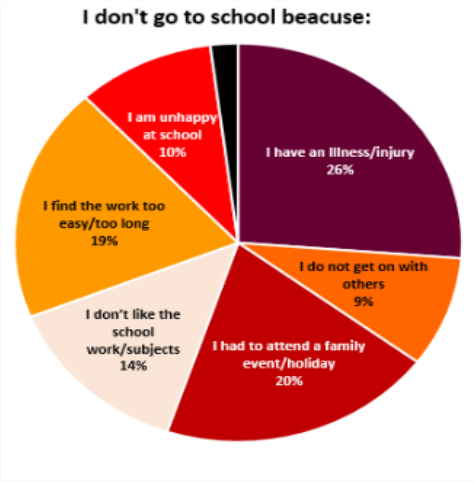
Working Together to Improve School Attendance

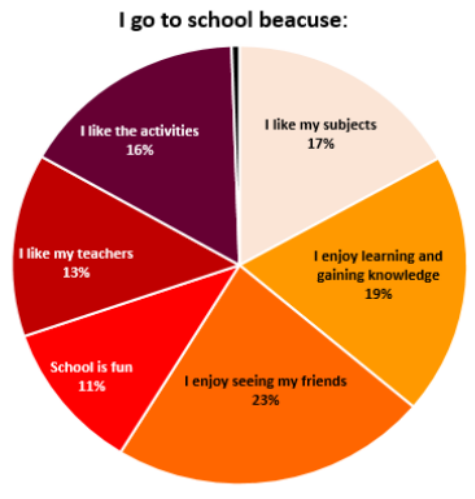
New guidance Working together to improve attendance was published in **April 2022** – will be statutory by **September 2023.** They set out expectations of schools and governors, all local authorities as a minimum are expected to:

-Rigorously track local attendance data to devise a strategic approach to attendance that prioritises the pupils, pupil cohorts and schools on which to provide support and focus its efforts on to unblock area wide barriers to attendance.

-Have a School Attendance Support Team that offers free services to all schools, including regular communication and advice, targeted support meetings using attendance data, multi-disciplinary family support, and legal intervention when necessary. These services aim to enhance attendance and address absenteeism issues by sharing best practices, identifying at-risk pupils, providing whole-family support, and enforcing parental responsibility measures when needed.

Acknowledging the impending changes the London Borough of Islington's Pupil Services conducted a survey on the voice of children in Islington to gain their views regarding attending school. interviewed their response is as follows:

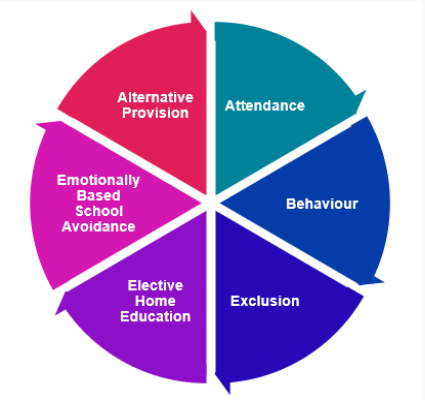




Effective preparation based on New Legislation

The London Borough of Islington's Pupil Services have acknowledged that the Legislation does give local authorities time to make the necessary transitions to meet these expectations and ensure that a School Attendance Support Team is built to meet the expectations. They have acknowledged that whilst there is a lot of room for improvement in this area they may consider that their local specification should stretch beyond these minimum standards, this is also in context of constraints on resources.

The Local Authority is aware of the implications if students do not feel like they belong for the reasons listed below. It is positive to see that the LBI has gained the voice of children to gain a sense of their lived experienced and relationship towards school. Below they have outlined what can happen when children do not feel they belong.



Extending the role of the Virtual School Head

The non-statutory guidance from the Department for Education aims to assist local authorities and Virtual School Heads (VSHs) in:

- Enhancing their strategic leadership role in promoting the educational outcomes of children aged 0-18 with a social worker or those who previously had a social worker.
- Make visible the disadvantages that children with a social worker can experience, enhancing partnerships between education settings and local authorities to help all agencies hold high aspirations for these children.
- Promote practice that supports children's engagement in education, recognising that attending an education setting can be an important factor in helping to keep children safe from harm.
- Level up children's outcomes and narrow the attainment gap so every child can reach their potential. This will include helping to make sure that children with a social worker benefit from support to recover from the impact of COVID-19.

Transitional Safeguarding

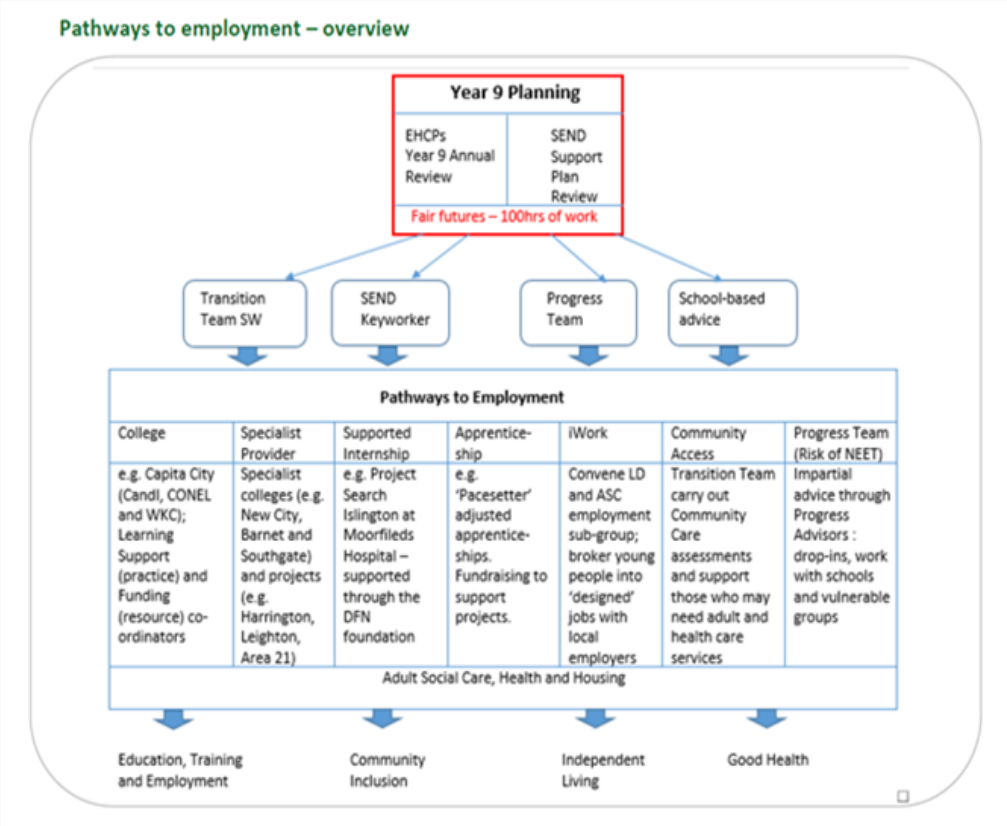
Transitional Safeguarding

The Bridging the gap report co-produced with the Chief Social Worker for Adults, Research in Practice et al (June 2021) defines the concept of Transitional Safeguarding as an approach to safeguarding adolescents and young adults that is adaptable across various developmental stages. It is informed by the most up-to-date evidence and draws from both children's and adult safeguarding practices. Its goal is to equip young people with the necessary skills and knowledge to navigate their transition into adulthood successfully. Transitional Safeguarding recognizes that the transition is an ongoing process rather than a one-time event, and that every young person experiences this journey differently.

The ISCP in conjunction with the Islington Safeguarding Adults Board (ISAB) sought to explore the multi-agency transitional safeguarding arrangements within Islington. A task and finish group was created to bring relevant agencies to ascertain whether there were any gaps within service provisions. It was also born out of a Serious Adult Review conducted by ISAB involving DD, a young woman had a complicated medical and vulnerable background who according to the Coroner passed away due to mismanagement of her diabetes medication (Islington SAB - Safeguarding Adults Review: DD).

Transition can be a difficult period for young adults. DD was known to children's services, but after becoming an adult, some services stopped while others passed her case on to adult services. DD was accustomed to and trusted certain children's services and found it challenging to adjust without the same level of support after transitioning to adult services.

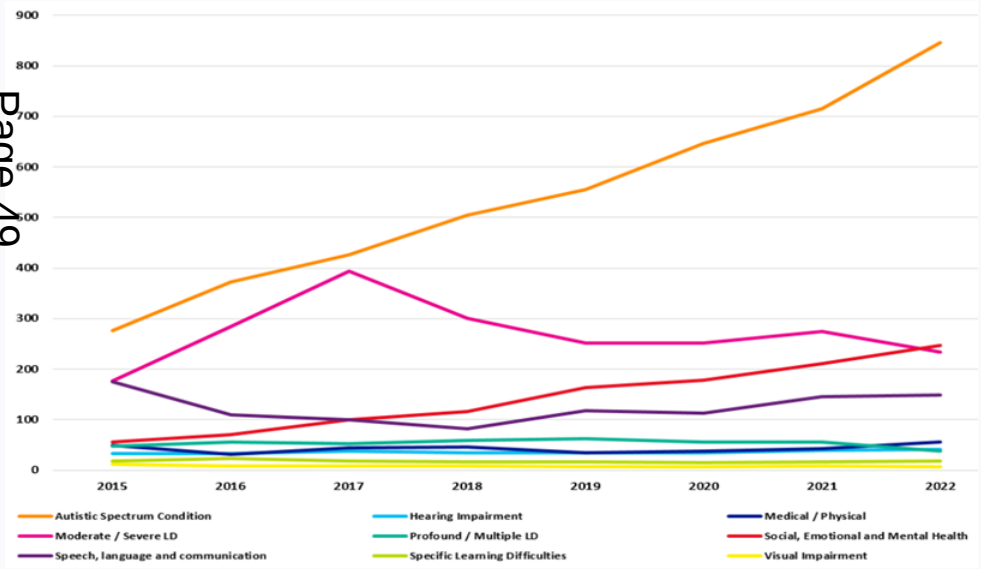
The SEND inspection by Ofsted, as mentioned earlier, highlighted the transitions planning is very strong. And the task and finish group demonstrated that there were several pathways available for vulnerable young persons to transition as evidenced by Islington's Multi Agency Progression to Adulthood Protocol (2019).



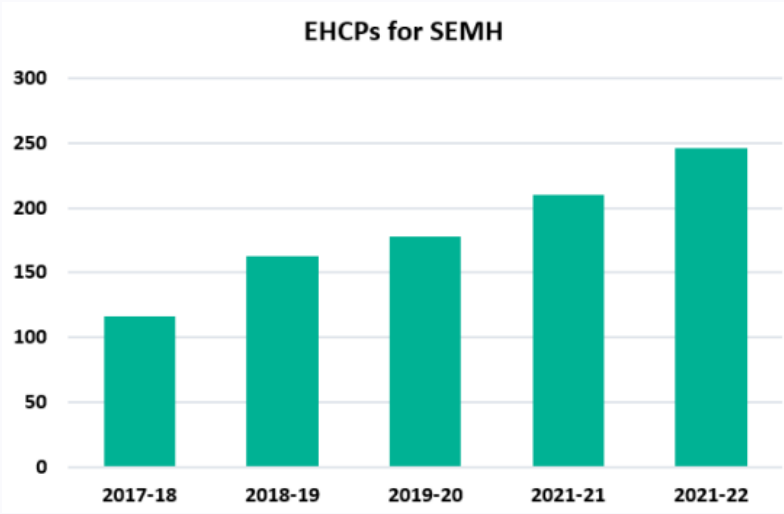
Transitional Safeguarding

Projections by SEND

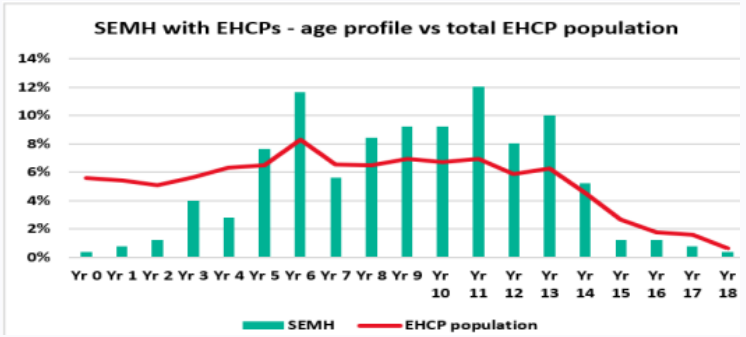
Whilst there is strong planning towards vulnerable children/young person's transitioning into adulthood, the SEND Projections report devised by Pupil Services envisions that the scope for vulnerabilities are likely to increase given the stark increase of EHCPs due to SEMH as well as diagnoses of Autism Spectrum Disorder.



These projections (specifically ASD and SEMH) highlight that there is likely to be a significant impact on how these vulnerable children transition into adulthood and may correlate with safeguarding concerns in adolescence, that may create unmet needs in Adult Services due to less services being available when an adult. ISCP will continue progress the Transitional Safeguarding task and finish group to gain assurances that the impact on vulnerable adolescents are mitigated.



The number of Islington children with EHCPs with SEMH as their main area of need has increased by 112% over the last five years and the age profile of those with SEMH as their main area of need does not follow the same local or national pattern as for all EHCPs, this is demonstrated in ages 6 and 8 to 14 years old where there is a disproportionate higher number of EHCP compared to national figures. As mentioned in the previous paragraph this may give partner agencies an opportunity to plan for services due to possible capacity concerns in SEMH services. This may also create reflections or explorations for the process of how EHCPs are assessed or carried out for SEMH concerns.



ISCP ANNUAL REPORT 2021-2022

North Central London Children and Young People's Mental Health and Wellbeing Transformation Plan

The purpose of their transformation plan is to improve the support for children and young people with emotional wellbeing and/or mental health concerns is a key priority for North Central London's NHS and Local Authorities (Barnet, Camden, Enfield, Haringey & Islington).

Their approach for facilitating the plan:

PHASE 1: Bring together an overview of achievements, challenges and priorities both at NCL population level and borough level. Agree direction of travel with key ICS stakeholders. 1st November 2021: Publish initial NCL CYP MH and Wellbeing transformation plan

PHASE 2: 'Keeping 'Live' In line with ICS development, work on joint plans with key ICS stakeholders, undertake prioritisation, further coproduction and engagement with service users, maintaining a 'live' document which we will update as plans develop.

Voice of the children informing Service delivery

NCL have the relevant data regarding Islington's demographics and deprived areas. This along with the impact that the pandemic has had on Islington, (young people are concerned about education, finances, and their future, while young children worry about their families) has contributed to informing the service delivery.

The Transformation plan has used engagement and coproduction with children and parents (service users) to inform their strategic health needs analysis. The local community have been involved in workshops, sharing their views in consultation exercises and helped shaped services. An example:

Islington
Participation project led by an organisation called Peer Power, engaged with over 100 young people some of whom on edge of criminal justice pathways or already known to YOS, to understand how they want to access health services.

The Transformational Plan incorporates a Thrive model:

Islington is progressing in the thriving domain in the following areas:

• Developed framework called iMHARS has been developed to support a whole-school approach to mental health and resilience in Islington schools.

•Trauma-informed training is being implemented in primary and secondary schools to embed principles and practices for addressing trauma and its intergenerational effects.

•In 2019, a central access point for children and young people was launched to access social, emotional, and mental health services (SEMH), integrating CAMHS into Islington's Children's Service Contact Team (CSCT) front door. This "no wrong referral" model improves access to various health, social, and digital community-based services for local children and young people.

The NCL have acknowledged the increased waiting times for CAMHS services in Islington and as a result have implemented a 'Getting Help' domain that aims to reduce waiting time for Autism spectrum assessments for children 5 to 18 and has already begun to address pathways into adulthood by developing a Joint Strategy across Council and ICB to support and set out our ambitions and activity to support 'Progression to Adulthood'

In line with transitions, they have set ambitions to extend current service models to create a comprehensive 0 to 25 offer to support transitions from CAMHS to AMHS where locality based wellbeing hubs for young adults with emerging mental health needs can be met

With the transformation plan the NCL have acknowledged that they need to improve how they monitor and make use of population and service data on ethnicity, gender, age sexual orientation, disability and other characteristics which is in line with the ISCP priority. .

Social Emotional Mental Health (SEMH) Review 2022:

SEMH Review:

Age Group: The SEMH review has also taken note of the ages of children and young person referred to their service. It is noteworthy, the numbers of <5 year olds being referred to local CAMHS has risen by almost 50% in the past three years.

Across NCL this age grouping has risen by 500 % between 2021-2022. This suggests CYP are accessing services earlier, benefiting from early intervention

Age Bands	Year 1: Oct19-Sep20	Year 2: Oct20-Sep21	Year 3: Oct21-Sep22
0-4 Early Years	69	118	157
5-10 Primary	473	553	694
11-15 Secondary	**560**	**848**	**1040**
Post 16	262	346	365
	1364	1865	2256

Waiting times for CAMHS

Contacts: SEMH referrals have increased significantly during the past 3 years and this has resulted in longer wait times and challenges meeting the 8-week KPI for first contact. The average wait time across SEMH is 8-12 weeks, with some waiting over 16 weeks. For CAMHS therapies, the average wait time for first contact is 11.6 weeks, and the average wait time for second contact is 11.3 weeks, an increase from 8.3 weeks in Q1 2022.

SEMH providers report CYP presenting with complex psychosocial difficulties. Providers record complexities for therapeutic intervention and redirection for further support. The Brandon Centre found an average of 7 presenting issues in 11.2% of cases in 2021-2022, including anxiety, low mood, self-esteem, and thoughts of self harm.

In order to respond to increased need: the SEMH team aims to reach more CYP faster with enhanced funding focusing on addressing equity of access in terms of Equality, Diversion & Inclusion. They plan to monitor and evaluate all CYP groups accessing the service through enhanced reporting structures and maintaining the SEMH Provider Dashboard. SEMH services will be promoted to all groups across all settings to increase the breadth of reach and empower CYP to seek advice and support through self-referral. A priority system is in development to ensure no CYP waits longer than necessary.

Progress of the implementation of the SEMH review will be monitored at the SEMH Partnership Board

Voice of Islington Children

Islington children and young people's Health and Wellbeing survey 2021-22.

The survey was commissioned by the Islington Public Health Team to collect robust information about young people's lifestyles. They surveyed **2799 pupils, in 25 primary and 9 secondary school settings in Islington.**

They covered areas such as: *Healthy weight, healthy lives, Physical activity, alcohol, smoking and drugs, relationships and sexual health, safety including bullying and online safety, & mental health and wellbeing*

Children's view about Internet Safety:

11% (5% in 2017) of primary pupils said that, in the last year, they have sent personal information or images to someone which they then wished they hadn't; 19% (11% in 2017) of secondary pupils said the same. 34% of primary and 33% of secondary pupils said they have viewed a message or picture in the last year that scared them or made them upset. When they received something nasty, 19% of primary pupils and 21% of secondary pupils deleted it without showing anyone. 12% of secondary pupils have been sent a violent photo, video or livestream; 6% have been sent links to extremist views or organisations

Overall Life Satisfaction

Overall life satisfaction has decreased compared to 2017. 64% (75% in 2017) of primary pupils and 50% (63% in 2017) of secondary pupils responded that they are 'quite' or 'very' happy with their life at the moment, while 18% (12% in 2017) of primary pupils (18% boys and 14% girls) and 21% (16% in 2017) of secondary pupils reported that they are 'fairly' or 'very' unhappy with their life at the moment.

High self-esteem and resilience levels help pupils persevere and cope with daily challenges. There has been an overall drop in self-esteem and resilience scores compared to 2017. 32% (23% in 2017) of primary pupils and 31% (17% in 2017) of secondary pupils had a medium-low self-esteem score (9 or less). 15% (12% in 2017) of primary pupils and 29% (26% in 2017) of secondary pupils had a low measure of resilience.

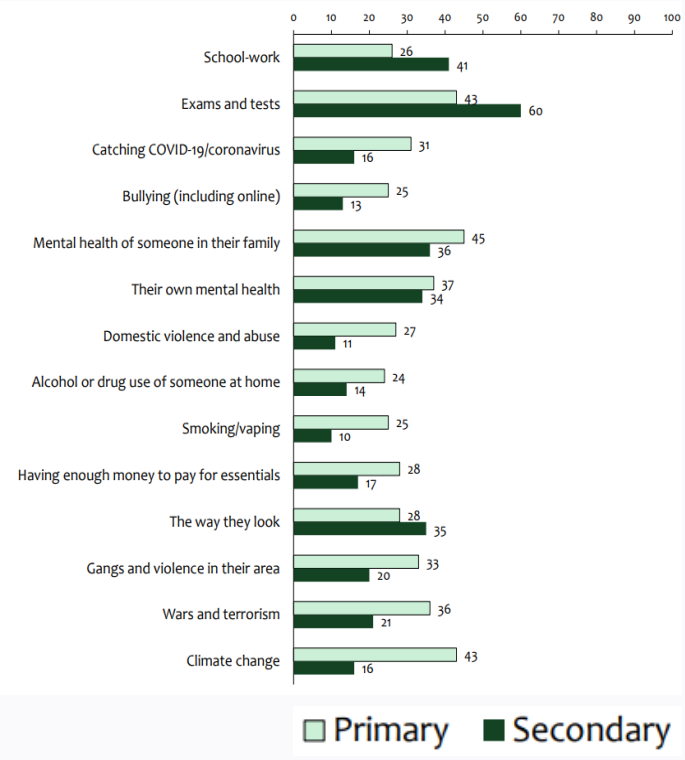
These statistics are quite helpful in understanding the lived experiences of children and young people across the borough and support the partnership to identify themes and patterns to support informing service delivery.

Mental Health and Well-being

90% of primary and 85% of secondary pupils responded that they worry about at least one of the issues listed 'quite a lot' or 'a lot'; 33% said they worry about more than 5 of them.

In most cases, primary pupils report more worrying than secondary pupils do.

Girls report more worrying than do boys. Worries 'quite a lot' or 'a lot' included:



Everyone's Invited & Operation Encompass

Everyone's Invited is a public website whose "mission is to expose and eradicate rape culture with empathy, compassion, and understanding." Thousands of public testimonies have been recording about children's experience of rape culture in schools and universities. The Department for Education requested that Ofsted carry out a review of safeguarding, the curriculum, multi-agency safeguarding arrangements, the victim's voice and reporting policies in schools and colleges. The review also included information about allegations and incidents, the extent of schools' and colleges' knowledge of the incidents, the safeguarding responses, the use of sanctions, their safeguarding knowledge, culture and effectiveness, the adequacy of the curriculum and teaching and the extent to which inspections explored relevant cases. This was because of the number of disclosures of sexual abuse and harassment made on the Everyone's Invited website. Ofsted's thematic review revealed how prevalent sexual harassment and online sexual abuse are for children and young people. For this reason, the report recommended that schools, colleges, and multiagency partners act as though sexual harassment and online sexual abuse are happening, even when there are no specific reports.

Evidence & Impact

As a result of this the ISCP created a task and finish group and created the protocol for managing child on child sexual violence, abuse and harassment in schools, settings and colleges. This was disseminated to all education provisions in November 2021. To support schools with the protocol the ISCP, Principle of Safeguarding in Education and the Health and Wellbeing Board developed and facilitated three well attended workshops (between 2021-22) to spread awareness and understanding about child-on-child abuse.

Operation Encompass

Designated Safeguarding Leads in Education need to be informed of domestic abuse incidents to monitor the child's welfare at school and, if necessary, implement additional support measures. To facilitate this information sharing, the MPS has introduced Operation Encompass.

Currently, the majority of state schools in Islington have joined the Encompass information sharing agreement. This allows police to share details of any domestic abuse incidents they know of with schools, ensuring schools are aware of the child's situation when they attend the following day. Although Operation Encompass is currently only available to state schools, it is hoped to expand the program to private schools in the near future.

Disproportionality and Inequality

Disproportionality and Inequality

Task and Finish Group:

The ISCP created a task and finish group to create systems and processes to understand and mitigate against the disproportionality and inequality impacting particular ethnic groups. The task and finish group created two work streams to focus on respective identified themes.

Workstream One:

Data Analysis- Gathering and understanding data regarding several ethnic groups across relevant agencies in the partnership and determining whether they are accessing services disproportionately.

Progress and impact: Relevant agencies have been able to demonstrate an understanding of the data available to them and identify areas of development such as recording ethnicities correctly and setting up a more robust recording system.

Voice of the children and families:
Incorporating a continuous exercise to obtain feedback from all service users who use their services. Consideration for the voice of the child and families encompassing their experience with services in the context of their ethnicity.

Working with partners to see to what extent their agencies are representative of the Islington population: Determining our partner agencies operational and senior management staff are representative of the services users' using services and the population of the local area.

Workstream Two:

Training: Gain an understanding of partner agency's training about cultural competence and then set an agreed benchmark on the expectations for partner agencies to promote awareness and understanding of cultural competence within their respective workforce.

