Public Document Pack

ISLINGTON

HEALTH AND WELLBEING BOARD

14 March 2023

SECOND DESPATCH

Please find enclosed the following items:

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Report of: Population Health Team (ICB) and North London Councils Team

Meeting of: Health and Wellbeing Board

Date: 14th March 2023

Ward(s): All

Subject: NCL Population Health and Integrated Care Strategy

1. Synopsis

1.1. As work continues to develop the Integrated Care Partnership (ICP), we have been working closely with colleagues from across the system to outline, in a single document, our approach to both population health management and integrated care.

1.2. Also on the horizon, and closely linked to the above strategy, is the Joint Forward Plan (JFP), which is to be authored by the Integrated Care Board (ICB), constituent providers, and Health and Wellbeing Boards. We envisage the JFP acting as a delivery plan for the Population Health and Integrated Care strategy and Joint Local Health and Wellbeing Strategies, outlining how we will turn our ambitions into reality over the coming years.

1.3. Considering the above and keeping in mind that these are very much system-owned documents, we would be grateful for the opportunity to present the latest draft version of the Population Health and Integrated Care strategy as we gather feedback to feed into the iteration process. This would also provide an opportunity to discuss the JFP and consider next steps to further move this along

2. Recommendations

2.1. Review and provide feedback on the current version of the NCL Population Health and Integrated Care Strategy

2.2. Provide feedback on slide 10, specifically whether Islington's Joint Health and Wellbeing Strategy is accurately summarised and feedback on the common themes

2.3. Provide feedback on JFP guidance and approach, and how it could support the delivery of Islington's Joint Health and Wellbeing Strategy

2.4. Agree the preferred level and method of engagement moving forward as work continues to develop the JFP, including a request to return to the HWBB closer to 30th June for sign off

3. Background

3.1. From 1 July 2022, all 42 integrated care systems (ICSs) across the country became legal entities, with statutory responsibilities to deliver for their local populations. Legally, ICSs comprise two core parts: an ICB, the budget-holding body, and an ICP, a broader coalition of partners within the system, to join up planning and delivery.

3.2. The ICP is required to produce an integrated care strategy to set the strategic direction for health and care services across the whole geographic area of the ICS, including how commissioners in the NHS and local authorities can deliver more joined-up, preventative, and person-centred care for their local population. In NCL, we have combined this strategy with our Population Health Improvement strategy to form a single Population Health & Integrated Care strategy.

3.3. The ICB and its partner trusts have a duty to prepare a JFP to set out how they will arrange and/or provide NHS services to meet their populations' physical and mental health needs. Systems are encouraged to use the JFP to develop a shared delivery plan for the integrated care strategy and joint local health and wellbeing strategy (JLHWS), that is supported by all partners across the system.

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. Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. ICSs were established across England on a statutory basis on 1 July 2022 in accordance with section 42 Health and Care Act (2022).

4.2.2. Included in the integrated care system (ICS) are Integrated Care Partnerships (ICP). This is a statutory committee formed between the NHS integrated care board and the LA that falls within the ICS area. The ICP will include partners concerned with improving the care, health and wellbeing of the population in the ICS area. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

4.2.3. The Integrated Care Board (ICB) is a statutory NHS organisation. It is responsible for developing a plan for meeting the needs of the population and the provision of health services in the ICS area. Local Authorities in the ICS area are responsible for social care and public health functions as well as other vital services for local people and businesses.

4.3.

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

4.4.1. The strategy refers to and places emphasis on the NCL Green Plan North Central London Green Plan 2022-2025 .

4.5. **Equalities Impact Assessment**

4.5.1. 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.

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

5. Conclusion and reasons for recommendations

5.1. We look forward to presenting our latest version of the NCL Population Health and Integrated Care Strategy to the Health and Wellbeing Board and look forward to the board's feedback.

5.2. The board's input is crucial in ensuring that our ambitions are aligned. We believe that by working together and taking into consideration all perspectives, we can create a strategy that meets the needs of our population.

Appendices:

- If an Equalities Impact Assessment has been completed it must be listed here and submitted alongside the report.

Background papers:

- None to note

Final report clearance:

Signed by:

Amy Bowen - Corporate Director of System Improvement, NCL ICB

Date: 20 February 2023

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North Central London Integrated Care System

North Central London Population Health and Integrated Care Strategy

DRAFT **16th February 2023**

Version **10**

DRAFT

Engagement has been core to our iterative process

North Central London Integrated Care System

What we heard	What we did about it
Inequalities – We must be able to emphasise that hyper-local delivery is key to reaching communities effectively and tackling health inequalities, as well as how inequalities impact different population groups	**Inequalities:** Our future state outlines the close working at place and neighbourhood level. We are focusing on our CORE20PLUS5 populations to ensure we are identifying and tackling inequalities.
Language: The strategy needs to be inclusive in its language to allow a wider audience to understand it	**Language:** We have been iterating our themes and development areas to make them more accessible – we have also tested language throughout engagement.
Integration: The strategy needs to define how different stakeholders will work together to deliver the strategy.	**Integration:** Our integrated care content outlines what we believe the future state to be, draws on examples of existing integration and a roadmap for further integration and delegation
Sustainability: The strategy needs to highlightg how the NHS is going to act as anchor institution and its contribution to climate change	**Sustainability**: Linking in to the 'Collaborating to tackle the root causes of poor health' theme which we describe our aim to strengthen our anchor network and deliver the NCL green plan
Prevention: Balancing addressing population health improvement in our current services and pathways along with shifting more focus and resource toward proactive care and prevention	**Prevention:** Our 5 priority areas will encourage holistic thinking and innovation – facilitating linkages across existing programmes and greater investment in improving prevention and early intervention.
Financial implications: Provide health economic data to quantify the problem and provide economic argument to tackle inequality	**Financial implications:** Although this strategy does not outline specific cost-benefit analyses, we have identified the importance of engaging with the CFO community in NCL.
Impact on residents : The report to be more explicit regarding the impact on residents	**Impact on residents :** We have developed a series of 'I' statements, linked to what our communities have told us, to describe what integrated care will look like for our residents and communities.
Education: Education for residents about how things are changing	**Education:** We have worked with communities to gather insight on our system challenges. Our Joint forward Plan (JFP) will be a public-facing document that outlines the delivery of our strategy.
Impact on providers: The strategy should describe what it means for the providers	**Impact on providers:** Our integrated care section describes the future state of integrated care across NCL as well as what this will mean for different organisations, including providers.
Digital : Strengthen approach to how we will use data to support and drive innovation and improvement	**Digital :** Central to our 'making population health everyone's business' delivery theme is improving our insights across NCL, including how digital will enable us to better community insights.
Collaboration with VCSE : Strengthen approach to how we will work in collaboration with VCSE	**Collaboration with VCSE**: Our integrated care section describes the horizontal integration with VCSE

Executive summary (titles of each slide)

North Central London Integrated Care System

- This document will bring to life how we will work together, as an integrated care system to achieve our collective ambition for our population
- Creating this document has been a collective effort across our partnership in the spirit of system-ownership
- To get involved in population health and integrated care, there are six key terms for everyone in our system to know
- Population health is why we are here and our shared purpose across the North Central London Integrated Care System
- We have a shared ambition across our partnership
- We are building on the existing Health and Wellbeing strategies, with common themes and principles
- We have worked to understand our population needs, residents' experience and system challenges
- Our 'I' statements define what integrated care needs to look like for our residents, our communities and our service users
- To become a population health system, we need to change in fundamental ways
- We have ten principles which will guide our new ways of working
- We have tailored the national NHS framework for health inequalities to the needs of our population
- We have developed a population health outcomes framework that reflects where we have significant local disparities across the life course
- Our outcomes framework has helped us identify five development areas for population health improvement in NCL
- Our five population health improvement development areas where system focus will deliver greatest impact
- What it looks like to take action on wider determinants of health
- There are key programmes already underway which are taking a population health approach
- NCL is uniquely rich in world class expertise in research, evaluation and improvement
- A key ingredient to change on the ground is how we join up and integrate care around individuals and communities
- Our future state – how integrated care will look at system, place and neighbourhood
- All partner organisations will look and feel different in our future state
- Integrated care is already happening across NCL – spotlight on children's health and well-being
- We are building on a foundation of integrated care across our five Borough Partnerships
- Our vision for Borough Partnerships will develop over time within a shared framework
- Our Roadmap for developing Borough Partnerships lays out the way forward over the coming 18 months
- Moving forward
- We will coordinate delivery around five themes
- Our key deliverables for each theme
- Moving forward – our model for change and how all the pieces fit together
- Next steps

Foreword

North Central London Integrated Care System

This document sets out our approach to improving the health of our population in North Central London. As an integrated care partnership, we are in a unique position to work together to tackle some of our biggest population health challenges – ones that no individual organisation or sector could achieve on its own.

The strategy describes our vision for a more prevention-oriented, proactive, integrated, holistic and person-centred approach to care. We focus on where we can make the biggest improvements in population health by taking a partnership approach. We put more emphasis on earlier interventions where we can transform outcomes by addressing the wider determinants of health, such as housing, air quality and education whilst recognising and working to minimise the impact of the climate emergency on the health of our population. At the heart of this strategy is a belief in the strengths and motivation of our residents, many of whom also work in NCL, often within our health and care sector. We want to celebrate and build on the capabilities of our residents.

This document brings together a number of separate asks into a single document. It covers how we will integrate care (Integrated Care Partnership's Integrated Care Strategy) and our approach to population health improvement (Integrated Care Board's (ICB) Population Health Strategy), creating the context for the NHS ICB 5 year joint forward plan. This document guides what we aim to achieve as a system, with our sectoral and organisational plans then enabling the benefits of an integrated population health improvement system to be realised.

Although this document forms a milestone in our population health journey, we will continue to develop our partnership working as well as our engagement with our communities.

This document will bring to life how we will work together, as an integrated care system to achieve our collective ambition for our population

North Central London Integrated Care System

Our Ambition

As an integrated care partnership of health, care and voluntary sector services, our ambition is to **work with residents of North Central London so they can have the best start in life, live more years in good health in a sustainable environment, to age within a connected and supportive community and to have a dignified death.**

We want to achieve this ambition for everyone.

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Creating this document has been a collective effort across our partnership in the spirit of system-ownership

North Central London Integrated Care System

Link to engagement appendix

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To get involved in population health and integrated care, there are six key terms for everyone in our system to know

North Central London Integrated Care System

Population Health

Improving the physical and mental health and wellbeing of people within and across a defined population, while reducing health inequalities.

Integrated care

Joining up the health and care services required by individuals, to deliver care that meets their needs in a personalised and efficient way.

Wider determinants

The range of factors which impact our health and wellbeing, including social, economic and environmental factors.

Integration

Aligning two or more historically autonomous organisations or sectors with the aim of delivering integrated care.

Equity

An environment in which everyone has a fair opportunity to thrive, regardless of who they are.

Proportionate universalism

Focusing our resources and delivery capabilities in proportion to the degree of need.

Link to glossary appendix

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Population health is why we are here and our shared purpose across the North Central London Integrated Care System

North Central London Integrated Care System

Core purpose of our Integrated Care System (ICS)

NHS Providers

1. Whittington Health NHS Trust
2. University College London Hospitals NHS Foundation Trust (UCLH)
3. North Middlesex University Hospital NHS Trust (NMUH)
4. The Royal Free London NHS Foundation Trust
5. Barnet, Enfield and Haringey Mental Health NHS Trust
6. Camden and Islington NHS Foundation Trust
7. Tavistock and Portman NHS Foundation Trust
8. Central and North West London NHS Foundation Trust (CNWL)
9. Central London Community Healthcare NHS Trust (CLCH)
10. Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH)
11. Royal National Orthopaedic Hospital (RNOH)
12. Moorfields Eye Hospital NHS Foundation Trust

Integrated Care Systems (ICS) are partnerships between the organisations that meet health and care needs across an area. Driving improvements in population health and reducing health inequalities is at the heart of our purpose. Our Integrated Care Partnership (ICP) between the Integrated Care Board (ICB) and our borough local authorities creates the opportunity for us to address the fundamentals of poor health and tackle what is preventable. We can become a proactive, rather than reactive system, focussing on health and wellbeing, not just on illness.

North Central London (NCL) is a complex health and care economy with 12 major healthcare providers (many of whom provide specialist services to the rest of London and across England) with a combined income of around £5bn, 5 local authorities, 33 primary care networks (PCNs), more than 280 domiciliary care providers and around 220 care homes and hundreds of voluntary, community and social enterprise (VCSE) organisations. The system is also supported by UCL Partners - our Academic Health Science Network (AHSN) - and a flourishing world-class wider academic community.

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We have a shared ambition across our partnership

North Central London Integrated Care System

New legislation

The **Health and Care Act 2022** came into effect in July 2022 creating the statutory bodies that make up the ICS:

- **Integrated Care Boards (ICB) -** NHS bodies, taking on many of the functions previously held by the CCGs as well as some NHS England functions.

Health and Care Act 2022

- **Integrated Care partnerships (ICPs)** bringing together NHS, local authority, and wider partners to focus on addressing wider determinants of health and developing integrated working.

The legislation also formalises the geographical footprint-based approach of system, place and neighbourhood to partnership and delivery structures outlined in the next section.

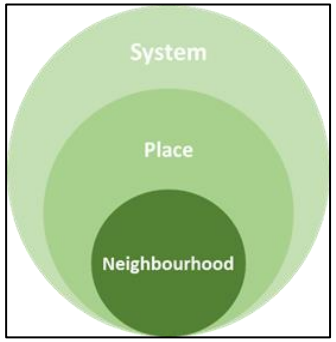
At the time of writing, we are awaiting the findings from the **Hewitt review**, led by Patricia Hewitt, which will consider how the oversight and governance of integrated care systems (ICSs) can best enable them to succeed.

We are expecting specific recommendations on:

- How to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending
- The scope and options for a significantly smaller number of national targets for which NHS ICBs should be both held accountable for and supported to improve by NHS England and other national bodies, alongside local priorities reflecting the particular needs of communities
- How the role of the Care Quality Commission (CQC) can be enhanced in system oversight

Clear Responsibilities

Improvements in population health will happen over three broad levels. How services integrate, where responsibilities and accountabilities are located and how resources are distributed across these levels is key to how the ICS will operate.



Neighbourhood (covering populations of around 30,000 to 50,000 people): where networks of GP practices (PCNs) work with NHS community services, social care, voluntary sector and other providers to deliver more targeted co-ordinated and proactive care.
Place (covering the geography of each of the five boroughs of NCL): where Borough Partnerships of health and care organisations, including local government, NHS providers, VCSE organisations, social care providers and others – come together to join up the planning and delivery of services.
System (covering the whole population of NCL): where health and care partners come together at scale to set overall system strategy, manage resources and performance, plan specialist services, and drive strategic improvements in areas such as workforce planning, digital infrastructure and estates.

Integrated Local Delivery

The **Fuller Stocktake** report sets out a comprehensive vision for locally integrating primary care with system partners, built around a 'Team of Teams' and an improvement culture.

At the heart of this report is a new vision that, if delivered well, will create the local structures for integrating care. Fuller focusses on 3 key offers:

- **streamlining access to care and advice** for those who use services infrequently, with more local options
- **providing more proactive, personalised care with support from a multidisciplinary team of professionals** to people with more complex needs, including those with multiple long-term conditions
- **helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

We are building on the existing Health and Wellbeing strategies across our five boroughs

North Central London Integrated Care System

- Each borough in NCL has a statutory Health and Wellbeing Board (HWBB). This is a partnership across the Council, the NHS, local voluntary and community sector organisations and Healthwatch. Each HWBB has a statutory duty to produce a Joint Health and Wellbeing Strategies (JHWS). This sets out how the local system will work together to improve the health and wellbeing of the local community and reduce health inequalities.
- Each of our borough Joint Health and Wellbeing Strategies is on a different cycle, with strategies for three of our boroughs being refreshed during 2023.

Priorities and focus areas in current JHWS	
Barnet (2021-25)*	1) Creating a healthier place and resilient communities 2) Starting, living and ageing well 3) Ensuring delivery of coordinated holistic care, when we need it
Camden (2022-30)	Long-term ambitions: 1) Start well - All children and young people have the fair chance to succeed, and no one gets left behind 2) Live well - People live in connected, prosperous and sustainable communities 3) Age well - People live healthier and more independent lives, for longer Short-term priorities for action: 1. Healthy and ready for school 2. Good work and employment 3. Community connectedness and friendships
Enfield (2020-23)	1) Eat well 2) Be active 3) Be smoke free 4) Be socially connected In order to: • Reduce the chances of people developing non-communicable diseases such as cancer, heart disease, Type 2 Diabetes or lung disease • Improve emotional and mental health and wellbeing and reduce the prevalence of mental health conditions • Reduce inequality in health outcomes.
Haringey (2020-24)	• Creating a healthy place • Start well • Live well • Age well • Violence prevention
Islington (2017-20)	1) Ensuring every child has the best start in life 2) Preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities 3) Improving mental health and wellbeing

Common themes

- **Life course approach (start well, live well, age well) -** with a clear focus on children and 'giving every child the best start in life'
- **Prevention and early intervention** – both in terms of long-term conditions but also intervening early in the life course with children and young people
- **Tackling inequalities**
- **Mental health and wellbeing across the ages**
- **Tackling lifestyle risk factors** – in particular physical activity and healthy eating
- **Action on the wider determinants of health** – including in particular housing, employment, environment, violence and social isolation
- **Role of partner organisations as anchor institutions within communities** – in particular in terms of employment and impact on the environment
- **Integration -** role of service integration but also digital integration through population health management tools
- **Making every contact count**
- **Social prescribing**

* Life cycle of current strategies

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We have worked to understand our population needs, residents' experience and system challenges

North Central London Integrated Care System

Our assessment of our population's needs tells us:

Health needs are growing and **inequalities are widening**. Whilst we still need to drive forward improvement in the quality of care we provide, we need to do more to **intervene earlier** when people start to become unwell and prevent people becoming unwell in the first place, through a greater focus on tackling the **lifestyle and wider determinants** of our health and wellbeing, if we want to improve health outcomes and reduce inequalities across our population.

Our communities tell us:

Our system is not meeting our communities' needs. Our **services are complex and hard to navigate**, with challenges entering the health system through primary care. Services need to be better integrated and provide **more holistic support, taking account of people's wider needs** e.g. related to issues such as housing or income, making best use of the assets within our voluntary sector. We need to build trust with some of our communities and develop more culturally sensitive services. We need to work with our communities to design person-centred solutions which **take account of differences rather than a 'one-size-fits-all' approach**.

Our system challenges tell us:

Our services and **workforce are straining under increasing complexity and growing demand**, within a **tight financial environment, and our resources are not aligned to our population's needs**. Our system is in parts fragmented and **decision making and accountability at the different system levels is not clear.** We need to understand and **use our strengths and assets across the system more efficiently and effectively** to meet our population's needs and make our system future proof.

To ensure that we can meet the needs of the populations that we serve and achieve our ambition, we need to **fundamentally change the way we work, including with our residents and communities, and where we prioritise our resources and efforts**. We need a new vision that will bring us together around a common purpose and approach.

Our ‘I’ statements define what integrated care needs to look like for our residents, our communities and our service users

North Central London Integrated Care System

I live in a safe, sustainable and health-promoting environments and communities, with timely access to the services and support that I need to keep safe and well, to stay healthy and to live as independently as possible

I have the information and advice that I need, when I need it and in a form that meets my needs, to make choices and decisions about my life and my health, the way that I live, as well as my care and support

I am supported to live a healthy life by people and professionals who I trust, who listen to me, respect me and involve me in decisions regarding my life, my health and the support or care that I need

My care and the support that I receive across different services is coordinated, timely and meets my needs, treating me as a whole person and helping me to live the life that I want to the best of my ability

When I move between services, settings or areas, there is a clear plan for what happens next, how information will be shared and who will do what, with all practical arrangements in place before change happens

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To become a population health system, we need to change in fundamental ways

North Central London Integrated Care System

We need to move from being a collection of health and care organisations that…	to become a population health system that…	so that our residents....
are reactive and demand-driven with a high-proportion of resources focused on urgent care	is needs-driven, prioritising prevention and proactive care	stay well and in control of their health
treats individual conditions not the drivers of poor health	sees the whole person and takes action on prevention and the wider determinants of health	feel heard and confident that their care is right for them
are focussed on their services and part of the pathway	integrates care around the person and communities	feel that the system is coordinated and communicates well
are focussed on illness and dependence	works to improve life chances, prevent illness and promote physical and mental well-being	can live more of their life in good health

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We have ten principles which will guide our new ways of working

North Central London Integrated Care System

To make our transition to a population health system that is needs-driven, holistic and integrated, we have identified 10 principles to guide us and examples of what that looks like in terms of changed ways of working.

Trust the strengths of individuals and our communities

We listen to our communities and develop care models that are strengths-based and focussed on what communities need, not just what services have always delivered

Break down barriers and make brave decisions that demonstrate our collective accountability for population health

We understand each other's viewpoints and take shared responsibility for achieving our ICS outcomes and our role as anchor institutions

Build from insights

We create digital partnerships and use integrated qualitative and quantitative data to understand need

Strengthen our Borough Partnerships

We build a system approach for local decision making and accountability to support local action on health inequalities and wider determinants

Mobilise our system's world class improvement and academic expertise for innovation and learning

We build the evidence base for population health improvement and innovative approaches to improve integrated working

Break new ground in system finance for population health and inequalities

We shift our investment toward prevention and proactive care models and create payment models based on outcomes.

Build 'one workforce' to deliver sustainable, integrated health and care services

We maximise our workforce skills, efficiencies and capabilities across the system

Support hyper-local delivery to tackle health inequalities and address wider determinants

We make care more sustainable by creating local integrated teams that coordinate care around the communities they serve

Relentlessly focus on communities with the greatest need

We embed Core20PLUS5 in all our programmes with a particular focus on inclusion health to make sure no-one is left behind

Deliver more environmentally sustainable health and care services

We prioritise activity which impacts our communities' health and environment, such as transport

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We have tailored the national NHS framework for health inequalities to the needs of our population

North Central London Integrated Care System

Across our population we know there are some communities who experience greater inequalities and poorer health outcomes, including shorter life expectancy and healthy life expectancy for a complex range of reasons. These groups are not mutually exclusive – for example many of our PLUS populations may also be amongst our 20% most deprived - and there are a multitude of ways the needs of these groups intersect with common inequalities in access, experience and outcomes.

The PLUS element of Core20PLUS5 provides a framework for us to look at some of these key population groups for our population in NCL as a whole, supported by our Inclusion Health Needs assessment and Joint Strategic Needs Assessments (JSNAs) in each of our boroughs, which identify additional population groups at a borough level.

Some of these groups may be comparatively small in number, compared to other populations, but their needs are disproportionate and often complex. We need to build our understanding of their health needs, working with these communities and better deliver services that meet those needs.

Core20 **Our 20% most deprived**	21% of people in NCL (around 364,000) live in the 20% most deprived areas nationally (index of multiple deprivation).	For example: in Enfield female child mortality is 2.7% greater in most compared to least deprived areas.

Our PLUS populations

Children and young people

Place holder for Children and young people's PLUS population

Adults

Black and minority ethnic groups experiencing greatest inequality	Inclusion health groups	People with severe mental illness	People with learning disabilities
Groups who experience inequalities due to the intersectionality between ethnicity and deprivation. • Start Well (0-18s): Black African Bangladeshi, Mixed Black communities Black Somali • Live Well (18-65s)): White Turkish and Bulgarian • Age Well (65+): Black Caribbean	• People experiencing homelessness, • Gypsy, Roma and Traveller communities • Sex workers • Vulnerable migrants • Those with a history of imprisonment.	These groups often have complex social and health needs and experience multi-morbidity and have lower incomes and lower rates of employment.	
For example: during 2020/21, in NCL twice as many Black pregnant women were obese compared to white women (24% vs. 12%)	For example: Gypsy, Roma and Traveller communities have the shortest life-expectancy of any ethnicity.	For example: The death rate for those with severe mental illness in Camden and Islington is 3x higher than the rest of the population.	

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We have developed a population health outcomes framework that reflects where we have significant local disparities across the life course

North Central London Integrated Care System

Across our health and care services, we have developed and **agreed a set of outcomes, based on our population needs identified through our NCL needs assessment and our borough JSNAs and Health and Wellbeing Strategies, that reflect our population health ambition** and for which we will collectively hold ourselves to account. The Outcomes Framework **follows the life course.**

An indicator set underpins the outcomes which will be mapped to all our key work programmes.

The outcomes framework is **a tool for us to assess variation and need, support prioritisation** and identify where we can make a difference by working together as a system, and areas which require focus at borough and neighbourhood level.

We have used the outcomes framework to identify 5 population health priorities, which will be our first areas for focus at an NCL-level. Borough Partnerships will continue to work across the breadth of the Outcomes Framework and will identify local priorities to sit alongside these.

Start well

Every child has the best start in life and no child is left behind

- Improved maternal health and reduced inequalities in perinatal outcomes
- Reduced inequalities in infant mortality
  Increased immunisation and new born screening coverage
- All children are supported to have good speech, language and communication skills

All children and young people are supported to have good mental and physical health

- Early identification and proactive support for mental health conditions
- Reduced prevalence of children and young people who are overweight or obese
- Improved outcomes for children with long term conditions

Young people and their families are supported in their transition to adult services

- All young people and their families have a good experience of their transition to adult services

Live well

Early identification and improved care for people with mental health conditions

- Reduced racial and social inequalities in mental health outcomes
- Improved physical health in people with serious mental health conditions
- Reduced deaths by suicide

Reduced early deaths from cancer, cardiovascular disease and respiratory disease

- Reduced prevalence of key risk factors: smoking, alcohol, obesity
- Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease

Reduced unemployment and increase in people working in fulfilling employment

- People are supported to stay in jobs, including mental health and musculoskeletal services
- Increased employment of local people in anchor institutions, including those with mental health illness, physical disability, and learning disabilities, and increased level of "buy locally", including using social value-based commissioning and contracting

Age well

People live as health, independent and fulfilling lives as possible as they age

- People get timely, appropriate and integrated care when they need it and where they need it
- Prevent development of frailty with active aging
- Earlier prevention, detection and management of long term conditions, including dementia, in older people

People remain connected and thriving in their local communities as they age

- People have meaningful and fulfilling lives as they age
- People are informed well and can easily access support for managing financial hardship (including fuel poverty), as they age

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Our five population health improvement development areas where system focus will deliver greatest impact

North Central London Integrated Care System

- Overseen by our Population Health and Inequalities Committee, we undertook an exercise to look across our population needs, outcomes framework, Core20PLUS5, borough priorities and community insights to identify five development areas for population health improvement to work together on as a system. These do not replace borough or sectoral priorities (for example, the five priorities for children set by the Directors of Children's Services. Rather, they represent opportunities to develop our work as an integrated care partnership and test and learn on key aspects of integration.

- **Setting these priorities will:**
  - encourage holistic thinking and innovation – facilitating linkages across existing programmes and greater investment in improving prevention and early intervention
  - drive improvement in areas which will have a large population impact
  - provide a practical test bed for learning about delegation, decision-making and accountability at all levels of the system
  - provide opportunity to understand and tackle inequalities at local and hyper-local level – through data segmentation and community insight
  - enable us to test and learn through the application of a population health approach in practice
  - enable us to focus measurement of success.

- Seeing improvements in access, experience and outcomes across these development areas will help reduce inequalities and contribute to the improvements required in current “pressure” areas in the health and care system, such as ambulance demand and elective backlog, improving quality of care.
- We will work to further refine these areas through insights work and involvement of residents and those delivering services.
- We have agreed as a system that within these 5 priorities we will begin with working on **childhood immunisations.**
- **These 5 demonstrators will, alongside our integrated projects, lead the ‘learn by doing’ approach in our roadmap.**

DRAFT

Our five population health improvement development areas are mapped across the life course

North Central London Integrated Care System

Development Areas

NCL population health improvement development areas

START WELL

Childhood immunisations

LIVE, WORK AND AGE WELL

Heart health - preventing heart disease and strokes

Cancer - prevention, early detection and good quality care for all

Lung health – e.g. asthma and COPD (chronic obstructive pulmonary disease)

WHOLE LIFECOURSE

Mental health and wellbeing (all ages)

Focus on communities and population cohorts experiencing severe and multiple disadvantage across all the priority areas.

RATIONALE

Multiple common risk and protective factors that provide opportunities for influence across the life course

Lifestyle factors such as smoking, alcohol, diet and physical activity

Wider determinants such as deprivation, housing, and air quality

Key contributors to health inequalities, and early and avoidable death across NCL

NCL is an outlier in London for coverage

Biggest causes of avoidable death (largely preventable and treatable)

Next highest cause of avoidable mortality and long term health problems

Increasing prevalence and underpins other aspects of wellbeing

- Inequalities in opportunity, access, experience, outcomes
- Drivers of high health and social care use, poor quality of life and number of years of life lived in poor health
- Affect large (and increasing) numbers of people - so potential for large population health gain

Opportunities for improvement across the pathway with contributions from partners across NCL, and advantages of tackling at an NCL-level

- Opportunities to rebalance the system - greater focus on prevention, early intervention and self-management, reducing future need
- Work already underway – to incorporate population health approach; and start to identify improvement ambitions and levers and some quick wins
- Overlap with the 5 clinical areas in Core20PLUS5.

Link to rationale for childhood imms start

DRAFT

What it looks like to take action on wider determinants of health

North Central London Integrated Care System

The Health Foundation outlines five ways an **Anchor institution** can make a holistic impact on local communities

Thinking ethically about how we purchase goods and services

Using buildings and spaces to support communities

Reducing our environmental impact (by delivering our NCL green plan)

Widening access to quality work

Spread learning with our local partners

The principles of '**Making Every Contact Count**' can be hardwired into all of our services, this holistic thinking can include:

Offering lifestyle advice on smoking and alcohol during eye checks

Community pharmacy playing a more active role in signposting eligible people to screening

Working with nurseries to tackle dental caries in the under-5s and improve MMR vaccine delivery

Closing gaps in care using our Population Health Management platform

DRAFT

There are key programmes already underway which are taking a population health approach

North Central London Integrated Care System

Community and mental health services strategic reviews
An innovative Core Offer has been developed, ensuring consistency across NCL and reflecting population need. The core offer includes co-ordination functions to facilitate access to services and better join-up. This will help to reduce health inequalities, improve the quality and consistency of provision across NCL and deliver more proactive, integrated care.

Work is also ongoing to co-develop a shared outcomes framework and KPI dashboard which will be used to track equitable outcomes improvement.

New primary care model for long term conditions
Developing a consistent proactive care model across NCL, based on the Year of Care approach. It is data driven, realistic and practical and has been co-designed with providers, people with lived experience and the voluntary sector. It's outcomes-focussed, person-centred, stratified, focused on need, evidence-based and clinically-validated, making use of the full range of general practice workforce, and complementing our community core offer.

We need to generate evidence of impact and value in these new models and the potential to create additional impact through integrating these programmes around local delivery.

A system approach to enablers
We are working toward using our system strengths and assets in a more coordinated way, reducing duplication of effort and working toward our shared vision for how the system will work. This may mean some organisations providing system leadership or sharing capacity where it is more efficient to do so.. This approach will be further outlined in respective strategies, including people, finance, quality improvement, digital, data,corporate, surgical and the capital plan.

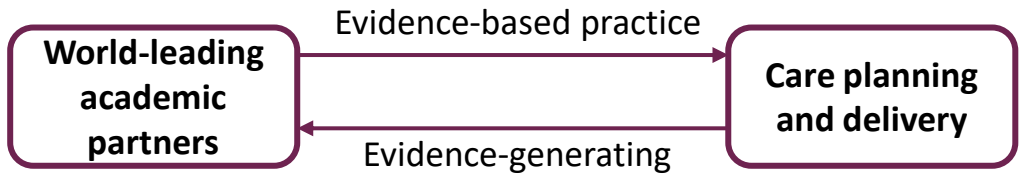
Start well
In November 2021, the partner organisations which now make up NCL's (ICS) formally launched a long-term programme looking at maternity, neonatal, children and young people's services, called the Start Well programme.

The case for change was developed using a combination of engagement and outcomes data and identified areas of variation and inequity where there are significant opportunities to improve care and outcomes for patients.

NCL is uniquely rich in world class expertise in research, evaluation and improvement

North Central London Integrated Care System

Evidence focus



Evidence-based practice

Co-ordinating with our various academic forums, including Academic Health Science Network (AHSN), Clinical Research Network (CRN), Applied Research Collaboration (ARC) and Biomedical Research Centres (BRC) to develop a common understanding of what each part of the research infrastructure does and provide a single point of access for the system.

Evidence-generating

Developing a system-wide set of research priorities will enable us to bring unique perspectives from each organisation into a topic.

With that in mind, we envisage a single process to identify, agree, re-visit them to ensure a shared set of priorities.

We also envisage leveraging our world-leading academic assets to build collaborations for new research, specifically to generate evidence and scale up existing evidence

System improvement approach

There are many different change approaches in use in NCL, each with their own strengths. Harnessing the improvement expertise and assets working in the system will key to delivering the priorities in our Population Health Improvement Strategy.

We will build a system improvement approach that balances consistent application of evidence-based methodology with the flexibility to empower place-based leadership of improvement work by frontline staff working together with local communities.

The principles our approach will embody are:

Consistent use of evidence-based improvement methods

Change will be locally led and draw on local assets and strengths

An open, participative theory of change that values all contributions

System-wide collaboration to share and scale-up success

A key ingredient to change on the ground is how we join up and integrate care around individuals and communities

North Central London Integrated Care System

Joining up services to make care more personalised, holistic, effective and efficient is the goal of integrated care. Integration needs to be vertical and horizontal and work effectively at each level of the system. Our task as a population health system is to make sure that each level has a clear scope, well-defined roles and accountabilities and the infrastructure it needs to deliver

Vertical integration

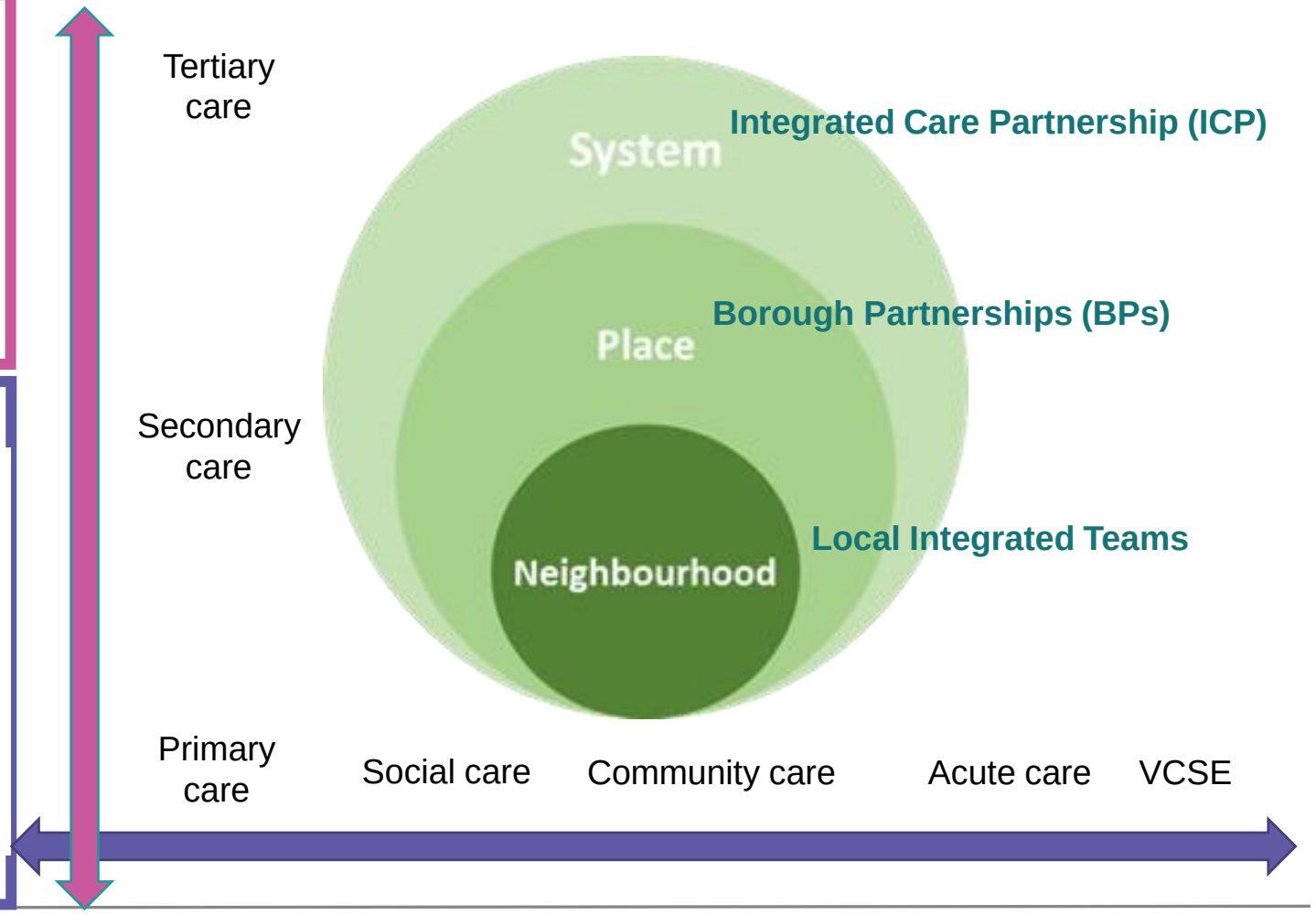
Aligning between healthcare providers to minimise handovers, maximise efficiency, address and incentivise downstream care and work across the whole continuum of need.

