ISLINGTON

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

Report of: Executive Member for Health and Social Care

Meeting of	Date	Agenda Item	Ward(s)
Health and Social Care Scrutiny Committee	**12 July 2018**		**All**

Delete as appropriate	~~Exempt~~	Non-exempt

Report: Q4 2017/18 Performance Report

1. Synopsis

1.1. Each year the Council agrees a set of performance indicators and targets which, enables the monitoring of progress in delivering corporate priorities and working towards the goal of making Islington a fairer place to live and work.

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

1.3. This report provides an overview of progress at the end of quarter four 2017/18 (1 April 2017 to 31 March 2018) against corporate performance indicators related to Health and Social Care.

2. Recommendations

2.1. To note progress at the end of quarter four against key performance indicators falling within the remit of the Health and Social Care Scrutiny Committee.

3. Background

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

4. Implications

4.1 **Financial implications**

There are no financial implications arising as a direct result of this report.

Any plans or strategies derived or agreed in relation to this report should use existing available resources and therefore not create a budget pressure for the Council.

4.2 **Legal implications**

There are no legal implications arising from this report.

4.3 **Environment implications**

There are no significant environmental implications resulting from this report.

4.4 **Resident impact assessment**

The Council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The Council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The Council must have due regard to the need to tackle prejudice and promote understanding.

A Resident Impact Assessment has not been completed because this is a report providing information about performance at the end of quarter three 2017/18.

5. Adult Social Care

ADULT SOCIAL SERVICES									
Objective	**PI No.**	**Indicator**	**Frequency**	Q4 Actual Jan-March 18	Q4 Target Jan-March 18	Target 2017-18	On/Off target	Same period last year	Better than last year?
Support older and disabled adults to live independently	ASC1	Delayed transfers of care (delayed days) from hospital per 100,000 population aged 18+	Q	885.93	N/A	N/A	N/A	776.0	No
	ASC2	Percentage of people who have been discharged from hospital into enablement services that are at home or in a community setting 91 days after their discharge to these services	Q	96.46%	95%	95%	On	95.7%	Yes
	ASC3	Percentage of service users receiving services in the community through Direct Payments	M	32.1%	35%	35%	Off	30.9%	Yes
Support those who are no longer able to live independently	ASC4	Number of new permanent admissions to residential and nursing care	M	127	130	130	On	137	Yes
*Reduce social isolation faced by vulnerable adults **(E)***	ASC5	The percentage of working age adults known to Adult Social Care feeling that they have adequate or better social contact. **(E)**	A	74%	73%	73%	On	70.6%	Yes

Frequency (of data reporting): M = monthly; Q = quarterly; T = termly; A = annual B=Biennial

(E) = equalities target

Supporting independent living

5.1 Delayed transfers of care

Data in this report covers the first quarter of 2018 and shows improvements from the previous reporting period. Whilst the data does indicate that DTOC performance has declined compared to last year, there have been significant pressures across the system which have contributed to this, including in particular challenges in the social care provider market such as embargos on care agencies and closures of residential homes in the latter part of the year which have had an impact. In addition, whilst there is an ongoing improvement plan underway in Islington's in-house reablement service, it has had capacity issues on a number of occasions in the last 6 months and this has impacted the service's ability to support discharges with maximum capacity.

Action has been taken to stabilise the market by reviewing fees, putting intensive support into underperforming sites and in April 2018 there was an expansion in the contracted homecare providers available in the borough. A process has also been established and successfully implemented when it's been necessary to deliver reablement support via external providers

where our in-house service has been at capacity. All of this activity has contributed to supporting to ensure there will be increased capacity in the system to address issues with our DTOC figures going forward. Outlined below are some the key steps taken to ensure improvements and build on progress to date.