Embed in Practice: Partner agencies to incorporate learning of cultural competence into practice. Consideration on how they will measure the impact this has on their service users' experience and to also be informed by the changes in data and feedback from young people and families.

Coordinated Service delivery: Identify gaps and create action plans to reflect needs to address these gaps across the Partnership.

Disproportionality and Inequality

Islington Youth Justice Service Disproportionality Action Plan

Islington Youth Justice Service (YJS) is committed to tackling disproportionality and working closely with partners to address these areas. They follow the council's anti-racist strategic vision and have developed an operational plan focused on disproportionality.

Plan: The operational plan aims to address education, courts, police, staff training, interventions, reports, and assessments.

Projects/ Partnerships: Islington Youth Justice Service holds monthly disproportionality meetings with relevant partners to increase joint working and invite services within Young Islington for e.g. YOS Police.

They liaise with the Independent Stop and Search Commissioner, this partnership working allows them to follow up on stop and search complaints and the regularly sit on the stop and search community monitoring group.

They partner with the Metropolitan Police Service to deliver a bi-monthly programme exploring young person and parent/carer experiences of policing.

They work with the Wipers Youth Service, which delivers a personal development and leadership programme addressing issues around race and identity.

Islington has a dedicated Interventions Lead developing interventions aimed at exploring identity with young people, a Group of Peer Advocates for increased feedback and input, and monthly reflective supervision for staff.

A staff survey is in development to obtain feedback and evaluate responses to issues around discrimination.

Action Plan

The YJS has set out an action plan for its operational staff to aid in mitigating against the disproportionality observed towards the global majority. A few examples are listed below

They aim to develop staff skills and confidence in understanding and addressing disproportionality and racism, and continue to promote anti-racist practice.

They have done this by exploring the use of language concerning race, racism, gangs, groups and youth violence through workshops, case discussions, supervision and QA processes. Implementing the use of genograms and ecomaps, create a resource pool for exploring identity, and develop the use of social graces in assessments.

Impact:

The workshop improved reflections of identity and intersectionality in assessments, and specific interventions addressing identity have been positively received by both young people and staff. Social GRACES are used in every YJS assessment, enhancing the understanding of young people and families.

Action

The YJS have also explored how they can support young people who are disproportionality stopped and searched by Police.

They have implemented this action by promoting stop and search information events for young people through the Islington Stop and Search commissioner. Invite YJS Police to local disproportionality meetings, review data on repeat stop and searches, collaborate with CHOICE on training new recruits.

Impact:

Police have allowed for specific cases of body worn footage to be reviewed to give young people a voice and hold police to account. A high number of student police officers have been trained by the YJS, young people and parent champions. Strong relations have been built between police colleagues and YJS and opened up communication for raising concerns regarding disproportionate stop and searches and ensuring there is oversight in addressing strip searches that take place to young people.

Next Steps

Islington YJS will continue to plan and develop and improve outcomes for Black, Asian, Mixed, and other Ethnic minority young people in the criminal justice system. They will continue to self-audit their assessments, reports, risk assessments, and use of breach to understand the impact of unconscious bias. They will continue to review their operational and strategic action plans, assess outcomes, and incorporate feedback from surveys. The management team will make individual pledges to tackle disproportionality within the youth justice system.

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Disproportionality and Inequality (SEMH) Review 2022:

SEMH Review:

Islington Social Emotional Mental Health Service have undertaken a review of its services and referral activity and were able to share some of its findings particularly relating to disproportionality and inequality from 2019 to 2022. The review identified that their mental health services were not meeting the needs of some of the ethnic groups within the local area of Islington.

Referrals:

Referrals sent into SEMH services demonstrate that there is a disparity among the referred ethnic groups against the Islington population.

• Across the three years the number/percentage of White British/Other has been consistent.

• There is an increase in the number of Black-African CYP being referred to the service however this group has remained underrepresented throughout this period.

• There is a significant proportion of ethnicity unknown and not recorded which has impact on true understanding of ethnicity accessing the service.

• There was an over-representation of people from White British backgrounds in inpatient CAMHS in North Central and East London (NCEL), and an under-representation of people from Asian and Asian British backgrounds in the study period (April 2018 to December 2020). These differences are statistically significant, suggesting there were significantly more White inpatients than expected, and significantly fewer Asian inpatients than expected, based on the demographics of the local population.

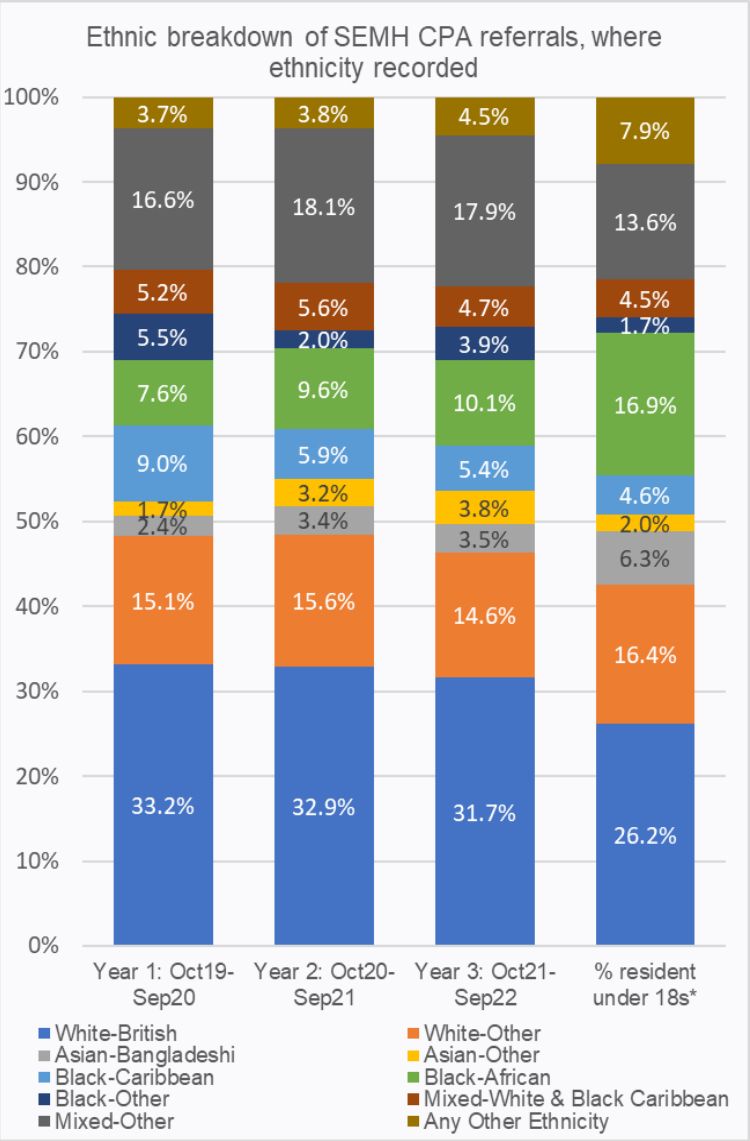
• 41% of the local NCEL population aged 11–17 years old are from White ethnic groups, but 54% of those admitted to CAMHS inpatient services in their dataset were from White ethnic groups.

• There appears to be an under-representation of children and young people from Black ethnic groups but this is not statistically significant.

• There appears to be a particular under-representation of some ethnic groups such as Pakistani (1.8% of inpatients in their dataset were Pakistani compared with 5.5% of the local population), Indian (1.4% of inpatients compared with 4.7% of the local population), and Black African (7.8% of inpatients compared with 11.7% of the local population). Statistical tests were not carried out on these differences.

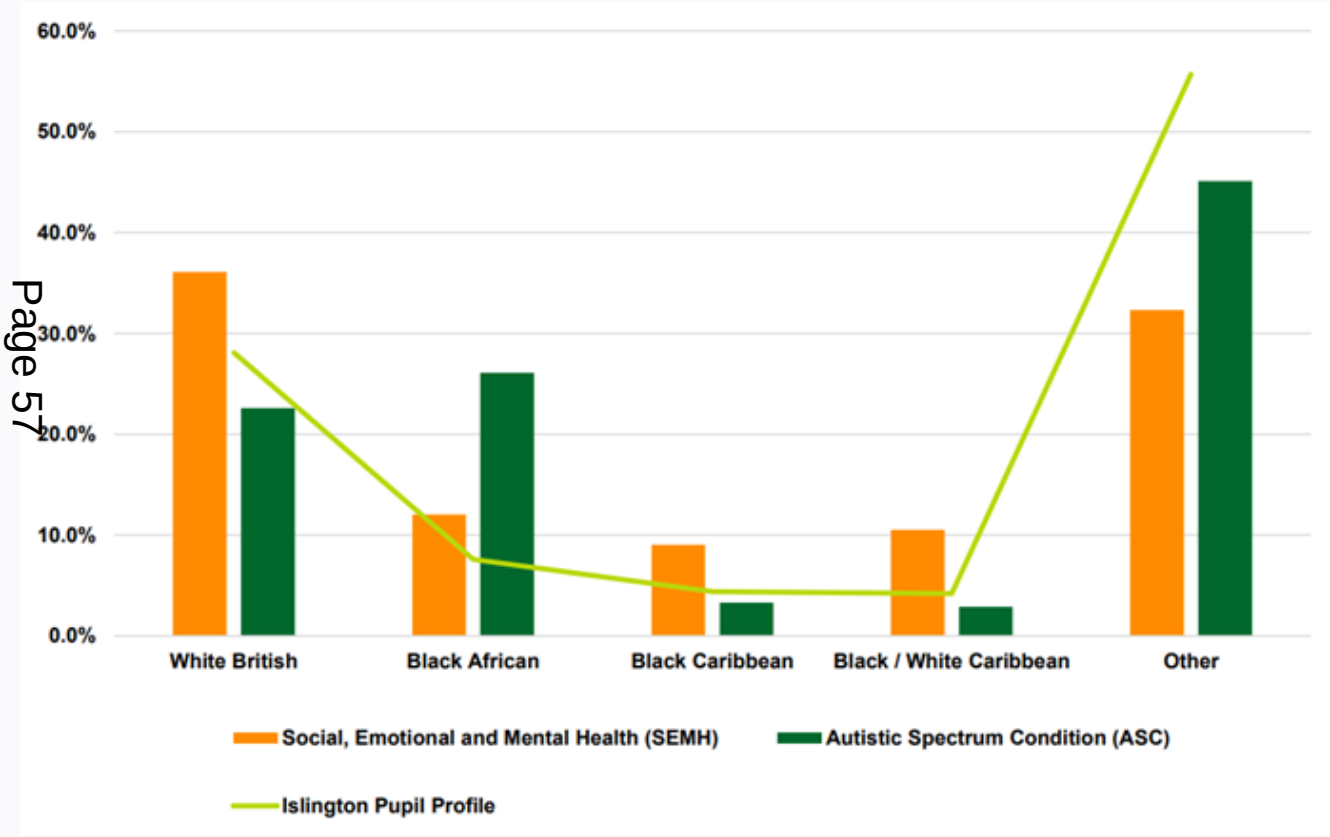
• There has been a disproportionate number of referrals made for Black African cohort between 2019-2022. Black African CYP make up 16.9% of the local population whilst referrals remained much lower for this group - 7.6% (19/20), 9.6% (20/21) & 10.1% (2022).

• Whilst there are indications that the numbers of referrals to CYP from the global majority population are increasing there is further investment taking place to increase access for underrepresented groups.



Disproportionality and Inequality (SEMH) Review 2022:

SEMH & Autism Spectrum Condition Disproportionality



What this tells us:

The light green line shows the profile for all Islington children.

For ASC (dark green) :

- Black African children are significantly over-represented in this area of need (26.1% of the ASC population vs 7.6% of the general population)
- White British, Black Caribbean & Black / White Caribbean are under-represented in this area of need compared to the general population (White British: 22% vs 28.1%; Black Caribbean: 3.3% vs 4.4%; Black / White Caribbean: 2.9% vs 4.2%)

For SEMH (orange):

- White British, Black African, Black Caribbean and Black / White Caribbean children are all over-represented in this area of need (White British by 8%, Black African by 5%, Black Caribbean by 5% and Black / White Caribbean by 6%)

Young Black Men and Mental Health

Young Black and Mental Health

LB Islington were able to identify the themes and patterns relating to work on engaging young black men with mental health services. The new Elevate Young Black Men and Mental Health initiative is a innovate community based, multifaceted and youth led mental health /well-being programme designed to support young black men aged 11-25 through a suite of culturally competent therapeutic and mentoring interventions to support young black men to thrive and access the best life opportunities.

Their proposed service delivery has been informed by their extensive engagement with 46 young black boys and men over the course of 4 months to help shape, design and construct the mental health programme.

The emerging themes from their research interviews demonstrated views such as:

- Negative images about Black Masculinity
- Lack of positive role model/ absent role models
- Lack of support in school
- Access to safe trusted spaces
- Everyday experiences of racism, discrimination and daily micro-aggressions

Voice of the Child on their experiences of Mental Health Services

How is mental health perceived in the Black Community?
It is not always seen as a big deal. Sometimes young black men don't want to show themselves to be vulnerable especially around white people as it is another excuse for them to be discriminated against. You have to be very careful. You don't want to show your distress. In my culture I don't want to let my parents down. White people will always get more help.
Young person aged 16

Definitely having role models that look like you who can share your pain and struggles will help a lot. There is a youth club I go to where there are a lot of black male youth workers – all my friends go there for that reason – because they are people who look like us and we can connect to.
Young person, aged 16

There are no spaces where we can access support and that's how young black men often end up in bad situations. We tend to hold it all in and deal with it in other ways sometimes illegal routes. I always struggled when I was growing up and I never saw counselling as worthwhile. It was not helpful. Counsellors never reflected who I was. *Young person, aged 16*

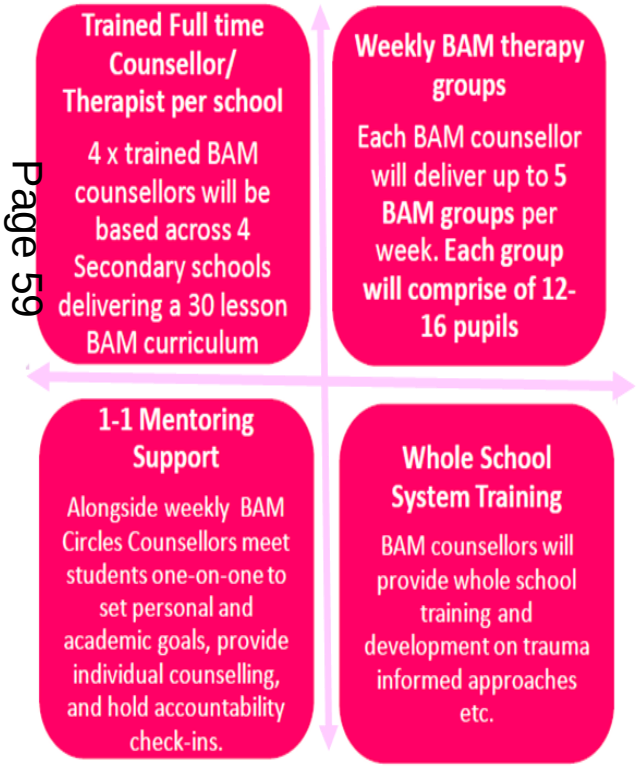
Their findings help shape and design their programme offer which starts with the Becoming a Man Programme (BAM) in four schools which plan to deliver 24 month group counselling and 1-1 support. BAM is an evidence-based, group counselling/mentoring programme that is focused on building social, emotional and behavioural skills among young male students.

Islington schools will deliver up to 5 BAM circles per school. Each circle comprises up to 8-16 young people, so 24-36 young people per school. Target Year 8, 9 & Year 10. Each school will be allocated a full time trained BAM counsellor who will deliver up to 5 BAM circles per week and offer 1.1 mentoring support to young people engaged in the programme. BAM counsellors will also facilitate training and awareness sessions across the school community .

To help facilitate the integration of BAM into each school we will work with schools in March to June 2023 through a series of theory of change events. At the end of Year 1, we will assess the learning, impact of programme through holistic assessments throughout its delivery; A BAM cross Islington schools delivery group will be set up to oversee its delivery and implementation across two schools .

Young Black Men and Mental Health

Becoming a Man Programme Offer



Impact and Outcomes

Individual level Outcomes

- Improve the educational attainment, aspirations and life chances
- Improvement in physical, emotional mental and well-being outcomes
- To reduce school exclusions and improve attendance to school
- Improvement in access to mental health interventions

Whole school level Outcomes

- Improve educational attainment, aspirations and outcomes for all pupils
- Reduction in school based exclusions (fixed term & permanent)
- Reduction in persistent school absenteeism
- Improvement in physical, emotional mental and well-being outcomes

The BAM programmes will commence in **September 2022** so the measured impact will be reported on, in the next annual report.

The Young Black Men and Mental Health programme also runs the new Elevate Hub which is a dynamic and innovative multidisciplinary team designed to provide a suite of holistic psychological therapies and youth work interventions for young people aged between 11-25 who are at risk of poor health outcomes, serious youth violence and exclusions from schools .

Private Fostering

PRIVATE FOSTERING

The Children Act 1989 defines private fostering as when a child under the age of 16 (or under 18 if the child has a disability) is cared for, and provided with accommodation by someone other than a close relative, guardian or someone with parental responsibility, for 28 days or longer.

LBI CSC specific responsibilities in relation to identifying, assessing and monitoring private fostering arrangements were outlined within their annual report, highlighting how they have met the *National Minimum Standards for Private Fostering*[*].

Evidence/ Impact:

LBI CSC evidence how they have met the National Minimum Standard, also outlining their recommendations for improvements.

Notification: LBI CSC reports a clear notification pathway where notifications coming through the Children Services Contact Team (CSCT) are immediately transferred to the Child in Need (CIN) Service for an assessment, well within 7 days.

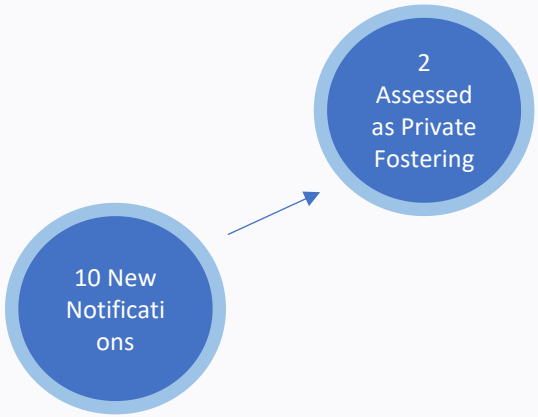
Safeguarding and promoting welfare: The report places a large emphasis on the social worker's due diligence in conducting a thorough a private fostering assessment to establish the suitability of the proposed or current private foster carer. This full assessment is then scrutinised by and signed off by the Assistant Director or Director of Safeguarding through the Access to Care and Resources Panel (ACRP) to ensure rigorous testing is applied.

Advice and Support: The report provides assurances that private foster carers, their privately fostered children and parents of privately fostered children are made aware of the processes this involves, including everyone's roles and responsibilities, information regarding financial support available and support services available for them to access.

Monitoring compliance with duties and functions in relation to private fostering: LBI CSC arranges that a Social Worker visits a privately fostered child in their area – in line with the statutory requirements. The LBI CSC data team is able to outline the effectiveness of this by using a tracker tool.

Evidence:

Between April 2021 and March 2022



Current private fostering arrangements: 3

LBI CSC acknowledges in their report that private foster care arrangements remain low in Islington therefore they continue to raise awareness through their foundation and refresher safeguarding training.

Impact:

Timeliness of visits has improved this reporting period.

In this reporting year, awareness-raising has focused mainly on ensuring that all safeguarding training offered to staff across the council includes a focus on private fostering.

Managers for across LBI CSC were recommended to renew and monitor initial and on-going visits to ensure social workers were visiting in timescales. 4 out of 5 children were visited on timescales, only 1 missed 2 timescales.

Added Recommendations for next reporting period:

The 2022-23 report will report on the impact of the Ukraine War and subsequent Homes for Ukraine scheme on private fostering arrangements.

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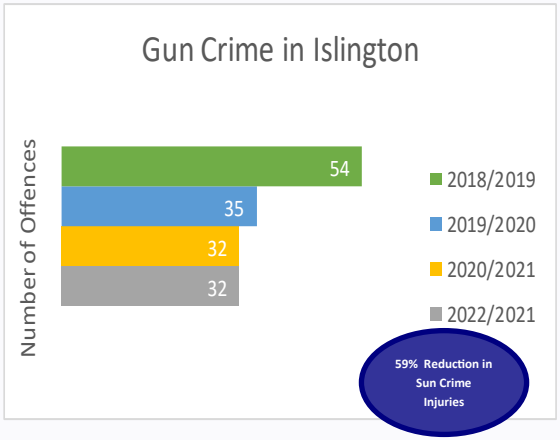
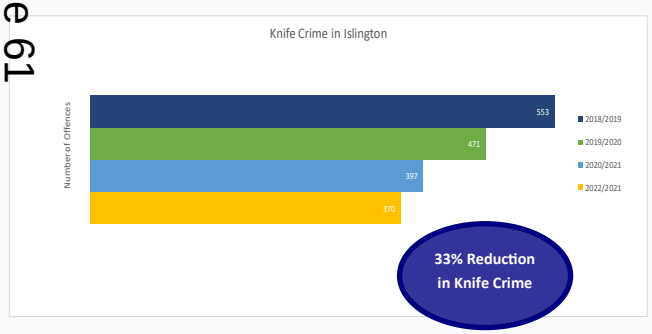
Update on Youth Safety Strategy 2020-2025

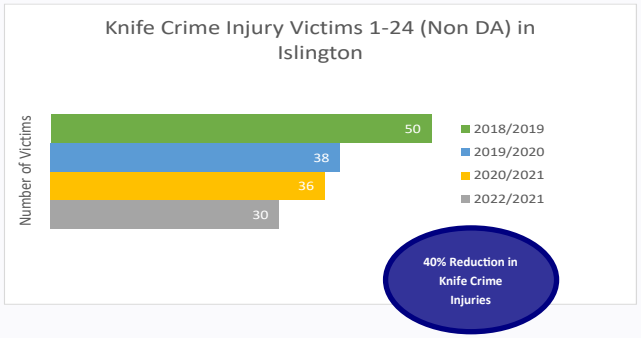
Islington Council launched the new, partnership-focussed five-year Youth Safety Strategy in November 2020; it focuses on protecting children and young people from violence, abuse, and exploitation.

Impact:

Whilst 2020 to 2021 were devasting years for teenage homicides in London, especially in knife crime, the youth safety strategy have shown evidence and impact of their services to reduce several areas, such as: knife crime, knife crime injury victims, gun crime, serious youth violence and youth violence in Islington.







Impact evidenced through the Youth Safety Strategic Objectives:

Prevention

The new young Islington universal offer is complete and includes continued high quality opportunities for young people aged 8+ across several youth hubs such as the Rose Bowl, Lift and Platform. Plus their vibrant summer offer – Summerversity and Launch Pad had over 900 young people engaged this year.

Identification

500 parents / carers have been offered online training and workshops from the Violence Reduction Unit (VRU) Parental Support Team.

96% agreed that training equipped them with practical knowledge that they will put into practice.

67% training helped them understand how to better support or access support for their children

Engagement:

Islington has large Somali population so 67 Somali parents / carers have completed the parent champions training since July 2021. 170 Somali parents/carers have been reached – empowering and enabling them to have more opportunities

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Update on Youth Safety Strategy 2020-2025

Diversion (from Youth Justice System):

Targeted Youth Support (TYS) led triage process exceeded the intended target of 80-85% with 91% diverted in 2021 to 2022.

Support:

74 young people engaged with VRU and TYS transitions project over the last 2 years. They noted a profound positive impact on young peoples' behaviour (80%) with an attendance and engagement of 85%. The parents reported an improvement in engagement with school (93%) and better equipped to communicate with school staff (80%).

Protection:

408 young people engaged and supported through their commissioned services with over **1,888** one to one contacts and **1,346** hours of mentoring. **168** Safe Havens have been developed with 197 viewed over the last 6 months (reporting period).

Disruption:

2,288 knives and other bladed items removed from the 6 knife surrender bins in Islington since October 2020

Enforcement & Prosecution:

The MPS predatory offender unit have secured the first slavery and trafficking risk order in the whole of the MPS in relation to county lines

The Youth Safety Strategy have listed out their priorities for 2022-23

Voice of the Child:

St Giles involved with young person due to concerns around gang involvement and SYV:

'Working with Maddie is positive, she calms me down and gives me a good mindset, I'm more able to think positively and clearly.'

