



AGENDA FOR THE HEALTH AND WELLBEING BOARD

Members of Health and Wellbeing Board are summoned to a meeting, which will be held in Town Hall on, **15 October 2014 at 2.00 pm.**

John Lynch
Head of Democratic Services

Enquiries to : Rachel Stern
Tel : 020 7527 3308 - rachel.stern@islington.gov.uk
E-mail : democracy@islington.gov.uk
Despatched : 7 October 2014

Membership

Councillors:

Councillor Richard Watts
Councillor Janet Burgess
Councillor Joe Caluori

Clinical Commissioning Group Representatives

Dr. Gillian Greenhough, Islington Clinical
Commissioning Group
Dr. Josephine Sauvage, Islington Clinical
Commissioning Group
Anne Weyman, Islington Clinical Commissioning
Group
Alison Blair, Islington Clinical Commissioning Group
Martin Machray, Islington Clinical Commissioning
Group

NHS England

Dr Henrietta Hughes, NHS England

Islington Healthwatch Representative

Olav Ernstzen, Islington Healthwatch

Officers

Julie Billett, Joint Director of Public Health Camden and
Islington
Sean McLaughlin, Corporate Director Housing and Adult
Social Services
Eleanor Schooling, Corporate Director Children's
Services

A. Formal Matters **Page**

1. Welcome and Introductions - Councillor Richard Watts
2. Apologies for Absence
3. Declarations of Interest

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

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

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

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

*(a)Employment, etc - Any employment, office, trade, profession or vocation carried on for profit or gain.

(b)Sponsorship - Any payment or other financial benefit in respect of your expenses in carrying out duties as a member, or of your election; including from a trade union.

(c)Contracts - Any current contract for goods, services or works, between you or your partner (or a body in which one of you has a beneficial interest) and the council.

(d)Land - Any beneficial interest in land which is within the council's area.

(e)Licences- Any licence to occupy land in the council's area for a month or longer.

(f)Corporate tenancies - Any tenancy between the council and a body in which you or your partner have a beneficial interest.

(g)Securities - Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

This applies to all voting members present at the meeting.

4. Order of Business
5. Minutes of the previous meeting 1 - 4

B. Items for Decision/Discussion **Page**

1. Strategic priorities and commissioning plans for 2015/16 5 - 20

	a. Islington CCG and Islington Council	
	b. Healthwatch	
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6.	JSNA executive summary	307 - 332
7.	Workplan	333 - 334

C. Questions from Members of the Public

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

D. Urgent Non-Exempt Matters

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

E. Exclusion of Press and Public

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

F. Urgent Exempt Matters

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

G. Confidential/Exempt Items for Information

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H. Any other business

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The next meeting of the Health and Wellbeing Board will be on 14 January 2015

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

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Agenda Item A5

London Borough of Islington
Health and Wellbeing Board - Wednesday, 16 July 2014

Minutes of the meeting of the Health and Wellbeing Board held at Committee Room 4, Town Hall, Upper Street, N1 2UD on Wednesday, 16 July 2014 at 2.00 pm.

Present: Councillors: Watts (Chair), Burgess and Caluori

Dr. Gillian Greenhough, Islington Clinical Commissioning Group
Anne Weyman, Islington Clinical Commissioning Group
Alison Blair, Islington Clinical Commissioning Group
Martin Machray, Islington Clinical Commissioning Group
Dr. Katie Coleman - Clinical Commissioning Group representative
Emma Whitby – Healthwatch Islington

Officers: Julie Billett – Corporate Director of Public Health
Sean McLaughlin - Corporate Director of Housing and Adult Social Services

Also Present: Councillors Gary Heather

Councillor Richard Watts in the Chair

1 WELCOME AND INTRODUCTIONS - COUNCILLOR RICHARD WATTS (ITEM NO. A1)

The Chair welcomed everyone to the meeting. Members of the Board introduced themselves.

2 APOLOGIES FOR ABSENCE (ITEM NO. A2)

Apologies for absence were received from Dr Henrietta Hughes, Olav Ernstzen and Dr Jo Sauvage. Dr Katie Coleman would be substituting for Dr Sauvage and Emma Whitby would be substituting for Olav Ernstzen.

3 DECLARATIONS OF INTEREST (ITEM NO. A3)

Dr Gillian Greenhough and Dr Katie Coleman declared an interest as GPs in agenda item B4.

4 ORDER OF BUSINESS (ITEM NO. A4)

The order of business would be as per the agenda.

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

That the minutes of the meeting of the Board held on 12 March 2014 be confirmed as a correct record and the Chair be authorised to sign them.

6 EARLY INTERVENTION AND PREVENTION: FROM RHETORIC TO LONG-TERM REALITY IN ISLINGTON (ITEM NO. B1)

Thanos Morphitis, Service Director, Strategy and Commissioning introduced the report,

Members acknowledged the importance of the early intervention work. Officers should always look for areas for improvement particularly around partnership working.

RESOLVED:

That, together with the Children and Families Board, the Board committed to a long-term focus on early intervention and prevention in Islington.

That an initial summit be held, jointly with the Children and Families Board, in November about children, young people and parent/families that considers:

Health and Wellbeing Board - 16 July 2014

- how smart investment can be applied to make a culture shift from late intervention to early intervention that results in local savings
- how the culture change required for early intervention can be achieved in the following areas:
 - balancing acute/complex/severe needs and early intervention
 - individual and collective leadership
 - funding early intervention
 - commissioning for early intervention and prevention, which includes
 - innovation and building local evidence – how we diversify our local evidence base on prevention and early intervention
 - collaboration and shared goals with external partners such as schools and the third sector

That a further summit be held to consider how the early intervention and prevention approach could be applied to the rest of the life course i.e. adults and older people.

7 **CHILD HEALTH STRATEGY (ITEM NO. B2)**

Sabrina Rees, Head of Children's Health Commissioning and Jason Strelitz, Acting Assistant Director, Public Health introduced the report outlining plans to develop a comprehensive health commissioning strategy for Islington children and young people.

Members would welcome a more explicit commitment to early intervention work in the Commissioning Intentions. The theme of patient voice and personalisation should also be reflected in the principles.

Members applauded the positive outcome data particularly given the high levels of deprivation in the borough. The Strategy should outline what differences would be made by the production of the document.

RESOLVED:

That the Health and Wellbeing Board endorse the production of a CYP Health strategy across Islington CCG and the Local Authority.

That the comments of the Board on the CYP Health Strategy be noted.

8 **WELFARE REFORM: HEALTH AND WELLBEING IMPLICATIONS (ITEM NO. B3)**

Lela Kogbara, Assistant Chief Executive (Strategy and Community Partnerships) introduced the report which explained some of the changes that had been introduced so far as part of the government's programme of welfare reform, the rationale for those changes and the impact that they were having in Islington on children and families and people in receipt of sickness and disability benefits.

Section 5 included some negative comments about GPs but these were just the reported opinions of some services and were not stated as true. They did not apply to all GPs and apologies were given if the report presented the data in a negative way.

Members congratulated officers on the 87% success rate on ATOS appeals.

The additional workload on GPs related to benefits assessments was onerous and challenging and the way this was managed needed to be examined.

The provision of appropriate employment opportunities important and this needed to be carefully managed.

RESOLVED:

The Board noted the impact of welfare reform locally, particularly households with children and people on sickness and disability benefits.

That the comments of the Board be noted by officers.

9 ONLINE PATIENT ACCESS TO RECORDS (ITEM NO. B4)

Dr Katie Coleman, joint Vice-Chair of the Islington Clinical Commissioning group introduced the report.

Members recognised that although the patient access was only intended for individuals to view their own records, there were likely to be concerns about other agencies having access to that data.

There would need to be extensive training on the new system, particularly around domestic violence and child protection issues which would have financial implications.

Records would be prospective not retrospective and would just include coding not full plain text of consultations.

RESOLVED:

That the report be noted.

10 TOBACCO CONTROL IN CAMDEN & ISLINGTON (ITEM NO. B5)

Julie Billett, Corporate Director of Public Health introduced the report.

RESOLVED:

That the priorities and planned actions for tobacco control in Islington, including joint activities with Camden be noted.

That the proposed partnership and governance arrangements for tobacco control across Camden and Islington be agreed.

11 REFRESHING THE JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) (ITEM NO. B6)

Julie Billett, Corporate Director of Public Health introduced the report.

Healthwatch may have a useful role in feeding back on the views of the voluntary sector.

There was a rolling programme of updating existing factsheets. Members could feedback further comments outside of the meeting.

RESOLVED:

That Islington's progress on the JSNA and the actions and timescales for updating it, particularly the work to collect resident and patient views be noted.

That the proposed approach and timetable for feeding back to the Health and Wellbeing Board on the JSNA be agreed.

12 UPDATE ON PROGRESS AGAINST THE JOINT HEALTH & WELLBEING STRATEGY PRIORITIES (ITEM NO. B7)

Julie Billett, Corporate Director of Public Health introduced the report.

RESOLVED:

That progress against the Health and Wellbeing Boards three priorities be noted.

13

LONDON FOOD FLAGSHIP BOROUGH APPLICATION (ITEM NO. B8)

Thanos Morphitis, Service Director, Strategy and Commissioning introduced the report.

Members noted that Islington had not been selected to be part of the London Food Flagship programme but officers had worked hard on the submission and the Food Strategy would be available as part of their work.

Members welcomed the process and the work of officers on this issue.

RESOLVED:

That the Project Team (from Children's Services, Public Health and Environment and Regeneration use the Flagship Plan as a basis to develop, with partners, a new Food Strategy for Islington.

That the actions within the Food Strategy be rolled out within existing resources.

That the Health and Wellbeing Board agree the Food Strategy, once finalised

14

WORK PROGRAMME (ITEM NO. B9)

RESOLVED:

That the work programme be noted.

MEETING CLOSED AT 3.00 pm

Chair



Report of: Director of Public Health

Meeting of:	Date	Agenda item	Ward(s)
Health and Wellbeing Board	15 th October 2014	TBC	All

Delete as appropriate	Not exempt	
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SUBJECT: ISLINGTON CCG AND ISLINGTON COUNCIL COMMISSIONING INTENTIONS FOR 2015/16

1. Synopsis

- 1.1 This paper sets out a high level overview of the approach to commissioning intentions for 2015/16 being taken by Islington Council's children's, adult social care and public health services and Islington Clinical Commissioning Group (CCG). It describes the overarching strategic approaches and aims informing the development of commissioning intentions.

2. Recommendations

- 2.1 Islington Health and Wellbeing Board is asked to note the approaches to commissioning for 2015/16

3. Background

- 3.1 This paper sets out a high level overview of the approach to commissioning intentions for 2015/16 being taken by Islington Council's children's, adult social care and public health services and Islington Clinical Commissioning Group (CCG).
- 3.2 Proposals for Islington Council's commissioning intentions are being developed in the context of a very challenging economic climate which has seen unprecedented levels of central government cuts to local authority services. During the period since 2010, Islington Council has had to make savings of £112m; over the next four year period, a further £95m may have to be found, amounting to a halving of the council's budget since 2010.
- 3.3 In terms of specific proposals for children's, adult social care and public health services

for 2015/16, these will be identified through the Autumn and consulted on as appropriate before formal decisions are taken in the New Year by Islington Council's Executive

4 Children's Services

4.1 Work on developing proposals for the new medium term financial strategy for Children's Services, starting in 2015/16, has involved four main stages of development:

1. Identifying principles and priorities underpinning the role of local authority children's services, working with partners including the Schools Forum and the Clinical Commissioning Group, in the context of the financial and operating environment for Children's Services.
2. Using service area analysis - performance/ financial/ legal/demographic – to support greater insight into the needs, service requirements and performance, and outcomes for children and young people and their families in Islington. As part of this workstream, detailed analysis has been undertaken on the overall 'shape' of the Children's Services budget, for example the relative investment in early intervention and prevention services compared to specialist services.
3. Assessing the evidence base in order to inform development of proposals for priorities, options development within and across service areas and new ways of working, with extensive engagement with stakeholders.
4. Developing proposals for the draft Financial Strategy for subsequent consultation, approval and implementation.

4.2 The overall budget for children's services in 2014/15 is £241m however, 71% of this budget is under the control of the Schools Forum. Therefore, it has been particularly important that the development of the draft medium term strategy for services for children and young people and their families has worked closely with stakeholders and considered all relevant budgets i.e. not just funding in the children's services budget but relevant funding streams including those administered through the Safer Islington Partnership and the Schools Forum, as well as Islington CCG expenditure on children's community health services and Public Health budgets for health improvement.

4.3 Children's Services proposals for the draft financial strategy and commissioning intentions are underpinned by a number of key strategic priorities:

- retaining a systematic approach to and investment in prevention and early intervention, to help ensure that children and families have the best start in life, as well as to identify and address emerging problems earlier and more effectively;
- strengthening the Community of Schools;
- investing in targeted services to ensure long-term service and financial viability for children's services over the next ten years;
- ensuring safe, specialist services;
- maximising joint commissioning opportunities with Schools and the NHS.

4.4 In support of these key strategic priorities, the following principles are intended to underpin both the Financial Strategy for Children's Services and the Children and Families Early Intervention Strategy. The main principles are:

- Early Intervention and Prevention
- Quality of Integrated Universal Services
- Reducing Inequalities

- Think Family
- From Participation to Co-production
- Connecting socially for a stronger community
- Innovation and evidence

4.5 The development of the draft financial strategy and proposals established a range of workstreams which engaged stakeholders in identifying key service and financial challenges and priorities for future service delivery and commissioning. This included engagement with stakeholders in the following service areas:

- Early Years Services and Childcare
- Pupil and School and Early Years Support Services
- Post 16 Education and Employment
- Social Care, Family and Parenting Support
- Health Services for Children
- Services for Disabled Children
- Play and Youth Provision
- Youth Safety and Crime
- Central (CS) Support Services

This led on to further engagement with stakeholders in identifying and developing potential service changes and savings, working with Children's Services Management Team (CSMT). Those 'shortlisted' by the CSMT against the priorities and principles outlined above have then been further developed and tested through more intensive analysis and stakeholder engagement.

4.6 The development process for proposals have also taken into account previous work on a number of substantial strategic service reviews and reconfigurations implemented as part of the 2011-15 Financial Strategy. These included:

- the reduction in management capacity and clustering of Sure Start Children's Centres;
- the ending of the schools services contract with Cambridge Education and the re-integration of key services back into the LA;
- the establishment of the Community Budget for Families with Multiple Needs including:
 - the Parental Employment Project;
 - the establishment of Families First;
 - the rationalisation of specialist services for those young people most vulnerable and/or at risk
 - the incorporation of the Troubled Families programme into the community budget model;
- the Youth Review including the development of the Youth Hubs at Lift and Platform;
- the Adventure Play Review and the establishment of a single contract for 6 voluntary sector playgrounds;
- the progress on the four strategic priorities in the Children and Families Strategy 2011-15:
- new legislative requirements;
- inspection requirements and outcomes

5. Adult Social Care

5.1 Adults Social Care commissioning in Islington is delivered in partnership with the

Clinical Commissioning Group. This joint working is underpinned by a partnership agreement under Section 75 of the Health Act 2006. £68m of funds are pooled between adult social care and the Clinical Commissioning Group. Close collaboration between local authority and NHS commissioning becomes increasingly important to make best use of decreasing resources to deliver the most benefit for our population. Islington is well positioned to do this, with a strong history of partnership working.

5.2 The key priorities for Adult Social Care commissioning for 2015/16 will be:

1. Delivering the requirements of the Care Act 2014.
2. Developing joined-up care and support in Islington, as defined in the integrated Pioneer proposal and programme plan, and the ambitions of the Better Care Fund
3. Developing a sustainable Adult Social Care offer in the context of rising demand and shrinking local Government resources.

5.3 The Care Act 2014

5.4 The Care Act passed into law on 14 May 2014. The draft guidance and regulations were published for consultation on 6 June 2014, with a closing date of 15 August 2014. The final draft regulations are expected in October 2014. Commissioning intentions at this stage are therefore based on the draft guidance. In terms of commissioning intentions, two of our main priorities in relation to the Care Act are as follows:

- To take a strategic approach to market development for social care in Islington, to ensure that we meet our requirements under the Care Act to develop social care provision that offers choice and quality to both those who fund their own care, and those who have support from the local authority. Our Peer Review at the end of September will support this approach.
- To ensure that there is adequate provision of information, advice and advocacy, which quickly signposts people to the most relevant and useful services. We are working with the Social Care Institute of Excellence to pilot their commissioning guidance for developing information, advice and advocacy.

5.5 Developing a joined-up approach to care and support in Islington

5.6 Adult Social Care Commissioning is part of the Integrated Care Board, which oversees the development of joined-up care and support in Islington, and which reports to the Health and Wellbeing Board. Some of the key initiatives which are being led within Adult social care include:

- A review of intermediate care, to ensure that services provide efficient and effective “step up” and “step down” services, particularly to prevent hospital admissions, and to help people to get home more quickly following a stay in hospital
- To build on our strong approach to personalisation in Islington through the “Making it Real Board” to support the development of personal health budgets.
- To support the development of localities of co-ordinated health and social care, where GPs, community health and social care services, and voluntary sector providers, work with individuals to achieve personalised goals. Our ambitions are described in the Better Care Fund plan.

5.7 Developing a sustainable offer for Adult Social Care

5.8 A key priority will be to scope options for Adult Social Care over the next four years in the context of decreasing resources. Our approach will be characterised by the following:

- Reviewing service provision which is underused or performing poorly, and decommissioning where relevant.
- Looking at how services can be delivered more flexibly
- Ensuring contracts deliver services as efficiently as possible, without compromising quality.
- Ensuring a joined-up approach across all parts of the Council and the CCG by commissioning together to get most value

The starting point for this work is the evaluation of current Adult Social Care investment and effectiveness with the “Use of Resources Tool”, which was developed by the Association of Directors of Adult Social Services. This will be completed by the end of October 2014.

6 Public Health

6.1 The Council’s public health investment is driven by the Health and Social Care Act 2012 which places a duty on local authorities to promote the health and wellbeing of their population and reduce health inequalities. The act mandates the delivery of the following services, all of which are commissioned or provided by the public health directorate:

- Sexual health services, including testing for and treatment of sexually transmitted infections and contraception (excluding HIV treatment and termination of pregnancy).
- NHS Health Checks: preventative health checks to reduce the risk of cardiovascular disease and diabetes.
- Local Authority role in health protection: local authorities are required to ensure plans are in place to protect the health of their population and also have a supporting role in infectious disease surveillance and control and in emergency preparedness and response.
- Public health advice: local authorities are responsible for providing population health advice, information and expertise to Clinical Commissioning Groups to support them in commissioning health services that improve population health and reduce
- National Child Measurement Programme: a programme to measure and weigh all children in reception and year six.

6.2 Besides these mandated services, the ring-fenced Public Health grant has a number of conditions on its use, which state that the grant must be used for services to improve public health. In 2015/16, the Public Health Grant for Islington has been announced as £24.6 million, the same level as in 2014/15. A further announcement on funding for health visiting, which is scheduled to transfer from NHS England to local authority responsibility in October 2015, is expected before the end of the year.

6.3 During 2015/16, Public Health will be progressing its transformation programmes which are designed to ensure that the public health grant is focused on delivery of the Health and Wellbeing Board’s strategic priorities; delivering key health outcomes and increased value and quality; and supporting reductions in health inequalities in Islington. The transformation programmes are organised under 3 main headings:

- Drug and alcohol services – this is largely focused on re-design of pathways for treatment and support in order to increase efficiencies and improve outcomes; making improved use of performance and quality incentives to drive improvements in outcomes; and review of resource use to ensure value for money in the major contracts
- Sexual health services – the two major transformational drivers for sexual health services that will be progressed through 2015/16 both involve working collaboratively with other London councils: the first is preparing for proposals to make significant changes in the way that local authorities pay for open access sexual health services through the introduction of a new integrated sexual health tariff, expected to be ready for implementation from April 2016; and a significant programme developing service transformation options designed to inform the future commissioning of GUM services
- Health improvement – mainly focused on changes in how health improvement services for adults are accessed and delivered, with greater integration of the offer including through primary care services. For 2015/16, the major proposals are to identify efficiencies within budgets and develop and prepare for new integrated commissioning models

6.4 The general approach under each of the 3 headings is that transformation will:

- be driven by an understanding of local need, priorities, reviews of what is currently in place, and evidence of ‘what works’
- seek to maximise efficiencies and productivity gains
- use incentives and levers to improve performance and maximise outcomes
- introduce alternative contracting and payment mechanisms to ensure payment more closely reflects levels of service being delivered (e.g. sexual health services, drug and alcohol services).
- help to develop opportunities for collaboration and joint working, whether with Camden, the local NHS or other London councils, to help to create synergies and efficiencies in meeting the needs of residents
- focus on service transformation and pathway re-design – where it is appropriate and safe to do so, shifting services into more cost-effective settings and delivery channels, taking advantage of new and emerging technologies (e.g. considering options for greater use of home testing for sexually transmitted infections), moving services into primary and community settings away from specialist provision, and changing the skill mix in clinical services, enabling residents more convenient access to services, closer to home.
- take a more holistic, integrated approach to the commissioning and delivery of preventative and wellness services, whether as part of wider initiatives or through ‘single points of access’ so that they address multiple needs, rather than commissioning a number of ‘single issue’ services in isolation.

6.5 As well as the above programmes of work on transformation, the responsibility for health visiting services will transfer from NHS England to local authorities in 2015. The transition to local commissioning responsibility is currently being managed jointly with Haringey Council, as both Islington and Haringey health visiting services are provided by Whittington Health. A joint transformation project group has been established to oversee the transition of commissioning responsibilities from NHS England to local authorities from October 2015, co-chaired by the Assistant Directors of Public Health from Islington and Haringey with engagement from Early Years and Children’s Health Commissioning. A local arrangement is being put into place through an Integrated Governance Framework which sets out how NHS England and Islington will work together during the transition period, to ensure there is continuity in commissioning and monitoring and oversight of performance as responsibilities transfer across.

7 Islington Clinical Commissioning Group

7.1 2015/16 is a crucial year in the development of longer-term plans for Islington Clinical Commissioning Group (CCG). The CCG has identified the key elements of a transformed service offer for Islington patients:

- An offer of early intervention and prevention for the whole population;
- Health and care systems and pathways that are co-produced with patients and users;
- Strong clinical leadership shaping and supporting change;
- Hospitals that plan and support discharge from the first day of admission;
- Better access to voluntary and community based services through better information and advice;
- Joined up care delivered through four localities based around GP practices. This 'network of care', comprising GP-led services and community provision which wraps around patients' needs, will be at the front end of service delivery, integrating provision. Outcomes will be improved across the spectrum of an individual's health using a multi-disciplinary clinical approach across health and care services;
- Better identification and co-ordination of care for patients/users at high risk of hospital admission;
- A programme of supported self-management for children and adults with long term conditions;
- More personalised service offers through the roll out of personal health budgets and increasing numbers of those who opt for a personal budget;
- Services that are more easily understood and accessed through single point of access, single assessment processes and 7 day working;
- Better alignment of physical and mental health services, thereby promoting parity of esteem across the health continuum;
- A skilled workforce that delivers care with dignity and compassion, is motivated to make a difference and is rewarded for its efforts;
- IT systems that support joined up care by becoming interoperable.

Islington CCG's Commissioning Intentions for 2015/16 are designed to support the above transformation objectives through a range of actions. These include the following areas.

7.2 Integrated Care including the Better Care Fund

7.3 Aims for the programme are two-fold: support for health and wellbeing at a whole population level; and at the same time providing better co-ordinated care for more intensive users of services. A life course approach to this work means that the health and wellbeing of children and young people is integral to all work streams. Priorities for 2015/16 focus on:

- Better co-ordination of care for older and vulnerable people, people with long-term conditions and people with mental health conditions.
- Introduction of the Better Care Fund; through development of the Locality Offer across community, social care and mental health services, supporting enhancements in primary care capacity; improved information sharing between services for patients' care; new incentives to support integrated care between providers and an increased focus on patient outcomes, including the introduction of the value based commissioning pilots for diabetes and mental health.

- Parity of esteem between services for physical and mental illness, particularly addressing the needs of patients who require support in both areas of their health.
- Mobilising individuals' own abilities and motivations, and community assets.

7.4 **Mental Health**

7.5 The priorities for mental health commissioning in 15/16 include:

- A new primary care mental health service for the assessment, treatment and care of people with mental health conditions working alongside GPs, to reduce the need for use of secondary care services, designed to improve care and patient experience.
- Improving the coordination of care for people living with dementia and their carers through advanced care planning and linked support across health, housing and adult social care.
- Improving psychiatric support to people with mental health conditions seen in acute general hospitals, so that their care is better managed.
- Staged implementation of a new Mental Health Tariff in secondary care services, based on clinical and patient outcomes.

7.6 **Children's health services**

7.7 Emerging findings from the Children's Health strategy indicate the following priorities for 2015/16 and beyond:

- Children and young people are able to live in an environment that allows health to thrive;
- Improvements in the early identification of health and other problems;
- Scope to reduce the need for hospital services, in particular A&E and unplanned admissions, through improved access to alternatives in community and primary care;
- Co-ordinated care for children with chronic needs (and their families) encompassing both physical and mental health;
- Support for the transition from children's to adult services, including delivery of Special Education Needs reforms;

7.8 **Primary Care Development**

7.9 Primary care development priorities will focus on:

- Improving access, together with an increased range of alternatives to hospital care in community or primary care settings, supported by establishing local networks of primary care services working together.
- Increasing early detection of conditions, to prevent more serious problems developing.
- Developing new pathways of care to improve multi-disciplinary care of patients with more complex needs or at greater risk of hospitalisation, enabling patients to be appropriately cared for outside hospital, together with improvements in specific condition management, such as COPD.
- Improving the ability, capacity and opportunities to support patients to self help, including targeted self-management programmes.
- Co-commissioning of primary care services. The Department of Health and NHS England are now working with CCGs to develop a method by which local primary care services may be commissioned jointly by CCGs with NHS England. Islington CCG has expressed an interest in co-commissioning with initial

priorities identified as: strategic oversight; premises; IT; and non-contractual performance.

7.10 Urgent Care

7.11 Camden and Islington CCGs' review of urgent care services has completed. Implementation will address the findings from the CCG's public and patient engagement: in particular, patients and public priorities for urgent care are being seen by a doctor quickly and receiving any treatment necessary as soon as possible, being seen face-to-face and close to home. Improving capacity in, and access to, primary care is the key to relieve pressures in A&E departments and delivering a better outcomes and patient experience for those needing care. The CCG will be preparing through 2015/16 for implementation of a new combined NHS 111 and GP out-of-hours service from April 2016 to improve patient experience of urgent care services.

8 Implications

8.1 Financial Implications

Adult Social Care

Islington Council's Adult Social Service department has a net expenditure budget of £81.9m.

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

The Commissioning intentions need to align with the MTFS saving programme and need to take into account future savings.

The implementation of the Care Act is being funded through New Burdens Funding; however at this stage it is unclear if this will be sufficient.

Children's Services

Islington Council's Children's Services department has a net expenditure budget of £82.56m.

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

The Commissioning intentions need to align with the MTFS saving programme and need to take into account future savings.

Public Health

Islington Council receives a ring-fenced Public Health grant from the Department of Health to fund the cost of its Public Health service. The grant amount for 2014/15 and for 2015/16 is £25.4m.

The Council's Public Health expenditure must be contained entirely within the grant funded cash limit indicated above. If any additional pressures are incurred management actions will need to be identified to cover this.

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

The Commissioning intentions need to align with the MTFS saving programme and need to take into account future savings.

8.2 Legal Implications

The Health and Social Care Act 2012 (“the 2012 Act”) established clinical commissioning groups, which have responsibility for commissioning healthcare services for their registered populations. Section 195 of the 2012 Act requires the Health and Wellbeing Board to encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner for the purpose of advancing the health and wellbeing of the people in its area.

8.3 Environmental Implications

None identified

8.4 Equalities Impact Assessment

Equality impact assessments are carried out as indicated and required as part of the development and implementation of commissioning intentions.

9. Conclusions

- 9.1 This paper has summarised the main strategic aims and approaches informing commissioning intentions for 2015/16 for children’s services, adult social care, public health and Islington CCG. It is set against a backdrop of unprecedented reductions in central government funding for services commissioned and provided by councils. It highlights, in particular, Islington’s strengths in integration and innovation in delivering services together to improve outcomes and reduce inequalities for people in Islington.

Background papers:

None

Final report clearance:

Signed by:



Director of Public Health

Date: 2nd October
2014

Received by: Head of Democratic Services

Date

Report Author: Jonathan O’Sullivan

Tel: 020 7527 1220

Email: Jonathan.o’sullivan@islington.gov.uk



Report of: Director of Public Health

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	October 15 th 2014	Item	All

Delete as appropriate	Exempt	Non-exempt
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SUBJECT: Healthwatch Islington Work Plan 2014 -15

1. Synopsis

- 1.1 This report provides an update on Healthwatch Islington's (HWIs) work plan for the year 2014-2015.

2. Recommendations

- 2.1 To note the contents of the work plan

3. Background

- 3.1 Each year in May/June, HWI sets its work plan based on health and care issues raised within the local community. The Steering Group then oversees the progress of this work. This update which is available at Appendix A is presented for information.

4. Implications

4.1 Financial Implications

None identified.

This paper provides an update only.

4.2 Legal Implications

The Health and Social Care Act 2012 amended section 221 of the Local Government and Public Involvement in Health Act 2007 (the 2007 Act”) so that it required a local Healthwatch organisation to be established in each local authority area from April 2013. Section 221 of the 2007 Act requires upper tier and unitary local authorities to contract with a local Healthwatch organisation which must be a social enterprise, to involve patients, service users and the public in the commissioning, provision and scrutiny of health and social services.

Local Healthwatch organisations are corporate bodies and within the contractual arrangements made with their local authorities must carry out the particular activities specified in section 221(2) of the 2007 Act. These activities are to promote involvement and provide support for the involvement of people in the commissioning, provision and scrutiny of local care services; enabling people to monitor and review the commissioning and provision of local care services for the purpose of considering standards of local care and whether and how they could or ought to be improved; obtaining the views of people about their needs for, and experiences of, those services; and making reports and recommendations to people responsible for commissioning, providing, managing or scrutinising those services which set out how local care services could be improved.

Section 194 of the Health and Social Care Act 2012 specifies that at least one representative of the local Healthwatch organisation for its area must be a member of the Health and Wellbeing Board. The Health and Wellbeing Board has a duty to involve the local Healthwatch organisation in the preparation of the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy

4.3 Equality Impact Assessment

HWI works to ensure that it is reaching out across the borough to gather views from the local community.

4.4 Environmental Implications

None identified.

5. Conclusion(s) and reason(s) for recommendations

5.1 To note the contents of the work plan. The report is an update and for information only.

Background papers: None

**Attachments: Work Plan
Final Report Clearance**

Signed by



26th Sept 2014

.....
Date

Director of Public Health

Received by

.....

Head of Democratic Services

.....

Date

Report author: Emma Whitby

Tel: 020 7832 5814

Fax:

E-mail: emma.whitby@healthwatchislington.co.uk

APPENDIX A

Healthwatch Islington Work Plan 2014 -15

Healthwatch Islington's remit is to gather views, report views, visit services and engage people in decision-making about health and care services in order to influence commissioning, provision and delivery of those services. We also offer information about services to local residents. We aim to work collaboratively with statutory partners to develop the best services for local needs, and we work closely with the voluntary sector. Findings we gather will be discussed and shared with commissioners and providers.

Aim	Status	Notes
1. Gather views of children and young people on a health strategy for the borough.	Complete	Worked with Islington Clinical Commissioning Group to gather the views of children and young people. These have now fed in to the strategy.
2. Improve access to interpreting services within primary care.	In progress	Gathering data on GP use of Language Line (interpreting service provider), gathering experiences from voluntary sector partners and local residents, plans to mystery shop services to assess procedures.
3. Investigate access to mental health services and advocacy.	In progress	Set up a meeting with service commissioner to discuss key issues. Aim is to bring together voluntary sector and commissioner's knowledge to support commissioning.
4. Gather the views and experiences of home care service users.	Postponed	Surveying was due to start in January 2015 but postponed following discussions with LBI.
5. Assess customer service in GP receptions.	In progress	Visits to five practices with young people have now taken place. Further visits being planned.
6. Measure 'user friendliness' of local safeguarding procedures.	In progress	Interviewing local organisations about how user-friendly they find reporting safeguarding throughout September and October.
7. Hold four public meetings to discuss key issues.	In progress	July meeting discussed care.data, September meeting will consider key social care issues, November meeting will look at mental health needs and services and in January 2015 we will consider the Care Act.
8. Continue to scope further issues of concern to our local community.	In progress	Trialling new comment forms, working with Help On Your Doorstep (door knocking on local estates), hosted a pop-up stall at Chapel Market (Nag's Head is next) and aiming to trial on-line surveys. We will meet with the Youth Health Forum to discuss how we can help influence health and care services for local children and young

		people.
Follow up on previous work:		
9. Making a complaint about services offered at local GP practices.	In progress	Sixteen GP practices now have improved information about complaints on their web-sites. We will mystery shop practices in the autumn to see if this information is also available in practices.
10. Clearer information for Deaf patients in local hospitals using British Sign Language.	In progress	Two hospitals have taken steps to improve the clarity of information and in identifying patients who need interpreters. One doesn't have the capacity to do this at present. The London Assembly have asked us to attend a Health Select Committee meeting to address this issue across London.
Developing relationships		
We continue to work closely with Healthwatch England and local statutory and voluntary sector partners.		

Moving forward to 2015 and beyond:

Healthwatch will continue to gather views from the local community and ensure its work plan for 2015-16 reflects the needs of local people. We will also continue to explore options for partnership working and external funding to support our work. Our work would not be possible without our team of dedicated local volunteers. We will continue to apply the Investing In Volunteers principles in our volunteer recruitment, management and support.

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Report of: Corporate Director Housing & Adult Social Services

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	15 October 2014	Item	All
Delete as appropriate	Exempt	Non-exempt	

SUBJECT: Housing and Health progress report

1. Synopsis

- 1.1 A summit organised by the Health & Wellbeing Board on Housing and Health took place on the Andover Estate, N7 in September 2013, to explore how Islington Council, the NHS and social housing providers can work together to improve health and tackle health inequality.
- 1.2 This paper presents progress made since that summit and sets out areas where joint working between health and housing can be further developed and strengthened, including some key actions to be taken going forward to maximise the positive impact on health and wellbeing for Islington residents.

2. Recommendations

2.1 The Health and Wellbeing Board is asked to:

- NOTE the range of work going on across the council and with key external partners
- CONSIDER how, as a Board, it can support and promote further action in this area.

3. Background

- The relationship between housing and health is well documented, and is known to be very complex with many different levels and directions of causal interaction between housing characteristics and health. Decent affordable housing is the cornerstone of good physical and mental health, but we know that decent housing on its own is insufficient. We know that people living in social housing in Islington have poorer health than local residents not living in social housing, yet we also know that the quality of social housing is good (as measured by the percentage of homes meeting the decent homes standard). Twenty-two percent of people living in areas with high proportions of social housing have a long-term health condition, compared with 9% in areas with no social housing. We also know that private sector housing conditions vary dramatically between properties, but don't necessarily know which properties need improvements.

- In social housing, there are high proportions of disabled people, people with long-term conditions, and older people, homelessness, and problems associated with high density housing such as noise, antisocial behaviour, and harassment. There is not enough social and affordable rental housing to meet demand. Problems associated with private housing include poor quality housing, poorly insulated properties, and a greater prevalence of damp and condensation compared with social housing. Issues affecting both social and private housing include overcrowding, poverty and fuel poverty.
- In September 2013, a summit organised by the Health and Wellbeing Board on Housing and Health took place at The Andover Estate, N7, to explore how Islington Council, the NHS and social housing providers can work together to improve health and tackle health inequality. Themes that emerged from the summit included more integrated working and information sharing, and the development of approaches based on needs defined by communities.
- This report presents the progress that has been made since the summit and sets out what is needed to maximise the impact of better coordinated joint working.

3.1 Influencing strategy and policy

- Outputs from the summit were fed into the consultation on Islington Council's Housing Strategy 2014-2019. Improving health and wellbeing is one of the four priorities in the strategy which makes a commitment to: reduce fuel poverty and help with the cost of healthy living; make homes more sustainable; look for new ways of working together to increase support and choice for older people to deliver better housing options and services; increase levels of independence; work to provide a better quality of life for some of our most vulnerable residents, building on the good working relationships between public health, housing and social care.
- There is a statutory duty on the Director of Public Health to produce an independent Annual Public Health Report (APHR) on the health of their population, highlighting key issues. Camden and Islington's 2013 APHR included a chapter focussing on healthier homes and makes a series of recommendations for building on existing work to tackle homelessness, overcrowding and poor and unsafe housing conditions.
- The council has been working with Islington CCG and the Local Medical Committee (LMC) on how we can better support claimants and GPs in relation to the provision of medical evidence as part of housing applications and benefits assessments. This includes awareness raising sessions and providing GPs and other health services with information and resources regarding welfare reform and local services and support.

3.2 Tackling cold homes and damp

- Tackling cold and damp housing is important because of its association with a range of health conditions, from common colds and asthma through to respiratory and heart conditions that can lead to early death. Cold and damp homes are also associated with poor mental health and poor social and economic outcomes as well as fuel poverty.
- The Council has insulated 99% of cavity walls in its own stock, and is currently insulating 623 of its remaining "hard to treat" properties with cavity walls. The Council has fitted external wall insulation to 269 solid walled properties at the Holly Park estate and 36 properties at Neptune House.
- The Holly Park external wall insulation work is being evaluated over three stages, measuring the impact on residents' self-reported thermal comfort, energy use and bills, damp and mould, and health and wellbeing. In Bunhill, the Council's Decentralised Energy Network is delivering reduced energy costs to 700 homes on three estates (and two leisure centres), among other benefits. A second phase will add to this by extracting heat from an electricity substation and a tube ventilation shaft.

- As part of Islington's Warm Healthy Homes Programme, residents receiving certain benefits with an older boiler can apply for an energy efficient replacement, whilst those not on benefits can apply for a grant towards a new boiler. In 2013/2014, 533 boilers were replaced under the Safe and Warm (6), Private landlords (13) and Boiler Replacement Programme (514) schemes. 109 of these were fitted in the homes of vulnerable households.
- Islington's Housing Services developed a condensation protocol in 2014 with colleagues in Environment and Regeneration, for the purpose of having an agreed, consistent approach to tackling the problem of condensation and damp in council homes. Addressing damp and condensation can be challenging as the source of the problem is not always easily identified and can be a mixture of factors including structural deficits, a lack of or faulty damp coursing or condensation dampness caused by both human and building factors. The protocol commits the council to identifying the source of damp and taking action to address it, through improvements and repairs to its properties and by educating residents about lifestyle changes they can make to reduce condensation in their home. The council invests £2m per year in addressing dampness in its properties and £10m in improving energy efficiency to help relieve these problems.
- Residential Environmental Health take action against private landlords where properties fall below regulatory standards. The council also runs a boiler replacement programme which includes private tenants.

3.3 Better partnership working and single point of contact

- A single point of contact makes it easier for residents to access the service they need, and provides the additional benefit of assessing the person for other services that they may benefit from, and making appropriate referrals. This was raised as a significant point at the summit, and over the past year, the council, with its partners, has been working to develop better partnership working and more joined up services.
- In March 2014 Residential Environmental Health introduced a single point of contact. Private tenants and landlords now only have to remember one number for all their housing queries. It's now easier for tenants to get through to the right person for advice about renting a property in the private rented sector, complaints or queries about repairs and standards, and for housing benefit and council tax advice. The lines are also for landlords interested in renting properties to the council or wanting advice about being a landlord. Within this service, there is a new post holder in the joint NHS/LBI funded Environmental Health Officer (EHO) role. Their primary objective is to develop partnerships and proactive referral streams with NHS colleagues such as GPs, to support the integration of housing into the multi-disciplinary team approach in Islington, and to also develop referrals from other health and social care professionals e.g. mental health workers and health visitors.
- The Seasonal Health Intervention Network (SHINE) is a referral system offering advice and support to Islington residents. The network co-ordinates 132 teams across 86 referring organisations, with 30 interventions helping to improve health. Interventions include working with Council services such as Residential Environmental Health, health services (falls assessments and smoking cessation), and general support such as AGE UK's enablement services and Disability Action in Islington's services to mitigate risk factors for poor seasonal health outcomes such as cold homes, trips and falls, etc. New services developed since the summit include support for accessing energy and water bill discounts, financial capability training and mental health enablement. During winter 2013/14, Islington piloted the country's first data sharing system to access energy rebates worth £135 for over 1,000 vulnerable households. In September 2014 SHINE joined the four locality multi-disciplinary teams, bringing housing and financial needs into the care plans of the borough's 2% most vulnerable patients.
- In 2013/14, 'Well Winter', a cold weather campaign coordinated by SHINE, worked with many local partners to help vulnerable people stay well over the winter. It worked with the Pillion Trust to provide cold weather shelters and support to access accommodation, jobs and training for rough sleepers; with North London Cares to reach over 2,100 residents aged 65 and over, connecting over 800 people at 34 social events, and providing additional support such as blankets or coats to 95 residents;

and with Age Concern to deliver a cold weather contact service. It also received additional funding for the Friendship Network for work to reduce social isolation.

- As part of its programme of out-reach work, Healthwatch Islington has been working with the local organisation Help On Your Doorstep to reach people on local estates. Through this work they have had a number of enquiries relating to housing and the potential impact on people's health. These queries are forwarded to the SHINE (Seasonal Health Intervention Network) team.
- Camden and Islington Public Health is looking at opportunities to develop a single point of access for local lifestyle services. This would potentially be a branded lifestyle service that would coordinate all referrals (self, GP, other services) through a central contact point/channel for a range of lifestyle and behavioural risk factors. The opportunity to link this service with other services provided across the council that tackle some of the wider determinants of health, such as income maximisation, affordable warmth, employment etc. is being developed as part of this new approach.
- A recommendation from the Housing and Health Summit was the inclusion of housing representation on the multi-disciplinary team meetings that are designed to co-ordinate and improve the care of people with complex physical and mental health needs linking into locality navigators and the integrated care pioneer. Now, a housing representative is working with the two Age Concern health navigators and another sits on the steering group of the Prevention and Early Intervention work stream of the Islington Integrated Care Pioneer programme.
- The N19 Pilot began in June 2013 and ran until March 2014. It involved a multi-disciplinary team comprised of social workers, district nurses, occupational therapists, physiotherapists, rehabilitation team members, mental health workers and administrators. The multi-disciplinary team, based in the same office, screens and assesses the service users. Where multiple services are needed, a care co-ordinator is allocated to bring together all the elements. Age UK has been commissioned to evaluate the pilot and the council and Islington Clinical Commissioning Group, with input from users and carers, are reviewing this evaluation and evidence. So far, there has been positive feedback for the model and learning from the pilot is informing our local integrated care work. Integrated care offers the opportunity to benefit 28,000 Islington residents who have one or more long-term conditions. People who could benefit most are identified through risk stratification, with multi-disciplinary teams involved in planning care for those people with the most complex needs. The systematic inclusion of housing within these multi-disciplinary teams has the potential to further improve outcomes and ensure a patient or user-centred approach

3.4 Supporting independent living

- Independent living is important because it enables people to have the same choice, control and freedom as any other citizen, either at home, at work, and as members of the community. Independence is a key factor in maintaining health and wellbeing, and quality of life.
- A work stream within the Adult Social Care Transformation Programme is looking at the supply of accommodation – specifically, how to meet the long term housing needs of older people, those with learning disabilities or mental health issues. This has already resulted in the council building and opening new accommodation for people with learning disabilities at Leigh Road. This is due to open in 2014.
- The Supporting People partnership delivers locally relevant, housing-related support services to help vulnerable people live independently in the community. This is achieved by providing housing-related support to prevent problems that can often lead to tenancy failure, hospitalisation, institutional care or homelessness. It can also help smooth the transition from accommodation-based residential support to independent living. It is a co-ordinated programme, where referrals received from a number of agencies are assessed and the most appropriate support needs arranged. In Islington, during 2013/14 there were 725 referrals. 60% of support needs were generic, 19% were for mental health and 7% for older people's needs. Less than 3% of people referred were not eligible for services. Short-term outcomes are measured when people leave a service, whilst long-term outcomes are

recorded for a sample of people in long-term services. Short-term outcomes were met for 77% of people in Islington in 2013/14 across the five supporting people outcome domains (achieving economic wellbeing, enjoy and achieve, be healthy, stay safe, and making a positive contribution). Long-term outcomes are available for 2012/13, during which period 98% of people were supported to maintain independent living.

- Through the Supporting People programme, the Council is about to jointly procure a Lesbian, Gay, Bisexual and Transgender (LGBT) young people's service in conjunction with Hackney and Haringey to provide supported housing to people between 16 and 25 years old. This supported housing service aims to assist young people who may have been excluded from their home in any of the three local authorities and also have support needs around their sexuality. In addition, these young people may have support needs as a result of offending, substance misuse, mental health needs or may have experienced domestic violence. The joint procurement aims to realise efficiencies and provide a more cohesive service across the three local authorities that have typically protected access to services based on the origin of the individual seeking housing assistance.
- We have also commissioned substance misuse, offender and young people services in the last year that are more outcomes focussed than in previous commissioning cycles. It is anticipated that this approach will enhance performance within these services and crucially better meet the needs of the service users accessing the service. These short term services will seek to move people on from supported housing more swiftly (from 2 years down to 6-12 months) to ensure that greater numbers of Islington residents are able to access housing related services and support.
- People who have a permanent or substantial disability may be eligible for equipment or adaptations in their home, to help manage everyday tasks. Islington made 392 adaptations in 2013/14, up from 350 the year before and 338 in 2010/11.

3.5 Prioritising need

- In some circumstances, a person's medical condition is made worse by their housing conditions. In such cases, additional points are awarded, effectively helping to prioritise their application for housing. Medical and welfare points are now assessed on a household basis with all household members assessed. There are currently 1,422 applicants on the Council's list who have a medical priority, which represents 8% of the housing list. In 2013/14, the Council housed 304 people with a medical priority, which represents 21% of the total number of applicants with a medical priority. This compares with 9% of all applicants being housed. 108 applicants were in the most pressing Category A, (20 housed, 19%), 465 in Category B (74 housed, 16%) and 849 in Category C (210 housed, 25%). Applicants who have a Category A need often require a specific type of accommodation, which can delay re-housing. Severe overcrowding and homelessness are also considered when prioritising housing applications.
- There were 2,436 overcrowded households in Islington in April 2014 waiting to be rehoused in a larger property, with 308 of those families classed as severely overcrowded (defined as households lacking two or more bedrooms). The Council moved 162 severely overcrowded households during 2014. The Council also offers advice on how to maximise space within the home and on rehousing older children into their own accommodation under the New Generation scheme. The Council also assists social housing tenants to downsize, thereby releasing larger homes for availability to overcrowded households. In addition, the Council's *New Generation* scheme for sons and daughters of residents living in social housing has been extended to those in private rented accommodation, helping to prioritise rehousing for overcrowded families irrespective of tenure.

3.6 Developing evidence based interventions

- Public Health have been working closely with Family Mosaic on their *Health begins at home* project, which is using a randomised controlled trial methodology. 600 social tenants aged over 50 (about 200 from Islington) have been allocated to one of three groups: regular assessments only; one group receives support from housing officers with extra training, and one group receives intensive help from

a new team of health support workers. The research has found that 92% of tenants aged 50 and over had a long-term condition.

- Having reached a point where the vast majority of participants (442 of 497) have now had their second assessment (9 month milestone), some interim results are now available (Sep 2014). Overall, the changes observed have largely not been statistically significant. However, on some measures some significant changes (at 95% CI) are starting to emerge. For example, group 2 participants (those receiving signposting support from their trained Neighbourhood Managers) are reporting a significantly improved ONS wellbeing score in comparison to the control group, and group 3 participants (those receiving intensive, 'hand-holding' support from a dedicated support worker) are showing a significantly reduced number of planned hospital appointments compared to both groups 1 and 2. It therefore seems that it is too early to yet observe any consistent significant changes in the overall health and wellbeing of the participants, but some improvements are starting to be seen across both group 2 and 3 participants. Further analysis will be conducted in spring 2015, by which point most participants will have completed their full 18 months in the study.
- During the project, 26 participants have been identified as having such a high level of need that they were removed from the trial and placed into group 3b, where they could receive the intensive support they required. Several of these individuals were not known to or engaged with local health services and consequently were not receiving the treatment they required. This has indicated the crucial role that housing associations can play in identifying and supporting some of our most vulnerable older people. Public Health is working with Family Mosaic to build profiles of these residents to better understand what action could have been taken earlier to support them and what barriers they faced in accessing services and support. These findings will be available in early 2015.
- Islington Council's tenancy management team carry out annual visits to residents aged over 75, living in a one-bedroom property or bedsit, whether or not they have a known vulnerability. The visits are to check how these residents are managing in their home, whether they need extra support to continue to live independently, and to make referrals if appropriate. In addition, the Housing Investigations Team carries out an audit of 10% of properties in the borough, and vulnerability checks will be undertaken during visits. Using learning from the findings from the Family Mosaic research, we will look at how these home visits could be used more effectively to identify health and care needs early and to support residents to access services, and how other services, including locality navigators and Help On Your Doorstep, could both learn from and support this work.
- The *Good Neighbours Scheme* aims to build a more cohesive community, to tackle isolation through residents volunteering to give one to one support to another neighbour, and helping out in an event or activity put on by the Good Neighbours Scheme. The scheme operates on the New River Green Estate. Islington CCG is funding a community wellbeing project and recently took part in a joint Community Fun, Health and Wellbeing event through the Good Neighbours Scheme, to improve the health and wellbeing of the residents of the estate and the surrounding area. The project aims to encourage local people to discuss their thoughts and opinions on how communities can work together to improve their overall health and wellbeing. This has included focus groups and surveys to encourage discussion while young people have been taking part in a filming project where they are gathering healthy insights from their families and social circles.
- The Council's Planning department will be commissioning a research project in 2015 which aims to find out if, following cycling infrastructure improvements, the uptake of cycling among its residents on housing estates matches the average take up, and if not then the reasons why it varies from the average. This research will help provide information to ensure that the delivery of these cycling infrastructure improvements will provide benefits to all groups, particularly those who stand to benefit the most from them.
- The Holly Park external wall insulation evaluation discussed in section 3.2 is also a key piece of research that will contribute to the evidence base. The full picture will not be available until after spring 2015, but interim findings are encouraging. Residents have reported a significant improvement in the temperature and comfort of their properties, reducing energy use and bills, and a small number

of residents reported an improvement in the damp and mould. This kind of evaluation helps gather intelligence to make better evidence based decisions and commissioning.

3.7 Better housing support

- Anti-social behaviour can pose a serious threat to community life, undermining people's sense of safety, their well-being and, ultimately, their health. In 203/14, 386 repeat callers made 1,679 calls to the ASB team, with noisy neighbours (408 calls) and noisy music (403 calls) being the most frequent complaints. The ASB out of hours team undertakes a vulnerability risk assessment and makes referrals as appropriate. Currently some work is underway to look at the mental health needs of people involved in ASB and the thresholds that trigger intervention, to understand the opportunities for earlier intervention and referral to mental health services, before crisis point is reached. At present, referrals are made to voluntary sector organisations for non-crisis point interventions.
- A new Joint Working Protocol (May 2014) sets out how Camden & Islington NHS Foundation Trust (C&IFT) and Islington Council Housing Services, (IHS) will work in partnership to promote the welfare of service users in Islington who experience mental health issues. It sets out what should be done when concerns about a client arise, arrangements for sharing information, and arrangements for accessing partners' services. A training programme is being designed for housing staff on how to better recognise and understand signs and symptoms of mental health conditions.

3.8 Targeted health promotion

- The evidence base in relation to which targeted health promotion activities and interventions are most effective in improving the health and wellbeing of social housing tenants is relatively weak, although local evidence tells us that positive activities like exercise classes and cookery classes are well received by tenants. We plan to continue using community venues for these activities and explore options for expanding these activities through greater partnership working with current providers.
- "NHS Health Checks" is a national programme to reduce people's risk of high blood pressure, heart disease, stroke, and kidney disease. Islington has taken a proactive approach to this programme because of high rates of cardiovascular deaths among people aged under 75, and high prevalence of long-term conditions, particularly among residents living in social housing. As well offering NHS Health Checks via GPs and some community pharmacies, Islington has taken advantage of community centres and community locations, including housing estates, to deliver targeted health checks. In 2014 these venues and locations have included:
 - Andover Estate events
 - Highbury fields community festival
 - Manor Gardens summer Fair
 - Holloway Neighbourhood group
 - Hanley crouch community centre
 - St Luke's community centre
 - Elizabeth house community centre
- Public Health, SHINE and other council colleagues have been working with Circle Housing to deliver health promotion information at their annual summer 'Pop-up' events. We will continue to work with Circle Housing, as well as with other Housing Associations, to explore other ways of working together.

3.9 Next steps

The activity in this report represents significant process in the year. However more needs to be done to tie this activity to health outcomes for residents.

- The evidence base for improving health outcomes through housing services needs to be strengthened. Work underway at Holly Park and with Family Mosaic needs to be built upon. Public

health will work with housing to carry out a longer term evaluation of housing redevelopment/ regeneration in health terms.

- There is scope to increase prevention and early intervention work by continuing to expand Islington's *Every Contact Counts* across all front-line staff. This still requires better information sharing and joint work between different services. Given that people in social housing have poorer health, there are opportunities to do more work with council services and housing associations to promote better health, building on the findings from Family Mosaic as they emerge.
- Whilst all of Islington Council's social housing meets the Decent Homes standard, available data on homes in the private rented sector suggests that it is falling behind. There is a need to do more to improve standards in the private rented sector in Islington. Work in Residential Environmental Health on expanding licensing of houses in multiple occupation will contribute to this, as will the setting up of a council Social Lettings Agency.
- Work to plan to meet housing need for an aging population, as well as those with higher support needs is in development. In future this work needs to encompass existing general needs housing as well as supported accommodation, and to draw in all relevant services.
- Housing and health services need to work more closely with GPs to develop a shared understanding of how medical need relates to housing need and how to work together to secure suitable housing for residents.
- The locality model and multi-disciplinary team approach seems to offer opportunities to work more closely around how someone's home affects their health. The council, health and social care services need to monitor and review both the nature of presenting housing problems, and how having housing services working with MDTs can improve outcomes.

4. Implications

4.1. Financial implications

None identified.

This paper provides an update across a wide range of programmes and services across the Council.

4.2. Legal Implications

Section 195 of the Health and Social Care Act 2012 requires the Health and Wellbeing Board to encourage integrated working.

Specifically section 195(4) provides that the Health and Wellbeing Board has power to encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health-related services in its area, to work closely together. This means that Health and Wellbeing Boards can encourage bodies involved in the wider determinants of public health, such as housing to work closely with those commissioning health services as well as with the Health and Wellbeing Board itself.

4.3. Equalities Impact Assessment

This paper provides an update report on Housing and Health work. Reducing health inequalities is an underpinning principle across the Board's work and poor housing is a key determinant of health inequalities. This report aims to identify ways in which interventions, services and programmes related to health and housing can reduce health inequalities.

4.4. Environmental Implications

None identified

5. Conclusion and reasons for recommendations

The Health and Wellbeing Board is asked to:

- NOTE the feedback and next steps of the summit
- CONSIDER how, as a Board, it can support and promote further action in this area.

Final report clearance:



Signed by:

Corporate Director of Housing and Adult Social Services

Date: 3 October 2014

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Report of: Corporate Director of Housing and Adult Social Services

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	15 October 2014	Item	All

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SUBJECT: Safeguarding Adults Partnership Board; Annual Report 2013/14

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 Annual Safeguarding Review, attached as appendix 1, describes this in more detail.

2. Recommendations

- 2.1 To note the contents of this report and to commend adult social services staff for their commitment to preventing abuse where possible and responding to concerns of abuse or neglect on vulnerable Islington residents.

3. Background

- 3.1 Islington Council has a statutory responsibility to lead the borough in safeguarding adults. Local authorities, along with other public agencies, are required to submit an annual review of safeguarding arrangements to their Executive Board, as part of the No Secrets statutory guidance.
- 3.2 Achievements this year:
Audits
We have established an audit framework for care management teams. Teams have been auditing cases for a year and findings have revealed strong practice in keeping people safe from the beginning

of a safeguarding investigation. Auditors have been taking learning from the audits back to teams to further improve practice.

Financial abuse toolkit

In light of the prevalence of financial abuse we have produced a financial abuse toolkit for service users and carers to help keep themselves safe.

Working with Trading Standards

We have started working with trading standards on supporting victims of scams and doorstep criminals.

Domestic Violence

We have continued to work closely with colleagues in community safety improving the number of MARAC referrals and creating a safeguarding adults and domestic violence flowchart for practitioners.

Sprinklers

Following a fatal fire in 2013 involving an adult at risk, we are working to install domestic sprinklers into homes for the people most at risk.

Hoarders

We have created a forum to address the needs and issues of hoarding. The aim of this group is to develop local policies and procedures and interventions to address and reduce the risks from hoarding behaviours.

Home fire safety visits

During 2013-14, London Fire Brigade received from agencies within Islington, the highest recorded number of home fire safety referrals of any Borough across London. The majority of these came from partners represented on the Adult Safeguarding Board. As a result, 2093 home fire safety visits were carried out in the Borough, smoke alarms were fitted where needed and 98% of these visits were carried out in the homes of the most vulnerable members of our community.

Community Risk MARAC

We are working closely with colleagues in the Police and Community Safety to address concerns resulting from anti-social behaviour where the victims are vulnerable and at risk of serious abuse or harm. The aim of this group is to prevent incidents like those experienced in the high-profile case of Fiona Pilkington.

SAPB partner safeguarding meetings

Moorfields Eye Hospital, Whittington Trust and Camden and Islington Mental Health Trust have all established senior level Safeguarding Adults meetings.

CCG involvement in Safeguarding Adults Unit

The CCG has contributed funding to the Safeguarding Adults Unit and has produced a work plan that addresses areas of learning and development for commissioners, compliance with regulations and updating of policies and procedures.

Themed SAPB meetings

We have introduced themed Board meetings which have resulted in some very interesting presentations from partners about how they contribute to the safeguarding agenda.

- 3.3** The review compares the statistics from 2013/14 with the previous year 2012/13. There has been an increase of 43% in alerts from the previous year and an increase in investigations by 4%. These figures are positive in that they show that professionals and members of the public are reporting safeguarding concerns about adults to us. We have been working hard to increase awareness among members of the colleagues and public and the increase in alerts may reflect this.

Physical abuse, financial abuse and neglect have remained the top three categories for several years. The picture is similar across the country. Since last year, neglect and financial abuse have been nearly equal in the number of investigations completed (at 32% and 28% respectively).

- 3.4** The percentage of cases which were substantiated (that is, the abuse was likely to have taken place) has remained the same as the previous year at 30%.
- 3.5** During 2013/14 a serious case review was held in Haringey relating to an Islington resident placed in a Haringey care setting. As a result of the review comprehensive training around choking has been set up and a new protocol has developed between Islington and Haringey around transfers of care arrangements.

Also during 2013 we participated in a Domestic Homicide Review. Actions to come from this review include reviewing the safeguarding policies to ensure that domestic violence is appropriately included, carers issues are addressed and non-engagement and refusal of service policies are reviewed. The action plan is currently being quality assured by the Home Office.

Our Establishment Concerns process was invoked for three care homes during the year. All three care homes have since demonstrated significant improvements and worked to detailed improvement plans.

- 3.6** The report looks at the use of Deprivation of Liberty Safeguards (DoLS) in Islington. Most referrals are for people who have dementia. Overall, application levels were similar to previous years, with more referrals from care homes and fewer referrals from hospitals.

In March 2014 the Supreme Court made a long awaited decision in a case known as 'Cheshire West' concerning the living arrangements of three mentally incapacitated individuals. It decided that all three were subject to a deprivation of their liberty. This judgment is important because it clarified the law around DoLS and introduced an 'acid test' to work out whether or not a deprivation of someone's liberty is taking place. We anticipate DoLS applications to increase significantly in 2014/15 as a result of the Cheshire West judgement.

- 3.7** The report details progress on delivering our 3-year Board strategy. An annual plan set out specific actions for the year to be carried out by the four subgroups of the Board. All actions have either been achieved or are on course to be achieved.

4. Implications

4.1 Financial implications

The Safeguarding Adults Unit 2013/14 gross expenditure outturn was £540k. Of this, £87k was funded through the Islington Clinical Commissioning Group (ICCG) contribution towards the service.

The Safeguarding Adults Unit 2014/15 gross expenditure budget is £510k. With the recent Supreme Court judgment in the 'Cheshire West' case which extended the definition of the Deprivation of Liberty Safeguards (DoLS), and has meant the number of people eligible for DoLS assessments has increased significantly. This has led to a pressure of £500k for the 2014/15 financial year, which will be contained within the Adult Social Services department.

4.2 Legal Implications

The DoH Guidance 'No Secrets; guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse' requires the Council to co-ordinate the development of local policies and procedures for the protection of adults from abuse. Paragraph 3.18 requires the multi-agency management committee (the Safeguarding Adults Board) to undertake an annual audit to monitor and evaluate policies, procedures and practices for the protection of adults who are at risk of abuse. The paragraph specifies that feedback on performance to all agencies should be a key feature of the audit process.

The "No secrets" guidance is issued under 7 of the Local Authority Social Services Act 1970, which means that local authorities are required to follow the guidance unless local circumstances indicate exceptional reasons which justify a variation. Failure to comply with the guidance may be challenged by way of judicial review.

The Care Act 2014, the relevant sections of which come into force in April 2015, establishes the first statutory framework for adult safeguarding. Sections 42 - 47 set out the provisions for safeguarding adults at risk of abuse and neglect. Section 42 imposes a duty on the Council to establish a SAB for its

area. Paragraph 4 of Schedule 2 requires the SAB to prepare an annual report, and specifies the matters that must be included in the report.

4.3 Equalities Impact Assessment .

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

Appendix B of the full annual review (attached) sets out the equality impact of work to safeguard adults who are vulnerable in Islington.

4.4 Environmental Implications

There are no major environmental impacts associated with the Safeguarding Adults Partnership Board. Minor impacts such as transport-related emissions and office-based resource usage (energy, paper etc) are managed by staff. 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.

5 Conclusion and reasons for recommendations

- 5.1 The annual safeguarding 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.

Background papers:

Appendix 1: Islington Safeguarding Adults Partnership: Review 2013/14

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486

Attachments:

Final Report Clearance

Signed by



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Corporate Director of Housing and Adult Social
Services

Date: 30th
September 2014

Received by

.....
Head of Democratic Services

.....
Date

Report author: Elaine Oxley

Tel: 0207 527 8180

Fax:

E-mail: elaine.oxley@islington.gov.uk

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Report of: Corporate Director of Housing and Adult Social Services

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	October 15 th 2014	Item	All

Delete as appropriate	Exempt	Non-exempt

SUBJECT: Better Care Fund submission – sign off

1. Synopsis

The Better Care Fund was announced in the June 2013 spending review and is aimed at supporting integrated working across health and social care. Islington Council and Islington CCG have worked jointly to develop our bid with an emphasis on three key areas:

- To support the work of the integrated care programme
- To support the continued investment in social care services that benefit health (for example reablement)
- To support the changes in social care as a result of the Care Bill, for example, a new statutory duty to assess the needs of carers.

The Better Care Fund plan spans two years, 2014/15 and 2015/16. 2014/15 is a preparatory year in which an additional £200m should be invested jointly and in 2015/16 the national figure is £3.8bn. Locally this equates to £5,894,000 in 2014/15 and £18,390,000 in 2015/16.

It is a requirement of the fund that the submission is signed off by the local Health and Wellbeing Board. The first submission of plans took place in April 2014. Subsequently, national changes were made to the policy framework underpinning the BCF. Renewed guidance was issued in July 2014 and submissions in line with the renewed guidance were required by 19th September 2014. Essentially the renewed guidance sought to address three issues:

- Concerns around the pay for performance element and implications for risk sharing

- Greater detail and assurance around plans for reducing hospital admission
- Lack of engagement of acute providers in developing plans

The Health and Wellbeing Board signed off the April and through Chair's action signed off the 19th September submission. This report provides some detail of the plan.

2. Recommendations

The Health and Wellbeing Board is asked to endorse the Better Care Fund Plan submitted to NHS England in September 2014.

3. Background

On 19th September 2014 Islington Council and Islington CCG submitted the BCF Plan to NHS England. The Plan sets out how we will use the Better Care Fund to support on-going integration of services.

This Section provides a summary of the schemes, both existing and new, to be funded through the BCF. The schemes are set out in further detail in the final BCF submission to NHS England.

14.01: Social Care investment to benefit health

This existing funding (announced before the BCF) partially supports the core adult social care offer of assessment and care management. It provides services commissioned by the London Borough of Islington, including domiciliary and residential care.

14.02: Locality Development – Primary Care Discharge

This new investment will support discharge arrangements across the system, ensuring a smooth transition between hospital and community care for high risk patients.

14.03: Locality Development – Rapid Response

This new investment will support the pilot of the new integrated Rapid Response function from 2014/15 by providing timely clinical assessment and treatment to prevent admission or A&E attendance.

14.04: Locality Development – Integrated Health and Care Teams

This new investment, spent across primary care, community health and social care teams, will develop new integrated health and care teams, wrapped around primary care, providing an integrated response to those patients most at risk of admission and other people who would benefit from a more joined up response.

14.05: IT Interoperability

Better quality information and sharing information is critical to modernising the NHS and care services. This new investment supports a variety of IT developments across health and social care, with an approach of working towards increasingly interoperable systems. This funding would support the local contribution to the business case for a person-held record and integration engine.

15.01: Social Care investment to benefit health

This existing funding (announced before the BCF) partially supports the core adult social care offer of assessment and care management. It provides services commissioned by the London Borough of Islington, including domiciliary and residential care.

15.02: Locality Development – Primary Care Discharge

This new investment will support discharge arrangements across the system, ensuring a smooth transition between hospital and community care for high risk patients. Full-year effect of investment will be received in 2015/16.

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15.05: Reablement

Reablement is funded from an existing Section 256 agreement and is commissioned via a joint Section 75 pooled budget between Islington CCG and London Borough of Islington. Reablement is provided by the Council and supports timely discharge from hospital and prevents admission by supporting people to become more independent in their own homes.

15.06: Disabled Facilities Grant

This is an existing national scheme providing home adaptations to support independent living.

15.07: Community Capacity Capital Grant

This is an existing national Department of Health grant to local authorities to support developments in personalisation, reform and efficiency.

15.08: Carers Funding

Including some legacy funding for Carers, this investment recognises the key role carers play across health and social care in Islington. This investment will support carers through providing additional interventions such as breaks and information services.

15.09: Support Implementation of Care Act

The Care Act 2014 brings together adult social care legislation in one place. Key developments from the Care Act include a duty to promote wellbeing, a 'cap' on charges for social care provision, a minimum national threshold for care and additional responsibilities for London Borough of Islington. This investment will support implementation of these responsibilities, and is a nationally mandated sum.

15.10: Develop Preventative Services

Plans drawn up with Public Health, the Local Authority and the CCG will focus on the wider preventative strategies across the core partners to focus on existing and innovative preventative services which delay and reduce demand on more intensive health and social care interventions.

15.11: Protection of Adult Social Services – moderate needs

Islington Council will maintain its current provision of services to people with Moderate FACS needs, reducing and delaying more intensive interventions. This investment ensures social care and support is available to more people across the borough.

15.12: Protection of Adult Social Services – demographic pressure

This investment mitigates increased demographic pressures on Adult social care budgets, above and beyond the demands of the Care Act.

15.13: Support mitigating pressures in health care for people with Learning disabilities and older people

This investment will support demographic pressures and substantial growth in NHS funded Continuing Healthcare for people with Learning Disabilities and, to a lesser extent, Older People.

15.14: Developing the Locality Offer

This investment will increase capacity in primary care, social care and community health to support the shift in activity from hospitals to community through 2015/16. This is a key part of achieving the targets within the BCF of reducing hospital usage.

15.15: Improving Access

This investment will support increased access and opening times in Primary Care from 2015/16. A separate paper detailing the proposals is being presented to Strategy and Finance committee and Governing Body alongside this proposal.

15.16: Incentivising Acute Hospitals to deliver change

This funding will be used to incentivise and pump-prime service changes in acute settings including ambulatory care, enhanced recovery and pathway redesign in support of value based commissioning.

15.17: Develop primary care capacity to support locality

This investment will support primary care capacity to develop more networked models of operation, increasing ability to provide more federated models of operation. In particular this will support primary and community services to transform care for older people and reduce avoidable admission.

4. Implications

4.1 Financial implications

The Spending Review 2013 announced a pooled budget of £3.8 billion for local health and care systems in 2015/16.

This pool is referred to as the Better Care Fund (BCF). The purpose of the fund is to create:

“a single pooled budget for health care and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities”

The makeup of the national fund is:

- £1.9 billion existing funding continued from 2014/15 - this money will already have been allocated across the NHS and social care to support integration.
- £130 million Carers' Breaks Funding.
- £300 million CCG Reablement Funding.
- £350 million capital grant funding (including £220m of Disabled Facilities Grant).
- £1.1 billion existing transfer from health to social care.

It also includes funding to cover demographic pressures in adult social care and some of the costs associated with the Care Act.

The BCF guidance that has been released by the Department of Health is not explicit as to the expected practical legal mechanisms underpinning the BCF. The inter relationship between the BCF and the Children and Families Bill and the Care Act is not clear and it is hoped that this will be made more explicit during 2014/15.

The national figures included in the proposed pool are primarily existing NHS resources, some of which are already transferred to local authorities and a significant sum which is expected to be transferred from the acute sector into community based services. The Local Government Settlement (released on 18 December 2013) identified the 2015/16 Islington BCF as £18.388m. An estimated breakdown of the Islington allocation is shown below.

	National Total	Islington Total	Organisation
	£m	£m	
NHS transfer from SR010 and 2012 White Paper	900	4.822	Held by NHS England, accessed by LBI via s.256 with CCG, and agreed by HWB
Additional NHS Transfer	200	1.072	Further Transfer to Social Care in 2014/15 (held by NHS England) to prepare for BCF.
Reablement Funding	300	1.20	LBI s.75 – Intermediate care pool
Disabled Facilities Grant	220	0.693	LBI capital funding
Social Care Capital Grant	134	0.716	New LBI capital in 2013/14
Carers	130	0.415	LBI/CCG
NHS Funding Transfer (Care Act)	135	0.663	LBI – Support Implementation of Care Act.
NHS Funding transfer	795	3.899	LBI/CCG - Development of preventative services, the protection of social care services and support mitigating pressures in health care for people with learning disabilities and older people.
NHS Funding transfer	1,000	4.908	CCG - Performance related payment
	3,814	18.388	

These changes will need to be planned in the context of significant reductions in Council funding together with increased responsibilities arising from the Care Act.

4.2 Legal Implications

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

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

the Better Care Fund, the Board must have regard to the need for provision of health services, health-related and social care services.

The BCF provides for £3.8 billion worth of funding to be spent locally on health and care to facilitate closer integration and improve outcomes for patients, service users and carers. A condition of accessing the money in the BCF is that CCGs and local authorities must jointly agree plans setting out how the money will be spent and these plans must meet certain requirements.

On 25 July 2014 revised BCF planning guidance was issued to Health and Wellbeing Boards (“HWBs”). This guidance was issued following a letter from the Department of Health to Chairs of HWBs dated 11 July 2014 requiring all areas to submit revised and strengthened plans together with additional information so as to ensure that they are in the best position to deliver more integrated health and social care. The July 2014 revised guidance sets out a number of key policy changes to the BCF, additional requirements for the revised plans and the timetable for plan development, assurance and sign off by the HWB. The revised planning templates issued with the guidance require further detail on the protection of social care services, including the new duties resulting from the Care Act 2014. Local plans are required to consider how the BCF may be used to support common areas of focus which will deliver the requirements of the Care Act 2014 but also underpin shared local priorities.

The timetable specified that revised BCF plans were to be submitted by 19 September 2014. The revised guidance states that the Government will use the NHS Mandate for 2015/16 to instruct NHS England to ring fence its contribution to the Fund and to ensure that this is deployed in specified amounts at local level for use in pooled budgets by CCGs and local authorities.

4.3 Equalities Impact Assessment

No equalities impact assessment has been undertaken with the draft plan.

4.4 Environmental Implications

No environmental impact assessment has been undertaken with the draft plan.

5 Conclusion and reasons for recommendations

The Better Care Fund has been introduced in order to drive better integration between health and social care at a national level. Islington has a legacy of excellent joint working through Section 75 and Section 256 arrangements and is also a Pioneer site for Integrated Care where we hope to deliver a step change to health and care outcomes in Islington, as well as improving the patient/user experience of care.

Our plans for the Better Care Fund are therefore closely aligned to the Integrated Care programme with investments across health and social care that will support more personalised and co-ordinated approaches to care that are delivered locally. These plans also support the strategic aims of the Council in terms of delivering more personalised supports; of the CCG in terms of delivering care closer to home and of course with the four priorities of the Health and Wellbeing Board.

Background papers: Annex to the NHS England Planning Guidance - Developing Plans for the Better Care Fund (see link below)

<http://www.local.gov.uk/documents/10180/12193/Developing+plans+for+better+care+fund+guidance.pdf/734c155e-7820-4761-976a-6c56053c0e78>

Attachments: Appendix 1 – Better Care Fund narrative
Appendix 2 – Better Care Fund finance and performance schedule

Final Report Clearance

Signed by



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Corporate Director of Housing and Adult Social Services

Date: 3rd October 2014

Received by

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Head of Democratic Services

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Date

Report author: Clare Henderson, Programme Director Integrated Care
Tel: 020 3688 2945
Fax:
E-mail: clare.henderson@islingtonccg.nhs.uk

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Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

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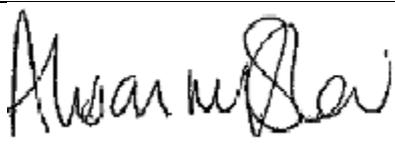
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1) PLAN DETAILS

a) Summary of Plan

Local Authority	Islington
Clinical Commissioning Groups	Islington CCG
Boundary Differences	Co-terminus
Date agreed at Health and Well-Being Board:	19 September 2014
Date submitted:	19 September 2014
Minimum required value of BCF pooled budget: 2014/15	£5,894,000.00
2015/16	£18,390,000.00
Total agreed value of pooled budget: 2014/15	£5,894,000.00
2015/16	£18,390,000.00

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Alison Blair
Position	Chief Officer
Date	19 September 2014

Signed on behalf of the Council	Islington
By	Sean McLaughlin
Position	Corporate Director Housing and Adult Social Services
Date	19 September 2014

Signed on behalf of the Health and Wellbeing Board	Islington
By Chair of Health and Wellbeing Board	Richard Watts
Date	19 September 2014

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Islington Joint Strategic Needs Assessment	Sets out the needs of the local population. http://www.islingtonccg.nhs.uk/about-us/jsna
Islington Joint Health and Wellbeing Strategy	Islington's joint strategy to improve health and wellbeing outcomes for our local population. http://www.islington.gov.uk/publicrecords/library/Public-health/Business-planning/Strategies/2012-2013/(2013-03-01)-Joint-Health-and-Wellbeing-Strategy-2013-2016.pdf
Adult Joint Commissioning Strategy	Islington's Joint Commissioning Strategy setting out the strategic direction from 2012-2017 http://www.islington.gov.uk/services/social-care-health/contacts-news-feedback/Pages/Joint-Commissioning-Strategy-Consultation.aspx
Islington Primary Care Strategy	Islington's Primary Care Strategy focuses on driving up the quality of primary care to meet the health needs of the population. It looks at making real improvements in: <ul style="list-style-type: none"> • GP services – working with the primary care teams • Dental services – general dental practitioners and community dentistry • Community Pharmacy Services – local pharmacists • Optometry Services – local opticians. http://www.islingtonccg.nhs.uk/about-us/strategies/primary-care-strategy.htm
Islington Urgent Care Strategy	This refreshed Urgent Care Strategy again aims to continue to improve urgent care provision from hospital emergency and ambulance services, but also strengthen patient access to urgent care from primary

	<p>and community services.</p> <p>http://www.islingtonccg.nhs.uk/about-us/strategies/urgent-care-strategy.htm</p>
Islington Care Closer to Home Strategy	<p>The Care Closer to Home Strategy demonstrates the group's holistic approach to achieving this vision through integrated care commissioning. The strategy will support areas where care closer to home initiatives have already been implemented and areas identified for further opportunities.</p> <p>http://www.islingtonccg.nhs.uk/about-us/strategies/care-closer-to-home.htm</p>
National Collaboration for Integrated Care and Support (May 2013) "Integrated Care and Support: Our Shared Commitment"	<p>Presents a shared vision for integrated care and support to become the norm over the next five years.</p> <p>https://www.gov.uk/government/publications/integrated-care</p>
"The NHS belongs to the People: A Call to Action" NHS E (July 2013)	<p>Sets out the challenges facing the NHS and sets out that the NHS needs to change to meet that challenge.</p> <p>http://www.england.nhs.uk/2013/07/11/call-to-action/</p>

2) VISION FOR HEALTH AND CARE SERVICES

- a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our vision for the Integrated Care Pioneer has underpinned our submission for the Better Care Fund. That is:

“To deliver a step change improvement in health and social care outcomes for our population, by taking a whole system approach to service planning and delivery and supporting the population to better manage their health through mobilising their own abilities and the assets of the community.”