Provider collaboratives support vertical integration and can themselves improve the efficiency and effectiveness of horizontal integration (eg Lead Provider models).

Horizontal integration

Aligning across sectors to take a more holistic and hyper-local approach to care and a 'helicopter view' of the health and wellbeing of their local population - taking action on the wider determinants and reducing inequalities with a dual focus on improving quality and access.

The ICP and Borough Partnerships support horizontal integration. Borough Partnerships need infrastructure as well as clear accountabilities and responsibilities to deliver population health improvement. Horizontal integration at place is key for continuity of care as well as coordinated urgent care.



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Our future state – how integrated care will look at system, place and neighbourhood

North Central London Integrated Care System

Purpose	Function
System: • Focuses on activities that are better undertaken at an NCL-level where a larger planning footprint increases the impact or effectiveness • Creates conditions for local delivery of population health improvement through borough partnerships	• Understand totality of system health • Integration principles • Delivers system population health priorities • Differentially resource for achievement of population health outcomes • Balance service efficiency with equitable access and outcome • Conditions for population health improvement – workforce, data integration, insights, estates, back-office functions • Establishes and supports improvement collaboratives across priority pathways and services • Interactive relationship with academia, AHSN, research, alliances, collaboratives
Place: • Works through borough partnerships focussed on bringing together partners to develop, integrate and coordinate services based on agreed priorities. • Drives hyper-local delivery	• Coordinate and oversee neighbourhood delivery and act as interface between sectors • Drive integration across the borough partnership • Accountable for local delivery of placed-based and system priorities • Drive local co-production, insights and transformation • Agree plans for sectoral partnerships and functional integration • Create new spaces and ways of working that enable every-day local integration • Ensures community involvement and insights to improve access, experience and population health gains
Neighbourhood: • Builds on the core of primary care networks through integrated multidisciplinary te ams delivering a proactive population-based approach to care at a community level	• Key unit of integrated care delivery for population health improvement • Balance proactive/preventative and reactive/episodic care • Multidisciplinary working • Close collaboration with voluntary sector partners • Risk stratification, case-finding, care coordination, anticipatory care and making every contact count • Co-produced targeted services and interventions to improve outcomes for communities

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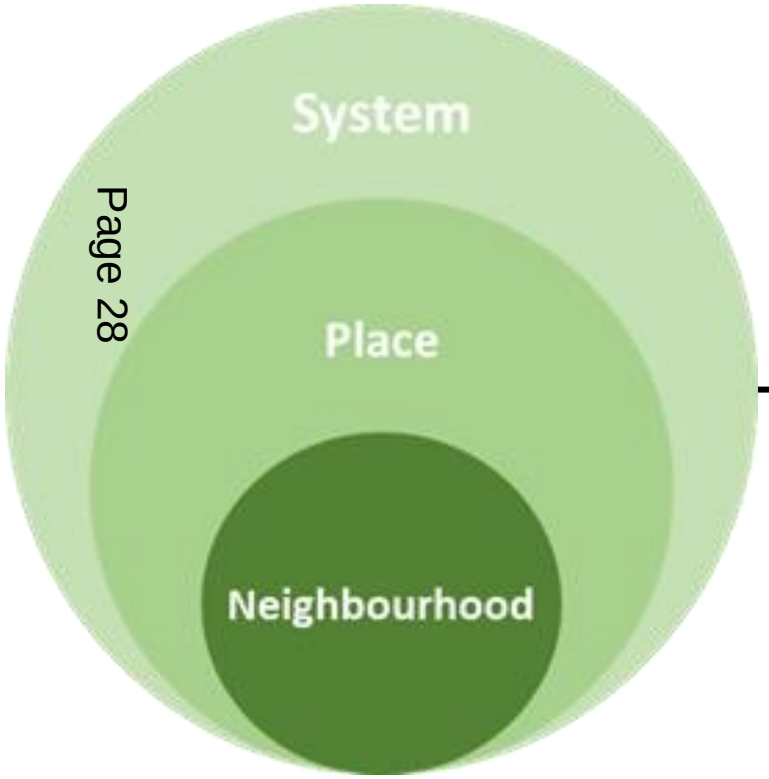
Working at our future state will look differently for each organisation across NCL

North Central London Integrated Care System



How our future state will look for:

Community Trust

'The community services we provide will need to be delivered around local neighbourhoods with more focus on multidisciplinary working with primary care teams, not just how we work with hospitals'

'We will focus more on equity of access and outcomes than just counting activity'

Acute Trust

Awaiting content

Mental Health Trust

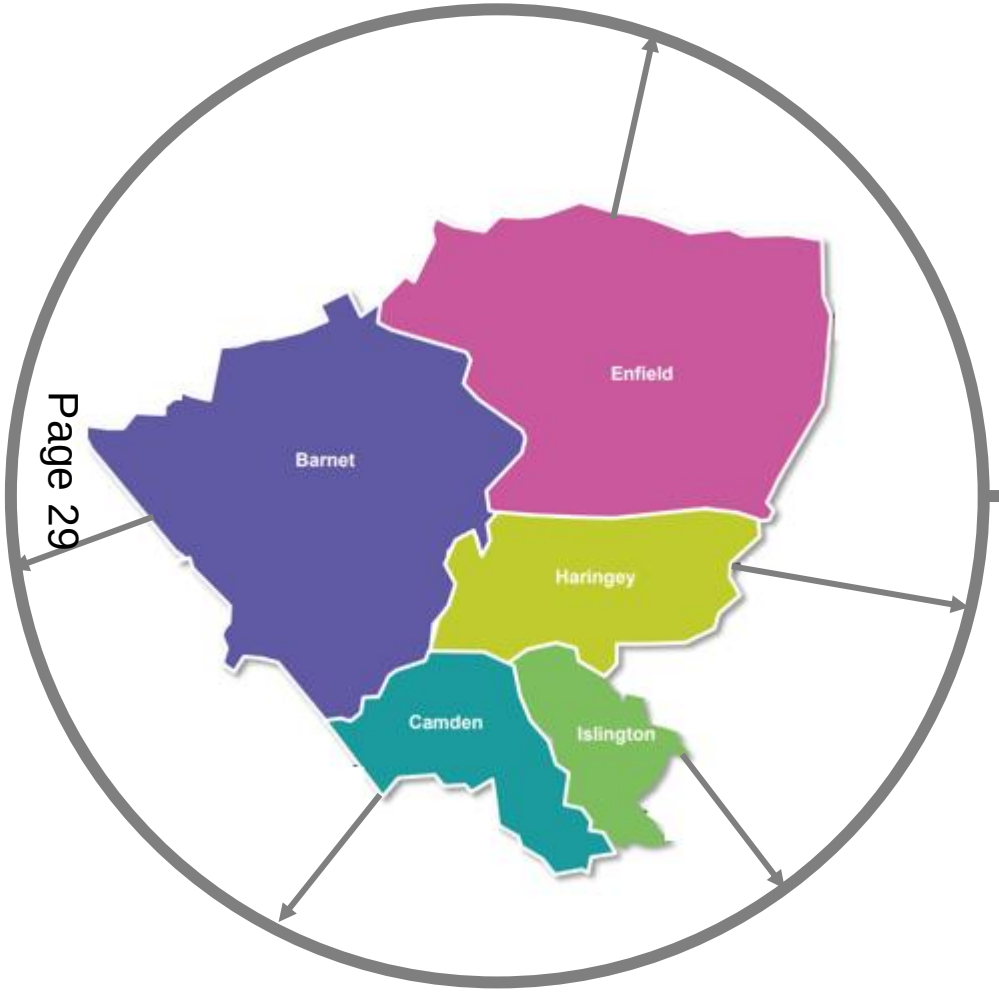
Awaiting content

GP

Awaiting content

Integrated care is already happening across NCL – spotlight on children's health and well-being

North Central London Integrated Care System



Integrated care for Children and Young People across NCL includes:

Awaiting content

DRAFT

We are building on a foundation of integrated care across our five Borough Partnerships

North Central London Integrated Care System

Integrated working already takes place within our boroughs as our BPs have been established – their experience and local programmes have given us a window into their future state. We think this is a defined place within which exists a series of horizontally integrated collaboration of organisations to improve outcomes for their local population. They will support neighbourhoods to address episodic care, long-term conditions, prevention and specific population health focuses. They will also be supported by the NCL system via strategic direction, cross-borough working, and enablers such as data, estates, and workforce.

Local community hubs: Creating a bridge between the Council's Early Help for All Strategy and a range of targeted support for residents in need. This includes in-depth support on health & wellbeing, jobs & skills, housing stability, and money.

Grahame park: Joint working between Council, NHS, Integrated Care Partnership, VCSFEs to develop an evidence-based neighbourhood model. The team focused on identified needs (for example substance misuse outreach services) and co-produced solutions with impacted communities.

Proactive Integrated Teams: Developing a multidisciplinary population health improvement approach to tackle elective recovery. MDTs routed in PCNs with wrap around input from community services and secondary care to reduce the number of patients on waiting lists

Childhood immunisations: Joint, iterative work between ICB, primary care, parent champions and community based organisations to raise awareness through focus groups, animation and pop-up clinics.

Integrated Front Door & Integrated Networks: Bringing together health and social care teams into a joint triage. Further joint working across integrated networks where MDTs of health professionals work across small networks of GP practices to discuss and support patients with complex needs.

Link to case studies

DRAFT

Our vision for Borough Partnerships will develop over time within a shared framework

North Central London Integrated Care System

Our vision: Borough partnerships in NCL will see partners take a 'helicopter view' of the health and wellbeing of their local population, including delivery at Neighbourhood level - helping reduce inequalities with a dual focus on improving quality and accessibility. They will enable the integration of health & social care and alignment of a broad range of services and community groups to address the wider determinants of health. They will have clear transformation priorities, are innovation spaces, and will 'lead on learning'.

All our Borough Partnerships are building their relationships and approach to local collaboration. Each is at a different point, with their own strengths and priorities for development. Working to the shared vision for Borough Partnerships, we are building a common framework for Borough Partnership development, giving clarity and with the goal of providing the flexibility for delivery according to local need.

The framework comprises nine key elements, however there are additional elements to be added. To develop the whole framework, we will take a 'learn by doing' approach, using a set of integrated projects as demonstrators as well as our population health development areas. These will be underpinned by a shared model for learning. The outputs from these demonstrators will shape the scope, responsibilities, accountabilities and the infrastructure needed for Borough Partnerships. They will also refine and further clarify what is needed at System level.

In the framework already

- Ambition/vision
- Leadership
- Functions, accountability, governance
- Priorities
- Neighbourhoods
- Resident and community engagement
- Commissioning and procurement
- Outcomes and impact
- Resources and capability

Additional elements to consider

- Finance
- VCSE
- Ways of working

Link to framework detail

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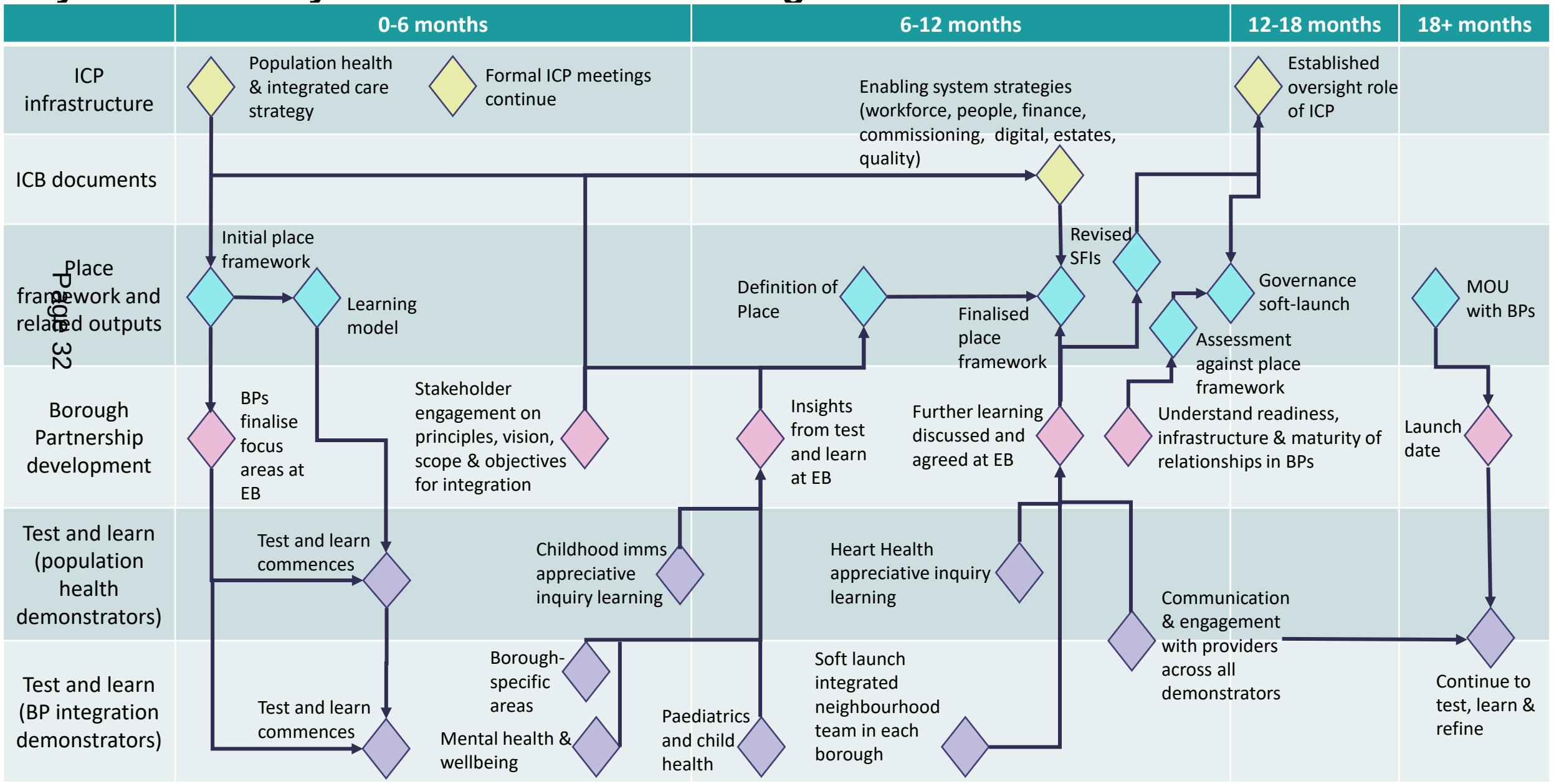
Our Roadmap for developing Borough Partnerships lays out the way forward over the coming 18 months

North Central London Integrated Care System



Moving forward

North Central London Integrated Care System

To address our population health challenges and become a population health system, we will organise delivery around three elements:

1. Five delivery themes
2. Population health development area demonstrators
3. Borough Partnership integration demonstrators

Across our demonstrators we will be willing to remove barriers, create new incentives and protect our teams so they can work more freely in response to what our communities tell us is needed.

We will build on existing learning, draw on and develop the five delivery themes, prototype delivery models and governance arrangements and work through the practical issues that arise when we work as an integrated care partnership.

This document sets out the broad vision of the test and learn approach, as well describing important delivery elements across our five themes. A more detailed plan (our Joint Forward Plan) with milestones, timelines and trajectories will be closely linked to this document and will describe the detail behind this high level view.

We will coordinate delivery around five themes

North Central London Integrated Care System

Aligning resources to need

Transforming how we make decisions about the use of resources by understanding where we have variation in outcomes and creating the frameworks and measures that redirect resources to close the gap

Making population health everyone's business

Developing and improving system-wide access to population health insights and embedding the fundamentals of population health at all levels of our system, including our front-line teams

Strengthening integrated delivery

Further developing our approach to integrated delivery in the Borough Partnerships by creating the context and conditions for success and support building our local integrated teams

Becoming a learning system

Working with NCL's world-leading research and improvement expertise to become a system that is evidence-based, evidence-generating to deliver impact, value, scale and spread.

Collaborating to tackle the root causes of poor health

Creating a better context for good health and well-being for everyone in NCL by collaborating to address the root causes of poor health outcomes and investing locally and responsibly in our communities

Test and Learn Demonstrators

Population Health Development Areas

BP Integration Development Areas

Our key deliverables for each theme

North Central London Integrated Care System

Making population health everyone's business	Strengthening integrated delivery
Developing and improving system-wide access to population health insights and embedding the fundamentals of population health at all levels of our system, including our health and care providers	***Further developing our approach to integrated delivery in the Borough Partnerships by creating the context and conditions for success and support building our local integrated teams***
Insights • Develop and embed system understanding of need • Build a networked intelligence function across partners, including provider organisations • Embed Core20PLUS5 (adults and children/young people) and other PHM insights into frontline care • Add social care, housing and other data sources to include wider determinants of health to integrated dataset • Embed health inequalities indicators across performance metrics • Deliver on the conditions for adoption of our PHM platform • Develop information and clinical governance for integrated care • Develop community and qualitative insights and co-production infrastructure **Fundamentals of population health** • Capacity building - build population health fundamentals into induction programmes across partners, includig provider organisations • Build MECC culture and processes, including incorporating into all staff PDRs • Establish pop health leadership academy across the ICS and build into role descriptions • Embed digital inclusion into all programmes	**Context and conditions for success** • Deliver Borough Partnership Roadmap, including scope, infrastructure and responsibilities/accountabilities • Deliver population health development area demonstrators • Deliver Borough Partnership integration demonstrators **Building local integrated teams** • Shape the neighbourhood offer including role of VCSE • Establish the deliver infrastructure to deliver integrated neighbourhood teams • Integrate and scale personalisation approaches (PCSP, PHB, co-production etc) • Develop a digital supported offer for more proactive care@home and increase levels of digital inclusion • Create the infrastructure and ways of working for one-workforce, one-team approach • Establish the flexible workforce, working to top of license, additional roles, greater use of wider workforce

Our key deliverables for each theme

North Central London Integrated Care System

Aligning resources to need	Collaborating to tackle the root causes of poor health
Transforming how we make decisions about the use of resources by understanding where we have variation in outcomes and creating the frameworks and measures that redirect resources to close the gap	***Creating a better context for good health and well-being for everyone in NCL by collaborating to address the root causes of poor health outcomes and investing locally and responsibly in our communities***
Understanding variation in outcomes • Baseline and monitor outcomes framework • Baseline current spend by geography and demography and how it compares to data on access, experience and outcomes • Define system values and approach to trade-offs to address health inequalities and the wider determinants **Frameworks and measures** • Develop the financial architecture that reflects the differential effort needed to achieve outcomes with different communities, options for movement of resource and investment in prevention • Agree a prioritisation framework with clear and transparent criteria including health inequalities • Develop a population health commissioning framework with increased emphasis on equitable outcomes rather than units of activity • Develop a decision-making framework that balances delegation to Borough Partnerships with system flexibility to support vulnerable populations • Develop plan for investment in the VCSE to support community engagement, volunteering, co-production and hyper-local delivery • Agree finance indicators to measure ambition and set trajectories that reflect the shift of resources to need	• **Anchors –** strengthen our anchor network and joint work programme to maximise our assets within our local communities to build local economies, improve the environment, widen access to good quality employment for local people and increase physical activity • **Social prescribing -** strengthening our social prescribing offer and reach • **Making every contact count –** consolidate our MECC offer in NCL building the wider determinants of health into the brief intervention model alongside lifestyle advice • **Health inequalities fund –** expand the Health Inequalities fund and strengthen scaling of interventions for greater impact • **Inclusion health -** take forward recommendations from the NCL Inclusion Health Needs Assessment • **Development areas –** coordinate action around the common risk factors for our population health development areas, to include both lifestyle risk factors as well as wider determinants of health, such as poor quality housing and air quality • **Green plan –** deliver the objectives of our NCL Green Plan • **Working with our communities –** strengthen our engagement and investment with our VCSE and communities to better understand and act on their needs

Our key deliverables for each theme

North Central London Integrated Care System

Becoming a learning system

Working with NCL's world-leading research and improvement expertise to become a system that is evidence-based, evidence-generating to deliver impact, value, scale and spread

Quality Improvement
- Shift from transactional quality surveillance to a QI approach with a consistent methodology and greater use of afteraction reviews and appreciative inquiry
- Build system improvement collaboratives across partners, including providers

Evidence-based practice
- Co-ordinate with our various academic forums, including Academic Health Science Network (AHSN), Clinical Research Network (CRN), Applied Research Collaboration (ARC) and Biomedical Research Centres (BRC) to develop a common understanding of what each part of the research infrastructure does and provide a single point of access for the system
- Develop our capabilities for evidence-based system problem formulation

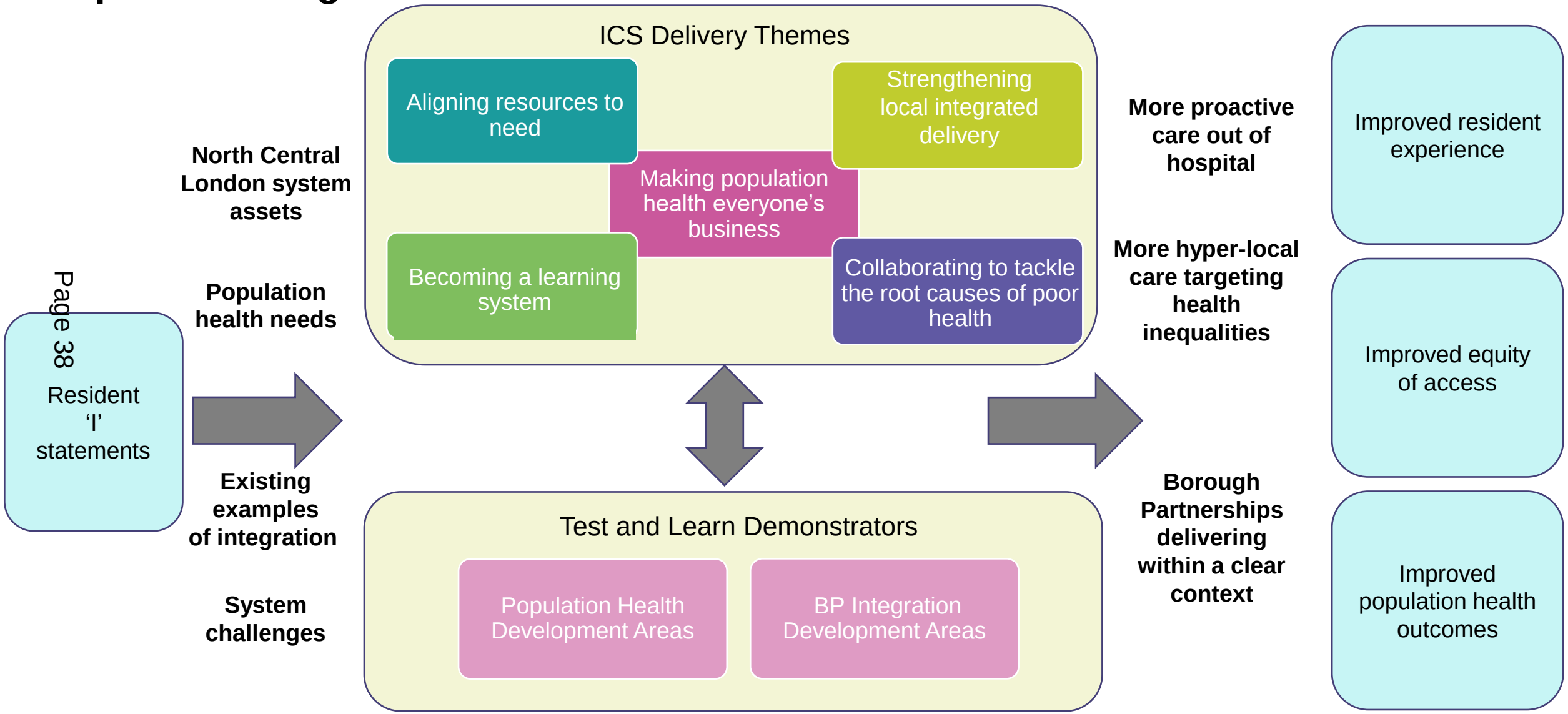
Becoming an evidence-generating system
- Develop our ICS research strategy
- Develop the list of research priorities shared across NCL
- Develop a our approach system-wide research collaboration to steer and scale up evidence-generation and act as a single point of research co-ordination

Build evidence and research – use our research networks to grow and apply the evidence base on high value interventions to tackle the wider determinants of health

Benefits realisation-
- collaborate with our AHSN to model and simulate impact of population health interventions on system demand over time
- Build a system evaluation framework to support evidence-based resource reallocation

Moving forward – our model for change and how all the pieces fit together

North Central London Integrated Care System



Next steps

North Central London Integrated Care System

- This document should set the strategic direction for NCL and guide our future ways of working in order to become a population health system. This document has been developed by, with and for the system so there will now be a phase of wide sharing of the concepts, principles, and deliverables with organisations from across the system.

- Mentioned within the strategy are next steps in the form of deliverables and demonstrators. We are developing a more detailed plan (our Joint Forward Plan) with milestones, timelines and trajectories which will describe the detail behind the high level view laid out in this strategy.

North Central London Integrated Care System

Appendix 1: Engagement summary

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Where we have engaged

North Central London Integrated Care System

PLACEHOLDER SLIDE:
Content in development

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North Central London Integrated Care System

Appendix 2: Glossary

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DRAFT

Glossary

North Central London Integrated Care System

	Definition
Anchor institution	Anchor institutions are large organisations such as NHS trusts and local authorities, which, by their nature, are unlikely to relocate, have a significant stake in their local area, and have sizeable assets which can be used to support local community health and wellbeing, including tackling health inequalities. (NHS Confederation, 2022. Accessed here).
Academic Health Science Network (AHSN)	Academic Health Science Networks (AHSNs) are membership organisations within the NHS in England. They were created in May 2013 with the aim of bringing together health services, and academic and industry members. Some of their aims are to promote economic growth, improve patient safety and putting research into practice. (AHSN. Accessed here).
Borough partnership	Borough Partnerships are partnerships at borough level that include ICB members, local authorities, VCSE organisations, NHS trusts, Healthwatch and primary care. They are responsible for working with local communities to improve health and wellbeing and reduce inequalities.
Becoming A Man programme	The Becoming a Man (BAM) programme is mental well-being intervention that aims to support young men's personal development by taking into account their lived experience and the often difficult environments they must navigate. (Mental Health Foundation. Accessed here).
Core20PLUS5	Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. Core20 refers to the most deprived 20% of the national population as identified by the Index of Multiple Deprivation the national level. The PLUS population are population groups experiencing inequalities who may not be included in the Core 20 are identified at local level. The '5' national focus clinical areas for adults are: Maternity , Severe Mental illness, Chronic Respiratory disease, Early Cancer diagnosis and Hypertension case-finding and optimal management and lipid optimal management and for children are asthma, diabetes, oral health, epilepsy and mental health. (NHSE. Accessed here).
Co-produced	Co-production refers to an approach that brings together service users, carers and staff to shape and develop services and programmes, rather than staff making decisions alone.
Environmental Sustainability	Environmental sustainability is the ability to maintain an ecological balance in our planet's natural environment and conserve natural resources to support the wellbeing of current and future generations. To support the co-ordination of carbon reduction, the NHS set out the requirement for trusts to develop a Green Plan to detail their approaches to reducing their emissions in line with the national trajectories. Given the pivotal role that integrated care systems (ICSs) play, each system are also required to develop its own Green Plan, based on the strategies of its member organisations. (NHSE. Accessed here).
Fuller Stocktake	The Fuller Stocktake report, published in May 2022, sets out a comprehensive vision for locally integrating primary care with system partners, built around a 'Team of Teams' and an improvement culture. (NHSE, 2022. Accessed here).
Health Equity	Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (for example, sex, gender, ethnicity, disability, or sexual orientation). It is the state in which everyone has a fair and just opportunity to attain their highest level of health. (WHO. Accessed here).
Health inequalities	Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. These inequalities are understood and analysed across four, often inter-related, factors: socio-economic factors such as income; geographic factors such as the area where people live; specific characteristics such as ethnicity, disability or sexual orientation; and excluded groups, for example, people experiencing homelessness. (King's Fund, 2022. Accessed here).

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DRAFT

Glossary

North Central London Integrated Care System

	Definition
HealtheIntent	HealtheIntent is a near-real time integrated health and care record in a population health management platform provided by a company called Cerner. It enables our frontline health and care teams to see where patients have gaps in care and creates a better understanding of population health needs and inequalities. (NCL. Accessed here).
Health and Wellbeing board	Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. (King' Fund, 2016. Accessed here).
Healthy life expectancy	Healthy life expectancy is the average number of years that a person can expect to live in good health.
Inclusion health Groups	Inclusion health groups describes groups of people who are socially excluded and may experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes groups of people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery. NHS. Accessed here).
Inequality	Social inequality refers to differential access to and use of resources across various domains (e.g., health, education, occupations) that result in disparities across gender, race, ethnicity, class, and other important social markers.
Inequity	Inequity refers to a lack of equity, which means "justice" or "fairness." Where there's inequity in a community, it means injustice, unfairness, and bias are being perpetuated.
Integrated care	The aim of integrated care is to join up the health and care services required by individuals, to deliver care that meets their personal needs in an efficient way. (Nuffield Trust, 2021. Accessed here).
Integrated Care Board (ICB)	Integrated Care Boards (ICBs) are statutory NHS organisation that are responsible for developing a plan to meet the health needs of the population, managing the NHS budget and arranging for the provision of health services in the area covered by an Integrated Care System (ICS). ICBs replaced Clinical Commissioning Groups (CCGs) in July 2022.
Integrated care partnership (ICP)	Integrated care partnerships (ICPs) are statutory committees that bring together a broad set of system partners (including local government, the voluntary, community and social enterprise sector (VCSE), NHS organisations and others) to develop an integrated strategy on how to meet the health and wellbeing needs of their local population.
Integrated care systems (ICS)	Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. An ICS is a way of working, not an organisation. Partners within the NCL ICS include: Acute Trusts, Mental Health Trusts, Community Trusts, Local authorities (Barnet, Camden, Enfield, Haringey and Islington), Healthwatch and VCSE (Voluntary, Community and Social Enterprise) sector. (NHSE. Accessed here).
Joint Strategic Needs Assessments (JSNAs)	JSNAs are assessments, produced by health and wellbeing boards, of the current and future health and social care needs of local communities. These are needs that could be met by services commissioned (bought) by the local authority, ICBs, or by NHS England to improve the health and wellbeing results of the local community and reduce inequalities for all ages. (GOV.UK, 2013. Accessed here).

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Glossary

North Central London Integrated Care System

	Definition
Lower Layer Super Output Area (LSOA)	Small areas designed to be of a similar population size, with an average of approximately 1,500 residents or 650 households. They were produced by the Office for National Statistics for the reporting of small area statistics. (GOV.UK: Accessed here).
Middle Layer Super Output Area (MSOA)	Middle Layer Super Output Areas are built from groups of contiguous Lower Layer Super Output Areas with appositely 5000 to 7200 residents. (NHS Data Dictionary. Accessed here).
Making every contact count (MECC)	The Making Every Contact Count (MECC) approach encourages health and social care staff to use the opportunities arising during their routine interactions with patients to have conversations about how they might make positive improvements to their health or wellbeing. (HEE. Accessed here).
Neighbourhood	Neighbourhoods are areas where groups of GP practices work with NHS community services, social care and other providers to deliver more co-ordinated and proactive care, including through the formation of primary care networks (PCNs) and multi-agency neighbourhood teams. (King's Fund, 2022. Accessed here).
Personalised care	Personalised care means that patients have more control and choice when it comes to the way their care is planned and delivered, taking into account individual needs, preferences and circumstances. (Personalised Care Institute. Accessed here).
Personal Health Budget (PHB)	A personal health budget is an amount of money individuals receive to support their health and wellbeing needs, which is planned and agreed between patients and their local NHS team. (NHSE. Accessed here).
Place based partnerships	Place-based partnerships are collaborative arrangements between organisations responsible for arranging and delivering health and care services and others with a role in improving health and wellbeing. Place-based partnerships typically involve the NHS, local government and other local organisations with responsibilities for planning and delivering services, such as voluntary, community and social enterprise (VCSE) sector organisations and social care providers. (King's Fund, 2022: Accessed here).
Population Health	Population Health refers to the health of an entire population. A population health approach. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies. (King's Fund, 2022. Accessed here).

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Glossary

North Central London Integrated Care System

	Definition
The four pillars of population health:	The four interconnecting pillars of the King's Fund vision for a population health system are the wider determinants of health, our health behaviours and lifestyles, the places and communities with live in, an integrated health and care system. (King's Fund, 2018: Accessed here).
Primary care networks (PCNs)	Network of general practices that work together at scale to support improved practice staff recruitment and retention, management of financial and estates pressures, provision of a wider range of services, and better integration with the wider health and care system. (King's Fund, 2022. Accessed here).
Population health improvement	Population health improvement aims to improve the health of our entire population by improving physical and mental health outcomes and the wellbeing of people, while reducing health inequalities across the life course.
Population Health Management (PHM)	Population Health Management refers to the use of integrated data by health and care professionals to drive improvement and reduce inequalities. This enables a risk stratified approach to delivering the care that residents need, recognising that there are differing levels of needs amongst our communities and residents. (NHSE. Accessed here).
Primary prevention	Primary prevention aims to prevent disease or injury before it occurs. Example of primary preventions are: immunisation, education about healthy habits and legislation to promote healthy practices. (NHS. Accessed here).
Proportionate universalism	Proportionate universalism is an approach that aims at resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. It is the recommended approach to reducing health inequalities, as outlined in the Marmot Review (2010) following extensive consultation with experts in this field, and building on decades of academic research. (GOV.UK, 2010. Accessed here).
Personalised care and support planning (PSCP)	Personalised care and support planning is a series of facilitated conversations in which the person, or those who know them well, actively participates to explore the management of their health and well-being within the context of their whole life and family situation. (NHSE. Accessed here).
Outcomes Framework	The Outcomes Framework provides a set of outcomes that reflect our population health ambitions for NCL across the life course. Organised around the three domains of Start well, Live well and Age well, these outcomes and indicators will enable us to identify areas of variation across the system, track progress and collectively hold ourselves to account.
The Barbers Round Chair Project	The Barbers Round Chair Project is a local Initiative in Islington where the local authority and the NHS partner up with local barbershops to deconstruct barriers to mental health support and create safe pathways into community mental health services . They do this by training local barbers in Islington to become community mental health ambassadors. (Islington Council. Accessed here).
Secondary prevention	Secondary prevention aims at detecting early stages of disease and intervening before full symptoms develop. (NHS. Accessed here).