5.2 A key factor upon our DTOC rates has been the establishment of the D2A Pathway 3, part of our Winter 17/18 D2A pilot (see below). 20 patients were discharged via Pathway 3 throughout the pilot, which resulted in an estimated 691 bed days saved for our acute partners the Whittington and UCLH – an excellent outcome for hospitals and residents. In addition to the patients who were successfully discharged, the work to move patients awaiting a CHC assessment to a dedicated intermediate care facility (where they can be supported by a fully trained CHC Nurse Assessor) is delivering greater benefits than predicted in the Q3 scrutiny report, at an average of 35 bed days saved per patient as opposed to 28.

5.3 Our DTOC rates are also being impacted by the other pathways: the dedicated social work post supporting Pathway 2 is improving discharge times in our intermediate care settings (which in turn improves overall throughput) through innovative joint working practices with Housing. To further increase this impact additional work is underway with the SPOA to ensure screening and triage for the intermediate care facilities becomes a core part of their role.

5.4 Changes to the setup of our hospital social work team is also playing an important role, ensuring social workers are embedded in the acute and working closely with ward staff to facilitate discharges. Improving both DTOC performance and length of stay in hospital for our residents continues to be an absolute priority going forwards both at an operational and strategic level.

5.5 Discharge to home or community setting

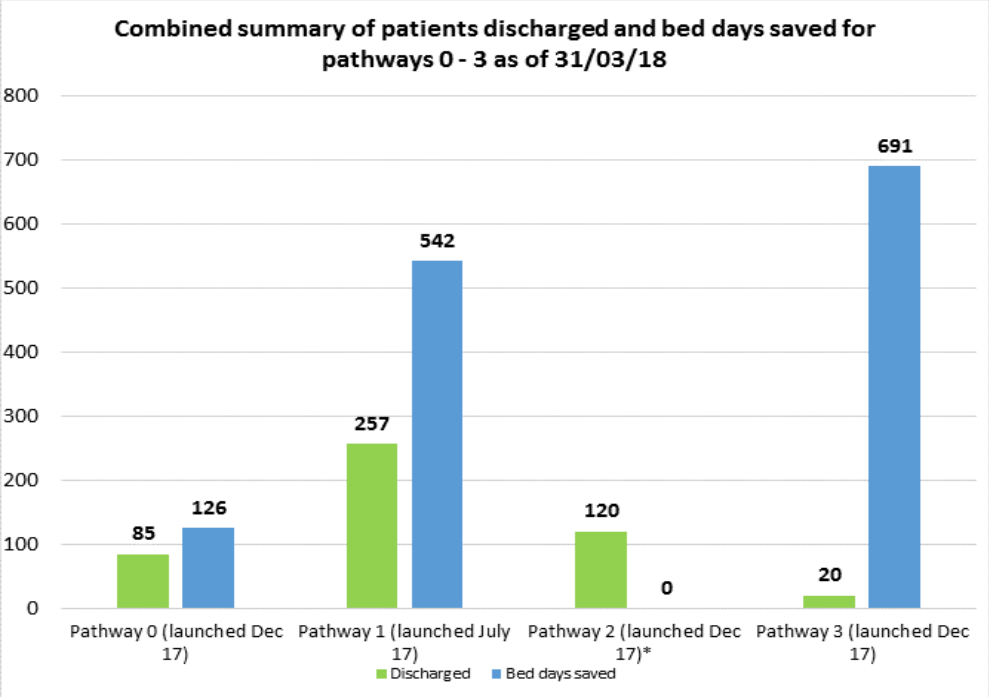
Over winter 2017-18 we successfully established a Discharge to Assess (D2A) pilot between LBI Adult Social Care and our acute health partners UCH and Whittington Hospital, as part of the Wellbeing Partnership between Islington and Haringey. The D2A service supports earlier discharge for medically optimized patients from hospital, and is based upon the 'Medway Model' discharge pathways 1-4:

- Pathway 0 – package restarts
- Pathway 1 – patients returning home with a Reablement support plan
- Pathway 2 – patients requiring ongoing rehabilitation within an intermediate care facility
- Pathway 3 – patients who have triggered the CHC checklist and have ongoing nursing care needs

This was achieved through the creation of the Single Point of Access (SPOA) service, a dedicated team of OTs and PTs who liaise closely with the hospitals and LBI Reablement service. The therapy-based model has supported ongoing improvements for service users within a community setting in regards to regaining mobility and independence, and reduced readmissions to hospitals.