Over the next five years we expect to have a health and social care offer that provides access to care at the right time, in the right place, in a co-ordinated and personalised way. Systems will be stream-lined, with pathways that reduce duplication, avoid unnecessary hospital admission and act swiftly to get people home and re-abled after illness. We also expect people to have a better experience of care and to feel like they have been given the information and advice they need to be informed of their condition and better able to manage by themselves or for those for whom they care

We have identified the key ingredients of our transformed service offer as:

- An offer of **early intervention and prevention** for the whole population
- Health and care systems and pathways that are **co-produced** with patients and users
- Strong **clinical leadership** shaping and supporting change
- Hospitals that **plan and support discharge** from the first day of admission
- Better access to voluntary and community based services through **better information and advice**
- **Joined up care** delivered through **four localities** based around GP practices
- Better **identification and co-ordination** of patients/users at **high risk** of hospital admission
- A programme of **supported self-management** for children and adults with long term conditions
- More personalised service offers through the roll out of **personal health budgets** and increasing numbers of those who opt for a **personal budget**
- Services that are more easily understood and accessed through **single point of access, single assessment processes** and **7 day services**
- Better alignment of physical and mental health services
- A **skilled workforce** that delivers care with dignity and compassion, is motivated to make a difference and is rewarded for its efforts
- **IT systems** that support joined up care by becoming interoperable
- **Patient held** records

The experience of Mr Angel of Islington set out below demonstrates how we wish to

transform and improve care for our residents.



We have developed this vision for health and social care through listening to what patients and users have told us. They have said they want to be listened to and heard, to be treated as a whole person and for professionals to understand how disempowering being ill is. They want their care to be co-ordinated with better access to healthcare through social services and vice versa and they want to be supported to help them-selves. We have also heard how people don't always have positive experiences of our care services; that they can be confused by who is doing what and that care isn't always delivered in a way that shows compassion and maintains dignity. In addition to this we have worked with over 250 patients to develop our own set of "I statements" and have used these as a basis of our Pioneer programme.

We have also taken note of wider partnership strategies, in particular the Joint Health and Wellbeing Strategy which has four priorities:

- Ensuring every child has the best start in life,
- Preventing and managing long term conditions to extend both length and quality of life and reduce health inequalities,
- Improving mental health and wellbeing, and
- Delivering high quality, efficient services within the resources available

These were developed in response to the needs identified within the JSNA.

Our JSNA is now an online, public-facing interactive web-based resource called the

Evidence Hub, allowing us to share more timely and accessible information about Islington's needs¹. We have looked at our population to understand the health and care needs so that we can prioritise resource to make greatest impact.

Islington is the 5th most deprived borough in London and the most densely populated borough in England. There is an unusual spatial distribution of affluence and poverty with rich and poor living cheek-by-jowl. The high level of deprivation is reflected in substantial inequalities in health and outcomes. In addition Islington also has high rates of social housing (nearly 50% of housing stock) and large numbers of single households.

Life expectancy has increased over time in Islington, but it remains low compared to other London boroughs and the country as a whole. Men in Islington have the lowest life expectancy in London, and women one of the lowest. Many other London boroughs with similar levels of deprivation have managed to successfully reduce the gap in life expectancy between their local area and the national average, but in Islington the gap has not closed. The key cause of the inequalities gap in life expectancy between Islington and England is premature or early death, particularly amongst men living with long-term conditions such as cardiovascular disease, cancer and chronic obstructive pulmonary disease. Nearly half of all deaths in the borough are in people under the age of 75.

Our programme of work is focusing on integrating long term condition pathways as well as improving physical health outcomes for vulnerable residents and those with mental health conditions and providing a more co-ordinated approach to those with complex needs. The programme of work looks beyond health, and focuses on promoting health, wellbeing and independence through the delivery of programmes that address the wider determinants of health (such as safe housing, sufficient income and social contact) and contributes towards preventing emergency admissions. A focus on supported self-management and personalising services will further strengthen the community response to long term condition management.

Islington has a long history of joint working and already has over £60m invested in pooled budgets across adult and children's services. We welcome the Better Care Fund as an enabler to our work and to quicken the pace of change.

We want to see an improvement, not only in the outcomes of care but crucially in the experience of care that is received and perceived by our residents.

Our plan mirrors the intention of the Integrated Care Programme in that it will support health and care integration across children's and adults.

b) What difference will this make to patient and service user outcomes?

Through our joint efforts we want to see a population that has a better experience of health and social care services, feels more involved in decision making and is

¹ <http://evidencehub.islington.gov.uk/Pages/HomePage.aspx>

supported to manage their own care better.

We want to see a continued improvement in key metrics that measure health inequalities so that we know care is reaching all those that need it.

We also want:

- Improved reported quality of life for both carers and those who use social care services
- Improved patient reported outcomes and improvement in patient experience measures
- A reduction in long term admissions to care homes
- A reduction in preventable emergency admissions
- An increase in the proportion of older people at home 91 days after discharge from hospital
- Improved physical health outcomes for adults with a mental health diagnosis
- Retention of our excellent track record in delayed transfers of care
- Fewer hospital readmissions within 30 days
- Improved mortality from preventable causes
- Improved take up of NHS health checks, particularly by those with mental illness and learning disabilities
- Increase in the uptake of personal budgets across health and social care
- Improved physical outcome measures which indicate a more “joined up” system including fewer falls, fewer pressure ulcers and improved flu, pneumococcal and shingles vaccination rates

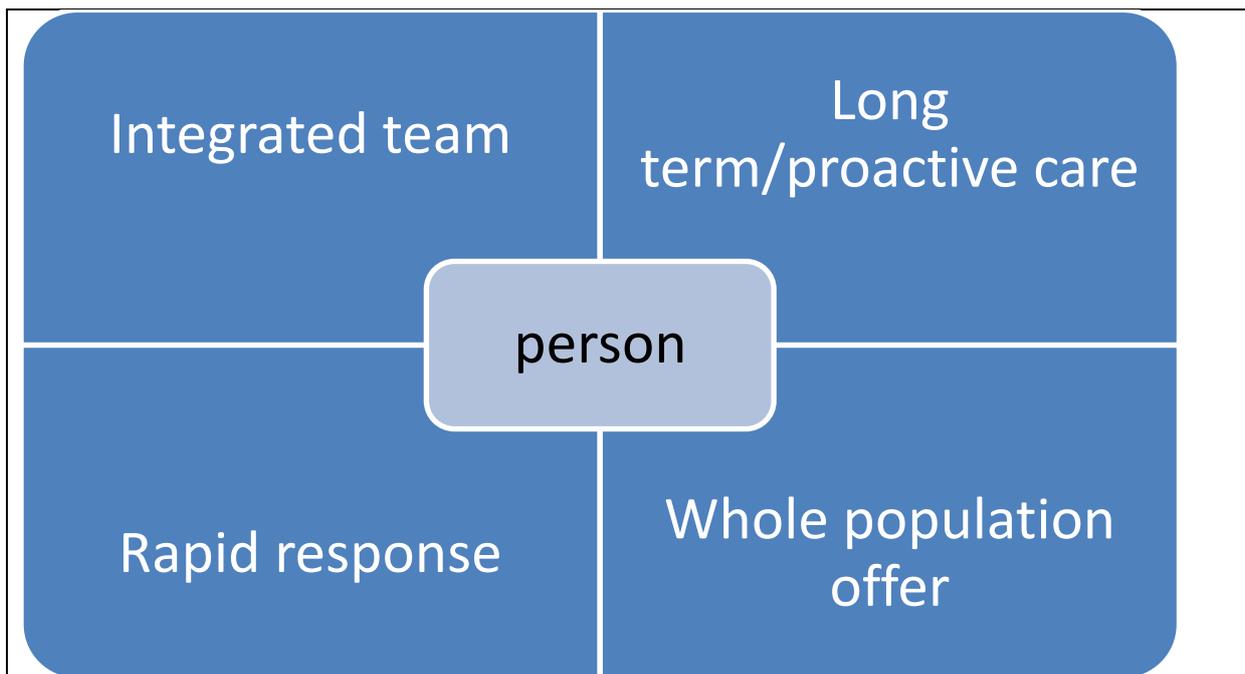
c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Although we already have integrated services in a number of areas including intermediate care, adult mental health and stroke discharge as well as a carer offer across health and care we know that residents don't always receive care that is joined up and delivers the best outcome.

Much work is already underway to make improvement and the BCF provides an opportunity to accelerate the pace through investment. To focus the BCF we have agreed a number of priorities:

1. The development of a locality offer across community, social care and mental health services to support primary care capacity

Our locality offer is the lynchpin to our integrated care programme and the BCF will mean that we can pump prime investment to support change. It describes at a high level how community based health and care services are structured within each of the four Islington localities. It has four components:



- **Integrated Teams**
Locality based, multi-disciplinary teams, structured around primary care, who provide co-ordinated care to those with the highest level of need.
- **Long term and proactive care**
Ongoing case management and care for patients not held by the MDT (“business as usual”) This will include social care clients who are stable but have long term care needs, patients who are stable yet have regular community nursing visits as well as patients who are supported by primary care but are stable.
- **Rapid response**
A borough wide rapid response service to the whole population, with close links to the two approaches above
- **Whole population offer**
Supporting population wide health improvement by mobilising local assets focussing on early support and prevention

By redesigning community services to deliver **joined up care** around **four localities**, aligned to GP practices our aim is to be able to **identify and coordinate care** for users at risk of hospital admission.

We want to streamline access and develop **seven day services** that are more efficient and free up capacity. We also see that by working differently we can transform communication and relationships between GPs and specialists. This would support provision of comprehensive disease management and preventive services to our population. We are likely to see some co-location of health and social care professionals to support more co-ordinated ways of working and opportunities for other partners such as housing and the voluntary sector to have space in which

to operate.

Staff within the integrated health and care teams will also be trusted to undertake a broader range of **assessments** on behalf of others and will be able to mobilise care packages when people need support to remain at home. Intrinsic to all care will be the ethos of **supported self-care** and **personalisation** so that users and patients can participate in planning their own care.

2. Enhancing primary care capacity

Primary care will have developed new ways of working that is able to meet demand in a planned way, with opportunities for proactively planning and managing of care particularly for those with higher needs and long term conditions. Working within MDT's they will be able to support healthier communities through signposting to non-traditional services in the voluntary sector. This will support the **prevention** function where we want to see better integration of our preventative offer and more proactive care, ensuring multiple risk factors can be addressed following a single interaction with a resident.

Our new offer is likely to mean that acute hospital provision reduces over time as care is provided in different settings and seven day access to primary and social care becomes available

3. IT and inter-operability to ensure patient information can be shared across integrated services and along care pathways

A fundamental enabler for improved joint working is the development of IT systems that are **inter-operable** so that clinicians and others can view and input information in "real time". Specialist services will remain borough wide but all health and social care professionals will be able to access information about patients and users more easily within an ethos of holistic, compassionate care co-ordinated around the individual rather than reliant on current structures and professional boundaries. We are working at a national and local level to develop IT systems that are inter-operable, this will be supported explicitly by the BCF. Similarly we are working to develop a **patient held integrated digital care record** so that patients and users can have better access to information. Service developments already in place include DOCMAN for electronic transfer of referrals and discharge letters, GP portals at UCLH and Whittington Health to allow GP's to view test results, Adaptor pilot at Islington Council to allow referrals to be sent between social care and health (Whittington and UCLH) and Medically Interoperable Gateways to allow UCLH and Whittington Health to view primary care records.

4. To meet demographic pressures in social care, and across health and care services for older people and people with learning disabilities

Islington has a high and increasing number of people living with learning disabilities. The needs of this group are planned for and funded via a S75 pooled budget between Islington CCG and the Council. There has been an increase in the numbers of people with a learning disability who meet NHS continuing healthcare criteria with a £1m pressure on the pooled budget. The BCF is being used to

support this demand.

There is also a lesser, but still substantial demographic demand for the care and support of older people. Again, this has also led to an increased pressure on continuing healthcare budgets which are there being supported by the BCF.

5. To maintain social care eligibility

Islington is proud of its history in protecting social care for those who need it and maintaining eligibility levels to ensure those with moderate needs and above are supported to live independently at home.

Demand is rising at a time of unprecedented budget pressure and work is being undertaken in partnership with the CCG, local NHS Trusts and the voluntary sector to ensure that adult social care services can be successfully sustained in Islington. This builds on existing initiatives to support pooled budgets that bring greater flexibility across health and care for new ways of working.

6. To incentivise providers to support integrated care

The Whittington, as the main provider of community services in the borough will have transferred staff and resource from the hospital into a broader offer of community provision with higher numbers of community and specialist nurses and therapists able to care for people at home. Consultants will be accessible to patients in new ways through an increased use of technology and will be outward facing providing support to primary and community colleagues. This has already started in the frail older people's pathway with a newly commissioned community geriatrician service that is providing clinical support, advice and assessment to patients and professionals in the community.

Services will be designed to work proactively with patients and users able to mobilise quickly to avoid unnecessary emergency attendance at hospital and to reduce hospital admission. That means joint teams will work at the front line and in services like A&E to be able to put packages of care in place for people to avoid deterioration in condition or hospital admission. We will also have a renewed focus on **planning and supporting discharge from the first day of admission** through the primary care discharge arrangements. The rapid response function is being built up with the use of the BCF and additional nurse capacity to support discharge to primary care is also being funded explicitly through BCF.

Mental health professionals too will work more actively to support primary care in managing people's physical health needs and we want to see a reduction in health inequalities across the population as those that find it harder to access the right care are supported to do so. We have already made an investment in 2014/15 contracts with Camden and Islington Foundation Trust to deliver a new offer from mental health professionals into primary care. The intention is that these will form part of the integrated health and care teams that are due to be piloted from September 2014.

We also want to see a higher uptake of NHS Health Checks by people with learning

disabilities so have commissioned a liaison nurse to support primary care – this work will be complemented through the development of individual health action plans.

Finally, access to information will be more streamlined with fewer telephone numbers and skilled staff able to triage and sign post effectively.

We believe our track record in delivery puts us in a strong position to succeed with this scale of change. We are London leaders in delayed transfers of care, national leaders in dementia diagnosis and our projects have already led to a reduction in COPD admissions and a decrease in the life expectancy gap for CHD.

We worked with the Whittington to develop an ambulatory care pathway as part of their 30 day readmissions programme and the pathway is now being designed to come out into the community to link with the hospital at home initiatives.

Similarly, we have commissioned CIFT to provide the “RAID” model in the Whittington as part of our investment programme and this is already improving the quality of response to adults with mental health problems, having around 200 referrals per month. RAID are co-located in the emergency department and are seeing patients within 60 minutes of referral. In addition they are supporting early discharge through identifying patients at ward rounds.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Although Islington has a reputation as a wealthy borough with some of the highest house prices in the country it is a borough of contrasts, with rich and poor living side by side.

It is in fact the 5th most deprived borough in London and 14th most deprived in England, leading to some poor health outcomes for our population, for example,

- 28,000 people in Islington (13% of the population) are living with 1 or more long-term conditions
- More than 30,000 adults experiencing some form of mental health problem
- 7-year gap in life expectancy between men in the highest income group and those in the lowest income group
- 10% gap in attainment between the most affluent and least affluent children by the time they leave primary school
- 22% of people living in areas with high levels of social housing have a long-term condition compared to 9% of people living in areas with low levels of social housing
- The highest incidence of people with psychotic disorders in England
- Highest rates of male suicide and alcoholic mortality in London
- One of the highest levels of child poverty in the country

What we know from our analysis from the Evidence Hub that has driven our case for change is:

1. Our population of older people is growing and becoming more diverse.

Greater London Authority population projections show that in the next 10 years there will be a 10% increase in those aged 65 and a 23% increase in those aged 85 years and older. The aging of the population in Islington over the next 10 years will lead to a growing number of people living with long-term conditions including dementia and mental health, **indicating an increasing need for health and care services to identify and manage these conditions earlier and more effectively.**

Age group	2014	2024	Change (2014 to 2024)	% Change (2014 to 2024)
65 - 74	10400	11100	700	6%
75 - 84	6100	6800	700	10%
85+	2300	3000	700	23%
65+	18800	20900	2100	10%

We think that by providing a **locality offer (BCF1 and BCF2)** we will be able to identify and manage conditions earlier, co-ordinate care to deliver better outcomes and that through supporting self-management programmes we can give our residents the tools to manage their conditions more successfully.

2. We have high rates of A&E attendances

Although Islington has a relatively young population, the demand for and use of health services by the 85+ population is significant. Islington has the fifth highest rate of A&E attendances and the seventh highest rate of emergency admissions in London. The rate of emergency admissions is greater than the London and England averages and has increased over time (a 14% increase between 2009/10 and 2010/11). Overall, 17% of A&E attendances lead to a hospital admission, but this rate increases to over 60% for people aged 85+. In addition, people aged 85+ are more likely to present at A&E multiple times, thus highlighting the high usage of A&E services and acute hospital beds amongst this population group.

In the 85+ population, the main reasons for emergency admissions were external causes (including accidents), circulatory diseases, respiratory diseases and genitourinary diseases (such as urinary tract infections). In the 85+ group, admissions for “flu and pneumonia” ended in significantly more “in hospital” deaths than other diagnosis groups (24%).

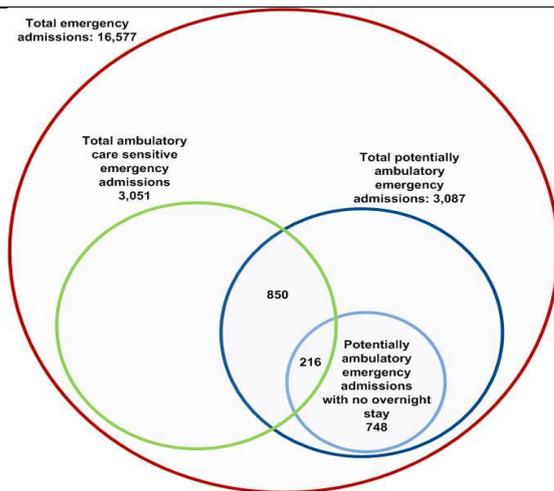
The percentage of people attending A&E three or more times in a year varies, ranging from 1% in people aged 30-39 to 9% in people aged 85 years and over. People aged 80 years and over have the highest percentage of people attending more than once (46%), while children aged 5-9 have the lowest (26%).

We have some schemes in place already that are aimed at reducing A&E attendances for older people, for example, our community geriatrician service and CareLink that provides rapid response reablement services to support discharge. In addition though the new **Integrated Rapid Response function (BCF2)** should provide timely clinical assessment and treatment, including rapid access to domiciliary care to prevent A&E attendance.

3. The percentage of attendances leading to hospital admissions increases with age with almost 70% of attendances in people aged 85 years and over leading to admission

Young and middle aged adults (aged 15-59) have the highest percentages of A&E attendances where the patient left without treatment whereas older people are more likely to be admitted. The top 3 primary reasons for emergency admissions are external causes, respiratory disease and diseases of the digestive system

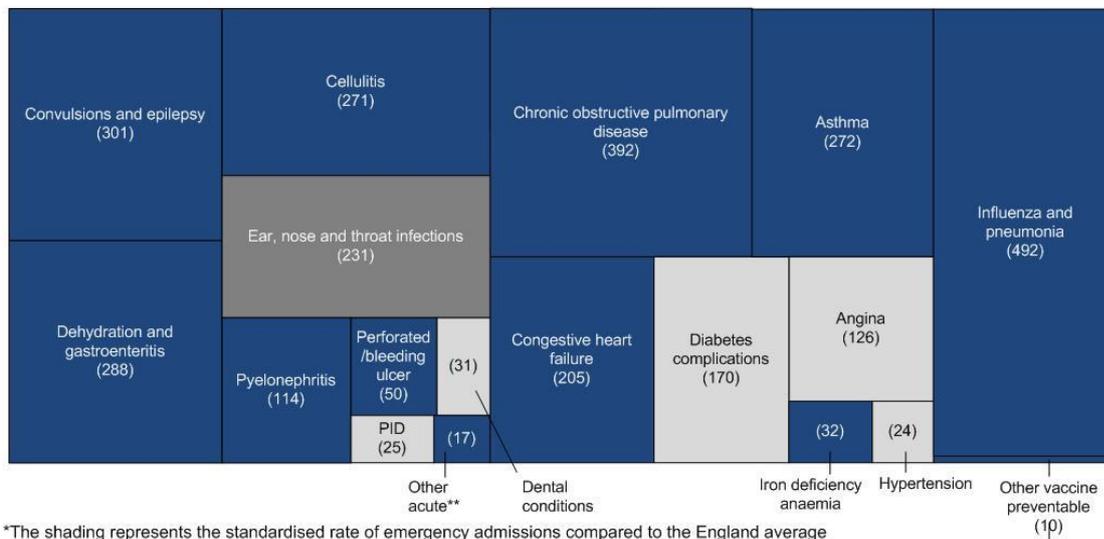
Of the total emergency admissions in 2011/12 approximately 36% were for ambulatory care sensitive conditions or potentially ambulatory admissions.



Ambulatory conditions are those conditions for which emergency hospital admissions in adults may be avoidable by effective management in primary care. In Islington respiratory diseases account for the largest proportion of ACS conditions.

The following chart shows the relative amounts of ACS admissions. The larger the box, the more admissions. Dark blue boxes indicate a higher rate of admissions against the England average.

ACS emergency admissions by primary diagnosis, Islington responsible population*



*The shading represents the standardised rate of emergency admissions compared to the England average (NHS Comparators, 2009/10 rolling year)***. Numbers of admissions are from SUS 2011/12

■ Lower ■ No different ■ Higher

**Gangrene and nutritional deficiencies

***National ACS admission rates currently unavailable from NHS Comparators

Source: Islington Emergency Admissions profiles

Source:

<http://evidencehub.islington.gov.uk/wellbeing/Healthsettings/HO/EA/Pages/default.aspx>

Developments already underway to reduce hospital admission include the Ambulatory Care Service at the Whittington and RAID. However, an integrated approach developed within the locality (BCF01 and BCF02) as well as work with

primary care and others to improve access (**BCF5**) and delivering more specialist services in the community eg IV at home (**BCF4**) will support our approach.

4. People are living with multiple long term conditions

Around one in six adults in Islington has at least one diagnosed **long-term condition**.

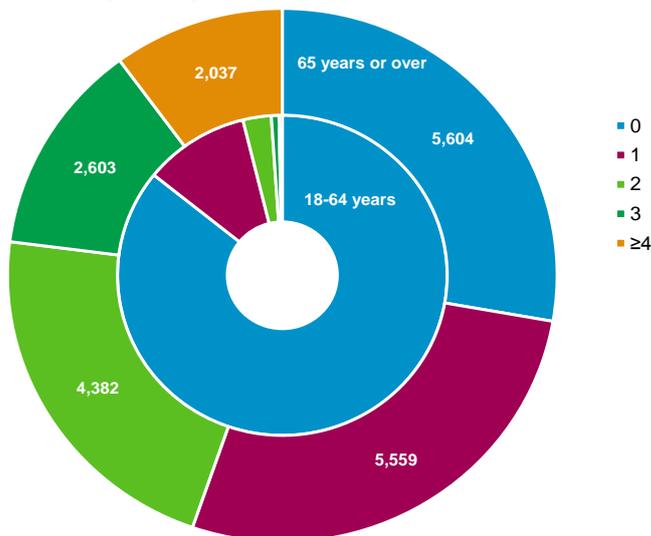
Overall, a third of adults with long-term conditions in Islington are living with multiple conditions and at relatively young ages. This highlights the need for planned and integrated care for people with multiple conditions to achieve optimal health outcomes.

However, it should also be noted that a large proportion of the illness associated with long-term conditions occurs in older people (those aged 75 and over). The most prevalent condition is high blood pressure followed by type 2 diabetes, chronic depression, psychotic disorders, cancer, coronary heart disease and chronic obstructive pulmonary disease.

People with mental health problems or learning disabilities have a higher prevalence of long-term conditions which highlights the need to ensure equitable access to services according to need, right across the patient pathway, from prevention through to end of life care.

It can also be expected that there will be an increase in the number of people living with multiple long term conditions including dementia and mental health. The number of conditions a patient has can be a greater determinant of a patient's use of health services than the actual condition.

Number of diagnosed long term conditions in people aged 65 and over, Islington's registered population, September 2012



Source: Islington's GP PH dataset, 2012

Pathway review for long term conditions has already reaped benefits in areas such as COPD where Islington has seen a reduction in acute admissions. The intention to commission the diabetes pathway differently and based on outcomes is designed to support care delivery that is bespoke to the individual rather than "one size fits all".

As it is an innovative solution to pathway redesign we are keen to support acute hospitals to work differently on this **(BCF10)**.

5. Mental health and dementia are prevalent amongst the local population

In 2011 there were over 3,000 people diagnosed with serious mental illness in Islington. People diagnosed with a serious mental illness have a significantly higher prevalence of all long term conditions.

There are more than 28,000 people living in Islington with depression, anxiety or both and 1 in 3 people with depression have another long term (physical) condition, compared to 1 in 10 of the general population.

There are significant variations in diagnosed prevalence between practices in Islington as well as in referrals to IAPT services and recording of key risk factors. This is a focus for primary care development and improvement in the borough.

Depression-related admissions

- There were 81 admissions for depression in 2011/12 among Islington's responsible population. In addition, there were another 1,186 admissions where depression was one of the secondary reasons for admission
- Hospital admissions for depression-related reasons include over 40 patients with multiple (3 or more) admissions in a year. The largest reason for admission is due to poisoning and other external causes: these patients are likely to be at significantly increased risk of suicide, which remains an important cause of premature deaths in the borough, and require close and timely follow-up and support to help reduce risk

Source: [Islington Depression and anxiety profile, 2012](#)

Dementia diagnosis rates are high compared to London averages but the impact of dementia is high

- In 2011, there were approximately 750 people recorded with a diagnosis of dementia amongst Islington practices
- Islington's crude diagnosed prevalence (0.37%) is significantly lower than the London average (0.32%)
- Statistical modelling of the expected number of dementia cases indicates that over 70% of the expected numbers of cases of dementia have been diagnosed in Islington; above the London and England averages (44%).
- People with dementia have a higher proportion of comorbidities compared to Islington's general population over the age of 65. Of those with dementia, 84% have more than one long term condition compared to 60% of the total population aged 65 and over, while 14% have five or more long term conditions compared to 4% in the older population.

Source: [Islington Dementia Profile, June 2012](#)

The mental health offer within the Locality model **(BCF1)** is designed to provide much more support to primary care to build capacity, provide swift access to

specialist advice and to case management at a local level with MDT input.

Finally, because of our poor health outcomes and high health inequalities preventing problems from occurring in the first place and then ensuring early intervention when they do, is important in not only managing and reducing the rates of A&E attendances and emergency admissions, but for promoting and maintaining good health and wellbeing and a sense of self-empowerment and independence. Ensuring prevention occurs, according to need and throughout a person's life course, will also help reduce health inequalities in Islington. **(BCF9)**

4) PLAN OF ACTION

- a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

As an Integrated Care Pioneer, much of the work set out within the Better Care Fund is under way, and builds on a well-established history of integration in Islington. Integration efforts in Islington are spread throughout providers and commissioners.

Detail around milestones are set out in the individual scheme descriptors, but April 2015 sees delivery of several key parts of the plan;

- Implementation of Integrated Health and Care Teams
- Implementation of Integrated Rapid Response Teams
- Transformation of Adult Social Care
- Improving Access to Primary Care

Projects are developed using a local project management structure with clinical leadership. Key milestones include:

2014/15

- Cohort for co-ordinated care agreed
- Test and learn integrated health and care teams
- Evaluation of MDT teleconferences
- Project teams developing commissioning options for rapid response and supported discharge
- Sign off IT strategy by Governing Body
- Development of business case and specification for IT inter-operability
- Consultation for new social care configuration
- Launch of workforce plan and listening events to develop new ways of working
- Development of new initiatives with primary care to support access
- Roll out of Patient Activation Measures, building on House of Care model of practice

2015/16

- Stage two of locality development – roll out of integrated health and care

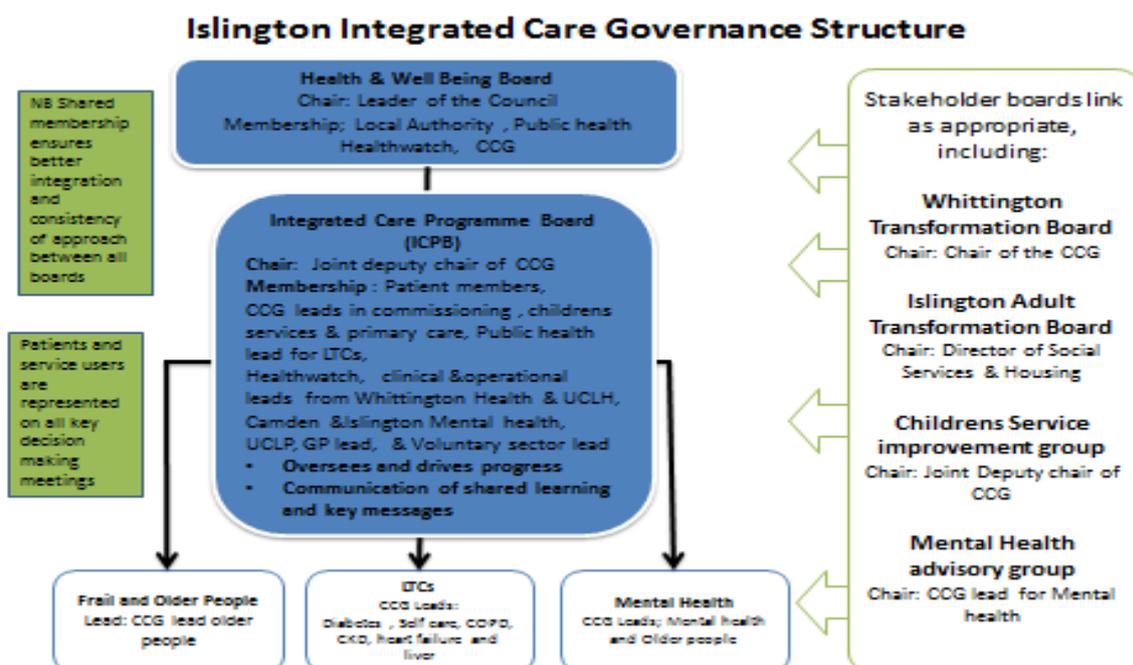
teams

- New adult social care model implemented
- New information and advice offer across care and health
- Mobilise IT
- Rapid response function streamlined
- Move towards greater collaboration in primary care
- Value based commissioning running in shadow form for diabetes and mental health pathways

b) Please articulate the overarching governance arrangements for integrated care locally

Islington's integrated care programme is supported by a Board that is made up of representatives from the Council, the CCG, provider organisations, patients/users and the voluntary sector, including Healthwatch. The Board is chaired by a GP and Vice Chair of the CCG.

The governance arrangement is set out in the picture below and builds on arrangements already in place that includes joint posts and functions across the CCG and the Council and pooled funding through Section 75 arrangements:



Governance of the BCF within the CCG will be through existing structures for S75's - quarterly S75 review meetings held jointly with the Council; regular review through the Integrated Care Board; annual reports to the Finance and Strategy Committee and annual reports to the Governing Body.

Governance of the BCF within the Council will be through existing structures for S75's - quarterly S75 review meetings (above); review through the Integrated Care Board; annual report to the Executive.

The Health and Wellbeing Board will receive annual reports as part of the existing S75 arrangements.

A Programme Director for Integrated Care, a joint appointment between the Council and the CCG leads on the programme management function across a range of local integration schemes. Operational Groups for individual Integration/BCF schemes report to the Integrated Care Board providing a level for resolving operational issues and a clear escalation route.

- c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

The CCG and Council already have joint commissioning arrangements and these will support the operational delivery of the BCF plan.

The Integrated Care Board has representation from the CCG and the Council and this will drive the projects through:

- Assessing project performance through highlight and exception reports
- managing delivery by exception
- Producing a report for Health and Wellbeing Board Programme on status, immediate challenges and accountable actions.

Each project team will report against project impact and elements that are off track via the bi-monthly Highlight Report.

A standardised bi-monthly highlight report will be developed for each project team to track delivery:

Activity: Outturns to underlying Direction of Travel and patient impact for all key metrics

Quality: Resident feedback included PROMS, user and carer QOL measures, feedback from Making it Real Board

Finance: In addition, finance is tracked through the QIPP programme with monthly reporting arrangements before bi-monthly Board

Risk: Risk review to Board

d) List of planned BCF schemes

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the Detailed Scheme Description template (Annex 1) for each of these schemes.

Ref no.	Scheme
BCF1	Locality development - Integrated Health and Care Teams
BCF2	Locality development - rapid response
BCF3	Locality development - primary care discharge
BCF4	IT interoperability
BCF5	Social care investment to benefit health
BCF6	Developing the Locality Offer
BCF6 (a)	Ambulatory Care
BCF6 (b)	RAID
BCF6 (c)	Carelink
BCF6 (d)	COPD Pathway
BCF6 (e)	Tissue Viability and Catheter Care
BCF7	Improving Access to Primary Care
BCF8	Develop primary care capacity to support localities
BCF9	Develop Preventative Services
BCF10	Incentivising Acutes to Deliver Change
BCF11	Reablement
BCF12	Carers Funding
BCF13	Support mitigating pressures in health care for people with Learning disabilities and older people
BCF14	Protection of Adult Social Services - moderate needs
BCF15	Protection of Adult Social Services - demographic pressure
BCF16	Community Capacity Capital Grant
BCF17	Disabled Facilities Grant
BCF18	Support Implementation of Care Act

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	How likely is the risk to materialise? Please rate on a scale of 1-5 with 1 being very unlikely and	Potential impact Please rate on a scale of 1-5 with 1 being a relatively	Overall risk factor (likelihood *potential impact)	Mitigating Actions

	5 being very likely	small impact and 5 being a major impact And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*		
Our plans are predicated on the understanding that increased investment in social care and community services will be matched by a reduction in use and so cost in the acute sector. The risk is that acute activity continues at a rate that makes the financial shift unlikely.	2	2	Medium	Evidence based schemes in development Financial modelling across whole system to inform schemes Regular review of performance
Acute providers are destabilised by shifts of resource to the community	1	1	Low	Whittington ICO is on our Integrated Care Board and is actively working with us to understand how the shift of care can be achieved within their current business plans Transformation Board has partners from Haringey and

				Islington, as well as Whittington Health to ensure impact is understood
Locality development is as much about culture change in the workforce as organisational structure. The risk is that our approach fails to motivate frontline staff who continue working in traditional ways	1	3	Medium	<p>We are developing a joint workforce development strategy and have identified leads in the key organisations to support culture change.</p> <p>Islington is now part of a Community Education Provider Network (CEPN) and as such has started a series of Listening events with staff to engage them with our proposals and new ways of working.</p>
IT Interoperability is a key enabler for MDT working	2	2	Medium	<p>As Pioneers we are working with other London boroughs and with national agencies to specify requirements for IT interoperability</p> <p>We are determined to develop solutions by purchasing an integration engine to support inter-operability. Our providers are partners in this work.</p>
Capacity within health and social care prevents delivery at the pace we have set	1	2	Low	As Pioneers we have set up clear governance arrangements between the CCG and Council that

				oversees the programme
Patients, service users and carers continue to experience poorly co-ordinated services that are not designed around their needs and the outcomes they want to achieve for themselves	2	2	Medium	We have set up the Making it Real Board where we hope to have input to the design of new ways of working.

*Financial impacts are detailed within financial modelling

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

In 2014/15 we have a QIPP programme of £15m and a BCF additional funding requirement of £1m above current S256 investment.

In 2015/16 we have a QIPP programme of £12m and BCF of £10m above current investment. Over the two years the BCF equates to c40% of QIPP.

We are confident in finding this additional investment and will prioritise within commissioning intentions as the CCG focuses on integrated care, urgent and primary care.

Commissioners have been working with acute trusts to reduce hospital admissions, particularly readmissions, and A&E attendances. We want to see a continuation of this work as well as a focus on acute productivity to bring efficiencies within the local health economy.

The impact of the Better Care Fund will be;

- A locality offer that supports integrated discharge and rapid response to avoid unplanned hospital admission or readmission
- Secondary care colleagues gain confidence that complex patients can be discharged into the locality
- Intermediate care services that support early discharge and therefore reduce length of stay
- Alignment of community services and social care functions, like re-ablement, to support independence in the community
- IT infrastructure that supports shared care and less duplication
- An expectation that specialists working in acute hospitals will be outward

facing and able to support community colleagues

- Acute trusts that focus on reducing unplanned admissions through ambulatory care, early supported discharge and services like RAID to support adults with mental health needs

In terms of savings:

- Acute productivity will lead to realised contract efficiency
- Development of a community offer will reduce unplanned admissions
- Ambulatory care services are being expanded at the Whittington and can already demonstrate reduced admissions and readmissions
- UCH are developing ambulatory care and we want to see this scaled up so that it provides a proactive triage
- RAID is delivering reduced admissions for adults with mental health needs at the Whittington and is within Islington's QIPP programme
- Through the skilling up of community colleagues in the management of long term conditions we expect fewer exacerbations leading to A&E attendance and fewer outpatient admissions
- Oversight of data at system wide level will enable clear oversight of spend
- New models of working will also be supported by the Urgent Care Review that seeks to streamline the urgent care offer

Failure to deliver will lead to:

- Continued pressure on CCG and Council budgets
- Continued risk to acute's ability to manage peaks in emergency attendances and admissions
- Continued pressure to meet NHS constitution targets
- Opportunities to invest in community and primary care will be compromised
- Opportunities for enhanced recovery are lost leading to more placements into long term care

Where we are now:

- We have agreed the 2014/15 and 2015/16 baseline with Camden and Islington Foundation Trust (CIFT) – 2014/15 contract signed
- Whittington – 2014/15 contract signed
- UCH baseline agreed for 2014/15, contract yet to be signed
- Whittington ICO is a net beneficiary of BCF through development of the localities and seven day working
- Urgent Care Review finalised

Contingency plan:

The CCG has made a commitment to release funds for BCF regardless of the non-elective reduction as integrated working is our direction of travel. Our contingency should the 3.5% not be reached is QIPP savings from elective and non-elective pathways.

6) ALIGNMENT

- a) Please describe how these plans align with other initiatives related to care and support underway in your area

North Central London CCG's have together agreed a vision for the BCF which is for people to live longer, healthier and happier lives by focusing on their abilities and potential with and without support. Safe and effective support will come from integrated multi-agency health and social care providers working with local people, and their carers, to deliver the best outcomes for individuals and their communities. The aims of the overall NCL BCF are consistent with the Islington BCF plan that focuses on delivery of the Pioneer Programme. Islington works closely with neighbouring boroughs, particularly Camden and Haringey to ensure that when commissioning integrated care programmes we have alignment. However, availability of resource varies between boroughs which means we may develop different solutions.

The Council has a programme of transformation work underway within adult social care services, the Moving Forward programme. This programme will ensure the requirements of the Care Act 2014 will be met, and that there is a sustainable social care offer in Islington. This programme is aligned to the BCF and Integrated Care Pioneer through joint oversight arrangements within the Housing and Social Care Management Structure (Service Director for Social Care is SRO for Moving Forward as well as member of Integrated Care Programme Board). Some areas of work sit across both programmes; for example the Locality development, supported by the BCF will be delivered jointly through Moving Forward and the Integrated Care Pioneer. Similarly, the development of personal health budgets is being delivered jointly with the Council using the same brokerage systems for both. This means that we can start to develop joint plans within an efficient and less bureaucratic system.

Islington CCG has representation on the UCH Clinical Integration Programme Board that seeks to align the integration initiatives across the organisation with stakeholder commissioners (UCH also have a seat on Islington's Integrated Care Programme Board). Examples of work that have been developed include the UCH at Home service that seeks to support early discharge. Further work includes improving rapid response to reduce admissions and reviewing the delayed transfers to ensure Islington residents are discharged in a timely way. The challenge for UCH as a local provider is the number of commissioners with whom it works and therefore different pathways in place. Support around IT inter-operability, being funded through the BCF should mitigate some of this.

The Mental Health Advisory Group brings together key stakeholders to oversee the development and commissioning of services and supports for adults with mental health needs. Camden and Islington Foundation Trust is a member of this and also a member of the Integrated Care Board. This group has aligned work with the integrated care programme including providing nurse input into supported housing schemes; developing a mental health offer into the four localities and investing in supporting adults with mental health needs back into employment.

The Whittington Transformation Board, a partnership across Whittington Health, Islington and Haringey CCG's and local authorities that aims to provide strategic oversight of major change projects. Integrated care is one of the trust's five strategic goals and there is representation at a senior level on Islington's Integrated Care Programme Board. As Whittington Health is an integrated care organisation it is anticipated that they will benefit from the developments of the BCF particularly around supporting the shift of provision into the community.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

As part of developing the Islington Operating Plan for 2014/2016 we have aligned our plans at borough level.

Work is underway at an NCL wide level to define the interventions that will be required on a collaborative level to support achievements identified under the local Better Care Fund initiatives. This will be important in maximising the commissioning effort across acute and community services where they serve more than one borough, and for Islington will be particularly significant in regards to its local Trusts; Whittington ICO, UCLH and CIFT.

The planning principles are shared here to demonstrate absolute alignment between the aims and objectives of the Better Care Fund and the overall approach to commissioning that the CCG has adopted for the following few years.

All identified BCF schemes are reflected in the Operating Plan submission for 2014-16 that was made in April and will be refreshed for the advent of 2015-16. We have recently assessed the source and application of funding over the 2 year period and provide the detail here.(see C)

1. 2 – 5 Year Planning Principles

At borough level in Islington, we have identified the key ingredients of our transformed service offer. We want to see:

- An offer of early intervention and prevention for the whole population
- Health and care systems and pathways that are co-produced with patients and users
- Strong clinical leadership shaping and supporting change
- Hospitals that plan and support discharge from the first day of admission
- Better access to voluntary and community based services through better information and advice
- Joined up care delivered through four localities based around GP practices
- Better identification and co-ordination of patients/users at high risk of hospital admission
- A programme of supported self-management for children and adults with long term conditions
- More personalised service offers through the roll out of personal health budgets and increasing numbers of those who opt for a personal budget

- Services that are more easily understood and accessed through single point of access, single assessment processes and 7 day working
- Better alignment of physical and mental health services, thereby promoting parity of esteem across the health continuum
- A skilled workforce that delivers care with dignity and compassion, is motivated to make a difference and is rewarded for its efforts
- IT systems that support joined up care by becoming interoperable

2. New ways of working in Islington

In developing our Five Year Plan, we want to renew those commitments but also recognise the challenges of the future. The following challenges exist for the NHS in Islington:

New Ways of Working

- We want services taken to people in their local communities or homes
- We want appropriate services in hospital
- We recognise there are different ways of delivering services, using smart phones, emails, the web and want our local hospitals and community services to take advantage of technology in this way
- In return, we want patients to become more self-reliant, taking more responsibility for their own care. We will invest in ways of helping them to do that

Value for Money

- We want services that add value; we will have to consider stopping services that do not or add limited value
- There can be no true value without high quality; Islington has some of safest and highest quality health services nationally and we want to preserve that legacy and improve in areas that need it
- Despite the lack of growth in budgets, we would never consider charging our patients for services that they do not already pay for (e.g. prescriptions, dentistry)

Nurturing Partnerships

- We want to work more closely with our fellow commissioners at borough level, whether that be through our excellent links with the local authority, public health and with our community partners and/or the voluntary sector
- We want to work very closely with the Whittington as our main provider of services in the community and at the hospital, as well as other hospitals such as University College Hospital and the Royal Free
- We have to develop more cohesive links with primary care and specialised commissioning teams at NHS England

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

NCL CCGs have submitted a joint application to adopt responsibility from NHS England for a range of additional primary care commissioning activities aimed at delivering our 5 Year Strategic Plan and supporting primary care transformation. Adoption of these responsibilities will allow us to:

- Ensure that local factors, (high premises and workforce costs, extreme health inequalities, the London acute landscape) are recognized within our commissioning intentions and resources; and
- Develop an integrated capitation funding model for patient pathways, particularly in relation to urgent care and personalized care for people with complex long-term conditions.

There is significant overlap in what all the CCGs are doing, and this will help our co-commissioning work. In addition this work will support our local Pioneer programme and the work being supported through the BCF:

- Extending access to appointments; including 8am-8pm opening;
- Ensuring GP provider collaboration and development of GP networks to integrate with other services (pharmacy, CHS, Specialist) to deliver personalized care for patients with complex long term conditions;
- Reducing variability and increasing quality;
- Improving patient experience and feedback ;
- Closing the gap on expected and observed prevalence for LTCs, and more proactive care;
- Promoting self-care;
- Integrating care better and ensuring that primary care plays a key part in successful delivery of integrated;
- Taking a strategic approach to primary care premises; and
- Supporting the primary care work force.

Working in the Locality integrated health and care teams GP practices will be further supported to deliver the proactive patient care set out in Transforming Primary Care; personalised care plans, named and accountable GP's , a care co-ordinator and better access to primary care.

We believe that co-commissioning will reduce some of the current risks in the system by bringing commissioning back to a local footing.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Islington is proud of its history in protecting social care for those who need it and maintaining eligibility levels to ensure those with moderate needs and above are supported to live independently in the community.

Demand is rising at a time of unprecedented budget pressure, and work is being undertaken in partnership with the CCG, local NHS Trusts, and the voluntary sector to ensure that adult social care services can be successfully sustained in Islington.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Islington has developed Section 75 pooled budgets as well as used Section 256 transfers to support the development of a strong social care offer. We plan to continue this way of working with the added requirement of supporting the new social care reforms including the development of a seven day offer.

We are using the Better Care Fund to support demographic pressure, to maintain eligibility and to support the additional demand for information and advice that we expect to see as a result of the new Care Bill.

We also want to invest in our locality offer which is likely to see an increase in demand for domiciliary support for those who are cared for at home as we reduce the numbers of those in hospital or in long term care institutions. This is a significant challenge at a time of budget reduction in local authorities, and the Better Care Fund will partially ameliorate this pressure, and provide some time and focus for the remodelling of adult social care. It is recognised that adult social care will need to be remodelled by March 2015 to both support the implementation of the Care Act, and the roll-out of a joined-up locality offer (Scheme BCF1). Options are currently being considered by the Moving Forward Programme, in partnership with the Integrated Care Board.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

£4.822m is provided for in the BCF for 2014/15 to protect adult social care (scheme BCF5). This will partially mitigate the anticipated significant budget reduction to adult social care in 2014/15 and 2015/16.

£6.598m is provided for in the BCF for 2015/16 to protect adult social care (Schemes BCF5, BCF14 and BCF15). Again, this will partially offset the significant budget reduction to adult social care in 2015/16, and enable social care to absorb demographic growth (Scheme BCF14 and BCF15). Islington aims to continue to provide social care services to those with a level equivalent to the current FACS Moderate. This supports the prevention of more acute needs developing, and therefore ameliorates pressure on health services.

£1.2m is allocated to Scheme BCF11 to support integrated reablement and rehabilitation in Islington. Reablement is provided by Islington Council.

£1.4m is allocated to Scheme BCF13 to mitigate demographic pressure on continuing healthcare budgets.

Islington has a high and increasing number of people living with learning disabilities. The needs of this group are planned for and funded via a S75 pooled budget between Islington CCG and the Council. There has been an increase in the numbers of people with a learning disability who meet NHS Continuing Healthcare criteria, with a £1m pressure on the pooled budget. The increased demands on the pooled budget will be met through Scheme BCF13.

There is also a lesser, but still substantial, demographic demand for the care and support of older people. Again, this has also led to an increased pressure on continuing health care budgets. These increased demands are also accounted for in Scheme BCF13.

£663K is allocated through Scheme BCF18 to support the implementation of the Care Act 2014. This is the exact proportion for Islington of the £135m allocated nationally for this.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Islington is well-placed to implement the requirements of the Care Act, having established a number of key requirements, such as a deferred payments scheme, a joint transition team, a comprehensive offer for carers, and a strong track record of personalisation. However, there will be an expected increase in demand due to self-funders and more family carers coming forward for assessment. We are currently quantifying this demand using local market intelligence and the tools shared by the national joint programme team. As reflected in the London Councils and ADASS response to the draft guidance and regulations, there remains a risk that any calculation of additional demand can be an approximation only, and more demand than expected might be experienced.

In addition, there are two prisons in Islington, and there could be significant additional demand on the Council depending on the requirements of the final guidance and regulations expected in October 2014.

It is recognised that the final guidance and regulations of the Care Act 2014 will not be published in time for the submission of the Better Care Fund templates. Therefore, there might be additional demands in the final guidance that have not been accounted for in this plan.

A sub-group of the Moving Forward Programme Board, the Care Act Implementation group, is overseeing this work, and is chaired by the Service Director for Adult Social Care.

v) Please specify the level of resource that will be dedicated to carer-specific support

£415k is allocated to support carers through Scheme BCF12.

Islington Council and Islington CCG have worked in partnership to develop a strong carers' offer through a pooled budget arrangement. Our approach is to identify and support carers in the right way at the right time to prevent the breakdown of caring situations. We have commissioned a Carers' Hub, which supports over 1,000 family carers and administers a short-breaks scheme.

As well as more traditional services such as respite and sitting services, Islington offers weekly direct payments for carers to spend flexibly in the way that most benefits them. Additional demand from carers is anticipated as a result of the Care Act, and we are planning to develop and extend our Carers' Hub model through the Better Care Fund. This will both protect the current offer for carers, and enable more carers to benefit from these services.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Local authority budgets have not been materially affected.

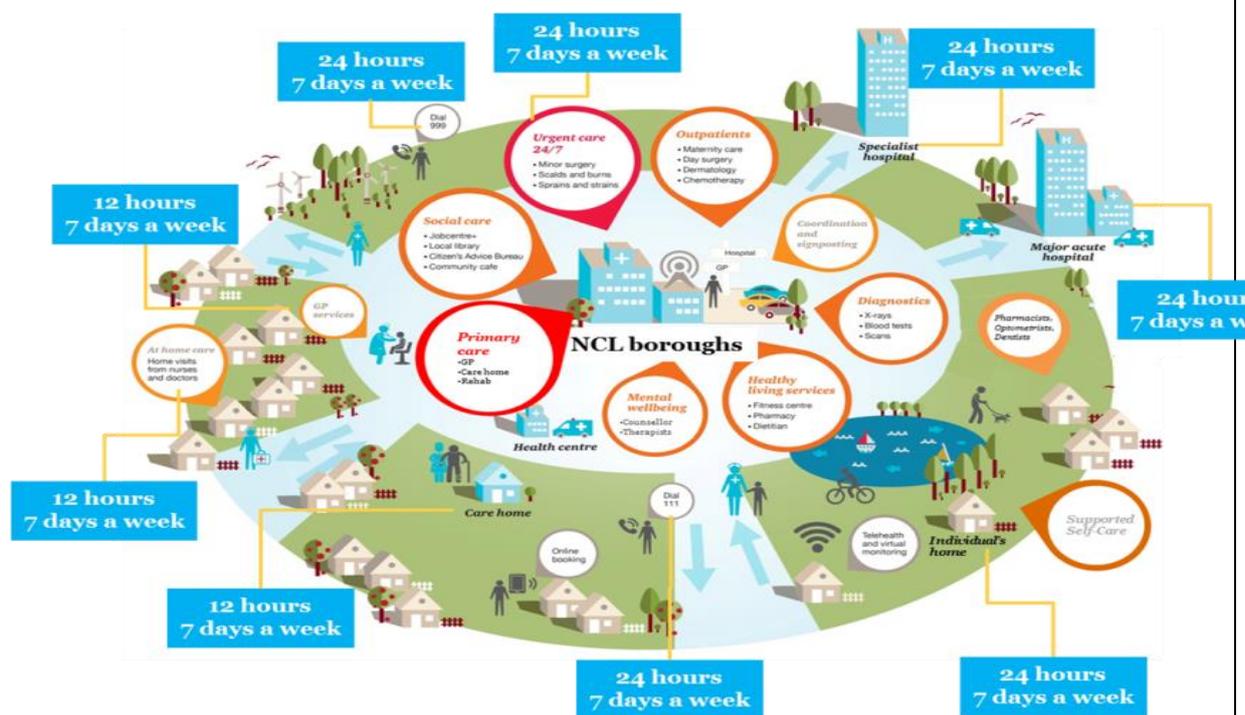
b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Compliance with Seven Day Service Clinical Standards will be delivered through:

- All local Urgent Care Working Groups have prioritised 7 day working in their Improvement Plans. This includes access to consultants, therapies, diagnostic and mental health services;
- Greater collaboration between providers to ensure "network working" to cover current gaps;
- The London Quality Standards have been included in the proposed KPIs for acute providers. Requirement for Remedial Action Plans in the case of non-compliance;

The diagram below summarises plans for 7-day working locally.



Islington has a strong commitment to providing seven day health and social care services across the local health economy, evidenced by our work to date to extend a seven day offering across key services.

We already have seven day working and response from reablement, with in-reach to acute hospitals, and strong links to the FEDS therapies team to identify people who could go home with reablement support. This seven day working has supported our

excellent track record on delayed transfers of care and our improved length of stay as we are able to mobilise professionals to support discharge outside of the traditional Monday-Thursday window.

The Whittington have developed a checklist against progress and are on track with plans to deliver a seven day offer.

Our plan is to build on learning to develop a sustainable seven day offer. We ran a pilot over the winter with a social worker on site at both hospitals and want to use the evaluation of this to inform the model for social work access over seven days. This model is being worked up as part of the Council's "Moving Forward" programme that seeks to transform social care services. During 2014/15 a new model will be designed so that staff consultation can take place prior to a go live date of April 2015.

We also want to quantify more clearly what the additional funding requirement is, although we plan to use the Better Care Fund to pump prime the offer. From experience at the Whittington where acute therapists were moved to seven day working it did require additional resource, partly because we still needed the same level of staffing during the week (more or less) to respond to demand, mobilise patients etc. and partly because of the enhanced payments for unsocial hours. The change there also included extended hours for the FEDS (Rapid response in ED) team, so that there is an 8.00 - 8.00 service. This expansion to seven day working did produce benefits such continuity of therapy input, support for the enablers e.g. so that people don't 'seize up' if discharged prior to weekend and not moving about or get reassurance if they are struggling. Also there was more interaction with families who may work during the week.

Primary care colleagues have already started to consider how they may collaborate to provide extended hours services and this is supported by a improving access locally commissioned service that will see an additional 144 hours a month available across practices.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

All health and care systems will use the NHS number as an identifier from 2014/15. The London Borough of Islington has already uploaded NHS numbers for current adult social care clients, and has systems in place to accurately record the NHS numbers of new clients.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Our ICT strategy and work programme requires our existing software suppliers to deliver open APIs and confirm that they meet current ITK standards. It is also a requirement for all future contracts including our bid for the development and implementation of a Person Held Record and interoperable platform recently submitted for integrated digital care funding.

We already have security systems in place including the use of GCSX email.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

Safe and secure sharing of information between and within health partners and Islington Council is paramount and the Council is interested in being a pilot site to adopt the new secure email service under ISB 1596 Secure email standard. Likewise the Council is level 2 compliant with the IG toolkit and had a full suite of IG policies. Housing and Adult Social Services is developing an action plan to meet all of the Caldicott 2 recommendations.

The CCG achieved Accredited safe Haven status in March 2014, in part by achieving 100% against level 2 of the IG Toolkit. It has a comprehensive suite of information governance policies and guidance in place. The CCG has developed good working relationships with key stakeholders across the health and social care economy, particularly with Public Health and patient representatives, and is currently compliant with all information governance requirements.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

The CSU is not using the CCG's locally developed risk stratification tool because of its interpretation of restrictions imposed by the Confidentiality Advisory Group, when it agreed a section 251 exemption for risk stratification.

Therefore up to date information is 'risk stratified' using the CSU's preferred tool, the Combined Predictive Model. Monthly SUS and EMIS data flows are made available to inform health and social care responses.

The Integrated Care Board has agreed that the Integrated Health and Care teams will initially **work with the top 2% at risk of admission together with any person that the team feels would benefit from the integrated approach.** We understand this population across a variety of measures which will inform our approach to shaping the teams as well as monitoring the impact of this development.

- Personal (age, long terms conditions, gender, risk score)
- Activity (across primary and secondary health care, mental health and social care provision)

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Islington's MDT processes have been in place for the last 18 months and are used as a platform to jointly assess and plan care for patients. The purpose of the MDT is to carry out these core activities:

- Each GP practice holds a patient register for those patients with LTC's
- Patients at risk of hospital admission are identified using the risk stratification tool
- An integrated care plan is used as a basis of care planning with the patient
- Cases are discussed at the MDT planning meetings
- A lead professional is identified to co-ordinate and follow up care
- The Voluntary Sector Navigator supports the patient to follow up goals
- Case conferences are used to review care

In order to inform the scaling up of the locality offer we have undertaken an evaluation of the MDT process in the early months of 2014/15. To date nearly 500 patients have been discussed and reviewed through the MDT.

Findings from the evaluation include a consistent reduction in A&E inpatient and outpatient activity after an MDT. Overall the report found a 27% reduction in A&E attendances from the group of patients discussed. Further findings support the scaling up of the process with the new locality offer.

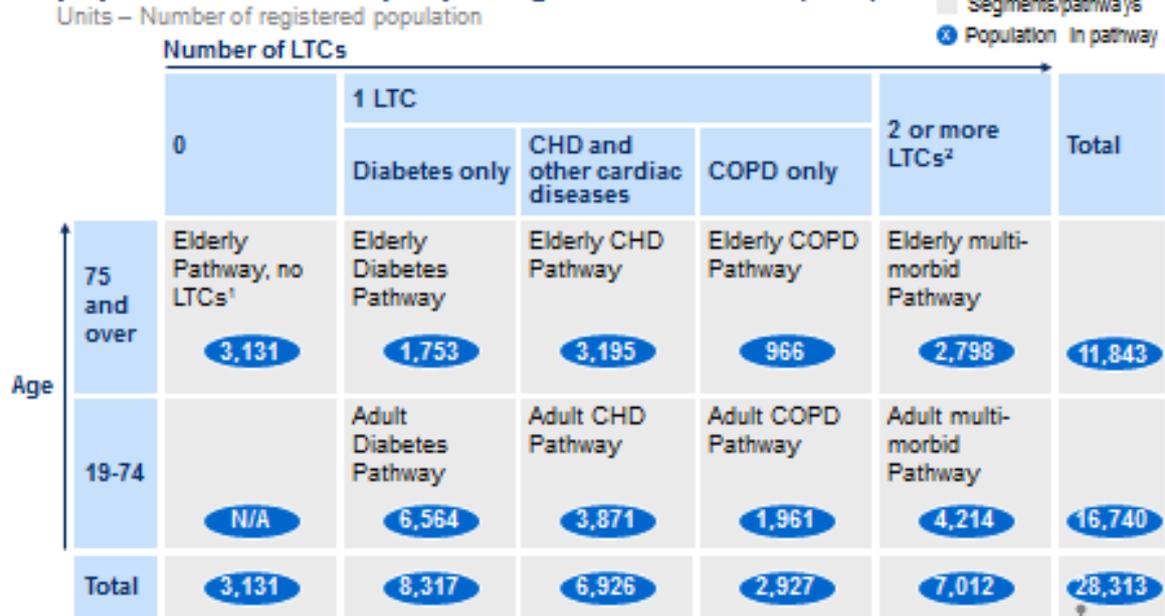
Islington has just been successful in a bid to become a Community Education Provider Network and we see workforce development as a key enabler in supporting new ways of working in localities. This includes developing a different skills mix so that professionals can take on broader roles within the care planning process. It is within this programme of work that we will be working, across providers, with frontline staff to develop new ways of working and support culture change.

Joint assessments and care planning will also be supported by the work we are doing on IT interoperability as we know that with the current limitations staff are having to enter information on different systems

Islington has developed its own risk stratification tool that was launched in September 2012 although this is currently under review. Early work looked to identify segments of the population that could benefit from integrated care.

4 **FOR DISCUSSION**
Integrated Care would benefit a large proportion of the local population: ~28,000 people registered with GP (13%)...

Wider definition of CHD and multimorbid



Total registered population: ~218,000
 ~13% is addressable by IC

¹ Includes: CHD, CHD/M, Heart Failure and Atrial fibrillation
² People ≥ 75 y.o. with 2 or more of the following conditions: Diabetes, CHD, COPD, chronic depression, psychotic disorders, CHD/M, CKD, stroke/TIA, chronic liver disease, Atrial fibrillation, or heart failure
 SOURCE: Islington Public Health data

It is expected that one of the areas of most benefit from use of risk stratification will be the tier 2/3 patients who are currently low/moderate users of health and social care. Identifying them at a lower level risk allows the opportunity to provide greater input within the community to prevent them from becoming more unwell and being admitted to secondary care.

Using risk stratification is a key element of the development of the locality service redesign as it will provide the opportunity to analyse need at a locality level (and at individual level within the locality) so that services can be designed accordingly.

As part of the Integrated Health and Care teams, we are commissioning new resource from Camden and Islington NHS Foundation trust to bring mental health services closer to Primary Care. This will provide psychiatry, psychology, mental health nursing and social work as a core part of the Integrated teams.

For people with dementia, we have Dementia Navigators, providing individual case management approach for people with Dementia and their carers to support them through the systems and ensure best use of resources.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

Approximately 13% of the at risk population already have a joint care plan in place as a result of the MDT approach.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

From the outset we have been keen to engage with patients and service users and worked with them to develop a set of “I” statements along the lines of those developed by Making it Real. These were crucial in helping us shape our vision and prioritise what was important to the people who receive services.

We have launched a Making it Real Board where we are working with users to develop plans to improve the delivery of care and identify areas of co-production. This Board has been successful in attracting a range of users and carers who can provide different insights from their experience of the health and care system which will be an invaluable resource. The Making it Real Board is co-chaired by the Service Director for Social Care and a service user. Both sit on the Integrated Care Board. In addition to these, a member of Healthwatch sits on the Board as well as two lay representatives from the community.

The Making it Real Board has developed its own action plan identifying areas of work that are a priority to users and their carers. In addition, the members of the group are supported to become leaders for other “experts by experience” through attending training and conferences, for example a cohort attended the TLAP conference in Birmingham.

During our work we have involved users and patients to co-produce service design and improvement. Examples include:

- Work with over 250 patients to develop our local “I statements”
- a report highlighting the experience of those who have one or more long term condition to inform how we co-ordinate care better
- working with women who have used mental health services to identify areas of work – this has informed the Integrated Care plans for Camden and Islington FT
- working with local community organisations to identify issues of access to services that has led to us working with GP front of house staff and community pharmacies
- commissioning St Joseph’s hospice to work with patients, family members and carers who have experience of the last years of life care services to provide feedback on those services as well as using them to develop an improved offer through district nursing
- using patients and users to undertake peer to peer research into the N19 pilot which is a short term project to test a model for integrated health and care teams
- working with patients and users to inform our model of multi-disciplinary working
- the development of peer researchers to support the development of a patient

- narrative for integrated care
- working with harder to engage groups through local community organisations

Finally, we have started to develop a communications strategy so that we can have a more streamlined approach to communication with all stakeholders.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

We have been working with partners over the last eighteen months to develop our plans for integrated care upon which we have based our Better Care Fund submission. We have harnessed the excellent leadership that exists in our local health and care economy so that we remain sighted on the challenges within the sector and develop change through a whole system model. We believe that this commitment to working in partnership both with service providers but also service users and patients has helped us to secure Pioneer Status for our integrated care programme.

Work to date has included workshops with health and social care providers from the statutory and voluntary sector as well as having provider representation on our Integrated Care Board and on work-stream project teams. We hold an annual conference for social care and housing support providers where we have consulted on our plans for integrated care as well as regular meetings through the CCG with health providers, for example, monthly GP forums and the Whittington Transformation Board.

The Council and Whittington Health have Section 75 arrangements and integrated management structures to better co-ordinate and deliver community health care and social services. They have used these relationships to start piloting new ways of working so that we can test and evaluate models as we develop our thinking.

Similarly our mental health services are delivered through pooled budget arrangements with another key provider, Camden and Islington Mental Health Foundation Trust who have been at the forefront of our work to shift care out of secondary health services. They are also supporting us to improve health inequalities by providing more proactive support for physical as well as mental health.

UCH is also a key player who has not only been represented at the Integrated Care Board but has jointly employed a Divisional Clinical Director - Integration with the Whittington to improve links between their acute provision and the local community offer.

All providers have been engaged with the North Central London CCG's to develop a

new approach to commissioning for outcomes; value based commissioning. This has focused on three pathways, frail elderly, diabetes and mental health. Working across providers, commissioners and users/patients we have been able to develop our thinking about how to contract differently and incentivise the system to work more closely together. This work dovetails with the development of our plans around the BCF where we want to understand the segments of our population in order to develop different contracting models.

ii) primary care providers

Islington supports a GP forum that meets bi-monthly and we have strong clinical support for integrated care initiatives. As well as two Clinical Leads from the Governing Body Islington also has four Locality Clinical Leads who chair the MDT's and have also been instrumental in supporting the development of the risk stratification tool.

The development of the rapid response and primary care discharge schemes outlined in this BCF come directly from engagement with GP's at the forum. As such the operational groups have a GP chair, able to provide the clinical leadership that will support wider change.

iii) social care and providers from the voluntary and community sector

As set out above we have held workshops with health and social care providers from the statutory and voluntary sector as well as having provider representation on our Integrated Care Board and on work-stream project teams. We hold an annual conference for social care and housing support providers where we have consulted on our plans for integrated care.

Furthermore the CCG has a quarterly voluntary and community sector forum where we have presented and discussed plans to deliver integrated care.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Our vision for acute providers is that they will provide care for those who need it; plan for discharge from day one and have active services at the front door to avoid admission.

Islington CCG is the lead commissioner for Whittington Health Integrated Care Organisation. The majority of acute services are provided by Whittington Health and University College Hospital.

Since 2012 there has been a Transformation Board for the Whittington across the partnership of Islington and Haringey that seeks to support the development of the hospital into securing Foundation Trust status. As the Whittington also provides community services across the two boroughs it is in an excellent position to work with commissioners to support the delivery of our vision for integrated care.

Commissioners have been working with acute trusts to reduce hospital admissions, particularly readmissions, and A&E attendances. We want to see a continuation of this work as well as a focus on acute productivity to bring efficiencies within the local health economy.

The impact of the Better Care Fund will be;

- A locality offer that supports integrated discharge and rapid response to avoid unplanned hospital admission or readmission
- Secondary care colleagues gain confidence that complex patients can be discharged into the locality
- Intermediate care services that support early discharge and therefore reduce length of stay
- Alignment of community services and social care functions, like reablement, to support independence in the community
- IT infrastructure that supports shared care and less duplication
- An expectation that specialists working in acute hospitals will be outward facing and able to support community colleagues
- Acute trusts that focus on reducing unplanned admissions through ambulatory care, early supported discharge and services like RAID to support adults with mental health needs

In terms of savings:

- Acute productivity will lead to realised contract efficiency
- Development of a community offer will reduce unplanned admissions
- Ambulatory care services are being expanded at the Whittington and can already demonstrate reduced admissions and readmissions
- UCH are developing ambulatory care and we want to see this scaled up so that it provides a proactive triage
- RAID is delivering reduced admissions for adults with mental health needs at the Whittington and is within Islington's QIPP programme
- Through the skilling up of community colleagues in the management of long term conditions we expect fewer exacerbations leading to A&E attendance and fewer outpatient admissions
- Oversight of data at system wide level will enable clear oversight of spend
- New models of working will also be supported by the Urgent Care Review that seeks to streamline the urgent care offer

Failure to deliver will lead to:

- Continued pressure on CCG and Council budgets
- Continued risk to acute's ability to manage peaks in emergency attendances and admissions
- Continued pressure to meet NHS constitution targets
- Opportunities to invest in community and primary care will be compromised
- Opportunities for enhanced recovery are lost leading to more placements into long term care

Where we are now:

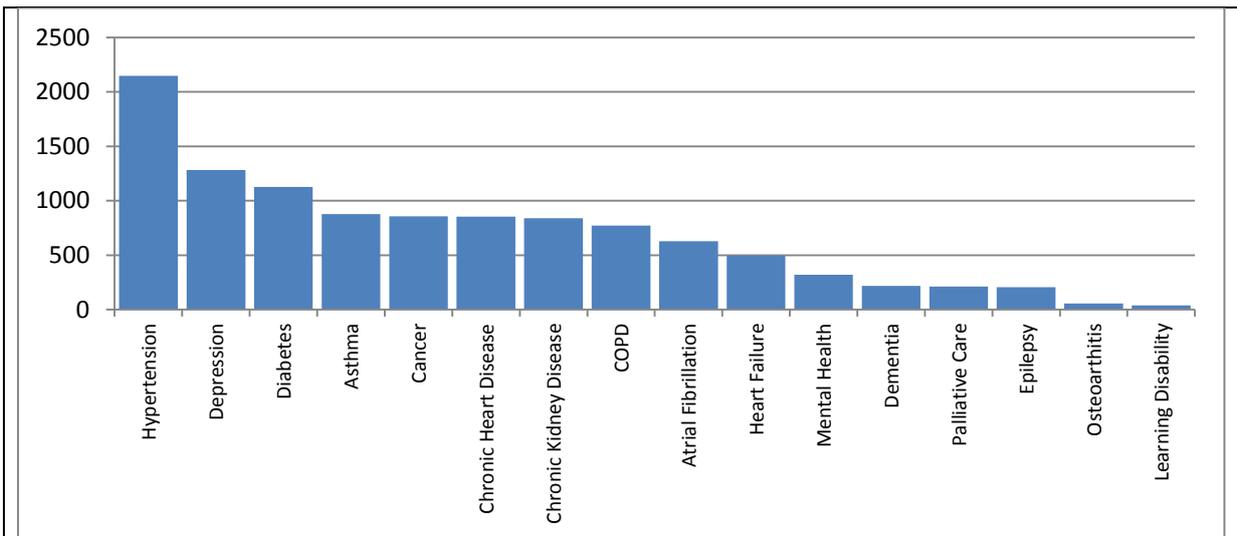
- We have agreed the 2014/15 and 2015/16 baseline with Camden and Islington Foundation Trust (CIFT) – 2014/15 contract signed
- Whittington – 2014/15 contract signed
- UCH baseline agreed for 2014/15, contract yet to be signed
- Whittington ICO is a net beneficiary of BCF through development of the localities and seven day working
- Urgent Care Review finalised

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

9) ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
BCF1
Scheme name:
Locality Development – Integrated Health and Care Teams
What is the strategic objective of this scheme?
<p>To provide integrated care within a community setting; focussing on those people most at risk of admission and those people who would most benefit from an integrated approach.</p> <p>This scheme aims to improve system capacity to deliver Care Closer to Home by bringing existing skills and expertise together with new investment in a co-ordinated approach.</p>
Overview of the scheme
<p>Please provide a brief description of what you are proposing to do including:</p> <ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted?
<p>This service will create integrated health and care teams wrapped around primary care. This multi-provider development brings together Primary Care, Social Care, District Nursing, Community Matrons, Allied Health Professionals and Mental Health Professionals, with support from Secondary Care colleagues as required. The service will be structured and led around primary care, alongside staff from Camden and Islington NHS Foundation Trust, London Borough of Islington, UCLH NHS Foundation Trust and Whittington Health NHS Trust together with voluntary sector providers.</p> <p>This work builds on our existing multi-disciplinary initiatives to developing and scale up the concept across Islington. These teams will work together on a regular (weekly/fortnightly) basis to share skills and expertise, and ensure a more joined-up approach for the patient.</p> <p>We have defined the target audience for this service as the top 2% of people at risk of admission, together with any person who the members of the team feel would benefit from an integrated approach. In Islington, the top 2% represents</p> <ul style="list-style-type: none"> • 4,650 people across 36 practices • 63% are over 60 • 44% have 3 or more long term conditions <p>Diagnosed Long Term Conditions within top 2% risk stratified population:</p>



We have mapped this population to our social care, mental health and community health populations. Bringing these data sources together provides a significant step forward in terms of understanding need and highlight opportunities for better co-ordinated activity. It will also provide a robust baseline in order to monitor impact of the scheme in terms of affecting risk scores.

We are keen that this model, while grounded in a risk stratified approach, places equal weight to professional opinion to ensure engagement and maximise benefits. We are piloting this service in 2014 and this will enable a better understanding of the cohort of 'people who will benefit from an integrated approach'.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Providers are detailed above. Islington CCG is the lead commissioner for Whittington Health NHS Trust and Camden and Islington NHS Foundation Trust. Camden CCG is the lead commissioner for UCLH NHS Foundation Trust. The London Borough of Islington and Islington CCG have a long history of joint working with a well-established joint commissioning team.

We anticipate expenditure during 14/15 on enabling participation in the pilots; this will fund staff time from primary care, community health and social care teams.

The lead commissioner for this work is the Integrated Care Programme Director at Islington CCG/Islington Council. The Operational Group comprises senior management from across Primary Care and key provider organisations.

We have identified 9 practices to engage in phase 1 (test and learn) of the development. This will launch in October 2014. We intend to roll out the model across the borough from April 2015.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Published evidence for these schemes is limited, but includes key sites such as Torbay²

Other evidence provided by the King's Fund³ shows that

- care co-ordination can have a significant effect on quality of life
- integrated primary care systems are associated with better patient experience
- models of chronic care management is associated with lower costs and better outcomes

Our own local evaluation includes an evaluation of the N19 pilot (a year long pilot in the north of the borough to test integrated team working) (June 2014)

Evaluation of Islington's approach to multi-disciplinary teleconferencing (August 2014)

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Moderate
2	Residential Admissions	Moderate
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	High
6 (local)	Carer Reported Quality of Life	Moderate

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Led by patients, Islington has developed a local version of the National Voices 'I Statements'.