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North Central London Integrated Care System

	Definition
Severe and multiple disadvantage	Severe and multiple disadvantage represents the most acute of our 20% most deprived, experiencing a complex and compounding set of issues associated with education, health, lifestyle, employment, income, social support, housing and criminal justice. For example, those experiencing homelessness, substance misuse and mental health issues. The nature of severe and multiple disadvantage (SMD) often lies in the multiplicity and interlocking nature of these issues and their cumulative impact, rather than necessarily in the severity of any one of them. SMD is distinct from other types disadvantage due to the degree of dislocation from societal norms these individuals' experience, which can make them reluctant or difficult to engage with services or solutions that could help.
Social prescribing	Social prescribing enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services to support their health and wellbeing.
Strengths-based	Strengths-based (or asset-based) approaches focus on individuals' strengths (including personal strengths and social and community networks) and not on their deficits. Strengths-based practice is holistic and multidisciplinary and works with the individual to promote their wellbeing.
System	System refers to a wide population area where partners in different sectors come together to set strategic direction and to develop economies of scale. The 'system' in NCL covers the population of 5 boroughs. (NHSE, 2019. Accessed here).
Tertiary prevention	Tertiary prevention denotes preventing complications in those who have already developed signs and symptoms of an illness and have been diagnosed. (Local Government Association. Accessed here).
Voluntary, community and social enterprise (VCSE)	The voluntary, community and social enterprise (VCSE) sector is an important partner for statutory health and social care agencies and plays a key role in improving health, well-being and care outcomes. VCSE are made up of charities, not-for-profit enterprises, informal, unregistered groups consisting of volunteers that act collectedly to provide a service to their local community.
Variation	Variation in healthcare is a difference in healthcare processes or outcomes, compared to peers or to a gold standard such as an evidence-based guideline recommendation.
Wider determinants of health	The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health. (GOV.UK, 2018. Accessed here).

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North Central London Integrated Care System

Appendix 3: Our population health needs

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Health inequalities

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. Health inequalities can involve differences in:

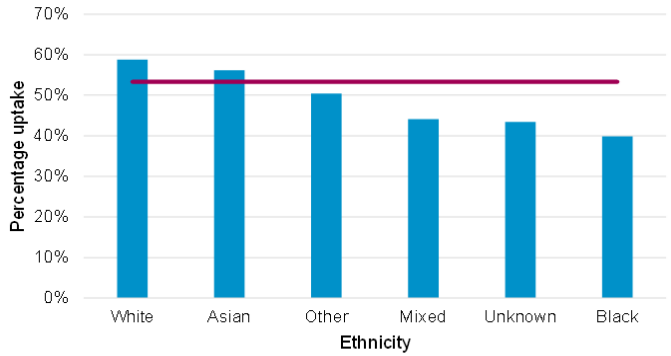
- health status, for example, life expectancy
- access to care, for example, availability of given services
- quality and experience of care, for example, levels of patient satisfaction
- behavioural risks to health, for example, smoking rates
- wider determinants of health, for example, quality of housing.

People may experience different combinations of these factors.

Disadvantage starts before birth and accumulates throughout life and the foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. Therefore it is important to **take a life course approach to improving health and tackling health inequalities**, starting with giving every child the best start in life, including preconception, and continuing through early years and adolescence, working age, and into older age.

North Central London Integrated Care System

Uptake of Covid-19 vaccination, NCL, August 2021



GP records, individuals' registered ethnicity by their GP, snapshot of records

Health inequalities follow a social gradient - the lower one's social and economic status, the poorer one's health is likely to be. As within the social gradient of health, everyone underneath the top has a greater risk of poor health, Marmot et al. (2010) in their first review of health inequalities proposed that resource allocation in healthcare should **follow the principles of proportionate universalism**, whereby health actions are universal but with a scale and intensity that is proportionate to the level of disadvantage. This will have the result of reducing the social gradient in health outcomes thereby reducing health inequalities. If we want to reduce unfair differences in health inequalities it is not enough simply to provide everyone with the same thing (equality) – we need to tailor our interventions and resources according to the needs of different population groups if we want to achieve equal outcomes (equity).

Health inequalities are largely preventable. **There is a strong social justice case for addressing health inequalities, but also a pressing economic case.** It was estimated at the time of the first Marmot review that the annual cost of health inequalities is between £36 billion to £40 billion through lost taxes, welfare payments and costs to the NHS and other services. This is likely to have increased.

As Fenton et al. (2020) showed**, the COVID-19 pandemic highlighted and exacerbated inequalities in health, in particular ethnic inequalities**. The unequal impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) communities may be explained by a number of factors ranging from social and economic inequalities, racism, discrimination and stigma, occupational risk, inequalities in the prevalence of conditions that increase the severity of disease including obesity, diabetes, cardiovascular disease and asthma. A key recommendation made by Fenton was the need to improve access, experiences and outcomes of NHS, local government and Integrated Care System-commissioned services and rebuild trust with our communities.

Inequalities are currently being further exacerbated by the rise in cost of living. We also recognise that climate emergency poses a major threat to human health and that **the populations most impacted by health inequalities are often those most impacted by climate breakdown and poor air quality.**

Sources: King's Fund: What are Health Inequalities? Update June 2022 https://www.kingsfund.org.uk/publications/what-are-health-inequalities; Marmot et al. Fair Society, Healthy Lives, 2010, https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf and Marmot et al. Health equity in England: The Marmot Review 10 years on, 2020 https://www.instituteofhealthequity.org/res
marmot-review-10-years-on-full-report.pdf ; Fenton et al (PHE) Beyond the data: Understanding the
impact of COVID-19 on BAME groups, 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_th

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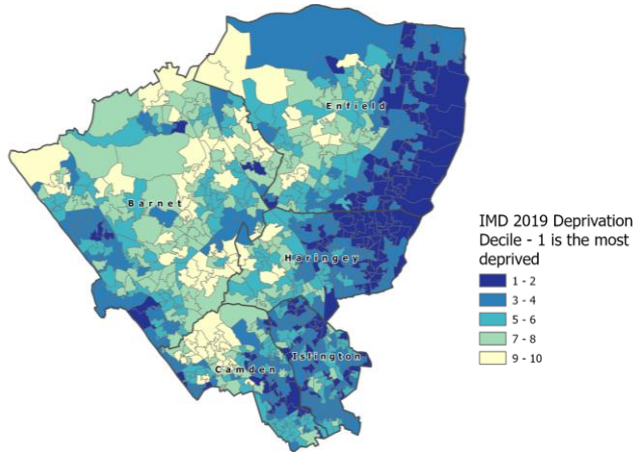
Our population – who do we serve

North Central London Integrated Care System

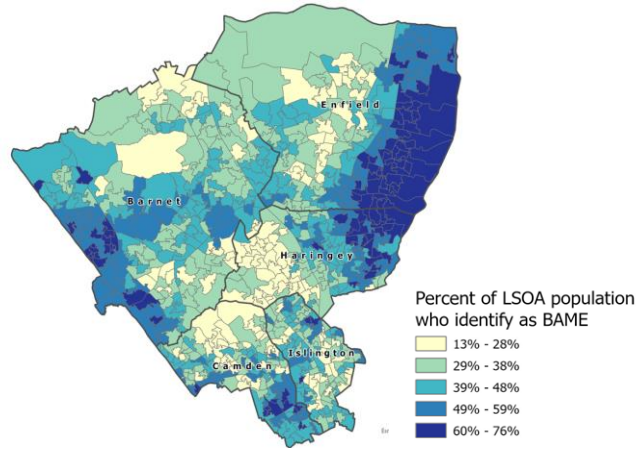
- North Central London (NCL) has a **relatively young resident population of just under 1.8 million people** and a similar number registered with our GPs. Despite large overlap these are not the same populations, and some of our residents remain unregistered anywhere, including from our inclusion health groups.* Alongside our residents, NCL ICS also provides services for people who work, study and visit NCL, as well as people who travel to access our primary and specialist health and care services, particularly tertiary and quaternary services, but do not live within our boroughs.
- Pre-COVID **NCL's resident population was expected to increase by 5% by 2030, with the largest increase in the 65+ year olds** (32% forecast increase overall, ranging from 27% increase in Enfield to 39% in Camden).
- **NCL is the second most deprived ICS in London and there are areas of deprivation across all 5 boroughs, often in close proximity to areas of affluence**. More than 1 in 5 people in NCL live in the 20% most deprived areas nationally, while almost 1 in 3 live in the second most deprived 20% areas. There are distinct spatial patterns of deprivation, with particular concentrations of deprivation towards the east of NCL, with Enfield, Haringey and Islington having on average higher levels of deprivation.
- **Our population is ethnically diverse.** Although, more than half of NCL residents are White, around 20% are of an Asian ethnicity and 20% a Black ethnicity. Barnet and Camden have larger Asian communities, whereas Haringey and Enfield have larger Black communities.
- **Different communities have very different age structures:** there are higher proportions and numbers of children and young people in Bangladeshi (30%), Black African (28%), Black Somali (32%) and Mixed (39%) communities compared to the NCL average (21%). White British (20%), White Irish (29%), Black Caribbean (19%) and Indian (18%) groups have proportionately more residents aged over 65 in their populations, compared to the NCL average (13%).
- **Across North Central London there is a high level of population health need and inequalities.** Improvements in life expectancy across NCL have stalled in recent years and life expectancy and healthy life expectancy have declined following the pandemic. **Residents in all our boroughs are living for 20 years on average in poor health.**
- **Life expectancy and healthy life expectancy varies within and across our boroughs.** Whilst residents in Barnet and Camden have higher life expectancy than the London average, Islington residents and men in Haringey have lower life expectancies. Life expectancy for men living in Upper Edmonton West in Enfield was around 15 years lower than for men and women living in Frognal and Hampstead Town (in Camden), across the five years before COVID-19. Similarly, there is nearly 20 years variation in healthy life expectancy between most and least affluent areas in NCL. For people experiencing homelessness average life expectancy is 30 years shorter than the general population, from largely preventable conditions.

Deprivation profile of NCL, by lower super output area (LSOA)



Source: Index of Multiple Deprivation (IMD_ 2019

Ethnic profile of NCL, by LSOA



Source: Census 2021

*inclusion health groups include for example: people experiencing homelessness, refugees and asylum seekers, sex workers, Irish Traveller and Gypsy, Roma and Traveller communities, t
people, and (ex)offenders.

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Our five boroughs: high level summary

Further detail on each borough's population provided in Appendix 1.

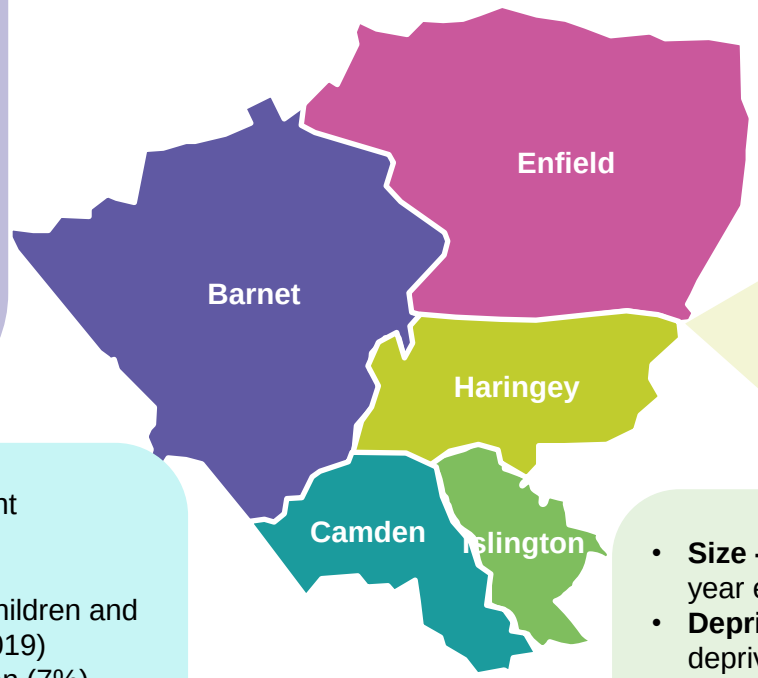
North Central London Integrated Care System

Barnet

- **Size-** 425,395 registered population; 400,064 resident population (GLA mid-year estimate 2020)
- **Significant older population -** 6.8% of the population of is aged 75 years and over, an increase of 11% since 2011 (Census 2021).
- Deprivation **-** 15% of Lower Super Output Areas (LSOAs) in the 30% most deprived nationally (IMD 2019).
- **Ethnicity -** 19.3% of people in Barnet identify as Asian, 7.9% as Black, 5.4% as Mixed, 9.8% as Other and 57.7% as White (Census 2021)
- Barnet has a significantly higher Jewish population (14.5%) compared to the London average of 1.7% (Census 2021), predominantly living in the south of the borough.
- **Some other key needs:** Significantly higher percentage of older people living alone.

Enfield

- **Size -** 338,201 registered population; 334,710 resident population (GLA mid-year estimate 2020)
- **Deprivation -** 7% LSOAs in the 10% most deprived nationally for income deprivation affecting children and 17% for income deprivation affecting older people (2019)
- **Ethnicity - 33.1**% of people in Enfield identify as White British or Irish, 18.6% as White other, 18.3% as Black, 12.1% as Other and 11.5% as Asian (Census 2021). Significantly high proportion of Turkish, Greek and Cypriot communities residing in Enfield.
- **Some other key needs**: 42.2% Year 6 pupils are overweight or obese (2021/22) significantly higher than London; significant high level of GP-diagnosed diabetes in Enfield (8.4%) compared with London (6.8%).



Haringey

- **Size -** 298,418 registered population; 269,506 resident population (GLA mid-year estimate 2020)
- **Deprivation -** 11% LSOAs in the 10% most deprived nationally for income deprivation affecting children and 44% for income deprivation affecting older people (2019)
- **Key ethnicities -** Black African (9%) and Black Caribbean (6%) (Census 2021)
- **Other key communities:** Orthodox Jewish community in Seven Sisters and South Tottenham wards; and Turkish speaking and Eastern European communities
- **Other key needs -** 1.3% population have a severe mental illness (significantly higher than national average).

Camden

- **Size -** 303,267 registered population; 274,695 resident population (GLA mid-year estimate 2020)
- **Deprivation -** 10% LSOAs in the 10% most deprived nationally for income deprivation affecting children and 24% for income deprivation affecting older people (2019)
- **Key ethnicities** - Bangladeshi (7%) and Black African (7%) (Census 2021)
- **Some other key needs -** 6% of the population 18+ are diagnosed with depression (2020/21) compared to 4% NCL average and 1.4% have a severe mental illness (significantly higher than national average).

Islington

- **Size -** 257,135 registered population; 245,320 resident population (GLA mid-year estimate 2020)
- **Deprivation -** 29% LSOAs in the 10% most deprived nationally for income deprivation affecting children and 50% for income deprivation affecting older people (2019)
- **Key ethnicities:** Black African (8% of population) and Black Caribbean (3%) – particularly Somali (Census 2021)
- **Some other key needs -** 7% of the population 18+ are diagnosed with depression (2020/21) compared to 4% NCL average and 1.4% have a severe mental illness (significantly higher than national average).

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Our population's health needs (1)

North Central London Integrated Care System

To inform our strategy and outcomes framework we are starting a high-level NCL needs assessment to complement the borough Joint Strategic Needs Assessments (JSNAs). Some of our key population needs and challenges highlighted by our Outcomes framework, our borough JSNAs, our NCL needs assessment, our inclusion health needs assessment or major service transformations are shown here:

Poor health accumulates throughout the life-course

Start well	Live well	Age well

Key population drivers compound and lead to poor health outcomes and inequalities

Health outcomes

Pre-natal - There were 238 still births in NCL between 2018-20; Haringey has a significantly higher rate of stillbirths than the England average.

Infancy - Newborn hearing screening coverage across NCL is lower than London & England.

Early years - NCL has the lowest 2 year old MMR coverage in England.

Childhood - Hospital admissions for asthma are higher than average for children and young people in Islington and for epilepsy, Barnet has a higher rate.

The prevalence of mental illness in under 18s in NCL is almost double London average.

Hosptial admissions for self-harm among young people are higher in Barnet and Islington compared to London.

Increasing mental and physical health needs and multi-morbidity - More than 1 in 4 people in NCL have a long-term condition (LTC). A quarter of those with LTCs have 3 or more conditions. 21% more people have 3 or more LTCs since the pandemic.

Nearly 6,000 new cancers are diagnosed each year, with rates higher in Enfield than London average.

Around 1 in 5 residents have a common mental health illness. Rates in Haringey and Islington exceed London rates.

NCL has the highest prevalence of severe mental illness (SMI), among ICS in England. Fewer than half of those with an SMI have a comprehensive care plan.

Missed opportunities for prevention and early intervention - Fewer than 1 in 3 people have an NHS Health Check, considerably lower than the London average.

Fewer than 3 in 4 people with Chronic obstructive pulmonary disease (COPD) have the flu vaccine, with coverage lower than London.

Cancer screening coverage in NCL is significantly lower than London - half of women do not get breast cancer screening.

All NCL boroughs fall short of the national standard that 60% of people with SMI should have a full physical health check in primary care.

Increasing needs – Haringey, Islington and Camden have among highest levels of frailty for 50+ in London. 65+ year olds with moderate/severe frailty are estimated to have increased by 15% due to the pandemic.

NCL has a higher prevalence of Dementia than London average but only 39% of people with dementia have had their care plan reviewed in the past 12 months.

Missed opportunities for prevention and early intervention - 24% early deaths in NCL (from cardiovascular disease, cancer and respiratory diseases) are thought to be avoidable (preventable and/or treatable).

65+ flu vaccination coverage is lower than London and England averages. Uptake is particularly low in Haringey.

1 in 5 older people went back hospital within 3 months of discharge into rehabilitation in NCL, higher than the London and England averages (2019/20)

Lifestyle risk factors

Smoking - 1 in 20 mothers are smokers at time of delivery, above London and England averages

Obesity - 37% pupils in NCL leave primary school overweight/obese, rising to 42% in Enfield. Obesity prevalence more than doubles from Reception to Y6.

Smoking - More adults smoke in NCL (16%) compared to London, with higher rates in the more deprived boroughs. Smoking cessation is lower in NCL than London

Obesity - While adult overweight/obesity levels are lower or no different than the London average, in Barnet and Enfield, nearly 60% are overweight/obese

Alcohol - While overall NCL has lower than average alcohol-related admissions, there are high rates in the most deprived boroughs, particularly Islington.

Health inequalities

Wider determinants

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Our population's health needs (2)

North Central London Integrated Care System

To inform our strategy and outcomes framework we are starting a high-level NCL needs assessment to complement the borough Joint Strategic Needs Assessments (JSNAs). Some of our key population needs and challenges highlighted by our Outcomes framework, our borough JSNAs, our NCL needs assessment, our inclusion health needs assessment or major service transformations are shown here:

Poor health accumulates throughout the life-course

Start well	Live well	Age well

Key population drivers compound and lead to poor health outcomes and inequalities

Health outcomes

Lifestyle risk factors

Health inequalities

Deprivation - Those living in the most deprived communities in NCL have a 50% higher death rate from avoidable causes of death compared to the NCL average. The prevalence of childhood asthma is almost double in the most deprived areas in NCL. People living in the more deprived areas of NCL have higher rates of GP appointments, A&E admissions and mental health contacts compared to those living in less deprived areas.

Ethnicity - Black communities in NCL are more likely to die prematurely from preventable (e.g. smoking cessation) or treatable (e.g. atrial fibrillation detection) causes of cardiovascular disease and are higher users of acute mental health services, with 27% of admitted patients being Black, compared to representing 11% of the NCL population.

Severe and multiple disadvantage and inclusion health groups - The average life expectancy of someone experiencing homelessness is only 45 years. The most acute of our 20% most deprived, experience a complex and compounding set of issues associated with education, health, lifestyle, employment, income, social support, housing and criminal justice and often fall through the gaps in service provision. They cost the system 10x that of an average resident.

Wider determinants

Education - Significantly fewer children in Enfield have good development at the end of Reception. Camden & Enfield have significantly fewer children achieving 5 or more GCSEs than the London average, only Barnet has more.

Poverty - Almost 1 in 5 under 16s live in poverty - Islington has the highest rate of child poverty in London.

Every borough in NCL has a higher percentage of older people living in poverty compared to the England average, equating to about 51,000 older adults.

Over a third of 60+ year olds in Islington live in poverty. A higher proportion of residents in Enfield (12.4%) and Haringey (14%) are in fuel poverty than the London average (2020).

These rates are likely to increase with the cost of living crisis.

Housing - Haringey has significantly higher levels of homelessness (22 per 1.000 households in 2020/21) compared to London and also overcrowding - at the time of the last census 16% households were overcrowded in Haringey, the 4th highest in London.

Employment - Significantly fewer residents are employed (71%) compared to London, with particularly low rates in Enfield. Only a third of people with severe mental health illness or a learning disability are in employment compared to nearly half in London.

Environment - Air quality (e.g. concentrations of PM2.5) is significantly poorer in Camden, Haringey and Islington than London, and poorer in all boroughs compared to England; air pollution accounts for 1 in 20 deaths. Between 2000-2019 there were 170 excess deaths attributable to heat in London each year.

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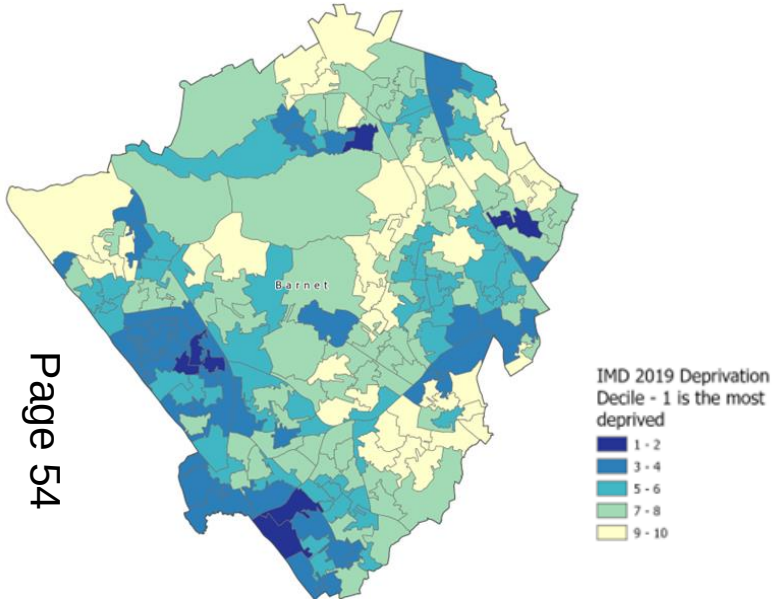
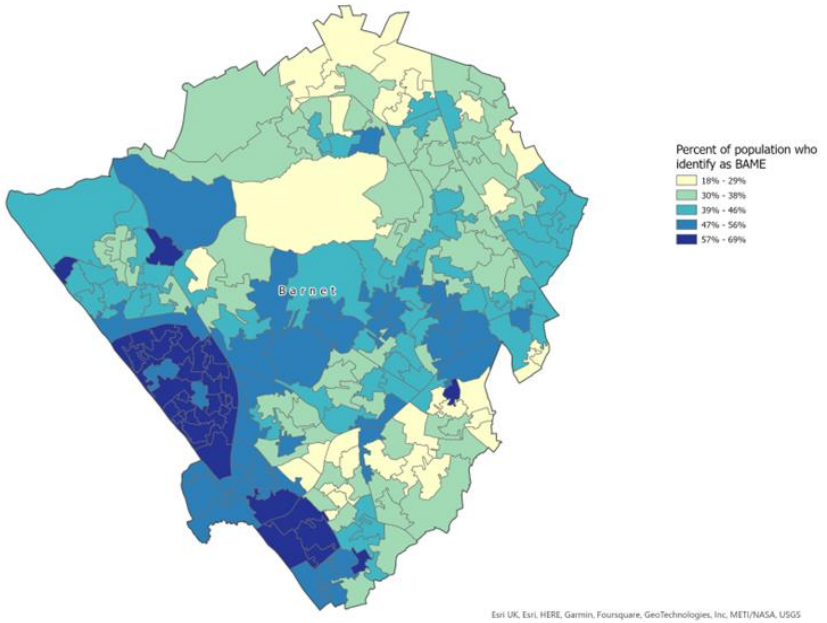
Barnet's population

North Central London Integrated Care System

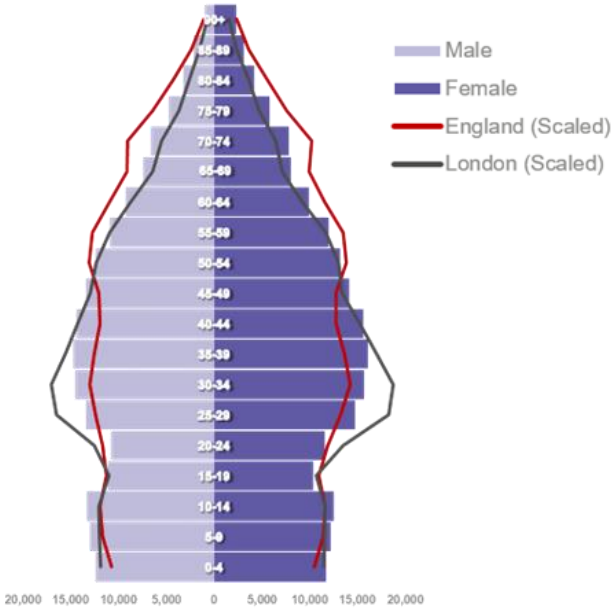
Deprivation profile by LSOA (IMD 2019)



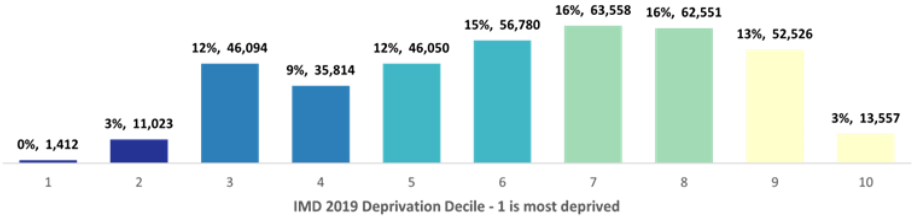
Ethnicity profile by LSOA (Census 2021)



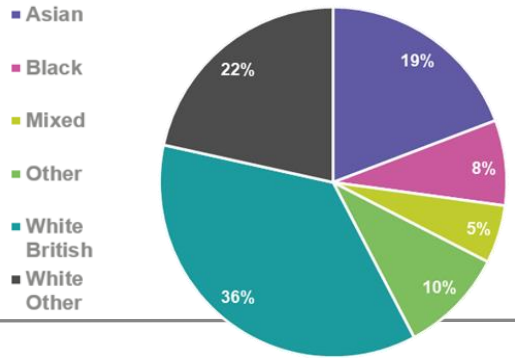
Age and sex profile (Census 2021)



Number and proportion of population in each deprivation decile (national ranking) (IMD 2019)



Proportion of population by broad ethnic group (Census 2021)



Key population groups experiencing inequalities

- 14.5% of people in Barnet are Jewish (Census 2021), significantly higher compared to the London average of 1.7%. The top three middle super output areas (MSOAs) in Barnet having the largest population of Jewish residents are in the south of the borough; Golders Green North (53.1%), Hendon Park (43.9%) and Hampstead Garden Suburb (42.9%) which, aside from Garden Suburb, are amongst the most deprived areas of Barnet.
- Ethnic groups with high proportion living in most deprived 40% - 0-18s of Black African ethnicity

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Camden's population

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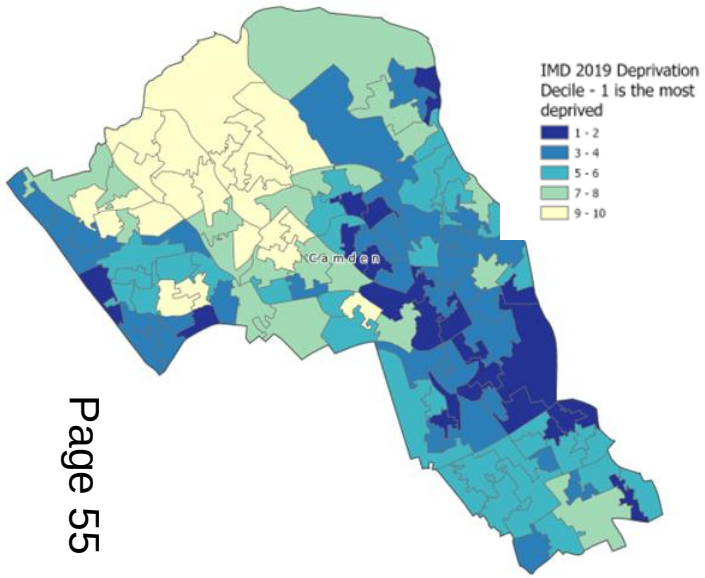
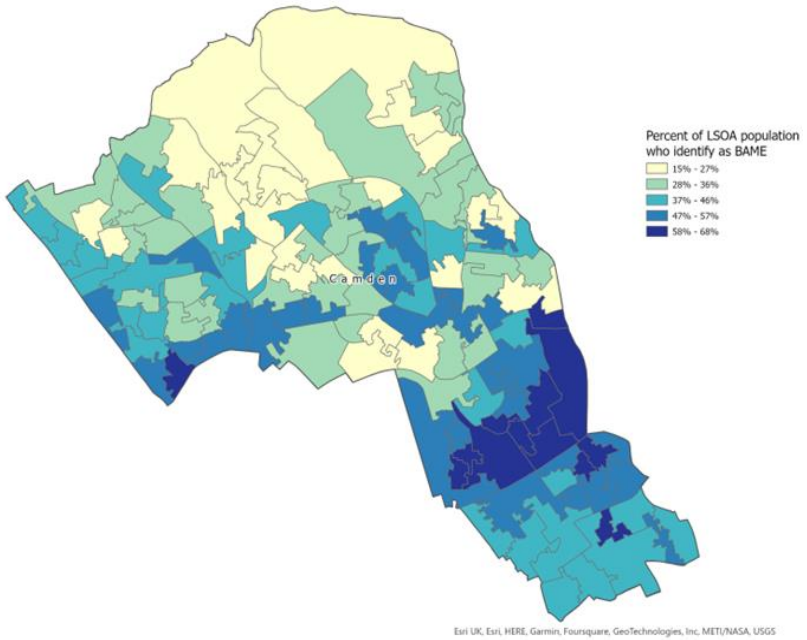
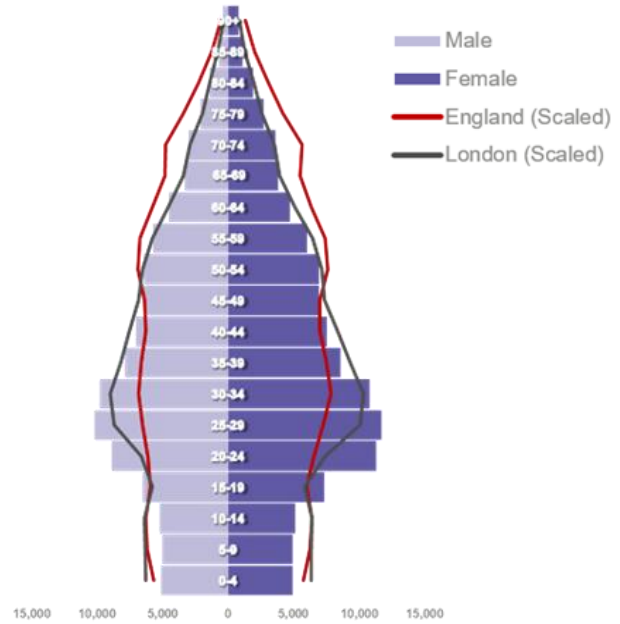
Deprivation profile by LSOA (IMD 2019)



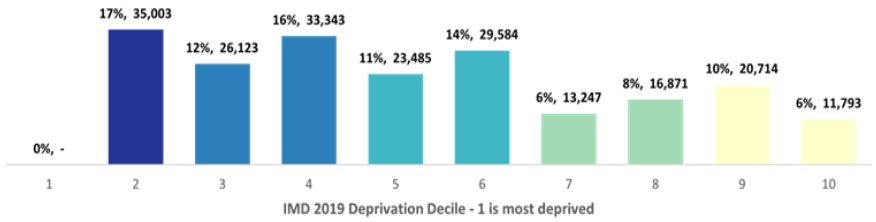
Ethnicity profile by LSOA (Census 2021)



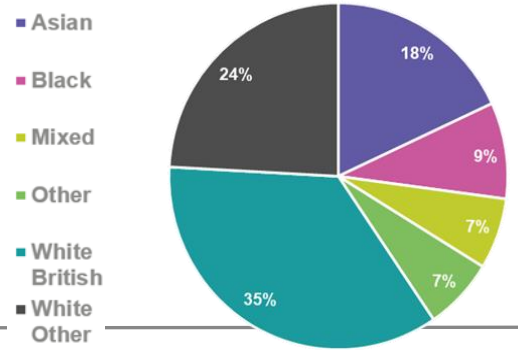
Age and sex profile (Census 2021)



Number and proportion of population in each deprivation decile (national ranking) (IMD 2019)



Proportion of population by broad ethnic group (Census 2021)



Key population groups experiencing inequalities

- Key ethnicities: Bangladeshi (7%) and Black African (7%) (Census 2021)
- Ethnic groups with high proportion living in most deprived 40% - 0-18s of Bangladeshi and Mixed Black ethnicities