Abianda Young woman -Reflection on the STAR project

'I let go of negativity and focused on me. I've learnt all you need is consistency and that consistency is progress'

Wipers Young person - reflection on the mentoring project

'I would recommend Wipers mentoring to any of my friends, especially the ones who don't have such support, my favourite part of each session was our discussion on the way to our activity. I felt heard and listened to by my mentor'

Impact:

- Decreasing school exclusion rates
- Reducing disproportionality in the youth justice system
- Increasing peer led support to parents/carers
- Supporting Parent champions to deliver a knife harm prevention programme in schools and youth clubs
- Improving awareness of services and opportunities for Young People and families including local youth provision and access to mental health and wellbeing services
- Strengthening Young People's relationship with the police through community led engagement events
- Sharing good practice around Co-production and engagement/empowerment of young

Update on VAWG Strategy 2021-2026

Violence Against Women & Girls (VAWG) Strategy 2021 to 2026:

The VAWG strategy was published in November 2021 and are currently 9 months into their journey. The strategy sets out the ambition that Islington continues

to be one of the leading and most forward thinking areas in the country when it comes to tackling all forms of VAWG. VAWG in Islington have outlined four aims as part of their strategy as follows:

Evidencing the Impact of VAWG from January 2022:

Police Performance:

- 2.076 Domestic Abuse related crimes reported to Islington Police
- 3.349 Domestic Abuse related incidents reported to Islington Police
- 8.7% Sanction detection rate for the Domestic Abuse offences
- 28% Islington Police Daily Safeguarding Meeting referral rate
- 1.105 Survivors supported by the VAWG services
- 126 126 Survivors supported by the VAWG counselling service
- 79% Of survivors supported stated that they feel safer after engaging with services
- 133 Staff attended VAWG Workforce Developme nt training

Update on VAWG Strategy 2021-2026

I left the house with empty hands. I have no cash with me and I am 6 months pregnant. You are providing me with knowledge I did not have and I feel hopeful. Thank you very much for your support from my heart'

Service User Samira Project

There are no words to express how I'm feeling. I've been through so many professionals and tried to explain what has been happening to me; consultants, psychiatrists, doctors, and yet nothing. There was still no support for me. You've actually listened and never judged. I've always felt judged in my life. You've done an excellent job.'

Survivor supported by Solace

'I really feel heard and hope that this time professionals support me in keeping safe. I want to keep safe for my daughter – she is my world and I want to model a good relationship for her, away from my ex-partner'

Survivor supported by MASH IDVA

Daily Safeguarding Meeting (DSM)

Islington Domestic Abuse Daily Safeguarding Meeting (DSM)

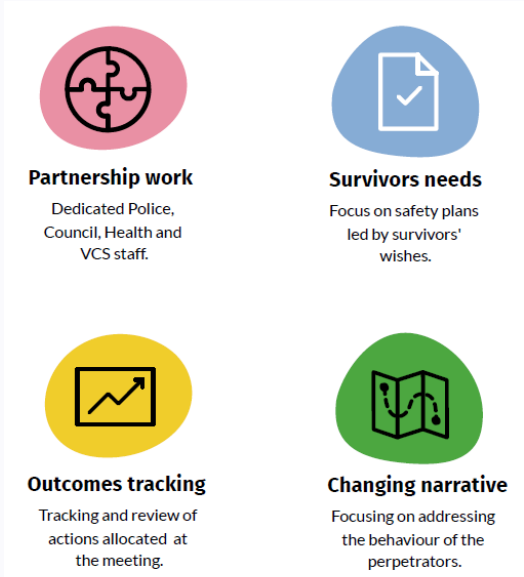
DSM (previously the DA MARAC) is a multi-agency led, fully integrated approach to needs management for survivors of high risk domestic abuse aiming to reduce the risk of serious harm or domestic homicide.

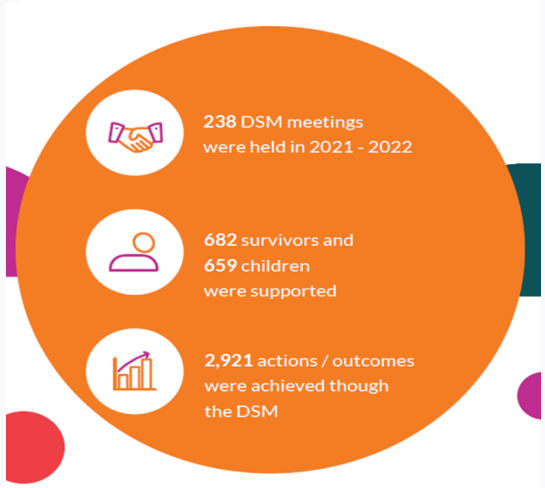
DSM fully replaced the DA MARAC which previously met monthly until January 2021. It was changed from monthly due to the struggle to cope with demand of hearing 35 to 55 cases with timescales causing high risk survivors a delay in intervention. The DSM currently meets each day during the working week in order to address the needs at the time the intervention will have the greatest impact and to maximise victim engagement.

DSM provides a dynamic information sharing and needs management approach, staffed by key agency decision makers who are able to contribute and work cohesively as a multi-agency team.

The DSM occurs daily from Monday to Friday and hears up to three being identified as high and medium risk of harm and domestic abuse.

Evidence of Impact:





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Daily Safeguarding Meeting (DSM)

DSM performance highlights (January - September 2022)

Increased reporting of domestic abuse incidents across all services

39% higher non-police (early identification) referral rate to DSM than national average across MARACs

Decreased repeat referral rate

6% lower repeat referral rate comparing to London average

Increased engagement with survivors

65% higher engagement with survivors comparing to same period engagement with MARAC in 2019

Increased accuracy of police referrals

61% increase since DSM launched with Islington being the highest across London (second highest borough accuracy rate is 34%).

Other KPI Performance highlights (2021 comparison)

Profile of survivors to be demographically representative of Islington's population

7%

increase in survivors supported by the VAWG services who are from **Black, Asian and minoritised communities (61% total)**

Increased engagement with under-represented groups

12%

increase in survivors supported by the VAWG services who disclosed **disability or mental health support needs (57% total)**

Increased engagement with under-represented groups

3%

increase in survivors supported by the VAWG services who are **LGBTQ+ (7% total)**

Increased the number of survivors accessing VAWG services and support

9%

increase in total number of survivors supported by the VAWG services (1,105 supported to date by commissioned services)

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Update on VAWG Strategy 2021-2026

DSM data Q1 2022

National and London 12 months comparison (based on National 292 MARACs and London 32 MARACs data average including Islington's DSM: July 2021 - June 2022)

REFERRALS IDENTIFICATION

Islington DSM saw nearly double the number of national average and SafeLives recommended volume of referrals for Islington.

REDUCING THE RISK

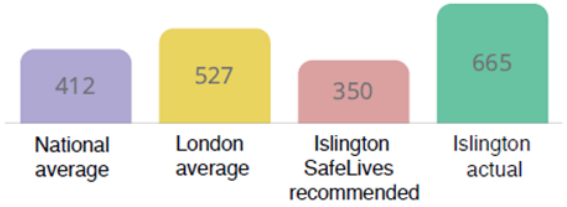
Islington DSM repeat referral rates are 7% lower than the national average and in line with London average.
*Islington MARAC data comparison from 2019/2020

EQUALITY

Islington DSM referrals for survivors from Black, Asian and minoritised ethnic communities and LGBTQ+ communities and for survivors with a disability are significantly higher than the London average.

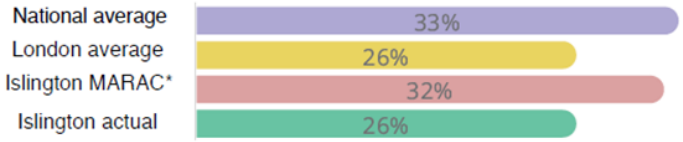
REFERRALS IDENTIFICATION

National and London comparison



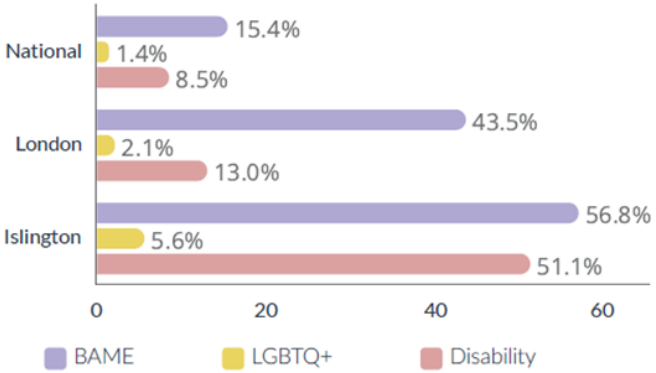
REDUCING THE RISK

National and London comparison



Equality

National and London comparison



Why is DSM making a difference?

Better engagement with survivors

76% of survivors engaged with the DSM process to express their wishes and feelings, compared to 18% with MARAC

Managing risks from the perpetrator

over **7 times higher** number of requests for civil and legal protection orders

Quicker response

responses to high and medium referrals were **15 times quicker** when referred to the DSM

Increased risk management

non-core agencies (including A&E, Sexual and Mental Health Clinics, GPs and Education) were **4 times more likely** to refer to the DSM than they had been to MARAC.

Assurances on Quality

ISCP Dashboard:

The ISCP quality assurance sub-group looks at five areas to assess quality assurance in partner *organisations performance data, audits, inspection reports, quality assurance frameworks, and annual safeguarding reports*. The LBI Data and Performance team previously provided the Quality Assurance sub-group with performance data in the form of PDFs highlighting the themes and patterns of contacts and referrals, CP and CIN plans, amount of strategy discussions and S47 within a given period. This would demonstrate how partner agencies worked together, looking at the amount and types of referrals they sent to the Children Services Contact Team.

This data is now being presented on a digitally interactive Power BI software. This will allow partners to interact and analyse the data presented once access is given to external agencies from the LBI.

Section 11 Education:

The Principle of Safeguarding in Education compiled the section 11 responses from 59 Islington Schools, Nurseries and Colleges (59) and 72 Islington Early Years provisions and produced a report that outlined their strengths and areas for development.

Summary of S11 feedback:

The audits have shown a widespread commitment to safeguarding children in Islington, with only a few schools failing to complete the audit despite reminders, and one school providing an independent review to demonstrate compliance with Section 11; while most settings provided comprehensive responses to the compliance checklist, those with limited responses will be contacted and offered support to ensure their safeguarding practice meets the necessary standards, and those who have not covered all key elements will be supported to create action plans, with cross-checking of Annual Safeguarding Reports to Governors to further assess compliance.

Key findings:

Trauma informed approach:

The report evidenced that several primary schools adopted a trauma informed approach that has led to reduced negative impacts of childhood adversity, improved child mental health, and more inclusive schools where students feel valued and supported.

Robust Safeguarding culture:

The section 11 self-assessment emphasizes developing a culture of safeguarding within a whole-school approach, requiring commitment from all stakeholders. Under Standard 1, the audit showed that most settings have strong pastoral approaches and encourage collaborative efforts between safeguarding governors, designated safeguarding leads, and other leaders. It also features safeguarding being a regular feature of staff and governing body meetings, and School Improvement Plans including online safety and clear responsibility for identified actions.

The Expanding Role of the Designated Safeguarding Lead:

The role of the Designated Safeguarding Lead (DSL) has expanded into a senior leadership role with wider responsibilities, and despite a requirement for both the DSL and their deputies to complete the same level of training and development, the enormity of their responsibilities, particularly since the pandemic and lockdowns, has not been recognised with additional funding or support. This may have resulted in experienced DSLs leaving the role; the achievement gaps between vulnerable children and their peers should be addressed as part of an organizational approach rather than being solely the responsibility of the DSL, and DSLs should be acknowledged and applauded for their hard work and the valuable role they play in safeguarding children to help them feel respected and highly regarded.

Child on Child abuse:

There were noted actions from schools to embed the ISCP child on child sexual violence and harassment protocol and to further progress their resources in this area as well as online safety. In addition to ensuring that child on child abuse is always on the agenda for staff safeguarding updates

Recommendations and actions created from the Section 11 audit:

The recommendations involve improving attendance at the DSL Forum, providing protected time for Designated Safeguarding Leads, delivering various training courses and workshops on safeguarding topics- including sexual and criminal exploitation, strengthening school practices related to KCSIE, safer recruitment, and record-keeping, as well as reflecting on allegations and lessons learned. These actions are to be taken by various teams including POSIE, LADO, CSC Exploitation and Missing Team, Prevent Education Officer, ISCP, and Bright Futures.

Assurances on Quality: Section 11

Section 11 of the Statutory Partners and Relevant Agencies: Seeking assurance on Safeguarding standards

Section 11 of the 2004 Children Act sets out the provision for Local Children Safeguarding Partnerships to undertake a self-assessment audit of how organisations and services are meeting standards to safeguard children and young people. It was recognised that all relevant agencies and VCS are at differing stages as it pertains to their responses against all 8 standards.

The ISCP received 9 comprehensive responses in the Section 11 Audit and they all demonstrated great compliance against the 8 standards provided. As part of one of ISCP action plans (LCSPR) there has been on going work to seek assurances on safer recruitment which has appeared to be quite thorough within the responses gathered from relevant agencies. We have chosen some the areas where they have evidenced strengths and areas for development:

Arsenal Football Club: Able to demonstrate an effective system of using the voice of the child to inform some of their service delivery and ensuring they have robust safer recruitment systems in place. However, they also acknowledge an area for development within their learning and development training and have proposed that they will be improving their recording system within 6 months of submitting their S11 response.

Chance UK VCS: Reporting strengths in their interagency working both at an Early help and a statutory intervention level. Given their youth workers often have close relationships with young person this aides the assessment and Information sharing aspect at all levels. They have also demonstrated areas for development in learning from reviews with trying to incorporate more reflective space and translation of themes throughout their teams.

Camden and Islington NHS Foundation Trust (CANDI) Whilst CANDI is an adult mental health Trust and are not commissioned to provide services to children they are aware that there is a need to strengthen its performance in ensuring their core staff are competent and capable and confident in incorporating a "Think Family" approach to recognise safeguarding concerns. They compound on this by ensuring their staff (in contact with parents) are trained in Safeguarding Level 3 a those not in contact with services users demonstrated competence in Level 1.

They have identified a need in ensuring that more bespoke safeguarding children training and have devised a plan to ensure this is completed to a satisfactory level.

North Central London Clinical Commissioning Group (now Integrated Care Board): The NCL CCG has demonstrated its ability to take the views of children and families to improve service delivery and this is evidenced in their involvement with the SEMH Review which looked at its impact on the LBI CSC contact team for referrals. Their collaboration with the Local Authority to commission services demonstrates the partnership working to ensure the welfare of children are promoted and safeguarded. Examples of this include the overall co-designing of workshops to engage young people collaboratively in architecting the design and development of the Young Black Men and Mental Health programme and service offer. of the new Young Black Men and Mental Health Elevate Service Provision. They demonstrated an area for development to improve effectiveness in confirming their auditing process regarding the use of safer recruitment and managing allegations procedure in the NCL CCG.

National Probation Service: They clearly outline their clear statement regarding their responsibility towards children and this being available to their staff, they evidence this through their pre-sentence report to ensure that the voice of the child is paramount in assessing and managing risk. This has been compounded by their involvement with the MASH Team in CSCT or being accessible for information where it involves checks pertaining to parents' involvement or being known to Probation. In service delivery they demonstrate how they work with partners in order to ensure children are safeguarded and their welfare promoted through attending CIN, CP, MAPPA meetings whilst also ensuring their staff are trained effectively to acknowledge risk and knowing where to report.

Whittington Hospital: They have evidenced in their report clear complaints procedures from using Patient Advisory report clear complaints procedures from using Patient Advisory Liaison Service (PALS) and Children's and Young Persons Integrated Care Service Unit (CYP ICSU) an active Young Person forum where they are able to gain the voice of children and families to improve services as it pertains to safeguarding children and promoting their welfare. They evidence areas for development for improved effectiveness which was raised in a recent rapid review report that highlighted a need for a more stringent discharge planning guidance policy that incorporated an agreed flowchart to improve processes.

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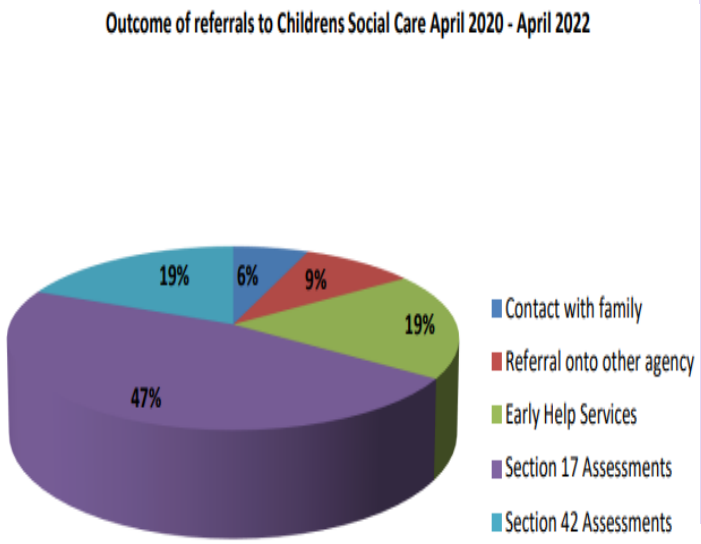
Assurances on Quality: Section 11

Moorfield Eye Hospital: Moorfields Hospital have been able to evidence statutory duty towards children in ensuring they are able to measure the impact of the referrals made to Children Services and their outcomes are. Whilst they take on the voice of children and families and incorporate into service delivery by having age-appropriate focus groups read and critique ophthalmic information leaflets, suggestions are incorporated reflecting their views and are then available in hospital. They have also acknowledged where areas of development can improve effectiveness such as strengthen their transitions process for vulnerable young people into adulthood.

They highlight an area for development in ensuring they are more effective in strengthen links with MASH by updating their information sharing agreement.



Local Authority: Following the outstanding rating from Ofsted's full inspection of LBI Children Services' in March 2020, this set tone for their Section 11 submission where they were able to highlight a vast amount of strengths through their inter- agency working, as well as evidencing outstanding leadership, management, and governance. OFSTED findings demonstrates that the LBI CSC effective in timely communication with the police and other professionals within the multiagency safeguarding hub (MASH) and external partners results in prompt help and protection for children. LBI CSC also spearheaded the data analysis of ethnic groups within the local area and how this demonstrated disproportionality and inequality in how the global majority accessed services.

Police: They report clear lines of accountability when it comes to safeguarding children and they acknowledge the need for this given the frequent changes in roles across their Basic Command Unit in Central North. They report their significant contribution to partner/inter-agency working in the context of being the number one referrer to Children Services whilst having an integral part of the MASH process in obtaining the necessary information to ensure children are safeguarded and their welfare promoted. The Police also committed to attending training organised by CSC and promotes this process across various corporate safeguarding courses. They have identified areas for development to improve effectiveness in the context of learning from review and the importance of this being fed into the BCU organisational learning hub to support staff development and practice.

CAFCASS: They evidence their service development has taken into account the need to safeguard children by incorporating their strategic plan setting out their vision which has been informed by their partners and staff. Their aim is to improve experiences and outcome for children and is being monitored by their CMT and bi-annual reporting to Cafcass Board. They are also able to incorporate the voice of the children from their family forum development work which features restorative 'listen and learn' and 'how was it for you' conversations with children. This adds to their collaborative audit process in order to continue to improve services and outcomes for children.

Assurances on Quality: FGM and No Further Action Audit

Female Genital Mutilation (FGM) and abuse linked to faith and belief

ISCP has continued to highlight the dangers and risks associated with FGM by working with the voluntary sector, relevant partners and communities to protect girls and young women from FGM.

Evidence of responding to local learning:

Manor Gardens is a Welfare Trust and a relevant agency within the ISCP. They are a part of Islington's FGM steering group and have conducted an audit alongside LBI Children Services to look at FGM referrals over the last 3 years (2019 to 2022) to ascertain a clearer understanding of the number of referrals made, the services initiating the referrals and the outcomes for children and families involved. In addition to the in-depth scrutiny of the referrals covered in the above timeframe

The examination of referrals over the mentioned period was thorough, and a comparison was drawn with the three years prior to it (2016-2018). The results showed that the referral rates were indeed higher in the earlier period, with 32 referrals. This can be partly attributed to the changes made in 2015 to the Female Genital Mutilation Act 2003, which made it mandatory for professionals to report cases of FGM as a form of child abuse. This increased awareness may have led to a rise in referrals during this time.

The Children Services Contact Team (CSCT) received 15 referrals who were all from African descent: 5 Somali, 1 Somaliland; 3 Ethiopian, 1 Eritrean; 2 Nigerian; 2 Ugandan and 1 Ugandan/Nigerian.

11 of these cases were no further action (2 referrals received for one family in time period)

2 cases referred to Targeted Services (Early Help)

4 cases were transferred to Children Social Care

They concluded that the low number of referrals could indicate the following:

A greater understanding within the affected communities about the harm and legal implications of FGM making the practice less prevalent. Contrastingly, the low referrals could mean that affected communities are still practicing FGM on girls, but this form of abuse still remains a 'hidden harm' that professionals have yet to adequately address.

It was noted that the referrals do not reflect the affected communities residing in Islington, as no referrals made for families of Middle Eastern background.

The audit concluded that the ISCP should continue to deliver training around FGM to create further awareness and increase professional curiosity. FGM is featured in all of ISCP core training such as foundation safeguarding training, refresher safeguarding and DSL training.

Audit on Child and Family Assessments with outcome of No Further Action:

The LBI CSC wanted to better understand the circumstances and decisions making that lead to an outcome of no further action. Their audit set to understand Child and Family Assessments of 275 children from 131 sibling groups within 9 month period.

They investigated the reasons for the children being referred to CSC, why the outcome of the Child & Family assessment resulted in "no further action":

-if there has been a subsequent repeat referral,

-If the children were seen during these assessments,

-if the professional network was consulted about the outcome, and

-the level of management supervision oversight involved.

These factors are important to understand the history of the case and to assess the appropriateness and effectiveness of any interventions or decision-making related to safeguarding these children.

They found that only 11% of the sibling groups were re-referred which demonstrates that safe decisions are made when closing a child's case but where there is reoccurring need, referrers are confident to refer back to Islington Safeguarding and Family Support Service.

Assurances on Quality: Children with Persistent Absence and Children in Care Proceedings

Children with Persistent Absence

LBI CSC carried out an audit of 41 children and has presented their findings on interventions for children with Child Protection or Child in Need Plans and persistent school absence, examining multi-agency collaboration to improve attendance.

68% of the cases the primary area of need was identified by the social worker
80% of cases evidenced joint working among the professional network
8% of cases plans were reviewed regularly with appropriate professionals involved
4% of plans included strategies to improve school attendance
54% of the cases a formulation of reasons for poor attendance was not included in the plan.
66% of the cases parental factors (mental health, DVA) were seen as a barrier to improving
66% of parents were motivated to improve school attendance.
44% of children were motivated to make improvements
63% of cases included fathers or non-resident parent
17% of cases auditors found concerns around racism and discrimination had been considered

DSL and Parental Feedback: (9 parents & 11 DSLs)
67% of parents felt the relationship with the social worker was respectful, 11% partially
78% of parents felt school attendance had improved as a result of intervention
100% of DSLs felt joint working with social workers and the school helped improved attendance
Overall, 77% of this audit was rated good with 20% being outstanding. This audit was able to demonstrate good partnership working with a multi agency approach in mitigating against persistence absence. The children lack of motivation further illustrates the point of why early intervention is vital to lessen the likelihood of wanting to attend school. It also showed that they understood what the child's lived experience was and understood the social, parental and financial factors an incorporated them to improve school attendance. It was also noticed that management supervision was purposeful 78% of cases drove best practice providing clear rationale for decision making and making steps to include fathers or non resident parents.

LBI CSC have already begun to work towards the recommendations made:

- ◊ Having explicit discussions in supervision with manager for children with persistent absence issues to implement improvements.
- ◊ Include explicit questions on culture identity and discrimination in the child and family assessment for all children and ensure quality assurance in supervision.
- ◊ Run a Headteacher's Forum dedicated to improving school attendance by the Director of Learning and Culture and the Headteacher of the Virtual School.

Children in Care Proceedings

Auditors reviewed records of 20 children who entered care proceedings and an interim care order was granted over the last 6 months in a London borough with a high number of children in care. The purpose of the audit was to scrutinize the records and explore whether entering care proceedings was the best option, whether other options were explored, and whether it was necessary to enter care proceedings. The auditors found that 60% of the records were good, 10% were outstanding, and 30% required improvement.

Demographics
30% mixed parentage | 30% white British
10% Black Caribbean | 10% white Irish
10% Asian | 5% Bangladeshi | 5% Any other white

Findings
80% of the cases found proceedings needed to be issued
85% of the cohort removed from their parent's care were placed with a stranger foster carer
35% of cases held a Family Group Conference (FGC) and
55% of cases, parents were resistant to having an FGC
65% of cases parents did not contest to the local authority's care plan at final hearing
55% of cases had an expert family assessment and in
85% a father or another parent was included in that assessment.