Patient Perspective	How this project will support this
I want to be listened to and heard	<ul style="list-style-type: none"> • Patients will have to repeat their story less as information will be shared across the Integrated Team • Care plans will be structured around patient outcomes, identified and articulated by the patient with support from the integrated team

² <http://www.kingsfund.org.uk/publications/integrating-health-and-social-care-torbay>

³ <http://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/care-coordination>

	<ul style="list-style-type: none"> We will measure success of the project by measuring how much we support patients to reach their outcomes
I want to be treated as a whole person and for you to recognise how disempowering being ill is	<ul style="list-style-type: none"> The most vulnerable people in Islington will be identified and have their care joined up; they will experience fewer hand-offs and reduced risk of 'falling in between the gaps' Staff will hold a holistic understanding of patient's need, working across boundaries to provide a response to the whole person's needs
I want my care to be co-ordinated and to have the same appointment system across services	<ul style="list-style-type: none"> Patients will have a named care co-ordinator who has meaningful oversight of interventions across primary care, social care, mental health and the voluntary sector Staff will understand each other's skills and roles, trust each other's assessments and act on them Referrals will be verbal and instant
I want to have longer appointments with someone who is well prepared so that I do not have to tell my story again	<ul style="list-style-type: none"> The integrated team will share records and information within the service and with the wider locality teams We will move from multiple interventions from multiple professionals, to more intensive interventions from one care co-ordinator
I want to feel supported by my community and get the most out of services available locally	<ul style="list-style-type: none"> The rotational staff model will support learning throughout the system, particularly regarding the 'whole population offer' and self-care developments The team will work closely with the single point of access and the voluntary sector to identify more local opportunities for support
I want you to put a greater focus on my mental well being	<ul style="list-style-type: none"> Mental Health services will be closely integrated into the model through a new model sitting between Primary Care and C&I services Increasing numbers of staff will have confidence in responding to mental health issues through training and peer support
I want to feel respected and to feel safe	<ul style="list-style-type: none"> When patients need ongoing care, they will be discharged effectively from the multi-disciplinary teams Safeguarding functions within Islington Council will be integrated into this team, sharing skills and capacity

External evaluation of our multi-disciplinary work (teleconferences) to date has demonstrated impact in reducing A&E attendance, reducing admissions and reducing GP appointments. As well as these activity measures, we want to monitor impact of the scheme by understanding

- Patient stories and feedback
- Staff feedback
- Risk scores for the relevant population
- Peer (i.e. patient) review of the process

What are the key success factors for implementation of this scheme?

This scheme will be piloted through 2014/15. This pilot will provide considerable information towards a successful full borough implementation in 2015/16.

While we need to create robust structures to enable these teams to function, detailing operational policies, creating effective information sharing arrangements and refining the patient cohort through risk stratification and professional opinion, our key focus for successfully implementing this scheme will be creating effective working relationships within the team.

Scheme ref no.
BCF2
Scheme name:
Locality Development – Rapid Response
What is the strategic objective of this scheme?
To shift health and social care interventions away from hospital and closer to home, and build capacity in primary care, by providing a rapid (2 hours) response from an integrated health and care team.
Overview of the scheme Please provide a brief description of what you are proposing to do including:
<ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted?
<p>Current provision involves a range of services delivering varied rapid response functions (across social care, district nursing, mental health, etc.) to different standards and models. This scheme will integrate these existing services with a newly commissioned clinical capacity, providing a multi-organisational response from Camden and Islington NHS Foundation Trust, London Ambulance Service, London Borough of Islington, UCLH NHS Foundation Trust and Whittington Health NHS Trust.</p> <p>The service will be a multi-disciplinary, 7 day service, comprising General Practitioners, Social Workers, Nurses, Mental Health professionals and Allied Health Professionals. The service will have access to rapid response Reablement services and Intermediate Care beds.</p> <p>We have identified the following activity as potentially appropriate for this service</p> <ul style="list-style-type: none"> • People approaching existing services for rapid support (awaiting data) • Presentations at A&E with no investigation/no treatment or Category 1 investigation/Category 1 treatment (c1100/month at Whittington and UCLH)* • LAS conveyances resulting in 0 or 1 day admissions (c240/month at Whittington and UCLH)* • Requests for home visits from Primary Care (c585/month) <p>* Evidence from the NHS Alliance suggests that around 10-30% of this work may be classified as appropriate for primary care.⁴</p> <p>We are explicitly not defining eligibility for this service based on conditions. Eligibility will be a matter of timely, co-ordinated professional assessment. However, we expect the following conditions to be potentially appropriate for this service.</p> <ul style="list-style-type: none"> • Exacerbation of long term condition, e.g. diabetes, COPD, Parkinson's, heart failure, etc. • Falls (without head injuries) • Infections, e.g. urinary/catheter issues, chest infections • Diarrhoea and vomiting • Minor injuries • Functional deterioration

⁴ <http://www.nhsalliance.org/publication/breaking-the-mould-without-breaking-the-system-3/>

- Acute episodes of chronic pain
- Breakdown in care and support networks, including safeguarding alerts requiring a rapid response
- Urgent breakdowns in equipment
- Urgent crisis relating to housing resulting in risk of admission
- Cognitive deterioration, e.g. dementia, delirium
- All lower limb cellulitis unless patient presents as systematically unwell with pyrexia or confusion.
- Lower respiratory tract infection in an individual without a previous diagnosis of a Long term condition

These conditions, together with the locations for the service, will be developed through the cross-organisational Operational Group. We are expecting to pilot this work in early 2015, going fully live by April 2015.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Providers are detailed above. Islington CCG is the lead commissioner for Whittington Health NHS Trust and Camden and Islington NHS Foundation Trust. Camden CCG is the lead commissioner for UCLH NHS Foundation Trust. The London Borough of Islington and Islington CCG have a long history of joint working with a well established joint commissioning team.

The lead commissioner for this work is the Integrated Care Commissioning Manager at Islington CCG. The Operational Group comprises senior management from across key provider organisations, and the group is chaired by a Primary Care clinician.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Published evidence for these schemes is limited, but includes

- Commissioning a new delivery model for unscheduled care in London, London Health Programmes 2012⁵
- Rapid Response Services, NHS Evidence, 2011⁶
- Emergency Care and Emergency Services, Foundation Trust Network, 2013⁷

To draw on best practice, we have worked with other local authorities who have developed similar schemes. Clinical opinion has led assumptions about impact.

⁵ <http://www.londonhp.nhs.uk/publications/unscheduled-care/>

⁶ <http://www.evidence.nhs.uk/aboutus/Pages/AboutQIPP>

⁷ <http://www.foundationtrustnetwork.org/resource-library/emergency-care-and-emergency-services-2013/>

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	High
2	Residential Admissions	Low
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	Moderate
6 (local)	Carer Reported Quality of Life	Low

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Led by patients, Islington has developed a local version of the National Voices 'I Statements'. Rapid Response has been matched to these 'I Statements' as follows

Patient Perspective	How this will be recognised
I want to be listened to and heard	<ul style="list-style-type: none"> • Care and support will be provided as close to home as possible, as quickly as possible • Access hours will be extended and arrangements will be simplified
I want to be treated as a whole person and for you to recognise how disempowering being ill is	<ul style="list-style-type: none"> • The team will work in a multi-disciplinary way, enabling a holistic and timely response to emergencies • The structure will be simplified for patients facing a crisis
I want my care to be co-ordinated and to have the same appointment system across services	<ul style="list-style-type: none"> • The team will understand and work closely with the variety of services supporting an individual, in particular the Integrated and Long Term care teams
I want to have longer appointments with someone who is well prepared so that I do not have to tell my story again	<ul style="list-style-type: none"> • The integrated team will share records and information within the service and with the wider locality teams • A common assessment and care plan will be shared within the team
I want to feel supported by my community and get the most out of services available locally	<ul style="list-style-type: none"> • The rotational model will support learning throughout the system
I want you to put a greater focus on my mental well being	<ul style="list-style-type: none"> • The team will incorporate elements of Enhanced Reablement, able to respond to cognitive decline • The team will build links with key Mental

<p>I want to feel respected and to feel safe</p>	<p>Health services within C&I NHS trust</p> <ul style="list-style-type: none"> • The team will have effective discharge arrangements to ongoing care and support • Safeguarding functions within Islington Council will be integrated into this team where a rapid response is required, sharing skills and capacity
<p>Key feedback loops will include confidence in the Rapid Response system by Primary and Secondary Care providers, decreased activity in secondary care and increased activity in community settings such as Reablement and Intermediate Care.</p> <p>As well as evaluating against these criteria, we will measure the shift in activity against the following</p> <ul style="list-style-type: none"> • People approaching existing services for rapid support (awaiting data) • Presentations at A&E with no investigation/no treatment or Category 1 investigation/Category 1 treatment (c1100/month at Whittington and UCLH)* • LAS conveyances resulting in 0 or 1 day admissions (c240/month at Whittington and UCLH)* • Requests for home visits from Primary Care (c585/month) 	
<p>What are the key success factors for implementation of this scheme?</p>	
<ul style="list-style-type: none"> • Integration of existing services across social care, primary and secondary (acute and mental health) health services • Commissioning additional clinical resource • Confidence in Rapid Response factors across the system • Admissions avoidance 	

Scheme ref no.
BCF3
Scheme name:
Locality Development – Primary care discharge
What is the strategic objective of this scheme?
<p>To strengthen discharge arrangements following hospital admission, focussing on ensuring more effective transfers of clinical care between secondary care providers and primary care.</p> <p>The strategic aim of this scheme is to reduce readmissions, build capacity in primary care to support people immediately post discharge and improve discharge processes to improve joint working between secondary and primary care.</p> <p>The scheme is being worked up in response to gaps being identified by GP practices in Islington through the GP Forum.</p>
<p>Overview of the scheme</p> <p>Please provide a brief description of what you are proposing to do including:</p> <ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted?
<p>We want to improve local discharge arrangements from Whittington and UCLH Hospitals. Discharge from hospital is a key point in a person's care arrangements; as well as the stress of a hospital admission, it involves a transfer of care and clinical responsibility together with a possible change in health and care needs. We want to better support clinicians and patients with this process, and mitigate unwanted outcomes.</p> <p>The patient cohort will initially be those people managed by the Integrated Health and Care Teams (scheme 14.04). This is defined as the top 2% at risk of admission and anyone who the team feels would benefit from an integrated approach.</p> <p>As part of the IHCT pilot running from October 2014 we will review discharge arrangements for this patient cohort. This will better identify needs and help shape the scheme in greater detail, including provider details.</p>
<p>The delivery chain</p> <p>Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved</p>
<p>This scheme will be worked up in partnership with providers across the acutes, community and primary care settings. The lead commissioner will sit within the Integrated Care Team within the CCG. As the scheme is developed an appropriate procurement route will be identified. Timescales for implementation are still being developed.</p>
<p>The evidence base</p> <p>Please reference the evidence base which you have drawn on</p> <ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
<p>Further work is required to identify best practice and evidence to support the development of a scheme. To date there is anecdotal evidence that discharge from acute hospital settings could be managed more successfully in primary care if:</p>

- information was provided in a more timely manner
- discharge notes were fully completed with clear information on, for example, updated medicines management
- primary care colleagues were provided with sufficient notice to be able to schedule visits to the patient within three days of arriving home

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Low
2	Residential Admissions	Low
3	Reablement	Low
4	Delayed Transfers of Care	Moderate
5	Patient / Service User experience	Moderate
6 (local)	Carer Reported Quality of Life	Low

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

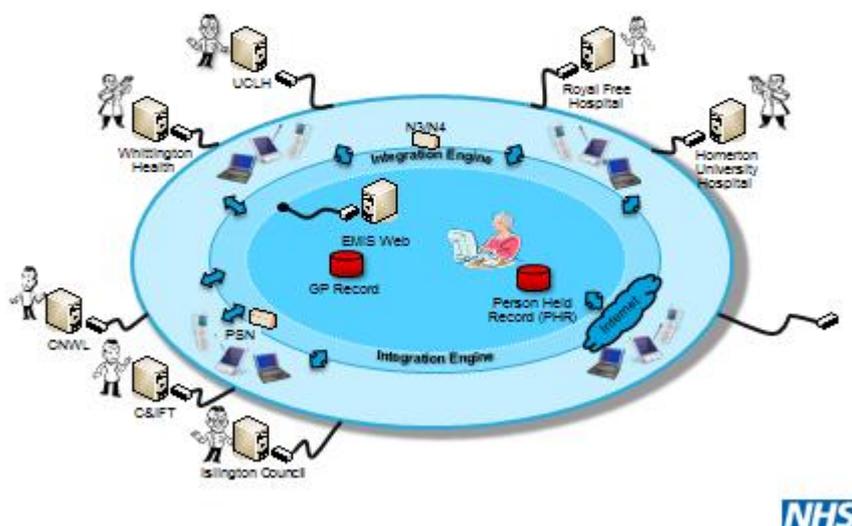
Led by patients, Islington has developed a local version of the National Voices 'I Statements'.

Patient Perspective	How this project will support this
I want to be listened to and heard	Patients will have to repeat their story less as information will be shared across the Integrated Team Care plans will be structured around patient outcomes, identified and articulated by the patient with support from the integrated team We will measure success of the project by measuring how much we support patients to reach their outcomes
I want to be treated as a whole person and for you to recognise how disempowering being ill is	The most vulnerable people in Islington will be identified and have their care joined up; they will experience fewer hand-offs and reduced risk of 'falling in between the gaps' Staff will hold a holistic understanding of patient's need, working across boundaries to provide a response to the whole person's needs
I want my care to be co-ordinated and to have the same appointment system across services	Patients will have a named care co-ordinator who has meaningful oversight of interventions across primary care, social care, mental health and the voluntary sector Staff will understand each other's skills and roles, trust each other's assessments and act on them

	Referrals will be verbal and instant
I want to have longer appointments with someone who is well prepared so that I do not have to tell my story again	The integrated team will share records and information within the service and with the wider locality teams We will move from multiple interventions from multiple professionals, to more intensive interventions from one care co-ordinator
I want to feel supported by my community and get the most out of services available locally	The rotational staff model will support learning throughout the system, particularly regarding the 'whole population offer' and self care developments The team will work closely with the single point of access and the voluntary sector to identify more local opportunities for support
I want you to put a greater focus on my mental well being	Mental Health services will be closely integrated into the model through a new model sitting between Primary Care and C&I services Increasing numbers of staff will have confidence in responding to mental health issues through training and peer support
I want to feel respected and to feel safe	When patients need ongoing care, they will be discharged effectively from the multi disciplinary teams Safeguarding functions within Islington Council will be integrated into this team, sharing skills and capacity
We will also work with clinicians to develop feedback mechanisms through the MDT approach to care planning.	
What are the key success factors for implementation of this scheme?	
<ul style="list-style-type: none"> • Successful and safe hospital discharge • Timely information flowing through to primary care • Reduction in readmission within 30 days 	

Scheme ref no.
BCF4
Scheme name:
IT interoperability
What is the strategic objective of this scheme?
<p>We are working jointly with Islington Council to jointly procure an Integration engine to allow the sharing of agreed data across health and social care through the development of an integrated digital care record. We aim to procure an IT solution that will allow clear data linkages between primary, secondary and community providers allowing cross clinician view of a patients record. This will give a seamless view of a patient journey across providers via the provision of an integration engine.</p> <p>This data will then feed into the patients PHR (Person Held Record), where the citizen holds and gives consent to sharing their record. It will allow the patient a clear view of their record along with the ability to input into certain areas. As this is a person held record it will travel with the patient across health and social care providers and across geographical boundaries.</p>
Overview of the scheme
<p>Please provide a brief description of what you are proposing to do including:</p> <ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted?
<p>Working with our partners across pathways to provide information in real time that supports and aids clinical decision making in the following programme areas:</p> <ul style="list-style-type: none"> • Urgent care • Integrated care • Primary care • Planned care <p>The solution will initially focus on people in crisis and then those with Long term conditions, rolling out to all people who wish to access their records in Islington.</p>
The delivery chain
<p>Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved</p> <p>Islington CCG working in partnership with London borough of Islington will work together with our providers to deliver the programme. The diagram below shows the providers we work with and how the system will connect together.</p>

Preferred option -3a



The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There are many advantages to investing in this joint project between Islington CCG and Islington Council to deliver inter-operability and a person-held record amongst health and care providers in Islington:

- **PIONEER SITE** – Islington is a pioneer site making it both an exemplar to other CCGs and also a test-bed for collaborative solutions to drive transformation and integration;
- **MOBILE POPULATION** – Islington has a transient population with the highest rate of people under the age of 45 moving in and out of the borough in London, driving the need for common information standards across CCGs;
- **CO-TERMINUS WITH LOCAL AUTHORITY** – Islington CCG and Islington Council have a well-established and long history of joint commissioning across health and social care that has delivered integrated services, giving better outcomes for people in Islington. Both organisations have a track record in delivering efficient and effective services through joint working. Integrated management information will transform the whole system, enabling us to take further steps forward in delivering personal health budgets for people with mental health, continuing health care and value based commissioning.
- **DIVERSE POPULATION** – Around 35% of Islington's population were born outside the UK whilst 20% do not speak English as a first language. Providing online functionality and person-held information helps to increase access to services;
- **INTEGRATED CARE** – This provides the capability to make Integrated Care viable amongst all health care and social care providers.
- **EMPOWERMENT OF PATIENTS AND CITIZENS** – The outcomes of this

project will be to patients and citizens at the centre, enabling them to have control of their record, give consent to share information and to manage their care

- EFFICIENCIES – In times of needing to do more with less, these digital improvements will help integrate health and social care and provide system wide efficiencies and savings.

We have worked together to identify the needs, market test what is possible, benchmark ourselves against neighbouring CCG's and are confident the solution we have specified will deliver the intended objectives.

Failure to act will result in the continuation of the current, inconsistent and manual/ paper-based processes and a missed opportunity to realise the benefits of more efficient working, whilst both organisations will be unsupported to achieve their strategies.

To do nothing would not support the integrated care agenda, release savings and in particular, this would be contrary to Islington's status as a Pioneer site, with the related expectations that it is able to test radical options and can overcome the barriers to delivering co-ordinated care and support.

Furthermore, doing nothing will not support the urgent care agenda by providing the ability to link up across London in the future. Islington CCG and Islington Council will be unable to deliver their work programmes, the outcomes required by the Better Care Fund and aspirations as a Pioneer organisation.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Benefits to Patients at the centre of care:

- Patients empowered to manage their own care and be part of decision-making Improved patient experience;
- Less repetition of health history every time treatment is accessed in different organisations, as up to date information will be available through the data sharing agreements once consent is given;
- Care is co-ordinated between providers giving patients greater reassurance, confidence and trust in the clinicians treating them;
- Greater access to health information, data and knowledge, helping to maintain health and wellness, not just treat illness;
- Improvements in the patient experience due to a reduction in unnecessary admissions and treatment in more appropriate care settings.

Benefits to Clinicians:

- Effective Information Governance ensured;
- Between different provider organisations;
- Between providers and citizens;

- To inform strategic health priorities;
- Better and faster / real time clinical decisions based on richer and more timely information;
- Improved continuity of care across provider organisations.

Improved outcomes

- Reduced prescribing errors;
- Increase safety and reduced risk in relation to vulnerable individuals and children;
- Reduced length of stay due to accurate, up to date information to aid clinical decision making;
- Improved patient outcomes due to improved self-management of post-operative care;

For Islington Integrated Care Pioneer, undertaking this change programme also means being able to deliver the expected benefits from the Work Programmes. For example:

- Urgent Care - Joined up services aiding clinical decision making; reduced errors
- Planned Care - Self-management of health; reduction in tests; reduction in missed appointments (DNAs)
- Integrated Care - improved Care Planning (Health and Social Care); joining-up care outside the borough
- Primary Care - linking across GP systems; reduction in missed GP appointments

We have attempted to quantify financial benefits for implementing a Person Held Record and interoperability in terms of cost efficiency and productivity savings. This high-level analysis is based on published evidence and statistical information for the potential benefits that such functionality can bring and provides a top-down view of the magnitude of benefits that could be achievable.

The indicative high-level financial benefits have been estimated at £14.0m across a 10 year period. These benefits will be realised across a wide number of organisations in the Islington Integrated Care Pioneer, including, General Practitioners and health and social care providers, such as Islington Council.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

A Programme Steering Committee will be formed to oversee the programme, supported by a project team. We will also have a challenge and confirm team made up of independent people from our governing body to provide additional governance.

Benefits realisation plans and risk register will be developed as part of the next phase of the project.

We have patients and clinicians at the centre of our planning, specifying, implementation and evaluation plans who will ensure that what is procured will meet the objectives.

The programme will be independently evaluated after implementation.

What are the key success factors for implementation of this scheme?

- Data moves across health and social care providers automatically to provide information and aid clinical decision making
- Information is provided in real time
- Patients and citizens have control of and access to their record

Scheme ref no.																					
BCF5																					
Scheme name:																					
Social care to benefit health																					
What is the strategic objective of this scheme?																					
This is the £4.822m transfer to adult social care in 2014/15, and £4.822m in 2015/16. This will directly ameliorate the budget reductions to adult social care in 2014/15 and 2015/16 as a result of the reduction in the revenue support grant.																					
Overview of the scheme Please provide a brief description of what you are proposing to do including:																					
<ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted? 																					
This partially supports the core adult social care offer of assessment and care management. This has enabled LB Islington to maintain low levels of delayed transfers of care, and maintain high performance in terms of the number of people still at home 91 days after discharge.																					
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved																					
These are services already commissioned by the London Borough of Islington. This includes domiciliary and residential care, provided through both block and spot contracts. No milestones are associated with this scheme.																					
The evidence base Please reference the evidence base which you have drawn on																					
<ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes 																					
NA																					
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan																					
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below																					
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BCF Metric	Description	Impact																			
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6 (local)	Carer Reported Quality of Life	Low																			
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?																					
NA																					
What are the key success factors for implementation of this scheme?																					
Protection of core social care offer.																					

Scheme ref no.
BCF6
Scheme name:
Developing the Locality Offer
What is the strategic objective of this scheme?
<p>This scheme will facilitate the shift of activity from hospitals to community by creating additional capacity within the Integrated Health and Care Teams and wider community based services.</p> <p>The focus on the investment is:</p> <ul style="list-style-type: none"> • Scaling up what works <ul style="list-style-type: none"> ○ building on our success with Ambulatory Care ○ RAID and Carelink ○ Long term conditions pathways, in particular COPD • Supporting innovation across community provision; <ul style="list-style-type: none"> ○ expanding services for children's community nurses ○ extending scope of community provision eg tissue viability ○ developing initiatives in Primary Care and the Voluntary Sector
<p>Overview of the scheme</p> <p>Please provide a brief description of what you are proposing to do including:</p> <ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted?
<p>We are currently working with providers to scale up existing initiatives which will be detailed in the six month letters.</p> <p>Further scoping is required to sign off the investment plans but work underway now includes:</p> <ul style="list-style-type: none"> • Piloting integrated health and care teams • Expanding ambulatory care to include IV at home • Review of RAID and Carelink • Community geriatricians developing evaluation and new model • Hospital at home service for children • Review of care homes support from primary care to ensure it utilises support from community geriatrician • Expanding initiatives in the community <p>This ICHT pilot will give us a more detailed, local picture of the existing gaps in provision which, if met, would enable us to support more people in the community.</p>
<p>The delivery chain</p> <p>Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved</p>
<p>These services will be commissioned by Islington CCG and by Islington Council. The lead for commissioning these services will be the Integrated Care team at Islington CCG.</p> <p>Providers will include Primary Care, Islington Council (Social Care), Whittington NHS Trust, Camden and Islington NHS Foundation Trust and the voluntary sector and</p>

private sector.
<p>The evidence base</p> <p>Please reference the evidence base which you have drawn on</p> <ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
<p>Detail in attachments:</p> <p>BCF6 (a) – ambulatory care</p> <p>BCF6 (b) – RAID</p> <p>BCF6 (c) – Carelink</p> <p>BCF6 (d) – COPD</p> <p>BCF6 (e) – Tissue viability</p>
<p>Investment requirements</p> <p>Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan</p>
<p>Impact of scheme</p> <p>Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan</p> <p>Please provide any further information about anticipated outcomes that is not captured in headline metrics below</p>
See attached
<p>Feedback loop</p> <p>What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?</p>
All projects are developed with evaluation methods embedded within, the Community geriatrician service is due to be evaluated, from a patient perspective, by Healthwatch in early 2015 for example.
What are the key success factors for implementation of this scheme?
<p>These schemes are designed to:</p> <ul style="list-style-type: none"> • Ensure that people receive care in appropriate settings • Reduce attendance at A&E • Reduce unplanned admissions • Reduce length of stay • Deliver joined up care for individuals • Focus all parts of system together on admission avoidance to hospital and or residential care, early supported discharge and care outside of hospital <p>All these schemes are operational now, so no milestones are included in the descriptors.</p>

Scheme ref no.
BCF6 (a)
Scheme name:
Ambulatory care
What is the strategic objective of this scheme?
Whittington Health is scheduled to open a new ACS centre from start 2014/15, with the aim of reducing length of stay and avoiding A&E attendances and unnecessary admissions by delivering care in a more pro-active and transformational way. The trust is proposing a tariff structure which reflects the pathways that will operate in the new service and valued to share the financial benefits of the new model between the trust and commissioners.
Overview of the scheme Please provide a brief description of what you are proposing to do including:
<ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted?
<p>Excerpt from Whittington Health Business Case</p> <p>The key features of the new adult ambulatory care service are as follows: The service will operate out of a dedicated facility with dedicated staff. The new unit will form a key part of and optimise the 'hot floor' alongside the Emergency Department, Acute Assessment Units and 'hot seat imaging.'</p> <p>The new facility has been designed with the help of patients and staff to provide a treatment space which is practical, appeals to patients and is pleasant for staff;</p> <p>The service is clinically led by Dr Clarissa Murdoch, a geriatrician by background as well as an acute physician; championing the benefits of caring for our complex elderly patients in an ambulatory way. Dr Murdoch is supported by, Dr Nathalie Richard Consultant in Emergency Medicine and GP by background. Such diversity in the clinical leadership of the service ensures that patients across the acute care pathway, regardless of age or presenting condition or complexity can be considered as a suitable candidate for the service. The service is staffed by a senior and experienced team comprising of consultants, medical, surgical and ED registrars, community matrons, senior nurses and HCA's;</p> <p>The service will provide a point of direct telephone contact which the consultant will provide real time management advice to GPs;</p> <p>The service will include supported discharge to the hospital at home service, with direct integrated support from the community nursing teams (Managerially, AEC sits with the Integrated Care and Acute Medicine (ICAM) division within Acute Services). Crucially as an Integrated Care Organisation, this means that Ambulatory Care is managed alongside our Emergency and Community Services by the Head of Acute Services;</p> <p>By diverting activity away from ED, the new service will help us with the achievement of the ED target which in turn will help commissioners achieve their quality bonus;</p> <ul style="list-style-type: none"> • The aim of the new service is to reduce adult emergency admissions trust wide by 11% on a like for like basis, plus potentially a reduction in surgical readmissions, and a further reduction in paediatric admissions.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Excerpt from Whittington Health Business Case

“Being part of an Integrated Care Organisation is at heart of this service already, with community matrons already being a vital part of our core multi-disciplinary team we aim to best serve the resident population of Islington and Haringey. Full expansion of this service will further demonstrate Whittington Health’s commitment to truly integrated acute, community and primary care and collaborative service delivery through providing the physical environment, staffing mix and technology to aid this. We aim to bridge the gap between primary and secondary care”.

The evidence base

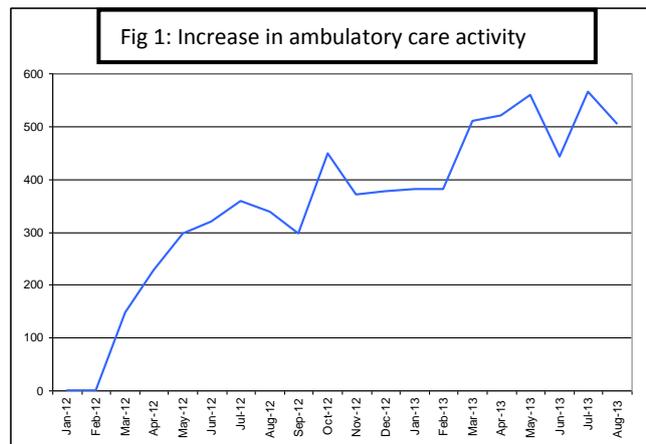
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Excerpt from Whittington Health business case

Overview

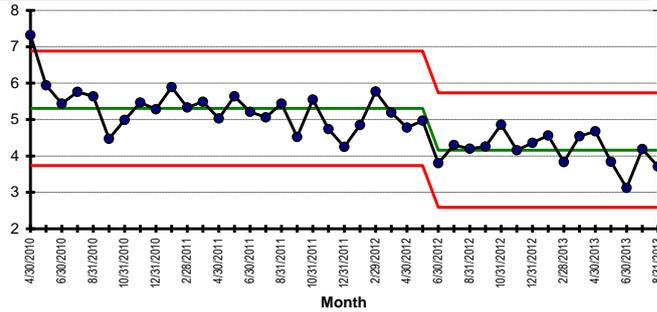
Unlike other AEC services, Whittington Health’s model of care is unique because it is not based on set clinical conditions, but instead is focused on what care is right for the patient and where this care can be delivered. It is a partnership between acute and emergency medicine and will facilitate earlier discharge from the wards as well as relieving pressure from ED by diverting flow away; and has integrated community services in the footprint - community matrons and hospital at home case finders. A service which everyday proves integration of services both throughout the hospital and into the community.



Current model

The current service that runs from three clinical rooms at the front of the Emergency Department has been operational since February 2012. The Monday-Friday service is staffed by 2 doctors and 2 nurses, overseen by the consultant of the day. There is a nurse led service providing treatment continuation at the weekends. The service has a distinctive model of care and is unique in its integrated approach to delivering care. It is a joint initiative between the acute medical and emergency medicine teams. Such diversity in the clinical leadership of the service ensures that patients across the acute care pathway, regardless of age or presenting condition or complexity can be considered as a suitable candidate for the service. There has been a steady increase in ambulatory care attendances since the service launch.

Fig 2: Reduction in length of stay for admissions with ambulatory care sensitive conditions



There has also been a coincident reduction in the average length of stay for non-elective admissions - the reduction in length of stay for ambulatory care sensitive conditions is even more significant.

This fall is in part due to the ambulatory care centre providing a role in supported

discharge including providing the medical cover necessary for community IV antibiotics. The fall is also due to the application of enhanced recovery principles to emergency medicine, and the trust's ability to link directly with community staff to discharge the patient earlier using district nurses to support patients in their own homes.

And whilst trusts across London have seen an increase in their conversion rate from ED to admissions, the Whittington's conversion rate has fallen from 21% to 19% over the last two years.

The role of the community matron as part of the ambulatory care team is key to ensuring a smooth transition for patients from hospital back to the community. The in-reach model sees senior community matrons facilitate early discharge of patients safely back to their homes from ED, ISIS, AAU and other inpatient wards. Adult patients under the care of the AEC will receive on-going assessment, delivery of direct clinical care and evaluation delivered by the community teams, coordinated and led by the AEC community matrons.

This model of care will build on Whittington Health's existing good practice by providing a credible, safe whole systems approach that supports clinical teams to continue to develop new integrated pathways, and ways of working that meets the needs of the patient, commissioners, the wider health and social care system.

The service has recently extended its opening hours, allowing the service to increase capacity to support winter pressures. The service now runs from 9am-8pm on weekdays, and also provides medical capacity at the weekend.

Future model

To establish whether more could be done with ambulatory care, an audit was undertaken of all admissions from ED over a period of a week in March 2013. The audit looked at the patient journeys of 262 patients to ascertain whether patients could have been diverted into AEC with more staffing and physical resources. The results demonstrated that 33% (85 out of 262) of patients would be appropriate for AEC, and of these 93% (78 out of 85) would attend on the same day as their ED attendance and 7% (7 out of 85) would be booked to return the next day. The number of patients identified as high risk of admission equated to 27%.

The audit concluded that scope exists for the service to treat more patients across a wider range of conditions and hence save more admissions, but capability is currently limited by the lack of available space in the area around the Emergency

Department.

The future model will enable the service to meet what is currently unmet demand from existing referral sources including directly from GP's and ED; many of whom will be identified via a new triage system at the 'front of house' in ED. With increased capacity and a more appropriate physical environment, we would look to increase the number of virtual ward patients we look after supported by our community matrons. The consolidation of resources will also allow us to increase our work with surgery, other medical specialities and care of the elderly.

A new triage facility will be implemented at the front of the Emergency Department to stream suitable patients to ambulatory care as swiftly as possible. In addition the MALS front entrance from Magdala Avenue will provide a community facing, direct access point for patients to the unit diverting unnecessary flow from ED.

Services across the acute care pathway will very much work in parallel in the first year because the increase in activity will not be achieved instantaneously. However it is crucial that from quarter two, the pathways across ED, ISIS, ambulatory care and AAU are monitored; with a view to changing the profile of ISIS and the distribution of staff from ED if the anticipated shift in activity is realised.

The relocation and integration of the Dorothy Warren Day Hospital (DWDH) services into the new AEC will not only centralise a lot of similar work, but also will provide the expertise to care for complex elderly patients. As part of the new service, AEC will be the hub of communication and resource for the integrated frailty service. Elderly patients make up the largest group of unplanned admissions, have significantly longer lengths of stay, significantly more adverse events in hospital and there is also evidence of de-compensation associated with hospitalisation.

The DWDH activity is charged as outpatient activity currently and will continue to be charged on the same basis under the new model. The activity reporting and recording will identify DWDH activity separately using a separate clinic code. The volumes associated with DWDH in the new model are shown on page 8.

Therefore, as part of the large-scale AEC service this integrated frailty service will identify patients in ED, from the community via GP, community matrons, teleconferences and JKU wards to provide multi-disciplinary reviews and high risk assessments including therapy input to avoid admissions for complex elderly patients with comprehensive geriatric assessments. The input of the consultant geriatricians will enable the service to work with GP's to flag those patients who are a risk and ensure that they receive the care and treatment that they require as soon as possible.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	High

2	Residential Admissions	Low	
3	Reablement	Low	
4	Delayed Transfers of Care	Low	
5	Patient / Service User experience	High	
6 (local)	Carer Reported Quality of Life	Low	
Feedback loop			
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?			
Monthly monitoring of activity and regular meeting with the Trust to evaluate the efficacy of the new service.			
What are the key success factors for implementation of this scheme?			
Excerpt from Business Case			
<p>1. <i>Ensure no decision about me without me</i></p> <p>Providing a patient-centered service in the right place, at the right time with the right person is what ambulatory care does – making sure that the patient and their regular support network receive the right amount of information and support around their care and treatment. Also working in partnership with colleagues across health and social care to promote independence and self-management where possible.</p> <p>2. <i>Deliver efficient, effective services that improve outcomes</i></p> <p>Nationally, 49 ambulatory care sensitive conditions have been published and used to demonstrate that there are a significant number of patients who can have their care delivered in an ambulatory way which ultimately enables trusts to manage the rise in emergency admissions. Inpatient admission, especially for complex elderly patients, can prove detrimental to health, so providing a solution closer to home has much broader benefits to their health. Providing a ‘hot floor’ service for patients on the acute care pathway provides better experience and outcomes for patients and staff alike.</p> <p>3. <i>Improve the health of local people</i></p> <p>The ambulatory care service will house both adult and paediatric services, providing the best care for all different age groups from young babies to our frail elderly patients. All cohorts of patients may be considered suitable for the services being provided in ambulatory care.</p> <p>4. <i>Change the way we work by building a culture of innovation and continuous improvement</i></p> <p>Already our ambulatory care service is being held up as an exemplar of good practice, and being able to consolidate our resources into a dedicated area will ensure we can continue to develop an excellent service which has already received praise nationally. A service which is transformational in the way that we want to care for our patients and fits perfectly with being part of the integrated pioneer status that Islington CCG is already striving towards.</p>			

Scheme ref no.
BCF6 (b)
Scheme name:
RAID (Rapid Assessment Interface and Discharge)
What is the strategic objective of this scheme?
<p>The RAID model of care provides integrated mental health input into the care of patients at the Whittington Hospital, particularly focusing on improving input to the needs of elderly people. The RAID model is an evaluated model of care (LSE 2011) that is demonstrated to both improve quality of multi-disciplinary care and to deliver cost savings. The aim is to implement this service model in order to replicate the impact of RAID in Islington.</p> <p>The project aims to ensure fast access to appropriate assessment, integrated care, and effective discharge based on an effective multi-disciplinary package of care. Specific areas for improvement will be in case finding, reduction in length of stay; avoidance of admission and reduction of readmission to inpatient care.</p>
Overview of the scheme
<p>Please provide a brief description of what you are proposing to do including:</p> <ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted?
<p>The service will ensure:</p> <ul style="list-style-type: none"> • One point of contact and access for the acute hospital, covering all liaison activity (including substance misuse activity) within the acute Trust. This will ensure consistency of response, as well as opportunities to ensure that a suitably skilled team is available, and for up-skilling in relation to self-harm and overdoses. All cases referred to the service will be assessed. This will include people living outside Islington. • Case finding, linking to existing dementia and alcohol posts. The enhanced resource will enable more assertive case finding as a result of the increased capacity available to enable this to take place. • Every referral in A&E to be seen within one hour and all other referrals seen within 24 hours, with appropriate and timely review, • Advice on alcohol problems, including detoxification and referral to our 'morning after clinic' or other community agencies, • Advice on substance misuse treatment, including methadone maintenance. • Assessment of care needs of older people with mental health problems, • Early detection of mental health problems to enable rapid and appropriate intervention, • Training and support to acute hospital staff on recognition and management of mental health problems • Continuity of care for people already known to mental health services, • Input to discharge planning, and general advice and support • Integrated communication to primary care, using general hospital discharge information (this could be participating as a when appropriate to MDT teleconference in Islington re ongoing management plan.) <p>Specifically, the project offers a comprehensive range of mental health specialities within one multi-disciplinary team, so that all patients over the age of 16 can be assessed, treated, signposted or referred appropriately regardless of age, address, presenting complaint, time of presentation or severity. The service operates 7 days</p>

week. The service will emphasise rapid response, with a target time of one hour within which to assess referred patients who present to A&E and 24 hours for seeing referred patients on the wards. The service will meet the mental health needs of all adult patients in the hospital, including those who self-harm, have substance misuse issues or have mental health difficulties commonly associated with old age, including dementia. It will provide formal teaching and informal training on mental health difficulties to acute staff throughout the hospital. It will also put an emphasis on diversion and discharge from A&E and on the facilitation of early but effective discharge from general admission wards.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The plans have been discussed with the CCG, local GPs and clinicians at Camden & Islington Foundation Trust and Whittington Health.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

RAID evidence demonstrates a benefit:cost ratio of 4:1. This level of benefit will be achieved over a multi-year timescale – and may require risk adjustment as the LSE evaluated RAID model may have started from a lower baseline of integration than is the case in Islington.

The projections of 2014/15 activity are based on data contained in the Whittington Health RAID Project Baseline Data Analysis.

Savings are expected in three areas:

1. Reduction in Average Length of Stay
2. Reduction in Emergency Re-admissions
3. Reduction in Admissions from A&E

The modelling assumptions for the first two are set out below.

Where appropriate an average tariff has been applied to the activity to estimate the financial impact of the proposals. The average tariff is £1980 per spell. Given the short timescale for producing this analysis it was decided that an average tariff should be applied, however, if time permits then the analysis may be revised to a more granular level and the HRG tariff applied.

1. Reduction in Average Length of Stay.
 - The analysis is based on the actual activity for April to October 2014, which was then extrapolated to a full year forecast based on monthly straight line projection (the activity was divided by 7 and multiplied by 12).
 - Only non-elective activity was included in the analysis as the trust has not shared the elective data.
 - The activity and average length of stay were projected for each category of patient, and a 0.5 day reduction in average length of stay applied.
 - From this a bed day reduction was calculated along with a bed reduction based on 365 days of the year and 85% occupancy.
 - Based on the analysis the trust would be able to reduce its bed capacity by over 7.6 beds if the 0.5 reduction in average length of stay was achieved.

- Baseline data at HRG level is needed to enable these savings to be split between Trust and commissioner, with respect to impact on excess bed days / trim point.

Islington						
April to October 2013						
Category	Activity	Bed Days	Avg LoS			
Dementia	318	2626	8.26			
Substance Misuse	418	1797	4.30			
Psychosis	155	793	5.12			
Non-psychosis and Other	502	2191	4.36			
Total	1393	7407	5.32			
2013/14 Forecast						
Category	Activity	Bed Days	Avg LoS	Bed Days Based on 0.5 days Reduction	Bed Day Reduction	Bed Reduction Based on 85% Occupancy
Dementia	545	4502	8.26	4229	272.71	
Substance Misuse	717	3081	4.30	2722	358.57	
Psychosis	266	1359	5.12	1226	133.43	
Non-psychosis and Other	861	3756	4.36	3325	431.00	
Total	2388	12698	5.32	11502	1195.71	3.85
Haringey						
April to October 2013						
Category	Activity	Bed Days	Avg LoS			
Dementia	185	1606	8.68			
Substance Misuse	180	688	3.82			
Psychosis	72	280	3.89			
Non-psychosis and Other	319	1598	5.01			
Total	756	4172	5.52			
2013/14 Forecast						
Category	Activity	Bed Days	Avg LoS	Bed Days Based on 0.5 days Reduction	Bed Day Reduction	Bed Reduction Based on 85% Occupancy
Dementia	317	2753	8.68	2594	159.14	
Substance Misuse	309	1179	3.82	1025	154.43	
Psychosis	123	480	3.89	418	62.00	
Non-psychosis and Other	547	2739	5.01	2466	273.43	
Total	1296	7152	5.52	6503	649.00	2.09
Trust Total						
April to October 2013						
Category	Activity	Bed Days	Avg LoS			
Dementia	576	4864	8.44			
Substance Misuse	851	3369	3.96			
Psychosis	299	1311	4.38			
Non-psychosis and Other	1054	4989	4.73			
Total	2780	14533	5.23			
2013/14 Forecast						
Category	Activity	Bed Days	Avg LoS	Bed Days Based on 0.5 days Reduction	Bed Day Reduction	Bed Reduction Based on 85% Occupancy
Dementia	987	8338	8.44	7844	494.29	
Substance Misuse	1459	5775	3.96	5046	729.43	
Psychosis	513	2247	4.38	1991	256.43	
Non-psychosis and Other	1807	8553	4.73	7649	903.57	
Total	4766	24914	5.23	22530	2383.71	7.68

Reduction in Emergency Re-admissions.

- The analysis is based on the actual activity for April to October 2014, which was then extrapolated to a full year forecast based on monthly straight line projection (the activity was divided by 7 and multiplied by 12).
- A 10% reduction in emergency re-admissions was modelled and this equated to 97 fewer admissions and a reduction of 520 occupied bed days.
- The analysis shows that the trust could reduce its bed base by over 1.6 beds if the 10% reduction was achieved.
- The estimated cost saving of the 10% reduction in re-admissions is c£191k, of which £104k for Islington and £51k for Haringey.

Islington									
April to October 2013									
Category	Activity	Bed Days	Avg LoS	Emergency Re-admissions	Re-admission Bed Days				
Dementia	318	2626	8.26	95	582				
Substance Misuse	418	1797	4.30	75	298				
Psychosis	155	793	5.12	40	206				
Non-psychosis and Other	502	2191	4.36	95	554				
Total	1393	7407	5.32	305	1640				
2013/14 Forecast									
Category	Activity	Bed Days	Avg LoS	Emergency Re-admissions	Re-admission Bed Days	10% Reduction in Emergency Re-admissions	Reduced Re-admission Bed Days	Bed Reduction Based on 85% Occupancy	Cost Saving
Dementia	545	4502	8.26	163	998	16	100		
Substance Misuse	717	3081	4.30	129	511	13	51		
Psychosis	266	1359	5.12	69	353	7	35		
Non-psychosis and Other	861	3756	4.36	163	950	16	95		
Total	2388	12698	5.32	523	2811	52	281	0.91	£ 103,526
Haringey									
April to October 2013									
Category	Activity	Bed Days	Avg LoS	Emergency Re-admissions	Re-admission Bed Days				
Dementia	185	1606	8.68	46	492				
Substance Misuse	180	688	3.82	29	100				
Psychosis	72	280	3.89	17	36				
Non-psychosis and Other	319	1598	5.01	59	288				
Total	756	4172	5.52	151	916				
2013/14 Forecast									
Category	Activity	Bed Days	Avg LoS	Emergency Re-admissions	Re-admission Bed Days	10% Reduction in Emergency Re-admissions	Reduced Re-admission Bed Days	Bed Reduction Based on 85% Occupancy	Cost Saving
Dementia	317	2753	8.68	79	843	8	84		
Substance Misuse	309	1179	3.82	50	171	5	17		
Psychosis	123	480	3.89	29	62	3	6		
Non-psychosis and Other	547	2739	5.01	101	494	10	49		
Total	1296	7152	5.52	259	1570	26	157	0.51	£ 51,254
Trust Total									
April to October 2013									
Category	Activity	Bed Days	Avg LoS	Emergency Re-admissions	Re-admission Bed Days				
Dementia	576	4864	8.44	157	1192				
Substance Misuse	851	3369	3.96	128	460				
Psychosis	299	1311	4.38	74	272				
Non-psychosis and Other	1054	4989	4.73	205	1112				
Total	2780	14533	5.23	564	3036				
2013/14 Forecast									
Category	Activity	Bed Days	Avg LoS	Emergency Re-admissions	Re-admission Bed Days	10% Reduction in Emergency Re-admissions	Reduced Re-admission Bed Days	Bed Reduction Based on 85% Occupancy	Cost Saving
Dementia	987	8338	8.44	269	2043	27	204		
Substance Misuse	1459	5775	3.96	219	789	22	79		
Psychosis	513	2247	4.38	127	466	13	47		
Non-psychosis and Other	1807	8553	4.73	351	1906	35	191		
Total	4766	24914	5.23	967	5205	97	520	1.68	£ 191,438

Reduction in Admissions from A&E

- The Birmingham model (where RAID staff intervened with patients at the MAU before being admitted to the wards) showed a 3% reduction in admissions.
- Islington RAID staff intervenes at A&E rather than MAU. Further baseline data is needed to model the relevant patient cohort through A&E, MAU and admissions to define the expected reduction and quantify savings.

Islington has applied a robust risk adjustment to the modelled savings. Collaborative work is needed in 2014/15 to establish quality benefits and savings for both Trust and commissioners.

Impact on WH Contract value in 14/15: £75k in-year, with a view to the service being self-funding (£250k pa) by year end.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Moderate
2	Residential Admissions	Low
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	Moderate
6 (local)	Carer Reported Quality of Life	Low

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Islington has applied a robust risk adjustment to the modelled savings . Collaborative work is needed in 2014/15 to establish quality benefits and savings for both Trust and commissioners.

What are the key success factors for implementation of this scheme?

Reduction in admissions and better patient and professional experience are the two key outcomes

Scheme ref no.
BCF6 (c)
Scheme name:
Carelink
What is the strategic objective of this scheme?
Carelink will provide a rapid response, quick access, extended hours Reablement type service for Islington residents or camden residents with an Islington G.P.
Overview of the scheme Please provide a brief description of what you are proposing to do including: <ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted?
<p>Patients over the age of 18 who either live in Islington, or who have an Islington GP and live in Camden. Referrals are accepted from Whittington and UCL Hospital Emergency Departments only.</p> <p>Acceptance criteria</p> <ul style="list-style-type: none"> • Population covered is as above • Patients will have capacity to accept and engage with the service, and have active goals appropriate for a Reablement type service • Patient is assessed by hospital staff as safe for discharge home with provision of any appropriate equipment from hospital, support from Carelink and any other services arranged by the hospital (e.g. District Nursing) • Patient is able to manage toileting needs at night with the support of appropriate equipment • Patient is able to transfer with equipment and with the assistance of maximum 1 person • Patient is able to manage nutritional requirements safely as assessed by appropriate hospital staff (assessed by SLT/Dietician for swallowing difficulties or OT/Nurse for nutritional needs) <p>Exclusion criteria</p> <ul style="list-style-type: none"> • Patients under 18 • Patients lacking capacity to accept and engage with the service • Patients not living in Islington or registered with an Islington GP • Patients requiring medical treatment that would require an admission • Patients requiring double-handed visits, or assistance from more than one person to transfer • Patients with mental health or dementia needs that prevent their engagement with Carelink <p>Carelink will provide patients with a structured reablement programme to improve independence, well-being and choice for those referred from Emergency Departments at Whittington and UCL Hospitals.</p> <p>The intervention will be a Reablement type care package for up to 10 days. The intervention will consist of up to four visits per day from Carelink staff supporting people with regaining independence in daily tasks like personal care, managing medication, supporting therapy exercises and interventions, cooking, dressing, shopping and housework.</p>

Service Description

Carelink is a Reablement type service. This involves interventions in the patients home to include

- Help with washing and dressing
- Help with medication
- Help with meal preparation
- Help with cleaning, shopping and laundry

The intention is for Carelink to work with patients to improve their confidence and independence in these areas.

Carelink can provide up to four calls per day. These calls will normally be for one hour from one care worker at a time. As much as possible, Carelink will try to provide calls at the time requested by the patient, and will aim to provide consistency in carers

Pathway

Carelink will accept referrals from Whittington and UCL Hospital Emergency Departments. Referrals will be accepted on paper and then acceptance will be confirmed by Carelink telephoning the ward to agree a start time.

Carelink will accept referrals from **Monday – Friday, 9am-8pm** and **Saturday-Sunday 9am-3pm**. Carelink will respond to faxed or email referrals within 30 minutes by calling the ward to agree the referral, reject the referral or request further information.

A copy of the referral form is included as appendix 1. The referral form is intended to be brief to facilitate rapid referrals. The referral form is to be given to the patient to act as an initial care plan. The referral form contains a timetable for visits and the outcomes expected from the Carelink intervention.

If accepted onto the service, Carelink will be able to start the first care visit within two hours from accepting the referral.

Once accepted onto Carelink, Carelink will provide full care co-ordination and case management for the patient. This will provide the patient with a single point of contact to resolve issues relating to health and social care. This will include, as a minimum,

- Telephoning Islington's Reablement service on the first working day following the start of the Carelink intervention to get any relevant history
- Regularly reviewing the patient's needs and adapting the care plan as appropriate. The intention is that for many patients, the involvement of Carelink will be reduced over the 10 days. This regular review process will involve feedback from Carelink workers and telephone calls or home visits with the patient and their carers.
- Working with the patients and carers to make changes to the schedule as required
- Responding to emergencies, such as 'no replies'

- Supporting the patient with interactions with other services, such as district nursing, by chasing up referrals, sharing information and co-ordinating care
- Identifying additional needs as required and referring on to other services
- Planning with the patient for their discharge from Carelink.
 - For patients where their needs can be resolved in 10 days or less, Carelink will work with the patient to identify when the service is no longer required and provide appropriate signposting to support in Islington, such as Age UK Enablement services.
 - For patients who are going to need support for longer than ten days, Carelink will, at an early stage, identify those patients and start discussion with Islington's Reablement service. Carelink will agree an appropriate transfer date with Reablement and provide a comprehensive handover to the Reablement team.

Where patients have an Islington GP but live in Camden, Carelink will arrange handover to the appropriate local authority support. This will need to be identified early during the Carelink intervention.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Carelink will need to develop effective working relationships with a variety of services and providers in Islington. This includes referrers at UCL and Whittington Hospitals, community providers including Whittington Health (District Nurses, REACH teams, specialist nursing teams) and Primary Care, London Borough of Islington's Reablement service as the main contact for onward social care / Reablement referrals, and the voluntary sector, primarily Age UK's Community Enablement service.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

- Relevant local strategies include Islington Joint Health and Wellbeing Strategy (2013), Islington CCG Care Closer to Home Strategy (2012), Islington CCG Urgent Care Strategy (2011) and the Joint Adult Commissioning Strategy (2012)
- National Service Framework for Older People 2001
- Community Care (Delayed Discharges etc) Act 2003
- Our Health, Our Care, Our Say (White Paper 2006)
- Maximising the Potential of Reablement, SCIE (2013)
- National Audit of Intermediate Care, NHS Benchmarking (2013)
- Intermediate Care: Halfway Home, DoH, 2009
- Ready to Go? Planning the discharge and transfer of patients from hospital and intermediate care, DoH 2010
- The Short Term Outcomes and Costs of Home Care Reablement Services, University of York, 2009

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Moderate
2	Residential Admissions	Low
3	Reablement	moderate
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	High
6 (local)	Carer Reported Quality of Life	Low

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Carelink will report on the following activity and quality indicators. Due to the pilot nature of this service, reports will be provided monthly direct to Islington Commissioners and no performance targets are being set beyond the process detailed in the specification as above.

At the end of the pilot period, Carelink and Islington Commissioners will meet to review the work.

What are the key success factors for implementation of this scheme?

- To reduce hospital usage for appropriate patients at Emergency Departments at Whittington and UCL Hospitals.
- To increase independence by providing short term Reablement services (up to 10 days) for people at home following an attendance at the Emergency Department
- To identify, refer and work with appropriate health and social care interventions during the Reablement period and to discharge to appropriate required interventions
- To improve the patient and carer experience within the target group during the hospital admission and after
- To improve identification of appropriate patients at the Whittington and UCL Hospitals Emergency Departments

Scheme ref no.
BCF6 (d)
Scheme name:
COPD Pathway
What is the strategic objective of this scheme?
An admission avoidance scheme based on the whole COPD pathway which focuses on improving the care given in primary care and community, including the delivery of the Acute Exacerbation COPD pathway
Overview of the scheme Please provide a brief description of what you are proposing to do including: <ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted?
Various elements of the whole pathway should impact upon reduction of emergency admissions including: <ul style="list-style-type: none"> • COPD Locally Commissioned Service for GP practices • Education for primary care clinicians to improve skills • Community nurse clinics • Regular home oxygen reviews • Pulmonary rehabilitation for patients to improve self-management • Acute exacerbation pathway which helps to support patients at home when they are experiencing an exacerbation rather than be admitted to hospital (target time for first contact = 4 hours, up to 6 visits at home). <p>The above initiatives are well established and continuing into 2014-15. CCG implementation of Map of Medicine should see greater use of community pathways including COPD in 2014-15 and support this reduction in emergency admissions.</p>
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Discussions have taken place between CCG and GPs, Community Respiratory Team and Whittington Health
The evidence base Please reference the evidence base which you have drawn on <ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Excerpt from: http://www.londonhp.nhs.uk/wp-content/uploads/2011/06/COPD-profile-Islington.pdf Emergency admission rates are significantly higher than the national average. Residents in Islington are more than three times as likely to be admitted for COPD as residents in the local authority with the lowest admission rate. The proportion of registered COPD patients admitted to hospital is also significantly above average. <ul style="list-style-type: none"> • Once admitted for COPD, patients from Islington spend significantly longer in hospital than other patients in England; over four days more than the local authority with the shortest length of stay. • Readmission rates within 90 days of an emergency admission for COPD are statistically similar to the national average. However, almost 40 percent of

Islington patients admitted to hospital for COPD return within 90 days.

- The high emergency admission rates are coupled with significantly high mortality rates; Islington residents are over five times as likely to die

Expected impact on providers

COPD Summary (5% reduction)	NEL	Short Stay	Total
Barts	£1,037	£0	£1,037
Homerton	£3,183	£726	£4,230
Other	£308	£0	£308
Royal Free	£572	£0	£588
UCLH	£31,858	£1,391	£34,528
Whittington	£27,770	£0	£29,423
North Mid	£40	£0	£40
BCF	£214	£0	£214
Grand Total	£64,982	£2,117	£67,099

The following HRG codes are expected to be impacted – worked example based on Whittington Health:

NEL

HRG Code	Reduction in activity	Savings
DZ21A	10.08	£6,139.9
DZ21J	4.08	£10,792.2
DZ37A	0.48	£301.1
DZ21H	2.64	£8,895.6
DZ21E	0.12	£463.0
DZ21K	0.60	£1,177.9
Grand Total	18.00	£27,769.70

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Moderate
2	Residential Admissions	Low
3	Reablement	Low
4	Delayed Transfers of Care	Low

5	Patient / Service User experience	Moderate	
6 (local)	Carer Reported Quality of Life	Low	
Feedback loop			
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?			
Islington has applied a robust risk adjustment to the modelled savings . Collaborative work is needed in 2014/15 to establish quality benefits and savings for both Trust and commissioners.			
What are the key success factors for implementation of this scheme?			
Patient Safety	Improves patient safety by ensuring appropriate clinical reviews and follow ups, support at home to manage conditions and avoid admissions		
Clinical Effectiveness	Care given in accordance with NICE guidance, reviews to ensure clinical effectiveness of care		
Patient experience	Improving patient experience by providing care closer to home and avoiding admissions, teaching self-care		
Workforce	Support to community and primary care from secondary care consultants improves skills and supports better community and primary care workforce.		

Scheme ref no.
BCF6 (e)
Scheme name:
Tissue Viability & Catheter Care
What is the strategic objective of this scheme?
This pilot aims to test a service model for the management of leg ulcers, urethral catheters and central venous catheters by the Tissue Viability (TV) and District Nursing Service (DNS) in Islington
Overview of the scheme Please provide a brief description of what you are proposing to do including:
<ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted?
<p>Previously, the remit of the DNS covered housebound patients only; ambulant patients were expected to be seen in general practice by practice nurses. Wounds such as leg ulcers are however difficult to manage in general practice because of the level of knowledge and expertise required, and the majority of practice nurses do not have the skills to undertake urethral or supra pubic catheterisation or the management of central venous catheters. This project transferred ambulant patient caseload activity to the TV and DNS. The aim was for the service to cover a caseload of approximately 90 patients in the first instance moving to cover an additional 200-300 in forecast unmet need following a survey conducted by primary care.</p> <p>The project has piloted a roll out of additional skills to the DN team to enable 24/7 care of patients with catheter issues (urinary and central venous line), and to support care of ambulatory leg ulcer patients. The expanded skill set enables rapid healing and faster discharge.</p>
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Discussions have taken place between CCG and GPs, Community Respiratory Team and Whittington Health
The evidence base Please reference the evidence base which you have drawn on
<ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
<p>Expected outcomes are:</p> <ul style="list-style-type: none"> • Reduced attendances at A&E for catheter related problems • Reduced emergency admissions for catheter, leg ulcer and cellulitis problems • Improved patient experience • Accelerated healing of ulcers <p>The expected level of reduction is</p> <p>30% reduction for catheter related admissions. *15% reduction for Cellulitis related admissions *15% reduction for Leg Ulcer related admissions. *The Whittington has had its figures risk adjusted to 8.5%</p>

Admission Avoidance (Leg Ulcers, Cellulitis, Catheters)

Projected 2014-15

Costs (Pre QIPP)

Provider	Catheter		Cellulitis		Leg Ulcers		All	
	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost
RAL	1	1274	11	47285	5	43655	17	£92,214
RKE	19	17758	115	239950	12	35038	146	£292,747
RRV	8	9369	59	137154	6	22935	73	£169,458
Grand Total	31	£30,915	213	£472,084	29	£122,229	273	£625,229

Projected 2014-15

Savings

Provider	30% Catheter		15% Cellulitis (Whittington 8.5%)		15% Leg Ulcers (Whittington 8.5%)		All	
	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost
Royal Free	0	382	2	7093	1	6548	3	£14,023
The Whittington	6	5327	10	20396	1	2978	16	£28,701
UCLH	2	2811	9	21945	1	3670	13	£28,425
Grand Total	8	£8,520	21	£49,433	3	£13,196	32	£71,150

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Moderate
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4	Delayed Transfers of Care	Low
5	Patient / Service User experience	High
6 (local)	Carer Reported Quality of Life	Low

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Islington CCG is awaiting data from Whittington Health to demonstrate quality and financial returns on investment. It is intended to renew the pilot for an additional year, following which a full evaluation will be conducted at end 2014/15. The intention is that the project should become self-funding at end of 2014/15 from savings.

What are the key success factors for implementation of this scheme?

Please refer to section on 'evidence base'

Scheme ref no.
BCF7
Scheme name:
Improving Access to Primary Care
What is the strategic objective of this scheme?
<p>To build on the first year of the access scheme which supported practices to develop their systems of work to improve patient access and experience, and reduce use of alternate sources of primary care urgent care (A&E, Urgent care Centres, Walk In Centres), for conditions suitable for primary care response.</p> <p>To provide additional capacity for booked appointments for Islington registered patients outside core hours</p> <p>To help practices respond to pressures and demands with additional capacity</p> <p>Medium Term:</p> <p>To support practices to prepare to respond to expected demands such as the developing London Wide Standards for Primary Care</p> <p>To enable a more localised system of primary care urgent care</p>
Overview of the scheme
<p>Please provide a brief description of what you are proposing to do including:</p> <ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted?
<p>Practices will be incentivised to provide additional working hours outside contracted opening, offering booked appointments to their registered patients. The number of hours will be proportional to their list size. These hours will be in addition to any currently offered by the Extended Hours DES. If all practices take up the scheme, an additional 120+ hours will be available. Appointments will be made available with registered primary care health professionals. Practices will be required to demonstrate that the offered hours have taken into account patients views.</p>
The delivery chain
<p>Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved</p>
<p>The service will be commissioned by Islington CCG using established governance processes for approval, and performance and payment routes in use with the remaining LCS programme.</p> <p>The service will be provided by Islington GP Practices. There are no alternative providers for this service as it requires access to both patient medical histories, and the registered patient list. The service is also a direct extension of the GMS core functions, although contractually outside this arrangement</p>
The evidence base
<p>Please reference the evidence base which you have drawn on</p> <ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
<ul style="list-style-type: none"> • The need for additional primary care capacity is well evidenced as a means to reduce reliance on secondary care or other sources of urgent care. • The methodology is established within the Extended Hours DES which has

<p>been established for over 5 years and demonstrated to work well</p> <ul style="list-style-type: none"> The practicality and deliverability is supported by the Local Medical Committee The need for additional capacity in primary care was supported by all practices as part of the July Pan Islington Forum 																					
<p>Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan</p>																					
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<p>The outcome measures are an extension of the Year 1 Improved Access LCS</p> <ul style="list-style-type: none"> Reduced attendance at A&E for 'minor' issues during GP practice opening hours Increased satisfaction shown in the IPSOS Mori bi-annual patient survey Measured opening hours from participating practices Number of used appointments from participating practices 																					
<p>What are the key success factors for implementation of this scheme?</p> <ul style="list-style-type: none"> Increased opening / availability of primary care in Islington Reduced attendance at A&E for 'minor' issues during GP practice opening hours Increased satisfaction shown in the Ipsos Mori bi-annual patient survey Development of a locality based service for urgent primary care from October 2016 																					

Scheme ref no.																					
BCF8																					
Scheme name:																					
Develop primary care capacity to support localities																					
What is the strategic objective of this scheme?																					
The strategic objective is to support the development of capacity within primary care that will be able to manage more patients in the community.																					
Overview of the scheme Please provide a brief description of what you are proposing to do including:																					
<ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted? 																					
We want to support primary care to develop a locality based collaborative model, creating benefits across the system for patients, providers and commissioners.																					
This key structural work will support improvements for all patients registered with Islington CCG.																					
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved																					
The Islington CCG commissioners will continue to support Primary Care across Islington.																					
The evidence base Please reference the evidence base which you have drawn on																					
<ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes 																					
The King's Fund ⁸ have set out expected benefits from federated models as																					
<ul style="list-style-type: none"> • strengthen clinical governance and improve the quality and safety of services • develop training and education capacity • strengthen capacity of practices to develop new services out of hospital • make efficiencies and economies of scale • improve local service integration 																					
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⁸ <http://www.kingsfund.org.uk/topics/commissioning/primary-care-toolkit>

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Patient surveys and complaints are the key means by which we have a feedback loop on success

What are the key success factors for implementation of this scheme?

Success factors include:

- more efficient mechanism for commissioning with a range of practices
- working collectively to agreed standards will lead to improved patient outcomes and experience
- creating a more sustainable model of primary care at a time of increased pressure and expectation

Scheme ref no.
BCF9
Scheme name:
Develop Preventative Services
What is the strategic objective of this scheme?
To reduce the number of preventable emergency A&E admissions in Islington's older population (over 65) through the delivery of a range of public health/social care services that address the main causes/risk factors of emergency A&E admissions.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
<p>There are a number of preventative services in Islington that contribute towards managing the main risk factors that are responsible for a large proportion of A&E admissions, including: excess cold (including fuel poverty and poor insulation), respiratory illness (including flu and pneumonia) and falls in the home. The scheme intends to improve the links between these services, offering greater integration of care for residents/service users and the ability to manage multiple risk factors simultaneously.</p> <p>The prevention offer will also include an additional scheme which intends to improve the proportion of people with learning disabilities that complete a health check. This will directly contribute to reducing emergency A&E admissions through the development of individual health action plans that address the main causes of admissions in this population group.</p> <p>As well as immediate prevention for A&E admissions, the aim is to build capacity within the community which, over a longer period of time, would support communities to manage and maintain their health and wellbeing. This would create a strong network that local people, particularly those who are from traditionally deprived communities in the borough, can access, thus offering a life course approach to support.</p> <p>The scheme comprises:</p> <ul style="list-style-type: none"> • SHINE – a single point of referral into a wide range of interventions (including those that address excess cold, fuel poverty, fire safety, falls assessment, enablement and befriending services) • Residential environmental health – targets the vulnerable residents in the private rental sector working with tenants and landlords to improve safety in the home and address insulation and excess cold issues • COPD housebound stop smoking service – offers a home based smoking cessation service for people with COPD • Winter well campaign – pro-active contract service that targets vulnerable residents over 75. The project acts as an extension to SHINE to residents that may not be aware of the existing referral systems. The programme will also promote flu and pneumococcal vaccination uptake among the eligible population. • Enablement service – an enablement and befriending service that forms part of the reablement pathway

<ul style="list-style-type: none"> • Community wellbeing project – this project is in partnership with Islington Giving and is being delivered by Help on Your Doorstep in the New River Green estate. The project has four key elements: <ul style="list-style-type: none"> ○ Research and insight with local community into their needs and skills ○ Design with local community ○ Delivery by local community ○ Evaluation with local community • Community co-ordination – to provide a way that the wellbeing work with the local community is supported, does not take place in silos and can be measured. Through the integrated care programme we are currently developing an approach which will commission, co-ordinate, monitor and evaluate the community wellbeing projects and programmes through a third sector organisation.
<p>The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved</p>
<p>Commissioners sit across Public Health and Social Care. Providers include:</p> <ul style="list-style-type: none"> • SHINE –delivered by Islington Council • Residential environmental health –delivered by Islington Council • COPD –delivered by Whittington Health • Winter well Campaign –previously provided by Age UK Islington • Enablement - delivered by Age UK Islington • Community wellbeing project – delivered by Help on Your Doorstep • Community co-ordination – provider to be identified
<p>The evidence base Please reference the evidence base which you have drawn on</p> <ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
<p>Local hospital and A&E data indicates that 15% of emergency admissions are linked to accidents and 12% are related to respiratory illnesses. Residents aged 85+ have the highest admission rate and almost 70% result in a hospital admission. A&E admission data indicates a seasonal trend, with increased rates during winter.</p> <p>The second highest rate of ambulatory care sensitive emergency hospital admissions in Islington are as a result of COPD (after admissions for influenza and pneumonia). These are admissions that could be avoided by better identification and management of COPD in primary care, including stop smoking services.</p> <p>Pressures in secondary services are expected to increase rapidly due to an aging population, people living longer and in some cases, living longer with long term conditions. Although Islington has a relatively young population compared to the England average, evidence suggests that the use of emergency services and secondary care services by this population group will continue to grow.</p> <p>The University of Birmingham published a policy paper highlighting the “10 high impact” changes related to prevention that should be embedded in older people’s services to reduce demand for secondary services (Allen and Glasby 2010). The majority of the ten high impact recommendations target the main causes of</p>

emergency admissions in Islington and include: promoting healthy lifestyles, vaccination programmes, falls prevention, housing adaptations, reablement services and partnership working.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Low*
2	Residential Admissions	Low*
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	Moderate
6 (local)	Carer Reported Quality of Life	Moderate

* We are expecting this work to take some time demonstrate impact, but will expect Moderate impact in the longer term

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The existing schemes have established evaluation pathways and the scheme would seek to use the information collected via these evaluations. This would include:

- Uptake and quit rate of COPD home based stop smoking service
- Referrals managed by SHINE service and what intervention(s) those referrals received
- Uptake of flu and pneumococcal vaccination programmes
- Process evaluation information from residential environmental health

Service user experience surveys are included in the evaluation of the COPD services
Community wellbeing project will create a full report of the qualitative data from research phase of the project and final evaluation

What are the key success factors for implementation of this scheme?

- Reduction in A&E admissions linked to respiratory illness and external causes in people aged 85+
- Increased cross referral between the projects
- Increased uptake of flu and pneumococcal vaccination programme
- Improvement of wellbeing score
- Attendance at-number of people at engagement events, community support or community projects
- Patient experience feedback on community projects

Scheme ref no:
BCF10
Scheme name:
Incentivising acutes to deliver change
What is the strategic objective of this scheme?
<p>We aim to commission services across the care pathway to deliver value and improve outcomes for our patients. Commissioning in this way will realign services to provide a more holistic journey for patients built around their needs rather than those of the service providers. It will transfer expertise out of the acute setting and into community based integrated practice units where other diabetes related services are co-located thereby reducing secondary acute activity.</p> <p>This project aims to develop and implement a new contract & funding model of diabetes and also mental health service provision specifically aligned to the achievement of both clinical and patient related outcomes. The VBC integrated practice unit model will be contracted through a different contracting model e.g lead provider with a payments being made based on the achievement of outcomes, in addition to activity and processes.</p> <p>This is one of a range of projects which will contribute to and support the overall BCF target of reducing secondary care admissions and attendances by 3.5%.</p>
Overview of the scheme
<p>Please provide a brief description of what you are proposing to do including:</p> <ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted?
Diabetes
<p>Current provision of diabetes services is delivered by a myriad range of providers with differing agendas - it is fragmented and does not directly address the needs of patients with diabetes.</p> <p>Value-based health care is about developing a shared common purpose to achieve the best possible outcomes for patients per pound spent. Developing a shared common goal unites the interests of all - patients, commissioners, providers - in support of a sustainable and high quality health care system. Value is defined from the perspective of the patient, and depends on results or outcomes that matter to patients, rather than inputs or volume of services delivered. Historically, care has been organised and paid for around volume of services delivered, rather than value.</p> <p>The new model of service provision will take the form of an integrated practice unit which brings together all aspects of diabetes care to be provided under a new contracting model which co-locating services in hubs which will provide a better, more integrated service for patients offering rapid access to specialist care, ease of referral through a single point of access and extended hours (8am – 8pm). The scope of the service includes all areas of care for patients with type 1 and type 2 diabetes in Islington and Haringey, providing care is specifically related to diabetes.</p> <p>Outcomes are condition-specific around groups of patients with similar needs, multidimensional, and include results which matter to patients. Existing approaches to health outcomes measurement have been limited mainly to things within one</p>

dominant provider's control. This has tended to reinforce existing 'silos' of care. The expected benefits of a value-based approach are improvements in outcomes that matter to groups of patients with similar needs, for no greater cost to deliver. In addition, this approach drives different providers to work together to better coordinate care for patients, improving their experience and outcomes. Where such an approach has been implemented, as in stroke care across London, measurable improvements in outcomes have been achieved.

Mental health

People who live with psychosis (clusters 10-17) experience inequitable access to physical health services and massive health inequality, dying up to 25 years younger than fellow citizens. The comorbid physical and mental health needs of this cohort are not given equal importance and attention by all health care providers. There are significant whole system costs to not treating comorbid severe and enduring mental illness and long term conditions, that could be ameliorated by reducing unplanned care and increasing preventative interventions e.g. earlier diagnosis and self-management. The scope will cover people with Psychosis in HONOS-Pbr clusters 10-17, provides an opportunity to

- Improve the experience of service users as described by the outcomes produced by the ERG
- to improve physical health outcomes for people in the clusters with comorbid Long Term Conditions (LTC)
- Increase life expectancy for those with a SMI
- to provide a mechanism for acute, community, primary care and mental health providers to work together to improve outcomes for people with psychosis
- to provide a large enough cohort (approx. 3,400 in Islington and 3,100 in Camden) in order to change the way service are commissioned through a new IPU.
- to provide truly integrated care

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Diabetes IPU will be commissioned jointly by Haringey and Islington CCGs. We have been working with University College Hospital London, Whittington Health and North Middlesex Hospital, along with our GP providers, public health, patients and carers and council.

The mental health IPU is being developed jointly by Camden and Islington CCGs. We are working with Camden and Islington Mental Health Foundation Trust, University College Hospital London, Whittington Health and Royal Free and Central North West London Trust, along with our GP providers, public health, patients and carers and council.

The following are key milestones

- Outline business case approved by October 2014
- Full business case approved by January 2014
- Implementation by April 2015

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Published evidence for value based commissioning schemes is in its infancy however the acknowledged guru is Professor Michael Porter some of whose work is outlined below:

- A review of value-based commissioning in mental health – NHS Midlands and East – 2013 Emma Perry, Jo Barber and Elizabeth England
- Value-Based Health Care – HBC October 2012 Michael Porter
- The Strategy That Will Fix Healthcare – HBC October 2013
- What is Value in Healthcare? – New England Journal of Medicine
- Great Western Hospital: High risk Pregnancy Care – HBC January 2013 (revised) Michael Porter

Through the developmental work that Islington and Haringey CCGs are undertaking with this project we expect to become pioneers for future value based commissioning service models and to be the source of evidence based best practice. We are supported by Outcomes based Healthcare and Cap Gemini who provide expertise on the principles and model of value based commissioning.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

We will be expecting providers to work together in a different way to provide joined up, integrated and seamless care for patients and that the health and well-being of our local population will improve as a result of commissioning in this way.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

We worked with patients, carers and clinicians across the pathways to identify the outcomes that are important to them. The achievement of the agreed patient centred outcomes is key to the success of the service and will be strictly measured. The provider will be paid on achievement of the outcomes. The financial model is currently in development. The approach we have taken has been to:

- Identify and agree scope and cohort of patients within the project
- Identify and agree outcomes
- Review and agree measures
- Identify and agree measurement tools to be used to measure the outcomes

The table below lists the outcomes expected for the diabetes pathway

1. Mortality

5. Outcomes related to Clinical Outcomes/Complications:

1a. A measure of mortality rate	5a. Lower limb amputation/PVD A measure of lower limb amputation /PVD rate
1b. A measure of premature mortality rate: years of life lost	5b. Preventable blindness A measure of preventable blindness / retinopathy
2. Health related Quality of Life	5c. Renal Disease A measure of renal disease
2a. A measure of quality of life	5d. Stroke (CVA) A measure of stroke
3. Outcomes related to Symptom Control (e.g. hypoglycaemia, lethargy):	5e. Heart attack (MI) A measure of MI
3a. Symptom-free A measure of symptom control	5f. Erectile Dysfunction A measure of erectile dysfunction
3b. Symptom recognition A measure of the recognition of high/low blood sugar	6. Amount of time out of normal routine
4. Patient Identified Outcomes	6a. Disruption A measure of disruption by care to life
4a. Control A measure of feeling in control of diabetes	6b. Impact on people around me A measure of whether family/carers are supported
4b. Confidence A measure of feeling confident in managing diabetes	7. Experience of Care/Treatment Process:
4d. Support A measure of feeling supported in managing health	7a. Care Coordination A measure of feeling that care is more coordinated
4e. Fear/anxiety A measure of feeling free from fear/anxiety	7b. Access A measure of timely and organised access to services
4f. Happiness/Mood A measure of mood	7c. Right person, right time A measure of feeling that I can access the right person/service at the right time
4g. Self-management: Monitoring A measure of being able to monitor diabetes	7d. Planned Care A measure of feeling involved in care planning
4i. Self-management: Understanding A measure of being able to understand how to manage diabetes	8. Clinical Outcomes/Complications over time (i.e. delayed onset)
4j. Self-management: Managing A measure of how to feel more able to self-manage diabetic care	8a. Amputation/PVD A measure of the onset of amputation/PVD
	8b. Preventable blindness A measure of the onset of preventable blindness
	8c. Renal Failure A measure of the onset of renal failure

	8d. Stroke (CVA) A measure of the onset of stroke
	8e. MI A measure of the onset of MI
What are the key success factors for implementation of this scheme?	
<ul style="list-style-type: none"> • Integration and fluid movement across a whole system pathway • Patients reporting satisfaction with a more integrated service which is flexible and attuned to their needs. • Fewer attendances and admissions to A&E • Patients reporting better ability to self-manage their condition • More patients being managed in primary care • Higher numbers of patients undertaking self-management programmes • Staff reporting improvement in ways of cross agency working • Shorter waiting times for support services • Providers working collaboratively • Ability to measure outcomes as well as current processes and activities 	

Scheme ref no.
BCF11
Scheme name:
Reablement
What is the strategic objective of this scheme?
To provide supported discharge from acute and institutional settings, and to prevent admission to acute and institutional settings, through the timely provision of reablement and rehabilitation support.
Overview of the scheme Please provide a brief description of what you are proposing to do including:
<ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted?
Reablement; intermediate care beds; specialist rehabilitation.
Reablement is an established intervention. We have some innovative aspects to our reablement service, including pharmacy input to support optimal medication concordance and mental health nursing to lead on reablement for people with dementia.
Reablement is open to all adults who would benefit, though the service is largely delivered to older adults.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
These services are currently commissioned through a pooled budget managed under the S75 between Islington CCG and the Council. The reablement and rehabilitation services are provided by Whittington Health and the Council via a provider S75 agreement. Bed-based intermediate care services are provided by a number of external providers.
The evidence base Please reference the evidence base which you have drawn on
<ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
The current reablement and rehabilitation services support low rates of delayed transfers of care, and high performance in relation to numbers of people still at home 91 days after discharge. Reablement is recognised as an effective intervention by SPRU/PSSRU research as outlined by SCIE. ⁹
It is recognised that the services need to increase productivity in order to meet increased demand within the current cost envelope, and better support the 3.5% admissions avoidance target. Analysis and modelling of the services is currently underway. This is a partnership approach between commissioners and providers.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

⁹ <http://www.scie.org.uk/publications/briefings/files/briefing36.pdf>

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Low
2	Residential Admissions	Moderate
3	Reablement	High
4	Delayed Transfers of Care	Moderate
5	Patient / Service User experience	Low
6 (local)	Carer Reported Quality of Life	Low

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Reablement currently monitor outcomes in terms of patient experience and satisfaction through exit surveys. Quantifiable data is gathered by discharge destination and reductions in support required. We participate in the National Audit for Intermediate Care which allows benchmarking against other Reablement organisations.