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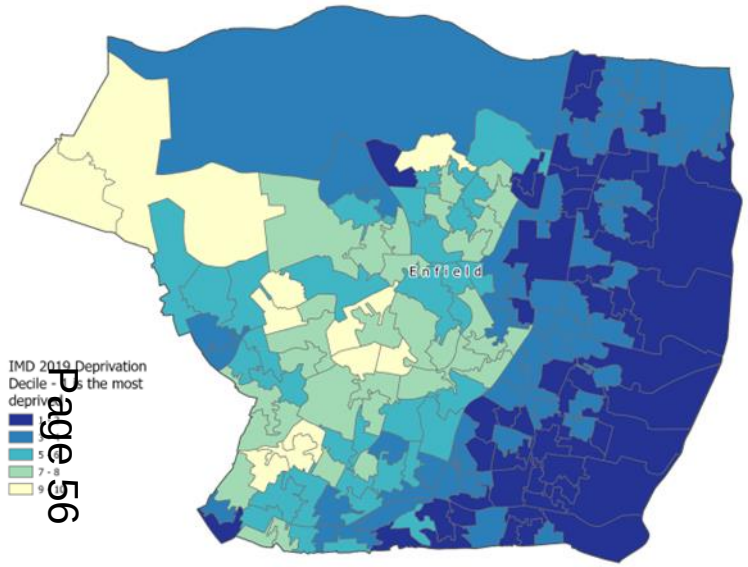
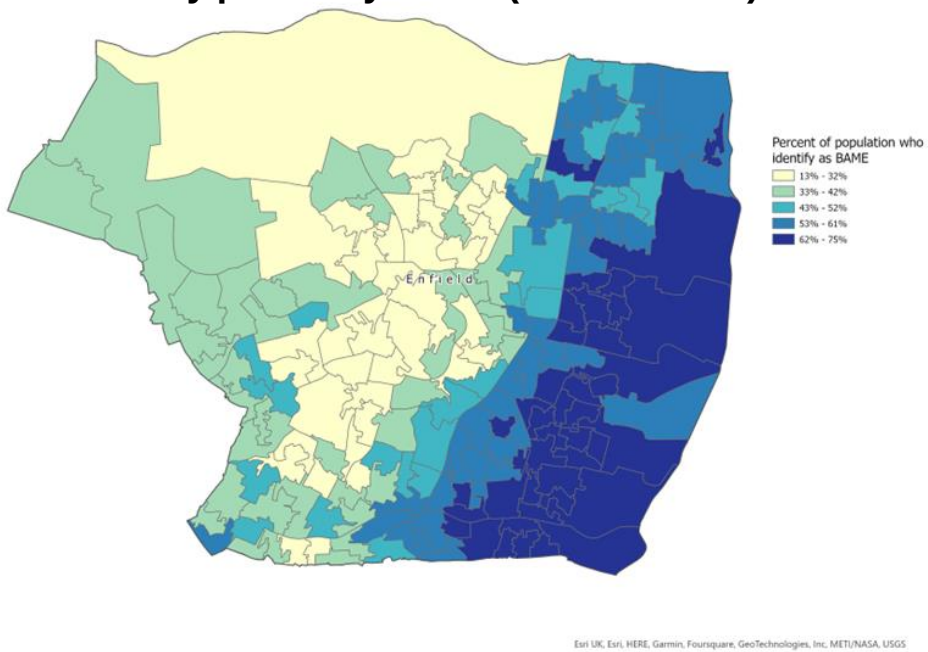
Enfield's population

North Central London Integrated Care System

Deprivation profile by LSOA (IMD 2019)

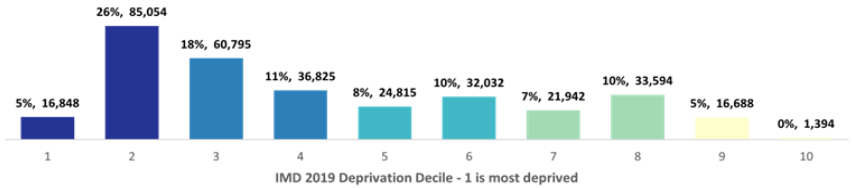


Ethnicity profile by LSOA (Census 2021)

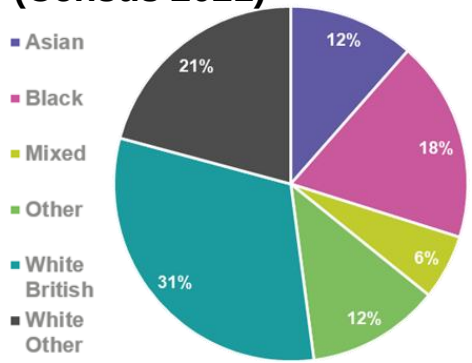


Age and sex profile (Census 2021)

Number and proportion of population in each deprivation decile (national ranking) (IMD 2019)



Proportion of population by broad ethnic group (Census 2021)



Key population groups experiencing inequalities

- Key ethnicities: Bangladeshi (7%) and Black African (7%) (Census 2021)
- Ethnic groups with high proportion living in most deprived 40% -
  - 0-18s - Black African, Black Somali, Bangladeshi
  - 19-64 – White Turkish and White Bulgarian
  - 65+ - Black Caribbean

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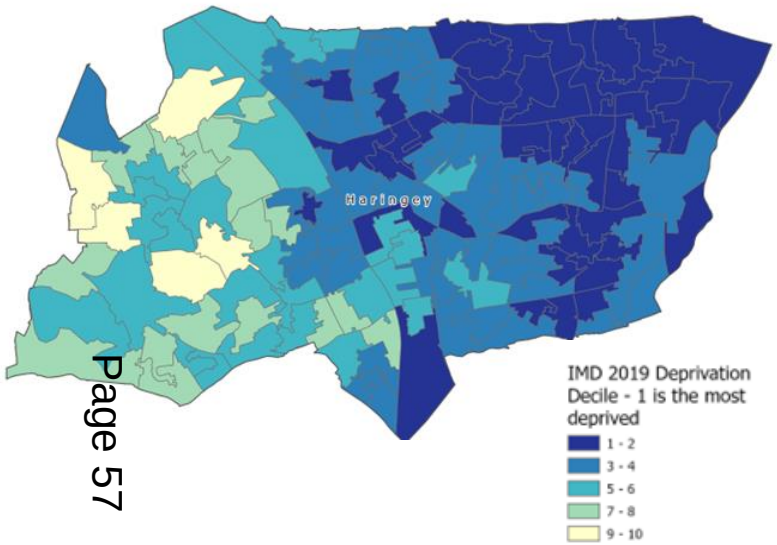
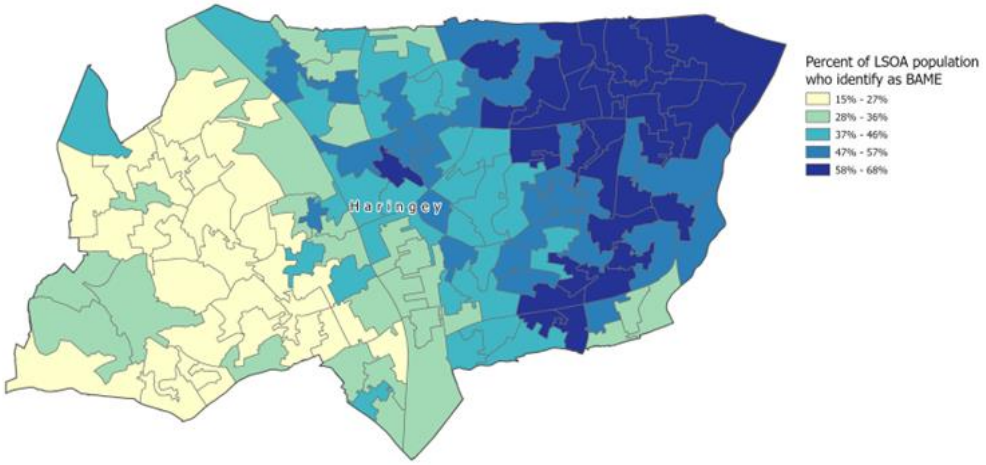
Haringey's population

North Central London Integrated Care System

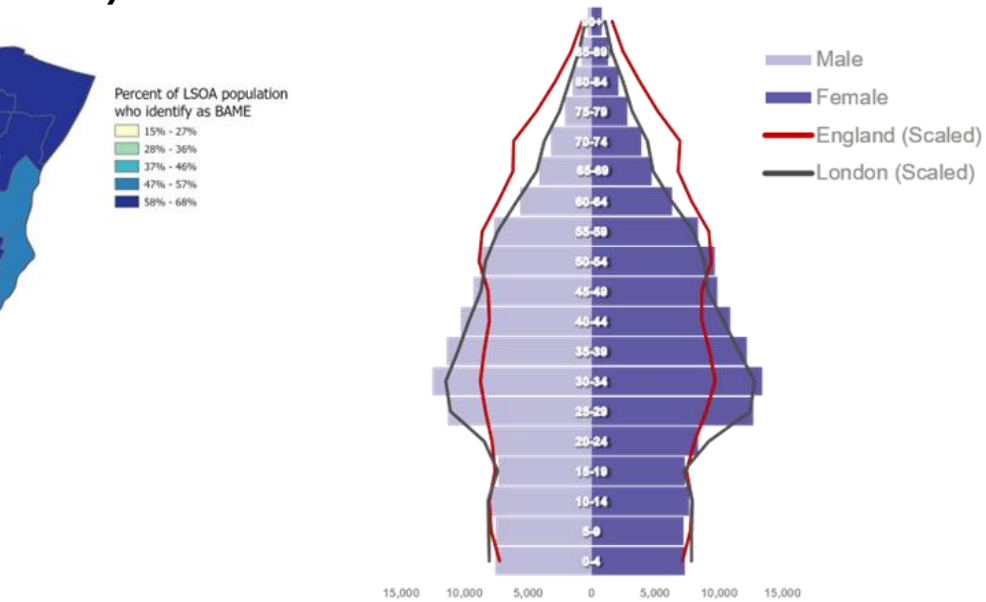
Deprivation profile by LSOA (IMD 2019)



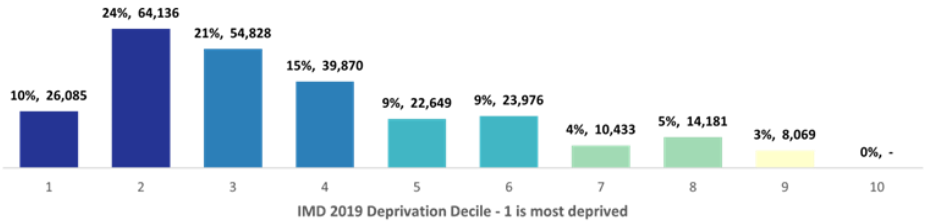
Ethnicity profile by LSOA (Census 2021)



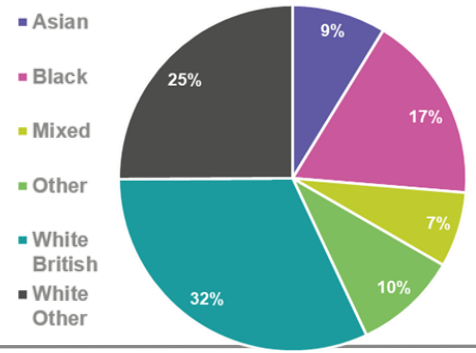
Age and sex profile (Census 2021)



Number and proportion of population in each deprivation decile (national ranking) (IMD 2019)



Proportion of population by broad ethnic group (Census 2021)



Key population groups experiencing inequalities

- Key ethnicities: Black African (9%) and Black Caribbean (6%) (Census 2021)
- Other key communities: Orthodox Jewish community in Seven Sisters and South Tottenham wards; and Turkish speaking and Eastern European communities
- Ethnic groups with high proportion living in most deprived 40% -
  - 0-18s - Black African, Black Somali,
  - 19-64 – White Turkish and White Bulgarian
  - 65+ - Black Caribbean

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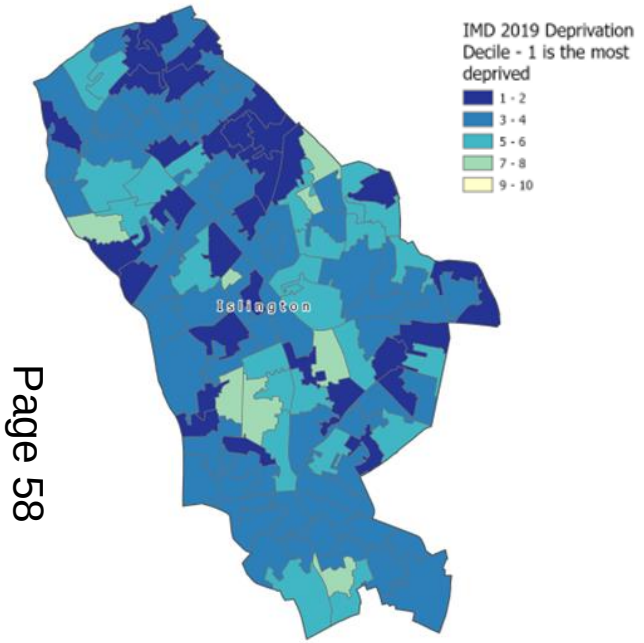
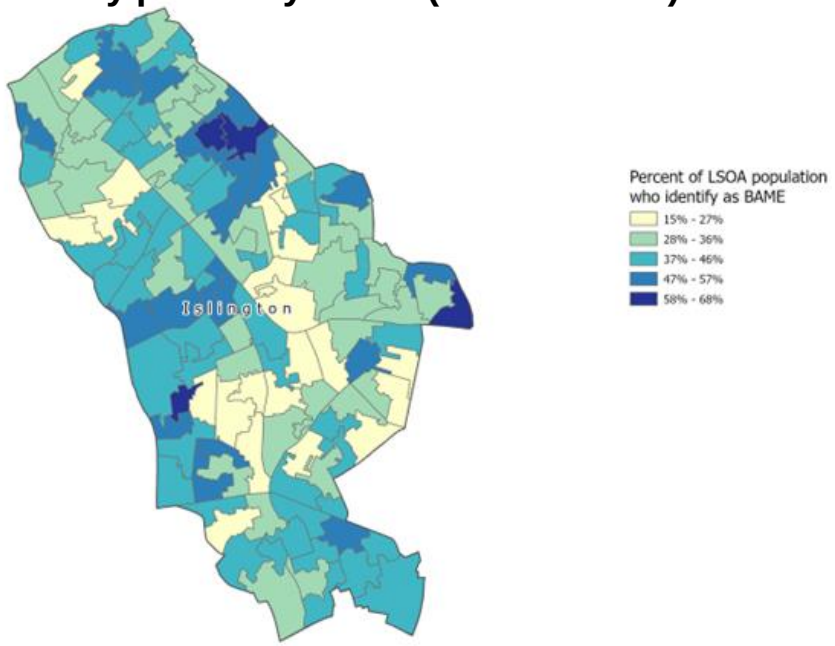
Islington's population

North Central London Integrated Care System

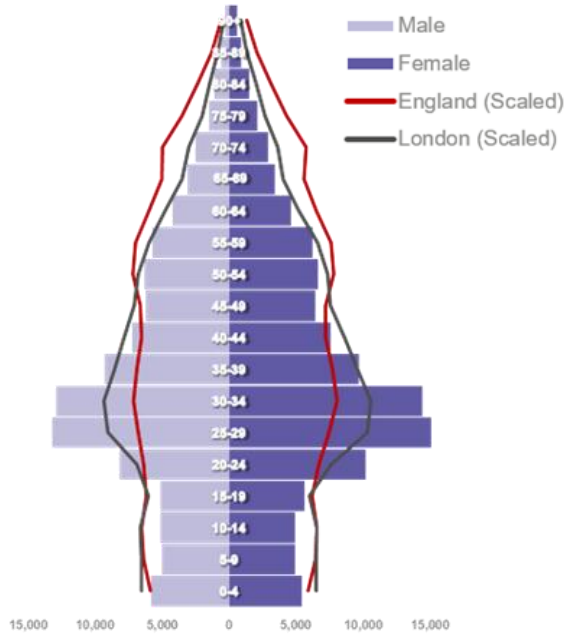
Deprivation profile by LSOA (IMD 2019)



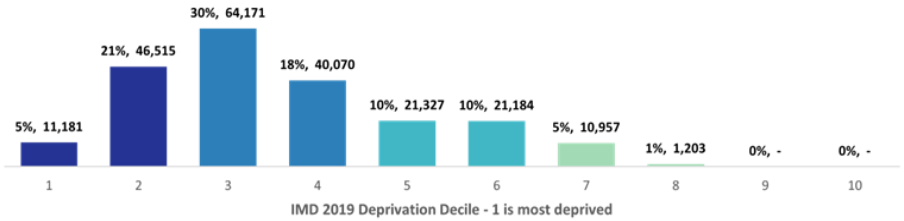
Ethnicity profile by LSOA (Census 2021)



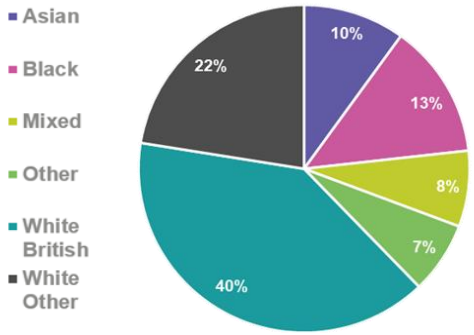
Age and sex profile (Census 2021)



Number and proportion of population in each deprivation decile (national ranking) (IMD 2019)



Proportion of population by broad ethnic group (Census 2021)



Key population groups experiencing inequalities

- Key ethnicities: Black African (8% of population) and Black Caribbean (3%) – particularly Somali (Census 2021)
- Ethnic groups with high proportion living in most deprived 40% - 0-18s of Black African, Black Somali and Mixed Black ethnicities

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North Central London Integrated Care System

Appendix 4: What our communities tell us

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What do our communities say?

North Central London Integrated Care System

While engaging and working with our residents and communities, we have consistently heard feedback and insights across several key themes;

No choice but to attend A&E

- Unable to get GP appointments (hard to get through on the phone, difficulties with online booking systems)
- Other drivers; poor experience of primary care services, life barriers such as zero hours contracts or not understanding how to navigate the system
- NHS 111 not reliable for support & advice
- Narrow eligibility criteria and/or limited access to services outside business hours or on weekends, mean people turn to A&E as health deteriorates

Lack of resourcing for VCSE partners who provide important community support and advocacy

- Community support enables local people to overcome the barriers to services, address the wider determinants and health inequalities
- Lack of funding for 'general' advice & support
- Residents value receiving information in their own language and having the opportunity check their understanding and go over important points with VCSE partners

More holistic, person-centred care

- Treat a whole person rather than a health condition, particularly when managing a long term condition
- Poor integration and communication between services, patients distressed at having to repeat their stories
- Better integration with wider services that impact health, such as housing and domestic violence services
- More shared discussions and involvement in decision making, empowerment to manage conditions and stay well

Lack of trust impacting on engagement, and use of services

- Building relationships and creating trust through consistency requires time, skills and resources to engage with communities
- Organisations don't always see the value, instead viewing engagement as time consuming requirement or legal duty

Lack of good quality and affordable housing, resources and green spaces that promote health

- Overcrowding and poor quality housing contributing to poor health
- More work needed on air pollution
- Importance of green spaces, and the need to make active travel accessible

System is complex & difficult to navigate

- Poor signposting, lack of and/or conflicting information about services available, how to access appointments etc.
- Reliance on services/staff to support system navigation doesn't support self management

Poor access to interpreters, lack of empathy for cultural and/or disability-related needs

- Difficulty accessing interpreting and translation support, particularly in primary care
- Residents from non-English speaking backgrounds feeling 'less than' when trying to access care
- Can result in people dropping out of care or avoiding engaging with clinical services at all
- Lack of cultural understanding or sensitivity, and culturally relevant or sensitive materials/ resources
- Language, communication and cultural understanding important for front of house and reception staff who support access and navigation of services

Mental health care

- Better transition from child to adult services
- More peer support, lived experience models of care
- Many experiencing isolation and loneliness

Keeping well

- More emphasis on & access to prevention support
- More consistency in services regardless of where you live

Digital exclusion, IT literacy and online safety remain key concerns for many

- Access to digital services may also be limited by availability of private spaces, access to laptop devices, smart phones, and wifi or data
- Existing challenges further exacerbated by the pandemic, particularly for accessing primary care
- Can be particularly difficult for people from non-English speaking backgrounds and/or with sensory impairments – may disrupt access completely
- Online settings can pose safeguarding challenges for those at risk of abuse

Constant worry about staying afloat as we move from the hardships of COVID-19 into the cost of living crisis

- Combined challenges of COVID-19, staying warm, affording food and accessing health services overwhelming
- Concerns around affording basic food and energy costs, losing homes, and maintaining access to benefits and other services that require digital or phone

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North Central London Integrated Care System

Appendix 5: Our system challenges

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Our system challenges

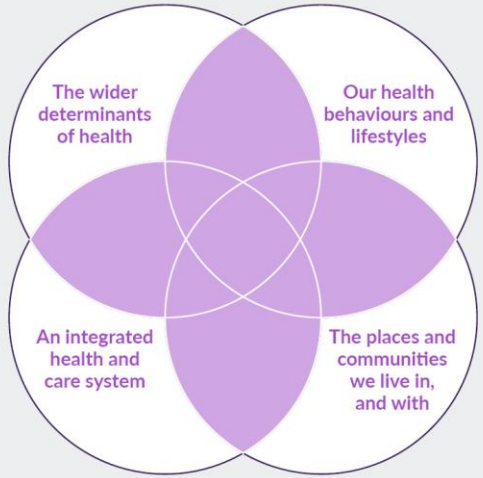
North Central London Integrated Care System

We know our population needs, outcomes and priorities but we also know that working in the way we always have will not be enough to achieve change

Our health and care system is fragile and beset with big challenges.

We have worked across health, care and voluntary sector partners to agree what we see as our system challenges.

We will meet these challenges through describing the change we need to make and the 10 key principles that will help us get there



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Our system challenges (1)

North Central London Integrated Care System

While we are driving efficiencies across the system, we are struggling to meet the growing and increasingly complex needs of our population	**For example:** • Primary care appointments across NCL increased by 23% from February 2020 to February 2022 • NCL outpatient appointment rates (pre-Covid) almost doubled for each condition a patient has, reaching an average of 7 appointments per year for those with 3 or more LTCs, while emergency admission rates increased more than tenfold (3.5 patient events per year per 100 population for those with no LTCs, compared to 38.5 patient events per year per 100 population for those 3 or more LTCs) • NCL has reduced our long waiting cohort (patient waiting over a year) by just under one third (32%) since Jan 2022, by far the largest reduction in London (average 10% growth) • However, 260,000 patients in NCL are waiting on an acute treatment pathway, a 30% increase on pre-covid levels • Increased demand and costs of services led to a 6% increased net spend on adult social care across North London Councils between 2019/20 and 2020/21 • Councils are delivering significantly more 24-hour packages and double up care for adult social care, while care home placement costs are rising close to the rate of inflation. • There has been a 24% increase in rough sleeping in the London overall in 22/23 (CHAIN report) with a 35% rise in those new to the streets compared with the same period last year" as example of impact we are already seeing re cost of living
Alongside historic differences in funding across the system, we are facing relentless financial pressures compounded by the cost-of-living crisis	**For example:** • The NHS in NCL is currently operating a £45m deficit • From 2017-18 to 2019-20, there was considerable variation in place-based allocations for community health services across NCL, with Enfield receiving the least and between 16% and 20% less funding per weighted capita compared to Camden with the highest allocation. • The average savings targets for local authorities in London for 2023/24 is forecast to be double the targets for 2022/23, level of greater than at any time since 2016
Our health and social care pathways are fragmented, acute-focused and demand-driven which leads to poorer outcomes for our population as well as inefficiencies, duplication and waste across the system	**For example:** • Acute health services accounted for more than half of (52%) of NCL's £1,493.6m of spend in 2020/21, even though primary care makes up 80-90% of health care contacts. • Between April 2018 and December 2020, nearly half of all adult admissions to Barnet, Enfield and Haringey Mental Health Trust were not under the care of any community mental health service at the point of admission. • Fragmentation and complexity in children's health and care service commissioning and delivery can delay and disrupt care impacting patient experiences and outcomes, as well as increasing the risk of children, particularly those with complex needs, falling through the gaps.
We have inequity and variation in service access, delivery and investment across NCL, which does not always reflect our population and their needs	**For example:** • Enfield's prevalence of diabetes is twice that of Camden (10% compared to 4%) yet the community diabetes resource is less than half the size 1.6fte compared to 3.5fte diabetes team staff per 100,000 weighted population • In Haringey children and young people have higher mental health needs relative to other boroughs, with highest number of children and young people presenting at A&E with mental health issues, but the spend per head is lower than NCL average
We do not operate as one system, and do not always understand the drivers, challenges and strengths of our partners	**For example:** • Divergent governance, funding mechanisms and capacity across the system can limit the ability of organisations to effectively plan, design and deliver collaborative initiatives • The statutory sector can both overestimate (short lead-in time for projects; misalignment between referrals and resource) and underestimate (underutilisation given the scale and reach on specific issues, with specific communities, often at hyper-local level) the capacity within the VCSE.

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Our system challenges (2)

North Central London Integrated Care System

Our workforce is stretched, we have rising levels of staff vacancies and falling retention across health and social care, and our senior staffing does not reflect our local population	**For example:** • Current staff vacancies stand at 11% for NHS staff and 12.7% for adult social care, the latter more than doubling since between 2020/21 and 2021/22 although still below the London average. • With just under one third of social care workers aged over 55 years, approximately 10,000 care staff in NCL will retire in the next 10 years. For NHS providers in NCL this figure is 14.4% of workers, equal to 6,400 staff • Average pay in the independent caring sector is £9.93 per hour, well below the London Living Wage of £11.95 per hour • The proportion of NCL staff from Black Asian and minority ethnic backgrounds increased by from 42% in 2019 to 46% in Jun 2022. However, there were significant differences by band: for example, 57% of Band 5 staff in NCL were from Black, Asian, compared to only 27% of Band 8 and 9 (London average 27%, national average 14%)
We do not always recognise and utilise the broad expertise, knowledge and strengths of our communities and voluntary sector	**For example:** • Insufficient funding and resourcing for wider engagement and collaboration, including capacity and infrastructure for strategic thinking conversations - production of work tends to be within allocated block • Fragmented short-term funding cycles, with a lack of alignment of funding and resourcing across NCL, which creates inefficiencies and limits the reach of the sector • Not involving the sector in system solution-solving discussions and not giving them a 'seat around the table' as plans are developed and decisions are made • Although we have a strong VCSE Alliance in NCL, it remains challenging to capture the input and share feedback to such a broad and diverse sector - particularly for smaller organisations with less visibility • Complex ICB processes limit smaller grass roots organisations from fully engaging in our work, which in turn may limit representation of under served communities.
The climate crisis and ecological emergency pose serious threats to our system and our population, via direct impacts on health and wellbeing, impacts on the wider determinants and disruptions to health and social care delivery	**For example:** • In England, the NHS responsible for an estimated 4% of the country's carbon footprint, and 40% of the total public sector footprint. • Between 2000-2019 there were 170 excess deaths attributable to heat in London each year • All five NCL boroughs have declared climate emergencies • A London Councils poll in September 2022 showed 62% Londoners felt their day-to-day life had been impacted by climate change, compared to 55% last year
Our estates and facilities are not fit for purpose, future proofed, and are not conducive to integrated and collaborative working	**For example:** • While 56% of Camden and Islington GP practices received a Quality rating of Raw Grade B, just under 40% were rated Raw Grade C • There is an opportunity to improve maternity and neonatal facilities within NCL, ensuring that the estate does not detract from the care or birth experience – for example we know that current the maternity and neonatal estate at the Whittington Hospital does not meet agreed modern standards.
While digital innovation has supported improved service access and experience for some groups, this is not universal and issues related to digital exclusion and online safety remain	**For example:** • Issues related digital inclusion affects around one in seven people in the UK; • Digital exclusion exacerbates existing inequalities – digital exclusion is 4x more likely in those from low-income households; those digitally excluded are 8x more likely to be aged over-65 years ; 56% of adult 'non-internet' users are disabled

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North Central London Integrated Care System

Appendix 6: Childhood immunisations rationale

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Rationale for starting with childhood immunisation

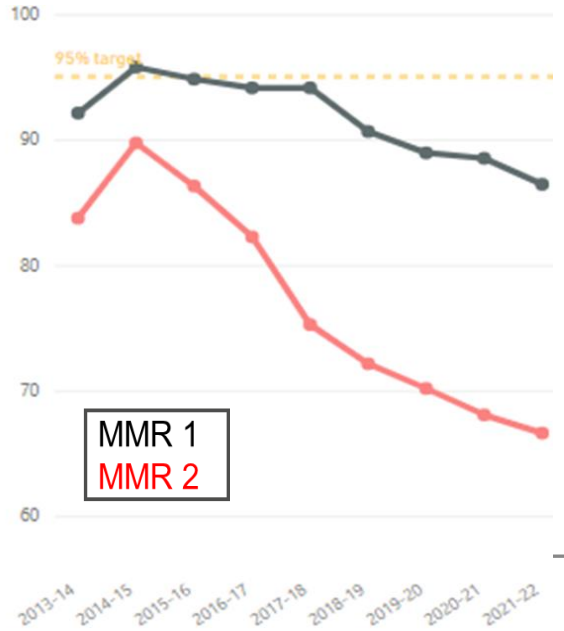
North Central London Integrated Care System

Contributes to meeting the following population health outcome within the Outcomes Framework:
Every child has the best start in life and no child is left behind: Increased immunisation and newborn screening coverage

NCL is an outlier in terms of vaccination coverage:

- Coverage is below London and far below England for almost all childhood immunisations across NCL as a whole, and in individual boroughs
- Coverage for Measles, Mumps and Rubella combined vaccine (MMR) by age 5 (69% in 2020/21) is far below the level for herd immunity and to achieve and sustain measles eradication (95%)
- NCL is the worst ICB in London for MMR first dose coverage.

MMR by age 5, Islington (% coverage), Cover data



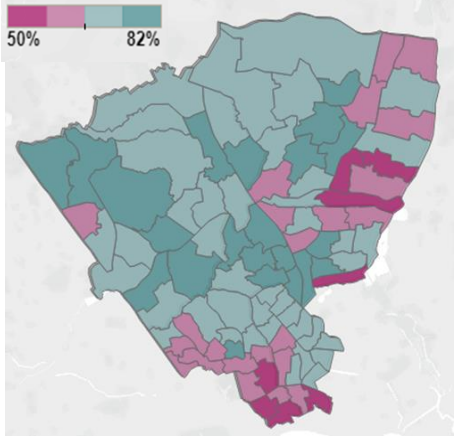
Population health fit and key inequalities:

- Proven, cost-effective, preventative intervention to improve public health - vaccinations have transformed the health of children across the world to prevent disease, long term disability, reduce deaths and rates of related illnesses and complications as well as build and develop 'herd immunity' which is essential to protect those who are unable to be immunised or vulnerable
- Uptake is lower amongst some communities– with lower routine childhood immunisation uptake in areas with high level of deprivation and a correlation between low uptake and some ethnicities and languages spoken
- We need to understand and work with communities who have low uptake through a hyperlocal approach.

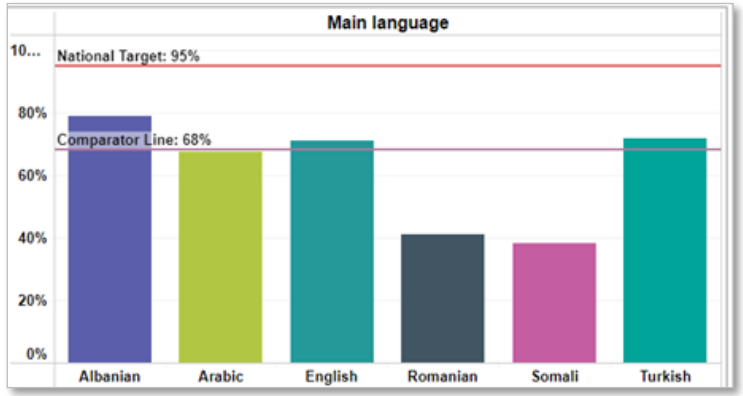
Key local levers:

- Build on learning from the COVID vaccine and the pan-London Polio campaign – around communication and community engagement, cross-system working, outreach, IT infrastructure and data flow, workforce and use of alternative providers.
- Insight from borough-based Parent / Carer Surveys to help us understand the barriers, motives and opportunities towards childhood immunisations - Barnet & Enfield completed in 2022; Islington, Camden & Haringey planned 2023

% population having all routine childhood immunisations at age 5, HealtheIntent



% population having all routine childhood immunisations at age 5, by the six most commonly spoken languages, HealtheIntent



Comparator line shows NCL coverage

Opportunities to improve performance and reduce variation with input across our ICS:

- Learning from Covid vaccination and areas with higher coverage, both within and across boroughs
- Since 2018-19, with the exception of Barnet, there has been a general decline in coverage across childhood immunisations, although coverage has picked up in Camden in 2020-21
- There are opportunities for improvement through patient education at key touchpoints before birth and throughout childhood; community engagement using a cross-system approach; as well as for improved process through service providers e.g. improved call recall and access.
- Improvement requires a whole-system approach, by those providing vaccinations (primary care, school nurses) and utilising opportunities through wider system partners including early years settings, health visitors etc.

Other drivers:

- Key indicator of primary health care performance
- Opportunity to improve how we engage with our communities across a range of healthcare issues and build trust in the health system more generally
- Provides a key infrastructure for encounters with medical professionals as a children grow and develops.

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North Central London Integrated Care System

Appendix 7: Integrated Care case studies

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Detailed case studies

North Central London Integrated Care System

PLACEHOLDER SLIDE:
Content in development

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Appendix 8: Borough Partnerships Decision Framework

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DRAFT FOR DEVELOPMENT

Our existing framework – key questions to consider

North Central London Integrated Care System

Ambition/ vision

- How do we address issues like poverty and exclusion in the context of shrinking budgets?
- There are differing levels of deprivation – how will areas with significant inequalities receive [as much] focus, funding and support as other parts of NCL?
- How do we engage residents and who does what?

Leadership

- Who has what responsibilities and how does it play into our accountability (individually and collectively)?
- How do collaborative leaders lead people from different organisations? Who has the power to direct actions?
- What is the leadership role of provider organisations? Voluntary sector leaders?
- In the absence of formal designated roles how will the borough partnership and neighbourhoods provide effective clinical & professional leadership? If formalised how does that ensure engagement and 'buy-in' from the constituency?

Functions, accountability and governance

- What is the role of the borough partnerships in quality improvement and performance? Where do regulatory powers sit? How is this changing across health and local gov?
- How do we hold each other to account? Who are the decision makers? Do all partners have equal accountability, responsibility and rights?
- Who is the BP accountable to? And who is accountable to it?
- What is the role of and interface with the provider alliance(s)?
- What steps might be taken to move towards a single accountable person / single point of accountability for place? Might this look different across the 5 partnerships?

Priorities

- We need to explore 'what trumps what' – when do collective priorities trump individual organisational responsibilities or vice versa?
- What process will we follow to understand the extent to which these align or don't?

Neighbourho-ods

- What are we expecting from neighbourhoods?
- Are they delivery units for more than General Practice?
- How much is this about self-organisation? Are they top down, or bottom up – or both? Why have we not landed this in the past?
- What counts as good & how would we identify a neighbourhood that was struggling?
- Infrastructure - what do we need and how is this achieved?

Commissioni-ng and procurement

- Do we still follow some / all of the commissioning cycle? Do we still follow an annual process?
- Local authorities and the ICB still have substantial commissioning and procurement roles, but these are shifting significantly in health.
- Is joint commissioning 'old world'? If so, what is new? What does this mean for the Borough Partnerships and how does it work in practical terms?

Resident and community engagement

- How do we communicate who we are and why we exist?
- Do BPs need branding? What should that look like?
- Do BPs need individual websites? What should that look like?

Outcomes and impact

- A lot of work has already been done on outcomes at place – is the origin and process understood? Will this be unravelled?
- Is it clear how this reflects NCL residents needs and priorities and how understanding of this will be dynamic and maintained?
- Do borough partnerships feel ownership of these outcomes?
- Should the ICS protect local priorities, and bridge between these and national objectives where they are in conflict?

Resources and capability

- Does each borough have an engine room? Who is in it? are these full time posts? Secondments?
- What skills are needed?
- Do all Council and Health teams and capabilities contribute e.g. for councils more than care and public health?
- What does this mean for resourcing models, for staff engagement and for leadership and management?
- How are resources prioritised in line with shared priorities – for example S106/CIL to support primary care, competing with affordable housing, community centres etc
- How do other teams engage in & support the borough partnerships?