Parental Feedback
77% of parents agreed their relationship with social worker was respectful 89% parents agreed with the social worker on what needed to change

Auditors found that care proceedings were the right decision for children in this category. So whilst the children looked after data appears to be high in comparison to statistical data, LBI CSC was able to evidence

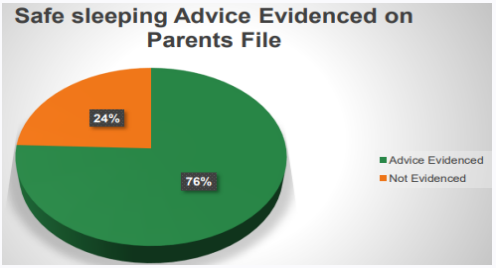
Assurances on Quality: Care Experienced Parents

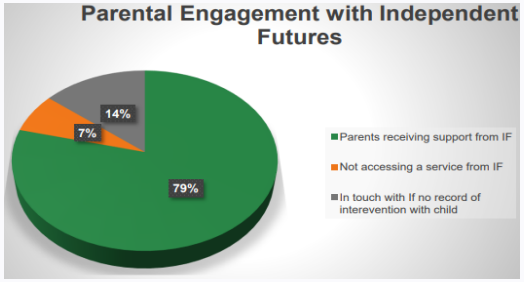
from their audit that decisions are being made on a proportionate basis. Also, while 45% of practitioners had evidence of understanding the children's culture and identity, only 25% effectively considered concerns about racism or discrimination in their assessments, possibly because most children in the audit were white British or white.

The audit evidenced a good working relationship between social workers and parents as well as with the children, this was demonstrated from 70% of children have a good rapport, trust and openness between them and their worker, 85% were visited on time and within statutory timescales.

Care Experienced Parents with children aged under 1

The LBI CSC has notified the ISCP of the death of 2 babies on separate occasions (in the last 3 years) who died suddenly and unexpectedly as a result of co-sleeping. Although, these deaths were not considered to result from neglect or abuse, there were indicators to suggest that co-sleeping arrangements had contributed to their deaths. In both occasions it was found that the parents were care experienced.
As part of their learning the LBI CSC sought to ascertain how practitioners worked with care experienced parents and explore how best to support parents who are often young and likely to have a limited amount of people they can rely on.
This audit looked at 41 (31 female and 10 male) care experienced parents with babies under the age of one years old and found the following:





The audit found that care experienced parents who are open to Independent Futures (Islington care leaver service for ages 16 to 25) do not have many children open to the Child in Need or Children Looked After service. Most parents had support with childcare, safe sleeping advice was recorded in 76% of cases, and 61% of children had a cot however only 41% of the children did not sleep alone. In some cases, information was not clearly recorded. Some children did not sleep in a cot, and 39% did not have a cot at the non-resident parent's home, indicating that they shared a sleeping space with a parent under the age of 1.
LBI CSC were able to demonstrate that their care experienced parents were being advised about safe sleeping arrangements with their babies, however although advised some parents chose to sleep with their babies.

Recommendations:
- Assistant Director for Corporate Parenting to agree a process or protocol whereby social workers and young people advisors are clear on what they need to explore with care experienced parents.
- Provide a clear steer to social workers and young persons advisors on what information about the child to include in parents' LCS record or pathway plan
- Hold safe sleeping sessions during team meetings and share information from the Lullaby Trust with all workers.

Care Experienced young people with children over 1

There were only 9 files audited for this cohort and a larger emphasis was made on the quality of the pathway plans to evidence how well it they address advice and support around parenting, help from family, the extended network and what role Independent Futures played in supporting them.
79% of the files were rated as Good.

Findings:
All audited plans had clarity on the services the parent received, and it was clear that the young person was a parent in all files. Non-resident parents were included in 66% of plans, but only 33% of plans had a rationale for not including them, indicating an area for improvement. Domestic violence or abuse (DVA) was not an issue in 22% of cases where it was not applicable, and in 45% of cases where DVA was present, it was included in the plan.
Parenting skills were partially considered in 55% of plans, and strengths in parenting were identified in 55% of plans. White British and other white backgrounds were the largest group of parents at 29% and 31%.

Assurances on Quality: Multi Agency Audit—CSCT/MASH Threshold

Multiagency CSCT/MASH Threshold Audit

Following a noticeable increase in the amount of contacts in the year 2021, this prompted a multi agency review of the contacts sent to Children Services Contact Team. April 2021 to March 2022 saw a high rise of contacts (12214) in comparison to previous years, the only year that had more contacts was from 2016 to 2017 (13671).

The multi agency audit looked at 100 children's cases to ascertain whether the appropriate threshold decision was made for : No further action | Targeted Services | Child and Family Assessment.

They found that 90 of the 100 cases, an appropriate decision was made regarding threshold.

A further 3 cases were considered appropriate on the available information however should have had further information to assist with the decision making and further information may have altered that decision.

The options within the audit asked did you agree with the decision – yes or no. A future audit could also ask the question "do you believe mash checks were required to make a decision?" - this coincides with a recommendation made following the Solihull JTAI ISCP comparison activity

Of the 7 cases where the outcome was disagreed 6 of these related to a decision of No Further Action where it was believed the family/child would have benefited from a service.

In 4 of these families CSCT agreed a service would have been beneficial however, the service offer was declined by the family and as such these families are required to be closed.

Findings

Further consideration should be given around the role of the Early Help practitioner in reaching out to families who are declining Early Help Services where it is felt that this may ultimately be of benefit to the child and prevent the delay in awaiting an escalation of need or crisis for the family.

This has demonstrated some of the difficulties in decision-making at CSCT when families have declined a beneficial service, while still having consent in place. Families have the right to decline services without interference with their fundamental rights to privacy and family life. This highlights the need for ongoing communication and information sharing among partner agencies and universal services.

Recommendations:

- Review of CSCT's framework which is required provide guidance around when MASH checks should be undertaken
- Feedback to CSCT workers around ensuring contact with alleged victims of domestic abuse ensures there is a discussion that victim is able to freely talk and this is case recorded. This may not address all situations where the alleged perpetrator may be present but will remind workers to be alert to this issue.
- Review in bi-monthly meeting this audit for further consideration around how to support families who decline offer of service.
- A further multiagency review to occur in 12 months.

Assurances on Quality: MPS Audit on S47s and Merlins

The Dedicated Inspection Team (DIT) is considered a critical role that provides the ability to independently conduct qualitative level 2 audit inspections of the MPS' work using the HMICFRS framework in 12 areas of Public Protection. Additionally, the DIT officers are part of the Aegis Team supporting Op Aegis by providing a bespoke auditing function for each BCU to provide both baseline, sustainability reviews and also inspects 12 core Public Protection theme MPS wide.

The DIT learning is shared with BCU's, Lead Responsible officers, policy makers, to improve safeguarding investigations and instil best practice within their teams. The audits main purpose is to understand and reinforce both policy, investigative compliance and to evaluate officers decision making and risk management. The DIT function has been praised as good practice by the HMICFRS and this relationship has been maintained to ensure we remain succinct and child centric.

Operation Aegis was created to support learning and embed the 'Improve model' to promote successful teams providing an operating rhythm. The Aegis team focusses on 6 Public Protection themes - Domestic Abuse, Child Exploitation, IIOC/YPSI, Child Abuse, Missing Children and SSO. The team are currently attached for 11 weeks to Central North BCU providing, mentoring, training and 121's for both Public Protection officers and response officers to share learning and best practice. The Aegis DIT team also provides snapshot audit for the 6 key Public Protection themes providing individual themed learning that is shared with the relevant Public Protection DI to support learning solutions for their teams.

Findings and Impact

In October 2021, the DIT audited Merlin reports (children coming to police notice). When comparing MPS results with Central North BCU (Camden and Islington Police), the good grad ed cases were comparable and positive, no inadequate cases were inspected. Across the Metropolitan Police, the main areas of learning, were officers not always speaking independently with children to obtain accounts, child exploitation not being explored where relevant and intelligence enquires to aid risk evaluation were not always being completed.

Findings and Impact

In December 2021, the DIT audited MPS wide Child Abuse investigations. The main MPS areas of learning found, wider safeguarding considerations for children placed with friends and family members were not always being considered and it is deemed good practice to conduct intelligence research to confirm there are no other apparent safeguarding risks with CSC, before placement is agreed, and concerns raised for suspects being spoken about the offence and not in accordance with PACE when conducting joint visits with CSC. Additionally, it is important that officers attend CP Medicals to brief the Paediatrician and obtain pertinent information as outlined by the LSCPs.

Impact

Locally, Central North BCU have implemented an Organisational Learning Board which allows for identified learning from DIT audits to be captured, disseminated and audited. The Board is chaired by a Senior Detective who has strategic oversight around the implementation of recommended learning which aims to improve the victim experience through the criminal justice process.

Early Help Subgroup

Social Progress Index

LBI are currently embarking on a similar journey to the London Borough of Barking and Dagenham in creating a social progress index at a locality level to allow them to understand the social well-being of the residents in Islington. The aim is to demonstrate how data can be used to help decision makers, businesses, charities and the general public understand how individuals are living and progressing within the borough and who is being left behind. In the context of the ISCP the early help subgroup would gain an understanding on how Early Help services could support those being left behind to make Islington more equitable by providing the necessary service from a multi-agency perspective.

LBI also wanted to develop a youth focussed version of a Social Progress Index for Islington. In order to implement this within Islington the data for LBBD was analysed in order to develop a proof of concept for Islington. One of the components chosen to attempt to explore was 'Personal Safety' given its background with "Stronger Families" and accessible data from LBI Community Safety team. This data could then be triangulated with:

LBI CSC child and family assessments involving domestic abuse – robbery offences by location of incident compared to resident population– rates of London Ambulance callouts for safety related reasons – Rate of incidents involving suspects who were (or thought to be) aged under 18 compared to under 18 population – rates of youth violence victims compared to resident population.

The data were able to demonstrate what this could potentially look like using the mentioned data points.

Possible Impact:

If successful, the Social Progress Index could be used by the statutory partners to have a better understanding of the children and families of Islington, subsequently being able to better meet their needs. This could potentially give scope in understanding the needs of each locality, therefore, being able to provide equitable resources to a specific area within Islington.

Youth & Play: Voice of the Child/Families:

LBI Play and Youth Commissioning Services brought evidence to the Early Help Subgroup A review conducted by the "Reflecting Reality" service included several case studies, one of which was a 16-year-old girl living with her mother and brother. Although the girl associated with males who joined gangs or were at risk of youth violence, she did not engage in these activities herself. She had limited experiences outside of the borough and was interested in studying creative subjects but planned to pursue a career in childcare based on her sibling's positive feedback. The girl lacked support and influences outside of her social peer group, limiting her cultural experiences and life expectations. Despite having no issues at school and good peer friendships, she faced challenges in achieving her full potential. The study provides insight into the experiences of young people in the borough and will influence how Youth Services can better relate to and engage with this cohort in the future.

Outlining of the Early Help Subgroup Priorities for 2022/24

Early Help System Guide

The Early help subgroup were able to gain feedback from relevant agencies using the Early Help System Guide formulated by Department for Levelling Up, Housing and Communities (DLUHC) in partnership with the Department for Education. The feedback informed the Early Help's sub group three priorities for the forthcoming year 2023.

Voice of the Family:

The incorporation of Family Voice into Let's Talk Islington data is considered a strength, with over 700 children included. Parents Champions, who have lived experience, contribute valuable insights. However, the current data does not fully represent the lived experiences of families who do not use the service. The need to hear their voices in regards to their experiences of inequality, necessary support in Islington, and how to access resources is highlighted. The goal is to make Family Voice a standard part of data presentation, and an application has been made to Research In Practice to be part of a Learning Network to strengthen Family Voice. It is a long-term project that will span over 5 years and will involve collaboration with Rees Centre.

Develop the Workforce

The focus is on developing the Early Help workforce across various sectors, including council, voluntary charity, health, education, police, probation, and youth justice, in order to align it with the workforce table. This will enable the workforce to identify needs early on and begin the early help process, or know how to link individuals to the appropriate services based on their role. Health Visitors and Midwifery are already completing early help assessments. The key questions being asked are how many early help assessments are being completed outside of council teams, and how often they are able to act as lead practitioners.

Data:

Recording system to enable partners to record their EH assessments and outcomes. Previously started but paused due to Covid 19. This priority is further elaborated in the next topic of the EHM Portal Project.

Liquid Logic Early Help Module (EHM) Portal Project:

The EHM Project provides a portal to allow partners to refer cases to Islington, replacing the MS Forms process. The project is in delivery and is nearing completion.

Key stakeholders including Children Services Contact Team, Early Help, the Disabled Children's Team and the SEMH team have been engaged in testing processes. Once implemented, further work to engage with and give access to external partners, such as the NHS, schools, play and youth providers. The portal creates a more collaborative approach to identifying and supporting children and young people early which is likely to lead to better outcomes and to avoid concerns escalating.

The ISCP's previous annual report stated that the EHM Portal would be ready for May 2022, however, this has not occurred as yet and it's inception and impact on services and subsequent families through effective information sharing will be reported on in our next reporting cycle.

Rees Centre Research:

In last year's ISCP annual report it described the beginnings stages of the proposal from Oxford and Sussex Universities: Rees Centre carrying out research with the aim to improve ways of evaluating impact, the LB of Islington commissioned a study: Children's Data, Coproduction and Use.

Effectiveness of impact: Rees Centre Research

They were able to provide some examples of tools or tool kits for gathering the views of parents. Evidence of the voice of the family across services has been gathered. Five families were interviewed as part of a small sample size – these were families whom had given positive feedback during the Local Authority's Children Services' week of auditing practice.

To test for reliability and consistency the families were asked the same questions by a 3rd party organisation to see if they gave answers consistent to the ones, they had supplied in practice week. All families were supported by Early Help services for approximately 6 to 9 months. It was positive the families did give answers consistent to the ones they had given in practice week, which were positive and showed that services worked well during Covid.

Early Help Auditing Activity

Audit of Early Help Assessments with an outcome of No Further Action (NFA) in Bright Start and Bright Futures

Bright Futures services (Early Help) set out to scrutinise the proportion of Early Help Assessments (EHA) that result in no further action (NFA).

They sampled 10% of the cases between Q1 to Q3 2021/2022 and wanted to observe indicators of good practice that may help to avoid an intervention ending with NFA before a family plan has been concluded.

The audit focused on:

5 families that disengaged

5 families that declined the service

6 families that stepped up to social care

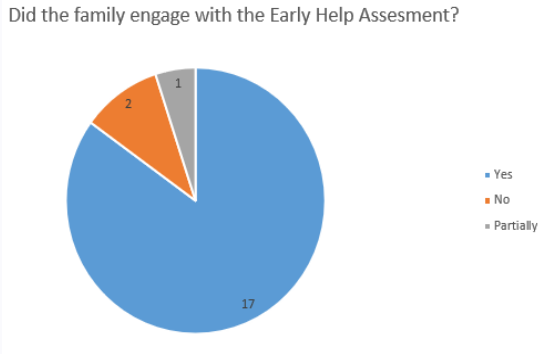
This was to examine the quality of practice and decision -making in cases where the intervention ended before a family plan was produced and concluded.

In addition, they audited 1 family that moved out of borough, 2 families that NFA'd after completing rapid response and 1 family where the outcome was 'service not available'.

Auditors were all Bright Start and Bright Futures manager (auditing cases outside their team)

Findings:

- Auditors agreed with the decision to NFA for all 20 cases
- Reasons for disengagement or declining the service included having unrealistic expectations, feeling that support was no longer required, minimal engagement with the service, and unclear reasons for disengagement in some cases.
- Auditors reported that the majority of families were engaged in the early help assessment (85%) and 63% of the children were seen in the family home as part of the EHA process.



- The majority of cases examined involved the professional network in the early help assessment, indicating effective collaboration among practitioners. Disengagement led to NFA outcomes in the 4 cases where the network was not engaged, and the auditors felt that engaging the professional network might have prevented disengagement in three of those cases. The professional network was consulted about NFA decisions in 40% of cases.

Recommendations:

- Case managers should provide support and direction to practitioners through supervision to ensure professional networks are involved in decision-making around NFA from EHA.
- Further work is needed with families who decline services or disengage after initial engagement to better understand engagement approaches, how services are promoted, and whether there is any variance in reaching different ethnicity groups.

This audit highlights the importance of having a team around the child as the auditor noticed that there was a possibility of disengagement when the professional network might not have been perceived as cohesive.

Case Review

Joint Targeted Agency Inspection (JTAI) Solihull

The Islington Safeguarding Children Partnership was tasked with compiling a report that highlighted the findings from the JTAI of Solihull and compared it to the multi-agency processes in Islington. A large proportion of the JTAI of Solihull findings relate to their MASH team and how under resourced it was, thus impacting their ability to make decisions in a timely manner. It should be noted that the JTAI of Solihull findings did not offer statistical data to emphasise the degree in which they fell short in some areas, however, they reported on what was not working well, what needed improvement and a few areas where they have observed positive practice such as multi-agency training provided to partner agencies.

The report highlighted 8 areas from the JTAI of Solihull that needed improvement. The ISCP's report concluded that a majority of the JTAI findings in Solihull would not pose the same problems in Islington, such as:

The timeliness and quality of the initial decision making in the MASH in relation to concerns received about children

All agencies' attendance at, and engagement with, child protection meetings, discussions and information-sharing forums needs improving.

However, there are some areas in Islington which needs further exploration, which formed the recommendations from the report as follows:

Recommendations:

LBI CSC to consider sample dipping their cases that are NFA or go to early help to ascertain if these cases were to go through the MASH process would there be a different outcome.

Progress: LBI CSC plan to conduct an audit (December 2022) on contacts made to CSCT to ascertain whether the outcome would change if cases went through MASH checks

Regarding Return Home Interview LBI CSC to ascertain what causes their statistics to be skewed, with specific attention to be paid to cases that are still in progress.

ICB NCL to consider how health information is disseminated for MASH purposes and whether there is any scope for primary care information (information from GP using EMIS) to be accessible to on routine health checks.

Progress:

ICB had responded to this stating that due to the complexity of the health landscape and multiple record keeping systems there is not a single health record that the MASH Health practitioner is able to access. There are local systems and processes in place to ensure that heath information is provided in a timely and effective manner.

ISCP has started to explore how the voice of the child can be obtained more throughout partner agencies.

ISCP has started implementing training for partner agencies that are aligned with their identified learning and training needs gathered by audits brought forth to the Partnership

Rapid Reviews / LCSPRs

Child U

This case initiated as a Rapid Review and involved a tragic suicide of a 17 year old. The Child Safeguarding Practice Review Panel (CSPRP) agreed with the ISCP's recommendation to progress with a LCSPR. The key line of enquiries wanted to ascertain the key junctures in Child U's lived experience of being a young carer to his mother, contextual safeguarding concerns, being subject to adultification by being taken directly to the morgue as opposed to A&E and concerns around his risky sexual behaviour and drug use.

Other factors involve the power dynamic between his step father towards his mother regarding her disability due to health reason and not being able to be the primary carer for her daughter, Child U's half sibling. Child U also faced difficulties he faced with his step father by also being physically assaulted by him on one occasion.

The findings highlighted a learning gap in how Adults Social Care and Children Social Care conducted their joint supervision and planning.

Learning and Impact:

Adult Social Care are currently in the process of devising a joint protocol to stipulate the frequency of joint supervision and planning when they have a case open to both services.

Another relevant recommendation was to ensure that ISCP incorporates appropriate training pertaining to adultification, how to support young carers and training around LGTBQ.

Whilst the LCSPR highlighted other concerns surrounding contextual safeguarding these findings were already being taken up by previous action plans relating to other LCSPRs.

Child V

This case involves the tragic death of a 11 week old girl (Mixed Parentage, white and black Caribbean and Black African Somali) whose death was consistent with accidental suffocation. The ISCP recommended that a Rapid Review was undertaken, however, the National Panel recommended we reconsider the need for a Rapid Review, as the criteria was not entirely met. The ISCP did agree that an internal management review would provide the necessary learning.

The internal management review made recommendations regarding the record keeping from health services used by mother and the development of a local multi-agency discharge planning meeting procedures. Other recommendations for the Local Authority to have clearer guidelines around information sharing between services, importance of observing sleeping arrangements as part of the assessment process and a review of the supervision order protocol.

Impact:

The ISCP business unit placed more emphasis on the importance of information sharing within their existing training programmes. Which has been received well by relevant agencies who attended.

Primary Care in Islington and Haringey created 7 minute learning sessions to mitigate risks of de-registration of vulnerable adults and children and hospital discharge of babies, children and vulnerable adults

Child V's parent were care leavers so an action involved the LBI CSC to conduct brief audit on care leavers who are parents of under 1 babies and ascertain their sleeping arrangements and understand whether parents know the dangers.

Whittington Midwifery also reviewing how their digital processes for receiving "outborn" postnatal discharges from other hospital Trusts to provide midwives with a framework to support the digital documentation of safeguarding concerns

Rapid Reviews / LCSPRs

Child W

This case involves a young person of Black Caribbean descent being a victim of serious youth violence by being stabbed to his torso and limb, this resulted in life long impairment to one of his limbs. This progressed to a rapid review and concluded with the ISCP recommending that there was no apparent threshold for proceeding to a LCSPR. The Child Safeguarding Practice Review Panel did not share the same view and believed there were compelling reason for this to progress to a LCSPR.

ISCP were able to learn from their rationale because it demonstrated a need for the ISCP to take into account issues relating to equality, diversity, and inclusion, including the possible impact of 'adultification' and transitional safeguarding arrangements given their age. The ISCP has progressed with the LCSPR which will be reflected in the next annual report.

Child Q (Hackney)

City and Hackney's local child safeguarding practice review (LCSPR) for the case of Child Q has been the subject of much disturbing details due to her treatment which causes for much needed analysis and reflection within the safeguarding community. The details of the LCSPR regards concerns being raised about a 15-year-old black female student, referred to as Child Q, who appeared to smell strongly of cannabis and may have been in possession of drugs. Despite prior searches of the child's bag and outer clothing by school staff that turned up nothing, two female police officers were called to the school and conducted a strip search of the girl in the medical room, using Section 23 of the Misuse of Drugs Act as justification. The search involved exposing Child Q's intimate body parts and was carried out on school premises without an appropriate adult present, despite the fact that the child was menstruating at the time. The search did not yield any drugs. Child Q later returned home and shared what had happened, seeking medical help due to her distress.

Learning and Impact:

This case highlighted several critical issues related to multi-agency working, communication, and decision-making in cases of child abuse and neglect. By examining the case in depth, we can gain valuable insights into the strengths and weaknesses of current safeguarding practices and this has been demonstrated by recommendations made by the LCSPR and where it applies to local changes the ISCP has formulated responses and an action plan to provide assurances:

The ISCP Business unit has incorporated learning from Child Q regarding professionals advocating for the safeguarding of children and how this is informed by legislation in the Children's Act 1989 /2004, into its Safeguarding Refresher and Practice review training The Central North Basic Command Unit also gave assurances to the ISCP from a briefing that included intensive and thorough data for stop and searches – where no strip searches (MTIP) were performed on children.

They also gave assurances to parents through schools acknowledging the regrettable incident and the learning taken from Child Q and their pledge to emphasise that Schools Officers are aware of the impact they have to ensure young people are not criminalised in circumstances they otherwise would not be if a police officer did not work in a school.

Safety School Officers began focusing on secondary schools to deliver workshops on young people's rights and reasons behind stop and search termly and 'know your rights cards' are shared with young people to understand this area further.

MPS re-focussed in delivering MTIP practical training for police officers.

Chief Inspector for Neighbourhood Policing Teams, Safer Schools already liaises with CHOICES a Stop and Search Community Monitoring Group.

Relevant agencies within the ISCP have already began to incorporate adultification training – through the ICB. The ISCP Business Unit have begun enquiries in providing this training to other relevant agencies in the ISCP.

ISCP Training Needs

ISCP Training needs:

The ISCP Business Unit currently has a vacant post for a Training and Quality Assurance manager that will be filled in the next reporting period. This vacant post has impacted the deliverance of bespoke training that would support in filling the ISCP's development needs as analysed through themes and patterns.

The ISCP Business Unit have continued to run the following core training:

Multi-Agency Foundation Safeguarding & Information Sharing

Request for training	Candidates trained	Percentage trained	Number of courses
223	162	73%	5

Multi-Agency Safeguarding Refresher Training

Request for training	Candidates trained	Percentage trained	Number of courses
283	227	80%	6

Multi Agency Designated Safeguarding Lead Training

Request for training	Candidates trained	Percentage trained	Number of courses
294	260	88%	9

Multi Agency Practice Review

Request for training	Candidates trained	Percentage trained	Number of courses
23	15	65	1

Throughout the reporting period of this annual report the ISCP training sub-group organised to use the skills from relevant agencies to deliver training for the ISCP.