What are the key success factors for implementation of this scheme?

Not applicable - reablement is an established intervention in Islington, which has been operating for several years. There are no milestones associated with this scheme.

Scheme ref no.
BCF12
Scheme name:
Carers Funding
What is the strategic objective of this scheme?
To better support carers in Islington by identifying, valuing and supporting their key role across the whole system.
Overview of the scheme Please provide a brief description of what you are proposing to do including:
<ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted?
<p>We know that carers are under-identified, and are also less likely to make effective use of health and social care support. This project seeks to both increase formal identification of people who are carers, and once identified, to support them through the health and care system to ensure their needs are best met.</p> <p>We have a strong offer for carers, but too often these services are not accessed at the right time. A key metric for Islington's BCF is 'Carer Reported Quality of Life' – ASCOF 1D. This service will directly seek to improve that metric.</p> <p>Islington Carers Hub service will continue to support carers to maintain and improve their health and wellbeing through the range of services offered by the Hub and through their partners. The Hub model is based on a single point of access which means that carers know where to go and will get accurate and timely information and advice. Carers will also be signposted accordingly for more specialised advice, information, support and other universal services through the work developed and pathways established with partners, including partners in the primary and secondary care setting. Identification of hidden carers is key to supporting carers to maintain and improve their health and wellbeing and thereby sustain their caring role. The Census tells us there are over 16,000 carers in the borough, the hub currently has a membership of over 1000 carers. The outreach and engagement role of the Hub will support organisations to develop innovative ways to identify carers and establish good practice. There is a target of identifying 150 hidden carers in 2015/16. This number is planned to grow year on year through embedding good policies and practices across partners and within the Hub service itself.</p>
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
<p>Islington has a long standing pooled budget for carers services, held between Islington CCG and Islington Council, and funding a variety of services for carers, including the local Carers Hub and Carers Breaks.</p> <p>Carers UK are the provider of the Carers Hub which will be used as the main vehicle for increasing carer support</p>
The evidence base Please reference the evidence base which you have drawn on
<ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
National Carers Strategy 2011

Islington Joint Commissioning Strategy 2012-17

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Low
2	Residential Admissions	Moderate
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	Low
6 (local)	Carer Reported Quality of Life	High

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

We already have a carers pathway group, made up by carers. This group feeds into project design, development and feedback

What are the key success factors for implementation of this scheme?

Islington Carers Hub service will contribute to the following outcomes measured as part of the carers offer:

- Carers are supported to maintain or improve their health and wellbeing
- carers will be able to access a range of services through the hub
- carers know where to go for information and advice
- carers are supported in their caring role
- carers can take up opportunities that they may have been excluded from because of their caring responsibilities
- carers can participate in their local communities including social and leisure opportunities

The Carers Hub is an established intervention in Islington. There are no milestones associated with this scheme.

Scheme ref no.																				
BCF 15.12																				
Scheme name:																				
Support mitigating pressures in health care for both people with learning disabilities and older people																				
What is the strategic objective of this scheme?																				
To mitigate the increase in NHS Funded Continuing Health Care pressures.																				
This will ensure that the S75 pooled learning disability budget, which is hosted by the local authority, does not lead to additional pressures on local authority budgets. It will enable the successful completion of the Winterbourne View action plan in Islington, which has already been successful in moving the majority of people in assessment and treatment centres into less restrictive and more appropriate settings.																				
Overview of the scheme																				
Please provide a brief description of what you are proposing to do including:																				
<ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted? 																				
£1m will be used to offset increases in demographic demand in the Learning Disabilities S75 pooled budget (where an increase in numbers of people eligible for continuing healthcare has increased significantly). £400k will be used to offset the increased demand for continuing healthcare support for older people.																				
The delivery chain																				
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved																				
Continuing healthcare services are delivered via the Continuing Healthcare framework contract.																				
The evidence base																				
Please reference the evidence base which you have drawn on																				
<ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes 																				
<ul style="list-style-type: none"> • Numbers of people eligible for continuing healthcare in Islington • Pressures identified on existing budgets. • The drive to support increased numbers of people with more complex needs at home as a result of the Winterbourne View action plan 																				
Investment requirements																				
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan																				
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BCF Metric	Description	Impact																		
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5	Patient / Service User experience	Low																		

6 (local)	Carer Reported Quality of Life	Low
<p>Whilst this scheme will have considerable impact for the patients and carers it works with, the overall impact will be low due to the numbers of people involved.</p>		
<p>Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?</p>		
<ul style="list-style-type: none"> • S75 governance meetings • Winterbourne View action plan (reported to CCG Governing Body, and HWBB) 		
<p>What are the key success factors for implementation of this scheme?</p>		
<ul style="list-style-type: none"> • Continued effective oversight of CHC pooled budgets through existing arrangements <p>The CHC pooled budget is an established intervention in Islington. There are no milestones associated with this scheme.</p>		

Scheme ref no.																							
BCF14 and 15																							
Scheme name:																							
Protection of Adult Social Care: <ul style="list-style-type: none"> • Protect the provision of adult social care services for those with moderate needs • Protection of Adult Social Care in the context of increased demographic pressure 																							
What is the strategic objective of this scheme?																							
<ul style="list-style-type: none"> • Continuation of meeting people's needs before they become critical, therefore reducing pressure on more intensive services • Mitigating the demographic increase in the demand on social care services, which is above and beyond the increase in demand due to the Care Act, and which needs to be met within the context of a reduced budget. 																							
Overview of the scheme Please provide a brief description of what you are proposing to do including: <ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted? 																							
Islington aims to continue to provide social care services to those with a level equivalent to the current FACS Moderate. This supports the prevention of more acute needs developing, and therefore ameliorates pressure on health services.																							
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved																							
These are services commissioned by the London Borough of Islington. This includes domiciliary and residential care, provide through both block and spot contracts.																							
The evidence base Please reference the evidence base which you have drawn on <ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes 																							
The demographic investment required to enable the sustainable provision of adult social care is based on modelling by LB Islington, and takes into account the need to efficiencies.																							
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5	Patient / Service User experience	Moderate																					
6 (local)	Carer Reported Quality of Life	Low																					

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Making it Real Board

What are the key success factors for implementation of this scheme?

That eligibility is maintained and that Islington residents who need support can access it in a timely way.

This is an established intervention, with funding to protect existing services. There are no milestones associated with this scheme.

Scheme ref no.																					
BCF16																					
Scheme name:																					
Community Capacity Capital Grant																					
What is the strategic objective of this scheme?																					
The Local Authority has received the ring fenced capital programme funding from the Department of Health's Community Capacity Grant fund to support the development of specific adult social care initiatives.																					
Overview of the scheme Please provide a brief description of what you are proposing to do including:																					
<ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted? 																					
The funding will be used to provide further investment in IT systems development to support the implementation of the Care Act changes, for the refurbishment and development of in-house daycare services.																					
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved																					
These are services delivered directly by the London Borough of Islington.																					
The evidence base Please reference the evidence base which you have drawn on																					
<ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes 																					
Draft guidance and regulations for the Care Act 2014																					
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan																					
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below																					
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Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?																					
NA																					
What are the key success factors for implementation of this scheme?																					
NA																					

Scheme ref no.																					
BCF17																					
Scheme name:																					
Disabled Facilities Grant																					
What is the strategic objective of this scheme?																					
Existing capital transfer to the local authority. The Disabled Facilities Grant has conditions set elsewhere which will form the basis for this scheme.																					
Overview of the scheme Please provide a brief description of what you are proposing to do including:																					
<ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted? 																					
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N/A																					
What are the key success factors for implementation of this scheme?																					
N/A																					

Scheme ref no.
BCF18
Scheme name:
Support Implementation of the Care Act
What is the strategic objective of this scheme?
Support the Implementation of the Care Act
Overview of the scheme Please provide a brief description of what you are proposing to do including:
<ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted?
<p>Islington is well-placed to implement the requirements of the Care Act, having established a number of key requirements, such as a deferred payments scheme, a joint transition team, a comprehensive offer for carers, and a strong track record of personalisation. However, there will be an expected increase in demand due to self-funders and more family carers coming forward for assessment. We are currently quantifying this demand using local market intelligence and the tools shared by the national joint programme team. As reflected in the London Councils and ADASS response to the draft guidance and regulations, there remains a risk that any calculation of additional demand can be an approximation only, and more demand than expected might be experienced.</p> <p>In addition, there are two prisons in Islington, and there could be significant additional demand on the Council depending on the final requirements of the final guidance and regulations expected in October 2014.</p> <p>It is recognised that the final guidance and regulations of the Care Act 2014 will not be published in time for the submission of the Better Care Fund templates. Therefore, there might be additional demands in the final guidance that have not been accounted for in this plan.</p>
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A sub-group of the Moving Forward Programme Board, the Care Act Implementation group, is overseeing this work, and is chaired by the Service Director for Adult Social Care.
The evidence base Please reference the evidence base which you have drawn on
<ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Draft guidance and regulations for the Care Act 2014
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Low
2	Residential Admissions	Low
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	Moderate
6 (local)	Carer Reported Quality of Life	Low

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

A sub-group of the Moving Forward Programme Board, the Care Act Implementation group, is overseeing this work, and is chaired by the Service Director for Adult Social Care.

What are the key success factors for implementation of this scheme?

A clear programme approach, with identified legal, finance and communications support.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Islington
Name of Provider organisation	The Whittington Hospital NHS Trust
Name of Provider CEO	Simon Pleydell
Signed on his behalf by	Siobhan Harrington, Deputy Chief Executive
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	2013/14 Outturn	9697
	2014/15 Plan	9547
	2015/16 Plan	9399
	14/15 Change compared to 13/14 outturn	-1.51%
	15/16 Change compared to planned 14/15 outturn	-4.63%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	146
	How many non-elective admissions is the BCF planned to prevent in 15-16?	438

Table 1: Schemes aligned to deliver BCF Non-Elective reductions

Scheme	14/15 (1 Quarter)		15/16 (3 Quarters)	
	ACT	COST	ACT	COST
Children's services - Hospital at Home	12	£34,456	37	£103,368
COPD	5	£6,942	14	£20,827
District nursing and leg ulcers	4	£7,175	13	£21,526
*Ambulatory Care Service	116	£137,271	349	£411,812
Carelink	9	£16,615	26	£49,845
	146	£202,459	438	£607,378

Outturn figures are taken from MAR returns which were submitted as part of the CCG operating plan; they have then been aligned with additional BCF requirements.

BCF scaled from 14/15 QIPP to project 15/16 position.
QIPP schemes and BCF are built in to 14/15 contract baselines

*The Ambulatory Care Service business case supplied by the Whittington had a 958 Non-Elective admission target. This has been risk adjusted.

For Provider to populate:

	Question	Response
1.	Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?	We agree that the data in terms of a reduction in non-elective admissions is in line with commissioners' assumptions.
2.	If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?	
3.	Can you confirm that you have considered the resultant implications on services provided by your organisation?	We continue to work through and consider the implications on services provided by our organisation. As an integrated care organisation we are identifying the benefits on community service provision of the local BCF plans.

Name of Health & Wellbeing Board	Islington
Name of Provider organisation	University College Hospital NHS Trust
Name of Provider CEO	Sir Robert Naylor
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	2013/14 Outturn	7431
	2014/15 Plan	7316
	2015/16 Plan	7202
	14/15 Change compared to 13/14 outturn	-1.55%
	15/16 Change compared to planned 14/15 outturn	-1.55%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	37
	How many non-elective admissions is the BCF planned to prevent in 15-16?	11

Table 1: Schemes aligned to deliver BCF Non-Elective reductions

Scheme	14/15 (1 Quarter)		15/16 (3 Quarters)	
	ACT	COST	ACT	COST
Children's services - Hospital at Home	9	£27,927	28	£83,781
COPD	4	£8,312	12	£24,937
District nursing and leg ulcers	3	£7,106	10	£21,319
Ambulatory Care Service	16	£24,634	49	£73,901
Carelink	4	£7,666	12	£22,997
	37	£75,645	111	£226,934

Outturn figures are taken from MAR returns which were submitted as part of the CCG operating plan

BCF scaled from 14/15 QIPP to project 15/16 position.
QIPP schemes and BCF are built in to 14/15 contract baselines

For Provider to populate:

	Question	Response
1.	Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?	<p>We support the BCF schemes as ones that will support reductions in emergency admissions. We feel the proposed reductions are highly ambitious and will require successful implementation of significant service redesign to enable the health economy to deliver them. We are committed to working closely with Whittington Health as the provider for community services in enabling these plans to be successful.</p> <p>UCLH have undertaken extensive work assessing re-admissions in the past and this has historically shown that over 80% of 30 day re admissions were in fact clinically appropriate. We are currently undertaking a programme of work to re-evaluate this over the next few months.</p> <p>Investment in COPD, Heart failure and Frailty with a view to radically changing current pathways is critical and UCLH are currently working collaboratively with Islington and Whittington Health to make this possible.</p>
2.	If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?	
3.	Can you confirm that you have considered the resultant implications on services provided by your organisation?	We are fully supportive of the target reduction levels. While this represents lost activity and income, we incur income penalties in relation to much of the targeted activity, either through the emergency marginal rate or through readmissions penalties. Reductions in targeted emergency admissions will also support us in our search for additional capacity due to rising demand in other parts of our clinical workload.

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Report of: **Director of Public Health**

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	15 October 2014	Item	All

Delete as appropriate		Non-exempt	
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SUBJECT: PHARMACEUTICAL NEEDS ASSESSMENT

1. Synopsis

This is Islington Health and Wellbeing Board's (HWB) first Pharmaceutical Needs Assessment (PNA) under new regulations and requirements. The PNA regulations require that each Local Authority HWB publish a PNA covering their area. The HWB is responsible for the following:

- Publishing the first PNA by 1 April 2015, ensuring that all required information and assessments are included;
- Ensuring an up-to-date map of services is included in the assessment;
- Publishing any statements or revisions within 3 years of the previous publication;
- Ensuring that other HWBs have access to the PNA;
- Consulting stakeholders and other areas about the content of the assessment for the minimum 60-day period;
- Responding to a consultation from a neighbouring HWB;
- Ensuring that once published, the PNA is kept up-to-date and any supplementary statements or full revisions are published as soon as possible following any changes.

Islington's PNA also included a comprehensive analysis of the health needs of the population at a locality level, qualitative research with local residents to better understand their views of pharmacy services, and a thorough assessment of each pharmacy service using service data to determine any gaps.

Overall, the assessment determined that Islington's population has sufficient provision of pharmaceutical services to meet the health needs of the population.

At this stage, a final draft PNA has been produced by the PNA Steering Group. Once approved by the HWB, the mandatory 60-day consultation will take place. The consultation will run from October 2014 to December 2014, with exact dates to be confirmed. Communications will be sent out to raise awareness of the consultation, and the consultation documents will be available on the Council website for downloading.

2. Recommendations

The Health and Wellbeing Board is asked to:

- APPROVE the draft PNA, prior to launching the mandatory 60-day consultation period.

3. Background

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the requirements of the PNA, as well the process for market entry of pharmacies into an area. The PNA, as part of this process, assesses the need for pharmaceutical services in Islington's population, identifying any gaps in service delivery and any areas for improvement. The PNA will be used by NHS England when determining whether to approve applications for pharmacies in the area to join the pharmaceutical list, and to inform NHS England's commissioned services.

Previously, PNAs were the responsibility of Primary Care Trusts (PCTs) to produce. The first PNAs were published in 2005, as the basis for deciding market entry of pharmacies to PCTs. The publication of the White Paper *Pharmacy in England: Building on strengths – delivering the future* proposed a review of the requirements of PNAs in order to make the process more robust, and make PNAs more effective in assessing the need for services. The Health and Social Care Act (2012) transferred this responsibility to local authority Health and Wellbeing Boards (HWBs), and further widened the scope of the PNA.

4. Key findings

The assessment has determined that Islington's population has sufficient provision of pharmaceutical services to meet the health needs of the population.

Islington has a similar rate of community pharmacies per 100,000 residents to the London average and there is at least one pharmacy in most wards of the borough, and a late opening pharmacy in three localities. Resident engagement has showed that pharmacies were generally viewed positively, with pharmacists viewed as professional, knowledgeable with regular pharmacy users in particular commenting that they highly value the support and personal service that they receive at pharmacies. However, there is scope for more work to improve awareness of the services offered by pharmacies, as well as improving their accessibility for people with mobility needs.

Data analysed indicates that the current demand for essential services is being met and there would be capacity, on average, to meet any increased demand for prescriptions that might arise over the next few years as a result of inward migration and an increase in the prevalence of long term conditions.

Within the context of the PNA, areas where improvements can be made in order to maximise the potential of community pharmacies in helping Islington's population stay healthy were identified. These are:

- Improving the awareness of available pharmacy services
- Improving the awareness of longer opening hours
- Addressing the areas where pharmacies can increase the provision of key public health programmes

These recommendations should also be reviewed by the commissioners responsible for the service, in order to determine ways in which pharmacy services could be improved in general.

5. Implications

5.1. Financial implications

None identified.

Any improvement recommendations should not cause a pressure for the council and should be carried out, if applicable, within available resources.

5.2. Legal Implications

Section 128A of the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 transferred the responsibility for publishing and updating a statement of the needs for pharmaceutical services of the population in its area, referred to as Pharmaceutical Needs Assessments ("PNAs"), from PCTs to Health and Wellbeing Boards.

Regulation 5 of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 specifies that each Health and Wellbeing Board must publish its first PNA for its area by 1 April 2015. The PNA will require board-level sign-off and a period of public consultation beforehand.

Failure to produce a robust PNA could lead to legal challenges because of the PNA's relevance to decisions about commissioning services and new pharmacy openings. PNAs must be aligned with other plans for local health and social care, including the Joint Strategic Needs Assessment (JSNA).

5.3. Equalities Impact Assessment

As this is a needs assessment, equalities were included in assessing pharmacy services. Protected characteristics were also considered, as required by the regulations.

5.4. Environmental Implications

The report will be available online, with printed versions only on request, as required by the regulations.

6. Conclusion and reasons for recommendations

The Health and Wellbeing Board is asked to:

- APPROVE the draft PNA, prior to launching the mandatory 60-day consultation period.

Background papers: None

Attachments: Islington Pharmaceutical Needs Assessment

Final Report Clearance

Signed by



23 September 2014

.....
Director of Public Health

.....
Date

Received by

.....
Head of Democratic Services

.....
Date

Report author: Dalina Vekinis, Senior Public Health Information Analyst
Camden and Islington Public Health

Tel: 020 7527 1237

Fax:

E-mail: dalina.vekinis@islington.gov.uk

Islington Pharmaceutical Needs Assessment 2015

Islington Health and Wellbeing Board

April 2015

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1. EXECUTIVE SUMMARY

This is Islington Health and Wellbeing Board's (HWB) first Pharmaceutical Needs Assessment (PNA) under new regulations and requirements. The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the requirements of the PNA, as well the process for market entry of pharmacies into an area. The PNA, as part of this process, assesses the need for pharmaceutical services in Islington's population, identifying any gaps in service delivery and any areas for improvement. The PNA is designed to inform commissioning decisions by Local Authorities (LAs) and Clinical Commissioning Groups (CCGs). The PNA will be used by NHS England when determining whether to approve applications for pharmacies in the area to join the pharmaceutical list, and to inform NHS England's commissioned services. The PNA will also be used as part of Islington's JSNA to inform future commissioning strategies.

Community pharmacies have a pivotal role to play in improving the health and wellbeing of the local population and it is important that opportunities to do this are fully realised to ensure a well-functioning local health economy which addresses residents' needs. To ensure that our community pharmacies are as effective as possible in meeting the health and wellbeing needs of Islington's population, this assessment has taken multiple data sources, information and resident and health professional views into account to present a complete picture of need and provision in Islington, identifying where we can make improvements to reduce health inequalities and improve health outcomes for our population.

1.1. Summary of the needs of the Islington population

Islington has a diverse resident population, with larger proportions of both younger people and minority ethnic groups than the overall London population. Islington also has one of the most deprived populations in the country, with the North locality being particularly deprived. Over 38,000 residents have a diagnosed long term condition, many have more than one condition, and it is estimated that the prevalence is actually much higher, with around 46,000 more long term conditions undiagnosed in the population.

1.2. Summary of the assessment of pharmaceutical services

The assessment has determined that Islington's population has sufficient provision of pharmaceutical services to meet the health needs of the population.

With 45 pharmacies overall, Islington has a similar rate of community pharmacies per 100,000 residents to the London average (21 pharmacies). One of the pharmacies in Islington is on a '100 hour' contract, providing coverage early in the morning and late at

night. There is at least one pharmacy in most of the borough's wards, and three of the localities have a late opening pharmacy. Resident engagement has highlighted that work could be done to improve the accessibility of some pharmacies for those who use a wheelchair or need a seat while waiting.

The average number of items dispensed per pharmacy in Islington is lower than most other boroughs. The low average per pharmacy suggests that current demand for essential services is being met and there would be capacity, on average, to meet any increased demand for prescriptions that might arise over the next few years as a result of inward migration and an increase in the prevalence of long term conditions.

Each commissioned service offered by Islington's pharmacies was assessed in this PNA to determine any gaps, and whether the service is necessary or relevant to meet the pharmaceutical needs of Islington's population¹. The table below summarises the assessment of each type of service provided by community pharmacies (essential, advanced, enhanced and locally commissioned)². Note that gaps in locally commissioned services are not used as a basis for market entry, but that filling these gaps is important in further improving the health and wellbeing of Camden residents.

The gaps in provision should be reviewed by the commissioners responsible for commissioning the respective services, to ensure high quality service provision and to identify opportunities for improved health and wellbeing outcomes for Islington.

1.3. Summary of pharmacy users' views of pharmaceutical services

In the focus groups with Islington pharmacy users, pharmacies were generally viewed positively, with pharmacists considered as professional and knowledgeable, with regular pharmacy users in particular commenting that they highly value the support and personal service that they receive at pharmacies.

The work also highlighted that some residents felt that they could not access a local, late night pharmacy, and in some cases would have to travel outside of the borough to use a pharmacy. Conversations also arose in focus groups where it emerged that some service users had been offered, or used, services that other people were not aware of, for example repeat prescriptions and text reminders; so there may be scope for more work to improve awareness of the services offered by pharmacies.

¹ Necessary and relevant services are defined in Section 2.3.

² Essential, advanced, enhanced, and locally commissioned services are defined in Section 2.5.

Table 1.1: Summary of assessment of pharmaceutical services, by type of service

	Assessment of service	Gaps identified
Essential services		
Mandatory services (for example dispensing, support for self-care, and disposal of unwanted medicines)	Necessary service	<ul style="list-style-type: none"> None identified; provision is suitable for current population and projected demographic changes. An increase in the impact of health promotion campaigns, perhaps through co-ordination with local work, would broaden the reach of public health interventions and services.
Advanced services		
Medicines Use Reviews (MUR)	Necessary service	<ul style="list-style-type: none"> There is limited provision after 7pm. On Sundays, most pharmacies offering this service are closed. Eligibility: The national three month rule may result in people who could benefit from the scheme being not being able to access this service who may otherwise benefit.
New Medicine Service (NMS)	Necessary service	<ul style="list-style-type: none"> There is limited provision after 7pm.
Appliance Use Reviews (AUR)	Relevant service	<ul style="list-style-type: none"> No participating pharmacies in Islington, and no need identified.
Stoma Appliance Customisation (SAC)	Relevant service	<ul style="list-style-type: none"> No participating pharmacies in Islington, and no need identified.
Enhanced services		
Minor Ailments Scheme (MAS)	Necessary service	<ul style="list-style-type: none"> Limited provision at weekends currently, but demand is constrained by existing 'voucher scheme'.
Medicines Reminder Devices	Relevant service	<ul style="list-style-type: none"> Access is limited on Sundays.
Seasonal 'flu vaccination	Relevant service	<ul style="list-style-type: none"> Overall, vaccination rates below national targets but they are similar to London average.

	Assessment of service	Gaps identified
Locally commissioned services		
Stop smoking service	Relevant service	<ul style="list-style-type: none"> There is limited provision of the service outside of standard working hours (9am-7pm).
Screening service (Health Checks)	Relevant service	<ul style="list-style-type: none"> Islington is already a high performer for Health Check delivery, but there may be scope for the already-commissioned pharmacies to increase the number delivered.
Emergency hormonal contraception service	Relevant service	<ul style="list-style-type: none"> Pharmacy provision is not uniform across the borough, with lower provision in the South West where teenage conception rates are highest. Availability is limited on weekends, due to restricted opening hours.
Needle syringe exchange service	Necessary service	<ul style="list-style-type: none"> Access is limited on Sundays, throughout the borough.
Supervised consumption service	Necessary service	<ul style="list-style-type: none"> Access is limited on Sundays, throughout the borough. On weekdays, only five pharmacies provide the service outside of standard working hours (9am-7pm).
Anticoagulation service	Relevant service	<ul style="list-style-type: none"> No gaps identified.
Palliative care medicines service	Relevant service	<ul style="list-style-type: none"> No gaps identified.

1.4. Wider recommendations

Within the context of the PNA, areas where improvements can be made in order to maximise the potential of community pharmacies in helping Islington's population stay healthy were identified. These are:

- Improving the awareness of available pharmacy services
- Improving the awareness of longer opening hours
- Addressing the areas where pharmacies can increase the provision of key public health programmes

These recommendations should also be reviewed by the commissioners responsible for the services, in order to determine ways in which pharmacy services could be improved in general.

Within the current health landscape, there is a responsibility to bring together organisations responsible for providing health services to local residents, and making sure that the offer is appropriate to need. The HWB is ideally placed to drive this change, improving the health and wellbeing and extending the life expectancy of Islington's population.

FOR CONSULTATION

2. INTRODUCTION

This is Islington Health and Wellbeing Board's (HWB) first Pharmaceutical Needs Assessment (PNA) under the new regulations and requirements, mapping our assessment of the need for pharmaceutical services in Islington. As set out in regulations, the PNA will be used by NHS England as the basis for determining market entry for new pharmacies in the area. The London Borough of Islington (LBI) and Islington Clinical Commissioning Group (CCG) will also use this assessment of need to plan pharmaceutical services for Islington's population, where they have commissioning responsibilities.

As a valuable and trusted public health resource with millions of contacts with the public each day, community pharmacy teams have the potential to be used to provide services out of a hospital or general practice environment and to reduce health inequalities³. In addition, community pharmacies are an important investor in local communities through employment, supporting neighbourhood and high street economies, as a health asset and as a long term partner with other local health services. To ensure that our community pharmacies are as effective as possible in meeting the needs of Islington's population, this assessment has taken multiple data sources, information and views into account to present a complete picture of need and provision in Islington, identifying where we can make improvements to reduce health inequalities and improve health outcomes for our population.

2.1. Background to the PNA

PNAs are designed to inform commissioning decisions by Local Authorities (LAs) and Clinical Commissioning Groups (CCGs). In addition, PNAs will be used by NHS England when deciding if new pharmacies are needed in the area and to make decisions on which NHS funded services need to be provided by local community pharmacies. The PNA will also be used as part of Islington's Joint Strategic Needs Assessment (JSNA) to inform future commissioning strategies.

Previously, PNAs were the responsibility of Primary Care Trusts (PCTs) to produce. The first PNAs were published in 2005, as the basis for deciding market entry of pharmacies to PCTs. The publication of the White Paper *Pharmacy in England: Building on strengths – delivering the future* proposed a review of the requirements of PNAs in order to make the process more robust, and make PNAs more effective in assessing the need for services. The Health and Social Care Act (2012) transferred this responsibility to local authority HWBs, and further widened the scope of the PNA.

³ "Healthy lives, healthy people", the public health strategy for England (2010)

Box 2.1: Health and Wellbeing Boards

Islington's HWB brings together key partners from various organisations relevant to health and care, to ensure services are available (commissioned) to the population of Islington across health, public health and social care to improve the health and wellbeing of the local population, and reduce health inequalities. Members include representatives from Islington CCG, LBI, Islington Healthwatch and Islington's voluntary and community sector. More information about the HWB can be found on Islington Council's website: <http://www.islingtonccg.nhs.uk/about-us/health-and-wellbeing-board.htm>

2.2. Duty of the HWB

The PNA regulations require that each Local Authority HWB publish a PNA covering their area. The HWB is responsible for the following:

- Publishing the first PNA by 1 April 2015, ensuring that all required information and assessments are included;
- Ensuring an up-to-date map of services is included in the assessment;
- Publishing any statements or revisions within 3 years of the previous publication;
- Ensuring that other HWBs have access to the PNA;
- Consulting stakeholders and other areas about the content of the assessment for the minimum 60-day period;
- Responding to a consultation from a neighbouring HWB;
- Ensuring that once published, the PNA is kept up-to-date and any supplementary statements or full revisions are published as soon as possible following any changes.

2.3. Minimum requirements for the PNA

The PNA regulations set out the minimum information that should be included in the report. A statement of the needs of the following must be included:

- **Necessary services:** services that are required to meet the pharmaceutical needs of the population. This includes current and future needs.
- **Relevant services:** services that improved pharmaceutical services in the area, including access to services. This includes current provisions and any gaps in future provision.
- **Other NHS services:** pharmacy services provided by other organisations such as the Local Authority, NHS England or the CCG, which impact on the need for pharmacy services in the area. Services of this type would improve pharmacy services, including access.

- How the assessment was carried out, including:
 - How localities were determined
 - How different needs of the localities were taken into account
 - How different needs of people with a protected characteristic were taken into account
 - A report on the consultation

- A map of showing the premises at which pharmaceutical services are provided.

2.4. The scope of the PNA

Identifying whether services fall within the scope of the PNA depends on who is providing the service, and what is provided.

The content of PNAs is set out in regulations published nationally⁴ and includes an obligation to assess all services “provided under arrangements made by the NHS Commissioning Board (NHSCB)”. This includes the provision of pharmaceutical services by a person on a pharmaceutical list (i.e. on the NHS England approved pharmacy list), providing pharmaceutical services under a Local Pharmaceutical Service (LPS) scheme, and / or the dispensing of drugs or appliances by a dispensing doctor.

The needs assessment should take different type of pharmacy services (essential, advanced and enhanced) and pharmacy contractors (community pharmacies or dispensing appliance contractors) into account, in relation to current and future need.

For this PNA, we have defined the scope as follows:

- a) Providing pharmaceutical services by a person on a pharmaceutical list is the **dispensing service**. The dispensing service covers the supply of medicines ordered on NHS prescriptions, and information and advice on their use to patients and carers, and the maintenance of appropriate records. This PNA will assess whether Islington’s population has adequate access to dispensing services, based on where services are provided and other factors.⁵

- b) The **dispensing of appliances** and provision of Appliance Use Review (AUR) service and Stoma Appliance Customisation Service (SAC). For the purposes of this PNA, we will assess whether patients have adequate access to these services. Other services that appliance contractors provide are outside the scope of the PNA. There are no pharmacies in Islington which are also dispensing appliance

⁴ NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013, available at <http://www.legislation.gov.uk/uksi/2013/349/contents/made>

⁵ http://psnc.org.uk/wp-content/uploads/2013/07/service20spec20es12020dispensing20_v1201020oct2004_.pdf

contractors. There are no standalone appliance dispensing services outside of community pharmacies. More information about these services is given in Section 2.5.

- c) For community pharmacies, the scope of this assessment is broad and covers a wide range of services offered. **Essential, advanced and enhanced** services provided under the terms of services for the pharmaceutical contractor are part of the scope. A definition of each type of service is given in Section 2.5.

Box 2.2: What should a good PNA cover? ⁶

The PNAs should meet the market entry regulations.

PNAs should include pharmacies and the services they already provide. These will include dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users.

It should look at other services, such as dispensing by GP surgeries, and services available in neighbouring HWB areas that might affect the need for services in its own area.

It should examine the demographics of its local population, across the area and in different localities, and their needs. It should also look at whether there are gaps that could be met by providing more pharmacy services, or through opening more pharmacies. It should also take account of likely future needs.

The PNA should contain relevant maps relating to the area and its pharmacies.

Finally, PNAs must be aligned with other plans for local health and social care, including the JSNA and the Joint Health and Wellbeing Strategy.

2.5. Pharmaceutical services: types of services covered

2.5.1. Pharmacy contractors

Essential services

For pharmacy contractors, essential services (as set out in the 2005 NHS regulations) include the following:

- Dispensing medication and actions associated with dispensing (e.g. keeping accurate records)
- Repeatable dispensing
- Disposal of waste medicines
- Promotion of healthy lifestyles
- Prescription linked interventions

⁶ <http://www.rpharms.com/promoting-pharmacy-pdfs/nhs-reforms---pnas-for-local-authorities---jan-2013.pdf>

- Public health campaigns (up to 6 campaigns per year)
- Signposting
- Support for self- care

All pharmacy contractors must provide the full range of essential services, as mandated by the NHS regulations. The provision of these services will be assessed at the Essential Services level.

Advanced services

There are four advanced services that form part of the regulations covering NHS community pharmacies. Pharmacies who wish to provide any of these services need to meet minimum criteria, published in national guidance. The advanced services covered are shown below alongside a brief description:

Medicines Use Reviews (MUR)	A medicine use review is conducted by an accredited pharmacist with patients on multiple medications. These can be for patients with diagnosed long term conditions, e.g. diabetes, or patients who GPs or pharmacies feel would benefit from having medications explained to them.
New Medicine Service (NMS)	This service is aimed at people with long term conditions with newly prescribed medications to improve adherence, leading to better health outcomes.
Appliance Use Reviews (AUR)⁷	These reviews, conducted by a pharmacist or a specialist nurse, are designed to improve a patient's knowledge of their appliance. It includes establishing the way a patient uses their appliance and advising on storage, disposal and use of the appliance.
Stoma Appliance Customisation (SAC)⁸	The aim of this service is to ensure that patients with more than one stoma appliance have comfortable fitting stoma and are aware of their proper use.

There are 42 pharmacies in Islington that provide one or more advanced services out of a total of 45 pharmacies. A full breakdown is available in Appendix A. There are limits to the number of MURs and AURs that a pharmacy can undertake, but no limit for SACs.

⁷ An 'appliance' is a medical device such as an inhaler, wound drainage pouch, or catheter.

⁸ A stoma is a temporary or permanent body opening, either natural or surgically created, which connects a portion of the body cavity to the outside environment to allow bodily waste to leave the body. A stoma appliance covers the stoma with a removable pouching system to collect and contain the output for later disposal.

Enhanced services

Enhanced services are commissioned by NHS England from community pharmacies, and defined in the Directions. Each service is defined within a service level agreement, provided by NHS England. For the purposes of this PNA, the enhanced services offered by Islington pharmacies will be assessed. These are:

Minor Ailments Scheme (MAS)	This scheme aims to help people to be treated quicker and more efficiently by going to their pharmacy rather than GP. A pharmacy registered for the scheme can provide medication and advice for certain illnesses and conditions. The scheme transferred back to NHS England from CCGs in April 2014.
Medicines Reminder Devices (MRD)	The service aims to support patients who require help to take their medicines correctly. This may include improving the patient's knowledge of the medicines, providing easier to read labels, or referring them to other health and social care professionals for support.
Seasonal 'flu vaccination	The scheme aims to deliver 'flu vaccination to key population groups, during September – January of each year.

2.5.2. Local Pharmaceutical Services (LPS) contractors

LPS pharmacies are commissioned directly by NHS England, under a local contract. There are no LPS pharmacies in Islington.

2.5.3. Dispensing Appliance Contractors (DAC)

DAC are contracted to provide a range of appliances (such as stomas and dressings). There are two dispensing appliance contractors in Islington.

2.5.4. Dispensing Doctors

There are no dispensing doctors in Islington.

2.5.5. Other services

The PNA must also take into account other services offered in the area that affect the need for pharmaceutical services. For this assessment, locally commissioned services and other NHS services have been taken into account.

Locally commissioned services

Locally commissioned services (LCS) are commissioned locally, by an NHS organisation other than NHS England or through the Local Authority. They affect the need for pharmacy services, or have been commissioned to meet a local need. The LCSs listed below are commissioned by LBI Public Health, or joint with the local NHS.

Stop smoking service	This service provides nicotine replacement therapy (NRT) as patches, gums or inhalers, and advice and counselling to support smokers in their attempt to quit.
Screening service (Health Checks)	This service provides a free NHS Health Check in community pharmacies, as another avenue for risk assessment and early diagnosis.
Emergency hormonal contraception service	This service provides free emergency contraception for women aged 13-24, as well as signposting and referral to other sexual health services.
Needle syringe exchange service	This service allows injecting drug users to exchange used injecting equipment for clean equipment, ensuring safe disposal of used needles and decreasing the likelihood of the transmission of bloodborne viruses, e.g. hepatitis B and C, and HIV.
Supervised consumption service	This service provides patients prescribed substitute opiate with regular consumption supervised by a pharmacist, ensuring the patient adheres to treatment.
Anticoagulation service	This service enables patients being treated with Warfarin can have their treatment monitored by the pharmacist.
Palliative care medicines service	This service ensures there is access to advice and medication for end of life care.

2.6. Excluded from scope

Pharmacy services commissioned by Islington CCG not covered by PNA regulations are outside the scope of assessment. These include prison pharmacies, secondary and tertiary care sites, and non-NHS services provided by community pharmacies.

Most patients in Islington are treated at one of the following local hospitals:

- The Whittington Hospital
- University College London Hospitals NHS Foundation Trust
- Moorfields Eye Hospital

There are two prison pharmacies in Islington, at HMPs Holloway and Pentonville. The PNA makes no assessment of the need for pharmaceutical services in hospital or prison settings; however the HWB is concerned to ensure that patients moving in and out of hospital/prison settings have access to integrated pharmaceutical services that ensure continuity of medicines support. In order to achieve this, local hospitals and prisons are asked to adhere to the Royal Pharmaceutical Society Professional Standards for Hospital Pharmacy Services⁹.

Community pharmacies also provide other services, such as home delivery. However, these services are not commissioned so are not in the scope of this assessment.

2.7. Updating and revising the PNA

Once the PNA has been published, the duty of the HWB will be to ensure the PNA remains relevant until the next publication (within three years). If there are changes to pharmacy provision during this time, it is a requirement that a revised assessment is published, unless a full revision would be a “disproportionate response to those changes”. Therefore, there are two options for publishing revisions, which will be used by Islington’s HWB as appropriate:

1. Supplementary statement

A short statement detailing the change to pharmacy provision in the area covered. Examples of detail included in this type of statement include pharmacy closures, pharmacy openings or changes to opening hours. Supplementary statements can also be published while a full revision is being prepared so that any changes in pharmacy provision can be taken into account as soon as possible.

2. Full revision

A full revision is necessary if there are substantial changes in the area. This could include the number of people in the area, the demographics of the population, or a change in the risks to the health and wellbeing of people in its area. If there is a full revision to the PNA, it will need to be consulted on as prescribed by the regulations.

⁹ Royal Pharmaceutical Society, Optimising Patient Outcomes From Medicines (2014). Available at: <http://www.rpharms.com/support-pdfs/rps---professional-standards-for-hospital-pharmacy.pdf>

3. DEVELOPING THE PNA

Islington's PNA has been led by a dedicated steering group, with engagement and consultation with a wide range of stakeholders. The information gathered has been used to create a comprehensive picture of Islington's population and their current and future health needs. The way in which pharmacy services can match these needs and can decrease health inequalities and increase healthy life expectancy has been assessed. More information on the methods and stakeholders are given in the sections below.

3.1. Method used in assessment

The PNA regulations state that the following must be taken into account when making the assessment:

- Demographic profile and health needs of the population
- Whether there is sufficient choice in pharmacy service
- Different needs of the different localities in the area (if any)
- Services provided in neighbouring areas and how they affect the need for pharmaceutical services
- Services provided by the NHS (inside or outside the area) affect the need for pharmaceutical services
- Whether further provision of pharmaceutical services would improve provision or access in the area.
- Likely future pharmaceutical needs, based on the assessment and any projected changes in the population, demographic profile or risk to their health and wellbeing.
- Mandatory 60-day consultation period with a range of specified stakeholders (see Section 3.3).

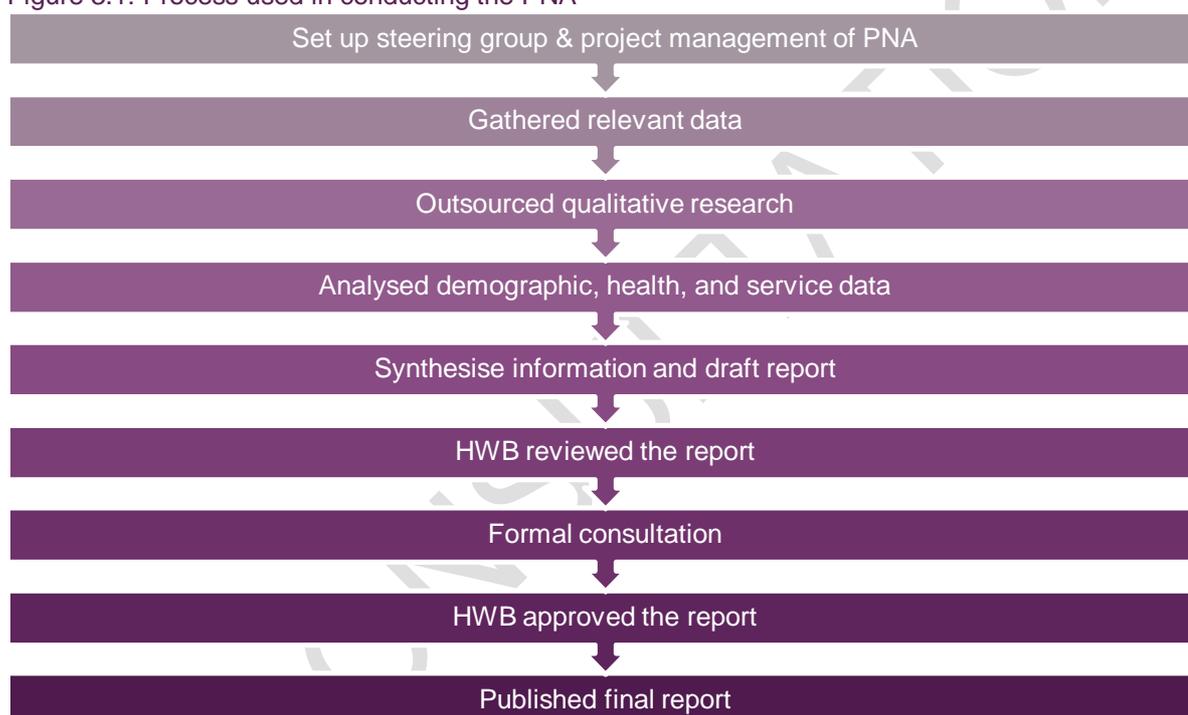
A mixture of methods and data were used in making the assessment of each type of pharmacy services, including engagement with local residents through dedicated qualitative research. This has included:

- Analysing Islington's population to assess health needs
- Reviewing existing pharmacy service data held by commissioners
- Carrying out focus groups of pharmacy users to understand their views and experiences
- Online questionnaire of pharmacists and other health professionals.

Data sources were varied, and included the Islington GP Public Health dataset for information on the health of the local population; the Strategic Housing and Land Availability Assessment population projections from the Greater London Authority, to estimate changes

in the borough's population and healthcare needs; information on the pharmacies in the borough from NHS England, which has been verified by a local survey; and service use statistics from the Clinical Commissioning Group, the Camden and Islington Public Health department, NHS England, and from ePact. Further details on the sources used can be found in the Appendices. Other published documents and reports were also used for information. These included Islington's JSNA and Annual Public Health Report, as well as various profiles and factsheets produced by Camden and Islington's Public Health department. Engagement underpinned each stage of the assessment process, including qualitative research carried out for the PNA; more details can be found in Section 3.3.

Figure 3.1: Process used in conducting the PNA



3.2. Governance and steering group

A steering group was set up to oversee the development of the PNA in accordance with Department of Health regulations. The work of the steering group was governed by Islington's HWB. The consultation documentation was approved by the HWB on October 15, 2014 and the final PNA was approved by the HWB at their meeting on January 14, 2015.

Members of the steering group included representatives from:

- Islington Public Health
- Islington CCG Medicines Management
- Local Pharmaceutical Committee
- Islington Healthwatch
- NHS England

- Islington Council Communications (as required)

The steering group met regularly to discuss key aspects of the PNA and make any required decisions. The group also ensured that the PNA captured the specific needs of the local populations, with a focus on reducing inequalities and aligning with the existing corporate plans of the HWB partners, where relevant. Progress on the PNA was reported to the HWB through the quarterly Officer's Group meetings. This group also advised on key decisions on behalf of the HWB.

Now published, the group will ensure that the findings of the PNA are disseminated widely, and will work towards implementation of the recommendations with relevant partners on behalf of the HWB.

The steering group was governed by terms of reference, agreed by all members. In addition, all members were required to declare any conflicts of interest. This is all described more fully in Appendix B.

3.3. Engagement during the development of the PNA

The PNA was developed in conjunction with internal and external stakeholders, taking an inclusive approach from the beginning with the local Healthwatch organisation on the PNA steering group. Their insight into Islington's population was invaluable when designing the approach and making the final assessments.

The data gathering phase also included a piece of innovative qualitative research that aimed to better understand the views of local residents as well as those of pharmacists and other health professionals. Gathering the views of people linked closely with pharmacies was essential to putting together a holistic view of provision and need in Islington. Local residents who use community pharmacy services (dispensing services, management of long term conditions¹⁰ or enhanced services) took part in focus groups. Residents were recruited to the focus groups through voluntary sector groups and through on-street recruitment. The second part of the research, an online survey of pharmacists and other health professionals, was carried out to better understand ideas for service improvement and integration, signposting and provision. The survey was sent out to all pharmacists and other health professionals in Islington. The key findings are in Section 5.6, and the full report is available as Appendix C.

Lastly, the mandated 60-day consultation period has also allowed for other members of the public, professionals and other stakeholders to comment on the draft PNA and whether it

¹⁰ A long term condition is a health problem that cannot be cured but can be controlled by medication or other therapies.

truly reflects the needs of Islington residents. A list of consultees specifically requested to take part is list in Appendix D.

3.3.1. Organisations contacted as part of the PNA process

Information to be taken from the consultation document.

3.3.2. Responses received

Information to be taken from the consultation document.

3.3.3. Regulatory consultation process and outcomes

The draft PNA has been consulted on for the mandatory 60-day period, from October 20, 2014 to December 19, 2014. The responses collected from the broad range of stakeholders invited to take part have been collated into a comprehensive report, and these are available in Appendix E, with a summary included in Chapter 7.

3.4. Context of Islington's PNA

Islington is an inner London borough, covering an area of 15 square kilometres. It is the most densely populated borough in England with about 14,500 people per square kilometre. Approximately 210,000 people live in Islington.

3.4.1. Area and demographics

Islington borders Camden, Hackney, Haringey as well as the City of London (Map 3.1). As an inner London borough, Islington's population also swells during the day due to the number of people coming in to the area. Reasons for this include children in school, residents from other areas travel in for work, and tourists. The latest figures show that, on an average workday, Islington's population increases to more than 40% its size to 350,000 people including 50,000 domestic and overseas tourists. This PNA takes this change into account when making recommendations.¹¹

More information about the demographics of Islington's population can be found in Chapter 4, which focuses on the health needs of Islington's population.

In Islington, there are 37 GP practices, 20 general dental practices, 50 community pharmacies and three hospitals, as well as other community based services. More information on service provision is given in Chapter 5.

¹¹ Greater London Authority (2013). <http://data.london.gov.uk/datastore/package/daytime-population-borough>

Map 3.1: London boroughs showing Islington's location, 2014



3.4.2. Priorities and strategies

Decision-making around the provision of pharmacy services in Islington is based on the findings from Islington's Joint Strategic Needs Assessment (JSNA), the Joint Health and Wellbeing Strategy and commissioning strategies.

The JSNA is an overarching needs assessment for the area designed to influence service planning and commissioning. It describes the current and future health and wellbeing needs of the local population and makes recommendations for action to meet these needs, taking into account current services and evidence of effectiveness. The JSNA is created jointly by the local authority, CCG, Healthwatch, and other partners including the voluntary and community sector (VCS). Undertaking and publishing a JSNA is a mandatory requirement of all HWBs and their partners. Islington's most recent JSNA is available online¹².

Informed by the JSNA, Islington's Joint Health and Wellbeing Strategy (JHWS) for 2013-16 prioritises three key areas of health and wellbeing to reduce health inequalities and improve life expectancy in Islington: ensuring every child has the best start in life, preventing and managing long term conditions to enhance both length and quality of life and reduce health

¹² <http://evidencehub.islington.gov.uk/Pages/HomePage.aspx>

inequalities, and improving mental health and wellbeing. The JHWB strategy can be found on the Islington Council website¹³.

Islington CCG's commissioning strategy takes the JSNA into account as well as other assessments and information to make decisions about priorities for the future. The priorities for Islington CCG are directly aligned with those of the JHWB Strategy with an additional priority to deliver high quality, efficient services within the resources available. The Islington CCG website offers more information in their commissioning strategy¹⁴.

Islington's joint Public Health (PH) function, which is part of the London Boroughs of Camden and Islington, takes into account all of the priority areas mentioned above when setting their own goals which inform commissioning of local services through pharmacies. Overall, PH strives to improve the health and wellbeing of Islington residents, while reducing the inequalities in life expectancy and quality of life that exist across its communities. This is carried out through a focus on nine key areas: children and young people; active, healthy lives; tobacco; alcohol and drug misuse; sexual health; mental health and wellbeing; early diagnosis; ageing; and health protection.

NHS England's mission is to provide patients with a safe, effective and positive experience, and it aims to provide services that give all patients access to services which give them greater control over their health and wellbeing.¹⁵

Healthwatch Islington's strategic priorities for the coming years are complaints about specialist services for children and young people, primary care services, home care services and mental health access as well as customer service in GP receptions and measuring 'user friendliness' of local safeguarding procedures.¹⁶

3.5. Deciding on the localities for the PNA

The regulations governing the PNA require that the area covered by the PNA is divided into localities, in order to take into account the differing needs of the population covered. These localities are used for making the assessment.

Localities for Islington's PNA have been chosen to match those used by Islington CCG for commissioning purposes: North, Central, Southeast and Southwest, as shown in Map 3.2. In this way, the PNA can easily be used to support the integration of health service

¹³ <http://www.islington.gov.uk/publicrecords/library/Public-health/Business-planning/Strategies/2012-2013/%282013-03-01%29-Joint-Health-and-Wellbeing-Strategy-2013-2016.pdf>

¹⁴ Islington CCG, <http://www.islingtonccg.nhs.uk/about-us/>

¹⁵ NHS England, <http://www.england.nhs.uk/wp-content/uploads/2013/04/ppf-1314-1516.pdf>

¹⁶ Healthwatch Islington, http://www.healthwatchislington.co.uk/sites/default/files/annual_report_2013_-_14_final_version.pdf

provision in Islington, as the CCG has already set up structures to monitor and deliver health services at this geographical level. The localities were discussed and agreed by the PNA steering group, and a proposal was put forward to Islington's HWB Officer's Group for approval. The localities were agreed without comment.

3.5.1. Resident population of localities

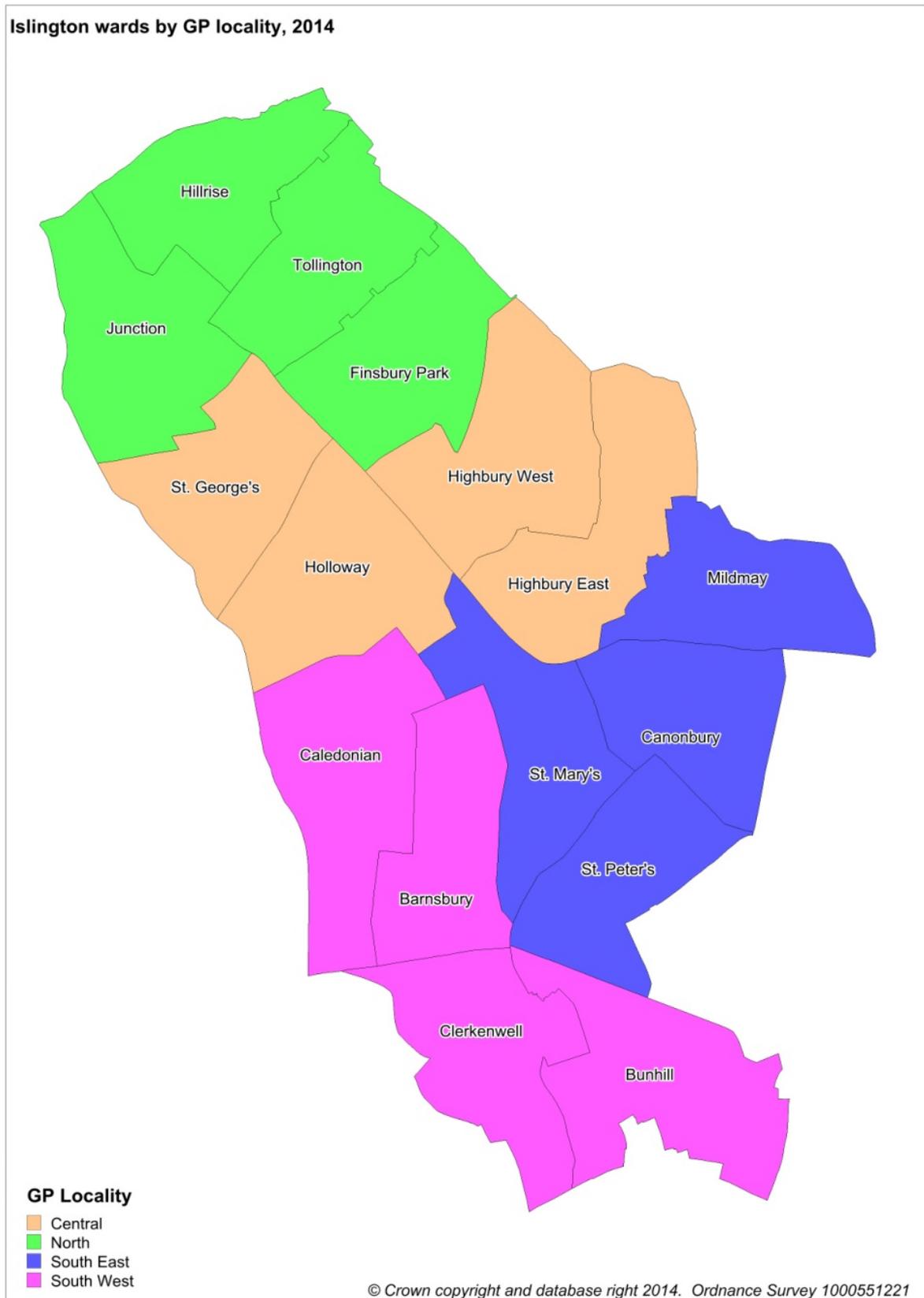
The resident population of Islington's localities varies, due to the varying population density between areas. The table below shows the resident population, using the 2011 Census findings. As a comparison, the GP registered population is also shown.

Table 3.1: Number of people registered with GP practices in locality, and resident in locality

Locality	GP Registered population (Sep 2012)		Resident population (2011)	
	Number of people	Percent of total population	Number of people	Percent of total population
North	59,551	27%	51,488	25%
Central	55,717	25%	54,047	26%
Southeast	56,904	25%	48,364	23%
Southwest	51,827	23%	52,226	25%
TOTAL	223,999	--	206,125	--

Source: GP practice IT systems / Open Exeter; Census 2011

Map 3.2: Islington Localities and wards



4. HEALTH NEEDS PROFILE FOR ISLINGTON

This chapter will provide a summary of the health needs of Islington's population, relevant to the PNA.

4.1. Key messages: impact of Islington's health needs on pharmacy provision

- Islington's diverse population is made up of more younger and working age people than a typical London borough. Islington is one of the most deprived London boroughs, with rich and poor living side by side. While the whole borough is deprived, the North locality is more deprived than the South West.
- The projected growth to 2024 will create additional demand for pharmaceutical services across Islington's existing pharmacy network, particularly among older people. New housing developments will also alter the way in which our population use services and the demands placed on community pharmacy.
- Understanding the diversity of Islington's population is important, given that disease rates and health conditions vary by age and ethnic group, and in particular, some smaller ethnic groups experience stark health inequalities. There are also geographical differences in where people are living with long term conditions, with those in the North locality experiencing more multiple long term conditions.
- High blood pressure, chronic depression and diabetes are the most commonly diagnosed long term conditions in Islington, accounting for 61% of the 62,800 long term conditions that have been diagnosed in 38,100 people. There is a high prevalence of mental health need locally, particularly in more deprived areas, with over 5% of people living with diagnosed depression. Not everyone with a long term condition has been diagnosed and current estimates suggesting that there are 45,950 undiagnosed long term conditions within the borough.
- While smoking prevalence in Islington is similar to the London and England averages, with around one-in-five residents reporting that they are current smokers, the high burden of disease associated with smoking means that supporting people to quit remains a high priority within the borough. Similarly, supporting people to maintain a healthy weight is important given the associated risks of developing long term conditions.
- Islington has a higher prevalence of drug and alcohol misuse than other London boroughs, particularly in relation to opiate and crack-use. The borough also has high rates of sexually transmitted infections and HIV, particularly among young people (Chlamydia) and men who have sex with men (MSM) (HIV, gonorrhoea and syphilis). Although the rate of teenage pregnancy in Islington has been decreasing in recent years, it is still higher than the London and England averages.

4.2. Population demographics

4.2.1. Population and projected growth

About 212,000 people currently live in Islington, with the population distributed across the four PNA localities and wards as shown in Table 4.1. More information about the localities and the rationale for their choice is covered in Section 3.4.

Islington's population is expected to rise to 242,470 by 2024, an increase of 13%¹⁷. This compares to a 10% increase in London. The largest percentage increase is expected in people aged 85 and over, with numbers in this group predicted to rise by 31% (402 people). The expected population rise in people aged 55-64 accounts for the largest change in terms of numbers of residents, with an estimated growth of 2,514 people. Expected population growth does not vary by geographical area within the borough of Islington.

The population of Islington is also highly mobile, with the highest rate of turnover in London. Almost 30% of Islington's population either moved in or out of Islington in the course of a year (Figure 4.1). There are more people moving into Islington than leaving the borough, increasing the population size.

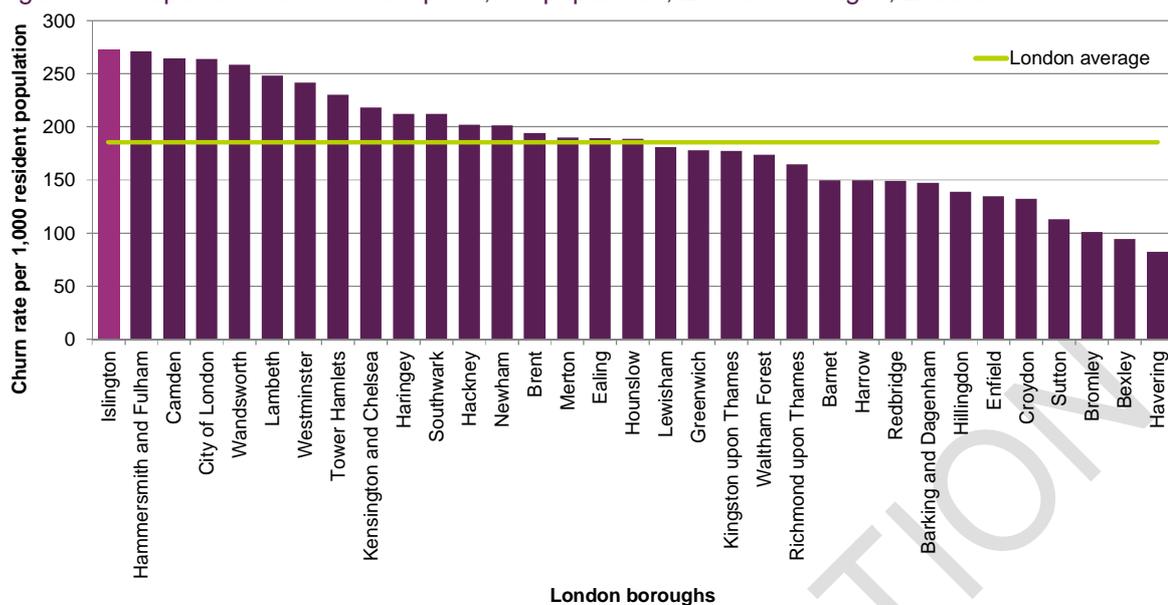
Table 4.1: Population by locality, 2014 estimates

Locality	Ward Name	Population
North	Finsbury Park	14,730
	Hillrise	11,970
	Junction	12,420
	Tollington	13,500
	North Total	52,620
Central	Highbury East	11,810
	Highbury West	15,600
	Holloway	15,510
	St George's	12,670
	Central Total	55,590
South East	Canonbury	12,190
	Mildmay	13,110
	St Mary's	11,970
	St Peter's	12,410
	South East Total	49,680
South West	Barnsbury	12,560
	Bunhill	15,690
	Caledonian	14,360
	Clerkenwell	11,940
	South West Total	54,550
Islington population		212,440

Source: GLA projections, 2013

¹⁷ GLA 2012 Round 'Islington Development v2'. Interim 2011 census rebased.

Figure 4.1: Population turnover rate per 1,000 population, London boroughs, 2008-09



Source: GLA, 2010

New developments will contribute to the projected increases in population. Islington's Planning Department estimated in January 2014 that there will be approximately 3,300 additional homes built in the borough by 2018/19, with a further 1,000 added by 2023/24 and another 1,900 by 2028/29 (Map 4.1). According to the 2011 Census, the average household size in Islington in 2011 was 2.06 people. Assuming a similar average household size applies to new developments, an estimated 15,500 additional residents arising from new development will live in Islington by 2026.

Residential development and the population increases arising from development are particularly concentrated around the Finsbury Park and King's Cross areas, Barnsbury, Bunhill, Archway and Clerkenwell. There are no projected residential developments in Canonbury between now and 2026.

It should be noted that further alterations to the London Plan (January 2014) requires Islington to deliver a minimum of 12,641 homes between 2015 and 2025, significantly more than identified by potential major developments.

4.2.1. Student population

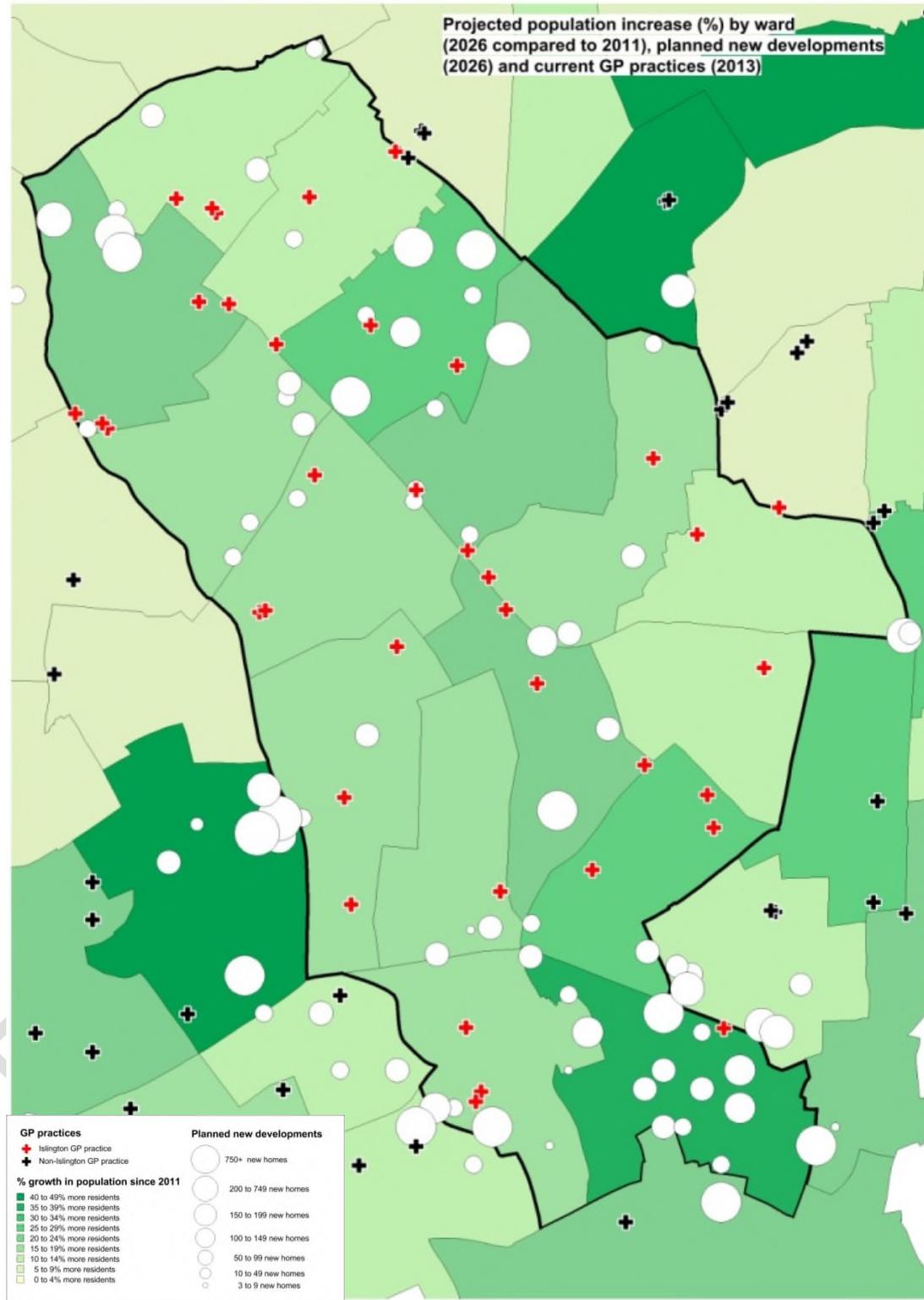
In Islington, there are 16 higher education institutions, and the student population is increasing as new private student accommodation is being built.

4.2.2. Daytime population

As an inner London borough, Islington's population also swells during the day due to the number of people coming in to the area. Reasons for this include children in school, residents from other areas travelling in for work, and tourists. The latest figures show that

Islington's population increases by approximately 40% on an average workday to almost 355,000 people, including 4,500 domestic and overseas tourists. About 200,000 of the total daytime population are workers, although it is not clear what proportion live and work in the borough.

Map 4.1: Projected percentage population increase by ward and planned new developments, Islington 2026

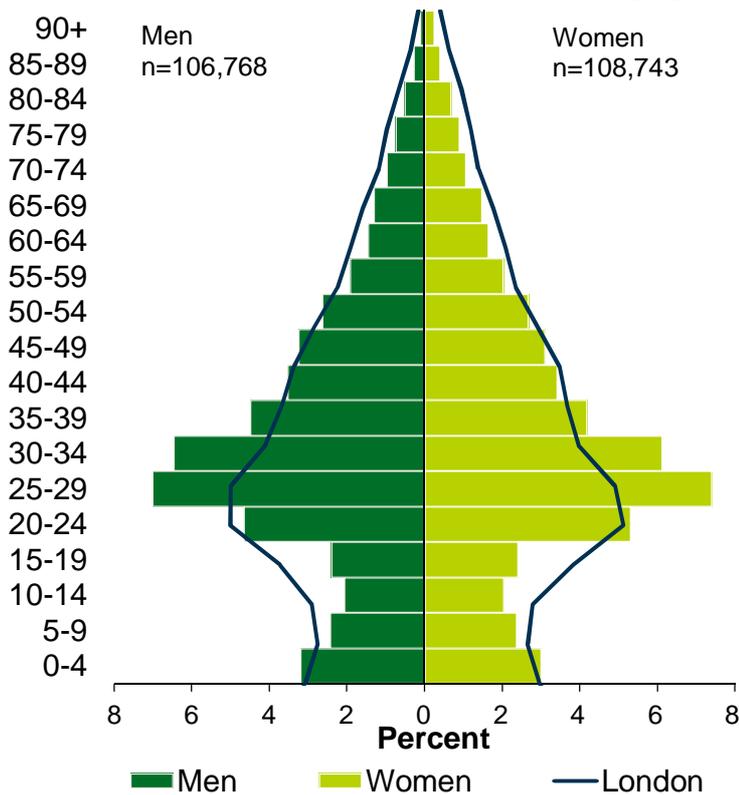


Source: GLA 2012 and Camden and Islington Public Health, 2013

4.2.3. Age and sex profile

As Figure 4.2 indicates, the main difference between Islington's population and London's is a much larger proportion of 25-35 year olds. Islington also has fewer children between the ages of 10 and 19 than the London average. The age and sex profile of Islington is similar to London for people aged 35 and older. This large group of younger working age people contribute to the borough's high turnover as people move in and out of the borough.

Figure 4.2: Resident population of Islington, by sex and age group, 2014

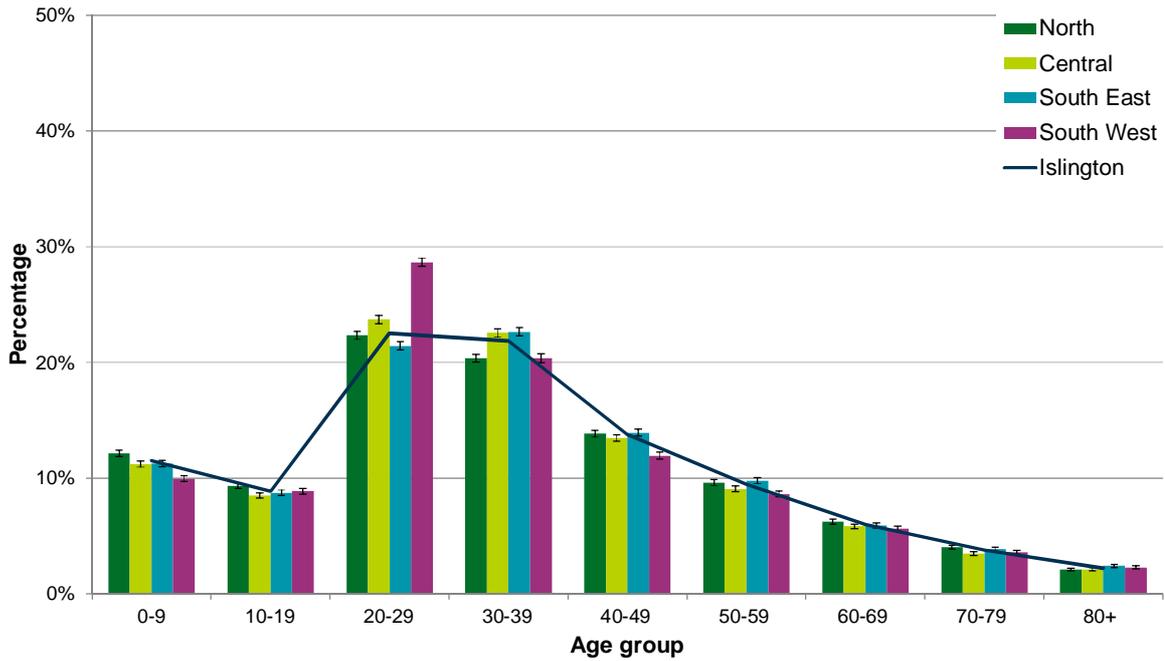


Source: GLA, 2014

In terms of the localities, the most significant difference in age structure is represented in the South West locality where there is a higher proportion of people aged 20-29 compared to the Islington average (Figure 4.3). For the other age groups the population structure in each locality is very similar to Islington overall.

Age is an important determinant of health, and by extension, the need for healthcare services including pharmacies. Although the prevalence of living in poor health increases with age, more than two-thirds of Islington people living in poor health are under 65 years of age. While people's health generally deteriorates as they get older, in Islington people start experiencing poor health earlier than in England, when residents are middle-aged.