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Public Health

4th Floor, 222 Upper Street, N1 1XR

Report of: Director of Public Health

Meeting of: Health and Wellbeing Board

Date: 14 March 2023

Ward(s): all wards

Subject: Annual Public Health Report 2023: Young People's Health and Wellbeing

1. Synopsis

1.1. Directors of Public Health in England have a statutory duty to write an Annual Public Health Report (APHR) to consider the state of health within their communities and provide evidence-based recommendations for improving health and wellbeing. The content and the structure of the report is decided locally.

1.2. Islington's Annual Public Health Report 2023 focuses on young people's (adolescent) health and wellbeing. Adolescence is a critical developmental period involving significant biological, social, psychological and behavioural changes with long-term implications for health and well-being. This cohort has also been affected by the impact of the Covid-19 pandemic, putting into stark relief many of the inequalities and effects of deprivation already experienced by this age group.

1.3. This APHR is not intended to be a comprehensive review of all health and wellbeing issues affecting young people. It is a high-level report that explores each of these topic areas:

- Healthy behaviours
- Mental health
- Youth Violence and safety
- Education, training and first steps into employment
- Long term health conditions

2. Recommendations

2.1. To note the content of the report.

2.2. To consider and discuss the report's major themes and recommendations, and the role of the Board in helping take forward the work on improving outcomes for young people in Islington.

3. Background

3.1. Adolescents experience different patterns of need from younger children and adults and this age presents a unique opportunity to intervene and promote health as they are known to experience different behavioural, emotional, and social changes as they transition into adulthood.

3.2. The impact of COVID-19 such as remote learning and lock-downs have also meant that they will have spent more time in the home with their family and have been separated from friends/peers. This will have disrupted their education, impacted on health and wellbeing and prevented them from accessing healthcare and support.

3.3. The report contains five themed chapters, each structured in the same way to cover:

3.4. Local insight: Focusing on inequalities and vulnerable groups, this section aims to build an understanding of young people's views, lived experience and priorities on the topic while presenting a picture of the local situation using local and national data.

3.5. What works: A high-level summary of the evidence on what works, using examples of local best practice and identification of local strengths/ assets and case studies. It also captures local strategies/programmes already in place.

3.6. Recommendations: each themed chapter sets out key recommendations for local action, developed through extensive engagement with partners

3.7. All chapters, including recommendations have been written in consultation with key stakeholders that include Council Officers, Health and Social Care Officers, Commissioners and experts including healthcare consultants.

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.

4.1.2.

4.2. **Legal Implications**

4.2.1. The Health and Social Care Act 2012 (2012 Act) confers duties on Local authorities to improve public health. Local authorities have a duty to take steps as they consider appropriate for improving the health of people in their area. The 2012 (s30) added in a new s.73A to the National Health Service Act 2006 requiring the appointment of a Director of Public Health. Under subsection s.73B (5), the Director is required to prepare an annual report on the health of the people in the area of the Local Authority and the Local Authority is required to publish this report. 5.4.2 Under the NHS Act 2006 as amended by the Health and Social Care Act 2012, Local Authorities are required to take particular steps in exercising public heath functions, and the regulations cover commissioning of services.

4.2.2.

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

4.3.1. Some of the recommendations made by the report will have an environmental impact as services change.

4.3.2.

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, because this report focusses on identifying and addressing inequalities in health and wellbeing for Islington's adolescent population and includes input and feedback from local residents throughout.

5. Conclusion and reasons for recommendations

5.1. Based on the report's major themes and recommendations, there are both significant strengths and opportunities to improve and support the health and

wellbeing needs of Islington's young people, particularly in light of the COVID-19 pandemic.

5.2. By working differently together with our local young people, drawing on support from partners across the system, there is the opportunity to improve health and wellbeing and reduce health inequalities and support all our young residents to live fulfilling lives.

Appendices:

- Islington's Annual Public Health Report 2023: Young People's Health and Wellbeing. Presentation for the Islington Health and Wellbeing Board.

Background papers:

Final report clearance:

Signed by:

Jonathan O'Sullivan - Acting Director of Public Health

Date: 02 February 2023

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Annual Public Health Report 2022: Young People's Health and Wellbeing

Presentation for the Islington Health and Wellbeing Board

14 March 2023

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Introduction

- Directors of Public Health in England have a statutory duty to write an Annual Public Health Report (APHR) to consider the state of health within their communities and provide evidence-based recommendations for improving health and wellbeing.

- Islington's 2023 APHR focuses on young people's (adolescent) health and wellbeing. Adolescence is a critical developmental period marked by significant biological, social, psychological and behavioural changes with long-term implications for health and well-being. This cohort has also been affected by the impact of the Covid-19 pandemic, highlighting and deepening inequalities.

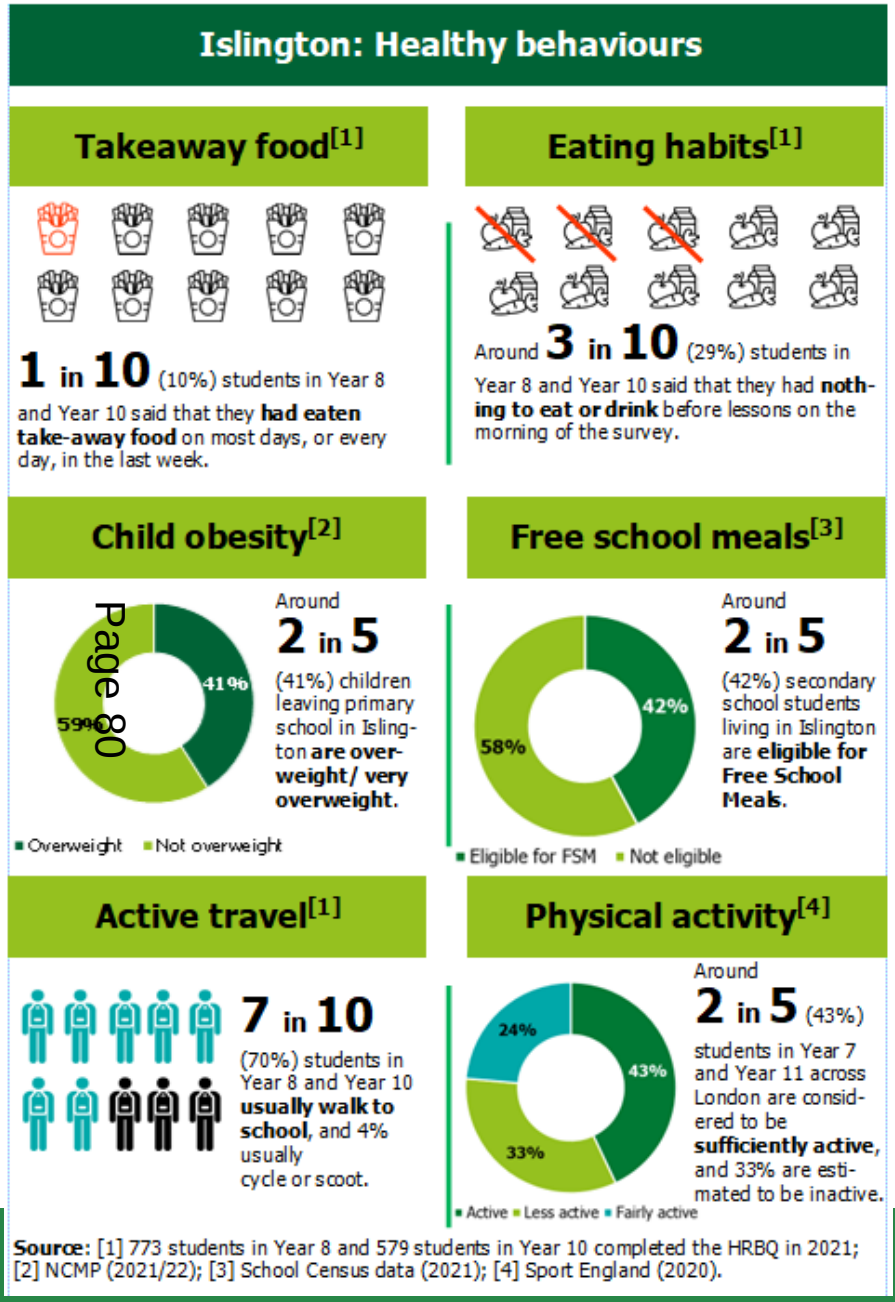
- The report is not intended to be a comprehensive review of all health and wellbeing issues affecting young people, but explores how young people are affected by five important areas, alongside some key recommendations for the future. This presentation summarises the findings. The topics are:

    - Healthy behaviours
    - Mental health
    - Violence and safety
    - Education, training and first steps into employment
    - Long term health conditions

Report Structure

- **Local data and insight**: Focusing on inequalities and vulnerable groups, this section aims to build an understanding of young people's views, lived experience and priorities on the topic while presenting a picture of the local situation using local and national data.
- **What works**: A high-level summary of the evidence on what works, using examples of local best practice and identification of local strengths/ assets and case studies. It also captures local strategies/programmes already in place.
- **Recommendations**: each themed chapter sets out key recommendations for local action, drawing on the above assessment

- The chapters have drawn on information and input from key stakeholders that include colleagues from other Council teams and the NHS, including healthcare consultants, and the community and voluntary sector and on local engagement and experiences of young people.



Chapter 1:
Healthy behaviours

- Behaviours established during adolescence and young adulthood influence a person's health throughout their life. However, healthy eating and physical activity become less common as young people move through adolescence.

- Top 3 recommendations:
  - Support **girls**, **boys from Black ethnic groups** and young people living in areas of **deprivation** to return to sport and physical activity.
  - Work in partnership with the school catering provider and schools to provide a **quality food offer** and support families to take up their eligibility for **Free School Meals.**
  - Explore local levers for promoting the availability of **healthy and affordable food on high streets.**

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Islington: Mental health

Mental health disorders[1]

In Islington it is estimated that **nearly 1 in 5 (19%) of 11-16 year olds** have a mental health disorder. This figure **increases to 22% for 17-19 year olds.**

Predicted mental health service use[2]

5,570 additional people aged under 25 in Islington are predicted to seek help from mental health services over the next 2-3 years, as a result of the pandemic.

Eating disorders[3]

45%

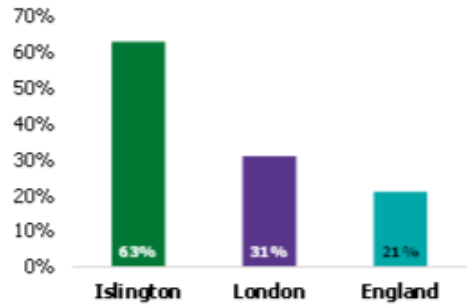
increase in referrals for specialist eating disorder services for young people since 2018 in Islington.

Mental health contacts[2]

15,060

contacts with Islington Child and Adolescent Mental Health Services in 2020/21.

Proportion of children and young people living in social housing[2]



Children and young people living in social housing are **significantly more likely** to have a mental health disorder than the national average.

They are also **twice as likely** as those living in a house owned by parents or caregiver.

Sources: [1] Mental Health of Young People in England 2017, [2] Forecasting future demand for mental health services in light of Covid-19: Camden and Islington (2021), [3] NCL Eating disorder services 2021.

Chapter 2:
Mental health

Adolescence is a formative period for immediate and long-term mental health and wellbeing. It marks a period of major educational, social and psychological transition, all severely disrupted during the pandemic.

Top 3 recommendations:

- **Ensure that service provision is in line with the Thrive framework**, addressing all levels of need, including prevention and mental health promotion, and helping to **reduce the gap** between need and access to services
- **Reduce waiting times for specialist eating disorder services** and increase awareness and understanding of eating disorders and body image issues through wider prevention work
- **Improve ethnicity data** on access and outcomes in all mental health and wellbeing services in order to address inequalities in mental health

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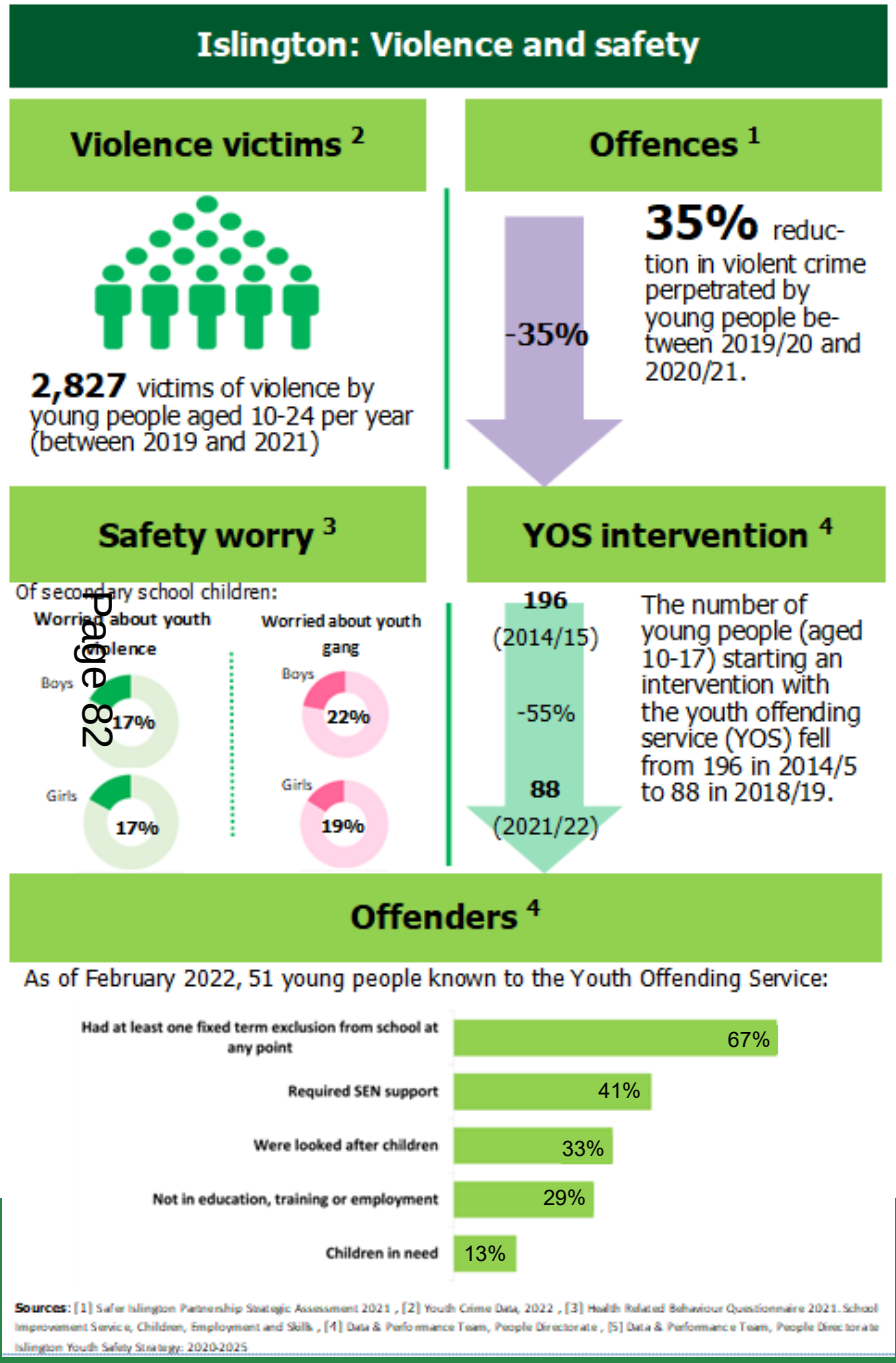

Chapter 3:
Violence and safety

Violence is driven by, and contributes to inequality, and perpetuates cycles of trauma for individuals and communities. In Islington we believe that by continuing to take a public health approach focusing on root causes and prevention, we can break this cycle and empower young people to thrive.

Top 3 recommendations:

- Ensure that we continue to have a strong focus on **early intervention and prevention**.
- Continue to deliver and promote **accessible and engaging youth services**, to provide a positive alternative to entry into gangs, crime or violence.
- Improve the relationship between **communities and the police,** particularly black and other minoritised groups.

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Islington: Education training and employment

Ofsted rating[1]

Good or better 70%

Achievement[2]

3 in 4 Islington 16 year olds left school **with a standard pass** (grade 4 and above) in English and maths in 2021.

2 in 3 Islington 16 year olds **eligible for free school meals** left school **with a standard pass** (grade 4 and above) in English and maths in 2021.

Attendance[3]

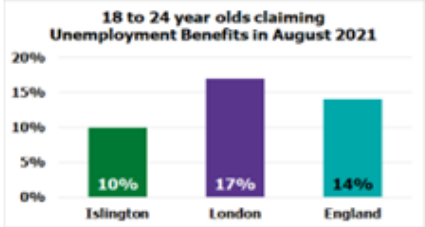
95% attendance levels for Islington secondary schools in autumn and spring 2020/21, **similar to England and Inner London averages.**

Exclusions[4]

There were **10 permanent exclusions** (rate of 0.11) in Islington secondary schools (2019/20), comparatively fewer than the national average (rate of 0.12).

In the same period there were **1,150 suspensions** (rate of 13.2), comparatively more than the national average (rate of 7.4).

Unemployment benefits[5]



Note: Attendance = 100 – absence, where absence = (total overall absence sessions)/total sessions possible) x 100; exclusion rate = number of permanent exclusions per 100 pupils in the 2019/20 academic year ; suspension rate = number of suspensions per 100 pupils in the 2019/20 academic year.

Source: [1]Ofsted, 2021; [2]National Statistics (key stage 4 performance revised/2020-21); [3]Department for Education, 2021; [4]National Statistics (Permanent exclusions and suspensions in England: 2019 to 2020); [5]ONS Claimant count by age, 2021

Chapter 4:
Education, employment and training

Education is a vital stage in young people's lives, which prepares them for life and equips them with the knowledge and skills to thrive in the next stage of their development, whether they opt for further education, employment or training. Good secondary education sets the scene for further education and better jobs and training opportunities.

Top 3 Recommendations:

- Continue to **support disadvantaged pupils** with access to technology and study space so that inequalities in access to out-of-class study are reduced.
- Improve **early identification** of pupils with Special Educational Needs.
- Ensure that the young people furthest from the labour market receive **intensive tailored support**

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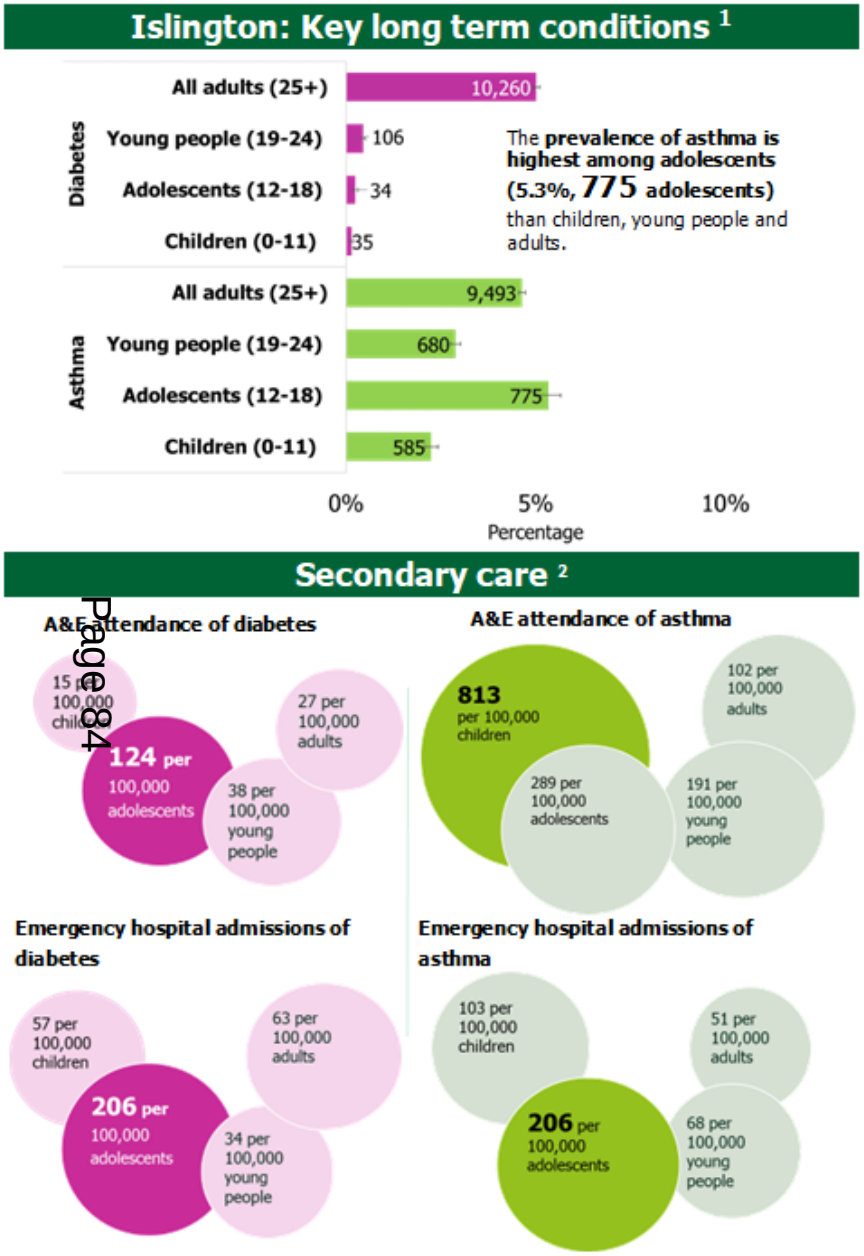

Source: [1] CSU GP primary care dataset, Dec 2021 [2] CSU SUS dataset, Dec 2020 - Dec 2021

Chapter 5:
Long term conditions

There are multiple risk factors for the development of long-term conditions in adolescence, including genetics, prenatal exposures and environmental determinants and some of these factors are preventable. Accurate diagnoses, early treatment and effective management of long-term conditions are critical to minimise their impact on young people's lives

Top 3 recommendations:

- Take a **whole systems approach** and commission seamless integrated services across the entire pathway from prevention to self-management, to in-hospital and out of hospital care
- Address inequalities by taking a **proportionate universal** approach to target support for those at increased risk
- Improve **transition into adult services** by following NICE guidance

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Next steps

- Based on the report's major themes and recommendations, significant work remains to effectively support the health and wellbeing needs of Islington's adolescent population, particularly in light of the COVID-19 pandemic.

- The recommendations in the report have been developed through extensive engagement with partners and we will continue to work collaboratively to deliver on these.

- The final report is due to be published in Spring 2023, and will be disseminated widely with stakeholders across Islington and Camden to galvanize action from partners across the system

- An update report can be brought to the Health and Wellbeing Board at an appropriate time to consider progress to date and further actions required.

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Islington Public Health
222 Upper Street, London N1 1XR

Report of: Acting Director of Public Health

Meeting of: Health and Wellbeing Board

Date: 14th March 2023

Ward(s): All

Subject: Health Determinants Research Collaboration (Evidence Islington) – progress on developmental year

1. Synopsis

1.1. On the 8th of November 2022 the committee received a paper on Islington Council selected by the National Institute for Health Research (NIHR) as one of thirteen successful sites across the UK to become a Health Determinants Research Collaborative (HDRC), following a highly competitive process.

1.2. The NIHR conditionally approved implementation of a full five-year HDRC in Islington starting October 2023, subject to delivering an agreed programme of development activities over year October 2022 – September 2023. The Health and Wellbeing Board agreed to receive progress reports on the development year, and to provide advice and support.

1.3. This paper provides the Health and Wellbeing Board with details of progress on the action plan agreed between NIHR and LBI for the developmental year.

2. Recommendations

2.1. To note the progress made against the development year activities.

3. Background

3.1. Islington council was awarded just over £230,000 for the period October 2022 to September 2023 to support development of foundations for research, successful completion of which will lead on to the full, five-year HDRC programme. Locally, we have renamed the HDRC as **Evidence Islington**.

3.2. By way of brief reprise, Evidence Islington is a partnership between the council, community groups (Healthwatch Islington and Diverse Communities Health Voice),

and the London School of Hygiene and Tropical Medicine and University College London. The full proposal is based around three core pillars:

- **Data systems**: the development and enhancement of Islington's data systems, integrating health and non-health data and working to improve data quality and accessibility. Evidence Islington's proposal further strengthens and enhances our ambitions to be a centre of excellence for data and insight focused on improving the wellbeing of, and reducing inequalities experienced by, Islington's residents.
- **Resident & VCS engagement**. The initiative aims to widen participation and develop engagement with residents in generating and using evidence to support action on health inequalities. This includes training and empowering community members in the skills to undertake community research to feed into strategic planning or evaluations.
- **Training and infrastructure**. Essential to achieving the goals of Evidence Islington, enabling staff, residents, and other partners to develop and use the skills needed to create, use and disseminate evidence in support of action, services and plans to tackle health inequalities.

3.3. For this developmental year, four subject areas have been agreed with the NIHR for further progress. These broadly relate to: the governance of the programme; engagement; use of data; and monitoring of the Evidence Islington programme for contractual purposes. Much activity during these first few months has been around set up with preparatory activities laying the foundations for delivery against these four areas by the end of the development year.

3.4. There has also been engagement with other HDRC areas to support the general initiative in local government. This has helped us to draw on learning and ideas from elsewhere, particularly since some of our developmental year goals are also the early focus of other HDRCs.

3.5. The four development areas are set out in the attached table, describing the agreed activities and outputs required for evidence of successful delivery under each heading and progress to the end of February. Of note:

- There has been significant early engagement with a range of groups and meetings/forums in the community about Evidence Islington. At the time of writing, a call for recruitment of community members to co-produce a strategy for community research is underway.
- The audit of data quality across data systems within the council has completed, with an action plan based on the results being drawn up.
- Governance arrangements of other HDRCs have been reviewed to assist us with developing our own ideas and proposals for options. Preparatory work to engage on governance, linked to the development of the community strategy and data and aligned to the council's wider approach on participation and engagement, is in train.
- A monitoring framework, as required for the full HDRC, is now in place for the Islington programme. It is already being used to record development year progress.

- A midway report on progress against the development year objectives is due to be submitted to NIHR at the start of April.

Steering the Programme and branding

3.6. A steering group for the HDRC is meeting on a regular (usually fortnightly) basis, bringing together colleagues from the council, academics and HealthWatch Islington. Its purpose is to support and coordinate activities for the development year, take stock of progress and help with any issues that arise, and ensure adequate pace and resource to achieve the goals. A monitoring framework (see table) has been put into place to record progress and milestones, which forms part of the developmental year priorities. A programme manager with extensive previous experience of research projects came into post at the start of March on a nine-month fixed term contract, to work with the steering group and manage the delivery of the outputs for the development year.

3.7. We have been working with Islington communications department and Healthwatch Islington to create a more accessible brand and name for the HDRC.

3.8. Evidence Islington has been adopted as the working title for the programme in Islington in place of HDRC, since the latter was generally viewed as too technical and feedback from engagement on the Evidence Islington name is that it is clearer and more understandable in terms of what the programme is seeking to achieve.

3.9. A page about Evidence Islington has been set up by Healthwatch What is Evidence Islington? | Healthwatch Islington to invite residents to be part of a co-design group to create the resident engagement and dissemination strategy which will underpin the research initiative.

3.10. A webpage describing the overall Evidence Islington initiative, including the resident co-design group, will also be created on the Islington council website.

4. Implications

4.1. **Financial Implications**

4.1.1. The HDRC grant will run from October 2022 to September 2028, with the grant covering October 2023 – September 2028 subject to satisfactory progress in the development year. The funding is spread over an initial development year at £233,888.86 (covering October 2022 – September 2023) and then 5 programme years totalling £4,999,663.74 (over the period October 2023 – September 2028). The department has identified the expenditure to utilise the funding for the development year in full, and subsequently in each year of the full programme. Any unutilised funding in the development year, or in subsequent years of the full programme, will need to be returned

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 will be no data system purchased in the development year. We will be working with the councils existing data and infrastructure.

We will be holding training sessions and working with residents. There is a budget allocated to this for the development year and as per other training carried out by the council it will require space, which may be council spaces or community spaces depending on availability. We do not forsee the use of any additional transport.

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. Evidence Islington's developmental year is close to its midway mark, and has involved significant foundational and engagement activities in all four areas identified with NIHR for development.

5.2. There will be a significant focus on co-production of a strategy for community research and dissemination over the next phase of the development year, linking also to wider participation and engagement processes; refining the proposed governance of Evidence Islington to support that strategy and facilitate maximum input into and impacts of developing research in local government, working with the community and other partners.

Final report clearance:

Signed by:

Jonathan O'Sullivan - Acting Director of Public Health

Date: 03 February 2023

Report Author: Mahnaz Shaukat,
Email: Mahnaz.Shaukat@islington.gov.uk

Appendix

Table 1. Development year goals and progress

Development year goals	Planned activities to respond to feedback	Progress	Agreed outputs by September 2023
A) Developing our approach for working with residents and community groups on research. Co-produce the community engagement and dissemination activities with residents and VCS groups and widen engagement and awareness with elected members, officers across the council and NHS, and other stakeholders.	In the development year, we propose to co-produce a strategy and model for the community engagement and dissemination activities that will underpin the role of residents and community groups within the collaborative. This will also support the dissemination and use of local research, and the selection of priority areas for research. In order to do this, we are currently looking to recruit residents to co-produce the strategy and approach with us. We will convene and support regular sessions with a core group of ten residents and VCS to co-produce the approach to engagement and dissemination activities for Evidence Islington. Together, we will look at ways which will best work with community groups and residents to be involved and actively contribute to the HDRC, and what	**Engagement strategy co-design group** In early February, we launched recruitment for the co-design group of around 10 residents. This group will meet monthly from April-Sep to develop the resident engagement and dissemination strategy for 2023-28. The recruitment process has involved tailoring messaging about Evidence Islington to people who may be less familiar with research and discussing the overall initiative and co-design group opportunity with: • VCS networks and organisations: Diverse Communities Health Voice network (Arachne Greek Cypriot Women's Group, Community Language Support Services, Choices, Disability Action in Islington, Eritrean Community in the UK, Imece Women's Centre, Islington Bangladesh Association, Islington Somali Community, Jannaty, Kurdish and Middle Eastern Women's Organisation, Latin American Women's Rights Service), locality networks, Octopus network, St. Luke's, the Old Fire Station and Brickworks Community Centres, Manor Gardens, Volunteer Action Islington,	A community participation, engagement and and dissemination strategy will be co-produced. This strategy will update our proposal on engagement, involvement and dissemination activities and methods with VCS and residents in the original application. The engagement is also already supporting us in the compilation of a directory of residents and organisations who express an interest in being involved in the full HDRC.

	types of dissemination strategies are likely to be most effective of most interest and use for different groups. Building on this work, we are keen to bring in others to inform and support the development and socialisation of this work. We will undertake a programme of awareness raising and engagement on the proposed Evidence Islington activities, including some translation considerations and innovative capturing of workshops (through, for example, methods such as visual scribing). These discussions will centre on what is an HDRC, how and why it matters to residents, members, officers and other stakeholders, and how it can be of benefit to them. As we develop this work, we plan to widen engagement and awareness with elected members, residents & VCS groups. These sessions will offer the opportunity to bring the co-produced strategy to a wider group for additional ideas and feedback. The development of this work is aligned with the Council's wider approach on participation and engagement , with the HDRC	Islington Refugee Forum, Islington Faiths Forum, Age UK, Help on Your Doorstep, • Youth councillors, Young People Forum, former youth health ambassadors • LBI service user groups: ASC, parent champions and the Family Hub working group, LBI Communities team We are also recruiting through ward-based LBI e-bulletins, ICB NCL resident health panel and the NIHR People in Research open call We intend to hold informal interviews with interested applicants from 27 March - 3 April, and convene the first workshop later that month. **Directory and future resident panel** Members of the Evidence Islington steering group hold monthly meetings with LBI's new Participation and Engagement (P&E) team to align efforts. We are currently planning for Evidence Islington to establish and pilot a cross-council resident panel in autumn 2023, including establishing governance processes to manage requests. Following the pilot, we aim to transition the coordination of the resident panel to the central P&E team. In the meantime, for new engagement projects, residents will be asked if they would like to be notified of other opportunities, specifying issues/population groups of interest and the frequency with which they would like to be contacted. We	

	steering group and the responsible team within the Community Wellbeing and Engagement Directorate working closely together. It is also informed by the approach and work with local residents and community groups carried out with HealthWatch Islington, who are part of the Evidence Islington steering group.	have also costed borough-wide recruitment channels (i.e., flyer to all households, ad in Islington Life, question added to random household resident survey) to reach residents who are not already involved.	
Development year goals	**Planned activities to respond to feedback**	**Progress**	**Agreed outputs by September 2023**

B) Using data better to understand the needs of residents and make an impact. Undertake pilot work to review and improve collection and coding of equalities and inequalities characteristics and exploring and scoping the challenges and issues involving linkage of datasets, including the ethical, information governance and practical considerations.	The plan we outlined in our HDRC bid to link datasets across council systems depends on good quality data. To provide evidence on the methodological feasibility of the plans we proposed in our HDRC, we will use the developmental year to conduct an audit of the main council data sets to understand 1. completion rate of the main inequality characteristics for residents in the main council systems. This will provide us with insight into the extent to which we can confidently analyse data by inequalities. 2. which council systems do not have a unique property reference number (UPRN) that allows linkage at a household level across different datasets 3. complete a data privacy impact assessment on a test use for linking different council datasets at a person level and household level to understand the potential methodological and other challenges. **Ethics** Ethics functions for research (ethics committees) are well established in the NHS and academia, but not in	**Ethics** In February, we received Institutional Review Board (IRB) approval from UCL to conduct the review of ethics processes in approx 15 LAs. Data collection is planned from March-June, first piloting in Islington, Cornwall and Middlesborough Councils. Internally, we convene a bimonthly working group with members from the Information Governance and Participation & Engagement teams to strengthen cross-council ethics review processes. We have updated and pilot tested ethics review, consent and participant information forms for projects that involve primary data collection; and, established referral processes to link ethics review with Data Privacy Impact Assessments and Equality Impact Assessment processes. **Unique Property Reference Number** We have identified the main applications in the council to prioritise the insertion of UPRN. Business relationship managers within digital services are designing a process to keeping systems and UPRNs up to date. **Equality Characteristics** An audit of the main council systems on completion of fields for ethnicity, disability and religion has been completed.	A review of ethical considerations and good practice in use of data in the public sector. A plan to locally address key ethical issues from the review and how they relate to existing council processes, including data protection and equalities impact assessments (DPIA, EQIA). A report detailing the main council systems and the proportion of records in these systems that have a unique property reference number (UPRN). A plan to attach UPRN to records that do not have one and a proposal of how these systems can be kept up to date. A report detailing the rate of completion of equalities characteristics fields for individual records in main council systems and considerations of how this could be improved, depending on findings. A data linkage and analytical plan for a test use case e.g., to understand extent of overcrowding or financially vulnerable residents in the borough

	local government. Ethics are a fundamental part of informing how proposals for research are identified and developed, and for assessing whether research proposals and methods should be approved for implementation. At its simplest, research ethics represent the moral principles (or ethical standards) that govern how research is carried out and protect the dignity, rights and welfare of people who are part of research and of wider society. In the developmental year we will undertake a scoping review of ethical considerations and good practice in using primary and secondary data for analytics and decision making. This review will inform the setup of the ethics function in the full 5-year HDRC.	The next steps will be to prepare a report on how the collection of these protected characteristics could be improved. **Data linkage** We have identified two areas where we are scoping out the information governance, ethical and practical considerations of linking data across systems in future. Both could give a better understanding of need and provide more insight for action. The two areas being explored relate to 1. Linking data on measures of housing quality with presence of health issues, such as respiratory disease and/or heart disease. 2. Linking different council datasets on debt and vulnerability to understand how we might better support residents in multiple debt or those who are at high risk of falling into deeper debt.	
Development year goals	**Planned activities to respond to feedback**	**Progress**	**Agreed outputs by September 2023**

C) Review and development of proposals for strategic leadership, governance and operating model in the local HDRC.	Following preparatory work in the first months of the development year, during the second half of the year we aim to undertake further engagement with elected councillors, senior council and other officers, Health & Wellbeing Board, and other relevant boards and committees, to further engage on and explain the aims and objectives of Evidence Islington. We aim to use these discussions to help strengthen the support for and engagement with our strategic direction and priorities. In light of these discussions, we will review the original HDRC proposal and it may lead to additions or refinements to proposals for engagement, governance and dissemination plans described in the two points above.	The Evidence Islington programme, including consideration of the community research strategy and governance, will be scheduled at a range of meetings and committees through the second half of the development year. A communications plan is being developed to aid the council and other organisations to raise awareness and understanding of the Evidence Islington initiative and ways it can help to deliver on ambitions to tackle inequalities and create a more equal Islington.	A summary document of feedback from engagement produced, with indicated changes. If indicated from feedback: A revised governance structure of HDRC will be presented, setting out how delivery and development of the HDRC will involve and engage elected members, operate across the council and work with the community and other partners. A refined set of aims and objectives of the set of Evidence Islington priorities to ensure that the HDRC and wider LBI plans and programmes continue to be aligned The communication and engagement plan for the delivery of Evidence Islington.
Development year goals	**Planned activities to respond to feedback**	**Progress**	**Agreed outputs by September 2023**

D) The monitoring framework for HDRC This involves: Defining milestones and achievements Recording (data capture) processes	Our original HDRC proposal used annual *evaluative* measures to help review and reflect on progress against the objectives of the HDRC – within the collaborative and with stakeholders. Based on that, we would adjust or revise the following year's plans. However, for the purposes of NIHR, more 'concrete' metrics are required against which progress and outcomes can be assessed. Islington Public Health has close working links with the Academic Research Collaborative (ARC) North Thames based at University College London (UCL). ARC has kindly agreed to share their data capture systems and processes for use with the local HDRC. Additionally, the team at UCL are providing mentoring at leadership and strategic and operational levels to assist us in developing performance metrics and monitoring framework for research.	An initial meeting was held with ARC North Thames in December 2022 to understand their monitoring processes. ARC North Thames progress monitoring forms and NIHR reporting templates have been reviewed and adapted, aligned to the development objectives for our HDRC. These are now being used by the HDRC Steering Group to capture and monitor progress against development year goals. Evaluation plans developed as part of the original application were revised in January and February 2023, and will be reviewed with council stakeholders and academic colleagues through the latter half of the development year.	A monitoring and performance management plan, including how to capture data on progress, will be produced for when we become a full HDRC. This will be linked to evaluation plans and also include more defined measures of performance management, drawing on models of good practice developed through UCL's Academic Research Collaborative for use in similar programmes.