The CSE Team within LBI CSC has delivered: Harmful sexual behaviour training – Child Sexual and Criminal Exploitation Training

Request for training	Candidates trained	Percentage trained	Number of courses
15	15	100%	1

The VAWG from LBI Young Islington have carried out domestic abuse and violence awareness training

Request for training	Candidates trained	Percentage trained	Number of courses
30	24	80%	2

Family Group Conference – Early Help Workshop

Request for training	Candidates trained	Percentage trained	Number of courses
31	23	74%	3

External training for the ISCP:
Reducing Parental conflict

Request for training	Candidates trained	Percentage trained	Number of courses
22	19	86%	1

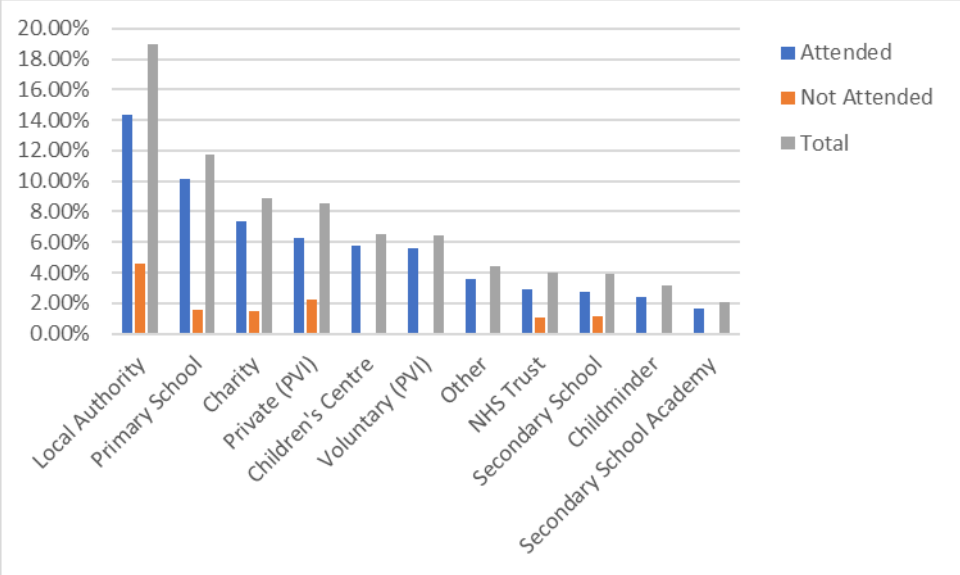
ISCP Training Needs

Workshop based on joint agency work around Camden and Islington, raising awareness around modern slavery, child exploitation and NRM, identifying themes between each agencies and is trauma informed practice. This was specific training statutory partners including Police, LBI CSC and Health partners. This gained positive feedback to better understand the NRM process especially as LBI CSC has pilot scheme

Impact

Request for training	Candidates trained	Percentage trained	Number of courses
953	766	80%	29

This demonstrates that overall we have maintained a 80% attendance rate from multi agencies attending our training. This is likely to be increased when the vacant Training Manager post has been filled



Feedback evaluation

To what extent did the training course meet YOUR learning objectives?	Excellent	366	44.1%
	Good	406	49%
	Average	57	7%

To what extent did the course meet its published objectives?	Excellent	397	48%
	Good	394	47%
	Average	38	5%

The course has helped your awareness of the subject area.	Strongly Agree	396	47.8%
	Agree	425	51.3%
	Disagree	8	1%

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ISCP Training Needs

Take into account the 6 lawful bases for information sharing before I share information, and being aware of private fostering in case it is happening to a child in my care

I have more confidence to report and keep reporting if i think something is wrong or not quite right

Take into account the 6 lawful bases for information sharing before I share information, and being aware of private fostering in case it is happening to a child in my care.

My awareness has increased in terms of thinking about the consent of children and how to keep this in mind when making decisions or sharing information; particularly where they don't have the capacity to do so themselves."

Found updates in legislation useful and legal bases for information sharing

Have more empathy and understanding for children who are criminally exploited. Be much more aware of the adultification of children being criminally exploited

Better understanding of LADO referrals and confidence in raising concerns to discuss ways forward.

As a new early years practitioner I have learnt a lot from this course and what to look out for but also how to support families before safeguarding may become a concern

My awareness increased in understanding thresholds and levels of intervention

Liaise with others in regard to e.g. nothing is to insignificant, to small and any information/ concerns will be shared with the correct agencies. I now have more confidence to make a referral.

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ISCP Membership

Chance UK, Voluntary Sector

Corporate Director Children's Services, London Borough Islington

Assistant Director of Public Health, Public Health (Camden and Islington)

Assistant Director of Safeguarding, London Borough of Islington

Business Manager, Islington Safeguarding Children Partnership

Consultant Community Paediatrician, Designated Doctor, Whittington Health NHS Trust

DCI, CN BCU Police

Designated Nurse, Safeguarding Children NHS North Central London Integrated Care Board

Detective Superintendent, CN BCU Police

Director - Housing Needs and Strategy, London Borough of Islington

Head of Pupil Services, London Borough of Islington

Director of Early Intervention and Prevention, London Borough of Islington

Director of Safeguarding, NHS North Central London Integrated Care Board

Director Young Islington, London Borough of Islington

Director, Safeguarding and Family Support, London Borough of Islington

GP, Named GP, NHS North Central London Integrated Care Board

Principal Officer Safeguarding in Education

Head of Safeguarding, Arsenal Football Club

Head of Safeguarding, Whittington Health NHS Trust

Head of Safeguarding & Mental Capacity Act, London Borough of Islington

Head of Safeguarding and Mental Health Law, Camden and Islington NHS Foundation Trust

Head of School Improvement, London Borough of Islington

Head of Service and Operations Designated Safeguarding Lead, Chance UK, Voluntary Sector Representative

Head of Service Camden & Islington LDU and Enforcement, National Probation Service

Headteacher, Newington Green School

Lay Member, Independent

Lead Member, Childrens, London Borough of Islington

Named Nurse, Whittington Health NHS Trust

Named Nurse for Child Protection and Safeguarding Children and Young People, Moorfields Eye Hospital NHS Foundation Trust

Palace for All, Voluntary Sector

Service Manager Private Law Team, CAFCASS

ISCP ANNUAL REPORT 2021-2022

Budget

INCOME	
Agency contributions	
London Borough of Islington	£132,200.00
SG Grant	£50,000.00
NCL ICB	£10,000.00
Camden & Islington NHS Trust	£7,500.00
Whittington NHS Trust	£15,000.00
Moorfields NHS Trust	£7,500.00
National Probation Trust	£2,500.00
MPS (MOPAC)	£5,000.00
Subtotal	**£229,700.00**

Expenditure	2022/23
Salaries including 0.5 Workforce Development post	£150,887.38
Independent Chair and Scrutineer (Projected)	£18,000.00
Part-time Training Administrator (approx.)	£18,000
Audits	£ 2,800.00
LCSPRs and Rapid Reviews	£ 8,337.50
TASP Membership Fee	£ 875.00
Miscellaneous Costs	£ 973.98
Subtotal	**£199,873.866**

Glossary

ASD	Autism Spectrum Disorder
ASIP	Adolescent Support intervention Project
ASV	Allegations against Staff/Volunteers
BCU	Basic Command Unit
CAMHS	Child Adolescent Mental Health Service
CCE	Child Criminal Exploitation
CYP	Children and Young People
CIN	Children in Need
CP	Child Protection
CQC	Care Quality Commission
CSC	Children Social Care
CSCT	Children Services Contact Team
CSE	Child Sexual Exploitation
DCI	Detective Chief Inspector
DIT	Dedicated Inspection Team
DSL	Designated Safeguarding Lead
FGC	Family Group Conference
FGM	Female Genital Mutilation
GP	General Practitioner
HSB	Harmful Sexual Behaviour
HMICFRS	His Majesty's Inspectorate of Constabulary and Fire & Rescue Services
ICB	Integrated Care Board
ICPC	Initial Child Protection Conference
IDVA	Independent Domestic Violence Advocate
ISAB	Islington Safeguarding Adults Board
IIOC	Indecent Images of Children
IMHARS	Islington Mental Health and Resilience in Schools
LADO	Local Authority Designated Officer
LBI	London Borough of Islington
LCSPR	Local Child Safeguarding Practice Review
MASH	Multi Agency Safeguarding Hub
MPS	Metropolitan Police Service
NCL	North Central London
NFA	No Further Action
NHS	National Health Service
NRM	National Referral Mechanism
QA	Quality Assurance
SEMH	Social Emotional Mental Health
SEND	Special Educational Needs/Disability
SSO	Safety School Officer
UASC	Unaccompanied and Separated Children
VCS	Voluntary and Community Sector
YJSMB	Youth Justice Service Management Board
YPSI	Youth Produced Sexual Imagery

Public Health

4th Floor, 222 Upper Street, N1 1XR

Report of: Director of Adult Social Services

Meeting of: Health and Wellbeing Board

Date: 31st October 2023

Ward(s): all wards

Subject: Better Care Fund (BCF) Plan.

1. Synopsis

1.1 This report seeks Health and Wellbeing Board approval of the Islington 2023-25 Better Care Fund (BCF) plan. Under the BCF, local authorities and NHS Integrated Care Boards are required to enter into annual pooled budget arrangements and agree an integrated spending plan for the BCF funding. The total Islington BCF in 2023-24 is £42.6 million, which includes an additional funding allocation of £2.8m to improve hospital discharge.

1.2 The report provides an overview of the two-year (2023-25) BCF Plan, which continues to act as a strategic enabler in the development of the Islington Borough Partnership. In effect, in Islington, the Borough Partnership is the vehicle for driving further integration, and the BCF supports that work.

1.3 The BCF plan includes proposed local targets for the national BCF metrics that measure the performance of the integrated health and care system. The targets set represent an ambitious aim to continue with the post-pandemic recovery and have been developed in partnership with social care and NHS colleagues.

1.4 In most previous years BCF plans were required for a single year, however, this year a two-year plan is required. For 2023-24 the Islington BCF Plan is largely a continuation of the expenditure plan for 2022-23 with adjustments for inflation, and new allocations to support improved hospital discharge.

2. Recommendations

2.1 This report recommends that the Islington Health and Wellbeing Board

- Notes the Islington Better Care Fund (BCF) 2022-23 performance; and the impact that the Better Care Fund continues to have in supporting further integration of health and care services in Islington.

- Agrees the Islington Better Care Fund (BCF) 2023-25 Plan; noting that the submission was already approved for submission by the Chair of the HWB to meet the national timeframes.

- Delegates to the Director of Adult Social Care the power to make further decisions in relation to the 2023-25 Islington BCF Plan and associated national reporting within the parameters set out in section 3 below.

3. Background

3.1 Framework

3.1.1 The Better Care Fund (BCF) is a national programme that aims to further develop integrated health and social care for residents. Under the BCF, NHS Integrated Care Boards (ICBs) (formerly Clinical Commissioning Groups) and local authorities are required to enter into annual pooled budget arrangements and agree an integrated spending plan to be approved by each organisation and then by the Health and Wellbeing Board. The BCF Plans will then be assured by NHS England and local government representatives.

3.1.2 Locally, the Better Care Fund represents one of several pooled budgets held between the Local Authority and the ICB. Islington is proud of it's tradition of integrated working. We want to build on this and continue to grow the partnership approach to ensuring our residents received the joined up care they want and need. This strategy is driven by the Borough Partnership, and the BCF plays an important role in supporting this work.

3.1.3 Every year, the Department for Health and Social Care publish a BCF Policy and Planning Requirements. These set out the conditions and framework under which BCF plans must be created, delivered, and include mandatory BCF plan templates and a timetable for submission. As in previous years, the BCF policy set out two overarching objectives to be delivered through BCF plans:

- enabling people to stay well, safe, and independent at home for longer.

- providing the right care, at the right place, at the right time

3.1.4 The BCF Policy also set out two key priorities that align with the overarching objectives:

- Improving overall quality of life for people, and reducing pressure on Urgent and Emergency Care, acute and social care services through investing in preventative services

- Tackling delayed discharge and bringing about sustained improvements in discharge outcomes and wider system flow

3.1.5 Unlike in previous years, all areas are required to submit a two-year, rather than one-year, BCF plans. The plans must be submitted by completing two templates. The first template is a 'Narrative Plan' setting out the overall approach to integrating health and social care in Islington which as noted above, is largely driven by the work of the Borough Partnership.

3.1.6 The second template is the 'Planning Template.' This requires an expenditure plan, setting out how the Islington BCF funding will be allocated, proposed targets for the BCF Metrics and a completed intermediate care demand and capacity analysis.

3.1.7 The Islington BCF submission has been approved by both the ICB and the Chair of the HWB in order to meet the deadline. The plan is subject to final Health and Wellbeing Board approval. This report therefore summarises the key elements of the Islington BCF plan and seeks Board approval of the plan.

3.2 Income and Expenditure

3.2.1 As above, we are submitting a plan for 2 years. This income is summarised below.

Source	2022-23	2023-24	2024-25
Disabled Facilities Grant	£1,939,775	£1,939,775	£1,939,775*
IBCF Contribution (from LBI)	£14,500,901	£14,500,901	£14,501,901
NHS Minimum Contribution (from ICB)	£22,045,222	£23,292,982	£24,611,365
Local Authority Discharge Funding	-	£2,033,004	£3,374,787
ICB Discharge Funding	-	£793,500	£1,537,960
TOTAL	£38,485,898	£42,560,162	£45,965,788

*Final DFG amounts for 2024-25 are not yet confirmed

3.2.2 As shown above, the NHS minimum contribution continues to increase each year. In addition, for 2023-24 there is the new Discharge Funding coming to the Local Authority and the ICB.

3.2.3 The BCF has mandated categories of expenditure that we use below to show how the income above is allocated.

Application	2023-24
Residential Placements	£12,847,404
Home Care or Domiciliary Care	£11,834,408
Community Based Schemes (predominantly Whittington Health services like District Nursing)	£3,859,046
Bed based intermediate Care Services (services provided at St Pancras and elsewhere)	£3,824,344
Home-based intermediate care services (Discharge to Assess, Take Home and Settle)	£2,621,394
DFG Related Schemes	£1,939,775
High Impact Change Model for Managing Transfer of Care (Hospital Social Work, D2A assessment and support)	£1,752,408
Prevention / Early Intervention (Voluntary sector services like HOYD, Stroke Association, Age UK)	£1,124,034
Assistive Technologies and Equipment (Community Equipment)	£1,064,596
Urgent Community Response (Whittington Rapid Response)	£910,000
Personalised Care at Home (joint funded care)	£401,156
Enablers for Integration (joint roles at the council and ICB)	£286,597

Carers Services (contribution to the Islington Carers pooled budget)	£95,000
Grand Total	£42,560,162

3.2.4 There is a key issue in relation to the use of the Discharge Funding. The councils and the ICB in NCL have struggled to reach an agreement on the use of the discharge funding for 23/24 and 24/25.

3.2.5 An alternative approach is being taken in accord with the principles we agreed for open book transparency between partners and the one-off allocation to social care of 50% of the ICB Discharge allocation in 2023-24 (£3.4m).

3.2.6 This has been agreed on the condition of a jointly appointed and funded independent financial expert, to review both the Discharge Fund, BCF and all relevant budgets within both social care and the ICB that the independent financial expert and CFO's feel necessary to resolve this issue, with open book financial reporting and activity reporting on both sides.

3.2.7 This independent expert's work will report jointly to a nominated council CFO –Jon Rowney, Executive Director, Corporate Services, Camden Council, and Phill Wells, ICB CFO and they will be able to make binding recommendations to inform how the 2024-25 BCF and Additional Discharge Fund are spent in an equitable way.

3.2.8 Terms of Reference, a specification and principles for the work including definitive timescales for completion will need to be jointly agreed between CFOs and the independent financial advisor before the final stages of BCF sign off including the sign offs are completed and the £3.4m one off for 23-24 is transferred to councils.

3.2.9 Given the dynamic nature of these plans, we are asking the HWB board to delegate to the Director of Adult Social Services the authority to agree the use of the Local Authority Discharge Fund for 2023-24 and to make agreements regarding the 2023-24 fund.

3.3 Metrics

3.3.1 The Better Care Fund for 2023-24 has five metrics as below.

Metric	2022-23 plan	2022-23 performance	2023-24 plan	Notes
Avoidable admissions	655	636	621	Exceeded target for 22-23
Falls	n/a	339	400	New metric for 23-24. The 2022-23 performance was exceptionally low, so we have set a cautious target, but

				showing a trend of reduction over 4 years.
Discharge to usual place of residence	91.8%	92.8%	92.6%	Exceeded target for 22-23
Residential admissions	80	88	88	We continue to see increasing complexity in care needs following the pandemic and are expecting this measure to increase in 23-24.
Reablement	79%	81%	87%	Exceeded target for 22-23

3.3.2 Note that full details of the metrics including technical specifications are available in the attached documents.

4. Implications

4.1. **Financial Implications**

4.1.1. There are no direct financial implications arising from this report.

4.1.2 The Better Care Fund, as all S75 arrangements, is overseen by the Islington S75 Partnership. This is co-chaired by the Director of Integration at the North Central London Integrated Care Board and the Director of Adult Social Services at the London Borough of Islington. Both organisations have appropriate financial representatives and oversee the spend of the budget through that body.

4.1.3 Any financial implications arising should be considered and agreed as necessary by the Council and/or the Integrated Care Board (ICB).

4.1.4 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 or the Integrated Care Board (ICB).

4.2. **Legal Implications**

4.2.1 The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund.

4.2.2 The NHS Act 2006 allows named partners (NHS bodies and local social services authorities) to contribute to a common fund (pooling resources), which can be used to commission health and social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care services. It enables joint commissioning and commissioning of integrated services.

4.2.3 The Better Care Fund is a National Programme which requires local authorities and Integrated Care Boards (ICBs), to pool budgets through a section 75 agreement.

4.3. **Environmental Implications and contribution to achieving a net zero carbon Islington by 2030**

4.3.1 There are no environmental implications from this report.

4.4. **Equalities Impact Assessment**

4.4.1 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.

4.4.2 An Equalities Impact Assessment is not required in relation to this report.

5. Conclusion and reasons for recommendations

5.1. **That the Islington Health and Wellbeing Board**

5.2. **Notes** the Islington Better Care Fund (BCF) 2022-23 performance; and the impact that the Better Care Fund continues to have in supporting further integration of health and care services in Islington.

5.3. **Agrees** the Islington Better Care Fund (BCF) 2023-25 Plan; noting that the submission was already approved for submission by the Chair of the HWB to meet the national timeframes.

5.4. **Delegates** to the Director of Adult Social Care the power to make further decisions in relation to the 2023-25 Islington BCF Plan and associated national reporting within the parameters set out above.

Appendices:

Islington BCF Planning Template 2023-25

Islington BCF Narrative Plan 2023-25

Final report clearance:

Signed by: **John Everson, Director of Adult Social Care**

Date: **11th October 2023**

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BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.

4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

7. Please ensure that all boxes on the checklist are green before submission.

8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “NHS minimum” then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Islington
Completed by:	Dan Windross
E-mail:	
Contact number:	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Kaya	Comer-Schwartz
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Ms	Sarah	Mansuralli
	Additional ICB(s) contacts if relevant	Ms	Clare	Henderson
	Local Authority Chief Executive	Ms	Linzi	Roberts-Egan
	Local Authority Director of Adult Social Services (or equivalent)	Mr	John	Everson
	Better Care Fund Lead Official	Mr	Dan	Windross
	LA Section 151 Officer	Mr	David	Hodgkinson
Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->				

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Islington

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£1,939,775	£1,939,775	£1,939,775	£1,939,775	£0
Minimum NHS Contribution	£23,292,982	£24,611,365	£23,292,982	£24,611,365	£0
iBCF	£14,500,901	£14,501,901	£14,500,901	£14,501,901	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£2,033,004	£3,374,787	£2,033,004	£3,374,787	£0
ICB Discharge Funding	£793,500	£1,537,960	£793,500	£1,537,960	£0
Total	**£42,560,162**	**£45,965,788**	**£42,560,162**	**£45,965,788**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£6,619,205	£6,993,852
Planned spend	£10,774,173	£11,419,607

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£8,169,620	£8,632,020
Planned spend	£9,210,547	£9,822,795

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	160.0	150.0	155 0	150 0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,779.0	2,051.0
	Count	339	400
	Population	20448	20448

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.4%	92.4%	92.4%	93.4%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	366	378

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	87 0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Islington

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You w ll then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources such as multi-disciplinary teams single points of access or 111. The template does not collect referrals by source and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this wi l be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people on average that can be provided with services.

At the end of each row you should enter estimates for the percentage of the service in question that is commissioned by the local authority the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the d fferent service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this w ll be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people on average that can be provided with services.

At the end of each row you should enter estimates for the percentage of the service in question that is commissioned by the local authority the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute rather than intermediate care. Where recording a virtual ward as a referral source pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	For all pathways below we do not identify specific levels of capacity based on community or hospital; our services respond to demands from both referral sources flexibly. We have either apportioned the split based on usual patterns of activity or have split the two equally. We w ll flex the 'community' and 'hospital' 'capacity' shown below to meet demand as required. For P2 beds we are planning for an average LOS of 21 days for the rehabilitation capacity but longer for the reablement beds. We share our beds across NCL (Barnet Camden Enfield Haringey and Islington) and so have access to a wider capacity of beds than is shown here but the figures below are

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Demand - Hospital Discharge

Trust Referral Source (Select as many as you need)	Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
ROYAL FREE LONDON NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	2	2	2	2	2	2	2	2	2	2	2	2
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		4	4	4	4	4	4	4	4	4	4	4	4
WHITTINGTON HEALTH NHS TRUST		4	4	4	4	4	4	4	4	4	4	4	4
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
ROYAL FREE LONDON NHS FOUNDATION TRUST	Reablement at home (pathway 1)	5	5	3	6	3	4	3	3	5	5	6	6
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		22	15	13	20	16	24	24	19	25	21	25	18
WHITTINGTON HEALTH NHS TRUST		23	16	13	20	14	26	26	19	26	21	26	18
OTHER		2	2	2	2	2	2	2	2	2	2	2	2
ROYAL FREE LONDON NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)	2	2	2	3	2	2	2	2	2	2	3	3
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		10	8	7	9	7	10	10	9	10	9	10	8
WHITTINGTON HEALTH NHS TRUST		9	6	8	9	6	9	8	7	10	10	6	9
OTHER		1	1	1	1	1	1	1	1	1	1	1	1
ROYAL FREE LONDON NHS FOUNDATION TRUST	Short term domiciliary care (pathway 1)	4	4	3	4	3	3	3	3	4	4	3	4
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		34	31	29	33	30	35	36	32	35	33	36	32
WHITTINGTON HEALTH NHS TRUST		36	33	31	35	32	37	38	34	37	35	38	34
OTHER		1	1	1	1	1	1	1	1	1	1	1	1
ROYAL FREE LONDON NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)	1	1	1	1	1	1	1	1	1	1	1	1
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		7	8	7	8	8	7	8	7	8	8	7	8
WHITTINGTON HEALTH NHS TRUST		3	4	5	6	3	4	3	4	4	4	4	3
OTHER		1	1	1	1	1	1	1	1	1	1	1	1
ROYAL FREE LONDON NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)	2	3	2	3	3	2	3	2	3	3	2	3
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		20	20	20	20	20	20	20	20	20	20	18	20
WHITTINGTON HEALTH NHS TRUST		11	11	11	11	11	11	11	11	11	11	10	11
OTHER		1	1	1	1	1	1	1	1	1	1	1	1
ROYAL FREE LONDON NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	1	2	1	1	2	1	2	2	2	3	1	2
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		5	2	1	2	2	1	2	3	2	2	3	2
WHITTINGTON HEALTH NHS TRUST		13	9	6	15	9	8	6	14	14	11	11	10
OTHER		1	1	1	1	1	1	1	1	1	1	1	1

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	209	216	209	216	216	209	216	209	216	216	195	216
Urgent Community Response	182	182	182	205	205	205	207	207	207	194	194	194
Reablement at home	20	20	20	20	20	20	20	20	20	20	20	20
Rehabilitation at home	182	182	182	205	205	205	207	207	207	194	194	194
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	1	1	1	1	1	1	1	1	1	1	1	1
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	10	10	10	10	10	10	10	10	10	10	10	10
Reablement at Home	Monthly capacity. Number of new clients.	44	45	44	45	45	44	45	44	45	45	43	45
Rehabilitation at home	Monthly capacity. Number of new clients.	20	20	20	20	20	20	20	20	20	20	20	20
Short term domiciliary care	Monthly capacity. Number of new clients.	75	76	75	76	75	76	75	76	75	76	76	76
Reablement in a bedded setting	Monthly capacity. Number of new clients.	13	14	13	14	14	13	14	13	14	14	12	14
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	34	35	34	35	35	34	35	34	35	35	31	35
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	15	15	15	15	15	15	15	15	15	15	15	15

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint
0%	100%	0%
0%	100%	0%
100%	0%	0%
15%	85%	0%
0%	0%	100%
100%	0%	0%
15%	85%	0%