Figure 4.3: Percentage of residents in Islington, by locality and age group, compared to Islington overall, 2014



Source: GLA, 2014

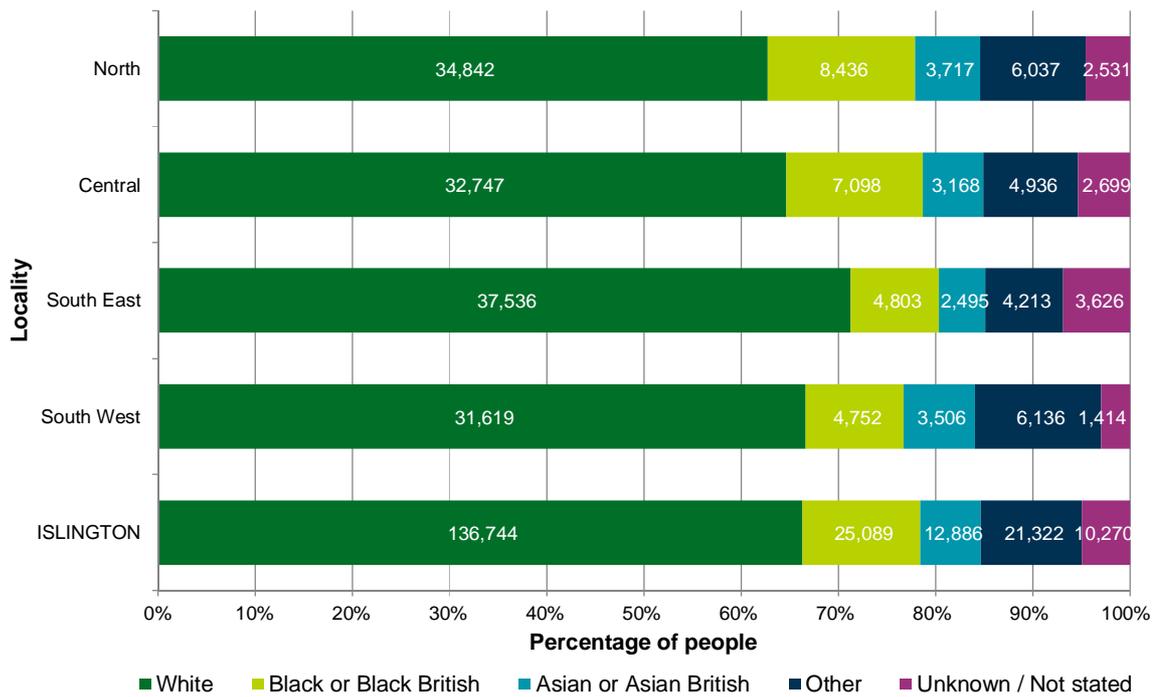
4.2.4. Ethnicity and language

Islington is a very diverse borough. Overall, about 30% of Islington's population are from black minority ethnic (BME) groups, ranging between 23% in the South locality and 34% in the North locality. The ethnic breakdown also differs slightly between locality, with a larger proportion of Black people in the North and Central localities (16% and 15% respectively) and the lowest in the South East and South West localities (both 10%). Figure 4.4 shows the ethnic distribution for people whose ethnicity has been recorded by their GP.

Generally the age structure of the BME groups is younger than the white population across all localities; 46% of children and young people aged 0 to 24 years are from a BME background compared to 20% of the population aged 65 years and over (Figure 4.5).

Numbers of people in certain ethnic groups are expected to increase more than others over time, with the 'Other Asian' (determined by the ONS 2011 census ethnic category) and 'Other Black' groups expected to grow by 31% and 30% respectively, while White are expected to grow by only 7% between 2011 and 2021.

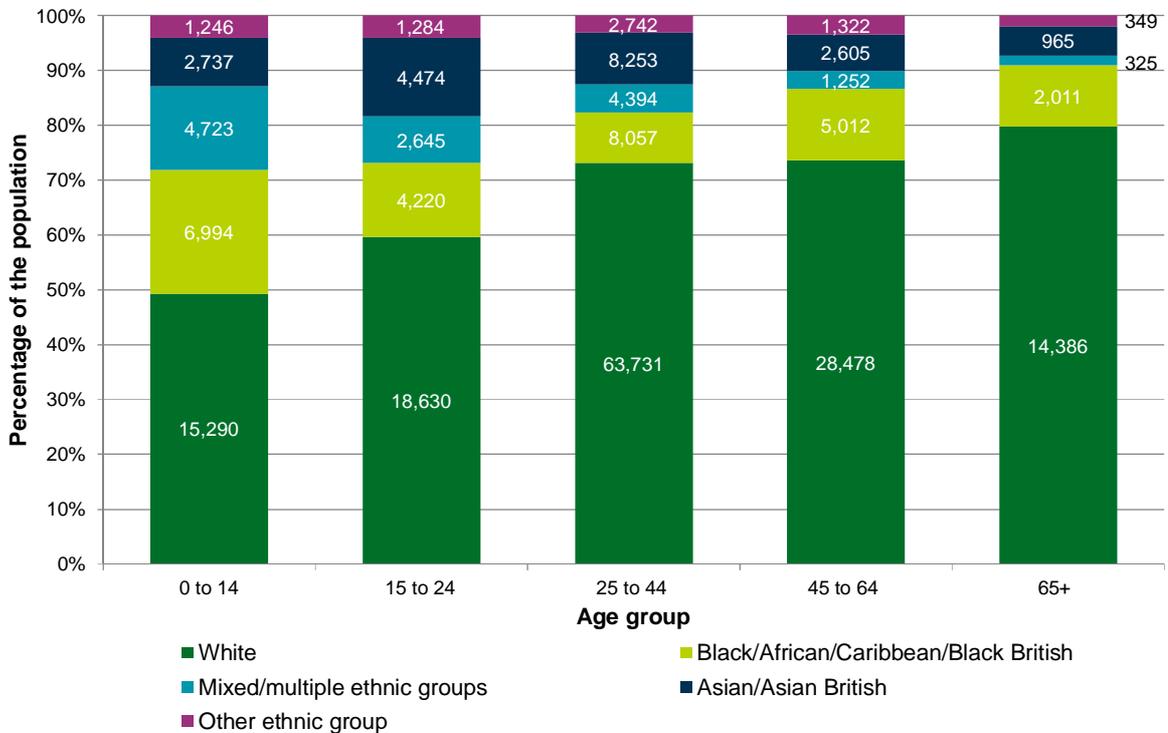
Figure 4.4: Percentage breakdown of GP registered population by ethnicity, Islington localities, September 2012



Source: Islington's GP PH Dataset, 2012

Note: for 10,270 people the ethnic group was not known/not stated

Figure 4.5: Percentage breakdown of Islington resident population by age group and ethnicity, 2011



Source: ONS, 2011

Almost half of people reporting living in poor health are White British, one-in-six are White Other, and one-in-eight are Black¹⁸. This largely reflects the ethnic profile of Islington's population. However, some of the smaller ethnic groups experience the starkest health inequalities. White Irish people are more than twice as likely to be living in poor health compared to the Islington average (12% versus 6%) having the highest level of poor health overall and 'Other' ethnic groups have the highest level of poor health in those aged under 65 years. More than a third of the 'Other' ethnic group are Arab, Iranian, and Kurdish, while Turkish/Turkish Cypriot people account for a fifth. There is a clear relationship among all ethnic groups between age and poor health with older people being more likely to be in poor health.

A further reflection of Islington's cultural diversity is seen in the variety of languages spoken. After English, the most commonly spoken languages are European languages (10%) and Asian languages¹⁹.

4.2.5. Deprivation

Islington is significantly more deprived compared to England, and is one of the five most deprived boroughs in London and among the 15 most deprived in England. Socioeconomic deprivation varies considerably between localities in Islington. In the North locality, more than half of people live in the most deprived areas of Islington while in the South West locality more than half of people live in the least deprived areas of Islington.

Across all localities, there are clear inequalities in the burden of long term conditions by deprivation: 31% of those living in the poorest areas are living with a diagnosed long term condition compared to those in the richest areas. After controlling for other risk factors such as age and ethnicity, deprivation remains a predictor of whether someone is living with a diagnosed long term condition, with nearly 12,000 of those people with a long term condition living in the 40% most deprived areas in Islington. It is important to remember though, that relative to the rest of England, most of Islington is categorised as deprived, so even those who are locally "less deprived" will not be affluent at a population level²⁰ (Map 4.2).

¹⁸ This is based on people reporting "bad" or "very bad" health in the Census 2011. The difference between Islington and England is less clear for people reporting "not good health" (defined as "fair", "bad", or "very bad" health).

¹⁹ Office for National Statistics. 2011 Census (Online). Available at: <http://www.ons.gov.uk/ons/guide-method/census/2011/index.html>

²⁰ Islington PCT, Annual Public Health Report (2011). Available at: [http://www.islington.gov.uk/publicrecords/library/Public-health/Quality-and-performance/Profiles/2013-2014/\(2013-04-04\)-2011-Extending-life-in-Islington.pdf](http://www.islington.gov.uk/publicrecords/library/Public-health/Quality-and-performance/Profiles/2013-2014/(2013-04-04)-2011-Extending-life-in-Islington.pdf)

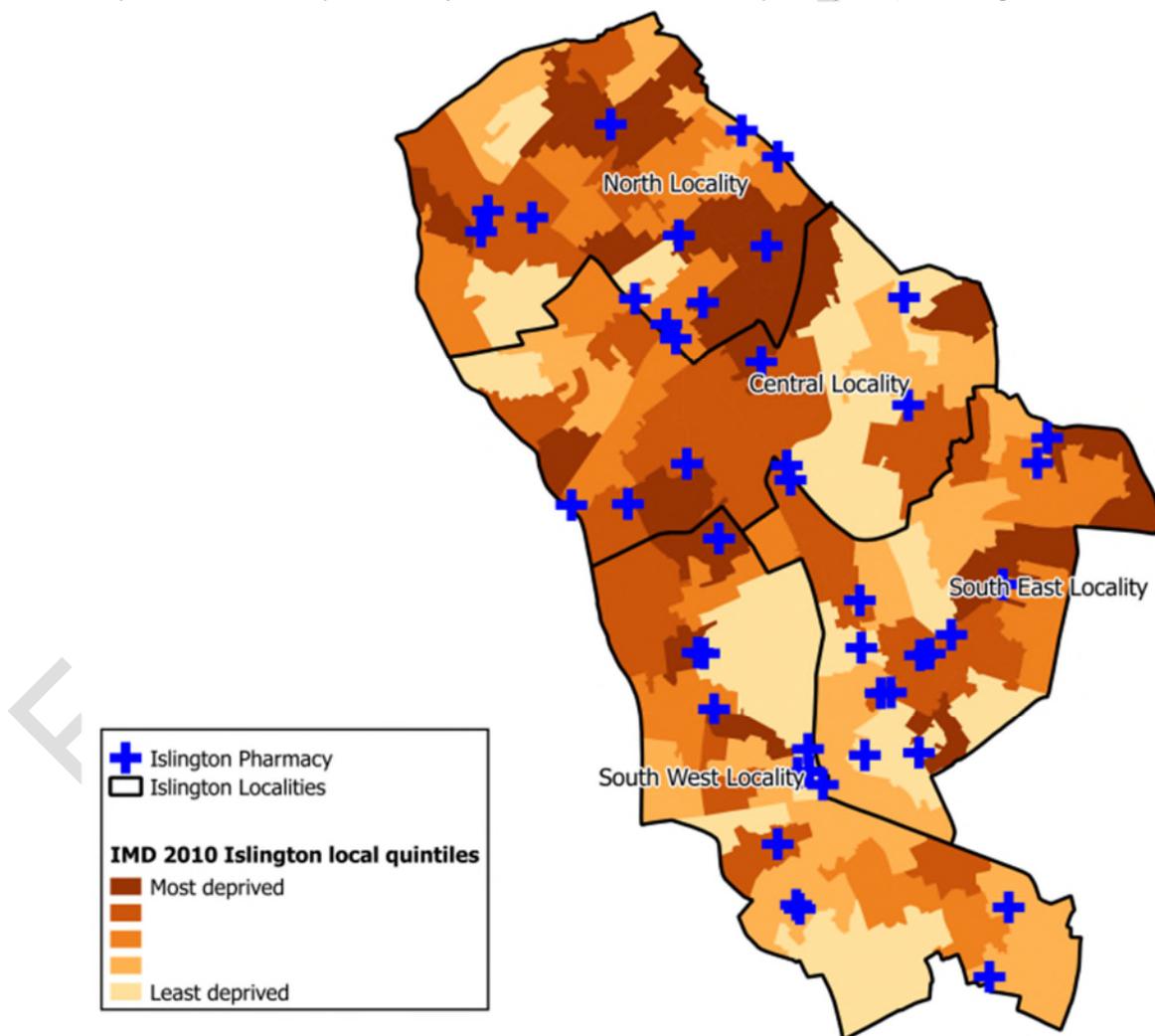
The most deprived people in Islington are more likely to be living with poor health compared to the more affluent. Among people diagnosed with one or more long term conditions, more deprived people are living with multiple long term conditions than affluent people. This is likely to reflect the complex relationship between deprivation and ill health, with deprivation following ill health and ill health following deprivation.

4.2.1. Social Housing

Social housing is also linked with deprivation and the distribution of social housing density varies between localities. The South West locality, for example, has the highest percentage of areas with more than 80% social housing and with no social housing (Figure 4.6). This highlights the mixed pattern of deprivation in Islington.

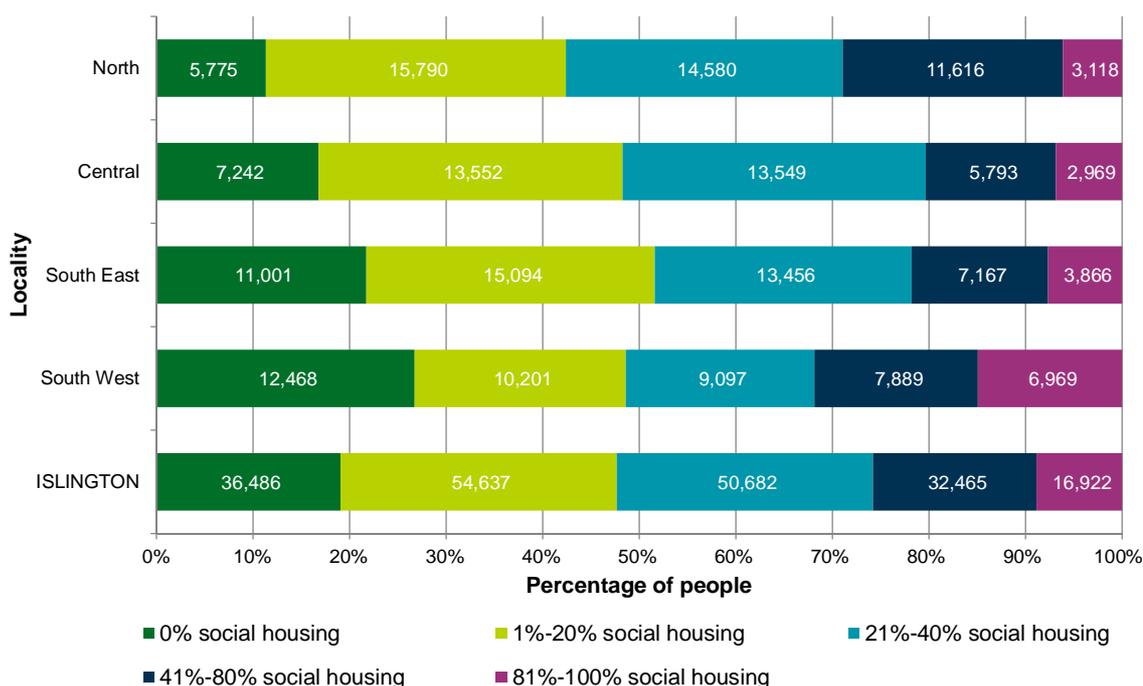
In addition, the greater the proportion of social housing in an area, the higher the proportion of people with diagnosed long term conditions (LTCs), with people in areas with the most social housing up to four times as likely to have multiple LTCs.

Map 4.2: Level of deprivation by small area, Index of multiple deprivation, Islington, 2010



Source: Department for Communities and Local Government, 2011

Figure 4.6: Percentage of registered patients by density of social housing, Islington localities and Islington average, March 2011



Source: Islington's GP PH Dataset, 2012

Note: 26,119 patients were resident outside of the borough, and could not be included in this graph.

4.3. Life expectancy

Life expectancy in Islington has increased for both women and men over the past ten years. It is now similar to England for women (83.2 vs 82.1 years) and for men (77.8 vs 78.1 years). The improvement in life expectancy has mostly been driven by fewer deaths from heart disease, and to a lesser extent chronic lung disease and cancer. There is no clear spatial pattern in life expectancy. This is because the most and least deprived people live side-by-side.

The distribution of poverty and deprivation and the low life expectancy across Islington means that when measured, the life expectancy gap is narrow for men in particular. However, this probably does not reflect the true scale of inequality in the borough: based on people reporting “not good health” across occupational groups, Islington has the largest estimated health gap in England for both men and women. The narrow life expectancy gap more likely shows the limitations of the methods used to measure inequalities using deprivation.

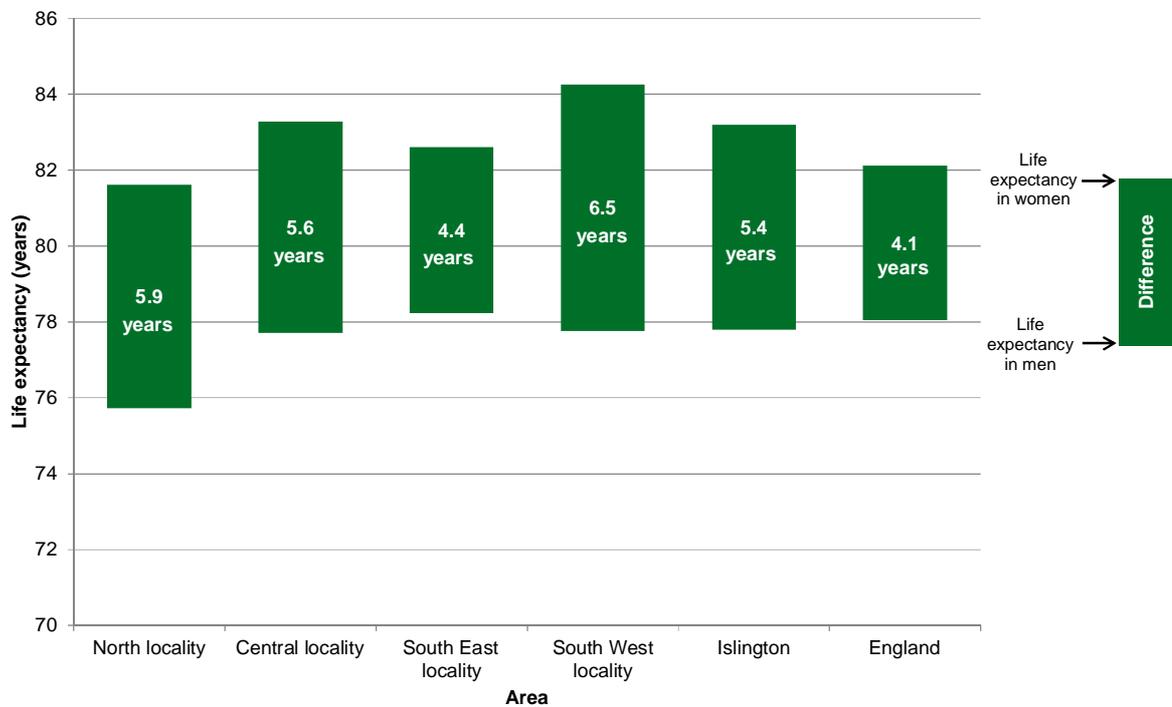
There are signs the gap in life expectancy may be increasing, however the more affluent residents may have experienced greater improvements in life expectancy over time than the most deprived. Furthermore, the improvements in life expectancy do not seem to have been shared equally across the population, with heart disease still being the largest

contributor to the life expectancy gap for men. For women, the life expectancy gap seems to be increasing but for men it appears constant.

The relationship between socioeconomic group and poor health in Islington has also become starker over the past ten years, suggesting Islington’s population is becoming more polarised. It is possible this trend is explained by increasing gentrification coupled by a high and consistent proportion of people living in poverty and deprivation.

The gap can also be seen at locality level. For men, the South East has the highest life expectancy (78.2 years), with the shortest in the North (75.7 years). For women, the variation is from 81.6 years in the North to 84.3 years in the South West (Figure 4.7).

Figure 4.7: Difference in life expectancy by locality and gender, Islington and England, 2008-12



Source: Greater London Authority, 2014; ONS, 2014

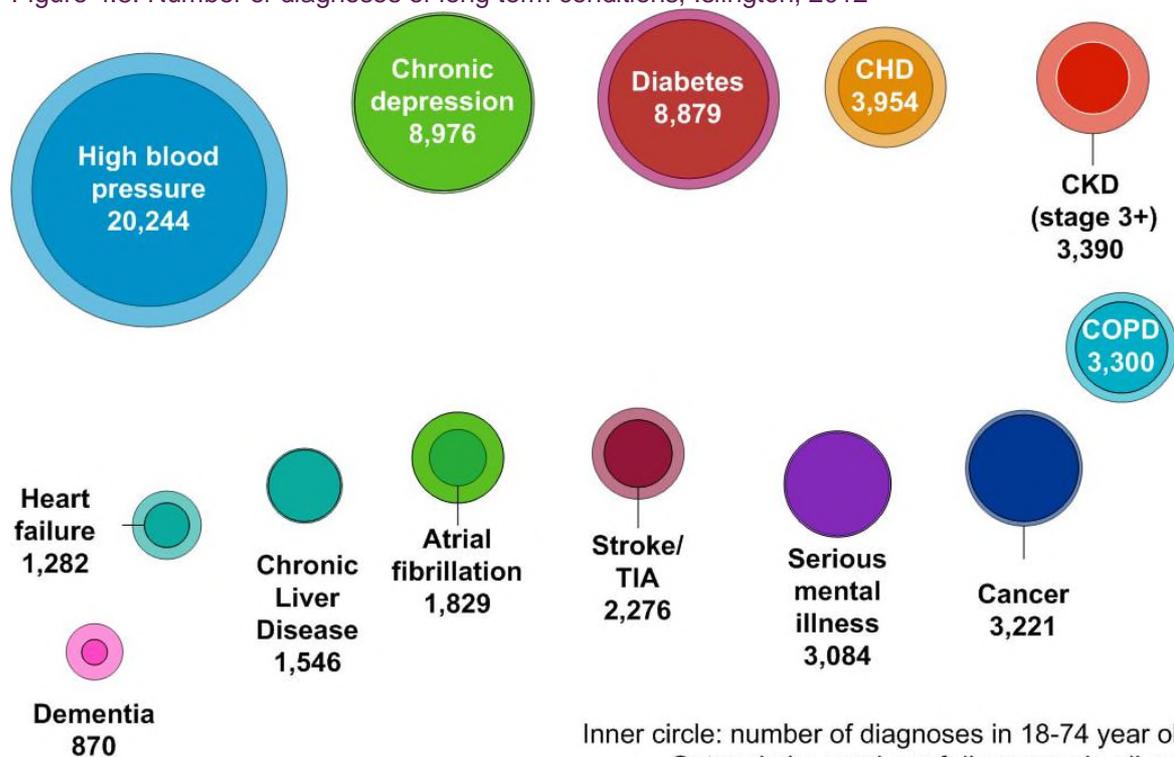
4.4. Prevalence of long term conditions

Overall, 38,100 people (17%) in Islington have at least one diagnosed long term condition, with over 62,800 diagnoses overall (Figure 4.8). The most common conditions in Islington, high blood pressure and chronic depression, make up almost half of all diagnoses.

Low life expectancy, poor general health, and mental ill health, including chronic depression and psychotic disorders, are problems affecting almost all areas in the borough rather than being localised to particular wards. Overall most areas are classed as deprived compared to England. There are pockets of affluence, however, but better off people tend to live side-by-side with the people who are worst off. This means the whole borough needs to be

targeted for interventions aimed at improving both physical and mental health and wellbeing.

Figure 4.8: Number of diagnoses of long term conditions, Islington, 2012



Inner circle: number of diagnoses in 18-74 year olds
Outer circle: number of diagnoses in all ages

Note: It was not possible to extract data for chronic depression for one practice

Source: Islington's GP PH dataset, 2012

The prevalence of long term conditions increases with age, with 62% to 67% of people aged over 55 diagnosed with a long term condition in each locality. The prevalence of having at least one diagnosed long term condition is highest among the black population and lowest among Asians, with no differences in the prevalence of long term conditions by ethnic groups across localities.

With the exception of cancer, there are more people in the most deprived areas living with all of the different type of conditions, than in the more affluent areas. For stroke, there is no difference in the numbers, while cancer is explained by a larger number of people in the more affluent areas developing and surviving breast cancer.

There is a significantly higher percentage of people with at least one long term condition in the North (17%) than Islington overall. The lower prevalence of long term conditions in the South West locality is consistent with the younger population profile of the locality. Overall, the most deprived areas in Islington have the highest prevalence of long term conditions. There is a significant difference in the prevalence of long term conditions between the most and least affluent areas in the Central (21%), South East (20%) and South West (19%) localities, compared to 17% overall. People in the most deprived areas are also more likely

to have two or more long term conditions than people in the least deprived areas; about 8% compared to 6%.

Depression is the most prevalent mental health condition in Islington. In 2012/13, 6.3% (11,841) of adults registered with an Islington GP were recorded on the depression register. This was significantly higher than the London average. The borough also has a higher diagnosed prevalence of serious mental illness than both London and England (1.4%; 3,084 adults). There are 870 adults with dementia (0.4%), no different to the London average. Statistical modelling indicates that over two thirds of the expected number of cases of dementia in Islington have been diagnosed (no similar models are available for depression or serious mental illness). A higher percentage of women are diagnosed with depression than men; the opposite is true for serious mental illness. Prevalence of both these conditions is significantly higher in more deprived areas of Islington.

The prevalence of individual long term conditions varies by locality, even after the age structure of the population is taken into account. Table 4.2 shows the long term conditions and localities where prevalence is significantly higher or lower than the Islington average. The reasons for these differences will be complex and related to levels of deprivation, individual risk behaviours (e.g. smoking) and personal characteristics such as ethnicity. More detailed information about the prevalence of long term conditions can be found in Islington's localities profiles, found in Appendix F.

Table 4.2: Difference in prevalence of long term conditions, by locality, Islington, 2012

Long term condition	North	Central	South East	South West
Atrial fibrillation (AF)	↓			↑
Cancer	↓			↑
Chronic depression	↓			↑
Chronic Kidney Disease (CKD)				
Chronic Liver Disease (CLD)	↓	↓		↑
Chronic Obstructive Pulmonary Disease (COPD)	↓			↑
Coronary Heart Disease (CHD)			↓	
Dementia				
Diabetes	↑		↓	↓
Heart failure				
High blood pressure (Hypertension)			↓	↑
Serious mental illness	↑		↓	↓
Stroke/TIA				

Source: Islington PH GP dataset, 2012

Note: Green arrows indicate where prevalence, adjusted for age is higher than the Islington average. Red arrows indicate where prevalence, adjusted for age, is lower than the Islington average.

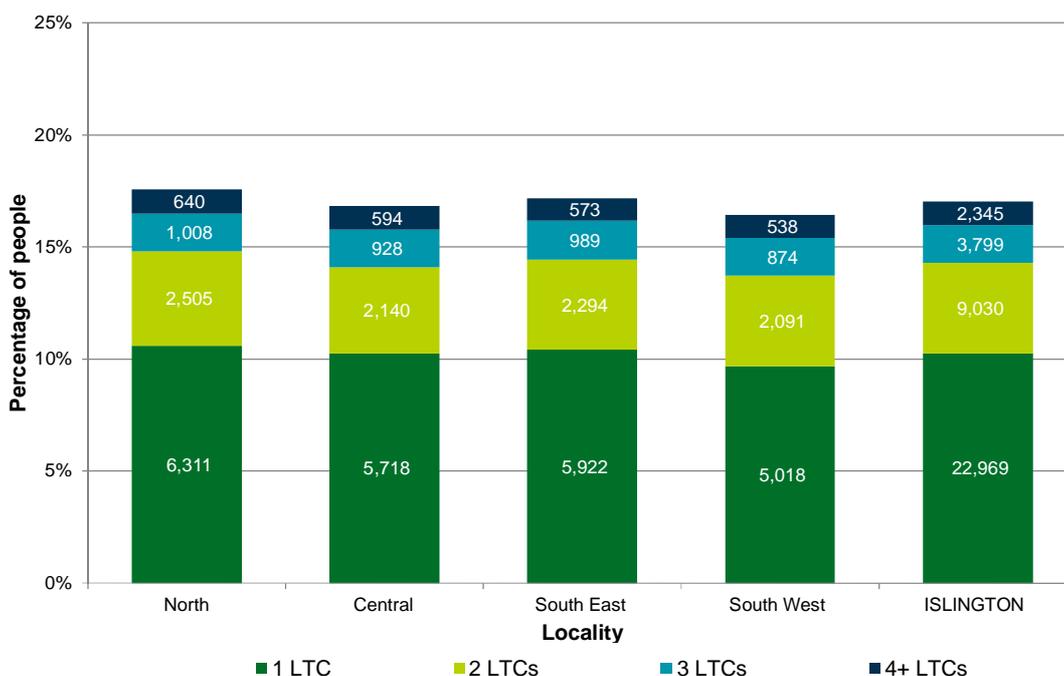
4.4.1. Comorbidities

Of people with a diagnosed long term condition, 40% have more than one (14,200 people), including 2,350 people with 4 or more long term conditions (Figure 4.9). The pattern of comorbidity varies depending on their first diagnosis, ranging from 59% of those first diagnosed with CHD having another long term condition down to 18% of those with dementia. In general, a higher proportion of people first diagnosed with cardiovascular conditions have another long term condition which probably reflects shared clinical and lifestyle risk factors between conditions (e.g. high cholesterol, physical inactivity). However, levels of comorbidity are also relatively high among those with psychotic disorders (26%) and chronic depression (22%), highlighting the importance of meeting the physical as well as mental health needs of people with serious mental health disorders.

Looking at the second diagnosis of those with more than one diagnosed long term condition reiterates the importance of high blood pressure. Between one third (psychotic disorders) and three-quarters (CKD stage 3+) of the second diagnoses for all long term conditions was high blood pressure. For 42% of those first diagnosed with high blood pressure, the second diagnosis was diabetes.

Older people are also more likely to suffer from more than one long term condition, with 44% of those aged 65+ years in Islington diagnosed with multiple conditions, rising to 59% for those aged over 80.

Figure 4.9: Percentage of GP registered patients by number of long term conditions, Islington localities, September 2012



Source: Islington's GP PH Dataset, 2012

People with diagnosed mental health conditions have a higher prevalence of comorbidities (additional long term conditions), with 38% of patients diagnosed with another long term condition across Islington. The distribution of comorbidities in people with a mental health condition across each of the localities is similar to the Islington average.

4.4.2. Expected prevalence of long term conditions

Statistical models are used to estimate the expected prevalence of long term conditions as not all those with a long term condition will have been diagnosed. The models take differences in age, gender, deprivation and smoking status between populations into account when calculating the number of people undiagnosed. There are currently models for high blood pressure, diabetes, coronary heart disease (CHD), chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD), and stroke/TIA. The latest models show that for these long term conditions, the estimated prevalence is higher than the diagnosed prevalence (Table 4.3), indicating about 45,950 undiagnosed long term conditions in Islington. Some people may have more than one undiagnosed condition.

Table 4.3: The prevalence gap for six major long term conditions, Islington GP registered population, aged 16+, September 2012

Long term condition	Diagnosed prevalence	Estimated prevalence	Number diagnosed	Number not diagnosed
High blood pressure	9.0%	20.4%	20,040	25,508
Diabetes	4.7%	6.8%	8,959	3,996
CHD	1.8%	3.6%	3,913	4,059
CKD*	1.8%	5.2%	3,312	6,330
COPD	1.7%	3.9%	3,281	3,977
Stroke/TIA	0.9%	2.0%	1,672	2,077

Sources: APHO prevalence models, 2012; Islington GP PH dataset, 2012; QOF, 2012/13

* CKD prevalence figures are for people aged 18+.

The undiagnosed prevalence of conditions varies by locality, reflecting local differences in deprivation, gender, age and ethnicity profiles of the population, smoking prevalence and rates of diagnoses by GPs (Table 4.4).

4.5. Lifestyle risk factors

Smoking, obesity, alcohol consumption, physical inactivity, and poor diet are all important modifiable risk factors that can impact on health outcomes. Supporting people to adopt healthier lifestyles can reduce the development of long term conditions, extend life expectancy and improve quality of life. For people with existing diagnoses, offering support to adopt healthier lifestyles can halt the development of comorbidities and aid overall management of long term conditions.

Table 4.4: Diagnosed and expected prevalence for six major long term conditions by locality, Islington GP registered population aged 16+, September 2012

Condition	Locality							
	North		Central		South East		South West	
	Diagnosed prevalence	Expected prevalence						
High blood pressure	9.2% (5,399)	21% (12,296)	8.9% (4,942)	21% (11,397)	9.0% (5,129)	21% (11,951)	8.8% (4,570)	19% (9,903)
Diabetes	5.4% (2,700)	7.9% (3,639)	5.0% (2,321)	6.9% (3,219)	4.4% (2,116)	6.6% (3,180)	4.1% (1,822)	6.6% (2,916)
CHD	1.8% (1,037)	3.8% (2,202)	1.9% (1,033)	3.5% (1,949)	1.7% (980)	3.9% (2,219)	1.7% (863)	3.1% (1,601)
CKD*	1.8% (852)	5.2% (2,525)	1.8% (811)	5.3% (2,436)	1.8% (882)	5.4% (2,565)	1.7% (767)	4.7% (2,116)
COPD	1.6% (784)	4.1% (1,985)	1.8% (837)	3.9% (1,820)	1.8% (851)	3.9% (1,908)	1.8% (809)	3.5% (1,546)
Stroke/TIA	1.0% (486)	2.2% (1,055)	0.9% (425)	2.0% (922)	0.9% (403)	2.1% (1,025)	0.8% (358)	1.7% (747)

Sources: APHO prevalence models, 2012; Islington GP PH dataset, 2012; QOF, 2012/13

* CKD prevalence figures are for people aged 18+. Shaded cells indicate where the largest gap lies for each condition.

Box 4.1: Recording of lifestyle risk factors

GPs record lifestyle risk factors for their patients on areas such as smoking, alcohol, and weight. The extent to which lifestyle risk factors in people are recorded in Islington differs according to risk factor, time, age and whether the risk factor is included within the Quality and Outcomes Framework, a national audit framework for GPs.

Smoking status is well recorded, a probable reflection of reward through QOF for GP practices. Alcohol recording, on the other hand, is poorly recorded which may be the result of low confidence amongst GPs in asking people their drinking status and the accuracy or honesty with which people reply. It may also reflect confusion over how alcohol units are measured, as this is not straightforward. BMI recording is also poor; however this is mainly driven by practices in the South West locality, where almost one-in-three patients do not have their BMI recorded (see Table 4.5). This could be due to the younger/student population at these practices leading to high turnover.

Table 4.5: Percentage and number of GP registered patients without risk factor information recorded, by risk factor and locality, Islington GP practices, September 2012

Locality	Smoking		Alcohol		BMI	
	n	%	n	%	n	%
North	11,138	23%	21,190	36%	17,896	30%
Central	9,405	20%	19,007	34%	15,111	27%
South East	9,265	19%	15,761	28%	14,414	25%
South West	9,102	21%	18,918	37%	18,065	35%
Islington	38,910	21%	74,876	33%	65,486	29%

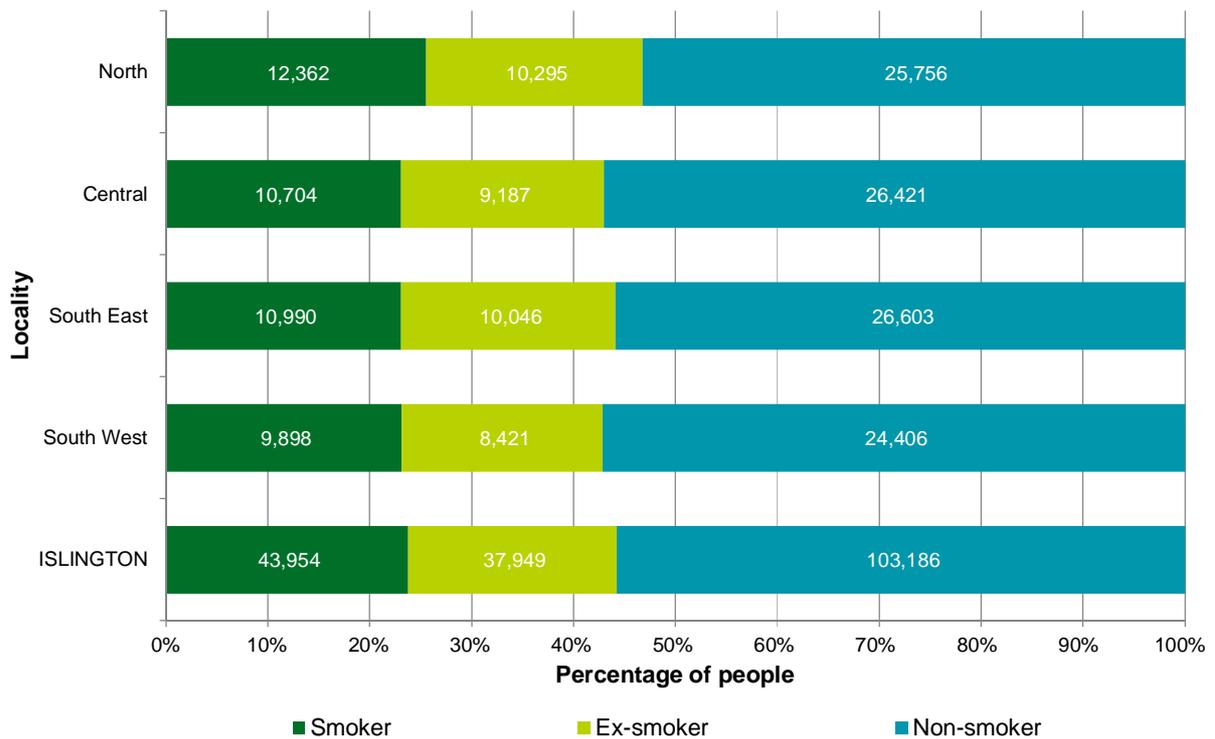
The variation by locality in the recording of alcohol and BMI needs to be considered when interpreting the data shown in the next sections, as low levels of recording can lead to under-reporting of the prevalence of these risk factors.

4.5.1. Smoking

Tobacco use is the single most important modifiable risk factor for early death and serious illness. It is particularly associated with lung and oral cancers, circulatory disease and respiratory disease. Smoking accounts for over half of the gap in risk of premature death between social classes; mortality rates from tobacco are two to three times higher among disadvantaged social groups than among the more affluent.

The number of people who smoke has declined in Islington over the past ten years. Overall smoking prevalence, based on survey data, has reduced from 34% in 2005 to 21% in 2011. Data from general practices in Islington indicate a prevalence of 24% (43,950 people), with a significantly higher prevalence in the North locality (26%) (Figure 4.10).

Figure 4.10: Percentage breakdown of GP registered population aged 16+, by smoking status, where recorded, Islington localities, September 2012



Source: Islington's GP PH Dataset, 2012

Note: 38,910 people had no recorded smoking status.

Smoking is a major contributor to the inequalities gap as people in routine and manual occupations, and living in areas of deprivation, are more likely to smoke than those in professional and managerial occupations or living in more affluent areas.

The fact that smoking remains more prevalent in key population groups highlights a need for targeted service provision. Groups with higher prevalence include:

- Men (30% prevalence versus 20% in women)
- Younger age groups, 16 to 34 year olds (45% of smokers are in this age group).
- The highest smoking prevalence is among the White and Black Caribbean ethnic group (33%), Turkish people (33%) followed by Irish (29%).
- People living in more deprived areas in Islington (28%) compared to those in the more affluent areas (20%).
- People with long term conditions (particularly those with mental health conditions and COPD). There are 85% more ever smokers with COPD compared to the general Islington population. This figure is adjusted for age. There is also an increased prevalence of serious mental illness, chronic depression, coronary heart disease and a number of other LTCs in ever smokers compared to the general population.

- Additionally, Islington has a higher proportion of women smoking in pregnancy than London, but lower than England as a whole. About 8% of pregnant women are smoking at the time of delivery in Islington

4.5.2. Alcohol

Alcohol misuse is a major cause of illness, injury and death. Although the immediate intoxicating effects of alcohol are often easily identifiable, the longer-term health consequences of drinking may remain undetected. Alcohol is linked to more than 60 different conditions, including liver disease, cancer, osteoporosis, stomach ulcers, and raised blood pressure. There is a strong correlation between alcohol abuse / dependence and mental health problems. Alcohol has also been linked to self-harm, suicide and psychosis. Evidence suggests that regular chronic heavy alcohol intake (more than 10 units per day) is a risk factor for alcohol related dementia, whereas mild to moderate alcohol intake may be protective against the development of dementia. People who drink alcohol may also be at a greater risk of sexually transmitted infections.

Alcohol also has a wider impact on society, and this can be caused by all levels of consumption, not just by those who are dependent drinkers. Alcohol-related harm includes crime, family dysfunction, traffic accidents, and problems in the workplace. Often it is the social impacts of alcohol where the effects of someone else's drinking is felt most. Alcohol, particularly heavy drinking, increases the risk of unemployment, and for those in work, it may cause absenteeism and performance issues.

There are three main types of alcohol misuse – increasing risk, high risk and dependent drinking. In addition, binge drinking is also a term frequently used to describe a pattern of alcohol consumption. These drinking patterns are determined by the risk alcohol consumption poses to the individual's health. According to estimates, 80% of the Islington's population drink alcohol, and a 20% are abstainers. Of the drinking population, the majority (72%) are considered lower risk, with about 9,700 (7%) at higher risk²¹. Around 20% of the adult drinking population in Islington binge drinks, i.e. they consume at least twice the daily recommended limit in one session.

Data from GP practices indicate that 1% of patients are drinking at higher or increased risk. However, these estimates exclude the large proportion of people where drinking has not

²¹ Lower risk drinkers are defined as:

- Men who regularly drink no more than 3 to 4 units a day;
- Women who regularly drink no more than 2 to 3 units a day.

Increasing risk drinkers are defined as:

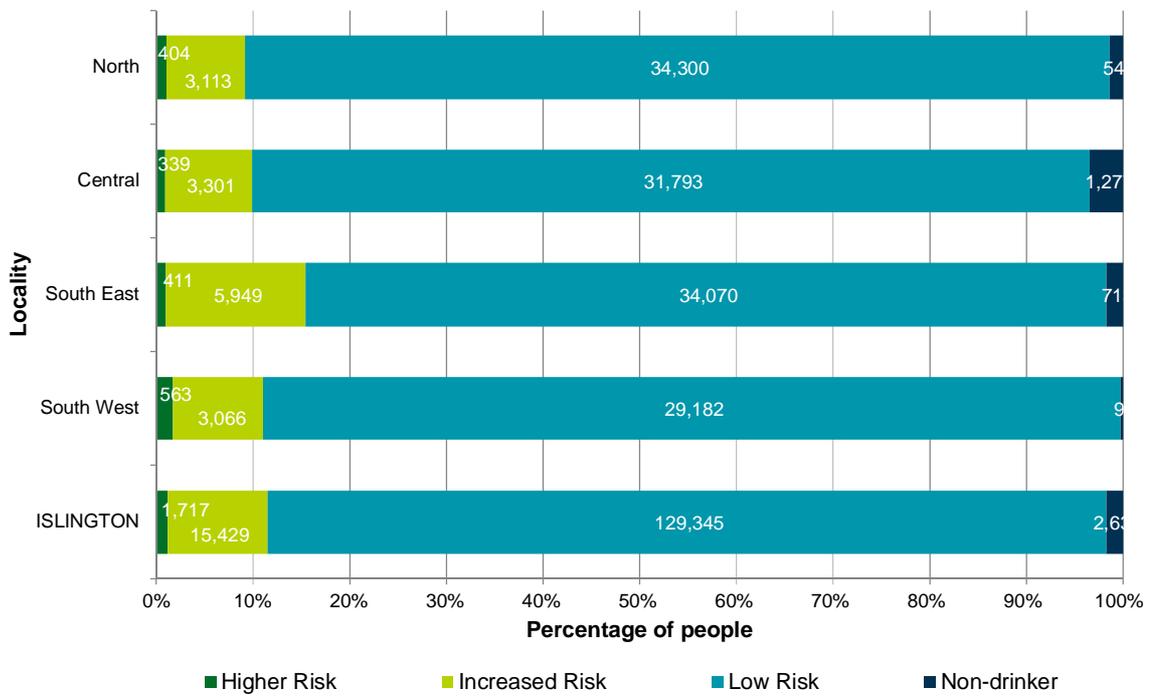
- Male who drink regularly more than 3-4 units a day (but less than higher risk levels)
- Female who drink regularly more than 2-3 units a day,

Higher risk drinkers are defined as:

- Male who drink regularly more than 8 units a day or more than 50 units of alcohol per week
- Female who drink regularly more than 6 units a day or more than 35 units of alcohol per week.

been recorded (33%), so the true pattern may be different (Table 4.5). The South East and South West localities have the highest proportion of higher and increased risk drinkers at 15% and 11% respectively (Figure 4.11).

Figure 4.11: Percentage of GP registered population aged 18+, by alcohol consumption, where recorded, Islington localities, September 2012



Source: Islington's GP PH Dataset, 2012

Note: 74,876 people had no recorded drinking status.

Alcohol also impacts on hospital admissions in Islington. The rate of alcohol-related admissions in Islington (1,997 per 100,000 population) is not significantly different to the rate for London (2,038 per 100,000) or England (1,974 per 100,000). People in the most deprived areas of Islington are significantly more likely to be admitted for an alcohol-related cause with Finsbury Park and St. George's having the highest admission rates. Overall, about a third of people were admitted to hospital more than once for alcohol related causes. Hypertensive disease and mental and behavioural disorders due to alcohol make up the largest proportion of these admissions.

Box 4.2: Defining harm related to alcohol

Alcohol-specific conditions include those where alcohol is entirely responsible for the admission, development of the disease, or death. For example, alcoholic liver cirrhosis and poisoning from alcohol are wholly related to alcohol.

Alcohol-related conditions include all alcohol-specific conditions plus those where alcohol contributes to a greater or lesser degree to the disease. A death or admission that is partly caused by alcohol can include high blood pressure, breast cancer, falls and accidents.

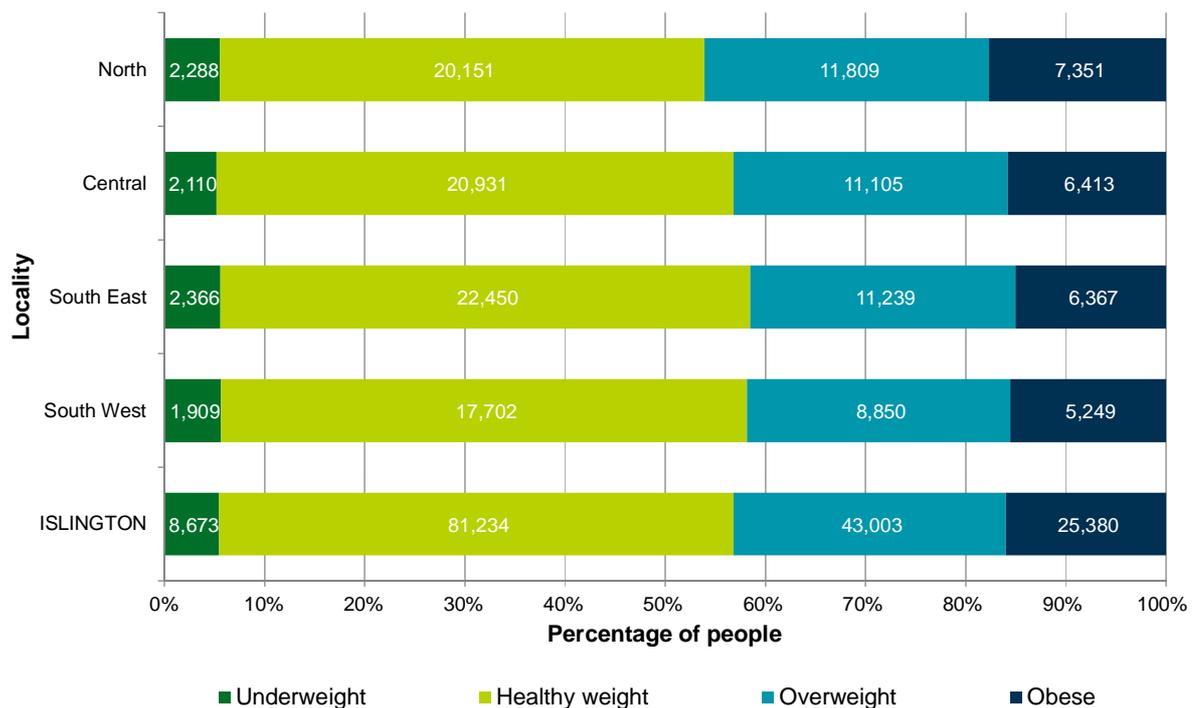
Alcohol-specific admissions are significantly higher amongst Islington men (887 per 100,000 population) compared to both London and England (529 and 506 per 100,000 population respectively). For women, the alcohol-specific admission rate (272 per 100,000) is also significantly higher compared to London and England (188 and 232 per 100,000 population respectively). The rate of people admitted for alcohol-related conditions is 50% higher in the most deprived areas in Islington compared to the least deprived. Just under a third of people admitted for alcohol-specific causes were admitted two times or more. Again, mental and behavioural disorders due to the use of alcohol, alcoholic liver disease and alcohol poisoning make up the bulk of these admissions.

4.5.3. Obesity

The modelled prevalence of obesity among people aged 16+ years indicates that obesity prevalence in Islington is 19%. This is similar to London (21%) but is lower than the England average (24%). However, obesity is an important factor contributing to Islington's inequality gap in life expectancy. Just over 69,000 adults registered with an Islington GP are obese or overweight, including two thirds of adults with a long term condition. The North locality has the highest proportion of obese and overweight people (46%) while the South East and South West have the highest proportion of healthy weight people (both 53%). The overall BMI distribution in the Central locality is similar to the Islington average (Figure 4.12). These estimates exclude the large proportion of people where BMI has not been recorded (29%), with under recording particularly high among GPs in the South West locality, so the true pattern may be different (Table 4.5).

Obesity prevalence increases with deprivation with those living in the most deprived areas of the borough being 27% more likely to be obese than those living in the more affluent areas. People from a black ethnic minority are also more likely to be obese compared to the Islington average.

Figure 4.12: Percentage of GP registered population aged 18+, by BMI status, where recorded, Islington localities, September 2012



Source: Islington's GP PH Dataset, 2012

Note: 65,486 patients had no recorded BMI, and 223 patients' BMI status is not known/unfeasible and not included in this graph.

Being obese or overweight increases the risk of developing a range of serious conditions, and having a long term condition can also increase weight. One-third of Islington adults with long term conditions are obese. Also, in Islington overweight/obese people are almost twice as likely to be diagnosed with a long term condition compared to those of a healthy weight. The difference is particularly notable for diabetes, for which overweight and obese are 3-4 times more likely to be diagnosed compared to people of healthy weight. Also, overweight people are 1.5 times more likely to be diagnosed with hypertension and about 1.8 times more likely to be diagnosed with one or more long term conditions compared to people of healthy weight.

4.5.4. Substance misuse

Drugs misuse is complex. Not everyone who misuses drugs will develop a serious problem. However, for the small number who do, the impact on their health and wellbeing, on families, partners and friends, and on the health and wellbeing of the local community, can be considerable.

If estimates for London from the Crime Survey for England are representative of the Islington population, over 15,000 (10%) Islington residents aged 16-59 years used illicit drugs in 2012/13. This included almost 6,000 people who used at least one Class A drug

(e.g. heroin, cocaine, ecstasy). Islington has one of the largest opiate or crack-using populations in London (2,300 people), including an estimated 570 injecting drug users, although cannabis and powder cocaine are likely to be the most widely used illicit drugs in the borough.

If 11-15 year olds in Islington have the same rate of drug use as England, almost 1,400 children in the borough would have used drugs ever, with 1,000 using drugs in the past year and 500 using them in the past month.

Levels of need in those in treatment for drug use vary between boroughs and people using different types of drugs. Islington's drug treatment population is amongst those with the highest need in the country, for both opiates and non-opiates. In Islington, one of the most commonly recorded issues that impacts negatively on chances of successful treatment is housing problems or having no fixed abode. A quarter of clients who are new to treatment, and a third of clients who are not new to treatment, report this issue.

4.6. Sexual health and teenage pregnancy

Sexual health and reproductive health are critical to population wellbeing. Poor sexual health can cause unintended pregnancies, sexually transmitted infections (STIs), cancers and infertility.

4.6.1. Teenage conceptions

Teenage conception rates in Islington have been consistently higher than London and England, and in 2012 Islington had one of the highest rates in London (30.1 conceptions per 1,000; 81 teenage conceptions). Although conception rates have decreased over the past ten years, the proportion of teenage pregnancies ending in an abortion in Islington (67%) are still higher than the national average (49%); though still similar to the London average (62%).

4.6.2. Contraception

The effectiveness of some methods of contraception (contraceptive pill and barrier method) depends on their correct and consistent use. Long acting reversible contraception (LARC) methods, such as intrauterine devices or hormonal implants, provide highly effective, long term contraceptive protection for women. The availability and rate of LARC prescribing is an important measure of choice and quality in local contraception services, and a key part of the offer to improve contraceptive services to help prevent teenage pregnancy. National comparative data is available on prescribing in GP practices. In Islington, the rate for LARC prescribing in GP practices in 2013 (18.1 per 1,000 registered female population) was significantly lower than the average in both London and England (25.1 and 52.7 per 1,000 population respectively). There are significant providers of community contraceptive

services, including young people's sexual health services, which also provide LARC in Islington. Therefore data from general practice should not be seen in isolation of this wider service provision, although it does point to the potential to increase prescribing through general practice.

4.6.3. Sexually transmitted infections (STIs) and HIV

The rate of acute sexually transmitted infections (STIs) in Islington is significantly higher than the London and England averages overall. However, there are differences in the ways in which the different infections affect the population groups. Young people and MSM are at particular risk of the transmission of STIs and good sexual education provision should be considered alongside high quality, open access sexual health services.

In Islington, the rate of diagnosis of chlamydia for people of all ages (727 diagnoses per 100,000) is significantly higher than both London and England (522 and 390 per 100,000). However, diagnosis rates vary by age group and those in younger age groups (aged 15-24) are particularly at risk of infection; diagnoses in this age group accounts for 40% of all diagnosed chlamydia infections in Islington. The rate of diagnosis is highest in those aged 20 to 24 for both men and women, this may, in part be explained by the National Chlamydia Screening Programme.

The rate of gonorrhoea and syphilis diagnoses are also significantly higher in Islington than London and England. Both of these infections predominantly affect men, specifically men who have sex with men (MSM), with 78% of gonorrhoea and 93% of syphilis cases diagnosed in Islington in 2013 being among MSM.

There were 1,295 people accessing HIV care in Islington in 2012. The rate of Islington residents accessing HIV care is significantly higher in Islington (8.4 per 1,000 population) compared to both London and England (5.5 and 2.1 per 1,000 population, respectively). Islington is considered to be an area of high prevalence, defined by Public Health England as having a rate of higher than 2 per 1,000 population. There has also been a significant increase from 2002 in those accessing treatment (from 6 per 1,000 in 2002 to 8.4 in 2012) as people are living longer with the virus and more people are diagnosed.

Of those diagnosed with HIV in Islington in 2013, 79% were men and 68% were men who have sex with men (MSM).

4.7. Seasonal 'flu

Flu is an infectious viral illness that is especially common in winter, which is why it is also known as "seasonal 'flu". 'Flu is more likely to cause complications (e.g. bacterial chest infection) in vulnerable groups including older people, young children, pregnant women,

people with certain long term conditions (diabetes, heart disease, lung disease, kidney disease or a neurological disease) and those that are immunosuppressed. During winter, seasonal 'flu increases service use in both primary and secondary care.

Vaccination helps prevent seasonal 'flu and the complications associated with it. It is recommended for all people aged over 65 years; children aged two and three years; pregnant women; people with certain conditions; healthcare workers or carers and those living in a residential or nursing homes.

'Flu vaccination is available at GP practices and pharmacies. The DH target for 'flu vaccination is 75% coverage of eligible population. In Islington during the 2013/14 'flu season 71% of registered patients aged 65 and over were vaccinated; 52% of patients aged 6 months to 65 years old with a 'flu-related condition; and 40% of pregnant women. This is below the DH target for each group, but better than the London average for people aged 65+ and pregnant women, and similar to London for patients aged 6 months to 65 years old with a 'flu-related condition.

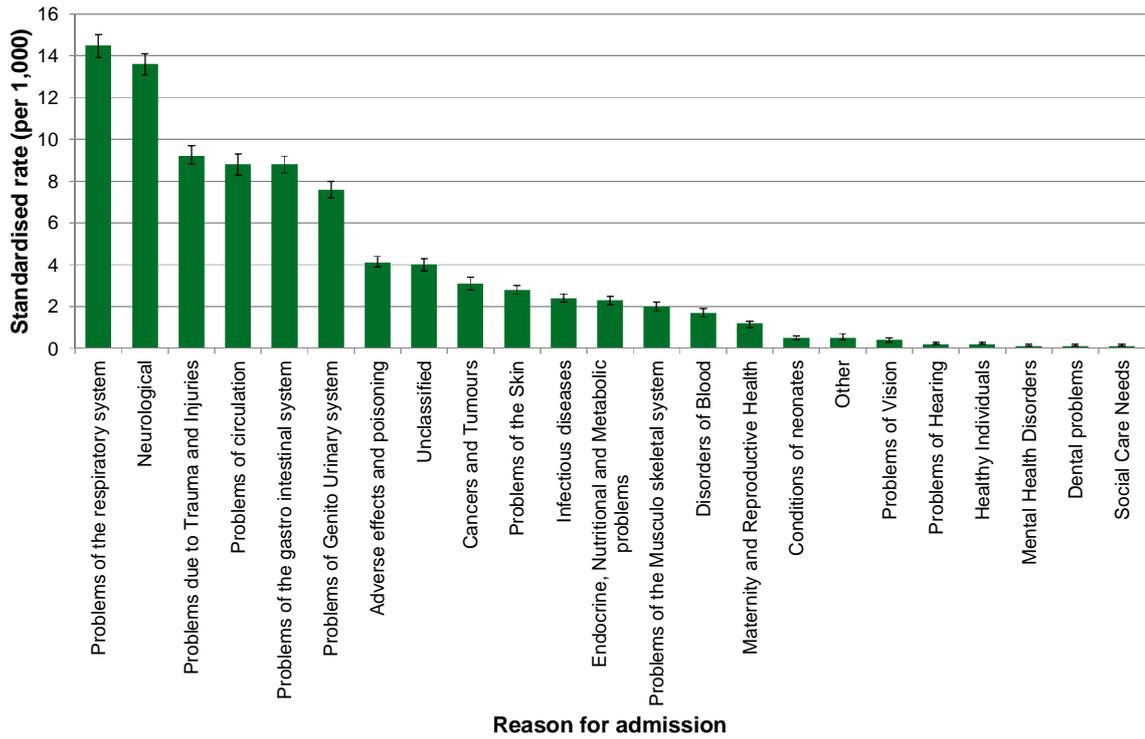
4.8. Hospital admissions

Emergency hospital admissions data allow for better understanding of which conditions are not being well-managed in the community or primary care. Rates of ambulatory care sensitive (ACS) admissions can be informative of a lack of good quality preventive and primary care services that, if enhanced, would prevent those admissions.

There were 92,300 A&E attendances in Islington in 2012/13 (411 per 1,000 GP registered population), and over 16,300 emergency admissions (87 per 1,000). Most of these admissions were for problems with the respiratory system (2,477 admissions) or neurological conditions (2,733 admissions, Figure 4.13). In this period there were 3,185 ACS admissions (19 per 1,000), a quarter of which were for 'flu and may have been prevented by vaccination.

Rates of emergency admissions are not available by GP localities, but all localities show variation in rates of ACS admissions by GP practices. The two practices that had significantly higher than average rates of ACS admissions were in the North and Central localities. The seven practices with significantly lower than average rates of ACS admissions were distributed amongst all localities.

Figure 4.13: Standardised rate of emergency hospital admissions, by reason for admission, Islington's GP registered population, per 1,000, 2012/13



Source: NHS Comparators, 2014

FOR CONSULTATION

5. CURRENT PROVISION AND ASSESSMENT

This section will describe the current picture of pharmacy provision in Islington. Findings from the qualitative research (see Chapter 3 for more information) will be included, from pharmacist and user perspective, drawing on the information presented in the Health Needs chapter. Taken together, an assessment will be made of how well current pharmacy services meet the needs of Islington's population.

As discussed in Section 2.3, the regulations covering the PNA require that pharmaceutical services are assessed in terms of the population's need and any gaps in necessary or relevant services, any improvements and better access, and other NHS services provided in the area. The PNA is also expected to explain where other services have been taken into account to influence the final assessment and recommendations.

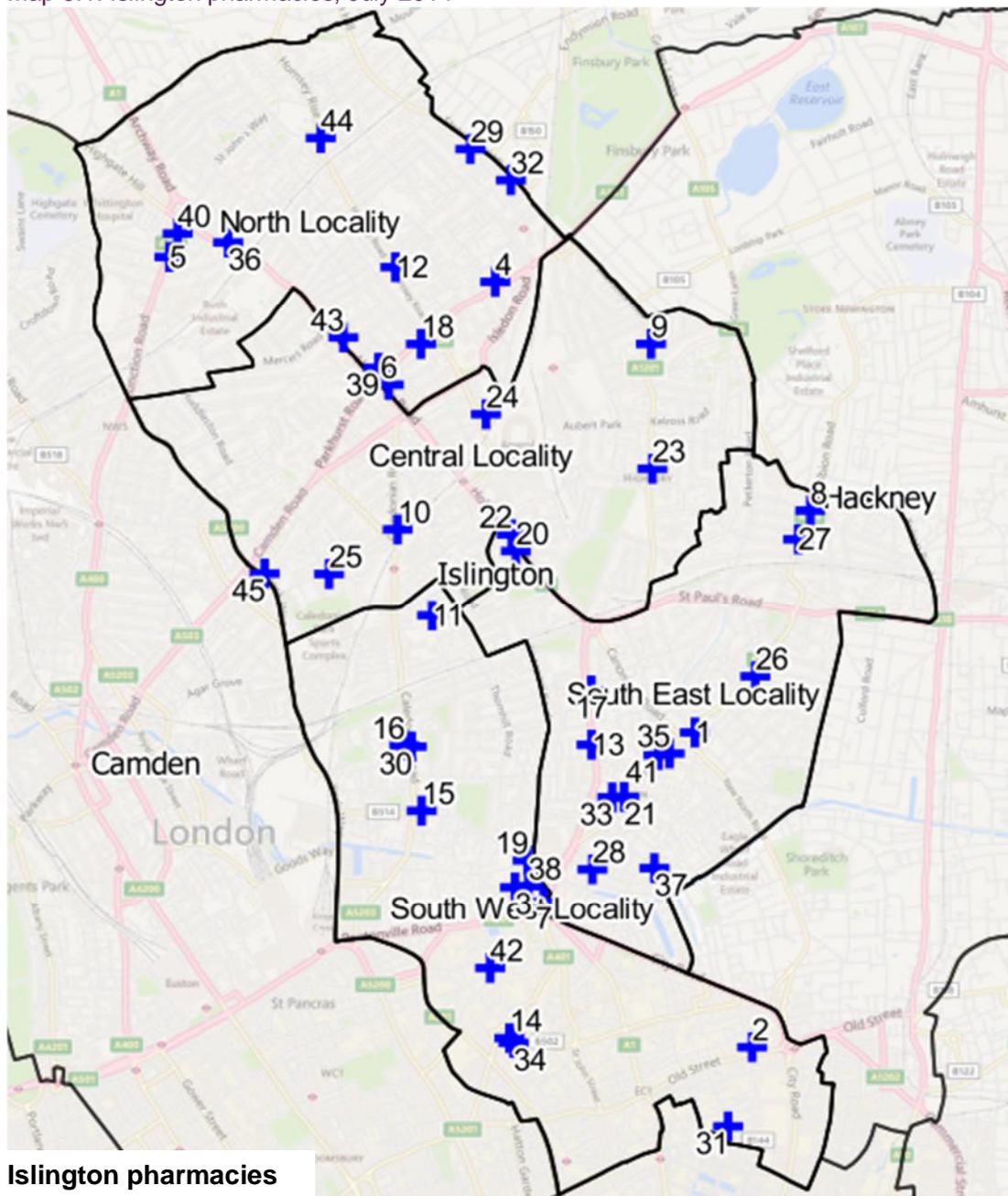
5.1. Pharmacies in Islington

5.1.1. Distribution of pharmacies

There are 45 pharmacies in Islington; for reference all of the pharmacies are shown on Map 5.1. Overall, Islington has 21 pharmacies per 100,000 residents, which is close to the London average of 23 pharmacies per 100,000 residents (Figure 5.1). The locations of Islington's pharmacies are shown in Map 5.1. In the North locality there are 12 pharmacies, 23 per 100,000 residents. Seven of the pharmacies are in the Finsbury Park ward, with a cluster near Finsbury Park station. The Central locality has fewer pharmacies (seven), and fewer pharmacies per 100,000 residents, than the other localities, however there are a number of pharmacies close to the locality boundaries and the borough boundaries which may help to serve the population. The South East and South West localities each have 13 pharmacies. Within these localities St Mary's ward has six pharmacies, with pharmacies clustered around Angel tube station and the busy shopping and business areas, while Canonbury ward only has one pharmacy. There are also a large number of pharmacies in the neighbouring boroughs which may serve people living in the South East and South West localities. The use of neighbouring pharmacies for dispensing and other services is discussed further in Section 5.2.4.

There are no mail order or internet-based pharmacies based in Islington, but residents do use mail order pharmacies. A full list of pharmacies in Islington can be found in Appendix A.

Map 5.1: Islington pharmacies, July 2014



Islington pharmacies

- | | | |
|--|--|---|
| 1. Apex Pharmacy (Essex Road) | 15. Clockwork Pharmacy (161 Caledonian Road) | 31. Portmans Pharmacy |
| 2. Apex Pharmacy (Old Street) | 16. Clockwork Pharmacy (273 Caledonian Road) | 32. Roger Davies Pharmacy |
| 3. Apteka Chemist (Chapel Market) | 17. Dermacia Pharmacy | 33. Rose Chemist |
| 4. Apteka Chemist (Seven Sisters Rd) | 18. Devs Chemist | 34. Rowlands Pharmacy |
| 5. Arkle Pharmacy | 19. Douglas Pharmacy | 35. Savemain Ltd |
| 6. Boots the Chemist (Holloway Road) | 20. Egerton Chemist | 36. Shivo Chemists |
| 7. Boots the Chemist (Islington High St) | 21. Essex Pharmacy | 37. St Peter's Pharmacy |
| 8. Boots the Chemist (Newington Green) | 22. G Atkins | 38. Superdrug Pharmacy (Chapel Market) |
| 9. C&H Chemist | 23. Highbury Pharmacy | 39. Superdrug Pharmacy (Seven Sisters Road) |
| 10. Caledonian Pharmacy | 24. Hornsey Road Pharmacy | 40. The Co-Operative Pharmacy |
| 11. Carters Chemist | 25. Islington Pharmacy | 41. Turnbills Chemist |
| 12. Chemitex Pharmacy | 26. Leoprim Chemist | 42. W C and K King Chemist |
| 13. Clan Pharmacy | 27. Mahesh Chemists | 43. Wellcare Pharmacy |
| 14. Clerkenwell Pharmacy | 28. New North Pharmacy | 44. Wise Chemist |
| | 29. Nuchem Pharmaceuticals Ltd | 45. York Pharmacy |
| | 30. P Edward Ltd | |

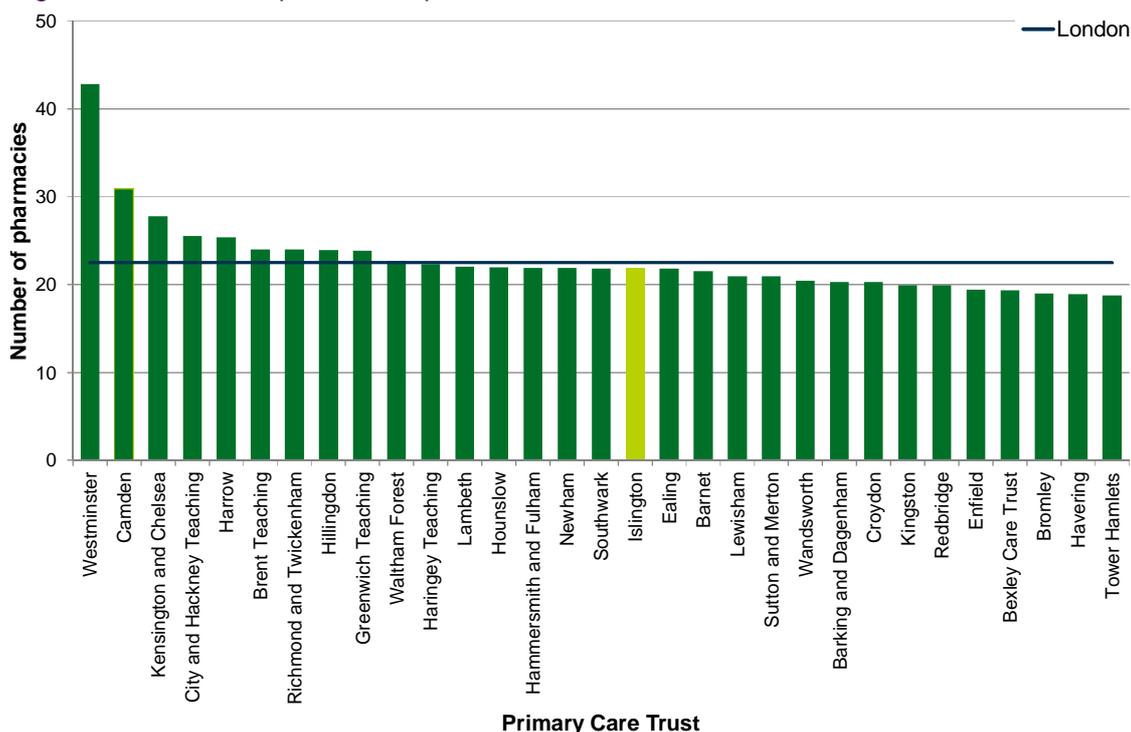
Source: NHS England, 2014

Table 5.1: Number of pharmacies by Islington ward and locality, and the number of pharmacies per 100,000 population.

Locality and Ward		Total population	Number of pharmacies	Pharmacies per 100,000 residents
North	Finsbury Park	14,930	7	47
	Hillrise	12,090	0	-
	Junction	12,610	3	24
	Tollington	13,620	2	15
	North Total	53,250	12	23
Central	Highbury East	11,930	3	25
	Highbury West	15,900	1	6
	Holloway	15,730	3	19
	St George's	12,810	0	-
	Central Total	56,370	7	12
South East	Canonbury	12,260	1	8
	Mildmay	13,230	2	15
	St Mary's	12,170	6	49
	St Peter's	12,710	4	31
	South East Total	50,370	13	26
South West	Barnsbury	12,720	4	31
	Bunhill	16,140	2	12
	Caledonian	14,560	4	27
	Clerkenwell	12,110	3	25
	South West Total	55,530	13	23
Islington Total		215,520	45	21

Source: GLA, 2014 and NHS England, 2014

Figure 5.1: Number of pharmacies per 100,000 residents, London PCTs, 2012/13



Source: HSCIC, 2014

5.1.2. Opening hours

Each pharmacy is required to open for 40 ‘core hours’ each week. The core hours are defined in the pharmacy’s terms of service and cannot be changed without the consent of NHS England. Many pharmacies also open for additional hours during the week, which are known as supplementary hours. In Islington there is one pharmacy on a 100 hour contract. A full breakdown of pharmacy opening hours can be seen in Appendix G.

Weekday opening hours

The most common opening hours on weekdays are 9am to 6pm or 7pm, with 37 Islington (82%) pharmacies opening between these hours (Map 5.2). One pharmacy, in the Central locality, closes for a lunch break Monday to Wednesday, and Friday; and on Thursday this pharmacy closes all afternoon. On a Wednesday one pharmacy in the South East closes at 2pm; on Thursday a pharmacy in the North locality closes at 12:30; and on Friday several pharmacies across the borough close early, the earliest at 3pm.

A total of eight (18%) pharmacies across the borough open before 9am. At least one pharmacy in each locality is open before 9am, with Islington Pharmacy the first to open, at 6am in the Central locality. Similarly, seven pharmacies open after 7pm, with two pharmacies in each of the Central, South East and South West localities and one in the North locality. This summary of opening hours is also shown in Table 5.2 and the exact opening hours (as at July 2014) are shown in Appendix G.

Weekend opening hours

Opening hours at weekends show more variation between pharmacies. Table 5.3 summarises the opening hours for Saturday, showing that there are 37 (82%) pharmacies open on Saturday (see also Map 5.3). Highbury West is the only ward which has a pharmacy but has no pharmacy open on a Saturday. Two pharmacies open at 8am on Saturday, one in the North and one in the Central locality. Only one pharmacy is open after 7pm, Islington Pharmacy which is open until 11pm again.

On Sundays there are six pharmacies (13%) open in Islington, two in the North locality, one in the South East, and three in the South West. Collectively they cover hours between 10am and 6pm. This data is summarised in Table 5.4, and also shown in Map 5.4, with the full list of opening hours are showing in Appendix G.

Bank holiday opening hours

Ensuring pharmacy coverage on a Bank Holiday is the responsibility of NHS England's Area Team – pharmacies are not required to open but pharmacies are encouraged to notify the Area Team of their intentions to allow for service planning. If the Area Team determines that too few pharmacies are intending to open in a particular area they can direct pharmacies to remain open. As the situation changes from one Bank Holiday to the next, it is not possible to present any specific data on Bank Holiday opening hours.

Out of hours services

Islington's out of hours GP service is provided by Harmoni; patients calling the NHS Out of Hours service will be referred to Harmoni's service, which offers emergency appointments at a small number of GP practices across the borough, covering from 6:30pm until 8am.