5.6 This pilot continues to be the focal point of our work to support improved hospital discharge. Funding has been confirmed for the project to continue for the next 12 months and fixed term recruitment is underway for the associated posts. The impact of the pilot can be seen in the graph below: the methodology for Pathway 2 bed days is still being agreed, but across

Pathways 0, 1 and 3, LBI have made a total of 1,359 bed day savings as of 31st March 2018. Further qualitative analysis of the pilot is being undertaken at the moment through a service user survey and partner feedback.



5.7 We are continuing to drive this work forwards, both as an active member of North London Partners in Healthcare and also through the Health and Wellbeing Partnership. Areas we're working on to further improve our discharge and admission avoidance offer include:

- Revisiting the Choice Policy across NCL to ensure we have a consistent approach to residential placement, which enshrines the principle of patient choice but also supports effective, timely discharge from the acute in-patient setting.
- Working to scale up our existing single point of access to deliver greater integration with community health partners as well as with LB Haringey.
- Developing a robust admissions avoidance offer with a sustainable social care component to help keep people well in the community wherever possible.
- Continuing to support our in-house reablement service through an improvement and transformation programme to ensure it is able to meet the demand generated through hospital discharge but also to have a meaningful community facing offer.
- Expanding our Pathway 1 and 3 offers to ensure patients with long term needs who have not triggered positive on the Continuing Healthcare Checklist are able to benefit from the D2A approach.

5.8 Direct Payments

Ongoing work around increasing Direct Payments (DPs) now mean that around 30% of all Islington care and support is provided through DPs; this figure has increased by 0.9% since Q3, which represents a good increase over a short period. Feedback from the 2017 service user survey showed that DP recipients felt that they had the most "choice and control over their care and support services" and had the highest percentage of those "extremely" or "very" satisfied with their service, which ties into our corporate value of Empowering service users.

Two key pieces of work are being taken forward to support the uptake of Direct Payments in Islington: the Spark a Solution mapping project, and the Personal Assistants (PA) Pathway proposal. The former has mapped out the entire DP set-up process to identify blockages and recommend areas of improvement. Within this is the PA Pathway proposal – Personal Assistants support better outcomes for service users and cost-effective delivery of services, and the proposed pathway would improve the recruitment, training and support offer for Personal Assistants across the borough.

Admissions into residential or nursing care

5.9 The Council provides residential or nursing care for those who are no longer able to live independently. The aim is to keep this number as low as possible, supporting more people to remain in the community. We have completed this quarter with a final total of 127 individuals admitted to residential or nursing care, successfully within our target of 130.

Reducing social isolation

5.10 Social isolation refers to a lack of contact with family or friends, community involvement or access to services. The next update for this indicator will be available in July 2018. A number of initiatives in the borough are in place to reduce social isolation which were highlighted in the previous Health and Care Scrutiny Report of 14th December 2017.

5.11 Reducing social isolation will be one of the key tenets of the upcoming Front Door project, which will re-envisage how residents first engage with adult social services and how we can support prevention and resilience through signposting or direct referrals to community settings, improving our advice and support services, and embedding a strengths-based approach at the core of all interactions with residents.

5.12 As part of this work we will be seeking to better understand the borough's assets in relation to reducing social isolation for the 18-64 population, especially around what we commission (e.g. day services, befriending services, supported employment services) and the extent to which they meet resident's needs. A mapping exercise has taken place to help better understand what is currently operating and providing outcomes for social isolation in the borough (both commissioned and non-commissioned). Work will now start with the sector to show what we have and what providers can do to help assist and support in providing these outcomes.