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	209	216	209	216	216	209	216	209	216	216	195	216
Urgent Community Response	Monthly capacity. Number of new clients.	200	200	200	200	200	200	200	200	200	200	200	200
Reablement at Home	Monthly capacity. Number of new clients.	24	25	24	25	25	24	25	24	25	25	23	25
Rehabilitation at home	Monthly capacity. Number of new clients.	200	200	200	200	200	200	200	200	200	200	200	200
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	1	1	1	1	1	1	1	1	1	1	1	1
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint
0%	100%	0%
100%	0%	0%
100%	0%	0%
15%	85%	0%
0%	0%	0%
100%	0%	0%
0%	0%	0%

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Islington

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Islington	£1,939,775	£1,939,775
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£1,939,775**	**£1,939,775**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Islington	£2,033,004	£3,374,787

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS North Central London ICB	£793,500	£1,537,960
Total ICB Discharge Fund Contribution	£793,500	£1,537,960

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Islington	£14,500,901	£14,501,901
Total iBCF Contribution	**£14,500,901**	**£14,501,901**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	**£0**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS North Central London ICB	£23,292,982	£24,611,365
Total NHS Minimum Contribution	**£23,292,982**	**£24,611,365**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	No

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£23,292,982**	**£24,611,365**	

	2023-24	2024-25
Total BCF Pooled Budget	**£42,560,162**	**£45,965,788**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Islington

<< Link to summary sheet

	2023-24			2024-25		
Running Balances	Income	Expenditure	Balance	Income	Expenditure	Balance
DFG	£1,939,775	£1,939,775	£0	£1,939,775	£1,939,775	£0
Minimum NHS Contribution	£23,292,982	£23,292,982	£0	£24,611,365	£24,611,365	£0
iBCF	£14,500,901	£14,500,901	£0	£14,501,901	£14,501,901	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£2,033,004	£2,033,004	£0	£3,374,787	£3,374,787	£0
ICB Discharge Funding	£793,500	£793,500		£1,537,960	£1,537,960	£0
Total	**£42,560,162**	**£42,560,162**	**£0**	**£45,965,788**	**£45,965,788**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24			2024-25		
	Minimum Required Spend	Planned Spend	Under Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£6,619,205	£10,774,173	£0	£6,993,852	£11,419,607	£0
Adult Social Care services spend from the minimum ICB allocations	£8,169,620	£9,210,547	£0	£8,632,020	£9,822,795	£0

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
1	Protection of Adult Social Services	Residential Placements	Residential Placements	Care home		129	138	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution
2	Protection of Adult Social Services	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		207822	196059	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution
3	Protection of Adult Social Services	Support for complex care	Residential Placements	Learning disability		11	10	Number of beds/Placements	Continuing Care		LA			<Please Select>	Minimum NHS Contribution
4	Protection of Adult Social Services	Welfare Rights	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution
5	Reablement	Intermediate Care	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		480	480	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution
6	Voluntary Enablement Service	Intermediate Care Services	Prevention / Early Intervention	Other	Community based support				Social Care		LA			Local Authority	Minimum NHS Contribution
7	Mental Recovery Pathway	Intermediate Care Services	Prevention / Early Intervention	Other	Community based enablement				Social Care		LA			Local Authority	Minimum NHS Contribution
8	Discharge to Assess	Social work support for hospitals	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution
9	Public Health support	Community Based Schemes	Prevention / Early Intervention	Other	Adult Social Care prevention				Community Health		LA			Local Authority	Minimum NHS Contribution
10	Disabled Facilities Grant	Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG grants		147	147	Number of adaptations funded/people	Community Health		LA			Local Authority	DFG
11	Community Rehab	St Pancras (CNWL)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step		500	500	Number of Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12	Community Rehab	D2A and IDT (Whittington)	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		5850	6000	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
13	Community LTC (Whittington)	Community LTC (Whittington)	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
14	District Nurse Services (Whittington)	District Nurse Services (Whittington)	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
15	Rapid Response (Whittington)	Rapid Response (Whittington)	Urgent Community Response						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
16	Discharge to Assess	Discharge to Assess	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		NHS			NHS Community Provider	Minimum NHS Contribution
17	Discharge to Assess	Discharge to Assess	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	iBCF
18	Discharge to Assess	Discharge to Assess	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	iBCF
19	Integrated Networks	Primary Care input to INC	Community Based Schemes	Integrated neighbourhood services					Primary Care		NHS			NHS	Minimum NHS Contribution

20	Integrated Networks	Social work support for Integrated Networks	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	iBCF
21	Locality Navigators	VCS input for INC and social prescribing	Prevention / Early Intervention	Social Prescribing					Other	Voluntary Sector	NHS			Charity / Voluntary Sector	Minimum NHS Contribution
22	Carers Support and Education	Bereavement support	Prevention / Early Intervention	Social Prescribing					Other	Voluntary Sector	NHS			Charity / Voluntary Sector	Minimum NHS Contribution
23	Carers Support and Education	Contribution to Carers Pool	Carers Services	Carer advice and support related to Care Act duties		200	200	Beneficiaries	Other	Voluntary Sector	LA			Charity / Voluntary Sector	Minimum NHS Contribution
24	Stroke Services	VCS input for stroke recovery and support	Prevention / Early Intervention	Social Prescribing					Other	Voluntary Sector	NHS			Charity / Voluntary Sector	Minimum NHS Contribution
25	Help on your Doorstep	VCS input for prevention	Prevention / Early Intervention	Social Prescribing					Other	Voluntary Sector	NHS			Charity / Voluntary Sector	Minimum NHS Contribution
26	Physical Disabilities	Support for complex care	Personalised Care at Home	Physical health/wellbeing					Continuing Care		NHS			Local Authority	Minimum NHS Contribution
27	CHC Social Work	CHC Social Work	Enablers for Integration	Integrated models of provision					Community Health		LA			NHS Community Provider	iBCF
28	Programme Management	Joint Commissioning Staff	Enablers for Integration	Programme management					Community Health		LA			NHS	Minimum NHS Contribution
29	Integrated Community Equipment	ICB	Assistive Technologies and Equipment	Community based equipment		974	974	Number of beneficiaries	Community Health		LA			Private Sector	Minimum NHS Contribution
30	Integrated Community Equipment	Whittington	Assistive Technologies and Equipment	Community based equipment		974	974	Number of beneficiaries	Community Health		LA			Private Sector	Minimum NHS Contribution
31	St Annes	St Annes	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		29	29	Number of Placements	Other	Private sector	LA			Private Sector	Minimum NHS Contribution
32	Mildmay	Mildmay	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		34	34	Number of Placements	Other	Private sector	LA			Private Sector	Minimum NHS Contribution
33	IC (Discharge) Whittington Staff* - LA	IC (Discharge) Whittington Staff* - LA	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
34	IC (Discharge) LBI Staff - LA	IC (Discharge) LBI Staff - LA	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Minimum NHS Contribution
35	St Annes - LA	St Annes - LA	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services	Bed-based intermediate care with reablement (to support discharge)		53	53	Number of Placements	Other	Private sector	LA			Private Sector	Minimum NHS Contribution
36	Mildmay - LA	Mildmay - LA	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services	Bed-based intermediate care with reablement (to support discharge)		34	34	Number of Placements	Other	Private sector	LA			Private Sector	Minimum NHS Contribution
37	IC (Discharge) Commissioning & Brokerage Support	IC (Discharge) Commissioning & Brokerage Support - ICB	Enablers for Integration	Programme management					Social Care		NHS			NHS	Minimum NHS Contribution
38	IC (Discharge) Whittington Staff* - ICB	IC (Discharge) Whittington Staff* - ICB	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution

39	IC (Discharge) LBI Staff - ICB	IC (Discharge) LBI Staff - ICB	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Social Care		NHS			Local Authority	Minimum NHS Contribution
40	First Point of Contact Budget	Point of Contact Budget	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Minimum NHS Contribution
41	Short term domiciliary care (P1)	Take home and settle service	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		470	470	Packages	Social Care		LA			Private Sector	Local Authority Discharge Funding
42	Short-term residential/nursing care for someone	Demographic pressures in Residential placements due to discharges	Residential Placements	Care home		116	197	Number of beds/Placements	Social Care		LA			Private Sector	Local Authority Discharge
43	Short term domiciliary care (P1)	Demographice pressures in Home Care or Domiciliary Care due to discharges	Home Care or Domiciliary Care	Domiciliary care packages		54169	90751	Hours of care	Social Care		LA			Private Sector	Local Authority Discharge
44	Funding for social care	Residential Placements	Residential Placements	Care home		273	257	Number of beds/Placements	Social Care		LA			Private Sector	iBCF
45	Funding for social care	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		346736	327109	Hours of care	Social Care		LA			Private Sector	iBCF
46	D2A Plan (P1)	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		7363	7780	Hours of care	Community Health		NHS			Private Sector	ICB Discharge Funding
47	D2A Plan (P3)	Residential Placements	Residential Placements	Short-term residential/nursing care for someone likely to require a longer-term care home replacement					Community Health		NHS			Private Sector	ICB Discharge Funding
48	Short term domiciliary care (P1)	Supporting the continuing high level of expenditure beyond BCF and base budgets on care to enable effective discharge from hospital including enabling discharges at weekends	Home Care or Domicillary Care						Social Care		LA			Private Sector	ICB Discharge Funding
49	Residential and nursing care (P3)	Supporting the continuing high level of expenditure beyond BCF and base budgets on care to enable effective discharge from hospital including enabling discharges at weekends	Residential Placements	Care home		25	0	Number of beds/Placements	Social Care		LA			Private Sector	ICB Discharge Funding
50	WorkForce to Support Discharges	Social Work Staff to support discharges.	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Private Sector	ICB Discharge Funding
51	Discharge Funding 2024-25 (TBC)	TO BE DETERMINED. NCL ICB and LA's plan to agree the final application of the Discharge Fund during 2023-24. All information in this line is placeholder only.	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Other	TBC	<Please Select>			<Please Select>	ICB Discharge Funding

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'

5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.

14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Islington

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	186.4	153.7	167.8	113.0	Islington already delivers a comparatively low rate of avoidable admissions (ranked 53/152 nationally). However, we believe that there are further opportunities from continuing to grow our Rapid Response services and improving our Integrated Front Door offer, so have set an improvement target for 2023-24. We have adjusted our plans to reflect our local analysis of the acutals in 2023-24, but delivered an overall reduction with different phasing. Our Q4 22-23 plan has been adjusted to reflect our internal projected delivery for this number to more closely reflect the actual.	Key services here are our Rapid Response services and Integrated Front Door. We work at an NCL footprint on rapid responses, delivering the UCR 2 hour target and working closely with 111 and other key referrers. The Integrated Front Door has access to this support, and is overseen by the Borough Partnership as a key driver of the plan.
	Number of Admissions	291	240	262	-		
	Population	242,467	242,467	242,467	242,467		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	160	150	155	150		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,619.5	1,779.0	2,051.0	We expect to maintain the average downward trend in Islington for this indicator over the last four years, and have set our ambition accordingly. 2022-23 saw a particularly low level of falls, and we expect this to revert to the longer term trend in 2023-24 but to continue the overall improvement trajectory. The average count for the three years 2019-20, 2020-21 and 2021-22 was 435 so we expect to show an improvement over this threee year average in 2023-24.	Our key intervention to keep people at home following a crisis is our Rapid Response service and Integrated Front Door, as described above. We are implementing falls specific interventions in NCL as set out in our narrative plan, alongside further work to increase referrals from care homes and 111 services to our UCR offer.
	Count	500	339	400		
	Population	20,448	20448	20448		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	92.2%	92.0%	92.6%	92.0%	Islington over delivered on this metric in 2022-23, planning to support 91.7% of people to be discharged home and delivering 92.2%. However, we are still below the national average of 92.6% and are looking for further improvement in 2023-24.	We will work closely with our D2A services, our integrated P2 offer and our growing virtual ward to support this ambition. In 2022-23, NCL worked as a system to review our overall discharge pathway alongside all five local authorities, and the work from this review will inform our redesigned discharge pathways in 2023-24.
	Numerator	3,191	3,195	3,189	3,596		
	Denominator	3,461	3,473	3,445	3,908		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
(SUS data - available on the Better Care Exchange)	Quarter (%)	92.4%	92.4%	92.4%	93.4%		
	Numerator	3,325	3,325	3,325	3,550		
	Denominator	3,600	3,600	3,600	3,800		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	366.2	350.8	385.9	378.5	In Islington we aim to remain stable with this indicator and not increase the number of admissions compared to the previous year. The final figures for 2022/23 won't be available till after the SALT submission. Early evidence shows that the number of new admissions has seen a slight increase compared to last year. Local anecdotal evidence suggests a higher level of complexity of people being discharged from hospital currently. We aimed to stay at 88 admissions for 65+ in the next financial year.	In 2022/23 we aimed to avoid any nurther increases in admissions through learning taken from the pandemic period and more joined up commissioning and collaborative working across Health and Social Care. The Home First model, strength based working and the development of an integrated Urgent Response model across Community Health and the Social Care discharge and hospital avoidance pathways will support services to enable residents to remain in their own homes for longer and with a better quality of life. For 2023/24 we are aiming to see no futher increases in admission taking the learning mentioned above.
	Numerator	80	80	88	88		
	Denominator	21,844	22,806	22,806	23,251		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan

NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1?*Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective?*Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise?*Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan
Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services?*Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement?*Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective?*Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans?*Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise?*Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan

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BCF Narrative Template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Islington Health and Wellbeing Board

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils), and how have you engaged these stakeholders?

The Islington Borough Partnership Board is the group that drives integration in Islington. We have used the plans of the Borough Partnership to inform this document.

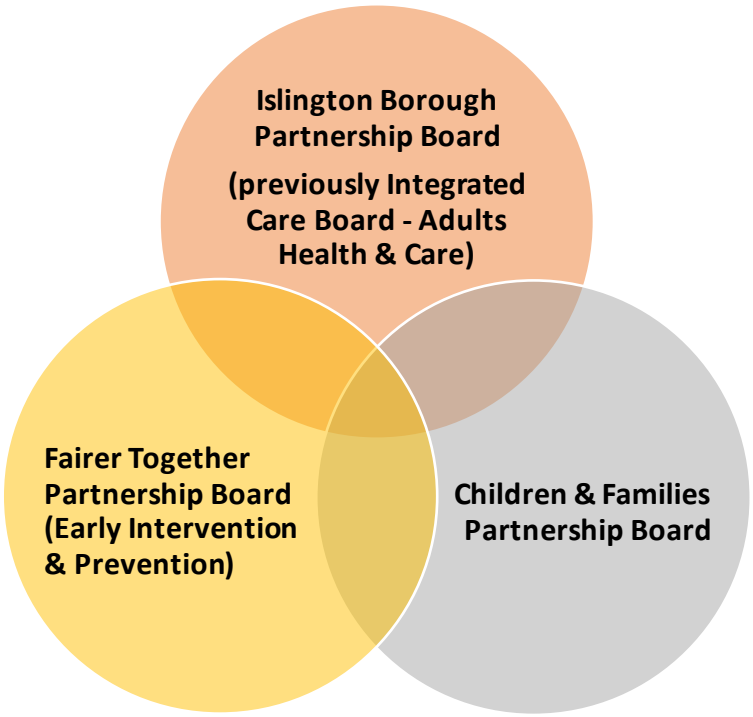
The members of the Borough Partnership include North Central London ICB, the London Borough of Islington (including Housing and Social Care), UCLH NHS Trust, Whittington Health NHS Trust, Camden and Islington NHS Trust, the Islington GP Federation, Voluntary Action Islington, Age UK and Islington Healthwatch.

The Borough Partnership have agreed a broad range of high-level priorities and outcomes to deliver real impact for residents. These have been developed through collaboration and co-production with our resident voice, resulting in a consistent set of "I Statements" that we use to describe our aspirations, and a set of "Problem Statements" that we use to focus our attention in delivering improvement. We use multiple methods and organisations to continue to prioritise our residents as stakeholders.

As a Borough Partnership, we have established a Joint Shared Vision and a Partnership Agreement which underpin our ways of working together.

Please briefly outline the governance for the BCF plan and its implementation in your area.

As above, our key governance structure is the Borough Partnership. It is this group that is driving service integration, is setting priorities and improving services for our residents. This group meets monthly and is co-chaired by the Islington DASS and the Director for Integration at the ICB.

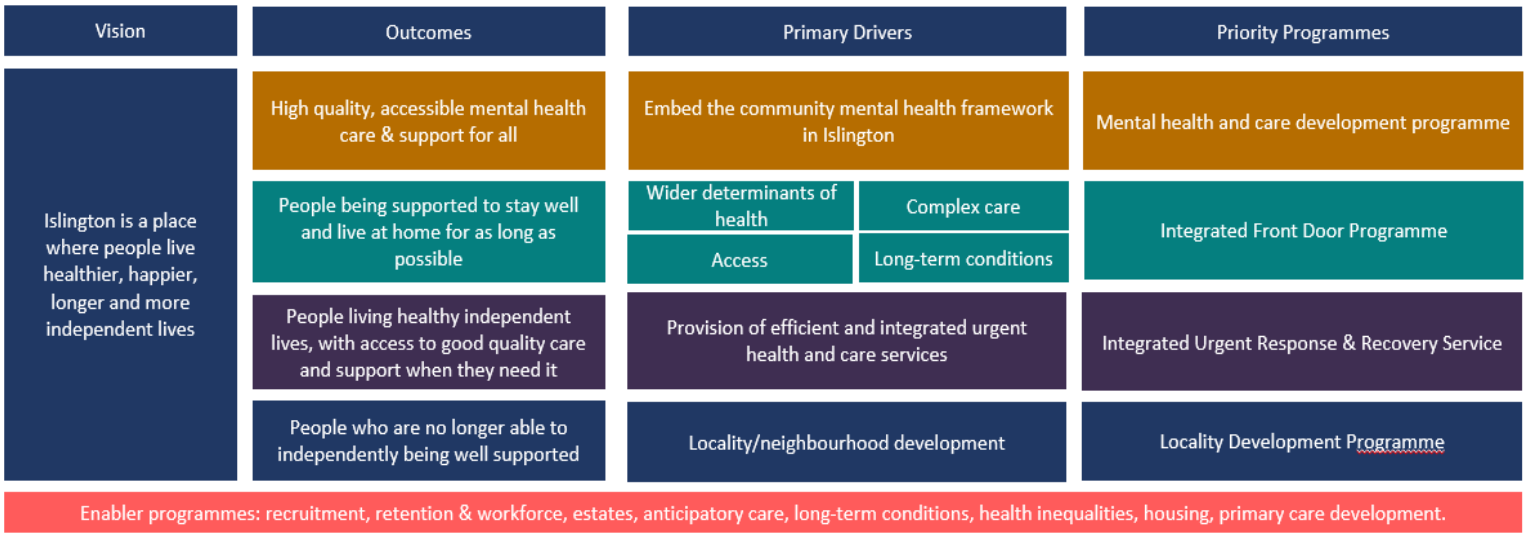


The board works collaboratively with the emerging partnership boards focusing on early intervention and prevention and children and young people to ensure join up on key shared priorities relating to health and care. Separately to the Board, we also have a Section 75 group (detailed below) which monitors delivery, progress against targets and addressing operational delivery issues as required.

However, each area has their own strategic programme plans to support delivery of broader agreed outcomes.

There will be overlap between programmes, where integrated working across partners and consistent communications will be delivering even greater impact (e.g. locality working).

Executive Summary: Priorities for 23-25



Our Four Priority Programmes are set out above. These Priority Programmes have been identified collectively by the Borough Partnership, informed by all our organisations and a borough wide engagement programme. This was informed by our Islington 'I Statements' that describe resident needs and expectations of health and care, and clarified the agreed 'Problems we are trying to solve' list.

The I-statements underpin the ambitions and priorities of the Islington Borough Partnership and are central in shaping our approach to Islington borough partnership programmes and ensuring the resident voice is central to the work we do. We have set these out in more detail below to describe our person centred approach.

This process formed a clear set of problem statements

Problem…	This means…
We work in places but aren't always collaborating with each other	People end up getting passed from service to service
Locality working happens in some but not all parts of the system	People have an inconsistent user experience across the borough partnership
We aren't necessarily building and strengthening networks in localities	People feel disconnected from their communities
We aren't always present and visible in our communities	People are unaware or don't feel connected to local services
Demand across the system is increasing	People find it hard to access services when needed

The problem statements were a significant aspect of driving our four priority areas which are set out in more detail below

Mental Health and Care (BCF schemes 7, 19, 20, 28, in tab 6a of the Planning Template)

A focused operational group across the council, ICB and C&I has been developed to support the mental health programme, including:

- Focusing embedding the community mental health framework – including employment support offers, crisis prevention pathway and SMI health checks.
- Delivery of the community mental health transformation – via expansion of the core teams.
- Delivery of the community mental health service review core offer.

Integrated Front Door (BCF schemes 4, 8, 16, 17, 18, 40, 48 in tab 6a of the Planning Template) / (HICM Change 1, 3)

- A single place to jointly screen and triage urgent health and all social care referrals.
- Introduction of a single referral form, which will combine the current 6 individual health and care referral forms and screening processes.
- This streamlined approach will improve processes and ensure efficiencies within the system, enabling better outcomes for residents.
- The programme's future ambition includes integration with mental health & housing within the Front Door.

Integrated Urgent Response and Recovery Service (BCF schemes 5, 6, 11, 12, 15, 51 in tab 6a of the Planning Template) / (HICM 3, 4, 5, 6, 8)

- Effectively aligning urgent health services and social care professionals to prevent hospital admission and support hospital discharge.
- Refreshed processes, pooled resources which will enable joint risk management and response.

Locality Development (BCF schemes 13, 14, 19, 20, 21, 22, 23, 24, 25, 29, 30 in tab 6a of the Planning Template) / (HICM 3, 9)

Islington already delivers many of the locality functions outlined in the recent Fuller report: MDT working, services operating on locality footprints etc.

- A true locality approach needs to be cohesive and integrated, providing systematic case finding, care and review – all done with appropriate leadership, infrastructure and support.
- We can use our existing structures and examples of good-practice to further Islington locality development and define our approach.
- The front door programme, includes exploring the option of creating 3 integrated locality hubs for health and social care professionals to support those with longer term more complex needs.

National Condition 1: Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- **Joint priorities for 2023-25**
- **Approaches to joint/collaborative commissioning**
- **How BCF funded services are supporting your approach to continued integration of health and social care.**

Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Our joint priorities are set out above in the previous section. These are

- *Mental Health and Care (BCF schemes 7, 19, 20, 28, in tab 6a of the Planning Template)*
- *Integrated Front Door (BCF schemes 4, 8, 16, 17, 18, 40, 48 in tab 6a of the Planning Template) / (HICM Change 1, 3)*
- *Integrated Urgent Response and Recovery Service (BCF schemes 5, 6, 11, 12, 15, 51 in tab 6a of the Planning Template) / (HICM 3, 4, 5, 6, 8)*
- *Locality Development (BCF schemes 13, 14, 19, 20, 21, 22, 23, 24, 25, 29, 30 in tab 6a of the Planning Template) / (HICM 3, 9)*

As set out in the executive summary, we coproduced a set of Islington “I Statements” with Islington residents / patients who told us what is important to them.

These underpin our priorities, but importantly, are central in our person centred approach and ensure the voice of the resident is central to the work we do. The “I Statements” are;

Islington has a long tradition of joint and collaborative commissioning. This is supported by pooled budgets but also by strong partnership approaches. LBI and NCL ICB currently have 6 pooled budgets with a total shared spend of over £90m p/a. The partners work closely together, with overall responsibility for the embedding integrated, person centred health and social care held by the Borough Partnership. This group is co-chaired by the Islington DASS and the ICB Director for Integration, and is supported by the Section 75 group as above.

Both partners are continually and collaboratively reviewing their approaches to joint working; LBI has recently completed a restructure of its functions to better align to the Borough Partnership and local priorities, and the ICB is restructuring in Sep-23 in response to national changes and to further support our partnership working. This has resulted in an NCL vision for a consistent aligned model (between the ICB and Local Authorities) that will further strengthen our partnership arrangements and ensure we are in the best possible position to deliver for our residents. A shared workplan across the LA and NCL teams will ensure that collaborative, joint working is strengthened.

National Condition 2: Use this section to describe how your area will meet BCF objective 1: Enabling people to stay well, safe and independent at home for longer.

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- **steps to personalise care and deliver asset-based approaches**
- **implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches**
- **multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake**
- **how work to support unpaid carers and deliver housing adaptations will support this objective.**

Our approach in this area is focussed on prevention; either preventing hospital admissions or preventing long term care needs following a hospital admission.