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Adult Social Care
222 Upper Street, London, N1 1XR

Report of: Director of Adult Social Care

Meeting of: Health and Wellbeing Board

Date: 14 March 2023

Ward(s): All

Subject: Safeguarding adults in Islington in 2021/22

A review of key achievements and priorities going forward

1. Synopsis

1.1. This report sets out highlights and progress of the council's leadership of adult safeguarding arrangements in the borough.

1.2. The published Annual Safeguarding Adults Review 2021-22, attached as appendix A, describes this in more detail.

2. Recommendations

2.1. To receive the Annual Safeguarding Adults Review and the contents of this report.

2.2. To commend adult social service staff for their commitment to preventing abuse where possible and responding to concerns of abuses or neglect of vulnerable Islington residents.

3. Background

3.1. Under the Care Act 2014, Islington Council has a statutory responsibility to lead the borough in safeguarding adults.

3.2. Key achievements:

- ISAB partners provided important feedback through government consultation on proposed changes to the Human Rights Act and the Liberty Protection Safeguards highlighted the crucial role those rights play in the delivery of day-to-day care of our most vulnerable residents and the importance for practitioners of these as core values
- Service user & carer subgroup members became involved in the London Safeguarding Voices Group, raising local viewpoints and lived experience with a wider London level
- Developed guidance for partner organisations on reducing restrictive practices such as restraint and seclusion
- Consulted on and adopted a new 3-year strategy
- Worked on the action plan arising from the 'Gertrude' Safeguarding Adults Review (SAR) to ensure that learning from this sad case is fully embedded
- Board partners have agreed to implement a risk escalation pathway for the most complex, challenging case of abuse and neglect by trialling a Creative Solutions Panel
- Our Quality Audit and Assurance subgroup reviewed safeguarding adults data, such as the Covid-Insight report and monitored local trends with particular focus on the impact of the Covid-19 pandemic on self-neglect cases, provider concerns, hijacked housing and domestic violence
- Preparation work for the implementation of Liberty Protection Safeguards is underway
- Islington remains one of very few boroughs with no backlogs in Deprivation of Liberty safeguards applications and renewals.

The annual report further details progress on delivering against the Islington Safeguarding Adults Board's 3-year strategy and annual plan. The board consulted on a new strategy and will be working towards this over the next 3 years (2022-25).

3.3. The review compares the statistics from 2021/22 with the previous year 2020/21. There has been a decrease in safeguarding adults concerns on the previous year (from 3,353 to 2,844).

Safeguarding enquiries (carried out under Section 42 of the Care Act 2014) have increased since last year (from 322 to 399). This means that in roughly 9 out of 10 cases people we were worried about, when we looked into it we decided not to progress it to a formal safeguarding enquiry. We continue to carry out regular case file audits to make sure that thresholds are being applied appropriately and proportionately by practitioners.

3.4. The most common types of abuse in Islington during the last year were neglect, financial, physical and psychological abuse. The pattern for financial abuse and neglect being the leading types of abuse has been noted in previous years. Neglect cases reduced from 26% last year to 18% this year.

3.5. The number of safeguarding concerns about modern slavery or sexual exploitation of adults with care and support needs remains low. As the signs of modern slavery and sexual exploitation can be hard to spot, the board continues to promote modern slavery training to partner organisations.

3.6. Two cases were referred to the Safeguarding Adults Review subgroup for consideration as a Safeguarding Adults Review under Section 44 of the Care Act 2014.

The issues raised in the referrals included concerns about:

- Neglect, poor care and out-of-date care plans
- Self-neglect and refusal of care
- Poor communication between agencies
- Fire risks
- Lack of professional curiosity

The subgroup agreed that both cases met the threshold for a Safeguarding Adults Review (SAR). One of the SARs, referred to as 'Gertrude' has concluded and the Board has devised an action plan to implement learning from the case. The other SAR, to be known as 'Liam', has not concluded yet.

3.7. **Key national developments**

- Due to the Covid-19 pandemic, implementation of the Liberty Protection Safeguards has been postponed by the government. We continue to be one of the few local authorities with no backlogs on Deprivation of Liberty Safeguards and are well-placed to transition smoothly into the new law.
- The health and care sectors were severely impacted by the Covid pandemic. Many care workers left the sector during the pandemic and many care providers are less financially stable than they were previously. ISAB continued its focus on seeking assurances from partners about the quality and continuity of local care provision.
- The Kerslake Commission has reviewed what worked well during the pandemic in tackling homelessness. The Islington Safeguarding Adults Board has sought assurance from partner organisations on the progress made in response to the Yi SAR which was published in 2019.
- The World Health Organization (WHO) and CQC have been calling for action against inappropriate use of force, restraint and seclusion for people with mental health needs. Reflecting on this, our Prevention & Learning subgroup has developed guidance for local partner organisations on reducing restraint.
- The tragic murder of Sarah Everard by a police officer and the inappropriate behaviour of a few police colleagues became a high-profile media story. There is no quick-fix but we will work towards helping our partner organisations review and improve their organisational cultures and recruitment practices in the coming year.

The annual report further details progress on delivering against the Islington Safeguarding Adults Board's 3-year strategy and annual plan. The board consulted on a new strategy and will be working towards this over the next 3 years (2022-25).

4. Implications

4.1. **Financial Implications**

4.1.1. The Safeguarding Adults Unit's 2021/22 gross expenditure outturn was £1,202K. Of this, £200,302 related to ISAB expenditure. £17K was contributed by the following organisations:

- £5K London Metropolitan Police
- £6K Moorfields Eye Hospital NHS Trust
- £5K Whittington Health
- £1K London Fire Brigade towards the Islington Safeguarding Adults Board

The CCG also contributed to the Safeguarding Adults Unit's funding.

The Safeguarding Adults Unit's 2022/23 gross expenditure budget is £1,315K.

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

4.2. **Legal Implications**

4.2.1. There are no legal implications arising as a direct result of the SAB annual report. The report has been prepared in accordance with the Council's statutory duty under the Care Act, Schedule 2 (Safeguarding Adults Boards) which requires the SAB to as soon as feasible after the end of each financial year publish an annual report on the matters specified at paragraph 4 of the Schedule.

4.2.2. Paragraph 4.1 (a – g) of Schedule 2, Care Act 2014 details the type of information which must be included with the SAB annual report; this includes details of what it had done that year to achieve its objectives; what it has done during that year to implement its strategy; what each member has done during that year to implement the strategy; the findings of the reviews arranged by it under section 44 (safeguarding adults reviews) which have concluded in that year (whether or not they began in that year); the reviews which are ongoing in that year (whether or not they began in that year); what it has done during that year to implement the findings of reviews arranged by it; where it decides not to implement a finding of a review arranged by it, the reasons for this decision.

4.2.3. When finalised, the SAB is under a duty to send a copy of the report to various individuals/organisations including the Chief Executive, leader of the local authority; the local policing body; the Local Healthwatch organisation and the Chair of the Health and Well-being Board (paragraph 4.2.(a-d), Schedule 2, Care Act 2014.

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

4.3.1. There are no major environmental impacts associated with the Safeguarding Adults Board. Minor impacts such as transport-related emissions and office-based resource usage (energy, paper etc) are managed by staff by actions including not printing documents unless absolutely necessary, using video-conferencing and encouraging walking, cycling and the use of public transport. Some work has the potential to benefit the environment, such as reducing fire risk or referring service users to the SHINE service, which gives advice to residents on saving energy.

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. Appendix B of the full Islington Safeguarding Adults Board annual review (Attached as Appendix A of this report) sets out the equalities impact of our work to safeguard adults.

5. Conclusion and reasons for recommendations

5.1. The annual safeguarding adults review sets out the main achievements in safeguarding vulnerable and disabled adults in Islington and details our aims for achieving our strategy and annual plan.

Appendices:

- Appendix A: Islington Safeguarding Adults Board Annual Review 2021-22
- Appendix B: Islington Safeguarding Adults Board Annual Review 2021-22 summary

Background papers:

- ADASS Covid Safeguarding Adults Insight Report
  COVID-19 adult safeguarding insight project - third report (December 2021) | Local Government Association

Final report clearance:

Signed by:

John Everson
Director of Adult Social Care

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Islington Safeguarding Adults Board

Summary Annual Review 2021 - 22

Our Achievements

Our Quality Audit and Assurance subgroup monitored local trends focusing on the impact of the Covid pandemic on self-neglect cases, provider concerns, hijacked housing and domestic violence.

We have agreed to implement a risk escalation pathway for the most complex, challenging cases of abuse and neglect. A Creative Solutions panel will be trialled in the year ahead.

After a public consultation, we adopted a new 3-year strategy for the Board. The strategy sets out our 6 guiding principles and key aims for the years ahead 2022 -25.

Our Prevention & Learning subgroup developed guidance for partner organisations on reducing restrictive practices such as restraint and seclusion.

We reflected on the recommendations arising from the 'Gertrude' Safeguarding Adults Review and have implemented an action plan to ensure that learning from this sad case is fully embedded.

Our service user & carer subgroup is directly involved in the London Safeguarding Voices group, raising local viewpoints and lived experience at a wider London level and shaping regional policy.

Board partners, service users and carers provided important feedback through government consultation on the proposed changes to the Human Rights Act and Liberty Protection Safeguards.

Key Statistics

Concerns about possible adult abuse or neglect decreased slightly from 3,353 last year to 2,844 this year.

In nearly 9 out of 10 cases, people were worried about an adult but when we looked into it, we decided a formal safeguarding enquiry was not needed

More than half of all cases of abuse and neglect took place in the adult's own home

New Deprivation of Liberty Safeguards (DoLS) referrals decreased 25%. This was due to Covid pandemic-related factors.

399 enquiries were carried out into suspected adult abuse (a slight increase on the previous year)

In nearly 90% of cases we either removed or reduced the risks through safeguarding action

Neglect cases have reduced from 26% last year to 18% this year.

The most common types of abuse found in safeguarding enquires in Islington are (1) financial, (2) neglect, (3) psychological and (4) physical

Key Developments

Health and care sectors were severely impacted by the covid pandemic with many care providers now less financially stable. We will continue seek assurances about the quality and continuity of care provision locally.

WHO and CQC have called for action against inappropriate use of force, restraint and seclusion, particularly for people with mental health needs. We will continue to promote restraint reduction guidance to our partners.

We continue to be one of the few places in the country with no backlogs on Deprivation of Liberty Safeguards applications and authorisations and are well-placed to transition smoothly into Liberty Protection Safeguards in 2023.

The tragic murder of Sarah Everard by a police office and the inappropriate behaviour of a few police colleagues prompted us to seek assurance from partners on their organisational cultures and recruitment practices.

We will continue to work on these developments over the next year.

NHS METROPOLITAN POLICE ISLINGTON For a more equal future

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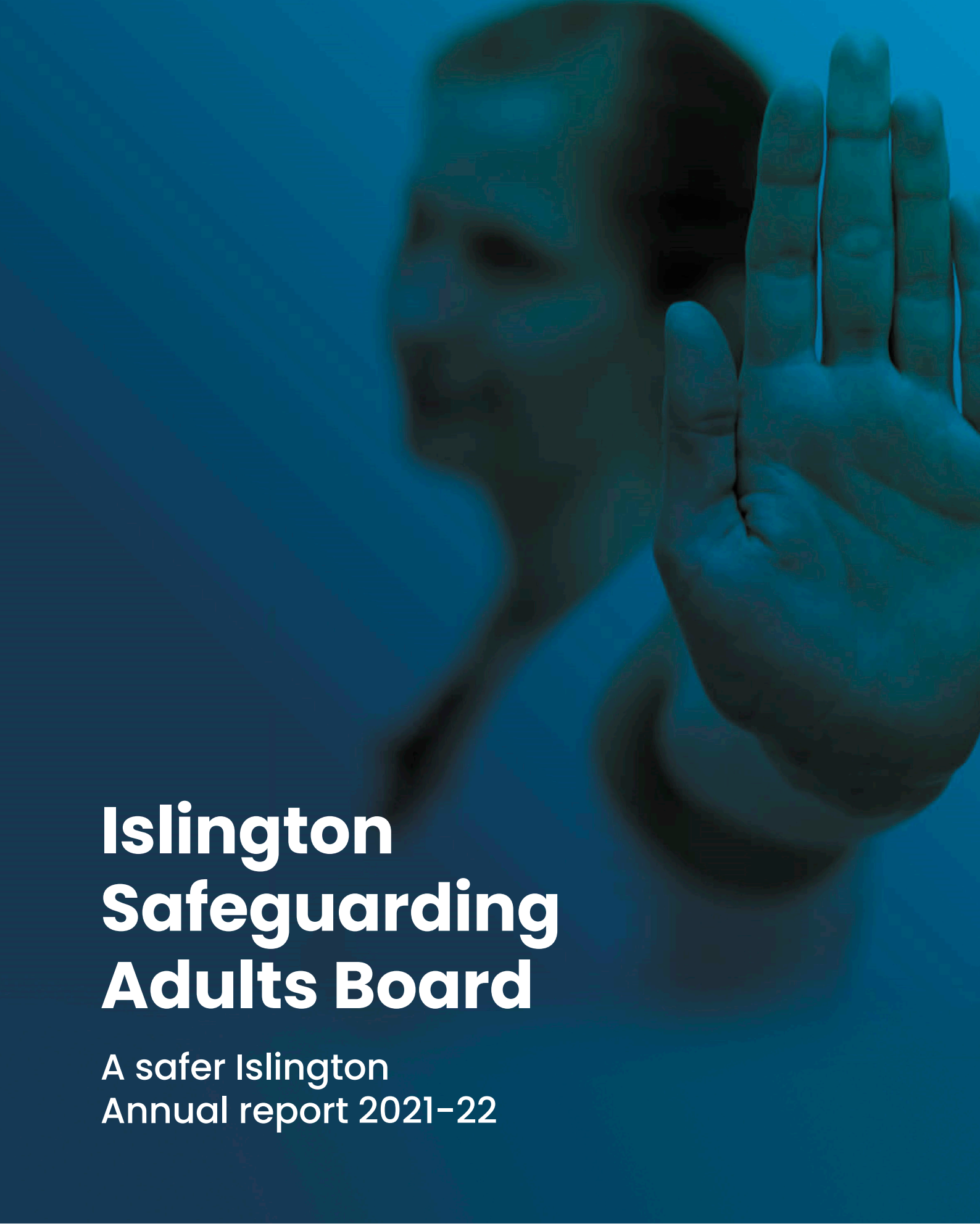

Islington Safeguarding Adults Board

A safer Islington
Annual report 2021–22

NHS

METROPOLITAN POLICE

ISLINGTON
For a more equal future

Foreword

One of the many privileges of Chairing the Board is the chance to introduce our annual report and pay tribute to the many people from across our communities and workforce who have, yet again, demonstrated better than my words can why it is that partnership working offers the most effective model for protecting our residents with care and support needs from abuse and neglect.

This report offers us an opportunity to reflect not only on the considerable challenges faced during 2021-22, but also the remarkable achievements. I am, at the time of publication, coming to the end of my first year as Chair in Islington. Throughout that time, I have been so impressed with the passion and commitment shown by our Board team, partners across statutory, voluntary and community organisations. They adapt, innovate and continually strive to improve practice so that, despite the many challenges, we can meet our joint legal responsibilities and moral obligations to adults at risk.

As you will see from the report, we have a new strategic plan to deliver. We aim to do this at a time when the rising costs of living presents new pressures. We anticipate that this will disproportionately impact on our most vulnerable residents. We also know that, despite our best efforts, too many residents still experience abuse and neglect. There is, therefore, no room for complacency. But that is not something I have ever seen in Islington!

I am so proud of our workforce who, not only recognise, report and respond effectively whenever an adult with care needs is at risk of abuse or neglect, they have also played an important part in shaping legislative reform and practice. During the year ISAB partners provided important feedback through government consultation on proposed changes to the Human Rights Act and the Liberty Protection Safeguards. They highlighted the crucial role those rights play in the delivery of day-to-day care of our most vulnerable residents and the importance for practitioners of these as core values.

I wanted to also take this opportunity to express my gratitude to the members of our service user forum for their ongoing commitment to making a difference to safeguarding practice not just across Islington, but across London. I am fortunate to also sit on the London SAB and know the positive, real impact that their voices have! We will always remain committed to hearing from those who have experienced safeguarding services, so if you (or someone you know) would like to get involved please do get in touch.

Thank you for taking time to read this report and for your continued interest in our work.

Best wishes,

Fiona Bateman
Independent Chair,
Islington Safeguarding Adults Board

Islington Safeguarding Adults Board
Annual Review 2021-22

Contents

About us

We are a partnership of organisations in Islington - all committed to safeguarding adults better.

All our work is centred on safeguarding adults with care and support needs who need help to stay safe from abuse and neglect.

Who made up the partnership during the year?

Age UK Islington
– Michael O'Dwyer, Head of Service

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

Camden and Islington Probation Service
– Mathieu Bergeal, Senior Probation Officer

Care Quality Commission
– Duncan Paterson, Inspection Manager

Crown Prosecution Service
– Borough Prosecutor

Healthwatch Islington
– Chief Executive, Emma Whitby

HMP Pentonville,
Sarah Bourn, Safeguarding Lead

Independent Chair
– Fiona Bateman

Islington Clinical Commissioning Group
– David Pennington, Director of Nursing and Quality

Islington Clinical Commissioning Group
- Dr Deepak Hora, Named GP for Safeguarding

Safer Islington Partnership
– Jan Hart, Service Director for Public Protection, Islington Council

Islington Council
– John Everson, Director for People's Services

Islington Safeguarding Children Board
– Michael Daley, Board Manager

London Fire Brigade, Islington
– Gary Squires, Borough Commander

Metropolitan Police, Islington
– Brian Hobbs, Detective Superintendent

Moorfields Eye Hospital NHS Foundation Trust – Jacob Adeymi, Lead Nurse Safeguarding Adults

Notting Hill Pathways
– Bryony Mitchell – Compliance Manager

Single Homeless Project
– Liz Rutherfoord, Chief Executive

Voluntary Action Islington
– Navinder Kaur, Chief Executive

Whittington Health NHS Trust
– Breeda McManus, Deputy Chief Nurse

Islington Safeguarding Adults Board
Annual Review 2021-22

Introduction

This review looks at what we, the Islington Safeguarding Adults Board, have done in the last year to safeguard adults in Islington.

Our work focuses on helping adults most at risk. Anyone can be vulnerable to abuse or neglect - but adults with care and support needs may need help and support to keep safe.

Safeguarding in the headlines

We are proud of our nimble approach to emerging local, national and international trends. We are quick to flex our annual delivery plan and respond to these emerging themes by including them in our workstreams.

Safeguarding adults is often in the news in one form or another. Sometimes led by widespread public concern; other times, the headlines are generated by government policy initiatives or developments in judicial case law.

We constantly monitor developments and public perception of safeguarding. Below are some of the key media and national policy themes from the past year.

Covid-19 (Coronavirus)

We constantly monitor developments and public perception of safeguarding. Below are some of the key media and national policy themes from the past year.

In the second year of the pandemic, Covid-19 continued to dominate headlines. Globally, Covid '...killed millions, affected billions and cost trillions'.[1]

Covid's impact on adult safeguarding, health and care systems and people's wellbeing has been extensive.

Through successive waves of infections and new variants of the virus, we have been impressed by how resilient and flexible our partner organisations have been in supporting those with care and support needs. But this has not been without its challenges. The strain on health and care services over the last two years has been evident.

1 Barrett D. Navigating through the storm: the role of healthcare leaders during COVID-19. Public Sector Focus 2021;33:44.

In 2021, the government introduced a **new law** requiring everyone working in healthcare, care homes and care agencies to be fully vaccinated against covid. While this was an understandable infection-control measure, it resulted in further staff losses in an already beleaguered sector. Those needing care or healthcare were being put at risk of neglect from an overstretched workforce.

By March 2022, the government responded to mounting concerns and ended the compulsory vaccination policy. It remains to be seen whether those health and care workers who **left the sector** during the pandemic will eventually return or not.

For Safeguarding Adults Boards around the country, the stability of staffing in the care sector and quality of care has been worrying. Moreover, the pandemic has blighted care homes financially, with 15% of care provider directors now saying they are concerned about their care home's **financial sustainability** compared with just 3% before the pandemic. In Islington, we have continued to keep a close eye on the care provider sector through assurance reports and our RADAR meetings, focusing on local care providers' contingency planning.

Several national surveys and reports identified that some groups of people felt left out and forgotten during the pandemic. A **SENSE survey** identified that 41% of disabled people felt unsupported by their local community. Similarly, the **Care Quality Commission** reported the pandemic had revealed the extent of gaps and poor care for people with learning disabilities. These findings chime to some extent with feedback locally from our service user & carer subgroup. We will continue to work with organisations locally to address social isolation and care standards.

Homelessness

The government's target to end rough sleeping by 2024 was accelerated by the **'Everyone in'** initiative announced at the beginning of the pandemic. These initiatives continued to have a positive impact on reduced rough sleeper numbers nationally and locally, and consequently on reducing some safeguarding risks.

While the 'Everyone In' initiative exposed the true scale of rough sleeping, it also revealed the tensions in the systems because a significant number of rough sleepers have no recourse to public funds (NRPF) due to their immigration status.

National homelessness organisations have started calling on the government to make changes for eligibility to services for street homeless people. Islington has long been at the fore in recognising that support is necessary to prevent the most vulnerable residents from experiencing destitution and safeguard them from the risk of abuse and neglect associated with a life on the streets. Islington Council hosts the national NRPF advice service, which helps other local authorities navigate the complex options for those who have NRPF. Any homeless person who has suffered abuse must be treated as a victim first, they should be safeguarded and supported to find refuge.

Some of the large homeless charities are predicting substantial rises in homelessness post-pandemic, including a rise in those left without a roof, unless government addresses the systemic causes of homelessness. The **Kerslake Commission** has reviewed what worked during the pandemic and recommended what needs to change to embed and build on that good practice.

Islington Safeguarding Adults Board
Annual Review 2021-22

Our partners have continued, including throughout the Pandemic, to respond to the challenges posed by the findings in the **Yi SAR** which was published in 2019. They have reported on the progress made to implement the recommendations and embed best practice in addressing homelessness, particularly rough sleeping. We remain committed to working with partners, through our public awareness campaigns, workforce training opportunities and assurance reporting to push for continuous practice improvement across all our partners.

Domestic violence

The ground-breaking **Domestic Abuse Act** was passed into law during the year under review. This law provides much-needed protections for victims and further clamps down on perpetrators.

Under this new Act, several new offences have been created, including the offence of non-fatal strangulation. Importantly, coercive behaviour offences have been extended to include abuse where perpetrators and victims no longer live together. The 'revenge porn' offence now also covers threats to share intimate images. Councils across England will have a legal duty to provide life-saving support such as therapy, advocacy and counselling in safe accommodation, including refuges.

Our training has been updated to reflect these changes in legal options for protecting victims of domestic violence.

Restraint and restrictive practices

Amidst a growing movement to curb the excessive use of force for people with mental health issues, the **World Health Organization (WHO)** called for global mental health care that respects human rights. Human rights abuses involving coercive practices are still far too common across the world.

In England and Wales, the **government and CQC's** combined focus on the inappropriate use of force is to be welcomed. Both have committed to working towards introducing greater transparency and accountability about the use of force in a variety of education, health, care and detention settings.

Reflecting this international attention on restraint, our Prevention & Learning subgroup has developed guidance for local partner organisations on reducing restraint. Email **safeguardingadults@islington.gov.uk** for a copy.

Deprivation of Liberty Safeguards and Liberty Protection Safeguards

The UK government announced further delays in the implementation of Liberty Protection Safeguards (LPS), while they consulted on the accompanying Code of Practice.

This has had the welcome effect of allowing us additional time to prepare for the introduction, particularly considering that many of our partner organisations had little capacity at the beginning of the pandemic to prepare.

Our local implementation network (LiN) responded to the government consultation on the draft Code of Practice, as did our Service User & Carer subgroup on the Easy Read version.

Organisational cultures

The tragic murder of Sarah Everard by a police officer and the inappropriate behaviour of a few police colleagues became a high-profile media story. It has called into question recruitment processes and **organisational culture** of organisations entrusted with keeping the public safe.

In response, we have included vetting checks in our partnership audit tool this year. However, there is no quick-fix to addressing misogyny, sexism and racism in organisations with safeguarding responsibilities. Changing organisational cultures takes time to embed. Our new strategy for 2022-25 includes partnership working on addressing inequalities in our safeguarding adults work.

Summary

The 2021/22 year has been a busy and successful year, despite shifting priorities and challenges for safeguarding adults.

In the following pages, we set out how we, the Safeguarding Adults Board in Islington, managed those emerging and evolving risks and challenges – all with the aim to prevent and stop abuse and neglect of society's most vulnerable.

Islington Safeguarding Adults Board
Annual Review 2021-22

About our strategy

Good intentions are not enough to make a difference. A plan of action is needed.

People are at the heart of safeguarding…from those adults supported by partner agencies to stay safe, to the general public on the lookout for abuse and neglect, to the people who work with our community to keep adults safe.

P	Personalisation
E	Equalities
O	Openness
P	Proportionate protection through partnership
L	Learn
E	Empower

Closing off our strategy 2018-22

When the pandemic struck, we extended our strategy by one year and revised it to reflect new priorities addressing potential pandemic-related risks.

In closing off that strategy, we are satisfied that we have largely achieved what we set out to do in the four years 2018-22. Our partners, despite the enormous challenges presented by the pandemic, never lost sight of our combined commitment to our statutory responsibilities for safeguarding adults in Islington.

Our subgroups, as well as our partners have each reflected on what worked well and what has been achieved (read more details in the next section of this report). We've also reflected on what still requires more work and needs to be carried over into our strategy for 2022-25.

Our new strategy for 2022-25

We ran a public consultation on a new three-year strategy, publicising it on the internet and twitter and sending it to our partner organisations for them to cascade internally and to their patient, user and carer groups.

Ordinarily, we would have run some face-to-face consultation sessions in care homes and day centres in Islington to reach the digitally excluded. As it was not possible to visit care homes or day centres during the pandemic, we relied on feedback from local service user and carer groups.

Although the overall number of consultation responses was lower than we would have liked, it was reassuring that responses and comments were broadly supportive of the board's proposed six strategic priorities and six guiding 'people' principles.

In view of the largely positive consultation feedback, we have adopted the strategy. However, we will incorporate some of the excellent feedback from consultees into the workplan for year ahead.

Our new 3-year strategy draws on six 'people' principles: personalisation, equalities, openness, proportionate protection through partnership, learning and empowerment.

Read our new **3 year strategy here**.

Partnership working

Although Islington Council leads on safeguarding adults in Islington, all of our partners contribute to our strategy.

This section sets out how our partners went about achieving the aims and objectives of our strategic plan.

We continued to be impressed by the lengths to which our partners went to in responding not only to the second year of the Covid-19 pandemic, but also to keeping adults and informal carers safe. Each encountered different challenges. That's why the Board was concerned to receive assurances from each partner about how they were responding appropriately to emerging safeguarding adults risks and trends in abuse/neglect in Islington.

With the Care Quality Commission having suspended inspections in the early part of the pandemic, so the role of local Safeguarding Adults Boards became crucial. We continued to monitor the local situation and reviewed systems, processes, providers or partners as needed.

Below we have set out the key achievements of each of our partners:

London Metropolitan Police

The London Borough of Islington is policed by the Central North (CN) BCU of the Metropolitan Police Service who also deliver local policing for our neighbouring borough of Camden.

Safeguarding remains a priority for the Police at Central North and they are determined to achieve the best possible outcomes for those who are unfortunate enough to become a victim of crime and to work with partners to safeguard and protect the most vulnerable members of our society. Last year, their officers in their Public Protection strand dealt with over 2700 cases of Domestic Abuse and around 700 cases of sexual assaults in Islington.

Whilst one crime is one too many and these figures may appear high, they compare quite favourably to other London Boroughs showing that Islington remains a safe place to live and work.

Of course, we are aware that 'The Met' has, understandably, attracted some criticism over the past year. At Central North London they remain committed to delivering quality

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policing at a local level and will be working hard to support their new Commissioner in his aim to deliver:

- More trust
- Less crime
- High standards.

Islington Clinical Commissioning Group

- The CCG Safeguarding Leads developed and delivered regular training to primary care professionals on the application of the Mental Capacity Act and provided ongoing support and advice to their primary care colleagues.
- work has begun to ensure that GPs will continue to have support and training as the CCG moves to an Integrated Care System (ICS)
- preparations are underway for the introduction of the liberty protection safeguards
- the CCG is participating in the joint work between the Children's and Adults safeguarding boards to explore safeguarding needs of our residents who would require support as they transition to adulthood.
- The CCG responded rapidly to a changing environment and developed ways to address issues with staffing capacity and Covid19 in each of their primary care, community care and care home environments, all while working with a reduced workforce with an exceptional demand on the workforce.
- Developed and delivered rapid information and training packages to support teams deliver safeguarding as part of the response to the pandemic, embedding learning from the pandemic.
- The CCG team have an established BAME engagement programme to address inequalities within the system
- Arrangements have been made for the ICS to continue to monitor the Leder system and information data and learning will be shared with partners.
- Contingency planning has included winter planning
- the CCG Safeguarding designates were core members of the COVID task and finish group which allowed for a dynamic approach to the CCG's ability to effectively safeguard residents in Islington.

Moorfields Eye Hospital NHS Foundation Trust

- A safeguarding adults activity data infographic for quarterly safeguarding adults committee (SAC) meeting includes which agencies/partners/services and where (UK wide) were generating queries and/or concerns. The complexity of concerns raised to the safeguarding adults team increased, particularly from external sources.
- Moorfields has continued engagement with the Dementia Friendly Community Steering Group, raising awareness of dementia by supporting the national Elf Day in December

2021, holding an information stall and promoting dementia-friendly messages and information to increase staff knowledge and response

- The Accessible Information Standards (AIS) Team have launched a Trust Wide Project launched to ensure that Moorfields captures information needs of patients and has a range of appointment letters and information in accessible formats, including Easy Read.
- Service Level Agreement with East London Foundation Trust has been renewed, which includes training and access to a mental health support helpline to assist staff to deal with mental health cases.
- Developed a domestic violence response pathway for patients been seen on the audio-visual consultation Attend Anywhere Platform.
- Pre assessment/pre-admission communication process with external agencies and pre-admission document has been reviewed.
- Strengthened collaborative working between staff and safeguarding adult team. Professional Curiosity Awareness disseminated across Moorfields in a variety of formats.

London Fire Brigade (LFB)

It was quickly identified during the first phase of the pandemic, that LFB frontline staff had continued access to people's homes at incidents etc, and by doing so would be able to identify safeguarding issues that other organisations were no longer able to identify by not being able to go into people's homes.

The LFB continued to monitor welfare and safeguarding referrals for emerging trends.

As a result of a recommendation from a SAR the Brigade now works with the London Ambulance Service to provide Home Fire Safety Visits to high risk hoarders (as identified by the London Ambulance Service).

The LFB's SAR Champion has developed a more coordinated and consistent approach to learning from SARs. Internal/ external action plans and review meetings are used to plan/ monitor progress post SAR.

Despite the pandemic, LFB continued to

- participate in the High Risk panel
- work with partners in the community to raise safety awareness
- offer fire safety awareness sessions to care workers and or other staff groups which visit residents at home.
- All staff, including frontline staff, were asked to re-visit and complete the LFB Online Safeguarding Learning package to refresh their knowledge.

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Camden & Islington Mental Health Foundation Trust

In response to the increase in domestic abuse, violence against women and girls (VAWG) and harmful practices agendas, the Trust agreed to a full-time substantive post for a Safeguarding Domestic Abuse Practitioner. This enabled a robust and timely response to such safeguarding concerns for Trust service users and staff.

Development of a safeguarding dashboard has supported Section 42 safeguarding enquiry workflow data, quality issues and ensured the adult safeguarding process is undertaken robustly. The safeguarding dashboard is live and accessible to Trust and specific local authority colleagues.

A strategic safeguarding alliance with Barnet Enfield and Haringey Mental Health Trust has enabled learning to be shared across the NCL footprint and collaboration on lunch and learn webinars based on local themes and trends from safeguarding performance data. Recordings of the webinars available on the Trust safeguarding intranet page.

In collaboration with Islington Council and Adult Social Care, a Section 42 workflow audit was completed, which resulted in a practitioner workshop and task and finish groups to address the gaps and challenges with the process.

A safeguarding hub/SAM's forum has also been established, which focuses on the operational aspect of this work.

Work is being undertaken to engage under-represented communities through:

- AR-DSA Network and Domestic Abuse Pathfinder work in relation to gender and sexuality
- Trauma informed collaborative
- Targeted work with asylum seekers, victims of modern slavery and people with no recourse to public funds

Collaboratively with LFB and BEH-MHT, the Trust delivered a lunch and learn webinar in response to the increase in self-neglect and hoarding. A self-neglect toolkit was re-launched via the safeguarding bulletin and Safeguarding Operational Group.