5.13 The Social Inclusion Service provided by Royal Mencap provides free and low cost activities for residents with a Learning Disability. These include day trips, sports activities and other group activities. The service also signposts to other services and provides travel training for participants aimed at reducing their social isolation.

6. Public Health

Objective	PI No	Indicator	Frequency	Actual April - Dec	Expected profile	2017/18 annual target	On/Off target	Same period last year	Better than last year?
Promote wellbeing in early years	PH1	Proportion of new births that received a health visit within 14 days	Q	96% (Jan – Mar)[1]	90%	90%	On	94%	Better
	PH2	a) Proportion of children who have received the first dose of MMR vaccine by 2 years old	Q	84% (Oct - Dec)[2]	95%	95%	Off	91.4%	Worse
		b) Proportion of children who have received two doses of MMR vaccine by 5 years old	Q	77% (Oct - Dec)[2]	95%	95%	Off	87%	Worse
Reduce prevalence of smoking	PH3	a) Number of four week smoking quitters	Q	423 (Apr – Dec)[3]	600	800	Off	New measure	
		b) Percentage of smokers using stop smoking services who stop smoking (measured at four weeks after quit date)	Q	46% (Apr – Dec)[3]	50%	50%	Off	46%	Same
Effective detection of health risk	PH4	Percentage of eligible population (40-74) who receive an NHS Health Check	Q	15%	13.2%	13.2%	On	New measure	
Tackle mental health issues	PH5	a) Number of people entering treatment with the IAPT service (Improving Access to Psychological Therapies) for depression or anxiety	Q	5,045	3,492	4,655	On	5,091	Same
		b) Percentage of those entering IAPT treatment who recover	Q	47% (Jan – Mar)[1]	50%	50%	Off	49%	Same
Effective treatment programmes to tackle substance misuse	PH6	Percentage of drug users in drug treatment during the year, who successfully complete treatment and do not re-present within 6 months of treatment exit	Q	17% (Oct – Dec)[2]	20%	20%	Off	18%	Same
		Percentage of alcohol users who successfully complete their treatment plan	Q	40% (Oct – Dec)[2]	42%	42%	Off	35%	Same
Improve sexual health	PH7	Number of Long Acting Reversible Contraception (LARC) prescriptions in local integrated sexual health services	Q	942 (Jul - Mar)	780	780	On	New measure	

[1] Cumulative data is not available
[2] Q4 and cumulative data not available
[3] Q4 data is not yet available

Promote wellbeing in early years

6.1 Health Visiting continues to perform well on timely delivery of new birth visits within 14 days. The local rate of 96% compares favourably with London* (93%) and England* (88%)
The provider has made considerable improvements to data quality and reliability over the last year such that they are now able to report with confidence their performance on four of the five nationally reported mandated health checks, and reported rates are rising. This improvement work is continuing.

6.2 Engagement of the Health Visiting service with the wider agenda of early years transformation to fully integrate services has improved markedly since the appointment of a new manager in February. The organisational changes required will still take time to enact, but these are now on course for co-location in September of this year, a crucial step in the path to integrated services for children under 5 and their families.

6.2 Measles, Mumps and Rubella immunisation rates for two and five year olds remain low relative to the target although similar to London rates. As reported previously, there have been substantial changes to the data recording of immunisations, with a complete reconfiguration across London introduced in late 2016/17. Public health is working closely with primary care commissioners in Islington to look at ways to increase the recording/rates among GPs practices in Islington.

Reduce prevalence of smoking

6.3 Due to the time lag in smoking quitting data, Q4 data is not yet available. In Q3, performance was below target with 154 people accessing the service successfully quitting, against a quarterly target of 200. The number of four quitter has increased since quarter 2, and it is expected that the number of four week quitters will continue to increase quarter on quarter, based on the providers delivery plans.