Proactive care and co-ordination

The BCF funds key services in this space. This includes

- PAWS; the Proactive Ageing Well Service *(BCF scheme 13)*. This multi-organisational service, working across primary, secondary, community, voluntary sector organisations works on a population health, preventative approach aimed at identifying unmet need and preventing further deterioration of moderately frail adults. Working from our population health tools (specifically Healtheintent and use of the EFI scores) the team identifies moderately frail adults and provides a wide range of preventative health and care interventions informed by a Comprehensive Geriatric Assessment. This could include support from social prescribers, medicines optimisation, ophthalmology referrals, mobility support and transport referrals, etc.
    - Development in 2023-24 include; optimising the screening processes to ensure we do this as efficiently and effectively as possible, further integration with existing frailty services across the borough with a focus on the locality model
- Integrated Networks (*BCF schemes 20, 21 and 22)*. These MDT's cover Islington, supporting around 1,200 people a year with complex, cross-organisational needs. The teams take referrals from across our system, including voluntary sector services, and co-ordinate personalised care around the individual. This helps join up our

services at the resident level, and enables our professionals (across primary, social care, community, acute, mental health and the voluntary sector) to work together on a locality footprint to co-ordinate support for our most complex cohort.
    - Developments in 2023-24 include integration with the Islington locality model, exploring efficiencies with the primary care intervention, building on the review completed in 2022 to ensure consistent take up of the services across all populations
- Carers services (detailed below in the carers section) (*BCF schemes 22 and 23)*
- District Nursing services *(BCF scheme 14)*. These teams provide ongoing health interventions in people's homes to help keep people well, at home and safe, preventing need for more intensive interventions and providing care closer to home. This could include temporary support for things like wound management or medication management, or supporting residents with long term conditions like diabetes. The services has a significant self care component ensuring that residents are supported to look after their own health care needs where possible. We have restructured our DN services to deliver the ambitions in the Fuller Report and provide care on a PCN level.
    - Developments in 2023-24 include closer integration with the Islington Single Front door model to bring DN services closer to social care models of delivery, and continuing to embed the approach with the redesigned Locality Model.
- Vital support for our social care provision. *(BCF schemes 1, 2, 3, 44, 45)*, This includes care at home (dom care) and residential and nursing care, helping residents to remain living in the community with as much independence as possible
- Support for community equipment *(BCF schemes 29 and 30)*, helping people to remain living at home independently with appropriate support

Responding to urgent need

The BCF funds several key services that can support people with urgent care needs in the community. This include

- Rapid Response teams *(BCF scheme 15)*; delivering the national 2 hour mandate to support people at home with urgent health and care needs. We are joining these services up to form an integrated front door as set out above. We have seen a substantial increase in activity in our rapid response services (over 40% increase in 2022-23). Our capacity and demand section (tab 4 on the Planning template) sets

out a small gap between demand and capacity. This is due to inappropriate referrals but also occasional short term capacity issues. We are working across NCL to address this through reviewing our service against the NCL Core Offer to identify specific gaps. The service in Islington is part of a broader model that works across Haringey and several other key services in the borough, and part of our approach to a co-ordinated rapid response offer is to ensure that we are able to flex our capacity across key services like Reablement to ensure a more responsive offer.

- Reablement *(BCF schemes 5 and 6)*; supporting people in the community to remain at home and become increasingly independent. This supports preventing admission as well as responding to hospital discharge needs. This team has been newly restructured, with increased capacity and ability to respond quickly to referrals using a new 'Take home and settle' approach that supports Discharge to Assess approaches
    - For 2023-24, our priorities include the Islington Integrated Urgent Response and Recovery Service set out above.

D2A (BCF schemes 8, 16, 17, 18, 46, 47, 48) and Care after Hospital (schemes 11, 12, 31 and 32) / (HICM 1, 3, 4, 5, 6, 7, 8)

- Our D2A and Reablement offer are being further integrated in Islington. We are joining up key services like virtual wards, our P2 offer and care at home to provide a broad range of support following hospital admission.
- The BCF supports our therapy teams in Islington, including our neuro and stroke rehabilitation services, helping people to continue their recovery
- During 2022-23, we jointly reviewed our discharge processes and pathways across NCL, working alongside all 5 Local Authorities and the ICB in a jointly commissioned piece of work. This has led to several recommendations regarding our discharge processes and ways of working that we will be implementing through 2023-25. For example, we are exploring the footprints of our transfer of care hubs, our ways of working across our system, our borough based P1 offer and reviewing our NCL approach to P2.
- We have established a comprehensive approach to people with housing and homeless needs in hospital. We have a pan-NCL offer providing dedicated housing support to our Transfer of Care Hubs, dedicated homeless P2 offers, and joined up approaches with our housing colleagues. We are continuing this work into 2023-25

In terms of developing our locality offer, the Borough Partnership has agreed the following strategic and operational framework which inform how we will grow and develop our locality functions

Locality Functions	
Strategic	**Operational**
Population health improvement – analytically reviewing local data to understand population needs and areas of unwarranted variation and health inequalities *(HICM 2)*.	• Led by population health data, operationally delivering service transformation and test and learn pilots to meet population health needs across the population health triangle - from early intervention through to complex care for cohorts of patients. • Using data to case find those at risk and to ensure systematic call and recall so that residents can be managed in a proactive way
Connecting and mobilising local communities to supplement quantitative population health data and develop an in depth understanding of population needs.	• Delivery of meaningful engagement and co-production with residents to support locality priorities and programmes. • Working with communities and the VCSE to design responses that will work for people Holding knowledge of the locality footprint, in terms of: • Assets – eg care homes, community centres, schools, Fairer Together Hubs, Family Hubs etc. • Estates - use and capacity across partners • Service provision - statutory and voluntary
Supporting a mixed programme of local priorities, as defined by the population health data and the Islington Integrated Care Board.	• Being clear of our priorities and ensuring that our front line staff understand those

	• Facilitating multi-disciplinary team working and drawing in required expertise from partners to deliver required transformation - e.g. secondary care consultants, voluntary sector roles.
Co-working alongside system partners and PCNs to deliver locality, PCN and borough partnership priorities.	• Having the right infrastructure that can support knowledge management – similar to a business manager role
Workforce planning, including developing flexible workforce models (*HICM 5)* and OD and development support.	• Systematic approach to workforce development and OD across localities • Opportunities for staff to come together to learn and share ideas • Ensuring we hear the voice of our communities in OD – using experts by experience or the VCSE to "make it real"
Driving improvement via monitoring impact and benefits realisation of locality work and adopting quality improvement methodology. Sharing learning across localities.	• Having the infrastructure that enables leadership teams to understand impact and areas for QI • Developing distributed leadership to ensure that all front line workers are considering impact and continuous quality improvement and have a degree of autonomy to act

In terms of learning from 2022-23, we have identified several areas for development. These include

- Continuing to grow our Personal Health Budget offer post hospital (*HICM 7)*. We launched successful pilots last year, with additional funding from the ASC discharge fund, that supported innovative ways to help people leaving hospital. We are continuing this into 2023-25
- Evolving our Locality Model in Islington. This is a substantial area of focus and is set out above.

- We have seen continued growth in our rapid response services, including expansion of the virtual ward model in Islington. We have doubled the capacity available to Islington residents, and are planning to have 40-50 virtual beds in 2023.

Finally, in relation to our capacity and demand models and learning in 2022-23, we have the following findings

- At a high level, our P0/1/2/3 demand numbers remain highly accurate. We work across NCL to develop this model and have established effective, daily reporting mechanisms that we use to track our flow in these pathways. We are exploring ways of improving this following the recommendations from our recent joint review, and are testing the OPTICA system in May-23

- While our demand model has worked well, our main areas of pressure across all pathways are in terms of the complexity of patient need that we continue to see.

  This manifests across all pathways and can include

  - P1: Complex housing and homeless needs, complex mental health needs, high clinical demand including delirium. We have launched a substantial, NCL wide approach to housing and homeless needs that has become embedded into our transfer of care hubs. We have also increased our virtual ward capacity which continues to support patients to receive care at home. Finally, we have a specific hospital discharge support offer from SHP, our VCS partner, that can provide a variety of interventions to support residents leaving hospital (e.g. shopping, topping up pre-paid meters, supporting minor home adjustments, enabling keys and other access issues). We have recorded this as P0 on the planning template.
  - P2: Increasing complex rehabilitation needs, including bariatric complexity, substance misuse, patients with criminal justice needs, complex braces and nuerological needs
  - P3: As well as a restricted provider market in general, we have increasing volumes of patients requiring 1:1 care, behaviours that challenge and other high levels of care needs that challenge our market

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as

- **where number of referrals did and did not meet expectations**
- **unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)**
- **patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);**
- **approach to estimating demand, assumptions made and gaps in provision identified**
- **where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?**

how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Our approach to demand and capacity modelling for 2023-24 draws on three key sources

- Hospital discharge data; both 2022-23 and the NCL ICB Operating Plan for 2023-24. We work across the ICS to develop the agreed operating plan; this means confirming expected hospital activity with all acute providers and breaking this down into P0/1/2/3. This is informed by the activity delivered in the previous year and our ICS wide planning approaches for the coming year.
- The service activity for 2022-23 and for the coming year. Intermediate Care is a sub-set of all P0/1/3 activity and so we monitor Islington services activity. We also need to adjust the figures in the operating plan to account for hospital discharges for Islington residents from out of sector hospitals; this is a relatively small % but an important area with key non NCL hospitals for Islington residents including Homerton and the Royal London.
- Finally, we review against our ambitions for 2023-24. For Islington, key changes in our hospital discharge approach are set out above, but include continued expansion of our rapid response service, establishing our Integrated Front Door, continuing to grow our reablement and hospital discharge pathways and seeking to maintain our level of care home admissions. In terms of P2, we are also launching a single clinical model across NCL and refreshing our LOS and occupancy ambitions.

We then take our demand modelling and review against our capacity. For 2022-23 we have largely been able to deliver against expected demand, however, we have recognised the following issues in our pathways

- For P1, we continue to relaunch our Reablement service. *(HICM 3, 4, 5)* We expect to be able to further increase our activity in 2023-24 as set out in the metrics section in the planning template. We want more Islington residents to benefit from Reablement at home. We are also reviewing our housing support pathways, in particular taking learning from the Discharge Fund in 2022-23 to review how our blitz cleans work and consider how we can build further capacity in this area.
- For P2, we are reviewing some of lower intensity units and considering how we can support Islington residents currently using these services to return home instead, in line with our residents preferences to be cared for at home. Our approach to managing capacity is set out in the assumptions section of the Planning Template, but a key mitigation to respond to seasonal or other spikes in demand is our approach to using P2 capacity across NCL. This means that all NCL residents have access to all NCL beds allowing us to smooth demand and ensure a consistent occupancy rate across the sector. This has had different impacts for boroughs depending on their historical use of bed bases and where those beds are. For Islington, the main rehab unit has been in Camden and delivered by CNWL *(BCF scheme 11)* however, the pathways are well established from the Camden unit to Islington, social workers are co-located on the site and MDT processes are effective with support and oversight from the IDT. Where Islington residents are placed in other P2 units, we are developing a consistent clinical model for the P2 units which includes interfaces and discharge pathways to optimise flow from, say, Barnet units, back to Islington.
- For P3, *(HICM 8)* as an inner London borough we have limited care home capacity and are unlikely to be able to grow this further. Our local beds have been under pressure following some temporary pauses in capacity longstanding remedial works required that are now resolving so we plan to be able to support more residents to access care homes closer to family and friends. We have an NCL wide market management group, and a key ambition of the ICS is to increase the capacity in our more complex care home beds as we see increased demand against this cohort. It is important to understand our approach to the Capacity and Demand template as set out in the assumptions section of the Planning Template. Our key issue is not a mis-match of demand and capacity, but the ability to place safely and quickly. We adopt a spot purchasing approach to placing residents where our local capacity is full; this means that we will always eventually be able to find a bed but the key issue is about how quickly we can do this.

Our submitted plan does not include schemes and commissioner for the ICB DF for 24/25. We have agreed a process summarised below that will support the development of schemes – note that both schemes, commissioner and funding per borough for the ICB DF for 24/25 is subject to change. In developing our approach we have engaged with our regional Better Care Manager and whilst it means we cannot identify our 24/25 spend at this stage, we are confident that our approach is fully aligned with meeting the BCF principles and outcomes.

The process we are working to locally is: The councils and the ICB in NCL have struggled to reach an agreement on the use of the discharge funding for 23/24 and 24/25. To move this forward, an alternative approach will be taken in accord with the principle we agreed for open book transparency between partners. The ICB will agree to the allocation to social care of 50% of the ICB ADF allocation as a one off in 2023-24 (£3.4m).

This is agreed on condition that we jointly appoint and fund an independent financial expert, to review both the ADF, BCF and all budgets within both social care and the ICB that the independent financial expert and CFOs feel necessary to resolve this issue, with open book financial reporting and activity counting on both sides.

This independent expert's work will report jointly to a nominated council CFO and Phill Wells as ICB CFO and they will be able to make binding recommendations to inform how the 2024-25 BCF and ADF are spent in an equitable way.

Terms of Reference, a specification and principles for the work including definitive timescales for completion will need to be jointly agreed between CFOs and the independent financial advisor before the final stages of BCF sign-off including the s75 sign offs are completed and the £3.4m one off for 23-24 is transferred to councils.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- **unplanned admissions to hospital for chronic ambulatory care sensitive conditions**
- **emergency hospital admissions following a fall for people over the age of 65**
- **the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.**

In terms of reducing unplanned admissions for chronic ambulatory care sensitive conditions, our key intervention remains the Rapid Response service. *(BCF schemes 5, 6, 11, 12, 15, 51 in tab 6a of the Planning Template) / (HICM 3, 4, 5, 6, 8)* This service has seen more Islington residents than ever in 2022-23, and we plan for this capacity to grow further in 2023-24. Key improvements we are making to this pathway include

- Further focus on the 2 hour target, improving our current performance
- Increasing referral pathways and opportunities, including exploring Single Points of Access across NCL, better working with LAS and with 111
- Locally, joint work between Whittington Health and London Borough of Islington to better integrate our Single Front Door approach which will increase capacity, responsiveness and resilience of the offer (*HICM 4, 5).*

In terms of care homes admissions, our ambitions are set out in the Planning Template. As noted above, we intend for our admissions to remain stable in 2023-24 though note this is in the context of growing older adults population and increasing complexity in the support needs across our borough. We are finding increasing numbers of patients requiring more intensive support such as 1:1 care and this is a challenge for our market as noted above. As noted above, we plan for local provision to come back online in increasing volumes in 2023-24 as specific capacity issues at local care homes are resolved and admissions can restart. This will enable up to 50 further P3 block beds in Islington to be reopened to support our residents.

Islington's BCF funds key services across this pathway, preventative services such as our community frailty teams, services to care for adults at home such as domiciliary care and district nurses, integrated co-ordination services to support multi-disciplinary working such as our Integrated Networks, support for hospital discharge teams, P1 and P2 services to help Islington residents recover and regain independence.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: Provide the right care in the right place at the right time.

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and

social care services are being delivered to support safe and timely discharge, including:

- **ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.**
- **How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.**
- **Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.**

Our approach to a home first approach is described above in some detail. Our priority areas to support home first within the BCF are *D2A (BCF schemes 8, 16, 17, 18, 46, 47, 48) and Care after Hospital (schemes 11, 12, 31 and 32).* The priorities for 2023-24 are set out above in page 10 above.

This approach is embedded across our organisations, and we use all available checkpoints in planning discharge to ensure that we are continuing to support people to go home (*HICM4)*. We have set a further improvement in our BCF metric for supporting people to return home following a hospital admission aiming to improve Islington delivery to above the national average.

A major focus in 2022-23 has been on standardising our P2 approaches across NCL. We have had a cross-provider project, working under our Community Services Transformation Board, to ensure a single clinical and operational model, a single demand and capacity approach (*HICM 2)*, and drive the benefits of a scaled approach.

For example, we have created a single point of access to our P2 beds across NCL. By launching the ICE (Intermediate Care Escalation) hub in 2022-23 we are able to have a consistent check and challenge approach to all requests for a P2 bed. By doing this, we have been able to divert 7% of all referrals (Q4 2022-23) to home first. This enables us to address any variation in referrer behaviour or expectation, and ensure that we support people to have rehabilitation and recovery at home.

This work is underpinned by the development of the 'NCL Core Offer'. This is a standard set of expectations that we expect all community providers to deliver. A key area of focus is P1

(HICM 4); we are working to ensure that all NCL residents have a consistent P1 approach, that they can manage the same levels of complexity, provide optimal referral response times, deliver a consistent intensity of offer; all of which will support our complex acute system to make best use of P1 offers where possible.

In terms of responding rapidly to discharge pressure, and preventing delayed discharges, we have effective local services that can respond as needed. Where required, we have local and ICS wide escalation routes so that we can respond to pressures and address complex situations. This includes daily calls with our hospitals, regular, structured escalation routes and an NCL wide SILVER call to address any complex delays.

Our NCL wide Discharge Operational Group is a key opportunity to drive best practice in discharge. This supports our Islington system by bringing together a larger group of discharge professionals and enabling system conversations with organisations like UCLH and Whittington where we need to work on a larger footprint. This group has led substantial improvements in our discharge flow in 2022-23, including

- Updating and re-launching the NCL wide Choice and Facilitated Discharge policy. *(HICM 7).* These policies support our patients and system when we are working with residents to exercise choice at the point of discharge. We are holding a Choice Summit in Jun-23, and for the first time have secured a consistent approach to choice and facilitated discharge across all acute, community, mental health and social care partners. This means we can be much more consistent in our approaches to managing choice delays in NCL. Importantly, the policy sets out a clear focus for home first approaches across our ICS.
- Working on a consistent and best practice led approach to early identification. *(HICM 1)* We have shared models across our system and developed our learning on the critical need to identify patients with likely care needs after discharge as early as possible. This has included checklists, scoring systems and other tools which allow us to get as 'upstream' in the discharge process as possible and to give residents the best chance of being discharged home as we identify any issues and barriers as early in the process as we can.
- Providing assurance frameworks, like a single discharge alert model, that enables our system to have confidence in sharing information about discharges where there are opportunities to improve. This has been launched across NCL in Jun-23 and will allow greater shared learning and best practice when responding to alerts and issues that

required support post discharge. As above, we want to develop a learning community of discharge leads that enables us to work consistently for our residents.

- Closer working with our mental health system *(HICM 3)*. We are aligning and reducing duplication wherever possible; this means a single escalation framework, shared approaches to resolving complex discharges, joint working with our MH beds and acute beds, and shared approaches across our community beds. We have launched a consistent approach to visibility of our long stayers, discussing them at the same NCL Silver and FOG senior meetings to support parity of esteem, and to demonstrate our shared commitments to home first approaches.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

Many areas of the High Impact Change model have been described above, such as our approach to early discharge planning, Home First, our approaches to Multi-Disciplinary working in the hospital discharge and community pathways, and our work on choice and engagement. Our narrative plan shows where we have specifically referenced the *HICM* and the work that we are planning to further develop our model.

The following table gives our current self assessment against the maturity model

1	Early Discharge Planning	Established/Mature
2	Monitoring and responding to system demand and capacity	Established
3	Multi-disciplinary working (MDTs)	Mature
4	Home First Discharge to Assess	Plans in place / Established
5	Flexible working patterns	Established/Mature
6	Trusted assessment	Established
7	Engagement and choice	Mature
8	Improved discharge to care homes	Established/Mature
9	Housing and related services	Mature

The following sections provide additional narrative in terms of developing the HICM where this has not been covered above, though we would emphasise that our approach to the HICM is referenced throughout the Narrative Plan.

In terms of our approaches to Monitoring Demand and System Capacity (*HICM 2)*, we have conducted a review of our approach across NCL in 2022-23, and are currently exploring tools to improve our operational and data approaches to discharge. One of our key limitations is the inconsistent approaches to the 'days delayed' data across our acute system in NCL. This has led to discussions to implement OPTICA across NCL which will meet our requirements to develop a 'single source of the truth' in terms of describing the discharge pathway where we work across multiple organisations and data systems. This is a national programme which sits on the Palantir framework, and has demonstrated impact in other areas in terms of improving joint working and supporting flow.

In terms of early identification (*HICM 1)*, we work as a system in NCL to support best practice in discharge. For Early Identification, this has meant peer reviewing and joint learning by bringing each acute trusts early identification processes to our Operational Group for in-depth review and exploration. This has led to increased consistency and delivery of best practice, for example in testing checklist based approaches, working with London Ambulance Service to identify housing issues in a more consistent way, and developing better approaches to early alerting to community and local authority services where residents are likely to need support to go home.

Finally, we have a developed Housing approach that works across NCL (*HICM 9)*. In practical terms, this has meant embedded housing officers working in each acute trust. These people support a wide range of housing needs, and are closely integrated with their local housing providers including the local authority. We also have dedicated P2 housing pathways, and wide ranging approaches to resolving housing issues, which has included increasing take-up of our personal health budget offer to support discharge. Our key local hospital IDT's have access to pre-paid cards where they can rapidly order items and services to support discharge (up to £400) and we see increasing take-up of this service.

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that <u>duties</u> under the Care Act are being delivered?

The workstreams and funding priorities identified across this report have been created to ensure that the Islington Borough Partnership can deliver our statutory duties in a safe and effective way whilst offering our residents choice and control.

The Partnership are committed to **promoting individual wellbeing** to ensure Islington residents can live healthy, fulfilling, and independent lives – connected to their community and with appropriate care and support as required.

Our approach to **preventing needs for care and support** is supported through investment in social prescribing services using the local VCS to deliver universal services and minimise the need for statutory services where possible. VCS partners also form part of our approach to **providing information and advice** which is being developed across the partnership and includes targeted support for carers services.

We have committed to invest BCF funding to **promote diversity and quality in provision of services** and ensure that the provider market for community and accommodation-based services is maintained. High quality Adult Social Care is a crucial contributor to the Council's Fairness Agenda – whether due to our work as part of Fairer Together, the Challenging Inequalities programme, or our contributions to the Community Wealth Building movement as an employer and a commissioner.

Safeguarding adults is a core function of all our organisations and this is supported through the Safeguarding Adults Board. Funding across all the streams ensures that providers and operational teams have the resources for effectively **co-operating** and deliver safeguarding duties in line with the Making Safeguarding Personal principals.

Promoting integration of care and support with health services has been supported through the BCF via joint commissioning functions across the Partnership and the ICB. This work is now being extended to include more operational functions from the shared front door for community services to the integrated rapid response teams.

Local authorities must **involve people in decisions about their care and support**, and **provide an independent advocate** where the person has substantial difficulty being involved and has no appropriate individual to support them. Commissioning integrated advocacy offers benefits including easier access to multi-skilled advocates, improved working relationships, and better communication. The duty to provide advocacy in the Care Act applies equally to those people whose needs are being jointly assessed by the NHS

together with the local authority, or where a 'joint package' of support is planned, commissioned or funded.

How the BCF supports unpaid carers, including carers breaks and implementation of Care Act duties

Islington Carer population

According to data from the 2021 Census, 15,000 residents in Islington providing unpaid care (7.2% of population), 7,400 residents self-identify as providing 20+ hours of unpaid care per week, with 3,900 residents provide 50 or more hours of unpaid care per week. The proportion and number of people providing unpaid care fell between 2011 and 2021, but unpaid carers tended to provide more hours of care in 2021. However, it is important to note, it is unlikely that the number of carers have reduced over the last 10 years, it is more likely many carers have not identified themselves as carers in the census. This is echoed in the recent publication by The Health Foundation that suggests one reason nationally only 8% of carers are currently making contact with local authority services for support, is low levels of carer identification. This suggests that few carers appreciate their status, eligibility and even the impact caring is having on them. They also cite the typical support available is not perceived by carers as attractive/impactful to them as another reason for low up take.

As of March 2023, 849 carers (aged 18+) were known to Adult Social Care directly; 3,723 carers were registered with Islington Carers Hub; and according to the GP Patient Survey in 2022, 449 patients registered with an Islington GP practice reported that they care for someone. In 2022/23, on average 744 carers accessed support from Islington Carers Hub per quarter and 11,000 carers accessed information and online support (delivered in partnership with Mobilise) over the year.

Islington already has a broad range of services and support available for carers, with a few key elements of the offer detailed below.

Adult Social Care

Residents have an entitlement to a carer's assessment if they are over 18 and provide unpaid care to someone over 18 living in Islington. The person they care for doesn't need to be getting support from social services. The assessment shows if there's extra support that can make caring easier for example respite, carers groups, benefits advice and carers emergency card.

Adult Social Care promote Direct Payments which enable carers, who have been assessed as needing care and support services, to choose and buy the care and support themselves.

Islington Carers Hub

Islington Carers Hub provides advice, information and support to all carers aged 18 or over who live or work in Islington or care for someone living in Islington. They do this either directly or through their work with other organisations. The Hub acts as a one stop shop for carers in the borough and offers up to two years support for people once their caring role has ended. Islington Carers Hub provides strategic leadership on Carers' issues across the local health, social care private and voluntary sectors.

A digital offer provided by Mobilise, enables carers to access information and connect with others for peer support online, including connecting with carers who live beyond Islington but share similar experiences, strengths, ideas and challenges. Services provided by the Hub include

- Information pack about the kinds of help for carers in Islington
- Advice and Information sessions at a range of venues
- Support groups for carers to meet and share ideas
- Programme of activities, social connection and training opportunities
- Counselling, delivered in partnership with Islington Mind
- Help with getting the Carers Emergency Card
- Flexible Breaks Fund
- A quarterly newsletter called Carers News
- Events and activities like Carers Rights Day
- Carers Assessment
- Promotion of the right to a statutory Carers Assessment and the benefits from this
- Support with benefit claims to maximise income
- Information on carers rights, including rights as employees
- Carers Providers Forum to share updates and good practice

Camden & Islington NHS Foundation Trust

- Services for Ageing and Mental Health support carers of people living with Dementia.
- Better Lives Family Service supports carers affected by someone's alcohol or drug use.