A lunch and learn webinar was held on 'Intersectionality and Harmful Practices', with expert speakers.

The Trust continues to look at learning identified from safeguarding adults reviews and safeguarding trends within the Trust for inclusion in the monthly safeguarding bulletin, further lunchtime learning and 7-minute brief reads.

Making safeguarding personal formed part of an audit to understand where challenges are. This led to improving this section within the L3 training and focusing on this within the safeguarding hub and safeguarding adults managers' forum.

Islington Council

The Council's commissioning team, in collaboration with the CCG, provided additional support and oversight to the local provider market to ensure safe care during pandemic and in the recovery period.

Significant planning has been underway in preparation for the introduction of the Liberty Protection Safeguards (LPS).

The Safeguarding Adults Unit scoped various models of risk escalation and pathways.

Practitioner Forum and Leaders in Safeguarding meetings have recommenced, helping to develop best practice in safeguarding and mental capacity law.

Making Safeguarding Personal (MSP) is well implemented in practice and is evidenced in the safeguarding forms. Further work is underway to ensure that guidance on MSP and the safeguarding enquiry process is co-produced with service user and carer groups in the borough.

Adult Social Care introduced a weekly safeguarding panel and surgery to discuss complex safeguarding cases. This improved practice as well as provided support and guidance to staff. It has also improved the outcome for our vulnerable residents who had experienced abuse and neglect.

The hoarding panel has been re-launched to ensure greater awareness among practitioners.

MARAC has been replaced by the daily safeguarding meeting (DSM). The DSM has produced significantly greater risk management support for victims of domestic abuse.

The introduction of a closure panel and case surgery have been effective measures in improving safeguarding practice and practitioner development.

An Early Intervention and Prevention service for adults has started, with coaching offered.

Through the Council's Fairer Together initiative, a pioneering co-produced early prevention programme to support young Black men and mental health is being tested.

The Council has broadened its Assistive Technology service eligibility and is now offering a wider range of preventative equipment from fall sensors to mobile apps. The service supports a preventative approach and will enable more people to access its benefits. The use of Assistive Technology can play a valuable role in supplementing traditional forms of care.

The **Streets Kitchen hub** for homeless people was refurbished by the council.

As part of the Council's work to make Islington safer, local businesses were asked to become a Safe Haven, so that they can help anyone in need.

Islington Learning Disability Partnership held regular 'Anti-Racism' discussion groups every six weeks to promote anti-racism practice.

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In-House day services re-opened, although at a reduced capacity. Partnership working with Community Catalysts CIC to develop great day support options for people with learning disabilities, is underway.

Rogue builder receives prison sentence

A rogue builder, prosecuted by the council for fraudulently charging vulnerable residents for unnecessary work to their homes, has been sentenced to four years and nine months in prison.

A total of £86,000 was collected from six elderly residents by the builder's companies Hamilton Roofing and Building Services Ltd and Maynard Roofing Ltd. Victims were falsely persuaded that their roofs were damaged and in need of repair, and in a few instances, damage was caused to roofs to provide evidence that work needed to be done.

All Islington residents should have a safe place to call home. That's why we are particularly proud of our Trading Standards team for their swift and careful actions which has led to the builder being successfully prosecuted. You can find a trusted trader with **Trading Standards**.

Rogue builder prosecuted by Islington Council sentenced to four years and nine months in prison

Several people were arrested in 2021, after a year-long investigation led by the Metropolitan Police's Modern Slavery and Child Exploitation Unit on the trafficking of Chinese women into the UK for the purpose of sexual exploitation.

Partner organisations worked together with the police about concerns at an address. Police who entered the addresses were accompanied by officers from the Modern Slavery and Child Exploitation Unit, interpreters and Mandarin speaking officers.

The individuals were arrested on suspicion of crimes including controlling prostitution for gain contrary and arranging or facilitating travel of another person with a view to exploitation. Vulnerable people at these addresses received support from specialist officers.

Single Homeless Project (SHP)

- With the conclusion of the Fulfilling Lives programme in Islington and Camden, SHP has legacy objectives to embed the multiple disadvantage approach into our safeguarding practice across the Single Homeless Project, including better identification of system blocks and barriers and working with partners to use FLIC's Team Around Me model.
- The work of SHP's Health Navigators Service in key boroughs such as Islington, Camden and Westminster has led to more MDT work in services and improved responses to self-neglect, Section 42 safeguarding concerns.

- SHP has also successfully implemented the MPS Philomena Protocol in their Young People's Services this year and launched our own LCSB digital grab pack on InForm (their client data system) for use with police and partner agencies in the events of young people going missing.

Healthwatch

Update

- During the pandemic Healthwatch adapted how it worked and supported its partners to do the same.
- Healthwatch continued to caller feedback about residents accessing health services by phone or online
- Shared feedback with commissioners to help them decide how health services can be offered most effectively going forward, to ensure that no one gets left behind.

Whittington Health NHS Trust

- Covid-19 caused a restriction in visitors to the Whittington Hospital. At all times, the hospital ensured visitors have been possible, those patients attending for appointments or being admitted to hospital who have for example a learning disability, dementia etc.
- Some patients were reluctant to allow visits from health care professionals to their homes. All cases had to be looked at to consider if there are any safeguarding concerns which need to be identified and then give a multi-agency response.
- Whittington Health led the successful roll out of Covid 19 vaccinations for Islington residents. Having a good awareness of the Mental Capacity Act was required for those cases where residents lacking capacity to decide about having a vaccine, had to wait to be vaccinated as family members attempted to prevent the vaccine being administered. In all cases, joint working with partner agencies was enacted to ensure the needs and wishes of the residents were central in all decision making.
- Safeguarding adult training had to move to remote/online teaching, yet compliance for safeguarding adult training remained high.
- Whittington Health identified significant increases in safeguarding adult referrals being made by Trust staff for particular ethnic groups. This was shared with the SAB and resulted in work being planned to ensure the appropriate resources are available for these groups, across the partnership
- Whittington Health is a key member of both the National and London NHS Liberty Protection Safeguards (LPS) Clinical Reference Group (CRG). As such, this allowed relevant resources and information to be shared across the partnership, to ensure other organisations are aware of the implications of this new legislation.
- Numbers of safeguarding adult referrals have continued to be high, demonstrating the competence of staff to identify suspected incidents of abuse.

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- Whittington Health continues to be a key partner in the LeDeR steering group, and in disseminating learning from reviews internally.
- Whittington Health introduced weekly safeguarding adult and Mental Capacity Act drop-in sessions for community staff to discuss complex cases.

Voluntary Action Islington

Key messages were promoted to local voluntary organisations via communication channels.

Our partners' annual reports

Health partners of the Safeguarding Adults Board have also published their annual reports for 2021/22 which can be found here:

Whittington Health NHS Trust

Camden and Islington NHS Foundation Trust

Moorfields Eye Hospital NHS Foundation Trust

Islington Clinical Commissioning Group
(now replaced by North Central London Integrated Care Board)

The Islington Health and Well-being Board has oversight of this Safeguarding Adults Board annual report. Further information about the Health and Wellbeing Board can be found on the **democratic services webpages here**.

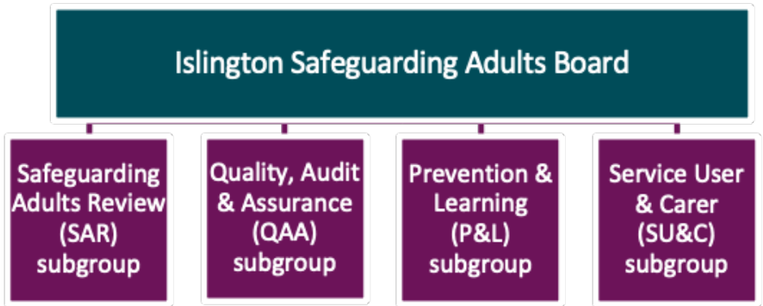
It would be impossible to list every single action and activity our partners took towards ensuring the safety and wellbeing of adults at risk. The specific achievements set out above are by no means all that partners achieved towards safeguarding adults – they are merely highlights.

For many of our partner organisations, safeguarding adults is routine and core to their every-day work which they continued throughout the year.

Subgroups

While the Board oversees the implementation of its strategy, the subgroups carried out much of the actual work. They are the engines behind the Board.

This section sets out the work and achievements of each subgroup.



Safeguarding Adults Review subgroup

During the year, the subgroup considered two cases, both of which met the criteria for a Safeguarding Adults Review (SAR).

In the case of 'Gertrude', Dr Adi Cooper was commissioned as Independent Author of the SAR. Publication of the full SAR report has been held back to accommodate the family. A 7-minute briefing is due to be published shortly. An action plan has been drawn up based on the report recommendations and the Board is working towards implementing the action plan.

In the case of 'Liam', Martin Corbett, a former London Fire Brigade Commander, has been commissioned to author the SAR and the SAR process is underway.

Liverpool SAB has conducted a SAR into the death of an Islington resident placed in Liverpool area. Some recommendations for the Islington SAB are likely and implementation of the learning will be followed up.

We continue to monitor trends in the cases submitted for review and make recommendations to the Board as appropriate. We are pleased that the Board has accepted our recommendation to implement a risk escalation pathway by trialling a Creative Solutions Panel.

DCI Brian Hobbs
Chair, Safeguarding Adults Review subgroup

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Quality, Audit & Assurance subgroup

The QAA subgroup continues to support the Board in providing a strategic overview of the quality of safeguarding activity within Islington. We have continued to meet quarterly, with representation from core partners and assurance provided by partners.

- During the year we reviewed safeguarding adults data, such as the Covid-Insight report and monitored local trends with particular focus on the impact of the Covid-19 pandemic on self-neglect cases, provider concerns, hijacked housing and domestic violence
- reviewed local DoLS activity
- received and reviewed updates on LeDeR and
- made recommendations to the Board regarding identified risks when appropriate.

David Pennington/Theresa Renwick
Chair, Quality Audit & Assurance subgroup

Prevention & Learning subgroup

The subgroup continued working towards meeting the Board's strategic objectives around embedding learning from serious cases with the aim of preventing future similar cases occurring again.

The following key pieces of work were undertaken:

- Produced a suite of resources on mental capacity law learning from multiple serious cases for including:
  - A video for practitioners
  - A 7-minute briefing for practitioners
  - EasyRead guidance on mental capacity for practitioners to use with service users and carers
- Held a very well attended and well-received multi-agency pressure ulcer prevention workshop led by a tissue viability nurse from Whittington Health
- Disseminated information about pressure ulcer prevention
- Developed multi-agency guidance on reducing restraint and restrictive practices

Graeme McAndrew
Chair, Prevention & Learning subgroup

Service User & Carer subgroup

A small, but committed group of service users, carers and advocates continue to generously give their time to inform the work of the safeguarding adults board. Without their input and expertise, the work of our board would risk being disconnected from the reality of people's lives. The lived experience is invaluable when consulting them about how to improve services for adults with care and support needs.

In the second year of the pandemic, we were able to return to face-to-face socially distanced meetings. Some members of the group preferred to continue with videoconference meetings. Attendance at the subgroup has suffered since the start of the pandemic, but we will endeavour to regenerate the group during the coming year.

Discussions have mostly focused on the impact of the pandemic on disabled people, those who were shielding and their carers. The group was particularly concerned about the social isolation of disabled people during the pandemic and how this might make them vulnerable to abuse.

Another topic of great interest to the group has been fire safety, personal evacuation plans and building fire safety. The tragic events at Grenfell Tower in 2017 caught their interest and caused them to question fire safety arrangements in Islington closely. We will be working with service users and carers to explore this topic in more depth over the next year, in part because fire risk and fire hazard identification are features of our current Safeguarding Adults Reviews.

The group continues to share rich feedback and insights into their personal experiences and their views on our new strategy have been invaluable.

We are delighted that one of our members is now actively representing in Islington at the ADASS **London Safeguarding Voices** Group and helping to shape, not only our local agenda, but the wider regional safeguarding adults agenda too.

Eleanor Fiske
Chair, Service User & Carer subgroup

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Experiences and Statistics

The human cost of abuse and neglect cannot be measured. The statistics that we collect only tell part of the story and this should be borne in mind when looking at our data.

But statistics are useful for pinpointing our strengths and highlighting areas for further analysis or development.

1. Experiences

No statistic can capture the trauma and impact of abuse, neglect and self-neglect. That's why it's important we get the soft data too and look behind the statistics at the human experience. We do this in a number of ways – through auditing case files, seeking feedback from people after a safeguarding case has been closed, analysing complaints and engaging with the public.

Just because information has been collected from qualitative observations, doesn't mean that it is unreliable. What soft data lacks in rigour, it makes up for in its richness and ability to give insights into the human experience.

Listening closely to our service user and carer subgroup is invaluable. Through their willingness to talk candidly about their experiences, we are able to reflect on and improve our practice across the partnership.

People who live in Islington were affected in many different ways by the pandemic. Some became more vulnerable to abuse or neglect. For example, we saw the severity of domestic violence increase. Isolation and loneliness enforced by the restrictions, which made some people more vulnerable to exploitation and self-neglect. But there were success stories, too, such as innovative working with rough sleepers.

2. Statistics

Some people experience multiple forms of discrimination and disadvantage or additional barriers to accessing support. As in previous years, we continue to monitor data on various groups to ensure that the needs of all victims are met and that no group is being overlooked.

This year's report contains data captured only by Islington Council. It is important, however, that we monitor statistics and trends from a variety of sources. This is to assure ourselves that adults with care and support needs are safeguarded in a range of settings, such as police cells and hospitals. We are getting closer to reaching agreement

on the range of data we'd like our partner organisations to share routinely so that we can develop a partnership dashboard for safeguarding adults. Only through shared aggregate data can we get a clearer picture of abuse and neglect trends and activity across the borough.

3. Safeguarding Concerns

When someone reports a concern about abuse or neglect of an adult with care and support needs, it is known as a 'safeguarding concern'.

During the year we had 2,844 **safeguarding concerns** reported to us, compared with 3,353 last year in 2020/21 and 3,228 in 2019/20.

Nationally, the long-term trend has been for a gradual increase in the number of safeguarding concerns over the years since the Care Act was introduced in 2015. We are not clear on the reasons why safeguarding concerns in Islington decreased during 2021-22. It could be attributable to in part to the lockdowns and other pandemic restrictions, which may have made it harder for professionals to spot the signs of abuse or neglect.

4. Safeguarding enquiries

In 2021/22 we had 424 **safeguarding enquiries** (**14%** of the total concerns raised). Of these 424 enquiries, 399 were carried out as safeguarding enquiries under Section 42 of the Care Act 2014.

A further 25 enquiries were looked into under another type of safeguarding enquiry. It may turn out that the Section 42 duty is not triggered because the concern does not meet the statutory criteria, but practitioners are not comfortable with the level of risk so a non-statutory safeguarding enquiry is carried out.

Even when we don't go ahead with a Section 42 enquiry, every point of interaction with a victim offers an opportunity for positive intervention and a chance to give support. We frequently signpost those people to appropriate sources of support.

Case example

Jayen, has mental health needs which fluctuate. When her mental health was good, she was able to able to work and had built up a pension pot, her only financial asset. One day, she received an telephone call purporting to be from a pension provider offering her a better deal on her pension by investing in spa resorts in Thailand. The offer also included a cash-back scheme in return for transferring her pension pot to the new pension provider and she was promised high financial returns. Jayen was lured into transferring her pension to the new company by the attractive images of the spa resorts in the glossy brochure they emailed her along with their promises of a comfortable retirement.

A couple of years later, Jayen started to get anxious when she was unable to contact anyone at the company to which she had transferred her money. She then contacted her bank to ask whether they knew how to contact her new pension provider. The staff at the bank said they had never heard of the company,

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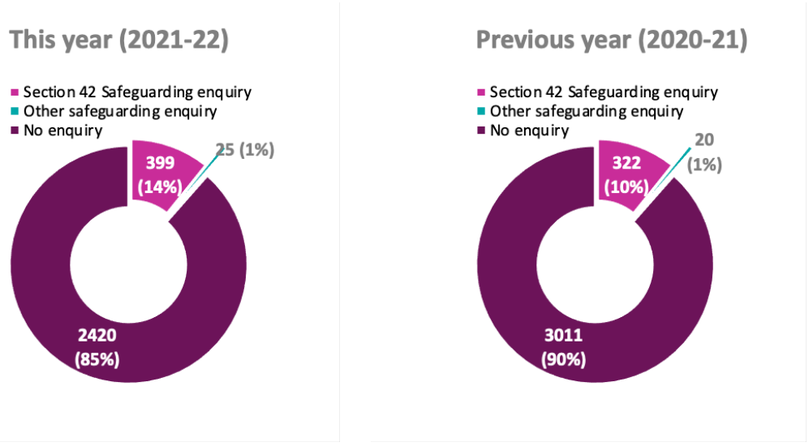
but suggested Jayen contact the Financial Conduct Authority (FCA) to see whether the company had been registered under a different name. It took Jayen some time to getting around to do this, but when she finally contacted the FCA, she was horrified to discover that no such pension provider existed and that she had been victim to an elaborate and sophisticated international scam.

A safeguarding enquiry was started involving the police, trading standards, adult social services and mental health services. Although it is doubtful whether Jayen's pension pot will ever be returned to her, services are working together to help and support Jayen's mental health, which has deteriorated further since the discovery of the scam. The local authority is in the process of applying to become appointee for Jayen's benefits while she lacks the mental capacity to manage her financial affairs. The police are working with international police forces and have made some encouraging progress in identifying the criminals behind this pension scam.

* Names and some details have been changed to preserve anonymity

5. Safeguarding concerns to enquiries 'conversion rate'

A similar number of safeguarding concerns to last year and a similar 'conversion rate'



* Some of the safeguarding concerns and enquiries shown in the above charts may have started in the previous year

** Due to rounding, percentages might not add up to 100

The Association of Directors of Adult Social Services (ADASS) in partnership with the Local Government Association (LGA) produced a framework to assist local authorities with making decisions on the duty to carry out Safeguarding Adults enquiries. The framework

was created to support practice, reporting and recording and to give local safeguarding adult boards the opportunity to benchmark against neighbouring authorities, regionally and nationally.

The framework supports decision-making about whether a reported safeguarding adults concern requires a statutory enquiry under the Section 42 duty of the Care Act, 2014 or a non-statutory response by either the local authority or other partners.

Our conversion rates in recent years have ranged between 10 - 15%, which are considered to be at an appropriate level.

Under the framework, outcomes of statutory enquiries can be referrals to other organisations, such as the Camden and Islington Mental Health Trust or a non-statutory response from the council or another organisation.

We continue to train staff to ensure they apply the framework correctly. We continue to carry out case file audits and workshops for social workers around safeguarding adults to ensure decision-making processes are well evidenced and that people who have experienced harm and abuse have their risks reduced or removed. We continually reflect on our application of the ADASS/LGA framework and respond to any support or training needs that our social workers may have.

We have introduced a weekly safeguarding closure panel and surgery to support practitioners in their safeguarding practice.

The **national data for 2021/22** allows us to benchmark our data. Data from previous years is also available from **NHS Digital website**.

Benchmarking has also been done against the **Third Covid Safeguarding Insight report**, which shows that the level of safeguarding concerns in Islington were broadly consistent with national trends during the year. Nationally, there was a slight increase in concerns on last year despite initial fears that referrals could drop with lockdowns. Nationally, there was an increase in domestic abuse and in the overall complexity of concerns.

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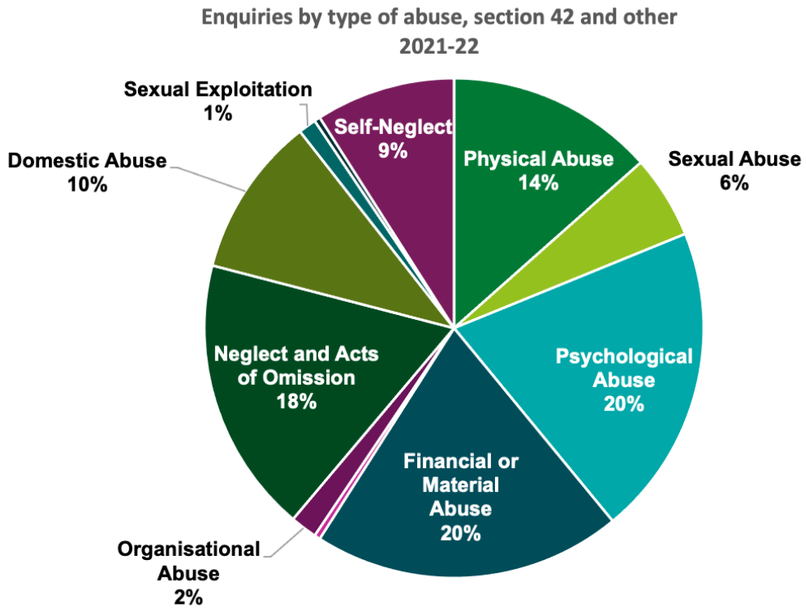
6. Types of abuse



The different types of abuse about which we made safeguarding enquiries during 2021-22 are shown in the chart below. When we look into a safeguarding concern about an adult, we often discover there is more than one type of abuse taking place.

The chart above shows that over the course of the 2021-22 year, the three most common types of abuse we made enquiries into were neglect, financial abuse and psychological abuse. A broadly similar pattern for the various types of abuse and neglect have been noted in previous years. However, neglect cases have reduced from 26% last year to 18% of cases this year. This data obscures the feedback from practitioners that during the pandemic the complexity of cases has increased.

Numbers of safeguarding concerns reported to us about modern slavery or sexual exploitation of adults with care and support needs remain low. We continue to raise awareness of these types of abuse. Our recording systems have also been modified so that it is easier to collect data and monitor trends in these types of abuse.

The signs of modern slavery and sexual exploitation can be hard to spot; so we will continue to raise awareness of what to look out for. Islington council continues to provide well-received in-house training on modern slavery and human trafficking.

We will continue to monitor trends over several years and compare our data with that of similar boroughs in London to see whether there are any emerging differences that we need to act on.

Feedback on training from participants

Approximately 200 people attended the very well-received Multi-agency pressure ulcer and safeguarding training delivered by a tissue viability nurse.

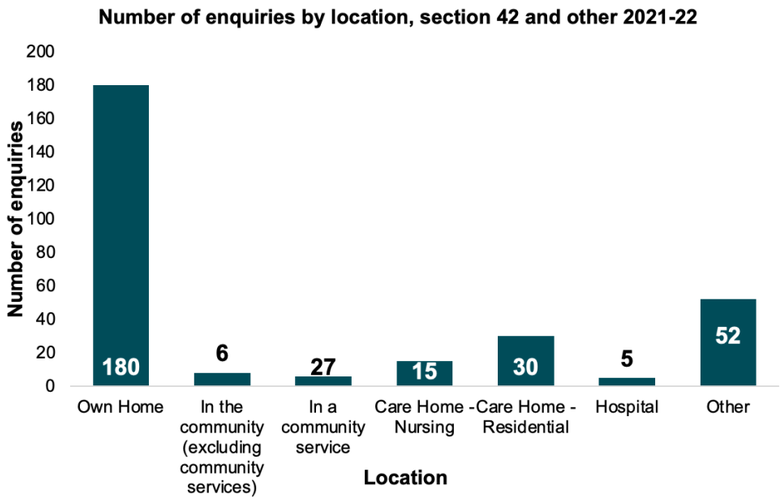
"Great presentation. It may have been fast but it captured all the essential information and I am more informed now than I was an hour ago! "

"Thank you very informative session :) "

"Very well presented. Good quality information. Thanks"

7. Where abuse took place

Abuse and neglect in care homes and hospitals tend to grab headlines. Because of this people may assume that a lot of abuse and neglect takes place in care homes and hospitals. But, the graph above shows the opposite – that more than half of all cases of abuse and neglect take place in the person's own home. This is not just true in Islington – it's a similar picture across the country. Lockdown restrictions prevented access to people's own homes, which made the task of carrying out safeguarding enquiries more complex. But as set out in section 1 of the report and as demonstrated by the graph below, partners adapted their practice and provided guidance for staff to enable effective enquiries.



Note: Hospital admissions have been grouped together due to small numbers being potentially disclosive

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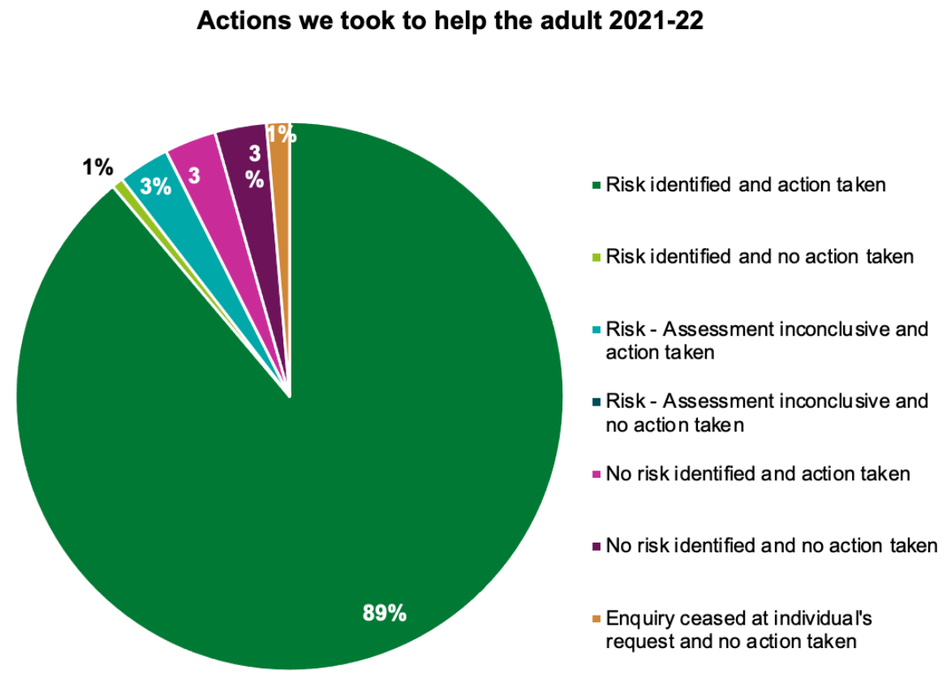
8. Action we took



*Due to the rounding of figures, figures may not total 100%

The graph above is based on the safeguarding enquiries that were closed in 2021-22. In nearly all of the cases we took some kind of action.

Recording the actions we took for all cases is now a mandatory field in our recording system. We identified and took action in 89% of the cases, unchanged from last year. We will continue to monitor whether social workers are correctly recording all the protective actions they take in a safeguarding enquiry. Through case file auditing, use of safeguarding surgeries and safeguarding case closure panel, we check that social workers have considered the full range of protective actions available to the adult.

The most common action is increased monitoring of the adult. Increased monitoring could include family and friends agreeing to visit an isolated adult more often. Or it could be a community nurse visiting patient at home regularly to check for pressure sores.

A wide range of other actions were also used. They included referrals to counselling, staff training, applications to the Court of Protection, change of appointee and restricting access to the person causing risk. In some cases, the concerns are serious enough for the Police to prosecute or caution the person who caused harm.

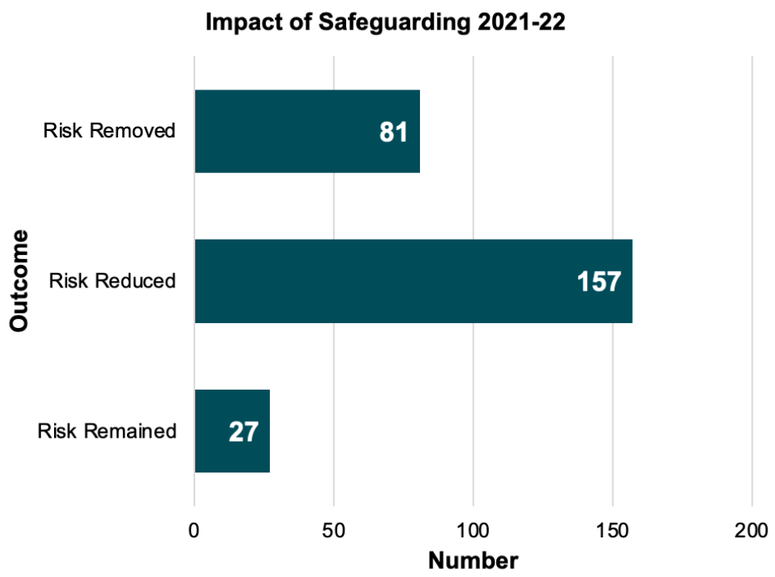
In 1% of the cases a risk had been identified but we took no action. But before reaching the decision to take no action, we would have assessed the risks and agreed that there was no significant ongoing risk to the adult.

In 1% of the cases, the adult told us they did not want us to take any action. Wherever possible, we make safeguarding person-centred and follow their stated wishes. Occasionally, the risks to other people are too great and we have to take action against someone's wishes. If this needs to happen, we carefully explain the reasons for our decision to the adult involved.

9. The impact of safeguarding

The purpose of safeguarding is to help people feel safer. One of the ways we measure this is by looking at our safeguarding actions to see if we have reduced the risk of future abuse or neglect happening. The chart below shows that in most cases, our actions have either removed or reduced the risk of harm.

In only a very few cases the risk remains. Usually this is the adult's choice. We always check first that the adult has the mental capacity to make decisions about the risk, is comfortable with the risk and understands the possible consequences of not taking steps to reduce the risk. We also factor in risks to other adults or children and whether the person causing harm is a paid professional. We also ensure that in all safeguarding cases that we assess as 'risk remains', the safeguarding is reviewed soon after to further support the adult.



This graph is based on the number of closed Section 42 enquiries in 2021-22 and not the overall number of enquiries. This is because some enquiries take longer than others to investigate. We have excluded any enquiries which were still being investigated at the time of submission of the year end data to NHS Digital.

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10. Making safeguarding personal

Putting the victim first is an important concept in criminal justice. So, it is also with safeguarding adults. Person-centred working, known as 'Making Safeguarding Personal (MSP)' is called for by the Care Act 2014. We've been working with practitioners and board partners to encourage them to adopt this crucial concept in the way they work with people at risk of abuse and neglect.

How do we know that staff are working in a person-centred way? Statistics alone will never give a clear picture of whether safeguarding enquiries have been carried out in a person-centred way. Only auditing case files and seeking feedback from people who have been through a safeguarding enquiry can really tell us. That's why our Board's Quality, Audit & Assurance subgroup together with our Service User & Carer subgroup are important mechanisms for overseeing the implementation of MSP across all partner organisations.

Islington Council – Adult Social Care has overall responsibility for all safeguarding enquiries. Adult Social Care has made changes to its internal reporting system to ensure that making safeguarding personal is captured as part of every enquiry.

At the safeguarding concern stage the adult (or their representative) is asked whether they want this concern to progress to a safeguarding enquiry and what outcome they want from the enquiry. The concern is also risk assessed and depending on this, it is progressed to a safeguarding enquiry.

We know from research nationally that being safe is only one of the many things people want for themselves. They may have other priorities too. That's why it's important we take the person's views into account.

To help us achieve this, every safeguarding enquiry has a set of seven 'I' statements that the adult at risk (or their representative) is requested to respond to during and towards the end of the enquiry. These statements not only address the issues of safety but also of choice, control, respect and justice.

We also record whether we were able to achieve the adult's preferred outcome. Our data from previous years shows us that we need to continue transforming practice and shifting work cultures to make our safeguarding work truly personalised. In the year ahead, we will be working with staff to explore more ways of enhancing an adult's choice and control as part of a safeguarding enquiry.

The previous year's data shows that we achieved either fully or partly the adult's preferred outcomes from the safeguarding enquiry. It shows that practice is transforming to keep the adult at the centre of all we do. People's preferences are indeed being taken into account.

Embedding a MSP approach remains a priority and forms one of the principles of our new 3-year strategy for 2022-25.

11. Safeguarding Adults Reviews

Sometimes when an adult with care and support needs has died or been seriously injured, we question whether services could have worked together better to prevent it happening. If we think that might be the case, we carry out a safeguarding adults review (SAR).

SARs are all about learning lessons; not about blaming people.

Under the Care Act 2014, the safeguarding adults board has a statutory duty to carry out a Safeguarding Adults Review (SAR) when an adult with care and support in its area dies; and the Board knows, or suspects the death was as a result of abuse or neglect and there is concern about how the SAB, its members or organisations worked together to safeguard the adult.

Referrals for Reviews

Two cases were referred to the Safeguarding Adults Review subgroup for consideration as a Safeguarding Adults Review.

The issues raised in the referrals included concerns about:

- Neglect, poor care and out-of-date care plans
- Self-neglect and refusal of care
- Poor communication between agencies
- Fire risks
- Lack of professional curiosity

The subgroup agreed that both cases met the threshold for a Safeguarding Adults Review (SAR). Although one of the SARs has concluded, neither of the cases has been published yet. There is some valuable learning to be extracted from these two cases, the Safeguarding Adults Review subgroup will hold multi-agency learning events and relevant recommendations will be published in next year's annual report. In addition, 7-minute briefings will be published to help disseminate the key learning points to staff and volunteers across the partnership.

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Learning from other reviews

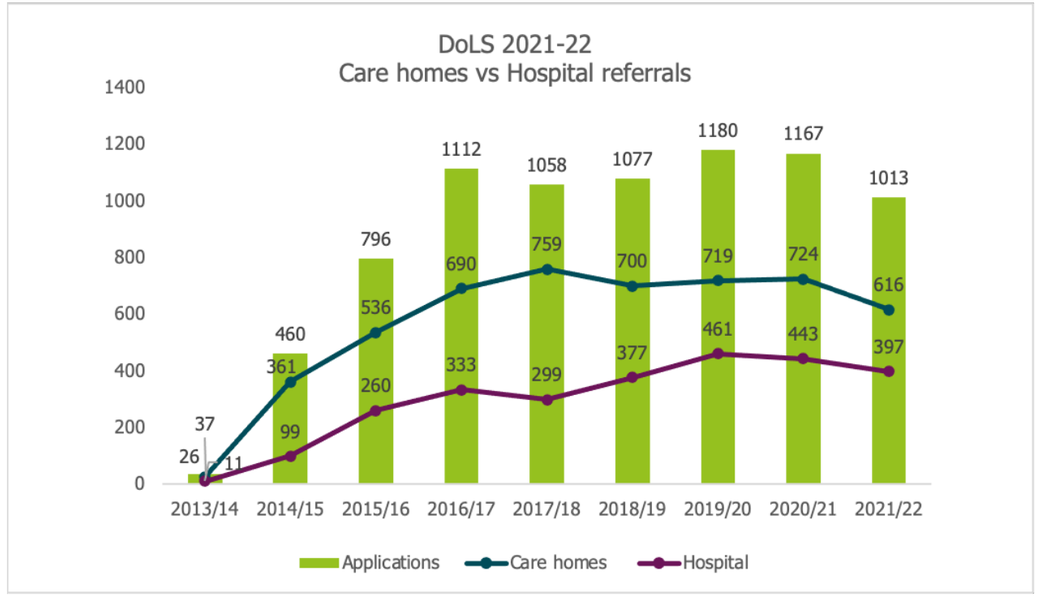
Learning from other types of review, such as Domestic Homicide Reviews, Coroner's Inquests, as well as SARs from other Boards is shared with our partners. This ensures learning from other places are embedded into practice and maintain good practice.