6.4 The quit rate was slightly below the 50% target at 46%, although the proportion successfully quitting has improved compared to last year, and is significantly higher than the Department of Health recommended minimum quit rate of 35%.

6.5. Commissioners are working with the service to increase the number of smoking quits. The provision of specialist support has increased, including out-of-hours services and drop-in mobile van sessions. A successful outreach campaign to mosques and high street shops took place in Q4. The service is also training staff from the Octopus (typo) Communities Network to deliver stop smoking support to local residents. Plans are in place to work with several large local employers to provide stop smoking support to staff. Finally, a dedicated member of staff is now working with GPs and community pharmacies to improve stop smoking performance in these settings.

Effective detection of health risk

6.5 In 2017/18, over 7,500 residents received an NHS Health Check. As well as delivering the service through GP practices in Islington, 1,200 NHS Health Checks have been delivered through a community outreach programme. Over half of NHS Health Checks delivered through the community programme have been to people living in the most deprived areas in Islington or from Black and South Asian ethnic groups - the two groups at greatest risk from cardiovascular disease.

Tackle mental health issues

6.6 In 2017/18, over 5,000 people entered the Improving Access to Psychological Therapy (IAPT) programme, with performance exceeding the annual target. In Q4, the percentage of those entering IAPT treatment who recover is just short of the nationally set target (50%), at 47%.

6.7 Islington's Mental Health Promotion projects continue to perform well. In 2017/18 the Direct Action Project delivered 37 workshops and creative programmes with young people and /or staff who work with young people. The Wellbeing Service reached 4,115 people through awareness and outreach activities and recruited eight new champions. 750 people were trained in Mental Health First Aid and Mental Health awareness. In addition, five "Mental health in the workplace for line managers" courses were held in 2017/18. Public Health convened a successful suicide prevention stakeholder workshop on 28th February, together with Islington Clinical Commissioning Group, CIFT and Manor Gardens Welfare Trust. The workshop was well attended with representation across a wide range of services and agencies. The focus of the workshop was on men as a high risk group for suicide.

Effective treatment programmes to tackle substance misuse

6.8 Q4 data are not yet available. In Q3, the percentage of drug users in drug treatment during the year who successfully completed treatment and who did not re-present within six months of treatment exit is just below the quarterly target (20%) at 17%. Islington saw a slight fall in this indicator. Treatment services undertook a significant data cleaning exercise in the latter half of the year, as part of the mobilisation of the new integrated drug and alcohol service in the borough, and this is likely to have impacted negatively on performance.

6.9 Q4 data are not yet available. In Q3, alcohol successful completions saw a small percentage increase. The proportion of alcohol users successfully completing treatment was just below target (42%) at 40%. Better Lives, the new Islington Integrated Drug and Alcohol Recovery Service, started on 1st April 2018. Camden and Islington NHS Foundation Trust are working in partnership with Blenheim CDP and Westminster Drug Project to deliver an innovative service with the following aims at its core: co-production, working with peer mentors, increasing the number of clients who experience recovery, supporting families, ensuring the service is accessible to those in need of support and partnership working. Service providers are working very positively with users, staff, commissioners, and other local agencies and services that work with this client group, as part of the mobilisation of the new service and to support the embedding of the new model.

Improve sexual health

6.10 Full year data shows that performance (942) has exceeded the annual target (780) for the number of women prescribed long acting reversible contraception in 2017/18. Long-acting reversible contraception, such as the contraceptive implant, is more effective than user dependent methods (such as the pill or condoms) in reducing unplanned pregnancies. Commissioners have been working closely with CNWL, the service provider, to fully mobilise the new service model, including the implementation of a pan-London e-service for people who are asymptomatic. The first phase of this new e-service service launched in North Central London in February 2018 with the second phase, SMART kits (off line kits available for users to pick up and to use within clinics), will take place from 21st May 2018.

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Final Report Clearance

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Date