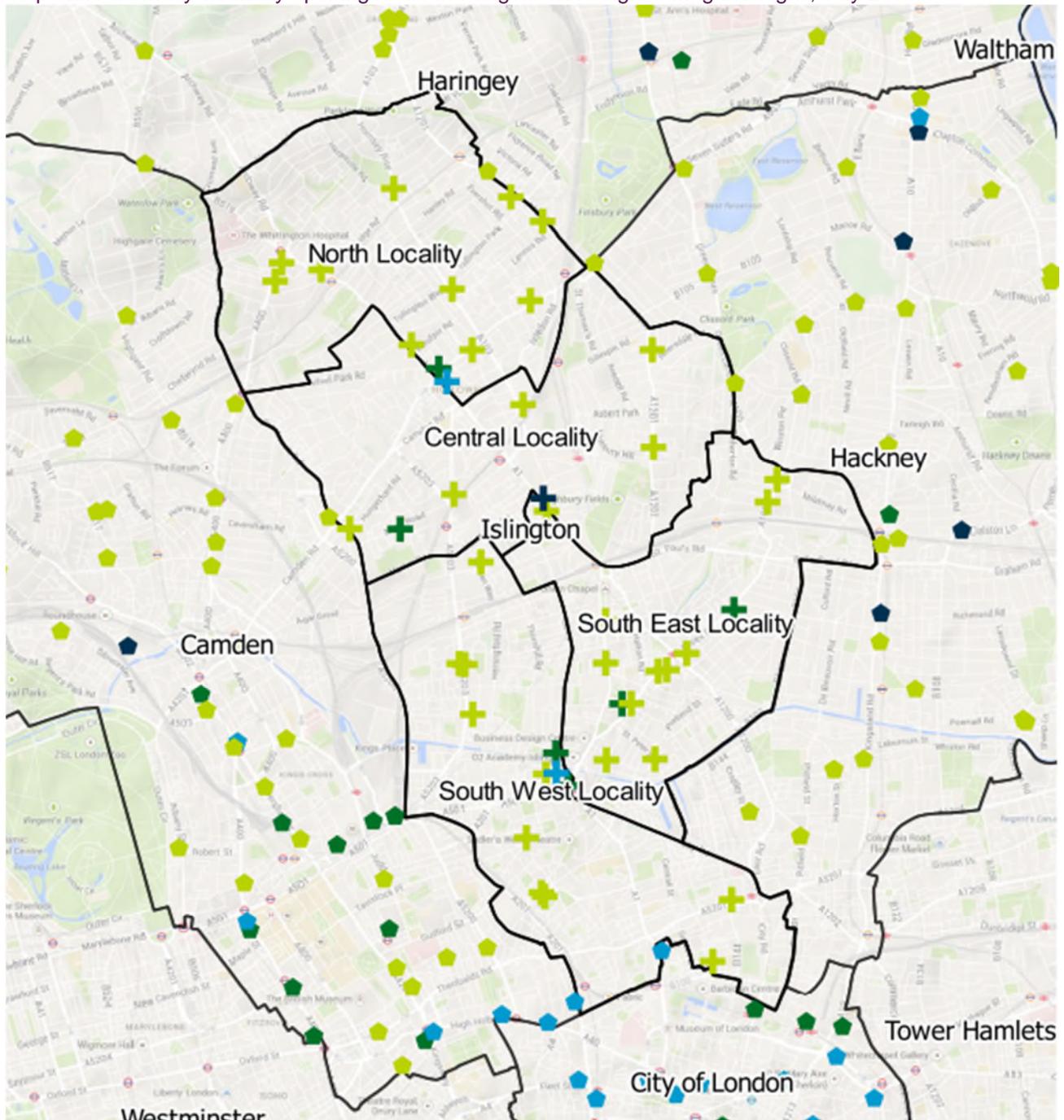
During the week there is one pharmacy in the Central locality which is open until 11pm each day. In the North locality there are no pharmacies open after 7pm, in the South East locality one pharmacy is open until 9pm, and in the South West there is a pharmacy open until 8pm. On Saturdays only one pharmacy in the Central locality is open late, again until 11pm; there are also pharmacies close to the Islington border in Hackney and Camden which are open late and may serve some of the Islington residents; however residents in the north of the borough are likely to have longer journeys to access a pharmacy on a Saturday evening. On Sundays, there are no pharmacies in Islington open after 5pm; residents would need to travel to neighbouring pharmacies on the north-side of Finsbury Park in Haringey, near King's Cross in Camden, or in the City of London. As there are no late-opening pharmacies in Hackney, residents on the eastern side of Islington may have longer journeys to access a pharmacy on Sunday evenings.

Table 5.2: Summary of pharmacy weekday opening hours, by locality and ward, July 2014

Locality and Ward		Standard Hours: Open between 9am and 7pm	Early Hours: Open before 9am	Late Hours: Open after 7pm	Extended Hours: Open before 9am and after 7pm
North	Finsbury Park	5	1	0	1
	Hillrise	0	0	0	0
	Junction	3	0	0	0
	Tollington	2	0	0	0
	North Total	10	1	0	1
Central	Highbury East	2	0	1	0
	Highbury West	1	0	0	0
	Holloway	2	0	0	1
	St George's	0	0	0	0
	Central Total	5	0	1	1
South East	Canonbury	0	0	0	1
	Mildmay	2	0	0	0
	St Mary's	5	0	0	1
	St Peter's	4	0	0	0
	South East Total	11	0	0	2
South West	Barnsbury	1	1	0	2
	Bunhill	2	0	0	0
	Caledonian	4	0	0	0
	Clerkenwell	3	0	0	0
	South West Total	10	1	0	2

Source: NHS England, 2014

Map 5.2: Pharmacy weekday opening hours in Islington and neighbouring boroughs, July 2014.



Islington pharmacy weekday opening hours

- + Extended Hours: Open before 9am and after 7pm
- + Standard Hours: Open between 9am and 7pm
- + Late Hours: Open after 7pm
- + Early Hours: Open before 9am

Islington Neighbours weekday opening hours

- Extended Hours: Open before 9am and after 7pm
- Standard Hours: Open between 9am and 7pm
- Late Hours: Open after 7pm
- Early Hours: Open before 9am

Map data © Google

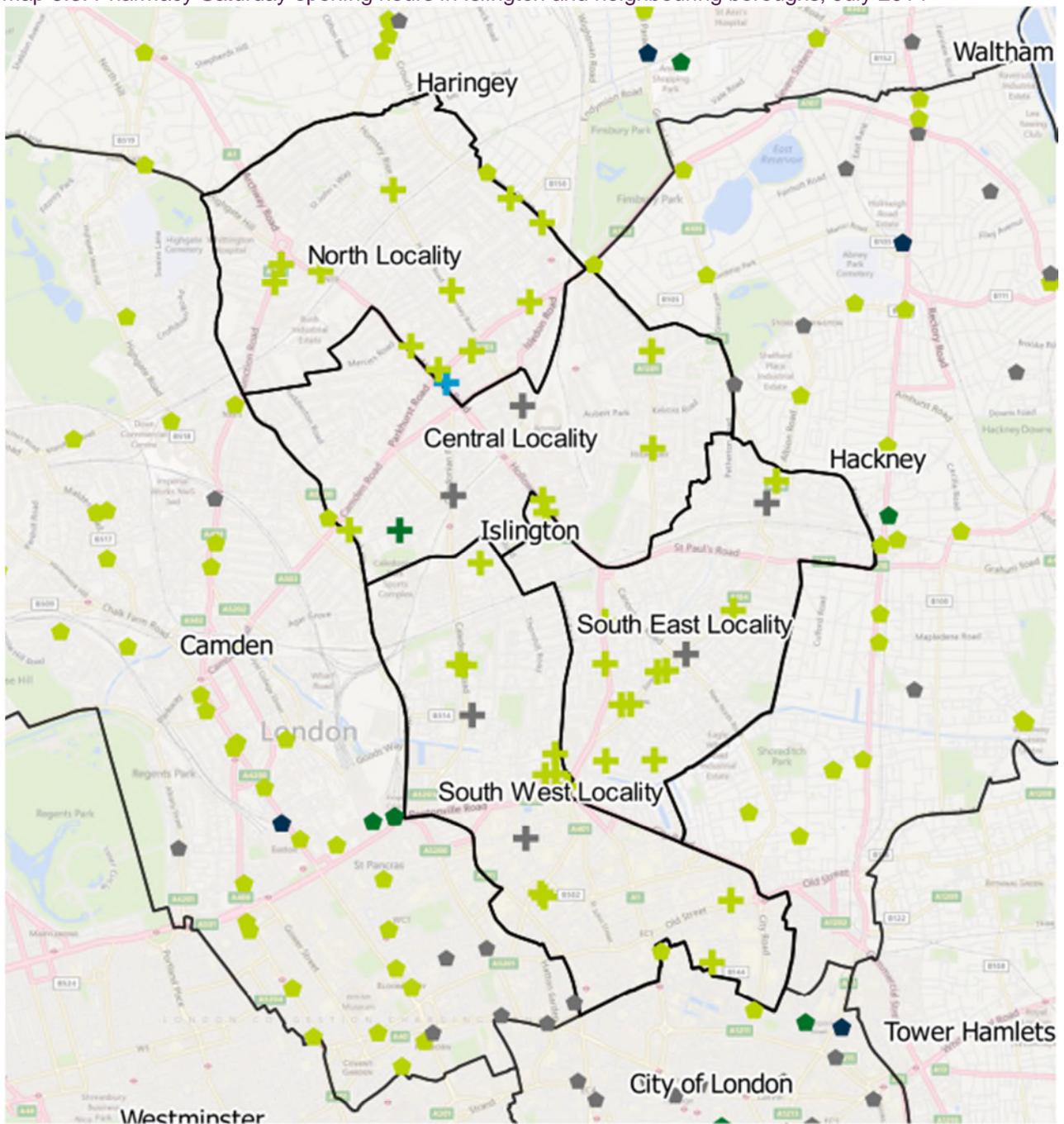
Source: NHS England, 2014

Table 5.3: Summary of pharmacy Saturday opening hours in Islington, by locality and ward, July 2014

Locality and Ward		Standard Hours: Open between 9am and 7pm	Early Hours: Open before 9am	Late Hours: Open after 7pm	Extended Hours: Open before 9am and after 7pm	Closed
North	Finsbury Park	6	1	0	0	0
	Hillrise	0	0	0	0	0
	Junction	3	0	0	0	0
	Tollington	2	0	0	0	0
	North Total	11	1	0	0	0
Central	Highbury East	3	0	0	0	0
	Highbury West	0	0	0	0	1
	Holloway	1	0	0	1	1
	St George's	0	0	0	0	0
	Central Total	4	0	0	1	2
South East	Canonbury	1	0	0	0	0
	Mildmay	1	0	0	0	1
	St Mary's	6	0	0	0	0
	St Peter's	3	0	0	0	1
	South East Total	11	0	0	0	2
South West	Barnsbury	4	0	0	0	0
	Bunhill	2	0	0	0	0
	Caledonian	3	0	0	0	1
	Clerkenwell	2	0	0	0	1
	South West Total	11	0	0	0	2

Source: NHS England, 2014

Map 5.3: Pharmacy Saturday opening hours in Islington and neighbouring boroughs, July 2014



Islington Saturday opening hours

- + Extended Hours: Open before 9am and after 7pm
- + Standard Hours: Open between 9am and 7pm
- + Late Hours: Open after 7pm
- + Early Hours: Open before 9am
- + Closed

Islington Neighbours Saturday opening hours

- Extended Hours: Open before 9am and after 7pm
- Standard Hours: Open between 9am and 7pm
- Late Hours: Open after 7pm
- Early Hours: Open before 9am
- Closed

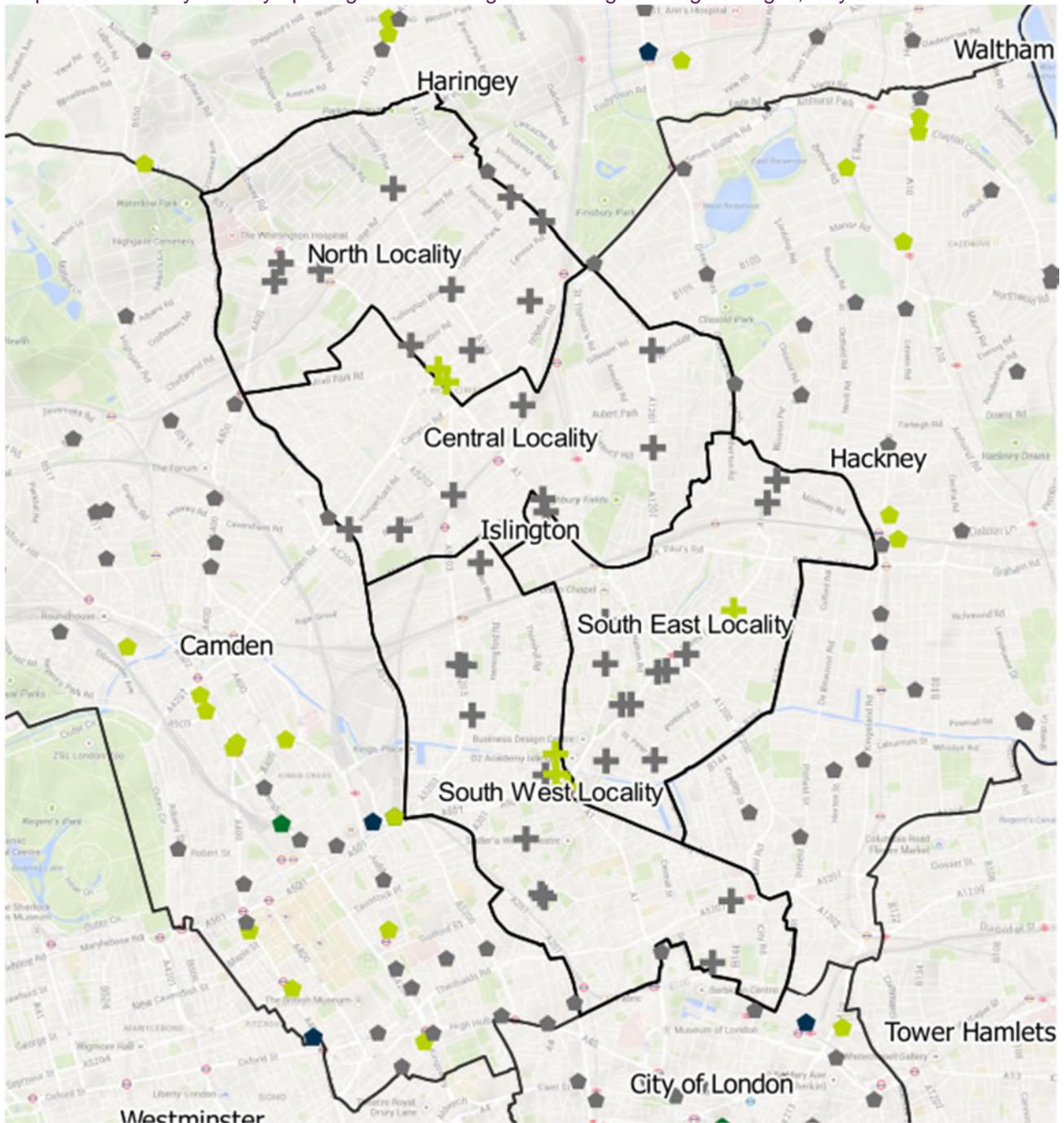
Source: NHS England, 2014

Table 5.4: Summary of pharmacy Sunday opening hours in Islington, by locality and ward, July 2014

Locality and Ward		Standard Hours: Open between 9am and 7pm	Early Hours: Open before 9am	Late Hours: Open after 7pm	Extended Hours: Open before 9am and after 7pm	Closed
North	Finsbury Park	2	0	0	0	5
	Hillrise	0	0	0	0	0
	Junction	0	0	0	0	3
	Tollington	0	0	0	0	2
	North Total	2	0	0	0	10
Central	Highbury East	0	0	0	0	3
	Highbury West	0	0	0	0	1
	Holloway	0	0	0	0	3
	St George's	0	0	0	0	0
	Central Total	0	0	0	0	7
South East	Canonbury	1	0	0	0	0
	Mildmay	0	0	0	0	2
	St Mary's	0	0	0	0	6
	St Peter's	0	0	0	0	4
	South East Total	1	0	0	0	13
South West	Barnsbury	3	0	0	0	1
	Bunhill	0	0	0	0	2
	Caledonian	0	0	0	0	4
	Clerkenwell	0	0	0	0	3
	South West Total	3	0	0	0	11

Source: NHS England, 2014

Map 5.4: Pharmacy Sunday opening hours in Islington and neighbouring boroughs, July 2014



Islington Sunday opening hours

- + Extended Hours: Open before 9am and after 7pm
- + Standard Hours: Open between 9am and 7pm
- + Late Hours: Open after 7pm
- + Early Hours: Open before 9am
- + Closed

Islington Neighbours Sunday opening hours

- Extended Hours: Open before 9am and after 7pm
- Standard Hours: Open between 9am and 7pm
- Late Hours: Open after 7pm
- Early Hours: Open before 9am
- Closed

Source: NHS England, 2014

CONCLUSIONS ON PHARMACY DISTRIBUTION AND OPENING HOURS

Islington has a similar density of pharmacies to the London average, which suggests that the number of pharmacies is adequate for the size of the borough's population. There are small pockets of the borough which are more than 500 metres from a pharmacy, however with pharmacies clustered around major transport connections it is likely that all residents can access a pharmacy fairly easily. There are a small number of pharmacies open early in the mornings and late evenings - residents who live a long way from Finsbury Park or Angel will have longer journeys to reach a pharmacy outside of normal working hours.

Access at weekends is particularly limited, with six pharmacies open on a Sunday and no pharmacies open before 10am or after 6pm. Again, there is coverage across the border in Haringey and Camden after these hours, both of which are served by good transport links.

Some focus group participants mentioned that pharmacies could do more to support people with reduced mobility, including access for wheelchairs and providing seating in pharmacies for people waiting to be seen.

Based on the information collated and discussed, new pharmacies are not required in Islington, but some additional capacity at weekends may be desirable.

FOR CONSIDERATION

5.2.2. Repeat dispensing

The repeat dispensing service allows patients to collect their prescription from their pharmacy, without requesting a new prescription from their GP. This service aims to reduce the amount of GP visits for repeat prescriptions, facilitate easier planning for pharmacies, reduce waste, and increase the convenience of patients on repeat medications.

Some focus group participants mentioned repeat dispensing as being a particularly efficient and useful service, which they felt contributed to the overall convenience of the pharmacy service.

The latest data indicates that for Islington, 5% of all items were repeat prescriptions.

5.2.3. Electronic Prescription Service

The Electronic Prescriptions Service enables prescriptions to be sent electronically from GPs to pharmacies. The service started in Islington in March 2014, and all of Islington's GP Practices are expected to be live on the EPS2 system by September. The latest prescribing data shows that a small number of prescriptions are issued through the EPS with just 1.5% in June 2014; however the proportion is thought to be rising rapidly (Table 5.5).

Table 5.5: Number and percentage of prescriptions issued through the EPS at Islington pharmacies

Month	Total prescriptions	EPS prescriptions	% EPS of total
April 14	201,858	43	0.2%
May 14	210,014	887	0.4%
June 14	206,331	3,040	1.5%

Source: ePact, 2014

5.2.4. Other services

Cross border dispensing services

Patients can choose to have their prescriptions filled by any NHS pharmacy, so a substantial number of people use pharmacies outside of the borough. In 2013/14, 17% (400,912) of items prescribed by Islington GPs were dispensed by pharmacies outside of Islington. The most frequently used pharmacies are listed in Table 5.6, and mostly fall in the immediately neighbouring boroughs.

Table 5.6: The top ten pharmacies most frequently used outside of Islington.

Pharmacy	Address	Post code	Borough
Silent Bob Ltd	147 Fortess Road	NW5 2HR	Camden
Boots UK Limited	29 North Square	N9 0HW	Enfield
Mr S Shah	182 Stroud Green Road	N4 3RN	Haringey
Park Health Limited	286 Seven Sisters Road	N4 2AA	Hackney
Boots UK Limited	31-32 The Mall	E15 1XD	Newham
Patel KG & JG	21 Brecknock Road	N7 0BL	Camden
Anchor Health Ltd	Unit 2 45-47 Elgin Avenue	W9 3PP	Westminster
Boots UK Limited	82-84 Kingsland High St	E8 2NS	Hackney
Patel BK	162 Green Lanes	N16 9DL	Hackney
Boots UK Limited	Unit 19 St Pancras Station	NW1 2QP	Camden

Source: ePact, 2014

Essential Small Pharmacies Local Pharmaceutical Services Scheme

There are no pharmacies in Islington which receive payment under the Essential Small Pharmacies Local Pharmaceutical Services (ESPLPS) Scheme.

Dispensing appliance contractors

Pharmacies can provide surgical appliances, including stoma and urology appliances. 'Dispensing Appliance Contractors' specialise in these appliances and do not necessarily provide the broader range of services that community pharmacies offer.

There are two pharmacies in Islington on a Dispensing Appliance Contract, as well as a pharmacy in Barnet which may also support Islington residents.

Health promotion campaigns run by NHS England

Pharmacies also take part in health promotion campaigns, as set by NHS England. Local Authority Public Health departments can also run campaigns based on the local health needs and priorities.

Islington pharmacies support a number of health promotion campaigns organised by the Public Health department, including:

- **Publicising the 'Don't bottle it up' campaign.** The Public Health department issued all Islington pharmacies with prescription bags that advertised the 'Don't bottle it up' alcohol awareness campaign. Pharmacies dispensed items in the bags early in 2014, also linking in with the 'Dry January' publicity campaign.
- **The Pharmacy Cancer Awareness Campaign.** The campaign utilised the power of word of mouth to disseminate information and educate customers on cancer. Pharmacists would initiate conversations about the prevalence, early signs and risk factors of cancer. Special posters and quizzes were created as a point of

conversation in order to enable better engagement with customers. The health professionals would be paid for every conversation they had. This was evidenced by a log book they would complete with details about each conversation.

- **Promoting early access to maternity services.** In coming months, local pharmacists will display posters within their pharmacies and encourage all women who purchase pregnancy tests or related items to contact their local maternity service or GP before the 10th week of pregnancy.

CONCLUSIONS ON ESSENTIAL SERVICES

Community pharmacies play a vital role in providing care to Islington's population, particularly in their role in dispensing prescribed medication. Feedback from residents indicates that they value the repeat prescription service as it saves them time.

The average number of items dispensed per pharmacy in Islington is lower than most other boroughs. The low average per pharmacy suggests that current demand is being met and there may be capacity, on average, to meet any increased demand for prescriptions that might arise over the next few years as a result of inward migration and an increase in the prevalence of long term conditions. As all pharmacies offer these essential services, there are currently no identified gaps in provision.

Finally, there is scope to increase the impact of health promotion campaigns run through pharmacies, potentially by ensuring that they link in with local public health work to broaden the reach of public health services.

Based on the information presented, it has been concluded that essential services are **necessary** to meet the pharmaceutical needs of Islington's population. The provision of services is suitable for Islington's current population and for projected demographic changes. All pharmacies in Islington offer these services, so conclusions around coverage and opening hours mirror those given in Section 5.1.

5.3. Advanced Services

Advanced services form part of the NHS community pharmacy regulations and are clearly defined in regulations. Each pharmacy contractor can decide whether they provide these services, but they can only be offered if a pharmacy meets the criteria set out in the Secretary of State Directions. This section will cover the provision of the advanced services currently included in the pharmacy contract: medicine use review, appliance usage review, new medicine service, and stoma appliance customisation service.

5.3.1. Medicine Use Review and Prescription Intervention Service (MUR)

The MUR service assists those on multiple medications (or one medication in the high-risk category), specifically those with long term conditions, identifying any problems and giving advice on adherence. The pharmacy must have provided pharmaceutical services to the patient for the three months before an MUR can take place. The specific target groups identified for this service are:

- People taking high-risk medications (non-steroidal anti-inflammatory drugs, anticoagulants, antiplatelets and / or diuretics)
- People that have recently been discharged from hospital, in order to provide a more integrated care pathway for patients.
- People on respiratory medication for asthma or chronic obstructive pulmonary disease (COPD)

At least half of all MURs in a year must be in people from these risk groups. Under the service specification, pharmacies can provide up to 400 MURs each year.

As at June 2014, NHS England data showed that 42 (93%) of Islington's community pharmacies delivered the service (Map 5.5). In the North, Central, and South East localities, one pharmacy offering MUR does so earlier than the standard hours during the week, and both the Central and South East locality have a pharmacy offering the service later than 7pm on weekdays. No pharmacies in the South West locality offer the service outside of standard hours (Table 5.8). On Saturdays, 13% of pharmacies offering this service are closed, but the closures do not have a substantial effect on the number of pharmacies open by locality. Only one pharmacy in the North locality opens early on a Saturday and none open late, and one pharmacy in Central opens early and late; no pharmacies in the South East or South West localities open outside standard hours on a Saturday. On Sunday, four pharmacies offering MUR are open – two in the North locality and two in the South West. However, all four of these pharmacies are close to the locality boundaries – the pharmacies in the North locality are both on the border with the Central locality, and the South West pharmacies are on the border with the South East locality, so could reasonably be accessed by residents in the neighbouring localities.

Data on MURs provided by pharmacies for 2013/14 show that 9,348 MURs were carried out by 41 (91%) pharmacies in Islington (Table 5.7). On average, 203 MURs were carried out per pharmacy in Islington; the lowest in London (Figure 5.3).

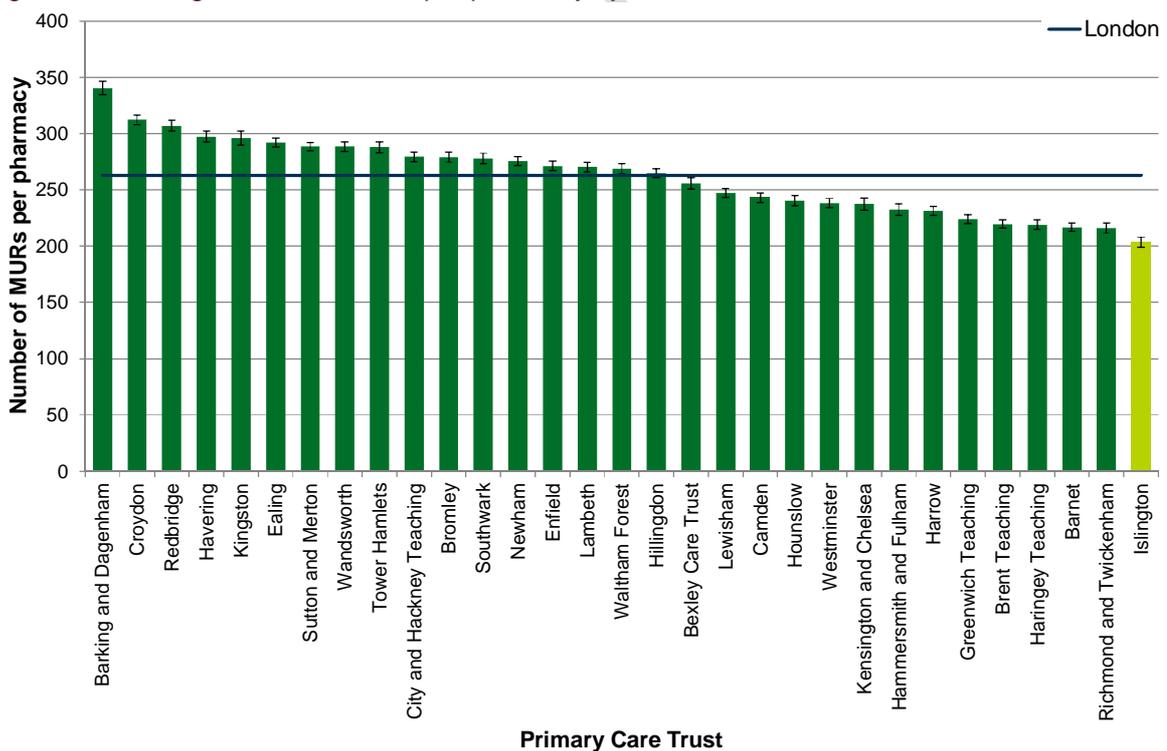
Table 5.7: Number of MURs provided, Islington pharmacies, 2013/14

Locality	Number of pharmacies	Total number provided	Average number per pharmacy per month
North	11	2,912	22
Central	5	932	14
South East	13	2,085	13
South West	12	3,519	24
Islington	41	9,348	19

Source: PSNC, 2013/14

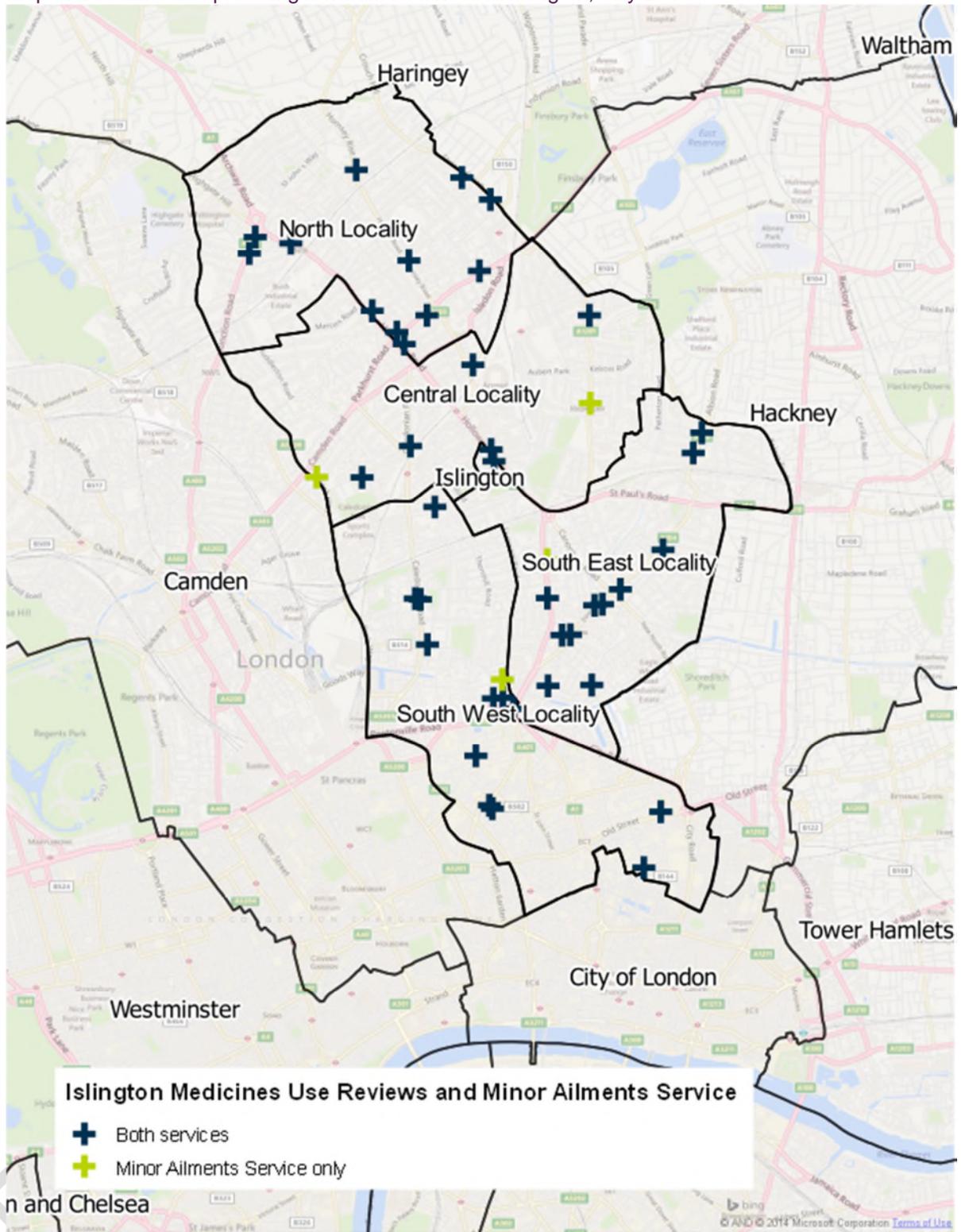
Due to the transience of Islington's population, the three month rule could result in people not being able to access this service that would otherwise benefit, or may mean that people who have recently arrived in the borough are travelling back to their previous borough of residence for appointments.

Figure 5.3: Average number of MUR per pharmacy by London PCT and London, 2012/13



Source: HSCIC, 2014

Map 5.5: Pharmacies providing advanced services in Islington, July 2014



Source: NHS England, 2014

Table 5.8: Opening hours of Islington pharmacies providing MUR, 2013/14

Locality and Ward		Weekday				Saturday					Sunday
		Standard Hours: Open between 9am and 7pm	Early Hours: Open before 9am	Late Hours: Open after 7pm	Extended Hours: Open before 9am and after 7pm	Standard Hours: Open between 9am and 7pm	Early Hours: Open before 9am	Late Hours: Open after 7pm	Extended Hours: Open before 9am and after 7pm	Closed	Standard Hours: Open between 9am and 7pm
North	Finsbury Park	6	1	0	0	6	1	0	0	0	0
	Hillrise	0	0	0	0	0	0	0	0	0	0
	Junction	3	0	0	0	3	0	0	0	0	0
	Tollington	2	0	0	0	2	0	0	0	0	0
	North Total	1	1	0	0	1	1	0	0	0	2
Central	Highbury East	1	0	1	0	2	0	0	0	0	0
	Highbury West	1	0	0	0	0	0	0	0	1	0
	Holloway	1	0	0	1	0	0	0	1	1	0
	St George's	0	0	0	0	0	0	0	0	0	0
	Central Total	3	0	1	1	2	0	0	1	2	0
South East	Canonbury	0	0	0	1	1	0	0	0	0	0
	Mildmay	2	0	0	0	1	0	0	0	1	0
	St Mary's	4	0	1	0	5	0	0	0	0	0
	St Peter's	4	0	0	0	3	0	0	0	1	0
	South East Total	1	0	1	1	0	0	0	0	2	0
South West	Barnsbury	3	0	0	0	3	0	0	0	0	0
	Bunhill	2	0	0	0	2	0	0	0	0	0
	Caledonian	4	0	0	0	3	0	0	0	1	0
	Clerkenwell	3	0	0	0	2	0	0	0	1	0
	South West Total	1	0	0	0	0	0	0	0	2	0

CONCLUSIONS ON MEDICINES USE REVIEW (MUR)

MUR can help people with long term conditions manage their conditions better and potentially remain healthier for longer, thereby helping to reduce health inequalities, Focus group participants with long term conditions also identified reviews as helpful, as patterns of medication use can change, and they may need reminding of this. The knowledge and expertise of pharmacists is crucial in this context.

Based on the information presented regarding the prevalence of long term conditions in the borough, the MUR service is a **necessary service** for Islington's population because of the high levels of need locally and the clear benefits of the service in addressing this need. We have identified the following potential current gaps:

- Islington has the lowest uptake of MUR in London. Pharmacies in the Central and South East locality provide fewer MURs on average than the other localities. In both localities only one pharmacy offering MUR does so outside of standard hours during the week. The North locality does not have any pharmacy offering MUR operating outside of standard working hours. An increase of pharmacies providing MUR services outside of working hours on week-days is recommended in all localities, as well as a general increase in offer and uptake.
- Opening hours: on Saturdays and Sundays, in all localities except the North, all the pharmacies offering this service were closed during standard working hours. An increase of pharmacies providing MUR at the weekend in all localities except the North is recommended.
- Eligibility: Given the high population turnover within the borough, the three month rule may result in people not being able to access this service who would otherwise benefit.

The findings of the assessment indicate that there is scope to increase the number of MURs carried out in Islington, as well as the number of pharmacies that offer the service.

People with long term conditions attending the focus group commented on how much they rely on the pharmacist for advice on patterns of using medicines, clashes between different medications and the chance to discuss their concerns. The medication review service was also considered to be important in this respect and those who had used it had a positive experience. It would be advisable for pharmacies to let patients know if they have a private consultation room available. By increasing the availability of MURs, this group may feel more positive about seeking help from pharmacies rather than their GP.

With the service's emphasis on integrated care, reducing hospital admissions, and better management of long term conditions, this service would allow for improved outcomes and a reduction in the number of GP consultations locally if NHS England (as commissioners) increased the breadth of this service.

5.3.2. New Medicine Service (NMS)

The NMS was introduced in 2011 and supports patients with long term conditions when a new prescription medicine is introduced. It aims to improve adherence to new medication, focusing on people with specific conditions:

- Asthma and COPD
- Type 2 diabetes
- Antiplatelet or anticoagulation therapy
- Hypertension

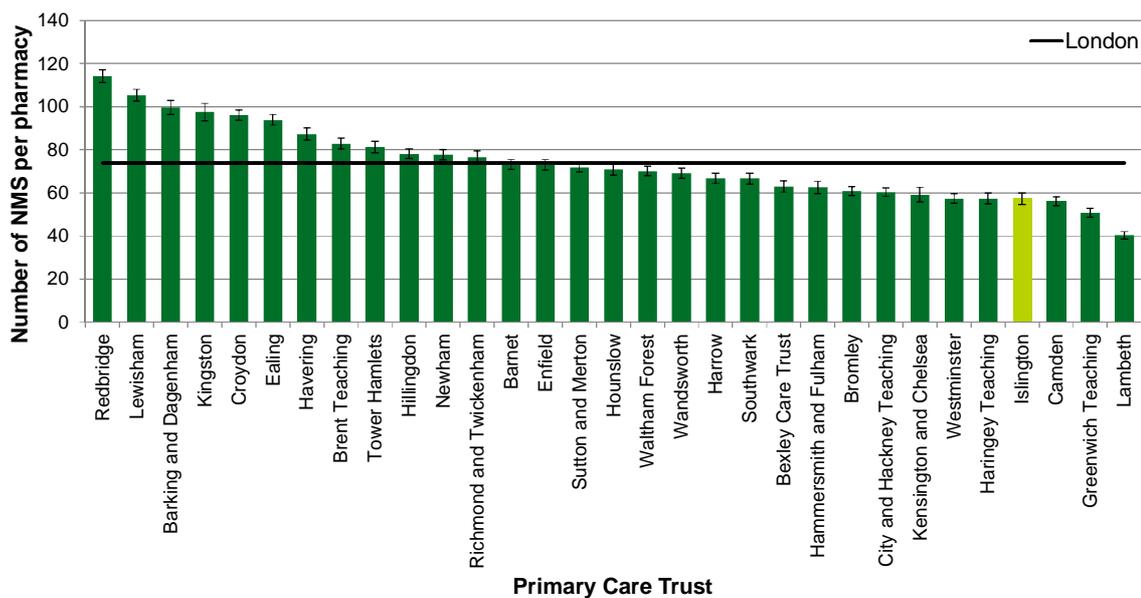
A patient may be referred by their primary or secondary care practitioner when starting to use a new medicine, and pharmacists can also identify suitable patients. Patients are eligible regardless of how long they have used the pharmacy (unlike MUR). The amount of NMS a pharmacy can undertake is linked to the total dispensing of the pharmacy overall. Though originally commissioned to March 2013, the service has been extended to March 2015, and further extension of the service is currently unknown.

The Department of Health Policy Research has published a national evaluation of the NMS concluding that the NMS significantly increased adherence by about 10% and increased numbers of medicines problems identified and dealt with, compared with current practice²².

NHS England data suggest that there are currently 30 pharmacies in Islington offering NMS to patients; however 34 Islington pharmacies were providing this service in 2012/13 according to data from the HSCIC. We will use 2012/13 data for this needs assessment as it is considered more accurate. There were a total of 1,948 NMS carried out in Islington pharmacies in that year. The number of NMS per pharmacy offering the service was amongst the lowest in London (57 per pharmacy, Figure 5.4).

²² Department of Health Policy Research, Understanding and Appraising the New Medicines Service in the NHS in England (2014)
<http://www.nottingham.ac.uk/~pazmjb/nms/downloads/report/files/assets/common/downloads/108842%20A4%20Main%20Report.v4.pdf>

Figure 5.4: Average number of new medicines services per pharmacy, London PCTs and London, 2012/13



Source: HSCIC, 2014

CONCLUSIONS ON NEW MEDICINES SERVICE (NMS)

NMS is aimed at people with long term conditions with newly prescribed medications to improve adherence, leading to better health outcomes. NMS is a **relevant service** for the Islington population, as it improves access to medication review, support, and enhances patient experience.

As with MUR, the pharmacies' opening hours could potentially represent an obstacle to access these services.

The number of NMS carried out per participating pharmacy in Islington in 2012/13 suggests that there is scope to increase the number of NMS carried out in the borough.

5.3.3. Appliance Use Review (AUR)

Appliance use reviews aim to improve patients' knowledge and use of their 'specified appliance' (as dispensed by the pharmacy), to improve adherence to medication and minimise waste. There is a limit to the number of AURs a pharmacy can carry out; again, these are linked to the total volume dispensed.

There are currently no pharmacies in Islington that have signed up to offer AURs, which is no different to 2012/13. Only nine pharmacies in London offered this service in that year. The level of AURs is low across England, and this can be partly explained due to the support patients receive in secondary care, or other clinics, when establishing their ongoing care.

5.3.4. Stoma Appliance Customisation (SAC)

The SAC service aims to ensure proper use and comfortable fit of a patient's stoma appliance, thereby extending the duration of use and minimising waste. There are specific appliances listed in the contract which are eligible for this service. There are no limits to the number of SACs that a pharmacy can carry out.

There are currently no pharmacies in Islington that have signed up to offer SACs, while there were two in 2012/13. In that year there were 77 pharmacies offering this service in London, carrying out on average 921 SACS per pharmacy.

The low level of SAC services offered in Islington may be explained by the advice and support patients receive from other care providers.

CONCLUSIONS ON APPLIANCE USE REVIEW (AUR) AND STOMA APPLIANCE CUSTOMISATION (SAC)

There are no Islington pharmacies currently providing either AUR or SAC, perhaps due to the advice and support patients receive from other care providers. As both services are designed to improve access, AUR and SAC are **relevant services** in Islington. Access to the services was not raised as a gap by focus group participants, and there have not been other complaints from other services. As such, there are no identified current or future gaps.

5.4. Enhanced services

Enhanced services are commissioned by NHS England from community pharmacies and are defined in the Directions. However, unlike advanced services, local commissioners can alter the specification of enhanced services. Each service is defined within a service level agreement, provided by NHS England.

5.4.1. Minor ailments service

The minor ailments service provides treatment to people who would otherwise seek advice from their GP or other urgent care services for a relatively minor ailment. By doing this, the service aims to divert patients away from primary and secondary care services to community pharmacies, thereby:

- Decreasing the number of consultations in primary and unscheduled care
- Improving access to care and advice
- Improving patient education and increasing awareness of self-care methods
- Better use of pharmacists' skills

Patients are able to access the service through self-referral, or by being referred from other healthcare professionals. Pharmacists must be accredited before offering the service. The scope of the service is limited to specific conditions including: colds and 'flu, dermatology,

pain, gastrointestinal, women’s health and other common conditions such as hay fever and cold sores.

In Islington, 45 (100%) of pharmacies offer the MAS. In the North, Central and South East localities one pharmacy offers the service before 9am, while only the Central and South East localities have pharmacies offering the service after 7pm (Table 5.10). On Saturdays, 39 pharmacies offering this service were open, with only two pharmacies providing coverage outside of 9am – 7pm. On Sunday, four pharmacies offering the MAS are open, and none are open outside of 10am and 5pm.

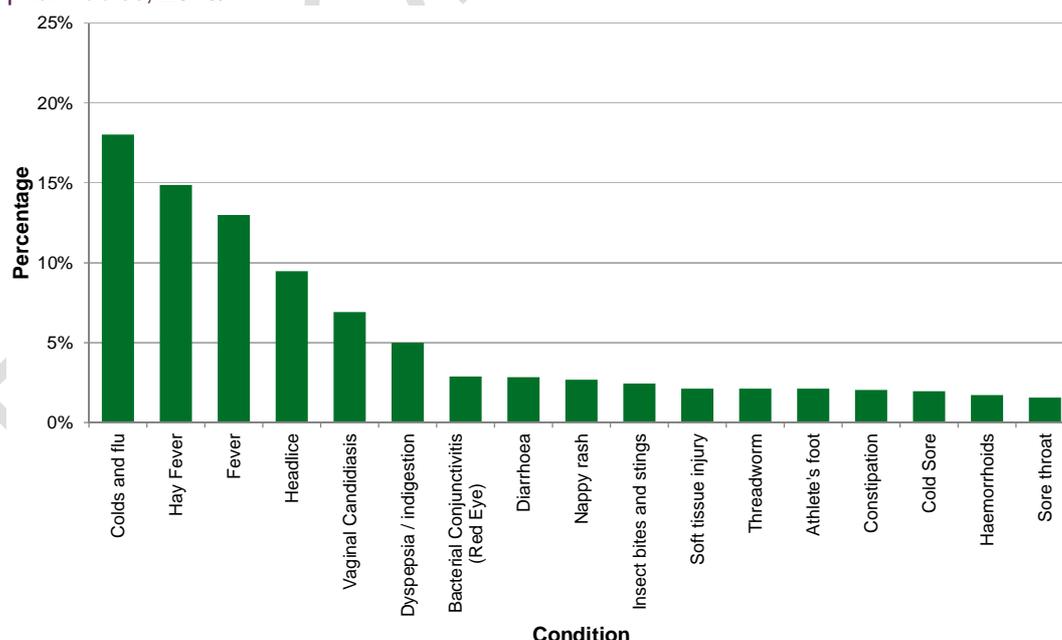
In 2013/14, there were almost 40,000 consultations as a part of the Minor Ailments Scheme, with over half of the consultations taking place in the South locality (Table 5.9). The mostly frequently diagnosed ailments are colds and ‘flu (18%), hayfever (15%) and fever (13%) (Figure 5.5).

Table 5.9: Number of Minor Ailments consultations, by locality, 2013/14

Locality	Number of consultations
North	12,494
Central	3,557
South East	13,672
South West	10,241
Grand total	39,964

Source: Islington Clinical Commissioning Group, 2014

Figure 5.5: Breakdown of the conditions diagnosed through the Minor Ailments Scheme, Islington pharmacies, 2013/14



Source: Islington Clinical Commissioning Group, 2014

Note: Eight conditions which each contribute less than 2% of consultations have been excluded from this graph for ease of interpretation, along with 542 consultations with recorded condition.

Table 5.10: Opening hours of pharmacies providing MAS, 2013/14

Locality and Ward		Weekday				Saturday					Sunday				
		Standard Hours: Open between 9am and 7pm	Early Hours: Open before 9am	Late Hours: Open after 7pm	Extended Hours: Open before 9am and after 7pm	Standard Hours: Open between 9am and 7pm	Early Hours: Open before 9am	Late Hours: Open after 7pm	Extended Hours: Open before 9am and after 7pm	Closed	Standard Hours: Open between 9am and 7pm	Early Hours: Open before 9am	Late Hours: Open after 7pm	Extended Hours: Open before 9am and after 7pm	Closed
North	Finsbury Park	6	1	0	0	6	1	0	0	0	2	0	0	0	5
	Hillrise	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Junction	3	0	0	0	3	0	0	0	0	0	0	0	0	3
	Tollington	2	0	0	0	2	0	0	0	0	0	0	0	0	2
	North Total	11	1	0	0	11	1	0	0	0	2	0	0	0	10
Central	Highbury East	2	0	1	0	3	0	0	0	0	0	0	0	0	3
	Highbury West	1	0	0	0	0	0	0	0	1	0	0	0	0	1
	Holloway	2	0	0	1	1	0	0	1	1	0	0	0	0	3
	St George's	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Central Total	5	0	1	1	4	0	0	1	2	0	0	0	0	7
South East	Canonbury	0	0	0	1	1	0	0	0	0	0	0	0	0	1
	Mildmay	2	0	0	0	1	0	0	0	1	0	0	0	0	2
	St Mary's	5	0	1	0	6	0	0	0	0	0	0	0	0	6
	St Peter's	4	0	0	0	3	0	0	0	1	0	0	0	0	4
	South East Total	11	0	1	1	11	0	0	0	2	0	0	0	0	13
South West	Barnsbury	4	0	0	0	4	0	0	0	0	2	0	0	0	2
	Bunhill	2	0	0	0	2	0	0	0	0	0	0	0	0	2
	Caledonian	4	0	0	0	3	0	0	0	1	0	0	0	0	4
	Clerkenwell	3	0	0	0	2	0	0	0	1	0	0	0	0	3
	South West Total	13	0	0	0	11	0	0	0	2	2	0	0	0	11

CONCLUSION ON MAS

The MAS helps to meet the Health and Wellbeing board priorities of reducing health inequalities, by improving access to treatment services, and partnership working, by extending the network of healthcare providers that can provide care for minor conditions.

The information shown indicates that the MAS is a **necessary service** in Islington, as it directs patients away from GP Practices by allowing them an easily accessible way to be treated for minor ailments.

The service coverage is good on weekdays as almost all pharmacies provide the service, and there are a number of pharmacies open late. However as with the overall pharmacy provision, coverage is lower at weekends; there is only one pharmacy open early and one open late on Saturday in the borough, and no pharmacies are open before 10am or after 5pm on Sundays. However, demand for the scheme at weekends is thought to be constrained by the current scheme, which requires a voucher to be obtained from the GP Practice, so weekend demand for MAS is limited to patients whose GP Practice is also open. A request to amend the scheme was made to NHS England but declined pending future commissioning decisions.

Improved accessibility to the MAS would help meet HWB goals by supporting a reduction in unscheduled or inappropriate A&E attendances and GP workload. It has been recommended to the commissioner that the Scheme be reviewed and access improved for 1 April 2015. This could be through adoption of an existing Scheme that offers 7 day access without GP attendance, similar to the variant of the MAS in operation in Haringey Local Authority.

5.4.2. Medicines Reminder Devices

The Medicines Reminder Device (MRD) service aims to support patients who require support to take their medicines. This support may include improving the patient's knowledge of the medicines, providing easier to read labels, or referring them to other health and social care professionals for support. The service aims to improve medicines adherence and therefore reduce unscheduled care visits.

In 2013/14 28 pharmacies were signed up to the MRD service; nine pharmacies in the North locality, five pharmacies in the Central locality, eight in the South East locality and six in the South West locality. Three pharmacies offering the MRD service are open before 9am on weekdays, and four are open after 7pm. Twenty-two pharmacies offering the service are open on Saturdays. On Sundays, two pharmacies offering the service are open, in the South East and South West localities.

CONCLUSION ON MEDICINES REMINDER DEVICES SERVICE

MRD is a **relevant service** in Islington, as it may help to reduce the number of unscheduled visits to primary and secondary care services.

The service offers good coverage from Monday to Saturday, with a number of pharmacies open in each locality. However there limited access on Sunday; it should be reviewed to see if there is demand for more pharmacies offering the service on Sundays.

There are fewer pharmacies providing the service in the West locality, but there appears to be limited demand for the service at the existing pharmacies.

5.4.3. Seasonal 'flu vaccination

NHS England London Region commissioned a pharmacy vaccine service in 2014/2015. Patients are eligible for the Seasonal 'flu vaccine if they are: aged over 65; aged between six months and 65 years and diagnosed with a related illness, including chronic respiratory diseases, chronic heart disease, and diabetes; pregnant women; and carers or health care staff. In 2013/14, 1,685 (5.0%) vaccinations were delivered through Islington's community pharmacies out of 33,777 delivered in the whole borough – most patients receive the vaccination at their GP Practice. Vaccination rates in Islington were lower than the national targets for people aged over 65, people with long term conditions, and for pregnant women, but had similar uptake to London overall.

In the 2014/15 'flu season 34 pharmacies will deliver the service. This high level of provision ensures that there is good coverage across each of the localities: 13 pharmacies in the North locality offer the vaccination, four pharmacies in the Central locality offer the vaccination, and 10 pharmacies in the South East, and seven pharmacies in the South West locality. Across the borough three pharmacies offer the vaccination before 9am and two offer the vaccination after 7pm. Thirty pharmacies offering the seasonal 'flu vaccination are open on Saturday, and five pharmacies are open on Sunday.

CONCLUSIONS ON SEASONAL 'FLU VACCINATION

The seasonal 'flu vaccination service in pharmacies provides an additional setting in which patients can have their vaccination.

Based on the data presented, it has been concluded that the seasonal 'flu vaccination services is a **relevant service** because it improves access to a service for 'at risk' patients.

With most pharmacies in the borough providing the seasonal 'flu vaccination there is good overall coverage.

5.5. Locally commissioned services

This section covers services that are commissioned locally, by an NHS organisation other than NHS England, or through the Local Authority. Locally commissioned services (LCS) by affect the need for pharmacy services, or have been commissioned to meet a local need.

Each of the locally commissioned services will be reviewed in terms of current need and an assessment made in terms of future need. Data held on each LCS will be complemented by findings from the qualitative research undertaken with pharmacy users, pharmacist and other health professionals.

The services that will be assessed are listed below:

Stop smoking service	This service provides advice and counselling, as well as any nicotine replacement therapy (NRT) such as patches, gums or inhalers required to support smokers in their attempt to quit.
Screening service (Health Checks)	This service provides a free NHS Health Check in community pharmacies, as another avenue for risk assessment and early diagnosis. The programme aims to prevent heart disease, stroke, diabetes and kidney disease by identifying and treating people at high risk of CVD, including those with high blood pressure.
Needle syringe exchange service	This service allows injecting drug users to exchange used injecting equipment for clean equipment, ensuring safe disposal of used needles and decreasing the likelihood of the transmission of bloodborne viruses, e.g. hepatitis.
Supervised consumption service	The service ensures that service users are able to take prescribed medication safely under the supervision of a qualified pharmacist in order to reduce the risk to individuals and local communities of: over usage or under usage of medicines; diversion of prescribed medicines onto the illicit drugs market; and accidental exposure to the supervised medicines.
Emergency hormonal contraception service	This service provides free emergency contraception for women aged 13-24 years, as well as signposting and referral to other sexual health services.

5.5.1. Stop Smoking service

Islington's Pharmacy Stop Smoking Services are delivered by smoking cessation advisers who are trained to assess levels of nicotine dependency, and advise on the most

appropriate programme of treatment. The service supports clients over 8 weeks, providing advice and counselling as well as nicotine replacement therapy (NRT) such as patches, gums or inhalers to support smokers in their attempt to quit. The eligibility criteria to access the stop smoking services includes that smokers must be 13 years of age or older; and live, work or study in the borough.

Overall, in 2012/13 there were 30 pharmacies that delivered the stop smoking service in Islington. From these pharmacies, ten are in the North locality, eight are in the South East locality, seven are in the South West locality and five are in the Central locality. This equates to 0.7 pharmacies per 1,000 smokers for the South East, North and South West localities compared to 0.5 pharmacies per 1,000 smokers in the Central locality, suggesting a potential gap in service provision in the Central locality.

The majority of pharmacies (26 out of 30) are open for standard hours on weekdays; 28 pharmacies offer the service on Saturdays, and one of these pharmacies is open before 9am with the others all open between 9am and 7pm. On Sundays four pharmacies are open and offering stop smoking services.

In Islington, approximately 4,670 people accessed stop smoking services in 2012/13 in a variety of settings. Pharmacies are the second largest provider of the stop smoking service, providing 23% of all quit attempts. However, GP Practices provide the highest proportion of smoking quit attempts (65%). Successful quit attempts are defined as quitting smoking at four weeks. In pharmacies 43% of smoking quit attempts were successful; this is similar to the Islington average (Figure 5.6).

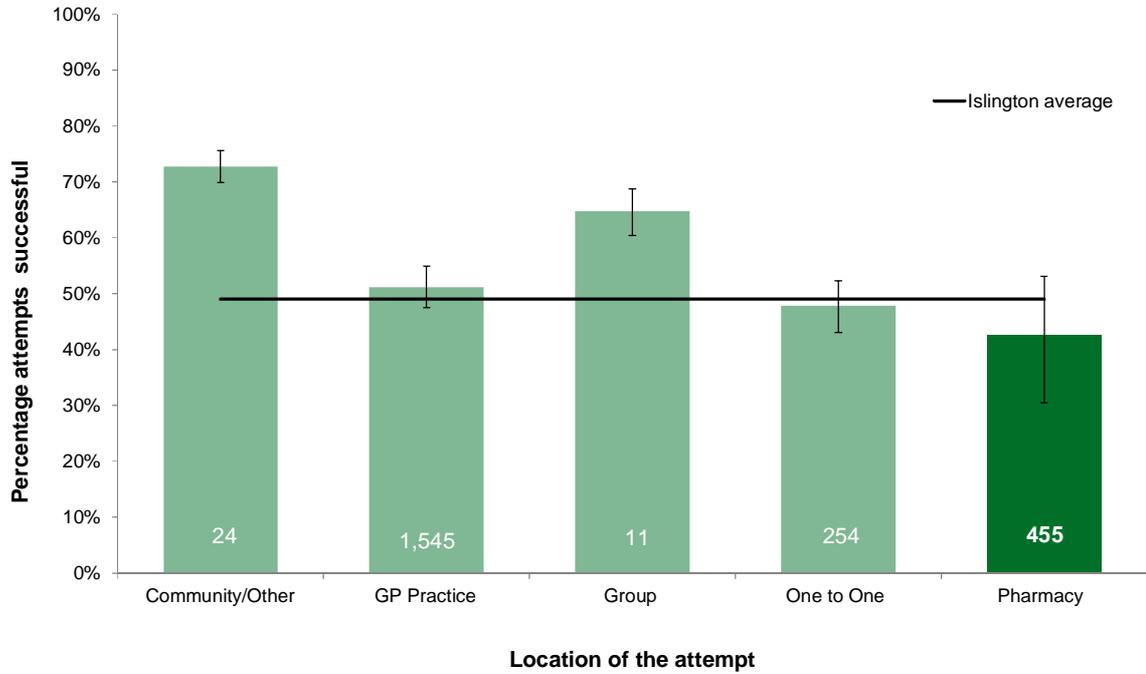
In contrast the community (73%) and group settings (65%) had significantly higher successful quit rates. This variation is probably because the group and community settings deliver a more intensive intervention to support people to quit smoking compared to pharmacy and GP Practice settings, and because they are delivered by specialist, full-time smoking cessation staff.

The number of quit attempts in pharmacies were higher in the North locality (400) and lowest in the Central locality (140), perhaps reflecting the higher number of smokers in the North locality (Section 4.5.1.). Although the number of pharmacy quit attempts are highest in the North locality, the proportion of successful pharmacy quits is lowest compared to the other localities (Map 5.6).

In Islington, a higher proportion of women (54%) accessed stop smoking services in pharmacies compared to men (46%). Smoking prevalence is higher in men compared to women (Section 4.5.1.). This suggests the pharmacy stop smoking service could be more targeted towards men. There are also variations in the prevalence of smoking by age; with

a higher prevalence in the age group 16-34 years (Section 4.5.1). The South West locality had a higher proportion of quit attempts in people aged 16-34 years compared to the other localities (Figure 5.8), this is probably a reflection of the younger age structure in this locality (Section 4.2.1.).

Figure 5.6: Success of quit attempts, by setting of the attempts, Islington's registered population aged 16+, 2012/13

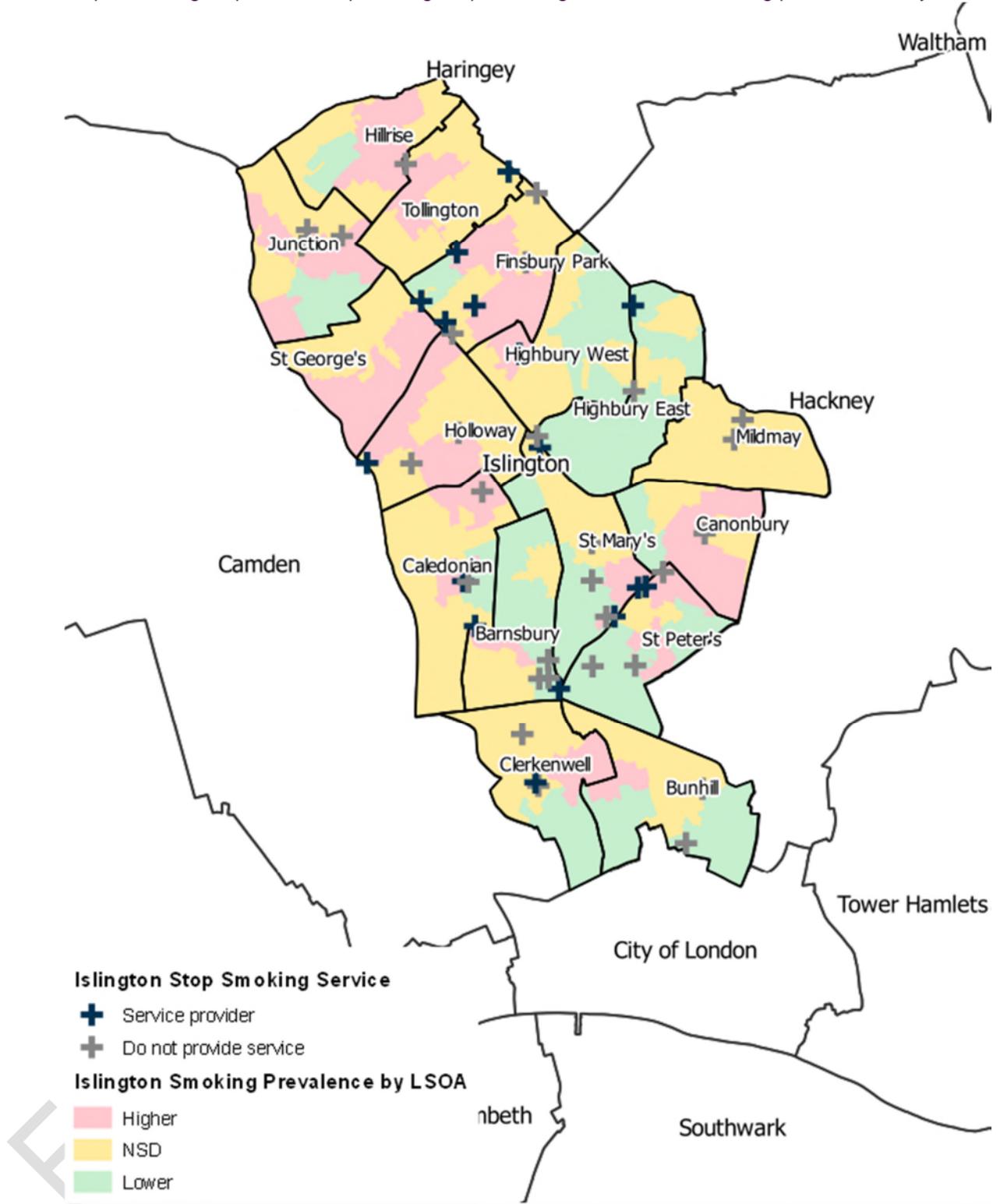


Source: Islington Stop Smoking Service, 2013

Note: Chart represents attempts rather than individuals, one individual may contribute more than one attempt.

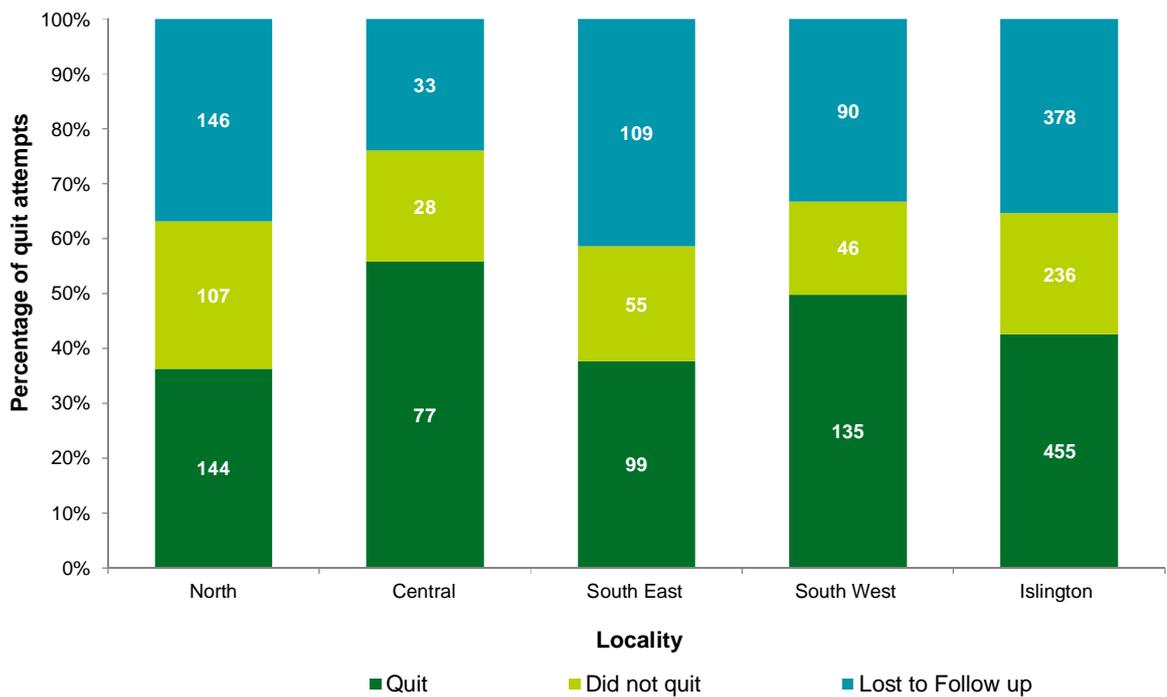
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Map 5.6: Islington pharmacies providing Stop Smoking Service, and smoking prevalence, July 2014



Source: NHS England, 2014

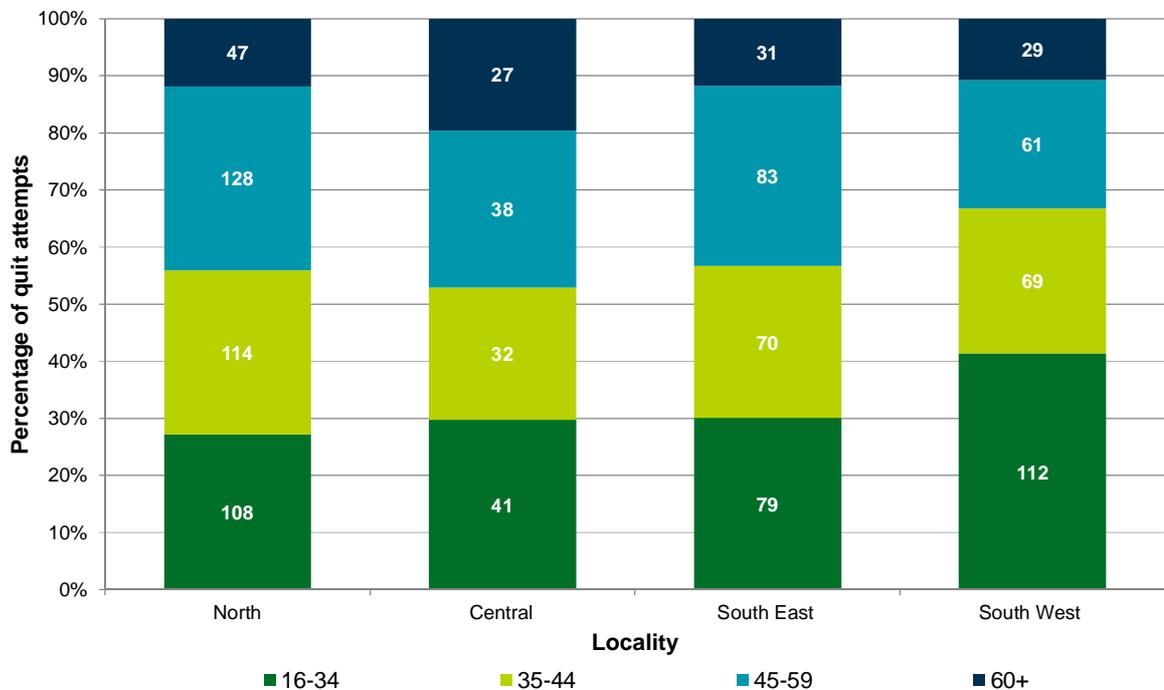
Figure 5.7: Outcome of quit attempts at Islington pharmacies, by locality and outcome, Islington, aged 16+, 2012/13



Source: Islington Stop Smoking Service, 2013

Note: Chart represents attempts rather than individuals, one individual may contribute more than one attempt.

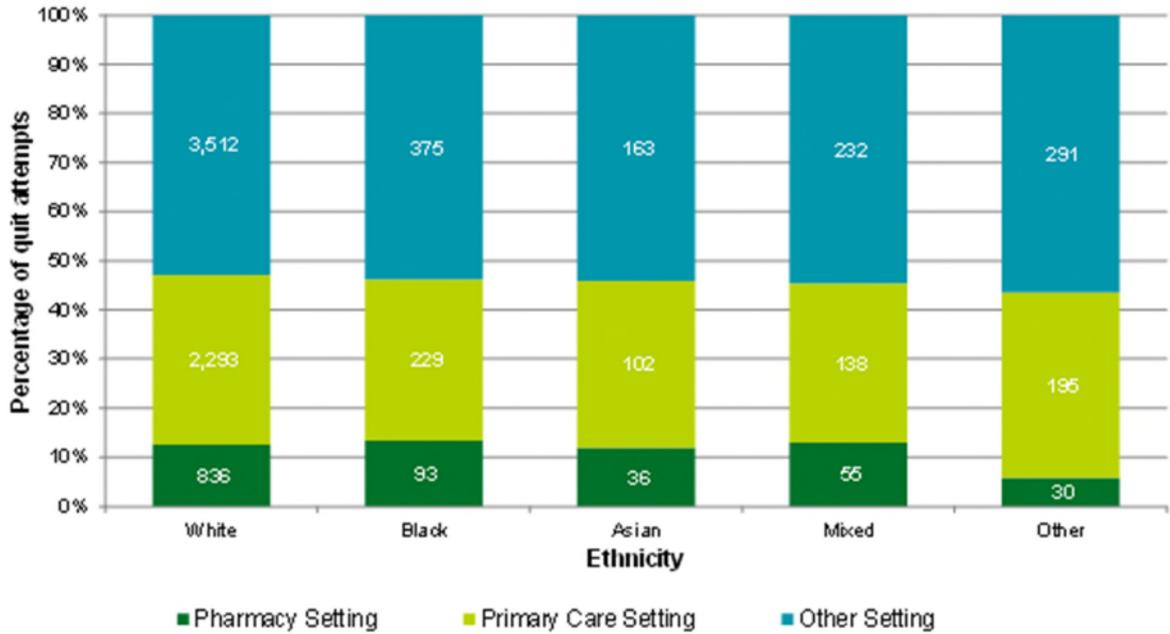
Figure 5.8: Percentage of quit attempts, by age and locality of pharmacy service attended, Islington, aged 16+, 2012/13



Source: Islington Stop Smoking Service, 2013

Note: Chart represents attempts rather than individuals, one individual may contribute more than one attempt.

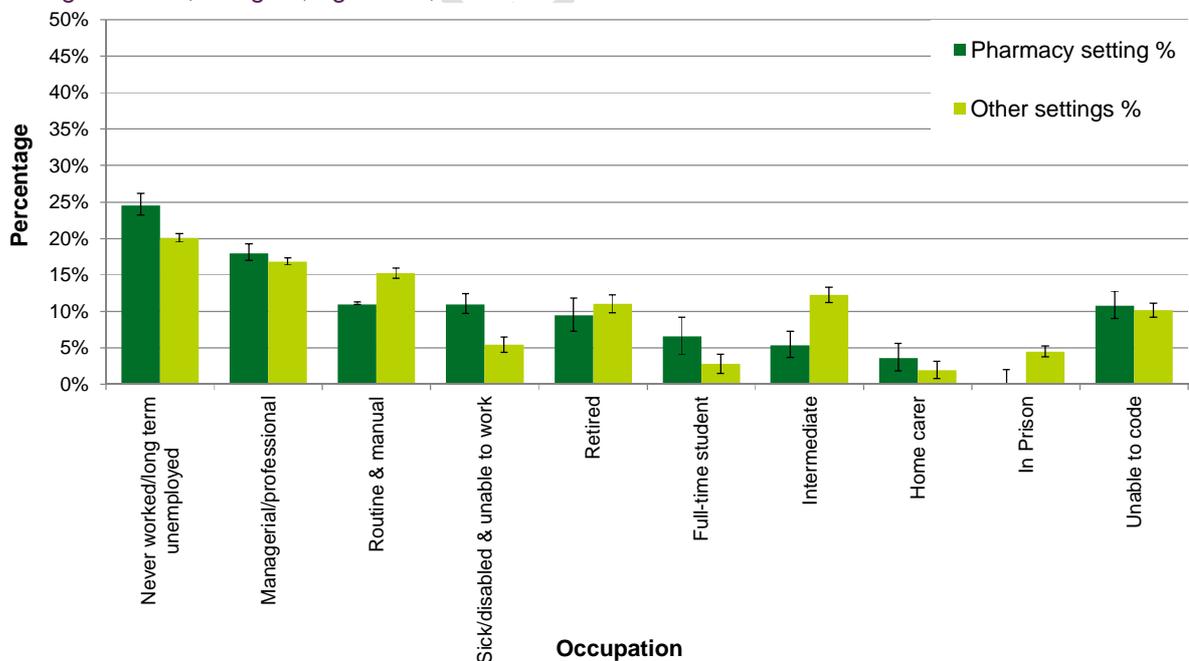
Figure 5.9: Percentage of quit attempts, by ethnicity of the user and type of service, Islington, people aged 16+, 2012/13



Source: Islington Stop Smoking Service, 2013

Notes: Chart represents attempts rather than individuals, one individual may contribute more than one attempt; 177 attempts with no recorded ethnicity have been excluded

Figure 5.10: Breakdown of Islington Stop Smoking Service quit attempts, by occupation and type of setting attended, Islington, aged 16+, 2012/13



Source: Islington Stop Smoking Service, 2013

Note: Chart represents attempts rather than individuals, one individual may contribute more than one attempt.

More white people accessed pharmacy stop smoking services than other ethnic groups, reflecting Islington's population structure overall. For all ethnic groups, people are less likely to access the pharmacy service compared to GP Practice and other settings for stop smoking services (Figure 5.9).

People recorded as never worked, sick/disabled or full-time student were significantly more likely to use stop smoking service in pharmacies compared to other settings (Figure 5.10). Service users in a routine/manual occupation or an intermediate occupation were significantly less likely to use pharmacy setting for stop smoking services. It is known that people from more deprived areas and low socioeconomic status are more likely to smoke; therefore the pharmacy stop smoking service should be targeting this group.

CONCLUSION ON STOP SMOKING CESSATION SERVICE

The pharmacy stop smoking service is a **relevant service**. Pharmacies have the second largest number of quit attempts compared to other settings, however, pharmacies could be providing more quits.

The number of pharmacies per 1,000 smokers is lowest in the Central locality, suggesting a potential gap in provision in this locality. In all localities there are no stop smoking pharmacies open for early, late or extended hours; representing an additional gap in service provision.

Taking into account the demographic breakdown of smokers in Islington, the Pharmacy stop smoking service could be more targeted towards men and lower socioeconomic groups.

5.5.2. NHS Health Checks

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74 years who has not already been diagnosed with one of these conditions will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. Islington's LCS also extends Health Check eligibility to people aged 35 to 39 because of the high rate of premature ill-health in the borough. In the first quarter of 2014/15 Islington had the second highest rate in the country of health checks delivered to its eligible population, and the highest rate in London. However, for the purposes of this needs assessment the analysis is based on 2013/14 data, so as to cover a full year.

In 2013/14, Islington providers delivered over 9,100 NHS Health Checks. The majority of all Health Checks in 2013/14 were delivered at GP practices (64%). About a third were

delivered in the community. Only four per cent of checks (333 Health Checks) were delivered by pharmacies. The national target for NHS Health Checks is to offer checks to 20% of the eligible population aged 40 to 74 every year. The eligible population is based on population registered with a GP practice, since there is no defined population for pharmacy or in the community. While not directly comparable with the national target, in 2013/14 18% of Islington's eligible population aged 35 to 74 were offered a Health Check and 8% received one.

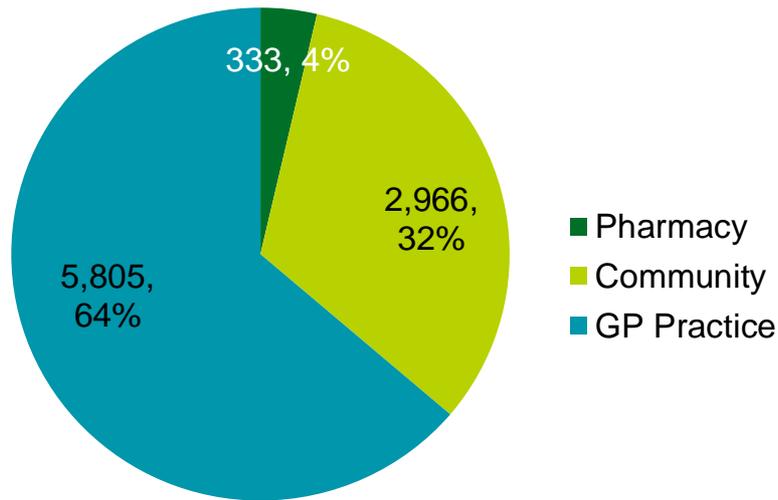
Of all Health Checks in Islington, 33% were delivered in the Central locality, 23% were delivered in the North, 21% were delivered in the South West, and 20% were delivered in the South East (4% were missing provider postcode). Taking population size into account, the North locality had the highest level of offered and delivered Health Checks overall (24% and 9% of the eligible population respectively), followed by the Central locality (19% and 8%). The equivalent figures for the South West were 17% and 8% and for the South East the figures were 13% and 7%.