Whittington Health NHS Trust

- Training on long term conditions is provided for both patients with long term conditions and their carers.
- Dementia care plans - 'What matters to me' include support for carers

Voluntary and community sector organisations

Many voluntary and community organisations in Islington have specialist services for carers or that can support carers. For example.

- Centre 404 Parent Carer and Family Carers Group offers person-centred support to people with learning disabilities and autism, and their families.
- Islington Mind Mother to Mother carers support project offers support to mothers whose children have mental health problems.
- Islington & Camden Young Carers service, delivered by Family Action works with young carers, their families and professionals offering whole family support, advice, guidance and resources. Young Carers service and Islington Carers Hub work together to support transitions.

Carers Pooled Budget

Islington has a dedicated S75 pooled budget to provide support to unpaid carers, which is part funded by the NHS minimum contribution to the BCF. The main objectives of the pool are to ensure that there is joined up health and social care support for unpaid carers and that the needs of carers are recognised and understood by health and social care statutory agencies, the wider voluntary sector and the community at large.

The main function of the pool is to commission the Islington Carers Hub, which is the central service for supporting carers in the Borough. Islington Carers Hub (ICH) service was commissioned in April 2009 to provide a comprehensive information, advice and guidance service to all unpaid carers living in Islington or with a caring responsibility for someone with care and support needs living in the Borough. The service was recommissioned in 2022. The incumbent provider, Age UK Islington, was successful. The contract started in March 2022 and runs for a period of 3+2+2 years.

The pool is also held for the funding of carers personal budgets across all customer groups i.e. older adults, learning disability, mental health and physical disability, including access to carers breaks.

Adult Carers Strategy

An Islington Adult Carers Strategy 2023-2030 is currently in development to build on the good practice and offer for carers, driving better outcomes for carers. The strategy is being co-developed in partnership with carers and key partners across Islington, including Adult Social Care and other Council departments, Health colleagues and Voluntary and Community Sector.

There is already a Camden and Islington joint young carers strategy but this strategy includes a priority on Transitions to adulthood.

Strategic Approach to using housing support and DFG funding to support independence

The 2022/3 allocation for the Disabled Facilities Grant (DFG) for Islington Council is £1,177k. This is from the £1,940k DHSC funding allocated to Islington, with remainder going to ASC for minor adaptations. This grant is for the provision of adaptations to disabled people's homes to help them to live independently for longer. The DFG is part of the Better Care Fund (BCF).

The aim is to use home aids/adaptations and technologies to support people in their own homes to improve outcomes across health, social and housing.

Our private sector Housing team in Homes and Neighbourhoods have responsibility for administering DFGs, under the Service Director for Community Safety in the Council, in partnership with our housing and adult social care service to ensure that they support continued independence in the home. Applications come through our access service in adult social care and are processed by a dedicated team which includes occupational therapy. There is close collaboration on policy and case work between the services, including supporting discharge from hospital.

We review spend and take up annually and commit to full spend of the budget given by central government. As mentioned previously, grants below £10,000 are not means tested. This decision, using the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002, was taken after evaluating why people did not take up their offer as we found that the means test was having an adverse effect on those with small pensions or savings pot who did not pursue the DFG because of cost they would incur after means testing. DFGs are available to all in the private sector – homeowners, social housing providers and

private rented. Our housing service has its own disabled adaptation scheme for residents who would otherwise have been grant applicants.

In 2022-23, there have been 139 grants completed, assisting with greater independence for Islington residents. The majority of the grants (66%) are between £5k and £15k, with the majority (58%) for residents aged over 65. Our largest grants are around the £25-£30k range. Six of the grants were for residents aged under 18, and the remainder were for adults. In addition, we have about 130 grants currently 'live' and working towards completion. We have had some supplier issues in the last year, but there are other stages of the process such as application, planning, estimation, or resident led delays (including hospital admissions) that impact delivery. The budget can also be used for low-cost adaptations managed within social care and associated operational costs. These grants average 70% to housing association tenants and 30% to owner occupier or tenanted properties.

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- **Changes from previous BCF plan**
- **How equality impacts of the local BCF plan have been considered**
- **How these inequalities are being addressed through the BCF plan and BCF funded services**
- **Changes to local priorities related to health inequality and equality and how activities in the document will address these**
- **Any actions moving forward that can contribute to reducing these differences in outcomes**
- **How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.**

Addressing health inequalities is a key focus of the Borough Partnership and is a thread running through each of the core and enabler work programmes. This work is supported by a well developed Health Inequalities Strategy across NCL ICB. NCL ICS reaffirmed its commitment to improve equity of access and outcomes to under-served communities, particularly those living in deprived neighbourhoods in 2023/24. The ICB committed non-

BCF £5m Inequalities Fund Programme to fund solutions to address these issues and improve the health and life chances of people in the 20% most deprived neighbourhoods.

The Programme was focussed largely on addressing the 'Core20Plus5' issues within the 20% most deprived neighbourhoods: alongside other sources of funding, such as the MH Transformation Fund, the Programme includes investments in projects supporting people living with SMI, those with or at risk of LTCs, such as cancer, COPD, CVD/hypertension, and inclusion health. We have engaged with PCNs to support the 'Plus' component. This includes, for example, Learning Disability and Autism as they form part of the Core20Plus5 cohort, and we have various initiatives (not BCF funded) to support addressing health inequalities here.

Our key Population Health Management tool is HealtheIntent. This tool allows us key insights to drive our inequalities approaches; for example segmenting our population by diagnoses, deprivation, ethnicity and being able to break this down at a practice, PCN and borough level.

In terms of our BCF, we work with individual services to ensure that they have a clear plan to understand and address health inequalities. This is necessarily service specific, but is underpinned by the ICS approach to health inequalities and utilisation of consistent tools like Healtheintent. For example, our NCL wide P2 beds programme has approaches to understand utilisation of the beds at a granular level to work against expected take-up and population ratios. This approach has informed, for example, development of patient information packs and engagement with referrers to consider where we are best able to ensure appropriate access and optimal outcomes from our services. This has included development of specific offers and services across NCL to focus on groups that may have challenges in accessing effective P2 rehabilitation (BCF schemes 11, 31 and 32). Similarly, we are working with Long Term Condition services with a focus on referral and access at a Primary Care level. This has identified opportunities with different practices to ensure that our referral pathways are working as expected. We have also trialled alternative pathways for access to specialist support for long term conditions where residents may have challenges in accessing Primary Care in the first instance. For example, we have developed a homeless health service, where we work with street homeless residents to ensure they have access to support through resident appropriate pathways. Finally, we have reviewed our Integrated Networks model recently (BCF schemes 19, 20 and 21) with a focus on ensuring that our demographic take up matches population expectations; this has led to a

focus on broadening referral pathways and ensuring that our voluntary sector has a consistent and equitable approach to bringing patients for discussion at the Networks.

We look to build on local Place-based initiatives to complement and develop existing statutory and voluntary sector initiatives within Boroughs. The Borough Partnership is supporting a range of local integrated projects focused on targeting our most deprived communities. These are based on local inequalities data, fostering collaboration between partner organisations. In total, £681,166 will be allocated to Health Inequalities projects in Islington in 23/24.

	Project Name	Provider Leads	Funding allocation
Existing projects	Community Research & Support Programme	Healthwatch Islington	22/23: £93,910 23/24: £69,958
	Hand in Hand Islington: A Volunteer Peer Buddy Scheme	Camden and Islington NHS Foundation Trust	22/23: £105,505 23/24: £97,624
	Islington Homelessness Health Inclusion Programme	Islington Council & Islington GP Federation	22/23: £83,250 23/24: £107,780
	Early Prevention Programme - Black Males & Mental Health	Islington Council	22/23: £260,518 23/24: £130,000
New Projects (23/24)	Childhood Immunisation	ICB Primary Care, Islington GP Federation, Public Health VCS Partners	£81,000
	Cancer Screening	Public Health, VCS Partners	£66,000
	Leaving Care Counselling and Psychotherapy	Brandon Centre	£19,000
	Progression to Adulthood	Brandon Centre	£65,000
	Learning Disabilities and Severe Mental Illness Cafes	Islington Council, Islington GP Federation, VCS Partners	£60,000
	Mental Health Inequalities Tool Kit	Healthwatch Islington and Islington MIND	£35,000

Delivery highlights from 2022-23 include

Community Research and Support Programme:

A community engagement project, talking to residents about their experiences of cancer screening and COPD services. The aim is to help services and commissioners to better understand barriers to uptake within specific communities where uptake is lower. Healthwatch Islington together with commissioners has developed specific questions for the engagement, and a bank of materials to help inform residents of what's available. These

resources have been used by the Diverse Communities Health Voice, a partnership of 12 community organisations across Islington, to engage with communities in Islington.

- 100+ residents supported to access appropriate interventions report improved well-being and/or access
- 500+ residents report knowing more about what services to access when, and share this with 800+ indirect beneficiaries (family, neighbours, friends)

Hand in Hand Islington: A Volunteer Peer Buddy Scheme

Hand in Hand Islington is a Volunteer Peer Travel Buddy scheme that has recruited, trained and supported 19 volunteers with lived experience of mental ill-health to accompany vulnerable residents to other locations in the borough for appointments, courses, services, green spaces, social activities and events.

The service aims to improve access to Islington's health and social opportunities for residents of the borough that experience substantial levels of inequality, stigma, and isolation as well as support peer buddies by creating a step towards meaningful activity and employment, building confidence, and gaining work readiness through volunteering.

- 26 peer buddies recruited and 19 peer buddies trained
- 273 peer buddy journeys completed

Islington Homeless Health Inclusion Programme

Identifying and treating the health needs of people experiencing homelessness (PEH) in Islington using a combination of engagement, diagnostic tools, health navigation, outreach nursing, and the provision of flexible GP appointments. The service offers a mixture of hub-based healthcare support; hostel outreach and drop-in sessions via Homeless Resource Centres and community facilities.

- 91 consultations have been conducted
- 55 health record reviews and 32 holistic health checks completed
- 17 individuals have been registered with a GP
- 50 onward referrals have been made

Early Prevention Programme – Black Males and Mental Health

The young Black men and mental health programme is an innovative programme designed to improve mental health and wellbeing outcomes for young Black men, and to improve their life chances is Islington. It has 4 workstreams:

- Early Intervention: Becoming a Man (BAM) – counselling and 1-1 mentoring in three secondary schools.
- Elevate Innovation Hub – Community hub which delivers therapeutic solutions based on culturally competent practice. There is a Senior Psychologist and Lead Psychologist as well as trained Elevate Coaches who support young black men aged 16-25 at risk of poor health, serious youth violence and exclusion from school.
- The Barbers Round Chair Project: Equips Islington Barbers as community mental health ambassadors.
- A cultural competency and anti-racist practice training programme for partners including GPs, social care and schools.
- 3 Islington Schools signed up for BAM
- 200-225 pupils supported via BAM this year
- 6 Barber shops engaged in programme and 10 Barbers completed Mental Health Ambassador training.

Public Health

4th Floor, 222 Upper Street, N1 1XR

Report of: Director of Public Health

Meeting of: Health and Wellbeing Board

Date: 31st October 2023

Ward(s): all wards

Subject: Drugs & Alcohol – Partnership and Delivery

1. Synopsis

1.1. At the Health and Wellbeing Board in October 2022, Public Health summarised the current national strategic context to drugs and alcohol, how we will structure our work to meet the objectives of the National Drugs Strategy, and the partnership arrangements that will support this. The Board agreed to receive, review and provide input and guidance into the local needs analysis and the Combating Drugs Partnership's plans for taking forward the national strategy, and to receive annual updates on progress once plans are agreed. This paper provides an update on this work and on some of the challenges to delivery.

1.2. The local governance structure prescribed by the national strategy is Combating Drugs Partnerships, by which senior representatives of relevant services and teams come together in order to deliver strategic goals. Islington's Combating Drugs Partnership will have its first meeting in December 2023. The work of this strategic group will be supported by data and intelligence products (including a local needs analysis) to illustrate local need and interventions (in development) and by a small number of operational sub-groups (established) focusing on care pathways and workforce.

2. Recommendations

2.1. To note progress against the National Drugs Strategy objectives and the current areas of Public Health focus around drugs and alcohol, in particular increasing the numbers of people accessing structured treatment and improving the continuity of care between criminal justice settings and the community.

2.2. To note that the Combating Drugs Partnership will meet in December 2023.

3. Background

3.1. Alcohol and drug use remain an important cause of preventable harm in Islington. As well as health and wellbeing, it has social, housing, economic, crime and community safety impacts affecting individuals, families and communities, and is a cause and consequence of health inequalities. Understanding and reducing the health harms of drug and alcohol use is a longstanding area of focus for Public Health.

3.2. Responsibility for drug and alcohol misuse services transferred to local government as part of the NHS and public health changes under the Health and Social Care Act 2012. Services in Islington are provided through the NHS by Camden & Islington NHS Foundation Trust (in partnership with two third sector organisations – Humankind and Via, formerly known as Westminster Drug Project) – Better Lives, in primary care through general practice and community pharmacies, the community and voluntary sector, and Islington Council.

3.3. In December 2021 the Government published a 10- year, national drug strategy From Harm to Hope ("the strategy"). The strategy outlines the Government's ambition to break drug supply chains, develop a world class drug and alcohol treatment system, and to achieve a generational shift in demand for drugs.

3.4. The strategy, which responds to Professor Dame Carol Black's independent review of drugs, is regarded as the first national drugs strategy which is cross-government, setting out its vision and requirements for how public services need to work together to address shared goals. The strategy was followed by detailed guidance for implementation, including requirements for local partnership arrangements (establishment of "Combating Drugs Partnerships"), and development of local delivery and spending plans to meet national programme objectives.

4. Drug and Alcohol Services in Islington

4.1. Islington's current integrated drug and alcohol treatment service, **Better Lives** ("the service"), operates from three locations in the borough, supporting people that use drugs, as well as their families and carers. Islington also commissions Via to deliver outreach support for people sleeping rough, or at risk of sleeping rough, and to deliver Islington's Individual Placement Support programme (supporting people into employment).

4.2. Drug and alcohol use is complex, and evidence shows individuals are more likely to benefit from a multi-faceted approach to their treatment and recovery. The treatment and recovery system reflects this diversity of need and multiple treatment options are made available, delivered by multi-disciplinary teams – including but not limited to, one to one key-working, counselling, psychological therapy, group work, day programme(s), self-help and mutual aid groups[1], pharmacological treatments[2], and residential rehabilitation.

4.3. The service also provides physical health support, including blood borne virus testing and treatment, and social support including housing and debt advice, skills coaching and Education, Training and Employment (ETE) support. Better Lives Family Service supports children and adults that are affected by drug or alcohol use by a parent or other family member(s).

4.4. The **Individual Placement and Support (IPS)** programme for people with drug and alcohol treatment needs has been operating in Islington since December 2022. IPS work with individuals for up to 12 months, providing support, advice and liaison to help people identify employment or voluntary opportunities suited to them. They then help with all stages of the applying for and starting a job. The service is provided by Via and is funded by the national IPS Grant, also administered by OHID.

4.5. The Rough Sleepers Drug and Alcohol Treatment Grant (RSDATG), also a national grant, has enabled Islington to commission the **In-Roads** service from Via. In operation since 2021, the service provides psychosocial support and prescribing outreach to people sleeping rough or at risk of sleeping rough in Islington. In-roads provide one-to-one key-working, connect people to health services, provide harm-reduction support, including Naloxone[3], and make referrals to a range of other support services.

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[1] Narcotics Anonymous and Alcoholics Anonymous are examples of mutual aid groups.
[2] For example, opiate substitution therapy (OST) such as methadone.
[3] Naloxone is a life-saving medication that reverses the effects of opiate overdose. Administered by injection or nasal spray, it works within minutes to reverse the effects of an opiate overdose, pending substantive medical treatment.

4.6. Islington has this year commissioned an additional programme to provide culturally competent holistic support to men of Black African or Black Caribbean background who are in contact with the criminal justice system and who have non-opiate substance use needs. **SWIM** (Support When It Matters) will deliver its 10-week structured support programme for up to 60 Islington residents, following its Prepare, Adjust, Contribute, Thrive (PACT) model. The programme is well-established in Hackney and is also being delivered in Camden and in Barking & Dagenham.

4.7. Service-user involvement. Service-user involvement in the design and delivery of drug and alcohol services is an essential part of quality assurance. Public Health are directly supporting the re-launch of its long-standing and highly valued service user group **Islington Clients of Drug and Alcohol Services (ICDAS)**. The relaunch will increase participant numbers, build resilience and improve diversity, so the group better represents the service user population and can be a more effective critical friend to commissioners and providers. This supports our ambition to achieve recognisable co-production in our commissioned services, improving their reach and outcomes.

4.8. Links to Community Safety. Public Health are working closely with colleagues in Community Safety to support the Combating Drugs element(s) of the **Safer Islington Partnership Plan 2023-26**, including supporting the facilitation of the SIP's August workshop session on strategy development. We recognise the many shared aims and common stakeholders of our work and the opportunities to align our efforts to deliver improvements for Islington residents.

5. Grant income and delivery plans

5.1. To support local authorities with the delivery of the outcomes outlined in the strategy, every local authority in England has been awarded the Supplementary Substance Misuse Treatment and Recovery Grant (SSMTRG) – this funding is focused on treatment and recovery. The grant is awarded by and manged by the Department of Health and Social Care/Office of Health Improvement and Disparities (OHID).

5.2. Local authority areas identified as having the highest levels of need have been prioritised for early investment, including Islington. Indicative funding allocations published by OHID state that Islington will receive just over £4.9 million over three years from 2021/22.

5.3. The SSMTR grant is received in addition to funding through the Public Health Grant. Alcohol and substance misuse is the single largest area of expenditure, within the local Public Health Grant, accounting for around £7.1 million (25%) of this budget. In addition to these funding streams, separate funding is also being disseminated for policing and related activities around the objective of action on

drug supply chains and related harms (this investment is through a programme called Project Adder). Other nationally funded drug and alcohol programmes being implemented in Islington include Individual Placement and Support (IPS), which provides tailored employment support to people in recovery, and activities under the Rough Sleeping Drug and Alcohol Treatment Grant programme.

5.4. Islington's SSMTR grant income for the financial year 2023/24 is £1,399,416 (including underspend of £44,895 from 22/23). Officers were notified of the grant allocation in late February 2023. Officers subsequently liaised with key delivery partners and grant leads at the Office of Health Improvement and Disparities to agree how the grant could be spent to support the council in achieving the outcomes outlined in the national Drug Strategy.

5.5. During this planning phase, OHID notified Islington that it had been designated a "priority partnership", i.e. that the Council has been identified as an area where the greatest gains in achieving particular outcomes of the strategy have been identified. These outcomes are: "*increasing the numbers of people accessing substance misuse treatment and improving the number of people engaging with substance misuse treatment on release from prison".* Officers were encouraged by OHID Leads to develop interventions to use the SSMTRG fund to focus on achievement of those two outcomes.

5.6. To that end, Islington's agreed grant spending plan includes a large number of additional staff posts within its existing integrated treatment service (Better Lives). This will provide additional out-reach capability to reach more people in contact with other services (particularly criminal justice system and acute or secondary care) who have drug and alcohol treatment needs and will increase capacity in the service to safely and effectively manage their care. Some of these additional roles will be co-located with key delivery partners including the local probation service, in-reach to prisons and police custody suites, co-location with mental health core community teams and increasing in-reach to supported accommodation sites.

6. Progress against the National Drugs Strategy

6.1. We have invested in a number of outreach roles which will provide greater opportunity to connect people with drug and alcohol services when they present in other areas of the system, particularly police and prison custody, and in healthcare. We have added strategic capacity to the Public Health team by funding a Public Health Strategist post specifically focused on drug and alcohol needs in Islington and developing the Combating Drugs Partnership.

6.2. Given all local authority areas are working towards similar objectives around drugs and alcohol, we are identifying areas for regional collaboration. Our Combating Drugs Partnership sub-group for workforce was formed from cross-borough

discussions in NCL around career pathways and recruitment challenges, and we anticipate partnering with other North London boroughs around prison pathways.

6.3. We recently led a self-assessment exercise to evaluate the continuity of care received by drug and alcohol users leaving custody. Our service provider was very keen to engage in this work, and the process helped us connect with the right people in the prison and probation services who are able to make changes. As anticipated, the process highlighted opportunities to improve several aspects of the pathway and information-sharing between partners. We have formulated an action plan, which will be owned by the Combating Drugs Partnership CJS sub-group.

6.4. We will host the first meeting of Islington's Combatting Drugs Partnership (CDP) in early December 2024, which will focus on establishing the partnership and securing buy-in from colleagues across the system. Combatting Drugs Partnership sub-groups are established and mobilising, and to date we have three groups - Criminal Justice System and Healthcare groups, focusing initially on treatment pathways, and the pan-NCL Workforce group, looking at resources.

6.5. We are developing our data and reporting framework, starting with a comprehensive local area profile, which will outline local need and services. The national focus on combating drugs and improving treatment outcomes appears to have directed resources into improving national data sets and to certain data products being generated or updated to support local teams. For example, drug and alcohol needs prevalence data has recently been refreshed, which will enable us to better estimate needs in Islington and how we might configure services to respond.

6.6. Over the next 6-12 months we will continue work with partners to focus on increasing the numbers of people accessing structured treatment, improving treatment outcomes, and improving the continuity of care for people with drug treatment needs that are exiting criminal justice settings.

6.7. Despite uncertainties around funding allocations, we are planning for next year, based on indicative figures and our learning from this year's investment.

7. Challenges in 2022/23

7.1. Internal resourcing challenges. In March 2023, the previously shared Camden & Islington Public Health service separated into two borough-based teams. The restructure required us to recruit to several key positions within the department, necessitated a degree of restructuring in our commissioning roles, and some interim staffing arrangements. We have now successfully recruited to our

vacancies in commissioning, strategy and contract support and have a clearly defined operating model to take us through the next phase of our work.

7.2. Governance challenges to timeliness. Islington's SSMTR grant allocation for 2023/24 was £1.4m. In accordance with OHID's delivery and spend guidance ("menu of interventions"), Commissioners' local delivery plans focussed on increasing numbers accessing treatment by increasing outreach and service capacity by creating new staff roles with the existing provider (Camden & Islington NHS Trust), thus allocating £1.1m of the grant to the Trust.

7.3. The funding will be issued to the provider as a grant, as agreed by Executive Decision in July 2023.

7.4. Whilst we do not anticipate receiving confirmation of the 2023/24 grant amount until the early months of 2024, we intend to formulate draft spending plans on the basis of indicative figures in good time. 2024/25 spending plans will be a key agenda item for the first Combatting Drugs Partnership meeting, which will take place before the end of the calendar year 2023.

7.5. The amount of funding we will receive from OHID for 2024/25 remains unconfirmed. This presents a challenge to our ability to work strategically and plan effectively – particularly with external partners and prospective recipients of funding, i.e. service providers. Islington's status as an OHID 'priority partnership', i.e. area with the potential to make greater gains in the absolute numbers of people in treatment, increases the requirement.

7.6. Workforce availability is a challenge to the programme in all regions, and particularly in London, where most people live within commuting distance of a range of local authorities, NHS Trusts and other provider organisations advertising vacancies. We might reasonably anticipate a 'seller's market' in front-line and specialist roles and some reliance on agency staffing, which can affect consistency of delivery. The short-term funding timeframes may compound this by reducing opportunities for smaller service providers, for whom it can be challenging to scale up their operations for short contracts.

8. Implications

8.1. Financial Implications

8.1.1 There are no financial implications arising from this report. The measures and recommendations proposed in this report are not currently quantifiable. If recommendations are subsequently made about the use of any money or grants, this will require a full set of Financial Implications.

8.2. Legal Implications

8.2.1 The council has a duty to improve public health under the Health and Social Care Act 2012, section 12.

8.2.2 The council must take such steps as it considers appropriate for improving the health of the people in its area including providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way), as well as providing services or facilities for the prevention, diagnosis or treatment of illness (National Health Service Act 2006, section 2B, as amended by Health and Social Care Act 2012, section 12 and Regulation 2013/351 made under the National Health Service Act 2006, section 6C).

8.3. Environmental Implications and contribution to achieving a net zero carbon Islington by 2030

8.3.1 There are no environmental implications as a result of this report.

8.4. Equalities Impact Assessment

8.4.1. 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.

8.4.2 An Equalities Impact Assessment is not required in relation to this report.

9. Conclusion and reasons for recommendations

9.1 That the Health and Wellbeing Board notes the recommendations and updates from this report.

Final report clearance:

Signed by: **Charlotte Ashton, Assistant Director of Public Health**

Date: **4th October 2023.**

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