Our Prevention & Learning subgroup published a series of 7-minute briefings from previous SARs and reviews to help embed key learning points. The subgroup undertook a thematic analysis of serious cases in Islington in recent years and identified that a better understanding of some parts of the Mental Capacity Act is needed. A thorough understanding of how to use the Mental Capacity Act is important, not just for social workers, but for many other staff and volunteers in our partner organisations.

12. Deprivation of Liberty Safeguards

All adults should be free to live life as they want. If someone's freedom is restricted or taken away in a hospital or care home, there are laws and rules to make sure it is done only when really necessary and in their best interests.

The rules are known as Deprivation of Liberty Safeguards (DoLS). We monitor how these safeguards are used in Islington.



Referrals during the year were at similar levels to previous years, and over the last six years referrals have been levelling off.

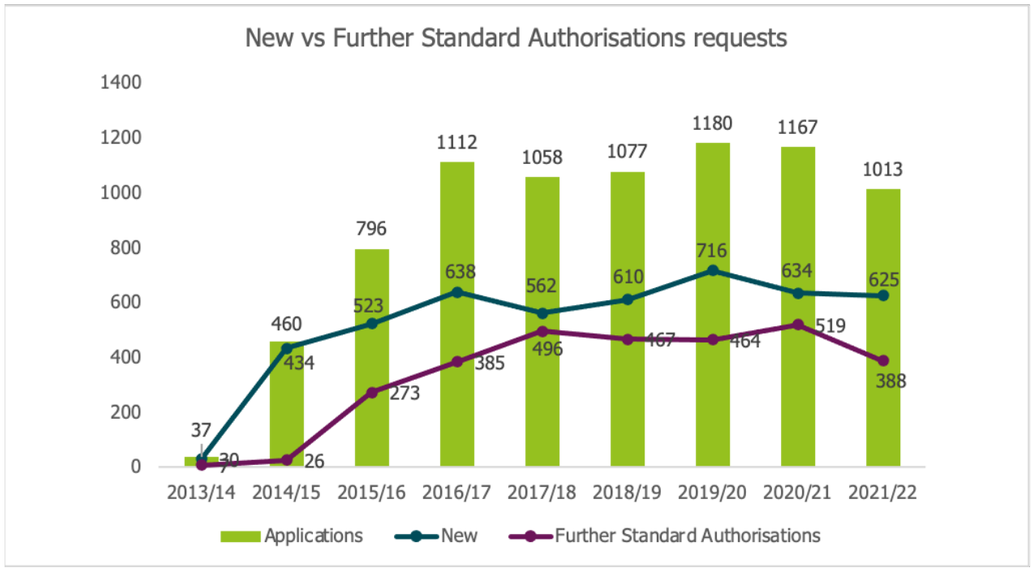
The majority of DoLS referrals (61%) are from residential care homes.

New referrals decreased by 25%. This was because during the initial phases of the pandemic the supervisory assessments were being completed virtually and the supervisory body agreed only to short authorisations for these cases. Since assessments have returned to face-to-face, this has allowed longer periods of authorisations to be put in place.

COVID-19 Pandemic

Throughout the Covid-19 the Islington DoLS office has continued working. We took account of government guidance, best practice and worked with our Residential Care Homes and hospitals to ensure the DoL Safeguards are implemented in a sensitive and proportionate manner taking account of the enormous pressures care homes and hospitals were under.

In 2021, after the relaxing Covid-19 restrictions, we returned to face-to-face assessments to assure best safeguarding practice. Out of 616 Best Interests Assessments only 150 were completed remotely. These were mostly prior to Covid-19 rules relaxation and for out-of-London cases. Since the start of January 2022, despite periodic care home lockdowns, our assessors consistently assessed face-to-face rather than virtually. Out of 215 Best Interest Assessor assessments, only 2 were carried out virtually.



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Safeguarding through DoLS

Where DoLS assessments identified care provider quality issues, these were recorded and then reported to RADAR meetings. Safeguarding concerns identified through DoLS assessments by paid Relevant Person's Representatives in their regular monitoring were passed onto social work teams.

If and when the resident under DoLS or their representative expresses objection to their placement, the social work teams are notified, and consideration is given to putting in place a paid Relevant Person's Representative to help facilitate a Court of Protection (COP) referral if appropriate. At year end, 11 active COP cases were subject to Section 21 challenges.

We continued to work closely with Islington Legal Department and Children's Social Care ensuring a joined-up approach for young people who will need to transition to the DoLS process.

Conditions and recommendations

The Supervisory Body attached conditions or recommendations to DoLS Standard Authorisations in 50% of all granted authorisations. This was 10% more than the previous year. Conditions were specifically attached to lessen the restrictions that the Relevant Person was subjected to.

Good examples of conditions or attached recommendations included:

- Improving access to social activities or community
- Review of care plan /needs
- Review of medication used to manage the behaviour of Relevant Person
- Request for a specialist assessment by the care home (i.e. Occupational Therapy, Speech and Language Therapy, Mental Health assessment)
- Review of physical restraint used
- Safeguarding alerts & Court Protection applications

Proposed new DoLS scheme:

Under the proposed new Liberty Protection Safeguards (LPS) scheme and proposed changes to the Mental Capacity Act 2005:

- the process will be more streamlined
- it will apply to people age 16 and over
- it will apply everywhere (not just care homes and hospitals)
- allowances for people with fluctuating mental capacity will be made

- greater safeguards for people will be made before they are deprived of their liberty.
- the person's wishes and feelings will be emphasised more

People who have their freedoms restricted to help them receive the best care and treatment will be put at the centre of a new system designed to better protect their human rights.

To inform this process, the Government has launched a consultation to update the Mental Capacity Act Code of Practice. This will identify better ways to support those with dementia, acquired brain injuries, learning disabilities and autism who may need assistance with their everyday decision-making but lack mental capacity to make decisions in their best interests.

The new system of Liberty Protection Safeguards (LPS) was originally due to come into force in October 2020 but at the time of writing this report, it has been announced by the government that implementation will be further delayed while it consults on the Code of Practice and EasyRead version.

The LPS will replace the Deprivation of Liberty Safeguards (DoLS) as the system to lawfully deprive somebody of their liberty. We have been working since 2019 to prepare for implementation of the new system locally.

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Next steps

We are proud of what we've achieved in the last year. But as we look ahead, we have further to go in safeguarding adults. There is no single solution to ending adult abuse and neglect. Tackling it requires creativity, energy and commitment from all our partner organisations in Islington.

We've got three years to work towards achieving the aims set out in our 2022-25 strategy. Additional issues we will be taking into account are:

Rising cost of living

At the time of writing this report, inflation, with the resultant squeeze on living standards, is driving much public debate. What's less spoken about, are the knock-on effects on adult safeguarding.

- When energy prices rise, poorer people switch to using candles and open fires. This increases the fire risk and can be particularly dangerous for adults with care and support needs who are on oxygen, require bed care or use emollient creams.
- When there's a cost-of-living squeeze, scams and theft increase. With the infirm and disabled seen as soft targets, they are often disproportionately affected.
- Self-funders of care are more likely to defer a move to a care home or reduce the number of domiciliary care hours they receive, putting them at risk of neglect, or self-neglect.
- The financial viability of care homes and domiciliary care providers may be affected, either resulting in poorer care standards or risk of sudden closure leaving residents without a place to live and/or care.
- With dwindling savings and increasing expenses, mental health conditions such as depression, anxiety and suicide are expected to increase.
- Domestic abuse can be triggered or exacerbated by money tensions in a relationship or former relationship.

Our Service User & Carer subgroup is rightly concerned about these possible effects on safeguarding. Consequently, we will be vigilant in monitoring data and trends and take preventative actions where possible.

Integrated Care Boards

With the introduction of the Health & Care Act, each area in England now has an Integrated Care Board and an Integrated Care Partnership. They are responsible for bringing together local NHS services and local government, such as social care, mental health services and public health advice, to deliver joined up care for the local population.

In doing away with Clinical Commissioning Groups, this shakes up the way local health services are delivered and is likely to have implications for local safeguarding adults arrangements.

We will keep a close watch on how these changes unfold locally and work together with the Integrated Care Partnership to address any gaps.

Creative Solutions to risk management

Learning from previous serious cases suggested we needed to implement a clearer risk management escalation pathway. After scoping various models used elsewhere, the Board has decided to trial a Creative Solutions Panel and pathway for multi-agency escalation of the most complex, highest risk cases.

We are hopeful that this approach will have a significant and positive outcome for adults at risk.

During the next year, we will be reviewing and refining this approach to case risk management.

Liberty Protection Safeguards

The implementation of the safeguards was delayed by government. This has allowed us additional time to prepare for adopting these important new systems and procedures.

Learning

We are committed to learning from serious cases. These cases are always sad and distressing for families, friends and the professionals involved, more so when we believe the situations could have been prevented had agencies worked better together.

We will continue to work on the learning flowing from the 'Gertrude' Safeguarding Adults Review.

A Safeguarding Adults Review into the death by choking of an Islington resident placed in Liverpool contains learning for our partners. Working together with Liverpool Safeguarding Adults Board, we will ensure learning from this case is embedded locally.

Our Safeguarding Adults Review subgroup is commissioning a Safeguarding Adults Review into the fire death of a resident. It is heartening to note that many of our partners are already starting to implement change ahead of the independent reviewer's report. When the report is ready, we will ensure recommendations are followed up.

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Listening

Your views are important to us. We are committed to listening to what our community has to say. If you want to share your views with us, please get in touch. Our contact details are at the end of this report.

Appendix A

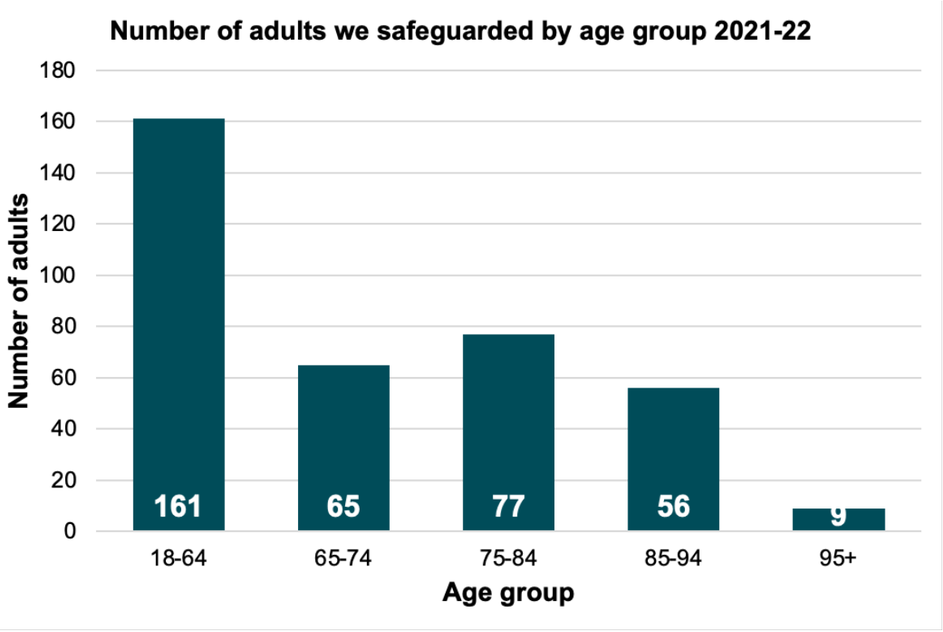
Making sure we safeguard everyone

Equality and diversity matter to us. We want to make sure that everyone who needs to be safeguarded is and that we are not missing people from particular groups.

Keeping a watch on who needs safeguarding in Islington also helps us target our services at the right groups.

In this part of our review we look at how the Islington population is represented by the people who had safeguarding concerns raised about them.

With their consent, we capture information about their age, sex ethnicity, sexuality, mental capacity and service user category. Having a clear overall picture of who we are safeguarding and where there are gaps, helps us to decide where to focus our attention in the future.



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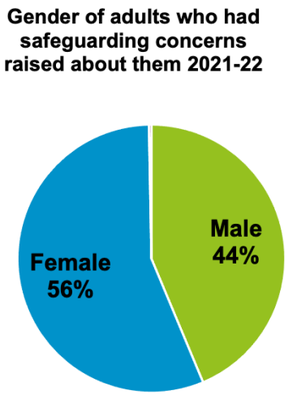
The chart on the previous page shows that this year (as in previous years) there were a lot of safeguarding concerns about people over 65 years of age. This is consistent with national and international research which shows that the older an adult is, the more likely it is that they will come into contact with services trained to spot signs of abuse and neglect. We know that adults with care and support needs are more at risk of abuse, so as adults become frailer, sadly they also become more at risk. Therefore, it appears we are continuing to do well- staff across our partner agencies, including voluntary, faith and community services, are vigilant and our awareness campaigns are encouraging people to come forward and report suspected abuse of older people.



This chart shows the same gender proportions as last year. There were more concerns reported about women than men. It is difficult to know whether this is because women experience more abuse or whether abuse of women is more commonly reported than abuse of men. National research (Scholes et al, 2007) found that women are more likely than men to experience domestic abuse.

There were no safeguarding concerns about people who identified themselves as transgender. This may be explained by transgender adults being a statistically small group of people (estimated to be 0.1% of the population). It may also be because transgender adults chose not to disclose this information to us. We will continue to foster among practitioners the need to ensure appropriate opportunities for transgender people and other groups receive awareness raising information and share concerns.

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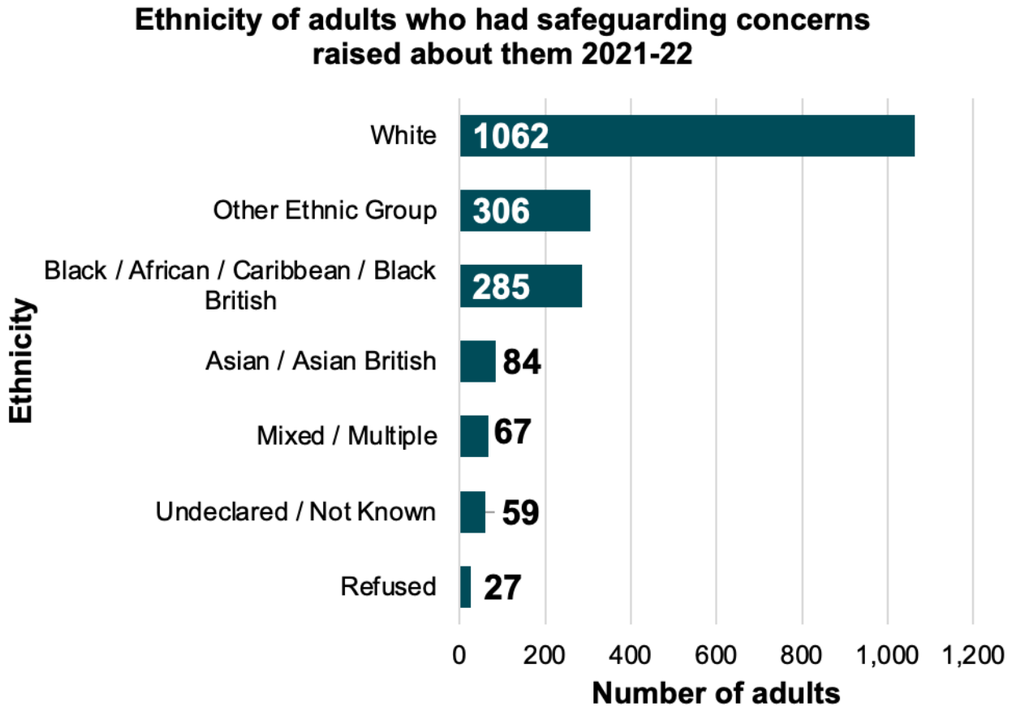


The data in the chart above shows that concerns were raised for people from a range of ethnicities during the year.

Different ethnic groups have slightly different proportions of adults with care and support needs. For example, the average age varies across ethnic groups in Islington. In an ethnic group where there is a higher proportion of older people, we would expect to see more safeguarding concerns for that group.

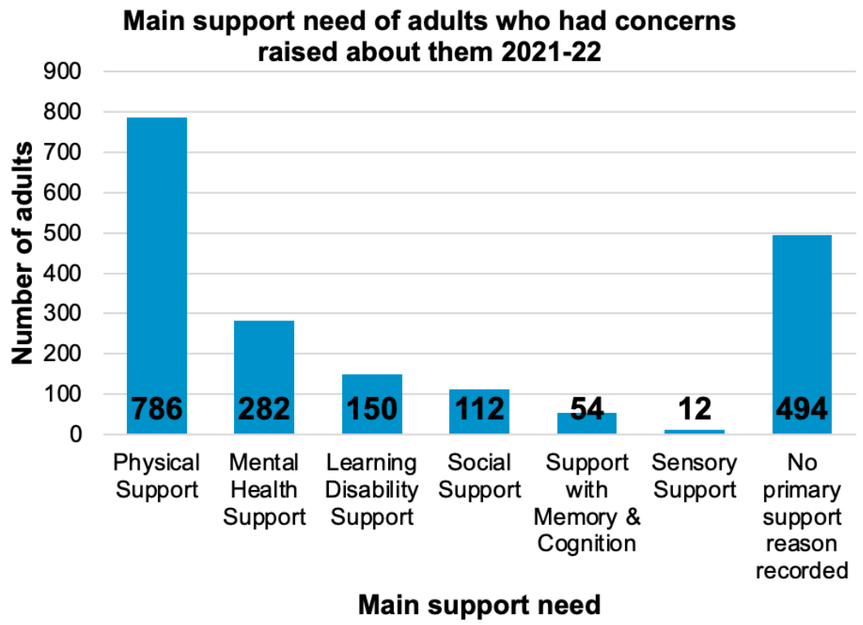
Our data shows that adults who identify as white are slightly over-represented in safeguarding data, while most of the other ethnicities are under-represented. We want to understand why some ethnicities are less likely to have safeguarding concerns reported about them. It may be that there are language barriers and that our awareness-raising materials are not reaching some communities. Or, it may be that some communities are less likely to trust services to respond sensitively to their concerns. To gain a better understanding of the issues, we have included an equalities strand of work in our new 3-year strategy for 2022-25.

We will also promote safeguarding adults through our range of leaflets and community language leaflets (Bengali, Chinese, Urdu, Greek, Turkish, Arabic and Somali). Using these and through engaging with local communities we help to ensure that safeguarding concerns are not being missed.

Sexual orientation of adults safeguarded during the year

The government estimates that roughly 6% of the UK population is lesbian, gay or bisexual. Although the department of health does not require us to collect and report on sexual orientation, in recent years we have started asking some of the adults we safeguard about this. We continue to work towards creating an environment where staff feel confident about asking questions about sexual orientation and the adults concerned feel safe disclosing their sexual orientation.

Even though our data is not complete, there may be enough data to suggest that lesbian adults are under-represented in safeguarding enquiries. We continue to work on this strand of equality and diversity and will engage with partner organisations on this aspect of equalities in our strategy for 2022-25. This will allow us to get a better understanding of any barriers this group may experience in accessing safeguarding support.

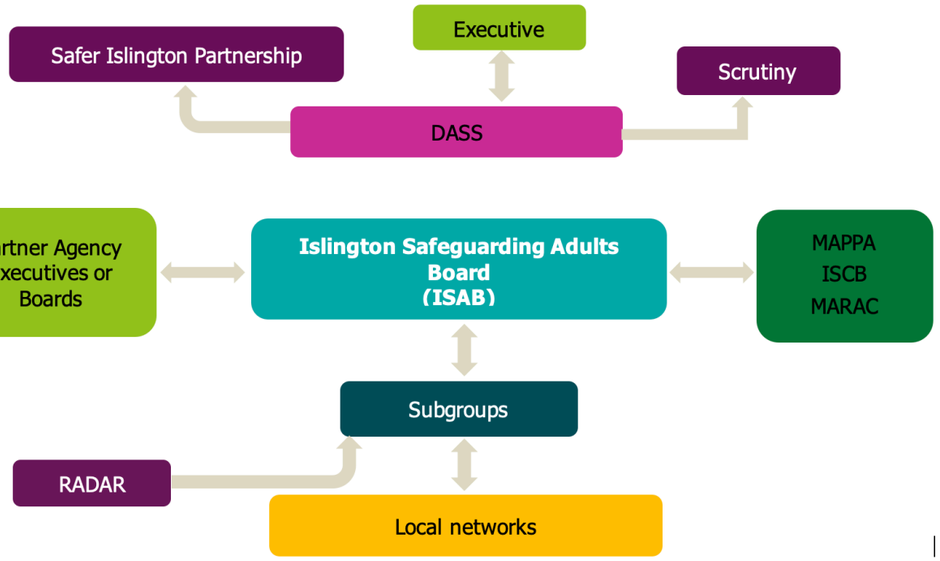


The above chart shows the main care or support needs of the adults who had safeguarding concerns raised about them. There continue to be more safeguarding concerns raised about adults with physical support needs than any other group of people. This is similar across the country. The chart shows that few concerns raised for people whose main need was that they care for someone else. It suggests we need to continue raising awareness amongst carers and organisations that support carers.

Appendix B

How the partnership fits in

The picture below shows how the Islington Safeguarding Adults Board (ISAB) fits in with other organisations and partnerships. The arrows and lines show who reports to whom.



Council	All elected councillors. It is the lead body for the local authority.
Executive	Eight councillors who are responsible to the council for running the local authority.
Scrutiny	This is a group of 'back bench' councillors who look very closely at what the council does
Safer Islington Partnership	This group looks at crime and community safety. It involves the council, police, fire service, voluntary sector and others.
DASS	Director of Adult Social Services (DASS) is responsible for setting up and overseeing the ISAB

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ISAB	Islington Safeguarding Children's Board works to safeguard children in the borough.
MARAC	Multi-Agency Risk Assessment Conference. This group responds to high-risk domestic abuse.
RADAR	This group looks at the quality of care providers in Islington.

Appendix C

Who attended our board meetings

Engagement from our partners is essential. While much of the work goes on behind the scenes, it is important for our partners to take part in our meetings. We hold quarterly Board meetings. Due to the demands of the pandemic on our partner organisations, we did not hold a challenge event.

The tables here set out the organisations represented at board meetings and subgroup meetings throughout the year.

Islington Safeguarding Adults Board Meetings	Board Meeting 12 May 2021	Board Meeting 21 July 2021	Board Meeting 3 Nov 2021	Board Meeting 26 Jan 2022
Partner Organisation				
Independent Chair	P	P	P	P
Police	P	P	A	A
Islington Council	P	P	P	P
Islington Clinical Commissioning Group	P	P	P	P
Moorfields Eye Hospital NHS Foundation Trust	P	P	P	P
London Fire Brigade	P	A	P	P
Camden & Islington Mental Health FT	A	P	P	P
Whittington Health	P	P	P	P
Community Rehabilitation Company	A	A	A	A
Probation	A	A	A	P
Safer Islington Partnership	A	A	P	A
Co-Opted Organisation				
Age UK Islington	P	P	P	P
Notting Hill Pathways	P	A	A	A
Healthwatch Islington	P	P	P	A
Single Homeless Project	A	P	P	P

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Islington Safeguarding Adults Board Meetings	Board Meeting 12 May 2021	Board Meeting 21 July 2021	Board Meeting 3 Nov 2021	Board Meeting 26 Jan 2022
Attendees				
Care Quality Commission	A	A	A	A
NHS England	N/A	N/A	N/A	N/A
Islington Council - Elected Councillor	P	A	A	P
General Practitioner	N/A	N/A	N/A	N/A
HMP Pentonville	P	A	A	A
Voluntary Action Islington	A	P	P	P

Key
P = Present
A = Apologies no substitute
N = No apology/ substitute recorded
C = Does not attend; receives papers only
N/a = not applicable

Quality, Audit and Assurance Subgroup	Subgroup meeting 28 April 2021	Subgroup meeting 7 July 2021	Subgroup meeting 6 Oct 2021	Subgroup meeting 12 Jan 2022
Partner Organisation				
Chair (Clinical Commissioning Group)	P	P	P	A
Islington Council	P	P	P	P
Whittington Health	P	P	A	P
Moorfields Eye Hospital NHS Foundation Trust	A	A	P	P
Camden and Islington NHS Foundation Trust	A	P	P	P
Notting Hill Housing	P	P	P	A
Police	A	P	P	A

Safeguarding Adults Review Subgroup	Extra ordinary Subgroup Meeting 19 April 2021	Extra ordinary Subgroup meeting 26 April 2021	Subgroup Meeting 10 December 2021
Partner Organisation			
Chair (Police)	P	P	P
Islington	P	P	P
Single Homeless Project	A	A	P
Islington Clinical Commissioning Group	P	P	P
Age UK	N/A	N/A	N/A
Camden and Islington NHS Foundation Trust	A	A	A
Whittington Health	P	P	P
Moorfields	N/A	N/A	N/A

Prevention & Learning subgroup	Subgroup meeting 6 May 2021	Subgroup meeting 9 June 2021	Subgroup meeting 26 July 2021	Subgroup meeting 13 Sept 2021	Subgroup meeting 25 Oct 2021	Subgroup meeting 6 Dec 2021	Subgroup meeting 1 Feb 2022
Partner Organisation							
Chair (Moorfields NHS FT)	P	P	P	P	P	P	P
Islington Council	P	P	P	P	P	P	P
London Fire Brigade	A	A	A	A	A	A	A
HMP Pentonville	A	P	A	A	A	A	A
Notting Hill Genesis	A	A	A	A	A	A	A
Camden and Islington NHS FT	A	A	P	P	A	P	P
Whittington Health	A	A	A	A	A	P	P
CCG	P	P	P	P	A	A	A

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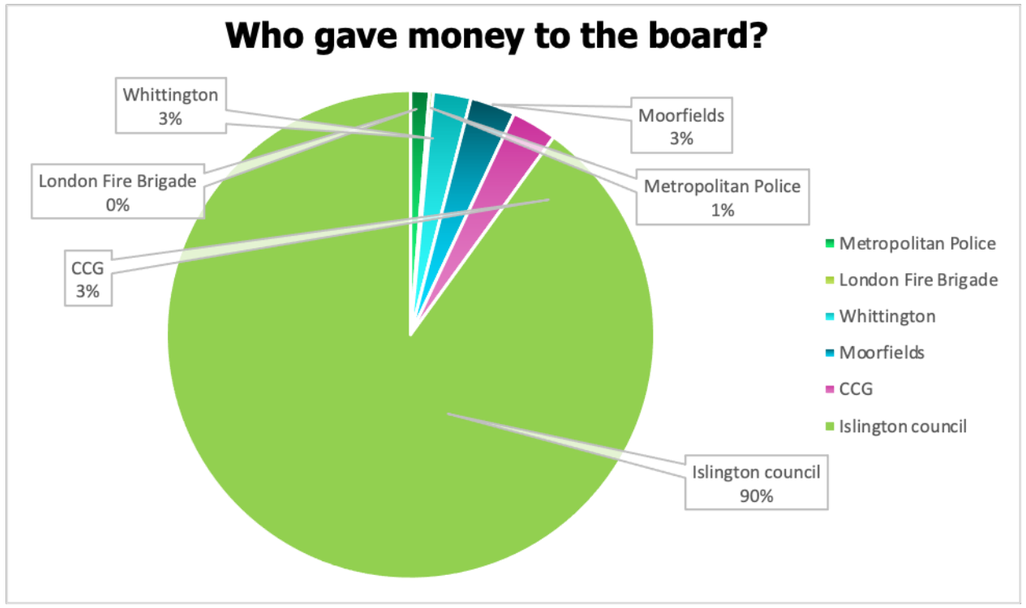
Appendix D [this section to be updated]

How is our Board resourced?

Primary responsibility for safeguarding adults rests with Islington Council. But all Board partners are expected to contribute to the resources of the partnership.



As the above chart shows, Islington council financed 90% of the costs of the Safeguarding Adults Board in Islington. Islington CCG also makes a significant contribution to the Council's functions relating to the Mental Capacity Act and Deprivation of Liberty Safeguards work in the borough that in part contribute to the Board's safeguarding aims. Discussions continue with other Board partners regarding future funding and resources.

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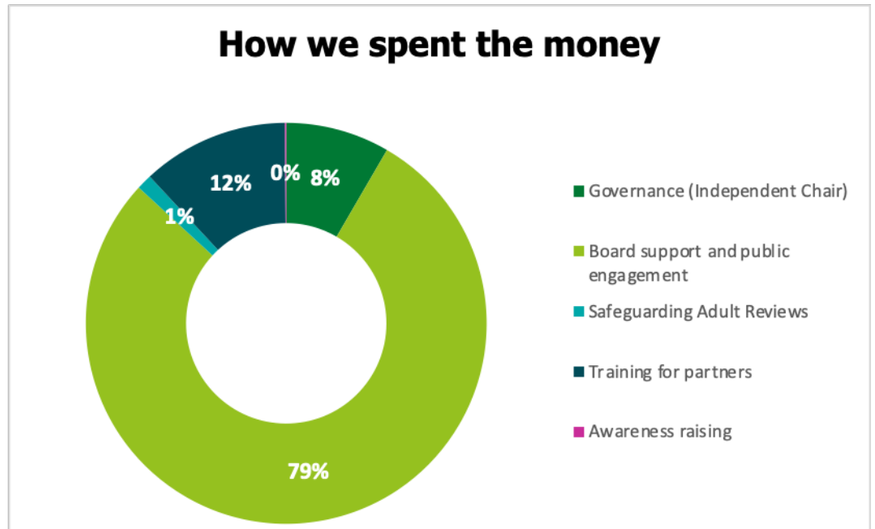

It cost roughly £200,302 to support the work of the Board during the year. This is an increase of approximately 6% on last year's expenditure.

A significant amount of the basic awareness around MCA/DoLS, community DoLS and modern slavery training have been delivered by in-house staff which helped to save on costs for external trainers. Some training has also been delivered online via e-learning modules. This included training on domestic violence, safeguarding adults at risk in Islington, and some MCA/DoLS training which have had a positive update.

Although direct costs for awareness-raising account for less than 1% of the board's expenditure, in reality several of the board support staff are routinely engaged in awareness-raising work as part of their daily work but these indirect costs are not reflected in the above chart because they are difficult to separate from the general board support functions.

Appendix E

Our impact on the environment

The work of the Safeguarding Adults Board has a low impact on the environment in Islington. Environmental impacts include fuel use for vehicles visiting service users, carers and their family and other general office impacts such as paper and energy use. Wherever possible we try to minimise the impact on the environment. For example, wherever we can we avoid printing documents and send out electronic versions instead to reduce paper and energy use. From time to time we hold 'virtual' meetings on line to cut our travel impact.

Sometimes our work also highlights opportunities to reduce household environmental impacts. For example, we might refer adults at risk to the Seasonal Health Intervention Network (SHINE). SHINE gives energy saving advice to residents. Not only does this help the environment, but it also reduces fuel poverty and improves the health and wellbeing of residents in Islington.

For more information about SHINE, **click here**.

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Appendix F

Jargon buster

Abuse
Harm caused by another person. The harm can be intended or unintended.

Adult at risk
An adult who needs care and support because of their age, disability, physical or mental health and who may be unable to protect themselves from harm

Care Act 2014
An Act of parliament that has reformed the law relating to care and support for adults.

Clinical Commissioning Group (CCG)
CCG's are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Channel Panel
Channel is multi-agency panel which safeguards vulnerable people from being drawn into extremist or terrorist behaviour at the earliest stage possible.

CRIS
This is a Police Crime Database. The CRIS database acts as a case management system for logging and recording crimes.

Community Risk Multiagency Risk Assessment Conference (CRMARAC)
A multi-agency meeting where information is shared on vulnerable victims of anti-social behaviour. The aim is to identify the highest risk, most complex cases and problem-solve the issues of concern.

Deprivation of Liberty Safeguards (DOLs)
The process by which a person lacking the relevant mental capacity may be lawfully deprived of their liberty in certain settings or circumstances. It operates to give such a person protection under Article 5 of European Convention on Human Rights (right to liberty and security).

Sometimes, people in care homes and hospitals have their independence reduced or their free will restricted in some way. This may amount to a 'deprivation of liberty'. This is not always a bad thing – it may be necessary for their safety. But it should only happen if it is in their best interests.

The deprivation of liberty safeguards are a way of checking that such situations are appropriate.

Female Genital Mutilation
Female Genital Mutilation involves any kind of procedure that partly or total removes external female genitals for non-medical reasons and without valid consent.

LeDeR
The LeDeR programme is a review of the deaths of people with a learning disability to identify common themes and learning points and provide support to implement these.

Liberty Protection Safeguards
A new set of safeguards which will replace the current system of Deprivation of Liberty Safeguards

Making Safeguarding Personal
A way of thinking about care and support services that puts the adult at the centre of the process. The adult, their families and carers work together with agencies to find the right solutions to keep people safe and support them in making informed choices.

Mental Capacity Act (MCA)
The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves. The MCA is designed to protect and restore power to those vulnerable people who lack capacity.

Merlin
Merlin is a database used by the Police to report persons who have come to notice due to any of a number of risk factors, such as going missing. Merlin is used to refer those concerns to partner agencies, such as mental health services.

Neglect
Not being given the basic care and support needed, such as not being given enough food or the right kind of food, not being helped to wash.

Safeguarding Adults Board
Councils have a duty to work with other organisations to protect adults from abuse and neglect. They do this through local safeguarding boards.

Safeguarding Concern
Any concern about a person's well-being or safety that is reported to adult social services. Safeguarding concerns can be reported by members of the public as well as professionals.

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Safeguarding Enquiry
A duty on local authorities to make enquiries to establish whether action is needed to prevent abuse, harm, neglect or self-neglect to an adult at risk of harm.

Seasonal Health Interventions Network (SHINE)
SHINE aims to reduce fuel poverty and seasonal ill health by referring a resident on to services. For example, it may refer someone for energy efficiency advice and visits, fuel debt support, falls assessments, fire safety and benefits checks.

RADAR meetings
A meeting which looks at the quality of care being provided in care homes, care in your home and hospitals for older people in Islington. The meeting helps us to share information on services to improve the quality of care for service users.

Prevent
Prevent is part of the Government's counter-terrorism strategy. It involves safeguarding people and communities from the threat of terrorism and extreme views.

Section 136 of Mental Health Act 1983
(Mentally disordered person found in a public place)

This law is used by the police to take a person to a place of safety when they are in a public place. The police can do this if they think the person has a mental illness and is in need of care.

Section 135 of Mental Health Act 1983
(Warrant to search for and remove patients)

This law is used by the police to take someone to a place of safety for a mental health assessment.

Section 5 of Mental Health Act 1983
(Application in respect of a patient already in hospital)

This law is used by a doctor or Approved Mental Health Practitioner (AMPH) to stop an adult from leaving a hospital in order to treat them in their best interest.

Section 6 of Mental Health Act 1983
(Application for admission into hospital)

This law is used by a doctor or AMHP to admit an adult to hospital in order to treat them in their best interest.

Appendix G

What should I do if I suspect abuse?

Everybody can help adults to live free from harm. You play an important part in preventing and identifying neglect and abuse.

If you suspect abuse or neglect, it is always safer to speak up!

If you suspect abuse of a vulnerable adult, please contact:

Adult Social Services Access and Advice Team
Tel: 020 7527 2299
Email: access.service@islington.gov.uk

You can also contact the
Community Safety Unit (part of the police)
Tel: 020 7421 0174

In an emergency, please call 999.

For more information:
Islington Community Safety **www.islington.gov.uk/community-safety**

For advice on Mental Capacity Act & Deprivation of Liberty Safeguards contact:
Tel: 0207 527 3828
Email: dolsoffice@islington.gov.uk

For more information, **click here**

All the people whose faces you can see in the photographs in this review have agreed for their images to be used.

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Thanks for reading!

We hope you enjoyed reading this review. For any questions, feedback or further detail, please email: **safeguardingadults@islington.gov.uk** or write to us at:

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