Two pharmacies in Islington provide NHS Health Checks (4% of pharmacies in the borough). One is located in the North locality and the other in the South East (but close to the heart of the borough). Both pharmacies in Islington providing NHS Health Checks are open standard opening hours Monday to Saturday and closed on Sundays. The pharmacy in the South East delivered more Health Checks than the pharmacy in the North (61%, 204 checks vs 39%, 129 checks) and also accounted for a greater proportion of the Health Checks delivered in the locality.

Focus group participants suggested the level of awareness is often low for some specialist services that pharmacies provide including NHS Health Checks but there is an appetite for more information.

Forty per cent of the Health Checks delivered by pharmacies were taken up by men. Demographic data are not available for Health Checks delivered by GP practices, but this figure is similar to that for checks in community locations (42%). The largest group of people receiving Health Checks at pharmacies were aged 40 to 49 years (42%), followed by people aged 35 to 39 (29%). Eight per cent were aged 60 or older. This is similar to Health Checks delivered in community locations.

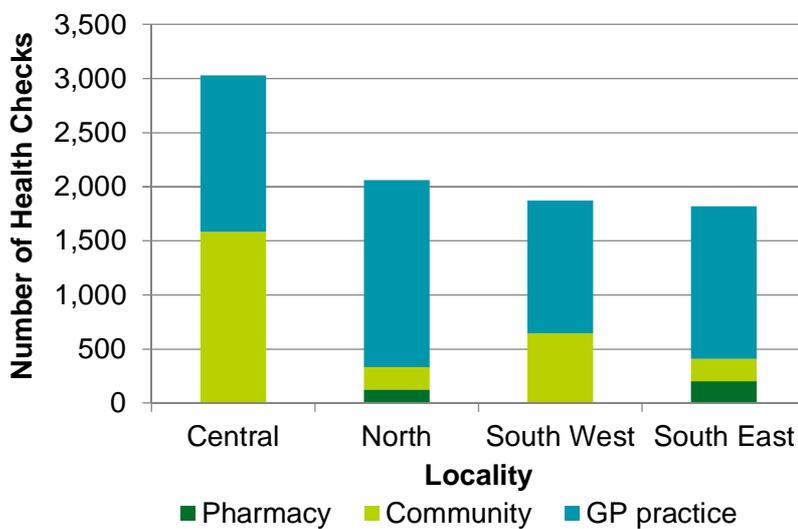
Figure 5.11: Number and proportion of NHS Health Checks provided, by provider type, Islington, 2013/14



Source: Camden and Islington Public Health, 2014

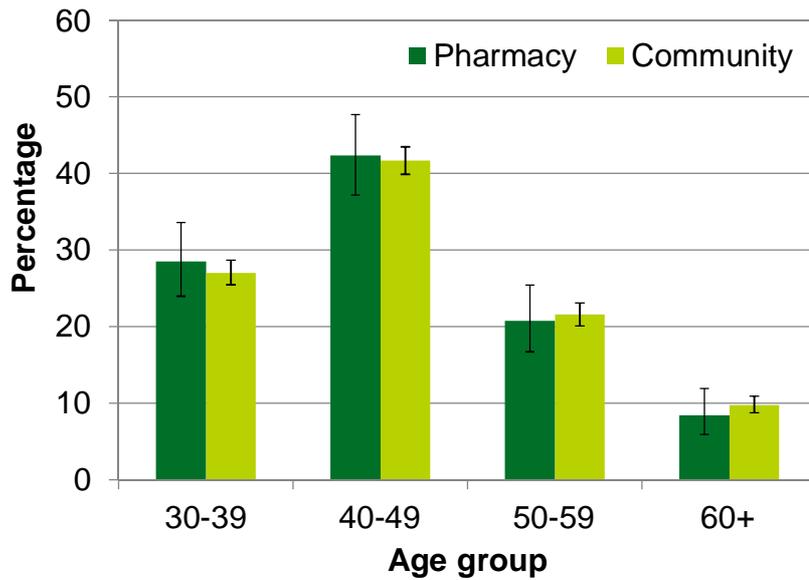
Note: Health Checks for GP practices cover the time period July 2013 to June 2014. Health Checks for pharmacies and community settings cover the financial year 2013/14.

Figure 5.12: Number of NHS Health Checks provided by provider type and locality, Islington, 2013/14



Source: Camden and Islington Public Health, 2014

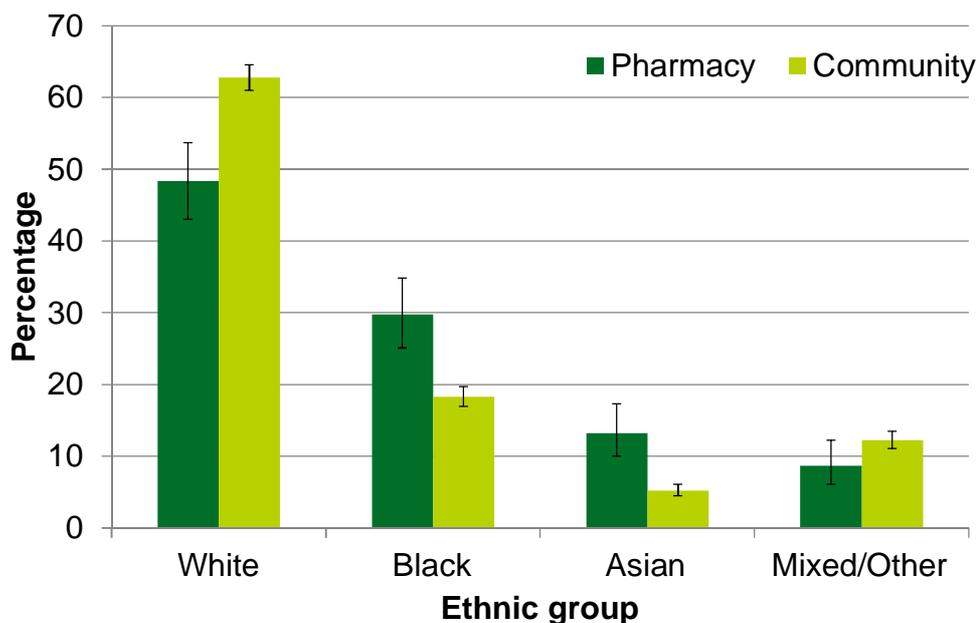
Figure 5.13: Proportion of NHS Health Checks by age group and provider type, Islington, 2013/14



Source: Camden and Islington Public Health, 2014

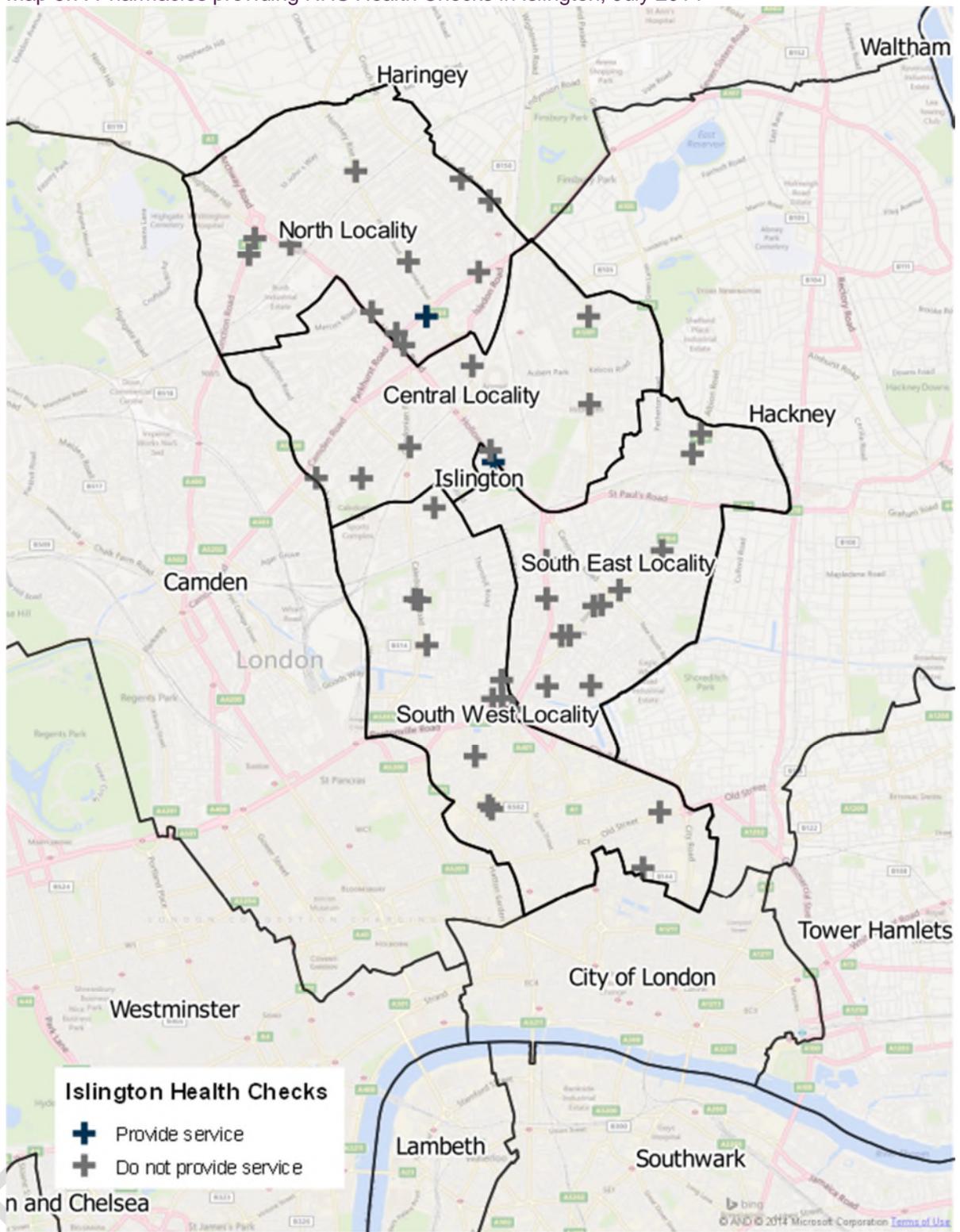
The largest group of people receiving Health Checks at pharmacies were of White ethnicity (48%), reflecting Islington’s population structure overall. Thirty per cent of Health Checks were received by people of Black ethnicity, while 9-13% were received by people of Asian and Mixed/Other ethnic groups. This pattern is different to that for checks in community locations, for which a larger proportion of checks were taken up by White people. The two pharmacies delivering Health Checks are both located in more deprived areas of Islington.

Figure 5.14: Proportion of NHS Health Checks by ethnic group and provider type, Islington, 2013/14



Source: Camden and Islington Public Health, 2014

Map 5.7: Pharmacies providing NHS Health Checks in Islington, July 2014



Source: NHS England, 2014

CONCLUSION ON NHS HEALTH CHECKS

NHS Health Checks are a **relevant service**. Although most health checks are offered and delivered through GP Practices and Community providers, pharmacies have the potential to improve access and uptake of Health Checks as they appear to have been successful at targeting people eligible for Health Checks from Black and Asian ethnic groups in particular.

Two pharmacies in Islington are currently delivering NHS Health Checks. Both pharmacies delivering Health Checks are closed during weekday evenings and on Sundays; but this may be covered by other providers.

There is an appetite among residents for more information on specialist services that pharmacies provide, including NHS Health Checks.

5.5.3. Emergency Hormonal Contraception service

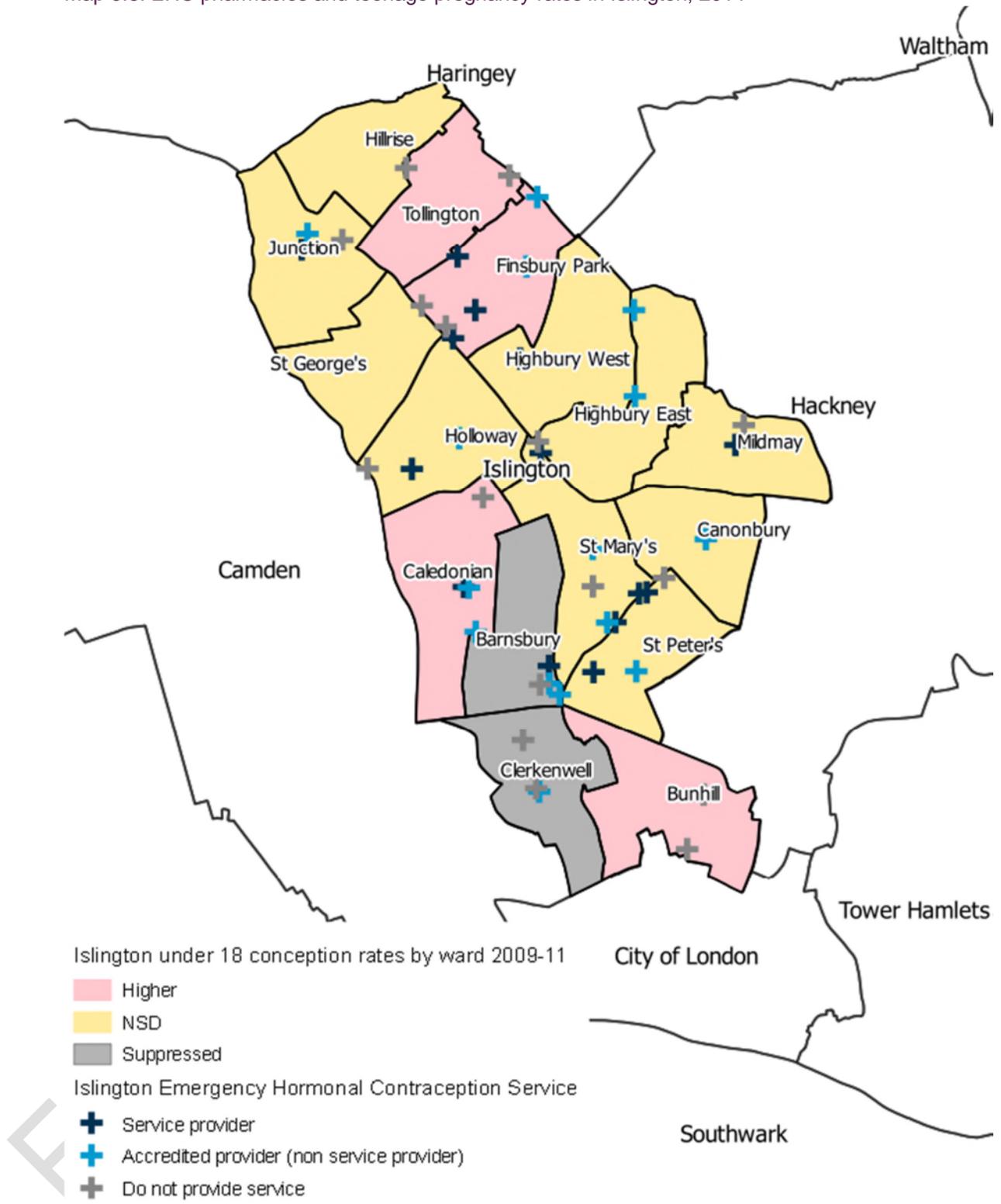
The Emergency Hormonal Contraception Locally Commissioned Service (EHC LCS) provides free contraception for clients (aged 13 – 24 years) following unprotected sexual intercourse. The service provides contraception alongside counselling, relevant signposting and referrals to other sexual health services. In order to provide this service, pharmacies must be accredited as set out in the contract; this includes signing a service level agreement (SLA), patient group directions (PGD) and completing a Disclosure and Barring Service (DBS) check. There are 27 (60%) pharmacies that are accredited EHC pharmacies in Islington; however in 2013/14 15 (33%) pharmacies delivered the EHC service. The analysis discussed below is restricted to the 15 pharmacies that have recorded activity for EHC delivery.

Ten of the fifteen pharmacies in Islington providing EHC services are open standard opening hours Monday to Saturday and closed on Sundays. Of the remaining five pharmacies, two are open standard hours on weekdays and three are open for either extended, early or late hours on weekdays. One pharmacy in Islington is open on a Sunday. Overall access to EHC pharmacies is extremely limited on Sundays and after 7pm on Saturdays.

Data from 2013/14 shows that there were 550 uses of EHC across Islington at the 15 pharmacies offering the service. As the service does not track individual clients, we are only able to provide demographic information for the number of EHC uses.

Map 5.8 shows the geographical distribution of pharmacies that deliver EHC services sourced from NHS England. The narrative below refers to service provider activity data for 2013/14 which may show different EHC pharmacy activity to the map sourced from NHS

Map 5.8: EHC pharmacies and teenage pregnancy rates in Islington, 2014



Source: NHS England, 2014

England. There are seven EHC pharmacies in the South East locality, five EHC pharmacies in the North locality, two EHC pharmacies in the South West locality and one EHC pharmacy in the Central locality. Teenage pregnancy rates are significantly higher than the national average in the North and South West localities (Map 5.8); however there are only two EHC pharmacies in the South West compared to five in the North locality, this is a gap in service provision. It should be noted that however, that there are other places where clients can access EHC services; for example at GP practices and sexual health clinics, and over the counter at pharmacies outside of the remit of this service.

Of all uses of EHC, the majority were in the South East locality (250 uses) and the North locality (240 uses); which is probably because these localities have the higher number of EHC pharmacies compared to the South West and Central.

A higher number of EHC uses were recorded in women aged 17-20 years in Islington (390 EHC uses) compared to EHC uses in women recorded as less than 17 years or more than 20 years (160 uses), In Islington, there are a similar number of recorded EHC uses for women recorded as White (190 uses) compared to BAME (Black, Asian and minority ethnic) (210 uses); largely reflecting the ethnicity of Islington's younger population structure overall.

CONCLUSION ON EHC

The EHC service provided in accredited pharmacies is a **relevant service** as it improves access to this service in the borough. Pharmacies provide an alternative setting to sexual health clinics and GP practices for which women can access timely contraception and advice.

EHC pharmacies are not evenly distributed across the borough; there are fewer pharmacies in the Central and South West localities offering EHC than in the South East and North localities. There are only two EHC pharmacies in the South West locality and this is where teenage pregnancy rates are high; this presents a gap in service provision. However women may be accessing EHC from other providers such as sexual health clinics and GP practices in this locality.

Opening hours for EHC accredited pharmacies is very limited, with only three pharmacies open for extended, early or late hours on weekdays and only one pharmacy on Sundays. There is very limited access to the service in times that young people are most likely to use the service. Currently there are low numbers of women using the service and there is scope to increase this. Service data has shown that the localities with the highest number of pharmacies offering the service are the localities with the highest EHC use.

5.5.4. Drug Misuse Services: supervised consumption and needle exchange services

The impact of drugs misuse on the wider community can be significant if not properly managed, with consequences for blood borne disease, health and safety and drug related crime. There are two commissioned services to support people in treatment for drug misuse in Islington: a supervised consumption service and a needle exchange service.

Clients with drug problems who access supervised consumption and needle exchange services tend to use these services for extended periods of time, so monthly average figures are presented. Due to a change in the payment system within the substance misuse commissioning team, data for April and May 2013 are not available. These months have been excluded and averages have been calculated on ten months' data.

Supervised consumption service

Supervised consumption services are focused on ensuring that clients in drug treatment programmes take and use their treatment as prescribed, and provide an opportunity for the pharmacist to make relevant interventions. To provide this service, pharmacists must have undertaken specified Centre for Pharmacy Postgraduate Education (CPPE) training and attended an annual accreditation event. Pharmacies must ensure controlled drug recording is made promptly; provide privacy for clients (e.g. private area for discreet consumption that is not in the dispensary); be open at least six days a week with the service available from an accredited pharmacist during all opening hours; not exceed the patient threshold set for the pharmacy; comply with Islington CCG governance requirements; have a standard operating procedure in place to cover all aspects of the service and adequate insurance. The Joint Commissioning team working in partnership with the CCG Medicines Management team visits all pharmacies to ensure they meet the service specification.

The supervised consumption service has recently been recommissioned, with 26 pharmacies commissioned from April 2014 compared to 29 pharmacies previously. At the time of writing there was not sufficient data available to assess service use under the new provision, so service use has been assessed based on 2013/14 data, but conclusions have been based on the current service provision.

Almost two thirds of Islington's pharmacies offered supervised consumption services in 2013/14. Service provision ranged from 43% of pharmacies in the Central locality to 75% in the North. On average there were 177 people registered for supervised consumption each month over the course of the year. It is not possible to estimate the prevalence of substance misuse for each locality, but the percentage of the resident population that are registered for this service was significantly higher than the Islington average in the North locality (Table 5.11).

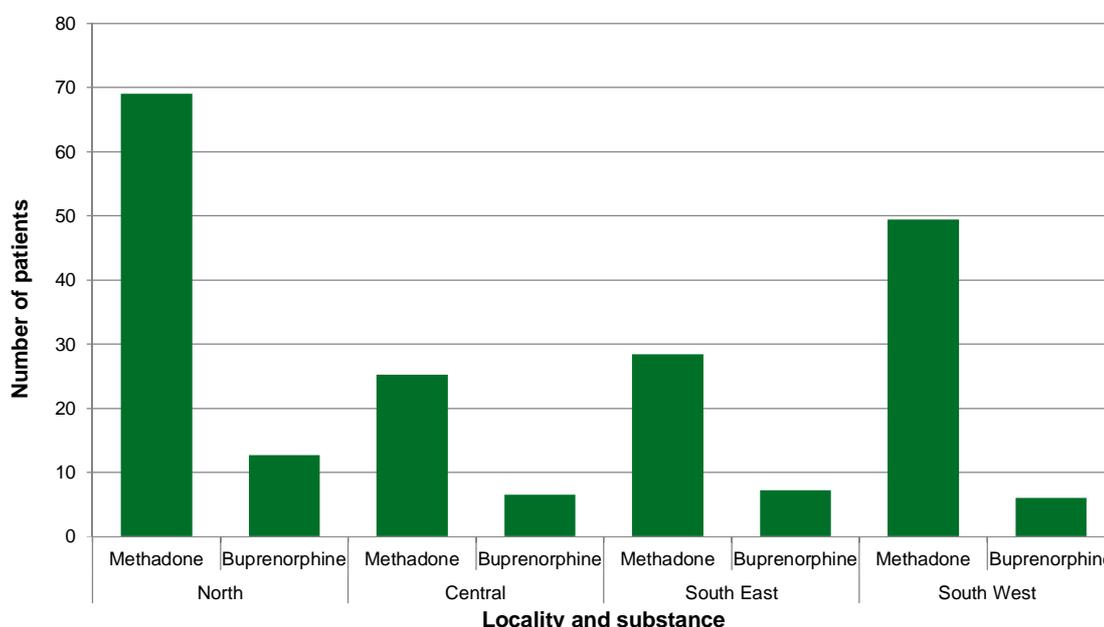
Table 5.11: Percentage of pharmacies offering supervised consumption service and average registered service users by locality, Islington, 2013/14

Locality	Providing service	Total pharmacies	% providing service	Monthly average number of patients registered with pharmacies	% total resident population registered with pharmacies
North	9	12	75%	82	0.2%
Central	3	7	43%	32	0.1%
South East	9	13	69%	36	0.1%
South West	8	13	62%	55	0.1%
Islington	29	45	64%	204	0.1%

Pharmacies offering supervised consumption are not uniformly distributed across Islington; the majority are in busier areas such as main roads (Map 5.9). Clients can also access supervised consumption at IDASS North, in the North Locality.

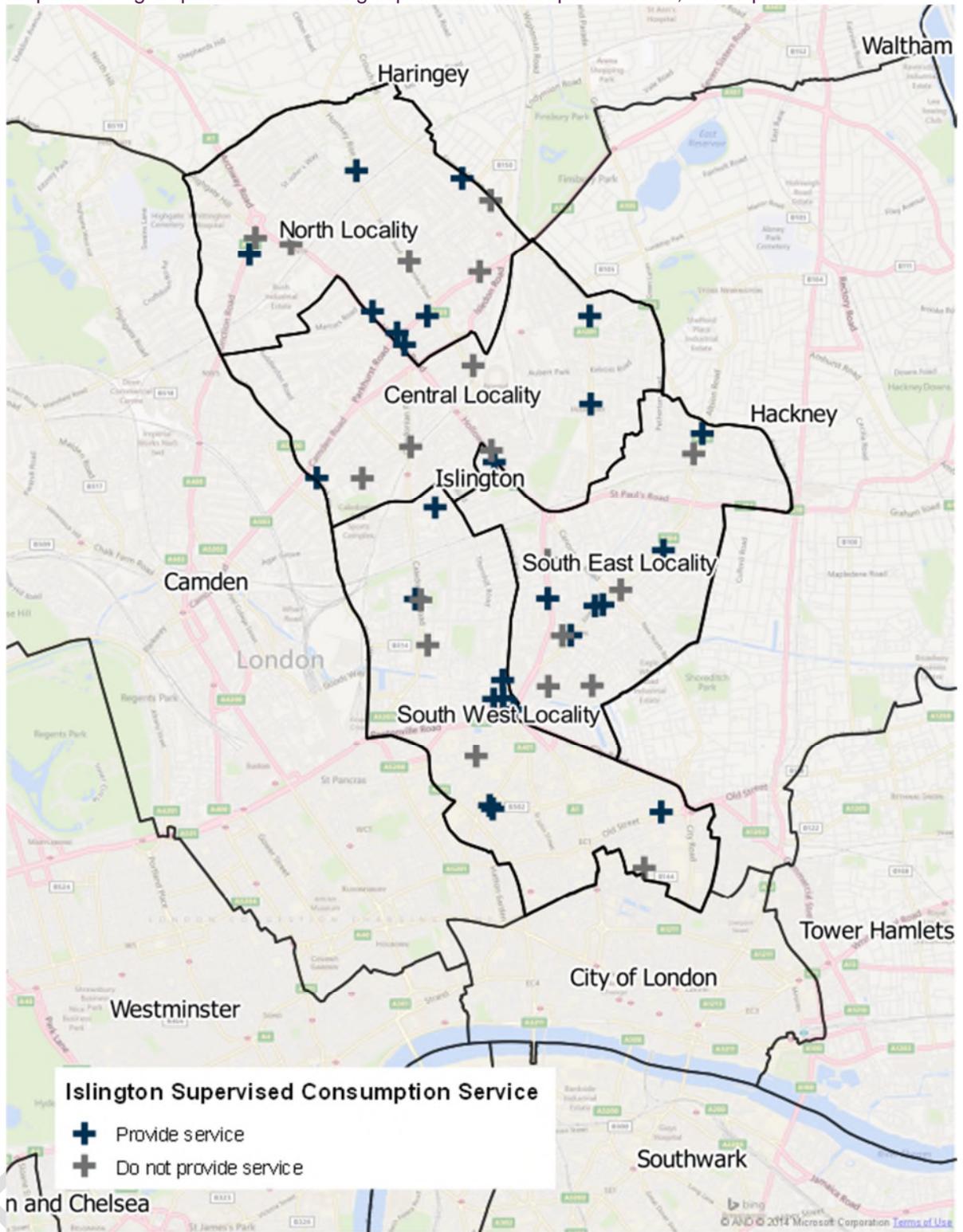
In 2013/14 there were an average of 172 clients (84% of the treatment population) receiving Methadone and 32 (16%) receiving Buprenorphine in Islington each month. There was no significant variation in the type of drug by locality (Figure 5.15).

Figure 5.15: Average number of patients receiving Methadone and Buprenorphine per month, by locality, Islington, June 2013 – March 2014



Source: Islington Substance Misuse Commissioning team, 2014

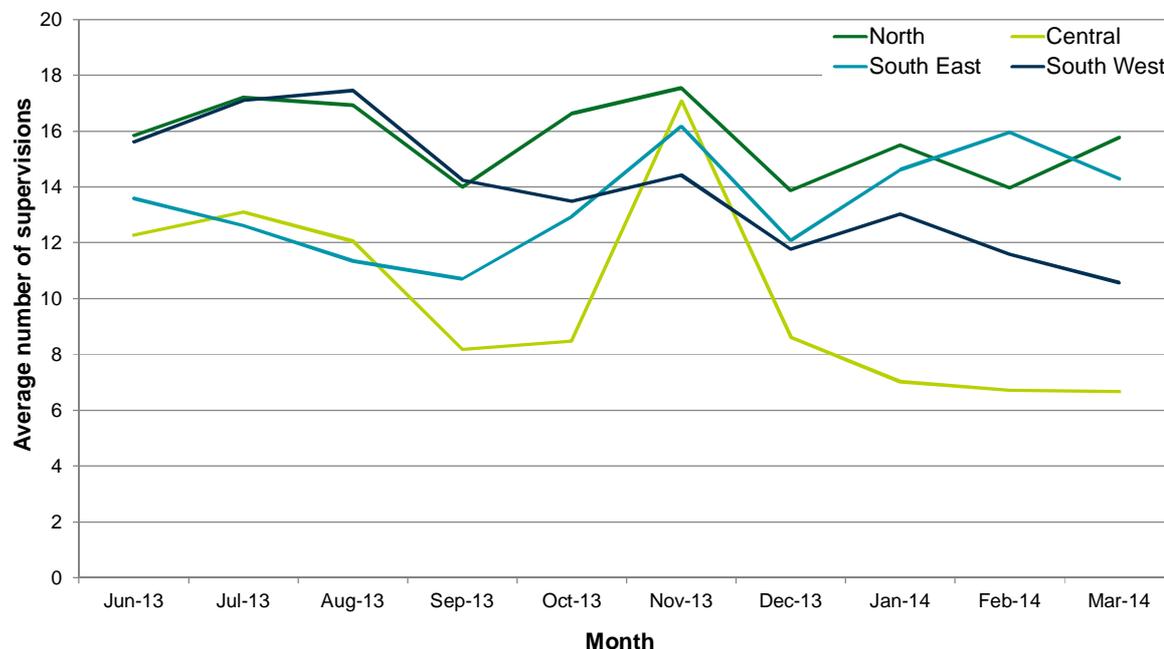
Map 5.9: Islington pharmacies offering supervised consumption service, from April 2014



Source: NHS England, 2014

Average Methadone supervisions fluctuated between 12 and 16 supervisions per patient per month in Islington between March 2013 and June 2014, with no discernible trend (Figure 5.16). Similar fluctuations and ranges of values were seen in each of the localities. The pattern for Buprenorphine supervisions was comparable with Methadone.

Figure 5.16: Average number of supervisions per client for Methadone each month, by locality, Islington, June 2013 - March 2014



Source: Islington Substance Misuse Commissioning team, 2014

To ensure patient safety and clinical governance each pharmacy can have a maximum of thirty clients at any one time. Between June 2013 and March 2014, monthly service use fluctuated between 25 and 40% of capacity in Islington. Service use was higher in the North and Central localities at 35-40% of the combined thresholds, while pharmacies in the South East were using 20% of their capacity.

Needle exchange service

Needle exchange services are focused on ensuring that injecting drug users have access to clean injecting equipment, are able to safely dispose of used equipment and have access to advice from pharmacists. In order to provide needle exchange, Islington pharmacists must undertake the required CPPE training and attend an annual training event. Pharmacies offering this service must provide the necessary level of privacy for clients (e.g. a consultation room for discreet conversations and advice regarding safer injecting), be open 6 days per week with needle exchange services available during all opening hours; display the national or local scheme logo indicating availability of the service; comply with Islington CCG governance requirements; have adequate insurance and have a standard operating procedure covering all processes involved.

The needle exchange service has recently been recommissioned, with 24 pharmacies commissioned from April 2014 compared to 16 pharmacies previously. At the time of writing there was not sufficient data available to assess service use under the new provision, so service use has been assessed based on 2013/14 data, but conclusions have been based on the current service provision.

Over a third of Islington's pharmacies offered needle exchange services in 2013/14. Service provision ranged from 31% of pharmacies in the South East and South West localities to 42% in the North (Table 5.12). Pharmacies providing needle exchange are distributed throughout the borough (Map 5.10). Open access needle exchange is available at two substance misuse treatment centres in the North and Central localities, as well as pharmacies across London. There is considerable movement of people between boroughs for this service.

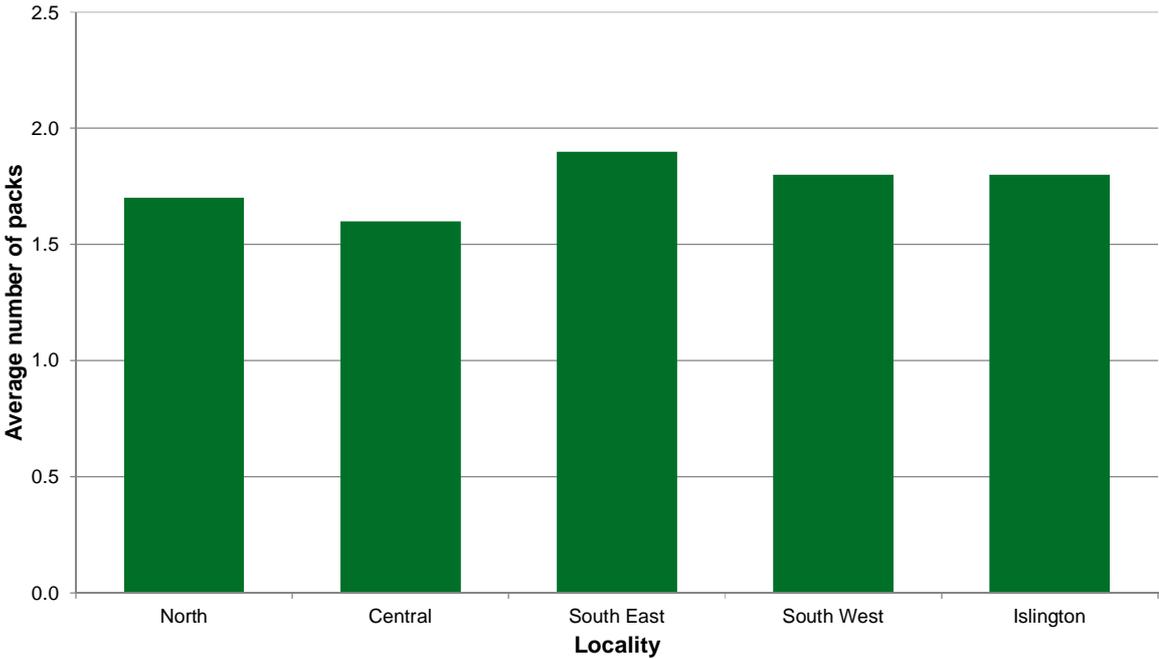
On average the 981 people used the needle exchange service each month over the course of the year (Figure 5.17). The percentage of the resident population using this service was higher in the North (0.8% of residents) and lowest in the Central locality (0.2%).

Table 5.12: Percentage of pharmacies offering needle exchange services and average number of service users by locality, Islington, 2013/14

Locality	Providing service	Total pharmacies	% providing service	Monthly average number of patients using the service	% total resident population using the service
North	5	12	42%	431	0.8%
Central	3	8	38%	132	0.2%
South East	4	13	31%	133	0.3%
South West	4	13	31%	285	0.5%
Islington	16	46	35%	981	0.5%

The number of needle packs distributed to each client was similar across Islington localities, ranging from 1.6 packs per month in the Central locality to 1.9 per month in the South East (Figure 5.17). Of the 17,300 needle packs distributed in Islington in between June 2013 and March 2014, the most frequently distributed packs were those containing smaller syringes, (blue, 69%; red 25%), which are most commonly used for heroin and crack cocaine.

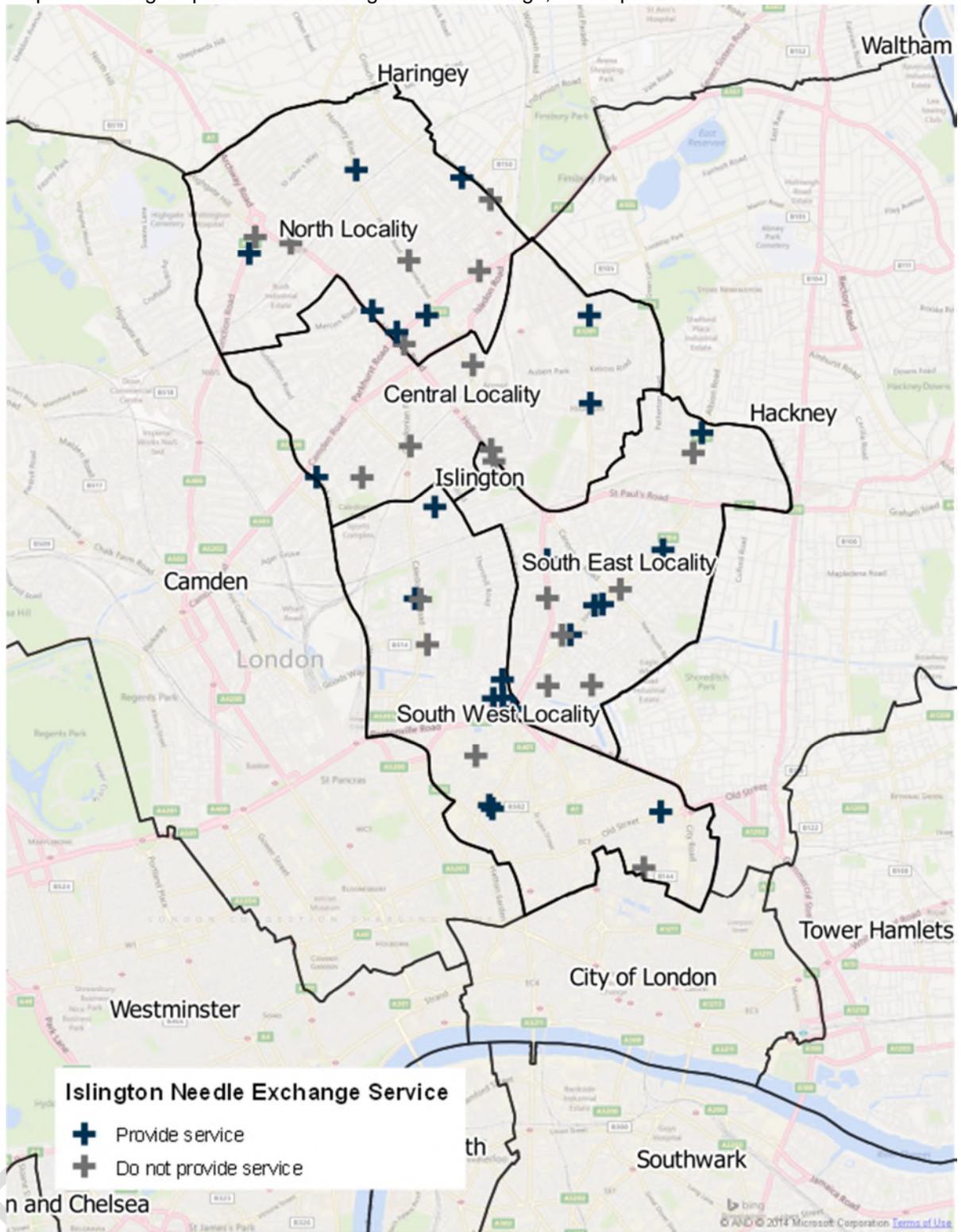
Figure 5.17: Average number of needle packs distributed to needle exchange clients per month, by locality, Islington, June 2013 to March 2014



Source: Islington Substance Misuse Commissioning team, 2014

FOR CONSULTATION

Map 5.10: Islington pharmacies offering needle exchange, from April 2014



Source: NHS England, 2014

CONCLUSIONS ON DRUG MISUSE SERVICES

As set out in our substance misuse needs assessment, Islington has one of the largest opiate or crack-using populations in London. As such, we conclude that both SSA and NEX services are **necessary services** to meet the pharmaceutical needs of Islington's population. We have identified the following potential current gaps:

Supervised consumption services

- **All localities:** Access to supervised consumption services is reduced on Sundays. Although all pharmacies offering this service are open on Saturdays (five with extended hours), only 15% of pharmacies offering this service in Islington are open on Sundays.
- **All localities:** Access to this service in pharmacies is limited to normal opening hours; just five pharmacies in the borough providing supervised consumption are open extended hours.

Needle exchange services

- **All localities:** Access to needle exchange services is reduced on Sundays. Over 80% of pharmacies providing this service in Islington are closed on Sundays. On Saturdays all pharmacies that provide needle exchange are open between 9am and 7pm, and none are open outside of these hours. During the week, only four pharmacies are open outside of these hours.

Public health commissioners should review whether access to both supervised consumption and needle exchange on Sundays needs to be expanded.

5.5.5. Anticoagulation service

Islington CCG commissions one pharmacy in Islington to provide an anticoagulation clinic (Highbury Pharmacy in the Central locality). This clinic provides support to patients currently being treated with Warfarin – they can attend the clinic where the trained pharmacist will monitor their treatment. Providing this treatment in a pharmacy setting helps to improve access to treatment monitoring across the population. The service currently works with around 20 patients.

CONCLUSIONS ON THE ANTICOAGULATION SERVICE

We conclude that this is a **relevant service** as it provides an additional source of support and treatment monitoring for patients, helping to reduce the number of unscheduled primary care attendances.

5.5.6. Palliative Care Medicines service

Islington CCG commissions a service which ensures that there is ready access to advice and supply of palliative care drugs for end of life care. Making these drugs available through community pharmacies helps practitioners and patients to obtain these unusual but urgently needed drugs to support palliative care. The service is delivered by one pharmacy in the North locality (Dev's Chemist) and one in the South East (Clan Pharmacy); access is only available between the hours of 9am and 7pm.

CONCLUSIONS ON THE PALLIATIVE CARE MEDICINES

We conclude that the Palliative Care Medicines service is a **relevant service** as it provides additional sources of medicines and support at a time when they are urgently needed.

5.6. Qualitative research into pharmacy services

As discussed in Chapter 3, the needs assessment included a piece of research undertaken to better understand local experiences and views of pharmacy services, including where improvements could be made. The research focused on people who use community pharmacies, pharmacists in Islington, and other health professionals who come into contact with pharmacies as part of their role.

A brief synopsis of the research is described here, with service specific information addressed within this chapter. For more in-depth information, the full report is included as Appendix C.

5.6.1. Method

The research was carried out in July 2014. To better understand the views of pharmacy users, 4 focus groups were held, each targeting different groups within the local population:

- residents with long term conditions
- residents with mental health support needs
- people living or working in Islington from lower income backgrounds
- people living or working in Islington from black and minority ethnic groups

Pharmacists and other health professionals completed an online survey to gather their views.

The key questions defining the research with the members of the public who used pharmacies in Islington were:

- How do residents use local pharmacy services?
- What impacts on their choice of community pharmacies?

- What would help residents use community pharmacies more, and make full use of their services to enable them to lead a healthier life?
- What works well and what doesn't work well in community pharmacies?
- How do community pharmacies help them manage their diagnoses?
- How could community pharmacies be improved?

The research with health professionals sought to gather the views on pharmacy services in Islington of local health professionals, including pharmacists, pharmacy staff, GP practice staff, and district nurses. The main research questions were:

- What do GP practice staff, district nurses and pharmacy staff think works well in community pharmacies?
- What could be done better in community pharmacies?
- For pharmacists, what would make it easier to signpost the public to relevant interventions?
- For GP practice staff, what are the challenges to signposting their patients to community pharmacies?

5.6.2. Key findings

Although the research involved a relatively small sample of Islington residents, pharmacists and health professionals, the results provide an insight into what is currently working well and not so well in pharmacies in Islington; barriers and gaps in accessing services in pharmacies; the priorities of local residents with different health needs; the relationship between pharmacies and other local health services and specific ideas for how services could be improved.

Pharmacies in Islington were generally viewed positively by focus group participants and survey respondents, particularly around their convenience in terms of location and access, responsiveness and ability to offer a personalised service to those managing multiple conditions. Participants in the focus groups with long term conditions and mental health needs had a high dependency on services as they were regular pharmacy users. These groups in particular were keen to see improvements, and had pragmatic suggestions in many cases of how this might be achieved.

Priorities

Pharmacists and health professionals identified that an increasingly ageing population and people with long term conditions are likely to have the biggest impact on pharmacy services over the next decade. These areas have also been identified within other analysis for the PNA.

The priorities of particular groups of patients when using pharmacies were discussed in the focus groups, to identify what was most important or valued amongst certain population

groups. Table 5.13 provides an overview of the factors that participants identified as being relevant and important to them. This helps to improve understanding of the way different users interact with pharmacy services in Islington.

Table 5.13: Summary of key priorities for pharmacy services for each user group in Islington

Population group	Summary of key priorities
General pharmacy users (low income and BAME)	Low level of dependency on specific services, but identified: <ul style="list-style-type: none"> ▪ Getting advice immediately without an appointment ▪ Longer opening hours to improve access outside of work hours ▪ Being confident in the knowledge of the pharmacist, and in some cases getting to know them in person
People with mental health needs	High dependency on pharmacy services. <ul style="list-style-type: none"> ▪ Being treated with extra sensitivity and patience when patients may not be feeling well ▪ Reassurance through having access to instant medical opinions ▪ Avoiding unnecessary repeat trips to the pharmacy ▪ Not being kept waiting in pharmacies ▪ Being offered the private consultation room where available ▪ Advice that is appropriate to the pharmacist's role and not infringing on the role of GPs.
People with long term conditions	High dependency due to frequency of pharmacy visits and complexities managing multiple conditions: <ul style="list-style-type: none"> ▪ Valued personal service – tailored to their needs. ▪ Friendly and respectful staff – particularly for the frail and more vulnerable ▪ Reliance on accurate advice over taking multiple medications. ▪ Time to listen and explain changes in prescriptions – important when suffering from memory loss ▪ Delivery options and reminders for prescriptions.

Recommendations

There are many aspects of pharmacies and their services that are viewed as working well by both the general public, and health professionals, and to an extent many of the priorities for pharmacy services in Table 5.13 are already being met, or partially met. The core services of dispensing medications, giving advice on over the counter medication and minor ailments or symptoms and providing these in many locations across the borough that are near to people's homes and workplaces can all be judged as a success. It was also apparent that many people trusted the knowledge and advice from pharmacies and particularly valued their accessibility in comparison to the difficulty many could experience in getting an appointment at their GP.

Through both strands of the research, a set of recommendations were identified that could potentially be addressed through the wider PNA process in Islington:

- **Opening hours of pharmacies in Islington:** The opening hours of pharmacies need to be mapped to ensure that there is equitable coverage of early and late provision across the borough. Clearer information could to be provided in pharmacies of out of hours services so pharmacy users know where to go. There was also a suggestion that a 7 day pharmacy and at least one 24 hour pharmacy were needed in Islington to avoid residents having to travel outside of the borough.
- **Promoting different prescription options:** Every pharmacy should make it clear which options are available for collecting prescriptions, particularly targeting those managing multiple conditions so they are fully aware of the range of ways that they can arrange to receive reminders about or pick up their prescriptions.
- **Promotion of pharmacy services:** Advertising in pharmacies about the range of services on offer could be improved, but also using different routes to disseminate this – via booklets, local advertising in papers, or door to door leaflets. The availability of different languages spoken in pharmacies also could be promoted more clearly.
- **Accessibility:** Pharmacies should ensure that they have seating and wheelchair access for those who are able to visit in person, and better promotion of the home delivery service for those who are not. This should be mapped across Islington to identify which premises are not currently accessible.
- **Links with between pharmacies and other services:** Pharmacists said they needed more information about health services elsewhere, and other health professionals reported that they wanted more information in order to signpost to pharmacies and improve their confidence in the services available there. It was also apparent that some would benefit between better face to face collaboration between pharmacists and other health services, and consideration should be given as to the most appropriate forum in Islington to bring these together.
- **Training:** To consider how to improve the training and skills of pharmacy and pharmacist staff – one suggestion was that joint training for GP and pharmacy staff could help – and would make each more aware of the services they provide.

In summary, there were many encouraging responses about pharmacies in Islington, particularly around their convenience, responsiveness and ability to offer a personalised service. Those with high dependency on services who are regular pharmacy users are keen to see some improvements, but had pragmatic suggestions in many cases of how this might be achieved. It was recommended that Camden and Islington's PNA Steering Group further consult with user groups in the borough on the needs of those with long term conditions in particular, given the strong feelings about accessibility in pharmacies, views

on it being hard to travel across Islington, and the likely future pressures on services from an ageing population.

5.7. Assessing the needs of people with protected characteristics

The PNA regulations require that the needs of people who share a protected characteristic (as defined by the Equality Act 2010) are taken into account when making the assessment. This section details how the needs of these populations have been taken into account in forming the assessment.

5.7.1. Age

In assessing the demographic profile of Islington, the projected population, and their health needs, age groups have been identified with specific pharmacy needs. These are listed below.

Young people

Though young people tend to visit pharmacies less often for medication dispensing, pharmacies can still play a role in health promotion for this age group. In addition, some locally commissioned services specifically target or are primarily used by people in this group; for example EHC for women aged 13-24 years, substance misuse services and smoking cessation.

Working age population

In people of working age, pharmacies can play a role in supporting people to change their behaviours. For example, pharmacies offering smoking cessation, NHS Health Checks and other health promotion campaigns targeted at this age group widen access, especially around working hours. In addition, screening can also help diagnose people earlier and introduce medication or other management at an earlier stage.

The prevalence of long term conditions in this age group necessitates a coordinated approach by pharmacies to offer pharmacy services at times and locations convenient to the working age population. People with long term conditions may also be eligible for some advanced or enhanced services (such as MUR, NMS or seasonal 'flu vaccination), in addition to the essential services offered by all pharmacies.

Older people aged 65 and over

As shown in Chapter 4, the prevalence of long term conditions increases with age, including an increase in the prevalence of comorbidities. People in this age group are more likely to need support in managing their long term conditions, and any associated medications. This will be reflected in the use of advanced services (such as MUR and NMS), essential services such as repeat dispensing, and enhanced services, such as seasonal 'flu

vaccination. Accurate information and advice, accessible to patients with sensory needs, may help with adherence to medication. In addition, supporting people to adopt healthier behaviours will help prevent the development of other long term conditions, and manage their current conditions. For example, smokers diagnosed with COPD would benefit from smoking cessation advice. Ensuring equitable access to these services will allow for sustained improvements in outcomes for patients and improved life expectancy overall.

5.7.2. Disability

National legislation means that all pharmacies must comply with the provisions set out in law. However, with 45 different pharmacies in Islington, there are varying degrees of accessibility. For example, the qualitative research highlighted that some pharmacies are more difficult to enter while using a wheelchair. These issues result in disabled people having less choice in which pharmacy to use. Pharmacies are also required to have a confidential consultation room, which in some cases may not be suitable for those in a wheelchair.

Other forms of disability are also included in the scope of this characteristic, such as sensory impairment and disability resulting from a long term physical or mental condition. There are many pharmacy users which will fall into this category, and ensuring equitable access to medicines, advice and support is inherent to good provision of pharmacy services in Islington.

5.7.3. Gender reassignment

Pharmacies have an integral role to play for people undergoing gender reassignment, as most treatments involve medical treatment. Ensuring patients have access to their medications without significant delay is also important. Pharmacies could also offer MURs to ensure adherence to medications, and identify any issues as early as possible.

5.7.4. Marriage and civil partnership

No specific needs have been identified for this characteristic.

5.7.5. Pregnancy and maternity

As some pharmacies offer pregnancy test kits, they are ideally placed to offer antenatal advice and health promotion to newly pregnant women, including helping pregnant women to quit smoking. They are also able to offer MURs to women on other medications, to ensure that the medication is safe to use during pregnancy and while breastfeeding.

5.7.6. Race

As discussed in Chapters 3 and 4, the population of Islington is very diverse with a high proportion of people from BME groups, and people from these groups also have a high

proportion of diagnosed long term conditions. For example, the Asian population has a higher prevalence of diabetes.

The NHS Health Check offer in Islington targets South Asians at a younger age, reflecting the increase in prevalence of cardiovascular diseases. In addition to offering health promotion advice, pharmacies can opportunistically offer Health Checks to this group, as well as other public health interventions, such as smoking cessation.

5.7.7. Religion or belief

Apart from the obligation to provide pharmacy services irrespective of a patient's religion, the only specific need for this group would be advising patients on suitable medication due to food restrictions (e.g. medication containing pork products) or during fasting periods (e.g. Ramadan).

5.7.8. Gender

Though pharmacy services target both men and women, there are some services that are gender specific. Women, for example, can use EHC and pregnancy testing at pharmacies. Men are less likely to use health services in general, so opportunistic screening (such as Health Checks), health promotion and public health interventions should be used to their full potential.

5.7.9. Sexual orientation

Apart from the obligation to provide pharmacy services irrespective of a patient's sexuality, no specific needs have been identified for this characteristic.

6. FUTURE SERVICES

Chapter 4 has already detailed the anticipated future changes in population in Islington, so this section will look at the services that may be provided in the future.

6.1. Healthy Living Pharmacies

In September 2014 Camden and Islington Public Health, Camden and Islington CCGs and Camden and Islington Local Pharmaceutical Committee (LPC) invited pharmacies to apply for the Healthy Living Pharmacy (HLP) Quality Mark. The HLP programme recognises the significant role community pharmacies play in helping reduce health inequalities by delivering consistent and high quality health and wellbeing services, promoting health and providing proactive health advice and interventions. The Healthy Living Pharmacy concept was developed by NHS Portsmouth (Primary Care Trust), working together with the Hampshire and Isle of Wight LPC. A Healthy Living Pharmacy:

- Consistently delivers a range of health and wellbeing services to a high quality
- Has achieved defined quality criteria requirements and met productivity targets linked to local health needs
- Has a team that proactively promotes health and wellbeing and proactively offers brief advice on a range of health issues such as smoking, activity, sexual health, healthy eating and alcohol
- Has a Healthy Living Champion
- Is recognisable by the public.

An official launch of the programme took place in January 2015, and the aim is that all pharmacies will eventually hold this quality mark. For more information visit: www.islington.gov.uk/pharmacy.

7. MANDATORY CONSULTATION

This section will be completed once the formal consultation period has ended. The report will form part of the final PNA, published before 1 April 2015.

FOR CONSULTATION

8. WIDER RECOMMENDATIONS

Community pharmacies make an important contribution to meeting local priorities for health and wellbeing in Islington. The essential services meet an immediate medication need and assessment, but the provision of other services allows for a wider reach, responding to specific, local health needs. By providing these services, pharmacies also decrease the burden on GP practices and secondary care services, enabling more cost-effective delivery of some interventions.

The PNA process for Islington has highlighted many areas where pharmacies are doing well in their provision of pharmacy services for the population they serve. Though no significant gaps in provision were identified as part of the PNA, some smaller potential gaps in service provision have been recognised and should be reviewed by the relevant commissioner of the service; improvements to these areas are within the scope of the current contracts. However, there are also areas where improvements can be made in order to maximise the potential of community pharmacies in helping Islington's population stay healthy. These wider recommendations are discussed below, and in sum are:

- Improving the awareness of available pharmacy services
- Improving the awareness of longer opening hours
- Addressing the areas where pharmacies can increase the provision of key public health programmes

8.1. Improving awareness of available pharmacy services

One of the key findings from the qualitative research was the low level of awareness, from most groups, about the services available to them through their community pharmacy. For example, participants had very different levels of awareness of the options available in terms of repeat prescribing.

The low levels of uptake of advanced services such as medicines usage review and new medicines service could also point to low levels of awareness; as these services are targeted at people on medication regimes or new medicines, people with long term conditions (including mental health conditions) would particularly benefit from these services. As well as supporting better adherence, better understanding, and improved outcomes for patients, greater usage of these services would help to reduce the burden on GP practices. The combination of a high prevalence of long term conditions and relatively low uptake of services does clearly highlight that there is some unmet need in this area which, the evidence suggests, could be met through better public awareness.

8.2. Improving awareness of opening hours

Our assessment of pharmacy opening hours in Islington shows that, for the most part, pharmacy opening hours are adequate in Islington. Out of hours access is available in all localities on weekdays, but access to pharmacies in early mornings and late evenings is limited at the weekends. The resident focus groups show that longer opening hours were consistently raised as an area for improvement. Some groups were not aware of where late opening pharmacies were, or that they were available within Islington at all. This is especially important for those groups with high levels of need, for example people with long term conditions, mental health needs or those needing drug misuse services. Ensuring that residents are aware of their closest late opening pharmacy, as well as those that are open on Sundays, could increase the uptake of all pharmacy services to better address local health needs and to reduce the burden on other health services.

8.3. Increasing the provision of key public health programmes

The locally commissioned services (LCSs) offered in pharmacy, particularly those focussing on health promotion also have capacity for increased provision. For example, this includes stop smoking service, NHS Health Checks, emergency hormonal contraception, 'flu vaccination, and some substance misuse services, as well as more general health promotion campaigns. There is a strong evidence base for all of these services, and community pharmacies have a key role to play in raising awareness to motivate people to change their behaviours and then supporting them to change. Maximising the potential of community pharmacies to provide these services will assist in addressing local health needs, reducing health inequalities and increasing life expectancy.

Commissioners of these programmes should ensure that where contracted, pharmacies are promoted as a point of contact for the services, and pharmacies are supported in their offer. The launch of the Healthy Living Pharmacy (HLP) Quality Mark scheme in 2015 should be used to encourage pharmacies to further develop a holistic approach to the public health services they offer.

FOR CONSULTATION

Appendix A: Services provided, by pharmacy

Locality	Pharmacy name	Post Code	Medicine Use Review	New Medicines Service	Minor Ailments Scheme	Medicines Reminder Devices	Seasonal 'flu vaccination	Stop smoking service	NHS Health Checks	Emergency Hormonal Contraception	Supervised Self-Administration	Needle Exchange	Anticoagulation service	Palliative Care
North	Apex Pharmacy (Essex Road)	N4 3NS	Yes	Yes	Yes	Yes	Yes							
	Apex Pharmacy (Old Street)	N19 5QU	Yes	Yes	Yes	Yes	Yes				Yes	Yes		
	Apteka Chemist (Chapel Market)	N7 6QA	Yes		Yes			Yes			Yes	Yes		
	Apteka Chemist (Seven Sisters Rd)	N4 3NS	Yes	Yes	Yes	Yes	Yes	Yes		Yes				
	Arkle Pharmacy	N19 5QU	Yes	Yes	Yes	Yes	Yes			Yes	Yes	Yes		
	Boots the Chemist (Holloway Road)	N7 6QA	Yes	Yes	Yes			Yes		Yes	Yes			
	Chemitex Pharmacy	N7 7HE	Yes	Yes	Yes	Yes		Yes		Yes				
	Devs Chemist	N7 6AE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes
	Nuchem Pharmaceuticals Ltd	N4 3PX	Yes	Yes	Yes	Yes	Yes	Yes			Yes	Yes		
	Roger Davies Pharmacy	N4 3EF	Yes	Yes	Yes	Yes	Yes							
	Shivo Chemists	N19 3JF	Yes		Yes		Yes							
	Superdrug Pharmacy (Seven Sisters Road)	N7 6AJ	Yes	Yes	Yes		Yes	Yes			Yes	Yes		
	The Co-Operative Pharmacy	N19 5QT	Yes	Yes	Yes		Yes	Yes		Yes				
	Wellcare Pharmacy	N7 6JP	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes		
Wise Chemist	N19 3QN	Yes		Yes		Yes	Yes			Yes	Yes			
Central	C&H Chemist	N5 2LL	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes		
	Caledonian Pharmacy	N7 9RP	Yes		Yes	Yes	Yes	Yes		Yes				
	G Atkins	N7 8JE	Yes	Yes	Yes	Yes								
	Highbury Pharmacy	N5 2AB	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes	
	Hornsey Road Pharmacy	N7 7NN	Yes	Yes	Yes	Yes		Yes		Yes				
	Islington Pharmacy	N7 9GL	Yes	Yes			Yes							
	York Pharmacy	N7 9LW	Yes	Yes	Yes		Yes	Yes			Yes	Yes		

Locality	Pharmacy name	Post Code	Medicine Use Review	New Medicines Service	Minor Ailments Scheme	Medicines Reminder Devices	Seasonal Flu vaccination	Stop smoking service	NHS Health Checks	Emergency Hormonal Contraception	Supervised Self-Administration	Needle Exchange	Anticoagulation service	Palliative Care
South East	Boots the Chemist (Newington Green)	N16 9PX	Yes	Yes	Yes		Yes	Yes			Yes	Yes		
	Clan Pharmacy	N1 1RA	Yes	Yes	Yes		Yes				Yes			Yes
	Dermacia Pharmacy	N1 2UQ			Yes		Yes	Yes				Yes		
	Egerton Chemist	N7 8LX	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
	Essex Pharmacy	N1 2SF	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes		
	Leoprim Chemist	N1 3PB	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes		
	Mahesh Chemists	N1 4QY	Yes	Yes	Yes	Yes				Yes				
	New North Pharmacy	N1 8BJ	Yes	Yes		Yes	Yes	Yes		Yes				
	Rose Chemist	N1 2RU	Yes	Yes	Yes	Yes				Yes				
	Savemain Ltd	N1 8LY	Yes		Yes	Yes	Yes	Yes		Yes	Yes	Yes		
	St Peter's Pharmacy	N1 8JR	Yes	Yes	Yes		Yes	Yes		Yes				
Turnbulls Chemist	N1 2SN	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes			
South West	Boots the Chemist (Islington High St)	N1 9LJ	Yes	Yes	Yes			Yes		Yes	Yes	Yes		
	Carters Chemist	N7 8XF	Yes	Yes	Yes	Yes	Yes	Yes			Yes	Yes		
	Clerkenwell Pharmacy	EC1R 4QL	Yes	Yes	Yes			Yes			Yes	Yes		
	Clockwork Pharmacy (161 Caledonian Road)	N1 0SG	Yes	Yes	Yes	Yes	Yes	Yes		Yes				
	Clockwork Pharmacy (273 Caledonian Road)	N1 1EF	Yes		Yes	Yes	Yes	Yes		Yes	Yes	Yes		
	Douglas Pharmacy	N1 0DG			Yes	Yes	Yes			Yes	Yes	Yes		
	P Edward Ltd	N1 1BB	Yes		Yes					Yes				
	Portmans Pharmacy	EC1Y 8NX	Yes	Yes	Yes		Yes	Yes						
	Rowlands Pharmacy	EC1R 4QE	Yes	Yes	Yes	Yes	Yes			Yes	Yes	Yes		
	Superdrug Pharmacy (Chapel Market)	N1 9EW	Yes	Yes	Yes		Yes			Yes	Yes	Yes		
W C And K King Chemist	EC1R 1UR	Yes	Yes	Yes	Yes									

Appendix B: The Islington Pharmaceutical Needs Assessment Steering Group

A steering group is oversee the production of the PNA, in accordance with Department of Health regulations and deadlines. The group worked to ensure that the PNA captured the needs of the local populations, with a focus on reducing inequalities and aligning with the existing corporate plans of the HWB partners, where relevant. The group consists of representatives from:

- Public Health:
 - Sarah Dougan, Deputy Director of Public Health (Chair)
 - Dalina Vekinis, Senior Public Health Information Analyst
 - David Clifford, Public Health Information Officer
- Local pharmaceutical committee
 - Yogendra Parmar, CEO
- Medicines Management
 - Amalin Dutt, Head of Medicines Management
 - Brian MacKenna, Prescribing Advisor
- Healthwatch
 - Emma Whitby, Chief Officer Healthwatch (Islington)
- NHS England Area Team
 - Anthony Marks, Community Pharmacy Advisor

The responsible HWB member is Julie Billett, Director of Public Health. Sarah Dougan (Chair) reports directly to her.

At the Group's second meeting the following Terms of Reference were agreed, to codify the aims and purpose of the PNA, as well as the Group and individual members' responsibilities.

Members of the Steering Group also completed forms to indicate that they had no Conflicts of Interest with the group's responsibilities.

Background

From 1st April 2013, Health and Wellbeing Boards (HWBs) assumed responsibility for publishing and keeping up to date a statement of the needs for pharmaceutical services of the population in their area, referred to as a pharmaceutical needs assessment (PNA).

Formerly published by primary care trusts (PCTs), the PNA is a key tool for identifying what is needed at a local level to support the commissioning intentions for pharmaceutical services and other services that could be delivered by community pharmacies and other providers. The last PNAs were published in 2011 by respective local PCTs²³.

The importance to HWBs

- HWBs have now a legal duty to check the suitability of existing PNAs, compiled by primary care trusts (PCTs), and publish supplementary statements explaining any changes.
- HWBs will need to ensure that the NHS Commissioning Board (NHSCB) and its Area Teams have access to their PNAs.
- Each HWB will need to publish its own revised PNA by **1st April 2015**. This will require board-level sign-off and a minimum period (of 60 days) for public consultation beforehand²⁴.
- Failure to produce a robust PNA could lead to legal challenges because of the PNA's relevance to decisions about commissioning services and new pharmacy openings.

What should a good PNA cover?

- The PNAs should meet the market entry regulations²⁵.
- PNAs should include pharmacies and the services they already provide. These will include dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users.
- It should look at other services, such as dispensing by GP surgeries, and services available in neighbouring HWB areas that might affect the need for services in its own area.
- It should examine the demographics of its local population, across the area and in different localities, and their needs and also look at whether there are gaps that could be met by providing more pharmacy services, or through opening more pharmacies. It should also take account of likely future needs.

²³ The most recent PNAs published by Camden and Islington PCTs in 2011 are available to steering group members upon request.

²⁴ The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs and can be found at: <http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/>

²⁵ <http://psnc.org.uk/contract-it/market-entry-regulations/>

- The PNA should also contain relevant maps relating to the area and its pharmacies.
- Finally, PNAs must be aligned with other plans for local health and social care, including the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy.

Steering group duties/responsibilities

The core purpose of the steering group is to oversee the production of the Camden and Islington PNAs in accordance with DH regulations and deadlines.

- The group will ensure that the PNAs specifically capture the specific needs of the local populations, with a focus on reducing inequalities and aligning with the existing corporate plans of the HWB partners, where relevant.
- Once published, the group will ensure that the findings of the PNA are disseminated to those who need to know and will work towards implementation of the recommendations with relevant partners.

Policy Implications

- The Pharmaceutical Needs Assessment is the document that NHS England uses when deciding if new pharmacies are needed and to make decisions on which NHS funded services need to be provided by local community pharmacies.
- The Pharmaceutical Needs Assessment can be used as part of the Joint Strategic Needs Assessment (JSNA) to inform future commissioning strategies.
- As a valuable and trusted public health resource with millions of contacts with the public each day, community pharmacy teams have the potential to be used to provide services out of a hospital or practice environment and to reduce health inequalities²⁶. In addition, community pharmacies are an important investor in local communities through employment, supporting neighbourhood and high street economies, as a health asset and as a long term partner.

Governance

The work of the steering group will be governed by the HWBs for Camden and Islington (for their respective PNAs). The consultation documentation will be approved by the HWB and the final PNAs will be signed-off by the HWBs.

Progress on the PNAs will be reported to the Health and Wellbeing Boards (HWBs) through the quarterly officer groups meetings of respective boroughs, and this group will advise on decisions such as how to structure localities for the PNA for example, on behalf of the HWBs. The HWBs will also approve the draft PNAs to go for consultation along with the consultation questions, and will sign-off the final PNAs alongside reviewing the consultation responses.

²⁶ "Healthy lives, healthy people", the public health strategy for England (2010)

Julie Billett, Director of Public Health will act as the responsible member of the HWB to maintain the PNAs going forward. Sarah Dougan, Assistant Director of Public Health (Chair of the PNA steering group) reports directly to her.

Conflicts of interest will be documented early on in the project process. All members will be asked and sign a conflict of interest declaration. Where members have declared a conflict of interest which would impact on their ability to make an impartial judgement, they will abstain from the decision-making process. Some pharmacy data are commercially confidential and cannot be released into the public domain. As the PNAs are publicly available documents, if and where required, these data will be suppressed in accordance to information governance arrangements surrounding their use.

Membership

Membership needs to reflect that pharmacy commissioning involves: NHS England, Public Health & CCGs. Other members will be co-opted at different times to advice on different areas of work as needed.

The following will be members of the steering group:

- Assistant Director of Public Health for Camden & Islington (Chair)
- Senior Public Health Analyst (Camden & Islington Public Health)
- Public Health Information Officer, (Camden & Islington Public Health)
- Clinical Commissioning Groups (CCGs) – Heads of Medicines Management for Camden and Islington
- Local Pharmaceutical Committee (LPCs) Lead (Chief Executive)
- NHS England – representative
- Health Watch representatives for Camden and Islington
- Co-opted members (to attend when required)
- Communications Lead
- Patient / Public involvement (PPI) Group Lead/s (patient association)

Frequency of meetings

The steering group will meet quarterly each year:

- December 2013
- March 2014
- June 2014
- September 2014
- December 2014

Appendix C: Qualitative research completed for the Camden and Islington Pharmaceutical Needs Assessment Steering Group by OPM Research

This will be hosted on the Consultation site.

FOR CONSULTATION

Appendix D: Plan for the public consultation

Background and context to the consultation

The Pharmaceutical Needs Assessment (PNA) is a statutory requirement of every Health and Wellbeing Board. PNAs are designed to inform commissioning decisions by Local Authorities (LAs) and Clinical Commissioning Groups (CCGs). In addition, PNAs will be used by NHS England when deciding if new pharmacies are needed in the area and to make decisions on which NHS funded services need to be provided by local community pharmacies. The PNA can also be used as part of Islington's JSNA to inform future commissioning strategies.

Previously, PNAs were the responsibility of Primary Care Trusts (PCTs) to produce. The first PNAs were published in 2005, as the basis for deciding market entry of pharmacies to PCTs. The publication of the White Paper *Pharmacy in England: Building on strengths – delivering the future* proposed a review of the requirements of PNAs in order to make the process more robust, and make PNAs more effective in assessing the need for services. The Health and Social Care Act (2012) transferred this responsibility to local authority Health and Wellbeing Boards (HWBs), and further widened the scope of the PNA.

The PNA regulations require that they are published by 1 April 2015, following a mandatory 60-day consultation period where a draft PNA will be made available. The consultation serves as a way to collate feedback about the PNA and its conclusions from a wide range of stakeholders. This document details the process for the formal consultation period.

Scope of the consultation

The PNA regulations state that the following organisations must be consulted for a minimum of 60 days about the needs assessment:

- the Local Pharmaceutical Committee
- the Local Medical Committee
- Pharmacists and/or dispensing doctors in the area
- LPS chemists in the area with whom the NHSCB has made arrangements for the provision of any local pharmaceutical services;
- Local Healthwatch organisation for its area, and any other group interested in the provision of pharmaceutical services in its area
- any NHS trust or NHS foundation trust in its area
- the NHSCB
- Local HWB and any neighbouring HWB.

The formal consultation period will also be used to gather the views of local people, other healthcare providers, patients in the area and other key stakeholders. These comments will be synthesised into a consultation report and included in the final PNA document.

Consultation engagement

The consultation will run for 60 days from October 2014 to December 2014, with exact dates to be confirmed. Communications will be sent out to raise awareness of the consultation. The consultation documents will be available on the Council websites for downloading. The survey questions can be completed using an online survey. For accessibility reasons, a paper copy will also be available for people to complete. Table D.9.1 lists the organisations invited to consult on the PNA.

Table D.9.1: List of organisations to be consulted on Islington's PNA

	Stakeholder	Channel	Cost	Responsibility
Compulsory	Local Medical Committee	Email link to the consultation document and online survey to LMC secretary for distribution.	No cost	TBD
	Local Pharmaceutical Committee	Email link to the consultation document and online survey to LPC secretary for distribution.	No cost	TBD
	Pharmacy contractors (including appliance & distance selling pharmacies)	Email link to the consultation document and online survey to group.	No cost	TBD
	LPS pharmacy contractors	Email link to the consultation document and online survey to group.	No cost	TBD
	Healthwatch	Email link to the consultation document and online survey to group.	No cost	TBD
	NHS Acute Trusts	Email link to the consultation document and online survey to Head of Pharmacy.	No cost	TBD
	NHS Mental Health Trusts	Email link to the consultation document and online survey to Head of Pharmacy.	No cost	TBD
	NHS Commissioning Board	Email link to the consultation document and online survey to Local Area Team.	No cost	TBD
	HWB Board	Email link to the consultation document and online survey to Health and Wellbeing Board secretary for distribution.	No cost	TBD
	Neighbouring HWB boards	Email link to the consultation document and online survey to Health and Wellbeing Board secretaries for distribution.	No cost	TBD
Wider engagement	General population	Links to survey on relevant (or new) webpages on council's website	No cost	Comms team at LA
		Council social media, e.g. Twitter, Facebook	No cost	Comms team at LA
	Health Scrutiny Committee	Email consultation document	No cost	TBD
	Public Health Department	Email consultation document	No cost	TBD
	CCG	Patient groups at the local CCG	No cost	TBD
	Local Voluntary, Health and community groups	Email to other relevant groups and organisations to give information about the survey and ask for participation.	No cost	TBD

Consultation questions

The following questions will be asked as part of the consultation.

About the PNA

1. Has the purpose of the PNA been clearly explained?
2. Has the information been presented clearly and in a way that is easy to understand?
3. Are the localities clearly defined throughout the report?
4. Do you think the PNA accurately reflects the health needs of Islington's population, and the needs of the individual localities?
5. Do you think the PNA accurately reflects the pharmacy provision throughout Islington, and the individual localities?
6. Do you think that the PNA accurately reflects the pharmacy provision in neighbouring boroughs which also serve Islington residents?
7. Do you think there are any unidentified gaps in service provision, i.e. where or when services are provided?
8. Do you think there are any services which could be provided, but have not been identified?
9. Do you think the PNA accurately reflects the future needs of Islington's population?
10. Do you agree with the conclusions of the PNA? If not, please note which sections you disagree with, and why.
11. Do you have any other comments on the draft PNA?
12. Are you responding as:
 - a. a member of the public?
 - b. a health or social care professional?
 - c. as, or on behalf, of a business or trader?
 - d. as, or on behalf, of an organisation?

For Pharmacists only

13. Does the PNA accurately reflect your:
 - a. opening hours?
 - b. service provision?

If not, please give updated details.

For NHS England respondents only

14. Do you think that the PNA provides adequate information to inform market entry decisions?

Equalities information

We are collecting this in order to understand whether different sections of the population have different needs, and whether everyone feels that they are treated fairly and equally. Information given below will be kept confidential and anonymous, and only used to make decisions about improving our services.

3. What is your gender?
 - a. Male
 - b. Female
 - c. Transgender
 - d. Would rather not say
4. What is your age range?
 - a. Under 18 years old
 - b. 18-34 years old
 - c. 35-59 years old
 - d. 60 years old or over
5. What is your ethnic group?
 - a. White British
 - b. White Irish
 - c. White European
 - d. White Other
 - e. Indian
 - f. Pakistani
 - g. Bangladeshi
 - h. Other Asian or Asian British
 - i. Black Caribbean
 - j. Black African
 - k. Other Black or Black British
 - l. Mixed – White and Black Caribbean
 - m. Mixed – White and Black African
 - n. Mixed – White and Asian
 - o. Mixed – Other
 - p. Other
 - q. Prefer not to say
6. What is your religion?
 - a. Christian
 - b. Jewish
 - c. Muslim
 - d. Hindu
 - e. Buddhist

- f. Other
 - g. Prefer not to say
7. Do you consider yourself to have a disability or long term condition?
- a. Yes
 - b. No
 - c. Prefer not to say
8. What is your sexual orientation?
- a. Heterosexual/Straight
 - b. Homosexual/Gay/Lesbian
 - c. Bisexual
 - d. Other
 - e. Prefer not to say
9. What is your employment status?
- a. Employed
 - b. Self-employed
 - c. Student
 - d. Looking after home
 - e. Carer
 - f. Unemployed
 - g. Volunteer
 - h. Retired
 - i. Other
 - j. Prefer not to say

FOR CONSULTATION

Appendix E: Responses to the Consultation, and Steering Groups responses to them

This section will be completed following the public consultation, at which point the PNA will be re-submitted to the Health and Wellbeing Board for final approval, along with any necessary changes to the main body of the document.

FOR CONSULTATION

Appendix F: Islington GP Locality profiles

The Islington GP Locality Profiles will be hosted online as a part of the consultation, but to reduce the size of the PDF for circulation, the files are available here:

<http://evidencehub.islington.gov.uk/wellbeing/Healthsettings/Pages/default.aspx>

FOR CONSULTATION

Appendix G: Opening hours

Table G.1: Total opening hours on Monday by locality and pharmacy

Locality	ODS Code	Pharmacy	Post code	Open	Close	06:00	09:00	12:00	15:00	18:00	21:00
Central	FQ525	C&H Chemist	N5 2LL	09:00	18:30						
	FK061	Caledonian Pharmacy	N7 9RP	09:30	18:00						
	FDG93	G Atkins	N7 8JE	09:00	19:30						
	FL630	Highbury Pharmacy	N5 2AB	09:00	18:30						
	FVQ29	Hornsey Road Pharmacy	N7 7NN	09:00	19:00						
	FWQ48	Islington Pharmacy	N7 9GL	06:00	23:00						
	FDN26	York Pharmacy	N7 9LW	09:00	18:30						
North	FWN43	Apteka Chemist (Seven Sisters Rd	N4 3NS	09:00	19:00						
	FND94	Arkle Pharmacy	N19 5QU	09:00	19:00						
	FMD33	Boots the Chemist (Holloway Road)	N7 6QA	08:30	19:00						
	FRE45	Chemitex Pharmacy	N7 7HE	09:00	18:30						
	FJ680	Devs Chemist	N7 6AE	09:00	19:00						
	FJA90	Nuchem Pharmaceuticals Ltd	N4 3PX	09:00	19:00						
	FF023	Roger Davies Pharmacy	N4 3EF	09:00	19:00						
	FLN42	Shivo Chemists	N19 3JF	10:00	18:00						
	FMD88	Superdrug Pharmacy (Seven Sisters Road)	N7 6AJ	09:00	18:30						
	FPA29	The Co-Operative Pharmacy	N19 5QT	09:00	19:00						
	FNE08	Wellcare Pharmacy	N7 6JP	09:00	19:00						
	FKF20	Wise Chemist	N19 3QN	09:00	19:00						
South East	FC511	Boots the Chemist (Newington Green)	N16 9PX	09:00	19:00						
	FXC57	Clan Pharmacy	N1 1RA	09:00	18:30						
	FWK02	Dermacia Pharmacy	N1 2UQ	09:00	18:30						
	FLM71	Egerton Chemist	N7 8LX	09:00	19:00						
	FEM36	Essex Pharmacy	N1 2SF	09:00	19:00						
	FPP76	Leoprim Chemist	N1 3PB	08:30	19:30						
	FDP65	Mahesh Chemists	N1 4QY	09:00	19:00						
	FVG24	New North Pharmacy	N1 8BJ	09:00	19:00						
	FL170	Rose Chemist	N1 2RU	08:00	20:00						
	FKR70	Savemain Ltd	N1 8LY	09:00	19:00						
	FDN39	St Peter'S Pharmacy	N1 8JR	09:00	19:00						
	FN508	Turnbulls Chemist	N1 2SN	09:00	19:00						
	FP111	Apex Pharmacy (Appliance)	N1 3AP	09:00	18:00						
	FG020	42 Colebrook Row	N1 8AF	09:00	17:00						
	FG894	Apex Pharmacy (Essex Road)	N1 3AP	09:00	18:00						

Locality	ODS Code	Pharmacy	Post code	Open	Close	06:00	09:00	12:00	15:00	18:00	21:00
South West	FWA79	Apteka Chemist (Chapel Market)	N1 9ER	09:00	19:00						
	FFX11	Boots the Chemist (Islington High St)	N1 9LJ	08:00	19:30						
	FWP49	Carters Chemist	N7 8XF	09:00	19:00						
	FRM14	Clerkenwell Pharmacy	EC1R 4QL	09:00	19:00						
	FAG14	Clockwork Pharmacy (273 Caledonian Road)	N1 1EF	09:00	19:00						
	FVA91	Clockwork Pharmacy (161 Caledonian Road)	N1 0SG	09:00	18:30						
	FRM52	Douglas Pharmacy	N1 0DG	08:00	20:00						
	FAC32	P Edward Ltd	N1 1BB	09:00	18:30						
	FJJ16	Portmans Pharmacy	EC1Y 8NX	09:00	18:30						
	FNM70	Rowlands Pharmacy	EC1R 4QE	09:00	19:00						
	FJ143	Superdrug Pharmacy (Chapel Market)	N1 9EW	08:30	19:00						
	FJE08	W C And K King Chemist	EC1R 1UR	09:00	18:00						
	FC850	Apex Pharmacy (Appliance)	EC1V 9NP	09:00	18:30						
	FHD65	Apex Pharmacy (Old Street)	EC1V 9NP	09:00	18:30						

Source: NHS England, 2014

Key: Core opening hours Supplementary opening hours

Table G.2: Total opening hours on Tuesday by locality and pharmacy

Locality	ODS Code	Pharmacy	Post code	Open	Close	06:00	09:00	12:00	15:00	18:00	21:00
Central	FQ525	C&H Chemist	N5 2LL	09:00	18:30						
	FK061	Caledonian Pharmacy	N7 9RP	09:30	18:00						
	FDG93	G Atkins	N7 8JE	09:00	20:00						
	FL630	Highbury Pharmacy	N5 2AB	09:00	18:30						
	FVQ29	Hornsey Road Pharmacy	N7 7NN	09:00	19:00						
	FWQ48	Islington Pharmacy	N7 9GL	06:00	23:00						
	FDN26	York Pharmacy	N7 9LW	09:00	18:30						
North	FWN43	Apteka Chemist (Seven Sisters Rd	N4 3NS	09:00	19:00						
	FND94	Arkle Pharmacy	N19 5QU	09:00	19:00						
	FMD33	Boots the Chemist (Holloway Road)	N7 6QA	08:30	19:00						
	FRE45	Chemitex Pharmacy	N7 7HE	09:00	18:30						
	FJ680	Devs Chemist	N7 6AE	09:00	19:00						
	FJA90	Nuchem Pharmaceuticals Ltd	N4 3PX	09:00	19:00						
	FF023	Roger Davies Pharmacy	N4 3EF	09:00	19:00						
	FLN42	Shivo Chemists	N19 3JF	10:00	18:00						
	FMD88	Superdrug Pharmacy (Seven Sisters Road)	N7 6AJ	09:00	18:30						
	FPA29	The Co-Operative Pharmacy	N19 5QT	09:00	19:00						
	FNE08	Wellcare Pharmacy	N7 6JP	09:00	19:00						
	FKF20	Wise Chemist	N19 3QN	09:00	19:00						
South East	FC511	Boots the Chemist (Newington Green)	N16 9PX	09:00	19:00						
	FXC57	Clan Pharmacy	N1 1RA	09:00	18:30						
	FWK02	Dermacia Pharmacy	N1 2UQ	09:00	18:30						
	FLM71	Egerton Chemist	N7 8LX	09:00	19:00						
	FEM36	Essex Pharmacy	N1 2SF	09:00	19:00						
	FPP76	Leoprim Chemist	N1 3PB	08:30	19:30						
	FDP65	Mahesh Chemists	N1 4QY	09:00	19:00						
	FVG24	New North Pharmacy	N1 8BJ	09:00	19:00						
	FL170	Rose Chemist	N1 2RU	08:00	20:00						
	FKR70	Savemain Ltd	N1 8LY	09:00	19:00						
	FDN39	St Peter'S Pharmacy	N1 8JR	09:00	19:00						
	FN508	Turnbolls Chemist	N1 2SN	09:00	19:00						
	FP111	Apex Pharmacy (Appliance)	N1 3AP	09:00	18:00						
	FG020	42 Colebrook Row	N1 8AF	09:00	17:00						
	FG894	Apex Pharmacy (Essex Road)	N1 3AP	09:00	18:00						

Locality	ODS Code	Pharmacy	Post code	Open	Close	06:00	09:00	12:00	15:00	18:00	21:00
South West	FWA79	Apteka Chemist (Chapel Market)	N1 9ER	09:00	19:00						
	FFX11	Boots the Chemist (Islington High St)	N1 9LJ	08:00	19:30						
	FWP49	Carters Chemist	N7 8XF	09:00	19:00						
	FRM14	Clerkenwell Pharmacy	EC1R 4QL	09:00	19:00						
	FAG14	Clockwork Pharmacy (273 Caledonian Road)	N1 1EF	09:00	19:00						
	FVA91	Clockwork Pharmacy (161 Caledonian Road)	N1 0SG	09:00	18:30						
	FRM52	Douglas Pharmacy	N1 0DG	08:00	20:00						
	FAC32	P Edward Ltd	N1 1BB	09:00	18:30						
	FJJ16	Portmans Pharmacy	EC1Y 8NX	09:00	18:30						
	FNM70	Rowlands Pharmacy	EC1R 4QE	09:00	19:00						
	FJ143	Superdrug Pharmacy (Chapel Market)	N1 9EW	08:30	19:00						
	FJE08	W C And K King Chemist	EC1R 1UR	09:00	18:00						
	FC850	Apex Pharmacy (Appliance)	EC1V 9NP	09:00	18:30						
	FHD65	Apex Pharmacy (Old Street)	EC1V 9NP	09:00	18:30						

Source: NHS England, 2014

Table G.3: Total opening hours on Wednesday by locality and pharmacy

Locality	ODS Code	Pharmacy	Post code	Open	Close	06:00	09:00	12:00	15:00	18:00	21:00
Central	FQ525	C&H Chemist	N5 2LL	09:00	18:30						
	FK061	Caledonian Pharmacy	N7 9RP	09:30	18:00						
	FDG93	G Atkins	N7 8JE	09:00	19:30						
	FL630	Highbury Pharmacy	N5 2AB	09:00	18:30						
	FVQ29	Hornsey Road Pharmacy	N7 7NN	09:00	19:00						
	FWQ48	Islington Pharmacy	N7 9GL	06:00	23:00						
	FDN26	York Pharmacy	N7 9LW	09:00	18:30						
North	FWN43	Apteka Chemist (Seven Sisters Rd	N4 3NS	09:00	19:00						
	FND94	Arkle Pharmacy	N19 5QU	09:00	19:00						
	FMD33	Boots the Chemist (Holloway Road)	N7 6QA	08:30	19:00						
	FRE45	Chemitex Pharmacy	N7 7HE	09:00	18:30						
	FJ680	Devs Chemist	N7 6AE	09:00	19:00						
	FJA90	Nuchem Pharmaceuticals Ltd	N4 3PX	09:00	19:00						
	FF023	Roger Davies Pharmacy	N4 3EF	09:00	19:00						
	FLN42	Shivo Chemists	N19 3JF	10:00	18:00						
	FMD88	Superdrug Pharmacy (Seven Sisters Road)	N7 6AJ	09:00	18:30						
	FPA29	The Co-Operative Pharmacy	N19 5QT	09:00	19:00						
	FNE08	Wellcare Pharmacy	N7 6JP	09:00	19:00						
	FKF20	Wise Chemist	N19 3QN	09:00	19:00						
	South East	FC511	Boots the Chemist (Newington Green)	N16 9PX	09:00	19:00					
FXC57		Clan Pharmacy	N1 1RA	09:00	18:30						
FWK02		Dermacia Pharmacy	N1 2UQ	09:00	18:30						
FLM71		Egerton Chemist	N7 8LX	09:00	19:00						
FEM36		Essex Pharmacy	N1 2SF	09:00	19:00						
FPP76		Leoprim Chemist	N1 3PB	08:30	19:30						
FDP65		Mahesh Chemists	N1 4QY	09:00	19:00						
FVG24		New North Pharmacy	N1 8BJ	09:00	14:00						
FL170		Rose Chemist	N1 2RU	08:00	18:00						
FKR70		Savemain Ltd	N1 8LY	09:00	19:00						
FDN39		St Peter'S Pharmacy	N1 8JR	09:00	18:00						
FN508		Tumbulls Chemist	N1 2SN	09:00	19:00						
FP111		Apex Pharmacy (Appliance)	N1 3AP	09:00	18:00						
FG020		42 Colebrook Row	N1 8AF	09:00	17:00						
FG894		Apex Pharmacy (Essex Road)	N1 3AP	09:00	18:00						

Locality	ODS Code	Pharmacy	Post code	Open	Close	06:00	09:00	12:00	15:00	18:00	21:00
South West	FWA79	Apteka Chemist (Chapel Market)	N1 9ER	09:00	19:00						
	FFX11	Boots the Chemist (Islington High St)	N1 9LJ	08:00	19:30						
	FWP49	Carters Chemist	N7 8XF	09:00	19:00						
	FRM14	Clerkenwell Pharmacy	EC1R 4QL	09:00	19:00						
	FAG14	Clockwork Pharmacy (273 Caledonian Road)	N1 1EF	09:00	19:00						
	FVA91	Clockwork Pharmacy (161 Caledonian Road)	N1 0SG	09:00	18:30						
	FRM52	Douglas Pharmacy	N1 0DG	08:00	20:00						
	FAC32	P Edward Ltd	N1 1BB	09:00	18:30						
	FJJ16	Portmans Pharmacy	EC1Y 8NX	09:00	18:30						
	FNM70	Rowlands Pharmacy	EC1R 4QE	09:00	19:00						
	FJ143	Superdrug Pharmacy (Chapel Market)	N1 9EW	08:30	19:00						
	FJE08	W C And K King Chemist	EC1R 1UR	09:00	18:00						
	FC850	Apex Pharmacy (Appliance)	EC1V 9NP	09:00	18:30						
	FHD65	Apex Pharmacy (Old Street)	EC1V 9NP	09:00	18:30						

Source: NHS England, 2014

Table G.4: Total opening hours on Thursday by locality and pharmacy

Locality	ODS Code	Pharmacy	Post code	Open	Close	06:00	09:00	12:00	15:00	18:00	21:00
Central	FQ525	C&H Chemist	N5 2LL	09:00	18:30						
	FK061	Caledonian Pharmacy	N7 9RP	09:30	18:00						
	FDG93	G Atkins	N7 8JE	09:00	19:30						
	FL630	Highbury Pharmacy	N5 2AB	09:00	18:30						
	FVQ29	Hornsey Road Pharmacy	N7 7NN	09:00	13:00						
	FWQ48	Islington Pharmacy	N7 9GL	06:00	23:00						
	FDN26	York Pharmacy	N7 9LW	09:00	18:30						
North	FWN43	Apteka Chemist (Seven Sisters Rd	N4 3NS	09:00	19:00						
	FND94	Arkle Pharmacy	N19 5QU	09:00	19:00						
	FMD33	Boots the Chemist (Holloway Road)	N7 6QA	08:30	19:00						
	FRE45	Chemitex Pharmacy	N7 7HE	09:00	12:30						
	FJ680	Devs Chemist	N7 6AE	09:00	19:00						
	FJA90	Nuchem Pharmaceuticals Ltd	N4 3PX	09:00	19:00						
	FF023	Roger Davies Pharmacy	N4 3EF	09:00	19:00						
	FLN42	Shivo Chemists	N19 3JF	10:00	18:00						
	FMD88	Superdrug Pharmacy (Seven Sisters Road)	N7 6AJ	09:00	18:30						
	FPA29	The Co-Operative Pharmacy	N19 5QT	09:00	19:00						
	FNE08	Wellcare Pharmacy	N7 6JP	09:00	19:00						
	FKF20	Wise Chemist	N19 3QN	09:00	19:00						
South East	FC511	Boots the Chemist (Newington Green)	N16 9PX	09:00	19:00						
	FXC57	Clan Pharmacy	N1 1RA	09:00	18:30						
	FWK02	Dermacia Pharmacy	N1 2UQ	09:00	18:30						
	FLM71	Egerton Chemist	N7 8LX	09:00	19:00						
	FEM36	Essex Pharmacy	N1 2SF	09:00	19:00						
	FPP76	Leoprim Chemist	N1 3PB	08:30	19:30						
	FDP65	Mahesh Chemists	N1 4QY	09:00	19:00						
	FVG24	New North Pharmacy	N1 8BJ	09:00	19:00						
	FL170	Rose Chemist	N1 2RU	08:00	20:00						
	FKR70	Savemain Ltd	N1 8LY	09:00	19:00						
	FDN39	St Peter'S Pharmacy	N1 8JR	09:00	19:00						
	FN508	Turnbulls Chemist	N1 2SN	09:00	19:00						
	FP111	Apex Pharmacy (Appliance)	N1 3AP	09:00	18:00						
	FG020	42 Colebrook Row	N1 8AF	09:00	17:00						
	FG894	Apex Pharmacy (Essex Road)	N1 3AP	09:00	18:00						

Locality	ODS Code	Pharmacy	Post code	Open	Close	06:00	09:00	12:00	15:00	18:00	21:00
South West	FWA79	Apteka Chemist (Chapel Market)	N1 9ER	09:00	19:00						
	FFX11	Boots the Chemist (Islington High St)	N1 9LJ	08:00	19:30						
	FWP49	Carters Chemist	N7 8XF	09:00	19:00						
	FRM14	Clerkenwell Pharmacy	EC1R 4QL	09:00	19:00						
	FAG14	Clockwork Pharmacy (273 Caledonian Road)	N1 1EF	09:00	19:00						
	FVA91	Clockwork Pharmacy (161 Caledonian Road)	N1 0SG	08:00	16:00						
	FRM52	Douglas Pharmacy	N1 0DG	08:00	20:00						
	FAC32	P Edward Ltd	N1 1BB	09:00	18:00						
	FJJ16	Portmans Pharmacy	EC1Y 8NX	09:00	18:30						
	FNM70	Rowlands Pharmacy	EC1R 4QE	09:00	19:00						
	FJ143	Superdrug Pharmacy (Chapel Market)	N1 9EW	08:30	19:00						
	FJE08	W C And K King Chemist	EC1R 1UR	09:00	18:00						
	FC850	Apex Pharmacy (Appliance)	EC1V 9NP	09:00	18:30						
	FHD65	Apex Pharmacy (Old Street)	EC1V 9NP	09:00	18:30						

Source: NHS England, 2014

Table G.5: Total opening hours on Friday by locality and pharmacy

Locality	ODS Code	Pharmacy	Post code	Open	Close	06:00	09:00	12:00	15:00	18:00	21:00
Central	FQ525	C&H Chemist	N5 2LL	09:00	18:30						
	FK061	Caledonian Pharmacy	N7 9RP	09:30	18:00						
	FDG93	G Atkins	N7 8JE	09:00	19:30						
	FL630	Highbury Pharmacy	N5 2AB	09:00	18:30						
	FVQ29	Hornsey Road Pharmacy	N7 7NN	09:00	19:00						
	FWQ48	Islington Pharmacy	N7 9GL	06:00	23:00						
	FDN26	York Pharmacy	N7 9LW	09:00	18:30						
North	FWN43	Apteka Chemist (Seven Sisters Rd	N4 3NS	09:00	19:00						
	FND94	Arkle Pharmacy	N19 5QU	09:00	19:00						
	FMD33	Boots the Chemist (Holloway Road)	N7 6QA	08:30	19:00						
	FRE45	Chemitex Pharmacy	N7 7HE	09:00	18:30						
	FJ680	Devs Chemist	N7 6AE	09:00	19:00						
	FJA90	NuChem Pharmaceuticals Ltd	N4 3PX	09:00	19:00						
	FF023	Roger Davies Pharmacy	N4 3EF	09:00	19:00						
	FLN42	Shivo Chemists	N19 3JF	10:00	18:00						
	FMD88	Superdrug Pharmacy (Seven Sisters Road)	N7 6AJ	09:00	18:30						
	FPA29	The Co-Operative Pharmacy	N19 5QT	09:00	19:00						
	FNE08	Wellcare Pharmacy	N7 6JP	09:00	19:00						
	FKF20	Wise Chemist	N19 3QN	09:00	19:00						
	South East	FC511	Boots the Chemist (Newington Green)	N16 9PX	09:00	19:00					
FXC57		Clan Pharmacy	N1 1RA	09:00	18:30						
FWK02		Dermacia Pharmacy	N1 2UQ	09:00	18:30						
FLM71		Egerton Chemist	N7 8LX	09:00	19:00						
FEM36		Essex Pharmacy	N1 2SF	09:00	19:00						
FPP76		Leoprim Chemist	N1 3PB	08:30	19:30						
FDP65		Mahesh Chemists	N1 4QY	09:00	19:00						
FVG24		New North Pharmacy	N1 8BJ	09:00	19:00						
FL170		Rose Chemist	N1 2RU	08:00	20:00						
FKR70		Savemain Ltd	N1 8LY	09:00	19:00						
FDN39		St Peter'S Pharmacy	N1 8JR	09:00	19:00						
FN508		Turnbolls Chemist	N1 2SN	09:00	19:00						
FP111		Apex Pharmacy (Appliance)	N1 3AP	09:00	18:00						
FG020		42 Colebrook Row	N1 8AF	09:00	17:00						
FG894		Apex Pharmacy (Essex Road)	N1 3AP	09:00	18:00						

Locality	ODS Code	Pharmacy	Post code	Open	Close	06:00	09:00	12:00	15:00	18:00	21:00
South West	FWA79	Apteka Chemist (Chapel Market)	N1 9ER	09:00	19:00						
	FFX11	Boots the Chemist (Islington High St)	N1 9LJ	08:00	19:30						
	FWP49	Carters Chemist	N7 8XF	09:00	19:00						
	FRM14	Clerkenwell Pharmacy	EC1R 4QL	09:00	19:00						
	FAG14	Clockwork Pharmacy (273 Caledonian Road)	N1 1EF	09:00	19:00						
	FVA91	Clockwork Pharmacy (161 Caledonian Road)	N1 0SG	09:00	18:30						
	FRM52	Douglas Pharmacy	N1 0DG	08:00	20:00						
	FAC32	P Edward Ltd	N1 1BB	09:00	18:30						
	FJJ16	Portmans Pharmacy	EC1Y 8NX	09:00	18:30						
	FNM70	Rowlands Pharmacy	EC1R 4QE	09:00	19:00						
	FJ143	Superdrug Pharmacy (Chapel Market)	N1 9EW	08:30	19:00						
	FJE08	W C And K King Chemist	EC1R 1UR	09:00	18:00						
	FC850	Apex Pharmacy (Appliance)	EC1V 9NP	09:00	18:30						
	FHD65	Apex Pharmacy (Old Street)	EC1V 9NP	09:00	18:30						

Source: NHS England, 2014

Table G.6: Total opening hours on Saturday by locality and pharmacy

Locality	ODS Code	Pharmacy	Post code	Open	Close	06:00	09:00	12:00	15:00	18:00	21:00
Central	FQ525	C&H Chemist	N5 2LL	09:00	17:00						
	FK061	Caledonian Pharmacy	N7 9RP	Closed							
	FDG93	G Atkins	N7 8JE	09:00	12:00						
	FL630	Highbury Pharmacy	N5 2AB	09:00	18:00						
	FVQ29	Hornsey Road Pharmacy	N7 7NN	Closed							
	FWQ48	Islington Pharmacy	N7 9GL	08:00	23:00						
	FDN26	York Pharmacy	N7 9LW	09:30	17:00						
North	FWN43	Apteka Chemist (Seven Sisters Rd	N4 3NS	10:00	14:00						
	FND94	Arkle Pharmacy	N19 5QU	09:00	18:00						
	FMD33	Boots the Chemist (Holloway Road)	N7 6QA	08:30	19:00						
	FRE45	Chemitex Pharmacy	N7 7HE	10:00	14:00						
	FJ680	Devs Chemist	N7 6AE	09:00	18:30						
	FJA90	Nuchem Pharmaceuticals Ltd	N4 3PX	09:00	17:30						
	FF023	Roger Davies Pharmacy	N4 3EF	09:00	17:00						
	FLN42	Shivo Chemists	N19 3JF	10:00	16:00						
	FMD88	Superdrug Pharmacy (Seven Sisters Road)	N7 6AJ	09:00	18:30						
	FPA29	The Co-Operative Pharmacy	N19 5QT	09:00	17:00						
	FNE08	Wellcare Pharmacy	N7 6JP	09:00	17:30						
	FKF20	Wise Chemist	N19 3QN	09:00	18:00						
South East	FC511	Boots the Chemist (Newington Green)	N16 9PX	09:00	18:00						
	FXC57	Clan Pharmacy	N1 1RA	09:00	18:30						
	FWK02	Dermacia Pharmacy	N1 2UQ	09:00	18:00						
	FLM71	Egerton Chemist	N7 8LX	09:00	14:00						
	FEM36	Essex Pharmacy	N1 2SF	09:30	17:00						
	FPP76	Leoprim Chemist	N1 3PB	09:00	18:00						
	FDP65	Mahesh Chemists	N1 4QY	Closed							
	FVG24	New North Pharmacy	N1 8BJ	09:00	14:00						
	FL170	Rose Chemist	N1 2RU	09:00	13:00						
	FKR70	Savemain Ltd	N1 8LY	09:00	18:30						
	FDN39	St Peter'S Pharmacy	N1 8JR	09:30	16:00						
	FN508	Turnbolls Chemist	N1 2SN	09:00	19:00						
	FP111	Apex Pharmacy (Appliance)	N1 3AP	Closed							
	FG020	42 Colebrook Row	N1 8AF	Closed							
	FG894	Apex Pharmacy (Essex Road)	N1 3AP	Closed							

Locality	ODS Code	Pharmacy	Post code	Open	Close	06:00	09:00	12:00	15:00	18:00	21:00
South West	FWA79	Apteka Chemist (Chapel Market)	N1 9ER	09:00	17:00						
	FFX11	Boots the Chemist (Islington High St)	N1 9LJ	09:00	19:00						
	FWP49	Carters Chemist	N7 8XF	09:00	17:00						
	FRM14	Clerkenwell Pharmacy	EC1R 4QL	09:00	17:00						
	FAG14	Clockwork Pharmacy (273 Caledonian Road)	N1 1EF	09:00	18:00						
	FVA91	Clockwork Pharmacy (161 Caledonian Road)	N1 0SG	Closed							
	FRM52	Douglas Pharmacy	N1 0DG	09:00	13:00						
	FAC32	P Edward Ltd	N1 1BB	09:00	18:00						
	FJJ16	Portmans Pharmacy	EC1Y 8NX	09:00	17:00						
	FNM70	Rowlands Pharmacy	EC1R 4QE	09:00	17:00						
	FJ143	Superdrug Pharmacy (Chapel Market)	N1 9EW	09:00	17:30						
	FJE08	W C And K King Chemist	EC1R 1UR	Closed							
	FC850	Apex Pharmacy (Appliance)	EC1V 9NP	09:00	18:00						
	FHD65	Apex Pharmacy (Old Street)	EC1V 9NP	09:30	13:00						

Source: NHS England, 2014

Table G.7: Total opening hours on Sunday by locality and pharmacy

Locality	ODS Code	Pharmacy	Post code	Open	Close	06:00	09:00	12:00	15:00	18:00	21:00
Central	FQ525	C&H Chemist	N5 2LL	Closed							
	FK061	Caledonian Pharmacy	N7 9RP	Closed							
	FDG93	G Atkins	N7 8JE	Closed							
	FL630	Highbury Pharmacy	N5 2AB	Closed							
	FVQ29	Hornsey Road Pharmacy	N7 7NN	Closed							
	FWQ48	Islington Pharmacy	N7 9GL	closed							
	FDN26	York Pharmacy	N7 9LW	Closed							
North	FWN43	Apteka Chemist (Seven Sisters Rd	N4 3NS	Closed							
	FND94	Arkle Pharmacy	N19 5QU	Closed							
	FMD33	Boots the Chemist (Holloway Road)	N7 6QA	11:00	17:00						
	FRE45	Chemitex Pharmacy	N7 7HE	Closed							
	FJ680	Devs Chemist	N7 6AE	Closed							
	FJA90	Nuchem Pharmaceuticals Ltd	N4 3PX	Closed							
	FF023	Roger Davies Pharmacy	N4 3EF	Closed							
	FLN42	Shivo Chemists	N19 3JF	Closed							
	FMD88	Superdrug Pharmacy (Seven Sisters Road)	N7 6AJ	11:00	17:00						
	FPA29	The Co-Operative Pharmacy	N19 5QT	Closed							
	FNE08	Wellcare Pharmacy	N7 6JP	Closed							
	FKF20	Wise Chemist	N19 3QN	Closed							
South East	FC511	Boots the Chemist (Newington Green)	N16 9PX	Closed							
	FXC57	Clan Pharmacy	N1 1RA	Closed							
	FWK02	Dermacia Pharmacy	N1 2UQ	Closed							
	FLM71	Egerton Chemist	N7 8LX	Closed							
	FEM36	Essex Pharmacy	N1 2SF	Closed							
	FPP76	Leoprim Chemist	N1 3PB	Closed							
	FDP65	Mahesh Chemists	N1 4QY	Closed							
	FVG24	New North Pharmacy	N1 8BJ	Closed							
	FL170	Rose Chemist	N1 2RU	Closed							
	FKR70	Savemain Ltd	N1 8LY	Closed							
	FDN39	St Peter'S Pharmacy	N1 8JR	Closed							
	FN508	Turnbolls Chemist	N1 2SN	Closed							
	FP111	Apex Pharmacy (Appliance)	N1 3AP	closed							
	FG020	42 Colebrook Row	N1 8AF	Closed							
	FG894	Apex Pharmacy (Essex Road)	N1 3AP	Closed							

Locality	ODS Code	Pharmacy	Post code	Open	Close	06:00	09:00	12:00	15:00	18:00	21:00
South West	FWA79	Apteka Chemist (Chapel Market)	N1 9ER	Closed							
	FFX11	Boots the Chemist (Islington High St)	N1 9LJ	10:00	18:00						
	FWP49	Carters Chemist	N7 8XF	Closed							
	FRM14	Clerkenwell Pharmacy	EC1R 4QL	Closed							
	FAG14	Clockwork Pharmacy (273 Caledonian Road)	N1 1EF	Closed							
	FVA91	Clockwork Pharmacy (161 Caledonian Road)	N1 0SG	Closed							
	FRM52	Douglas Pharmacy	N1 0DG	Closed							
	FAC32	P Edward Ltd	N1 1BB	Closed							
	FJJ16	Portmans Pharmacy	EC1Y 8NX	Closed							
	FNM70	Rowlands Pharmacy	EC1R 4QE	Closed							
	FJ143	Superdrug Pharmacy (Chapel Market)	N1 9EW	10:00	16:00						
	FJE08	W C And K King Chemist	EC1R 1UR	Closed							
	FC850	Apex Pharmacy (Appliance)	EC1V 9NP	Closed							
	FHD65	Apex Pharmacy (Old Street)	EC1V 9NP	Closed							

Source: NHS England, 2014

Appendix H: Bibliography

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Alcohol-Related Hospital Admissions profile 2012:
<http://evidencehub.islington.gov.uk/wellbeing/Lifestyles/BRF/profiles/Pages/default.aspx>

Annual Public Health Report 2013: Widening the focus: tackling health inequalities in Camden & Islington: www.islington.gov.uk/aphr

Islington Joint Strategic Needs Assessment:
<http://evidencehub.islington.gov.uk/yourarea/jsna/Pages/default.aspx>

Islington LAPE profile 2014: <http://www.lape.org.uk/>

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<http://evidencehub.islington.gov.uk/wellbeing/Mentalhealth/Pages/default.aspx>

Sexual health profile 2014:
<http://evidencehub.islington.gov.uk/wellbeing/Lifestyles/BRF/profiles/Pages/default.aspx>

Smoking prevalence and smoking cessation services in Islington 2014:
<http://evidencehub.islington.gov.uk/wellbeing/Lifestyles/BRF/profiles/Pages/default.aspx>

Substance misuse needs assessment 2014:
<http://evidencehub.islington.gov.uk/wellbeing/Lifestyles/BRF/profiles/Pages/default.aspx>

The London Plan (January 2014): <https://www.london.gov.uk/priorities/planning/london-plan>

Appendix I: Abbreviations

ACS	Ambulatory Care Sensitive	LBI	London Borough of Islington
AUR	Appliance Use Review	LCS	Locally Commissioned Services
BAME	Black, Asian and Minority Ethnic	LPC	Local Pharmaceutical Committee
BMI	Body Mass Index	LPS	Local Pharmaceutical Service
CCG	Clinical Commissioning Group	LTC	Long Term Condition
CHD	Coronary Heart Disease	MAS	Minor Ailments Scheme
CKD	Chronic Kidney Disease	MSM	Men who have sex with men
COPD	Chronic Obstructive Pulmonary Disease	MUR	Medicine Use Review
CPPE	Centre for Pharmacy Postgraduate Education	NHS	National Health Service
DAC	Dispensing Appliance Contractors	NHSCB	National Health Service Commissioning Board
DBS	Disclosure and Barring Service	NMS	New Medicine Service
DH	Department of Health	NRT	Nicotine Replacement Therapy
EHC	Emergency Hormonal Contraception	ONS	Office for National Statistics
ESPLPS	Essential Small Pharmacies Local Pharmaceutical Services	PCT	Primary Care Trust
GLA	Greater London Authority	PGD	Patient Group Directions
GP	General Practice or General Practitioner	PH	Public Health
HLP	Healthy Living Pharmacy	PNA	Pharmaceutical Needs Assessment
HWB	Health and Wellbeing Board	SAC	Stoma Appliance Customisation
HSCIC	Health and Social Care Information Centre	SLA	Service Level Agreement
IDASS	Islington Drug and Alcohol Specialist Services	STI	Sexually Transmitted Infections
JHWS	Joint Health and Wellbeing Strategy	VCS	Voluntary and Community Sector
JSNA	Joint Strategic Needs Assessment		
LA	Local Authority		
LARC	Long Acting Reversible Contraception		

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Report of: Director of Public Health

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	October 15, 2014	Item	All
Delete as appropriate		Non-exempt	

SUBJECT: Joint Strategic Needs Assessment (JSNA) Executive Summary

1. Synopsis

Local authorities and Clinical Commissioning Groups have an equal and explicit duty to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), through Health and Wellbeing Boards. Their outputs, in the form of evidence and the analysis of needs, should be used to help determine what actions local authorities, the local NHS and other partners need to take to improve the health and wellbeing of the local population and reduce inequalities.

An updated executive summary of Islington's JSNA, describing existing and future health and wellbeing needs and the potential implications of changing needs is attached. The summary is intended to support strategic discussion. The JSNA factsheets, which include more detail on specific topics, can be found on the Evidence Hub and should be used to inform changes in delivery or commissioning of services:

<http://evidencehub.islington.gov.uk/yourarea/jsna/Pages/default.aspx>

Islington's 2014/15 JSNA update included the following:

1. New JSNAs on domestic violence, children and young people with disabilities, and private housing.
2. Commissioned community researchers to engage with local residents to collect views on health and wellbeing in Islington.
3. Updated all current JSNA factsheets on the Evidence Hub.

2. Recommendations

The HWB is asked to:

- NOTE the intelligence gathered since the previous summary, particularly the work to collect resident and patient views.
- COMMENT on the 2014/15 JSNA Executive Summary.

3. Implications

3.1. Financial implications

None Identified.

This paper provides an update across a wide range of programmes and services being delivered by various organisations including the Council and the CCG in support of the Health and Wellbeing Board's priorities.

3.2. Legal Implications

The duty to prepare a Joint Strategic Needs Assessment ("JSNA") and joint health and wellbeing strategy are set out in section 116 and 116A respectively of the Local Government and Public Involvement in Health Act 2007 (the 2007 Act"). Section 116(1) provides that an assessment of relevant needs must be prepared in relation to the area of each responsible local authority. Section 116(4) requires the responsible local authority, and each of its partner clinical commissioning groups to prepare any assessment of relevant needs under the section, in relation to the area of the responsible local authority.

Section 116(8) of the 2007 Act provides that in preparing the JSNA, the responsible local authority and each partner clinical commissioning group must co-operate with one another, and must have regard to any guidance issued by the Secretary of State.

By virtue of section 196 (1) of the 2012 Act, the functions of a local authority and its partner clinical commissioning groups under sections 116 and 116A of the 2007 Act concerning the preparation of the JSNA, are to be exercised by the Health and Wellbeing Board established by the local authority

3.3. Equalities Impact Assessment

None on these reports. The JSNA factsheets report detail dimensions of equality for each topic, highlighting the key measures taken to reduce inequalities.

3.4. Environmental Implications

None identified

4. Conclusion and reasons for recommendations

The HWB is asked to:

- NOTE the intelligence gathered since the previous summary, particularly the work to collect resident and patient views.
- COMMENT on the 2014/15 JSNA Executive Summary.

Background papers: None

Attachments: Islington Joint Strategic Needs Assessment 2014/15 Executive Summary

Final Report Clearance

Signed by



.....
Director of Public Health

.....
Date: 3rd October
2014

Received by

.....
Head of Democratic Services

.....
Date

Report author: Dalina Vekinis, Senior Public Health Information Analyst
Camden and Islington Public Health

Tel: 020 7527 1237

E-mail: dalina.vekinis@islington.gov.uk

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Joint Strategic Needs Assessment 2014/15

EXECUTIVE SUMMARY

August 2014

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1.0 Islington's JSNA

A Joint Strategic Needs Assessment (JSNA) is a way local authorities, the NHS and other public sector partners work together to understand the current and future health and wellbeing needs of the local population and to identify future priorities. Local authorities and Clinical Commissioning Groups have an equal and explicit duty to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), through Health and Wellbeing Boards.

The JSNA is not just about health and personal social care services - it is also about the wider aspects of health and wellbeing including poverty, employment, education, housing and the environment. The purpose of the JSNA is to use the information gathered to identify local priorities and support commissioning of services and interventions that are based on need. This helps us achieve better health and wellbeing outcomes and reduce health inequalities in Islington.

Islington's JSNA is a 'live' web-based resource, in the form of the Evidence Hub. It allows analysis to be carried out on a regular basis, highlighting the main issues emerging within the Borough. The information and intelligence on the site forms the basis of this executive summary, which summarises the key facts and recommendations for Islington.

2.0 Islington's population

The population of Islington is living longer, growing and constantly changing. Women in Islington, in line with national picture, live longer than men. Life expectancy at birth for men in Islington is now 77.8 years, an increase of 4.3 years over the past decade (2010-12). However **life expectancy for men in Islington remains lower than England (79.1)** and is one of the lowest amongst all London boroughs. **For women in Islington life expectancy is 83.2 years and is similar to England.**

According to the latest estimates from the Greater London Authority about **217,620 people are living in the borough of Islington** (2014). Since the 2011 census, the population has increased by approximately 11,000 people (5%) and is predicted to rise to around 241,780 people by 2024.

The number of people moving in and out of the borough is also high. In 2013, an estimated 19,900 people moved into the borough and 21,500 moved out – about 9% of the population. Movement is particularly high in those aged 16-24 years old. Constant population churn impacts on the type of services that are provided and the way in which services are provided e.g. cervical screening or educational attainment if children and young families enter the borough and start school mid-way through an academic year.

Recent years have seen a small decrease in the number of births in Islington, and there are now **about 2,800 births a year**. The general fertility rate reflects this, as the 46 births per 1,000 women in Islington is lower than London (58 births per 1,000 women aged 15-44) and less than the national average rate (62 per 1,000). However, over the next few years the birth rate is projected to slowly increase, reaching 3,150 births a year by 2020.

In terms of age, Islington's population is relatively young. In absolute numbers the largest age group are people aged between 20 and 39 years. This presents a significant opportunity for prevention of ill health as people under 40 are unlikely to have developed conditions that are the most significant contributors to death and disability in Islington. Though older people make up a relatively small proportion of Islington's population, in the next 10 years there is projected to be a 17% increase in those aged 80 years and older and a 9% increase in those aged 65 years and older. The percentage increase of children and young people in the borough is also predicted to significantly increase, especially in those aged 11-15 years old, which has implications for education and children's services.

Table 1: Islington estimated population by age and projected numbers, 2014 - 2024

Age group	2014	2024	Change (2014 to 2024)	% Change (2014 to 2024)
0-3	10,890	11,370	480	4%
4-10	14,810	17,050	2,240	15%
11-15	8,870	10,660	1,790	20%
16-19	8,630	9,070	440	5%
20-39	99,810	107,050	7,240	7%
40-64	55,770	65,680	9,910	18%
65-79	13,970	15,220	1,250	9%
80+	4,870	5,690	820	17%
Total	217,620	241,780	24,170	11%

Note: Numbers may not add up due to rounding

Source: © GLA 2012 Capped Population Projections – SHLAA

Islington's population is increasingly ethnically diverse. In 2001, 57% of Islington residents described themselves as White British. **In the 2011 Census, this had reduced to 48% describing themselves as White British**, with particularly high proportions of Turkish, Irish and Black African and Black Caribbean populations resident in Islington. Ethnicity also varies considerably by age in Islington. The younger population is more diverse compared to the older population, with **almost half of those aged under 25 from a black minority ethnic (BME) background** (45%) compared to one-in-five (20%) of the population aged 65 years and over.

This changing demographic picture has important implications for local health services since there are higher rates of some long term conditions in some BME communities; for example of heart disease and stroke, or of diagnosis of serious mental illness. Additionally, some behavioural risks, such as smoking, are more common in particular BME groups. These factors are often linked to significant socio-economic disadvantage and social exclusion.

In the 2011 census, there were 16,300 carers in Islington. Carers are themselves at significantly greater risk of both physical and mental ill health than the general population. With the ageing of the local population, together with increasing levels of long term conditions contributing to a relatively high level of disability in Islington, it can be expected that the number of carers in the borough will also increase.

What does this mean for Islington?

- The aging of the population in Islington over the next 10 years will lead to a growing number of people living with long-term conditions, indicating an increasing need for health and care services to identify and manage these long term conditions earlier and more effectively. It can also be expected that there will be an increase in the number of people living with multiple long term conditions.
- The increase in the older adult population will mean an increasing number of people with dementia, and with the increase in the over 80s, an increasing number of whom will also be physically frail.
- Work with local communities/specific population groups to improve understanding about how to improve the accessibility and reach of services.
- Raise awareness of the needs of carers and improve access to support and training for carers.
- Ensure that the commissioning and provision of services are culturally sensitive and provide equity of access responsive to a changing population with differing health needs.

3.0 Resident engagement

In order to add more 'voice' from the community within the JSNA, a programme of community research was planned to improve our understanding of the health and wellbeing priorities of the communities in Islington. The aim was to capture more accurately residents' views and experiences of health and wellbeing within the borough and ensure their priorities are being fed into commissioning and planning of services locally.

Fifteen community researchers trained in Participatory Appraisal (PA) methods carried out the research. PA is a process which combines community research, learning and collective action. The approach uses a series of interactive tools which largely rely on visual methods and encourage involvement and participation in the research process. In total over 500 residents participated in various localities such as libraries, sports centres and community centres.

Initial results show that participants mostly equated a sense of being healthy with: eating healthy foods, exercise, getting ample sleep and avoiding smoking and alcohol. The participants also stated that activities like walking, playing sports and cycling had positive impacts on their health, along with the presence of family and friends. Alcohol, smoking, easy availability of unhealthy food, being overweight, mental health problems, long term physical health conditions and pollution were most mentioned negative influences on participants' health and as the biggest issues in Islington. Long waiting times for appointments and other barriers in accessing care, such as migrant language issues and poor experiences with doctors and staff led to some participants seeking support and advice from family and friends. All of these responses were followed by the participants' suggestions for improving their level of care and being provided with better and more accurate information on available services, as well as suggestions for personal behavioural changes like stopping smoking, exercising more, playing sports, cycling and healthier eating. The participants also called for more affordable exercise opportunities, including swimming, and an increase in green spaces around the borough.

What does this mean for Islington? [DRAFT UNTIL REPORT FINALISED]

- The current focus on healthy lifestyles is important to residents so should remain a focus in Islington
- Work to improve the awareness and dissemination of availability of local services should be ongoing
- Making use of local residents' views on health and wellbeing is a previously untapped resource, which can inform service provision and planning.

4.0 Social, economic and environmental determinants

Many factors combine to affect the health of individuals and communities. Whether people are healthy or not is determined by a mix of genetic factors, their circumstances and environment, their lifestyle choices and their access and use of health services and other services that influence health (e.g. lifestyle change services, social care services). In the long term it is our circumstances and environment (which include factors such as how safe we feel in the environment in which we live, the physical condition of our housing as well as availability, job security, income and education levels) that have the strongest impact on health outcomes.

4.1 Housing

The availability and quality of housing (e.g. accommodation that may be cold, damp or overcrowded) impacts on both physical and mental wellbeing. Homes in poor physical condition can put occupants' health and safety at risk, especially when they are children, older, ill or disabled people. In Islington, private rented homes are more likely to fall below the Decent Homes Standard and are less energy efficient than affordable homes. Living in overcrowded situations can also adversely affect health and wellbeing, particularly for children. As of May 2013 there were 5,089 households on Islington's housing register living in overcrowded housing (Islington Housing Strategy 2014-19).

The uncertainty that goes with living in temporary accommodation can have a negative impact on health and wellbeing. In Islington high house prices and private rents mean securing affordable housing is a key challenge for many households. The number of households placed in temporary accommodation has remained largely unchanged since 2007/08. In November 2013, 774 people in Islington were being helped through short term supported housing services, funded through the council's Supporting People Programme.

Islington has made greater use of the private rented sector in an environment of high house prices and where demand for social housing exceeds supply. In Islington, private rent is 40% of the average income; the fourth highest rent to income ratio in London. The combination of changes in benefits entitlements and rising private rents could result in many households being priced out of the rental sector. Key groups affected by these changes include those from low income households renting privately, and elderly or disabled households.

However, private rented homes are more likely to fall below Decent Homes Standard, and are less energy efficient than affordable homes. Work is also ongoing to increase the professionalism of landlords, encouraging them to improve the condition of their properties, particularly for vulnerable tenants, through the landlord accreditation scheme. Various teams in Islington provide advice and support to households who are renting privately, including assisting where tenants are experiencing harassment, illegally evicted, or in sustaining private rented tenancies.

4.2 Education

A good education is strongly associated with better health outcomes including life expectancy. Overall educational attainment at key stages for children going to Islington schools is improving and achievement was similar to or just above the national average in 2012/13. Children not on

free school meals achieve better results than those eligible for free school meals (which is a proxy for deprivation).

Attendance at school improves the chances of educational attainment, and Islington schools have seen an improvement in attendance since 2007/08. Unauthorised absences in Islington secondary schools (2012/13) are now at 1.5%, similar to England (1.4%) and London (1.3%). t 8.4% of 16-18 year olds in Islington are not in education, employment or training (NEET), significantly higher than London (4.5%).

4.3 Employment

Being in good and secure employment has a positive impact on wellbeing whilst low quality and insecure jobs have a negative impact on both physical and mental health. Overall unemployment levels in Islington are lower than London, with 7% of the working age population unemployed (10,700 people). The highest levels of worklessness are in young adults aged 16-24 and social housing tenants. Groups with particularly high levels of unemployment in Islington include Black Minority Ethnic communities, those with learning disabilities and lone parents. A large number of people claiming out of work benefits in Islington also do so because of long-term illness or other health conditions. Mental ill health accounts for the largest proportion of claims for incapacity benefits reflecting the high prevalence of mental ill health in the borough.

4.4 Poverty

Poverty is a key determinant of poor outcomes in health and wellbeing. Islington is ranked the 5th most deprived borough in London (out of 33) and 14th most deprived in England (out of 354). Higher levels of deprivation are linked to numerous health problems (e.g. chronic illness and lower life expectancy) and unhealthy lifestyles (e.g. higher levels of obesity, smoking, drugs misuse). These factors mean that needs for health, social care and lifestyle services are higher amongst populations living in more deprived areas.

The impact that poverty (in terms of unemployment or low income) has on families with young children is particularly important. The emotional health of children is correlated with poverty, with particularly vulnerable children being those who are looked after, youth offenders and children of parents with mental health problems. Disadvantaged experience in childhood strongly ties with poor health throughout life, and in Islington child poverty rates are very high at more than double the national average. Islington also ranks as the second most deprived area in England on the Income Deprivation Affecting Children Index (IDACI) with just under half of all children aged 0-15 years living in income deprived households. In 2011, 38% of children in Islington were living in poverty (over 13,500 children), compared to 21% nationally.

According to the older people's deprivation index (IDAOP), over two fifths (41%) of older people aged 60 years and over in Islington are income deprived compared to 18% across England.

4.5 Domestic violence

In 2012/13, there were just over 3,800 incidents of domestic violence reported in Islington, resulting in 1,500 offences. Islington's rate of domestic violence offences is the second highest in North London, which can be an indication of higher violence, or of greater confidence in reporting incidences to the police. Domestic violence can affect anyone, but women, transgender people and people from BME groups are at higher risk than the general population.

The estimated cost of domestic violence is almost £26 million in Islington, with most of the cost being borne by physical and mental health services (£7.7million).

Islington Council's Community Safety team coordinates the overall response to domestic violence and all forms of violence against women and girls (VAWG) through developing strategies to tackle different forms of VAWG, raising awareness, commissioning services, training staff in the statutory and voluntary sectors, coordinating the local Multi Agency Risk Assessment Conference and Domestic Violence Persistent Perpetrators Panel. Locally there are a number of projects and services that work to support those affected by domestic violence and all forms of VAWG.

What does this mean for Islington?

- A large scale, systematic and co-ordinated approach to reducing health inequality is needed that involves all partners and focuses on the wider socio-economic and environmental determinants and on family and individuals.
- Poverty is one of the greatest threats to health and wellbeing in the borough. Getting people into work and particularly those population groups that face persistent barriers to moving into work, should be a focus.
- The impact of welfare reform on vulnerable groups should be monitored and services to provide advice and support to population groups affected made available. Housing and security of housing is a particularly area that will be affected by welfare reform.
- Continue work on projects and services to support those affected by domestic violence and other forms of VAWG.

5.0 Lifestyles and risk factors

Regular exercise, maintaining a healthy weight, reducing harmful levels of alcohol consumption and stopping smoking can prevent illness or at least delay it for many years. Unlike other factors such as age and genetics, poor lifestyle behaviours can be altered and in the medium term improve population health outcomes.

5.1 Smoking

The number of people who smoke has declined in Islington over the past few years. Overall smoking prevalence in Islington, based on the Integrated Household Survey, has reduced from 34% in 2005 to 22% in 2012. Current estimates are not significantly different to that estimated for England (20%), but significantly higher than London (18%). Despite these improvements, smoking remains prevalent in key population groups including the Turkish and Irish populations and those living with long term conditions (including mental health). People from these groups may find it harder to quit and need more intensive support. Greater effort is therefore required to support people from these groups to stop smoking.

After an increase last year, the rate of smoking in pregnancy has fallen again in the past year to 8%, but is still above the London average.

5.2 Alcohol

Islington has the second highest alcohol-related and alcohol-specific hospital admissions among men in London, second highest alcohol-specific deaths among men, and fourth highest rate of alcohol-related recorded crime. The number of alcohol-related admissions for both men and women rose by 22% between 2008/09 and 2011/12, and then it levelled off for men and slightly decreased for women in 2012/13.

5.3 Obesity and overweight

Almost 1 in 4 children aged 4-5 years old and 2 in 5 children aged 10-11 years old had excess weight in 2012/13. The proportion of children aged 4-5 years with excess weight in Islington schools has continued to show a slight decrease and is currently similar to the prevalence in England and London, however in the last year, there has been a slight increase in children that were obese. The percentage of pupils aged 10-11 years who are overweight and obese in Islington has recently shown a decrease, and is similar to London but higher than England.

Just over 69,000 adults registered with an Islington GP are obese or overweight and approximately two thirds of adults with a chronic illness are overweight and obese. Obesity increases with deprivation, with those living in the fifth most deprived areas of Islington being 27% more likely to be obese compared to the Islington average.

5.4 Physical activity

Almost one-in-five Islington adults are inactive, and 21% of children are not active for 6 or more hours at the weekend. Women, older people, persons from lower socio-economic groups and those with a disability or illness are less likely to regularly exercise than other groups.

What does this mean for Islington?

- Supporting people to live healthier lives across the life course remains a priority. Programmes and services to support people to adopt healthier lifestyles should be delivered at sufficient scale and appropriately targeted in order to improve population health outcomes, and reduce health inequalities within the borough. Specific areas of focus include:
 - **Tobacco**
 - Educate and prevent young people from starting smoking
 - Ensure smoking cessation services target high risk populations to quit.
 - Reduce second hand exposure
 - Regulate and enforce the laws on sale and display of tobacco products
 - **Overweight and obesity**
 - To continue to commission and evaluate interventions that promote physical activity, both universal services and those targeted at population groups most in need e.g. people on low incomes, people with disability.
 - To continue to commission weight management services for children and adults and evaluate their effectiveness.
 - **Alcohol**
 - Increasing awareness of alcohol locally through the provision of clear, sensible advice around what is low risk drinking and why this is important.
 - Approaches for the provision of identification (screening) and brief advice (IBA) and alcohol liaison models to be implemented consistently and at scale.
 - Proactive enforcement continues to be a key part of reducing alcohol harm by managing alcohol availability locally.
 - Building on work already occurring locally, to ensure there is a strong partnership approach to maximise alcohol harm reduction, including enforcement of licensing regulations, IBA and high quality treatment services.

6.0 Physical and mental ill health

Cancer, cardiovascular disease (CVD), and respiratory disease remain the leading causes of premature deaths and all deaths in Islington, although death rates are declining across the population as a result of people living longer. Table 2 below shows the average number of deaths in under 75 year olds and across all ages by primary cause of death in Islington between 2010-12. Diabetes, high blood pressure and obesity are also prevalent conditions that, although frequently not recorded as the underlying cause of death, significantly contribute to early death; similarly, mental health conditions significantly increase the risk of early death in a number of conditions. The increasing number of deaths due to liver disease associated with obesity and excessive alcohol consumption is also of growing importance.

Table 2: Number of deaths by cause of death, and age group, Islington residents, 2010-12 (three-year average)

Cause of death	Aged under 75	Aged 75+	All ages*
All cancers	167	149	316
All cardiovascular diseases	106	181	288
All respiratory diseases	36	94	130
All digestive diseases	36	29	65
All external causes	37	11	48
All infectious and parasitic diseases	10	6	16
Neo-natal	8	0	8
Other	46	112	158
Total*	446	582	1,029

Source: PCMD, 2012. * Note: Figures may not add up to the total due to rounding.

Promoting healthy lifestyle behaviours will help to prevent or delay many deaths caused by long term conditions. As well as prevention, earlier diagnosis of these conditions, facilitating lifestyle advice and behaviour change and earlier medical management help to reduce the longer term ill health and disability associated with these conditions, as well as preventable deaths. This represents the **closing the gap** challenge, increasing the proportion of long term conditions in the population that have been diagnosed in order to provide earlier and more effective help and care (see Table 3).

Table 3: The prevalence gap for six major long term conditions, Islington's registered population, aged 16+, September 2012

Long term condition	Diagnosed prevalence	Estimated prevalence	Number diagnosed	Number not diagnosed
High blood pressure	10.8%	24.2%	21,000	25,900
Diabetes	4.8%	6.8%	9,300	3,800
CHD	1.7%	3.6%	3,900	4,300
CKD*	1.8%	5.2%	3,400	6,300
COPD	1.7%	3.8%	3,400	4,000
Stroke/TIA	1.0%	1.7%	2,300	1,500

Sources: APHO prevalence models, 2012; Islington GP PH dataset, 2012; QOF, 2012/13

* CKD prevalence figures are for people aged 18+.

Prevalence modelling

Expected (total or estimated) prevalence is a statistical estimate of the percentage of people who might be living with a long term condition, regardless of whether the condition has been diagnosed or not. This can be used to give an indication of how many people (aged 16+ or 18+) are living with undiagnosed conditions.

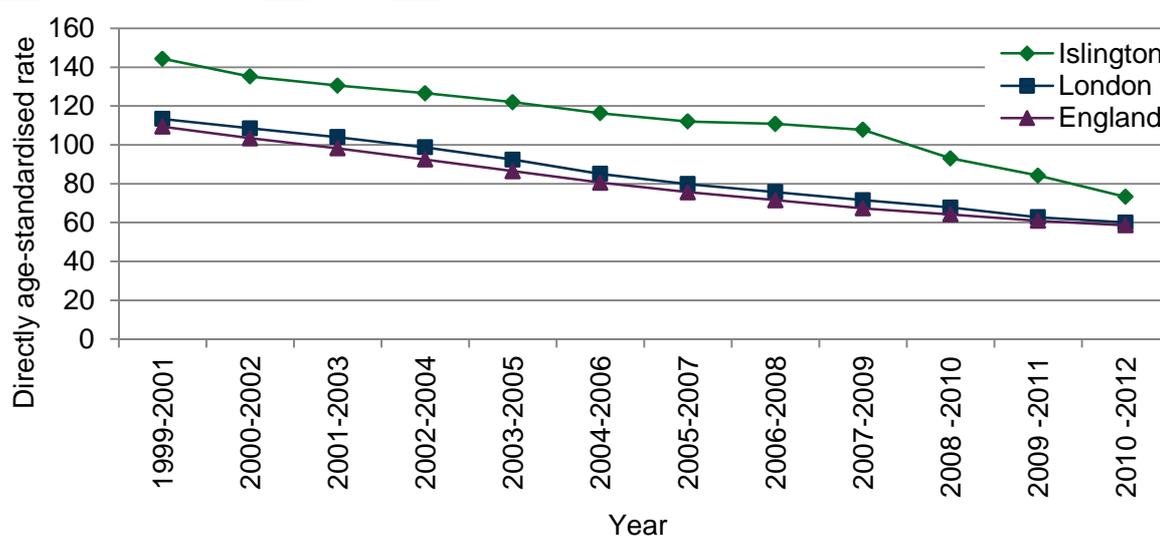
The prevalence models were developed nationally and are statistically sophisticated (using a Bayesian statistical model). However, there is always uncertainty around models so the outputs should be used as an indication of the size of the prevalence gap (ie. Are there 10s or 1,000s of undiagnosed patients). Models are based on GP practice level data with adjustments made for differences in the practice's population structures, ethnicity, smoking prevalence and deprivation. For full details see the briefing produce by the Association of Public Health Observatories: <http://www.apho.org.uk/resource/item.aspx?RID=100181>

The long term conditions described below disproportionately affect people living in deprived communities. Older people and people with more than one long term condition are at significantly higher risk of poor quality of life. Nearly a third of all people with long-term physical conditions also suffer from depression or anxiety. This association is particularly strong for cardiovascular disease, diabetes and chronic obstructive pulmonary disease (COPD).

6.1 Cardiovascular disease

Early deaths (deaths before the age of 75) from cardiovascular conditions including coronary heart disease are declining, although cardiovascular diseases remain the second leading cause of death across all ages in the borough. The rate of early deaths remains significantly higher than London and England for both men and women in Islington (Figure 1). However, for the last six years, the rate of early deaths from heart disease has been falling at a faster rate than in England and London. This means that, although still higher than the England average, the inequalities gap in early CVD mortality between Islington and England has significantly narrowed and Islington is making significant progress in reducing early deaths from CVD.

Table 4: Directly standardised rate of under 75 mortality rate from CVD (provisional), Islington, London, and England, 1999-2001 to 2010-12



Source: Health and Social Care Information Centre, December 2013

6.2 Diabetes

The gap between the number of people with diagnosed diabetes and the number expected to have the disease in Islington suggests a significant number of undiagnosed cases (over 4,000 people) in Islington. Islington's prevalence gap for diabetes is significantly higher compared to the gap in London and England. High levels of excess weight amongst younger people is likely to increase the number of people developing diabetes in future, which will increase their risks of heart disease, stroke, kidney failure, blindness and amputations. A locally commissioned service, developed with GPs in Islington, aims to enhance the management of diabetes and those at risk of developing diabetes in primary care.

6.3 Respiratory disease

Respiratory diseases are important causes of ill health in Islington and of emergency admissions to local hospitals, particularly among older people, many of which are potentially preventable. The main impact associated with COPD in Islington is a significant reduction in the quality of life of people with COPD and their carers, and frequent hospital emergency admissions caused by exacerbations of the condition. The second highest rate of potentially preventable hospital admissions in Islington are as a result of COPD (second only to admissions for influenza and pneumonia). Many of these admissions could potentially be avoided through earlier diagnosis and better medical and lifestyle management; stopping smoking would prevent the majority of cases of COPD occurring in the first place. The COPD local enhanced service introduced in primary care and closer working with secondary care has resulted in emergency admissions for COPD decreasing by 14%. However, there are an estimated 4,000 cases of undiagnosed COPD in Islington. Higher levels of pollution in inner city areas like Islington will also contribute to respiratory disease morbidity in both children and adults and earlier mortality.

6.4 Cancers

Cancers are the leading cause of premature deaths (under 75) in Islington. The rate of early death from all cancers has been falling in the borough with a faster rate than England, decreasing the inequalities gap in early cancer mortality between Islington and England. Lung cancer is the largest contributor to early death amongst all cancers. The proportion of people who are alive after a diagnosis of prostate, breast, lung and colorectal cancer at 1 year and 5 years is generally similar compared to England. There is scope to further improve survival by increasing awareness, early detection and treatment.

6.5 Liver disease

Most liver disease is preventable and much is influenced by alcohol consumption and obesity prevalence, which are both amenable to public health interventions. Islington currently has significantly higher mortality from liver disease compared to England and similar boroughs, and the death rate from liver disease has steadily increased over time, whereas the rates from other major diseases are falling. Liver mortality rates are higher for men in Islington than women.

6.6 HIV

With advances in treatment, HIV is now also considered a long term condition. In 2011, about 9 people per 1000 population aged 15-59 were diagnosed with HIV. This is the 7th highest prevalence rate in London. The majority of diagnosed HIV infections in the borough are in gay

and bisexual men. Although there continue to be a significant number of newly diagnosed infections each year, improved treatment and survival has led to a shift in the age distribution of HIV diagnosed persons receiving care, with a much greater proportion aged 50 and over (X). The impacts of poverty and of stigma and discrimination continue to be important issues associated with HIV. As with other long term conditions, there are also higher rates of mental health conditions among people living with HIV.

6.7 Mental health

Mental health conditions affect all groups in the borough, although the types and prevalence vary according to gender, ethnicity and age, and are influenced by a wide range of factors including family, early life experiences, social, economic and environmental determinants. It has been estimated that mental health conditions are the single largest cause of ill health and disability in the population aged under 65, and they continue to be an important cause among people aged 65 and over. Mental health conditions can intensify the effects of a physical illness and considerably raise the cost of physical health care. Rates of hospitalisation and early death due to physical health conditions for those with mental health problems are up to three times higher than for others.

Islington has the highest percentage of patients with recorded serious mental illness on primary care registers (schizophrenia, bipolar disorder and other psychoses) in the country. There are significant numbers of people with depression (over 22,000 people) the highest rate in London. Increasing financial, relationship and other pressures caused by long term austerity and the impact of welfare reforms may particularly affect mental health needs in the borough.

There were 822 people aged 65 and over with a diagnosis of dementia registered with Islington GPs in 2012/13. In the same year, Islington had the highest percentage of dementia diagnosed compared to estimated prevalence, as part of efforts to improve access to earlier diagnosis and support. Dementia is strongly correlated with age: the predicted ageing of Islington's population over the next few years, particularly significant in people aged 80 and over, can be expected to increase demand on dementia services. There is increasing recognition that a proportion of future cases of dementia could be delayed or prevented.

Deaths due to suicide and undetermined injuries have potentially reduced in recent years. However Islington's rate is the third highest in London according to 2010-2012 data, and higher than the London average. There continue to be significant risks for suicide in the general population of Islington.

6.8 Sexual health

Sexual health is critical to population wellbeing, particularly in a borough such as Islington with its young adult population, high levels of mobility, deprivation and key groups at increased risk of sexual ill health including gay and bisexual men and people from some BME groups. Poor sexual health is associated with increased rates of unintended pregnancies, sexually transmitted infections (STIs), some cancers and infertility.

Islington has higher rates of diagnosed acute STIs than the average for London and England, although rates are not dissimilar to some other deprived inner London boroughs. Like England and London, the most commonly diagnosed STI is Chlamydia. The prevalence of chlamydia infections is highest in young sexually active adults (15-24 years). Young black people,

particularly of black Caribbean origin, have a higher rate of chlamydia positivity than other groups. There have been recent marked increases in gonorrhoea, new cases of HIV and syphilis among gay and bisexual men.

What does this mean for Islington?

- There are a significant number of people living with a long term condition but who have not yet been diagnosed. The Health Checks Programme is a vital part of action to address this key need, as well as to identify risks earlier. Islington's closing the gap local enhanced service, which aims to find undiagnosed long term conditions should continue and be evaluated.
- Programmes raising awareness of signs and symptoms of long term conditions including cancers and COPD should be targeted at deprived communities to encourage early presentation.
- Implement strategies and programmes that encourage people with long term conditions to self-manage and stay independent.
- Improve lifestyle and medical management of long term conditions, of those at significant risk of long term conditions, to improve quality of life.
- The strong link between physical health and mental health underlines the importance of the movement towards models of care that address both mental and physical health together.
- All those with a physical long term condition should be offered screening and help for depression.
- Ensure high quality sex and relationships education, sexual health promotion and HIV prevention, and access to effective contraception methods and sexual health services to improve choice and control over fertility and reduce the risk of HIV and STIs.
- Providing high quality, accessible and integrated sexual health promotion, testing and treatment services that are responsive to changes in population trends and needs.

7.0 The best start in life: children and young people and their families

There is clear evidence of the importance of giving children the best start in life, and there are a range of early interventions (starting not only in pregnancy, but pre-pregnancy) that are effective in achieving better long term outcomes and reducing inequalities. Although the majority of children and young people in Islington live healthy lives, there are high levels of vulnerability and disadvantage. Groups particularly at risk of poorer outcomes, in childhood or later on in adulthood, include: children living in poverty, young carers, children with disabilities, looked after children, youth offenders, children with mental health conditions and children of parents with long term mental health problems including personality disorder, or problem alcohol and substance misuse.

7.1 First 21 months

Interventions that address inequalities early on tend to demonstrate the best and most cost effective impacts on narrowing the gaps between groups. This is the underpinning basis for Islington's First 21 Months priority. Key indicators of health and wellbeing include:

- Early access to maternity services (booking by 12 weeks plus 6 days) to ensure women and their partners receive timely care and support through pregnancy, including early identification of health or social problems that may require extra support. Although early access has improved, Islington's two major maternity services remain below the 90% target, achieving 79% in Q1 2013/14. Earlier and more effective referral systems are needed, as well as promotion of the early access message into the community.
- Immunisation rates have significantly improved, including MMR and pre-school boosters. By Q3 2013/14, Islington achieved 98% uptake for the vaccinations among one-year old children, above the London (89%) and England (94%) average.
- Exclusive breastfeeding provides a significant level of protection against the future risk of childhood obesity. Initiation rates of breastfeeding in Islington are higher (90%) than London (87%) and England (74%). By 6-8 weeks the rate is 75%, but still remains higher than London and England.
- The Family Nurse Partnership is demonstrating good short-term outcomes for teenage parents and their babies, particularly with breastfeeding, immunisations at 24 months, smoking reduction and hospital admissions.
- Although there are significant risk factors in the population, particularly those linked to deprivation, data for 2010-12 show that the rate of infant mortality is significantly lower than England (2.2/1000 live births; 20 deaths) and the rate of low birth weight babies is similar to England (3%; 79 infants). The perinatal mortality rate (6.2/1000 births; an average of 14 stillbirths and 5 neonatal deaths per year) is also similar to England. The rates have reduced over the previous ten years, though the numbers are too small for these differences to be statistically significant.

- Childhood obesity rates remain high in both Reception and Year 6 children in Islington, increasing the risk of long term health problems for these children. Excess weight in children is further covered in section 5.3.
- Mental health conditions in children and young people are estimated to be 36% higher than the national average, with more than 3,700 children and young people aged 5-17 experiencing a mental health condition during any one week. This estimate is primarily based on national survey data which is now close to 10 years old, and there is a key need for a new national survey. Mental health conditions in childhood, particularly if untreated, are an important risk factor for mental health problems in adulthood. Schools and Children's Centres are increasingly important sources of referrals to CAMHS services.
- **Admissions for asthma** and some other long term conditions have been much higher for Islington children and young people compared to their national counterparts. This is being addressed through steps to improve medical management and self-care in community and primary care settings.

What does this mean for Islington?

- There is a need for maternity services to improve early access.
- A strong preventive and early intervention offer in pregnancy and the early years is important to reduce long term inequalities.
- Promoting exclusive breastfeeding, healthy eating, physical activity and access to weight management support to children and their families continues to be important to reduce high levels of obesity and excess weight.
- Access to effective services for conditions such as asthma or mental health problems in community and primary care settings will help to improve outcomes.

7.2 Children and young people with Special Education Needs and disabilities

The best available estimates for children and young people with disabilities come from special educational needs (SEN) data. However, not all children with disabilities and long term life limiting conditions have SEN, and further work is being done to estimate local numbers. Almost one-in-four Islington pupils have a SEN, significantly above London and England (19%). In January 2013, around 5,800 children and young people aged under 19 in Islington had a Statement (820) or had additional educational need without a statement (5,000). There has been a slight rise in the number of children and young people with a statement in Islington over the previous five years, equating to an average of 19 additional statements each year.

Among children and young people with a statement, an Autistic Spectrum Disorder was the most prevalent primary need in 2013, followed by Speech, Language and Communication Needs and Moderate Learning Disabilities. Prevalence of SEN needs varies by gender and ethnicity. About 75% of Islington pupils with a statement are boys, which is similar to the national picture. Some

ethnic groups were more likely than the general Islington population to have a statement for certain specific types of SEN, for example, Black African children were around twice as likely to have Autistic Spectrum Disorders.

Pupils with a SEN or disability face barriers that make it harder for them to learn than most pupils of the same age. People with SEN also face poorer outcomes than their peers in terms of educational achievement, physical and mental health status, social opportunities, and transition to adulthood. Evidence shows that nationally, people with learning disabilities are less likely to lead healthy lifestyles compared with the general population, with unhealthy diets and low levels of physical activity among people with learning disabilities contributing to poorer health outcomes.

Effective ante- and post-natal care, smoking, alcohol and substance misuse, maternal diet and maternal age are important determinants of SEN and disability. Families with a child with a SEN or disability are more likely to live in poor housing, in unemployment and poverty, and face social isolation and discrimination; these are also associated with poorer health and educational outcomes.

Well-co-ordinated planning and advice makes a positive difference to young people's futures. Early identification and assessment can help to significantly improve mental and physical health, educational attainment, and employment opportunities, and interventions early in primary and secondary school and during the years leading into adulthood can improve health outcomes. High quality teaching and well trained teaching assistants and support staff are important factors in raising educational outcomes. Giving parents control through providing information, inclusion in planning and strategic development, and good multi-agency co-ordination can also improve outcomes for children and young people with SEN and/or disabilities.

The Children and Families Act (2014) introduced a new, single system from birth to 25 for all children and young people with SEN and their families. The Act extends the SEN system from birth to 25, giving children, young people and their parents greater control and choice in decisions and ensuring needs are properly met. It takes forward the reform programme including:

- replacing old statements with a new birth- to-25 education, health and care plan
- offering families personal budgets
- improving cooperation between all the services that support children and their families, particularly requiring local authorities and health authorities to work together.

What does this mean for Islington?

- The new SEN system will be less adversarial for parents, focus more on outcomes and extend rights from 0-25 (instead of 5-19 as present).
- The number of children and young people with SEN and disability is unlikely to change as a result of the SEN Reforms however the levels of attainment, attendance, and exclusions of this cohort are expected to show improvement, which improves long term life outcomes.

- All staff across Children's Services, schools and health partners who work with children and young people with Special Education Needs and disabilities will need to work differently as a result of the reforms.

7.3 Reproductive health

Teenage conception rates have decreased by 30% in Islington over the last ten years; from 62 to 30 per 1,000 population. Conception rates in Islington have been consistently higher than averages in London and England over time.

Between 2000-02 and 2009-11, the proportion of teenage pregnancies ending in an abortion have increased in London (from 58% to 61%) and England (from 46% to 50%) as well as in Islington (from 58% to 64%).

High-quality education about relationships and sex is effective for the prevention of unintended pregnancy.

In Islington, rates of GP prescribed long-acting reversible contraception have increased over time. However, rates are significantly lower than London and England. The availability of community sexual and reproductive healthcare services may offset lower GP prescribing.

The rate of abortions and of repeat abortions among women of all ages in Islington is similar to the London averages but higher than the national rates, which points to the need to improve access to choice and control over contraceptive methods as well as the continuing importance of high quality sex and relationship education and information.

What does this mean for Islington?

- Ensuring high quality sex and relationships education, sexual health promotion and HIV prevention, and access to effective contraception methods and sexual health services to improve choice and control over fertility and reduce the risk of HIV and STIs.
- Providing high quality, accessible and integrated sexual health promotion, testing and treatment services that are responsive to changes in population trends and needs.

8.0 Vulnerable groups

8.1 People with learning disabilities

The events at Winterborne and the subsequent report by the Confidential Inquiry into premature deaths of people with learning disabilities highlighted the responsibilities that public services have to ensure that people with learning disabilities receive equitable and accessible care and support. National data show that people with learning disabilities are three more times likely to die early compared to others, and as a result their life expectancy is up to 20 years less than the general population. Some of the difference may be accounted for by higher rates of specific health issues including coronary heart disease, respiratory disease and epilepsy, however many of these deaths are potentially preventable through a mix of earlier diagnosis and better and more responsive management of health conditions.

In spite of these stark inequalities, life expectancy for people with learning disabilities is increasing, this is in part due to rising numbers of young people with complex needs surviving into adulthood as well as longer life expectancies amongst adults with learning disabilities.

There has been an increase in the number of people with learning disabilities who have received health checks in Islington, but improving the delivery of preventative interventions and earlier identification and management of physical health issues in people with learning disabilities remain important.

What does this mean for Islington?

- Ensuring prevention and treatment services are accessible and able to meet the needs of people with learning disabilities in order to improve outcomes and reduce inequalities.

8.2 Vulnerable children

A needs assessment focusing on vulnerable children is currently being prepared. Key facts information from this will be included after the assessment is published.

9.0 Next steps

Through the development of the Health and Wellbeing board stakeholder engagement plan, timetabled opportunities to explore communities', service users' and patients' views on findings from the JSNA and their local health and wellbeing issues will be used to inform the on-going development of the JSNA.

DRAFT

HEALTH AND WELLBEING BOARD WORK PROGRAMME 2014/15

ISLINGTON

FULL BOARD

16 JULY 2014

1. Early intervention place pioneer
2. JSNA refresh
3. Implementation of Welfare reforms in Islington and their impact
4. Patient access to records
5. Child health strategy
6. Joint tobacco control
7. JHWS Priorities updates (for information only)
8. Flagship food borough (for information only)

FULL BOARD

15th OCTOBER 2013

1. Commissioning Intentions for 2015/16 – ICCG, LBI and Healthwatch
2. Pharmaceutical Needs Assessment
3. Health & Housing
4. Safeguarding Adults Partnership Board Annual Report
5. Better Care Fund update
6. JSNA executive summary

FULL BOARD

14th JANUARY 2015

1. Feedback from summit and next steps
2. ICCG Commissioning Strategy and Operating Plan for 2015/16
3. Update on progress on HWB priorities Update on Joint Health and Wellbeing Strategy
4. Children and Families Early Intervention and Prevention Strategy 2015-2025
5. Developing Person Held Integrated Digital Care Records
6. Future focus of the HWB and ways of working
7. Children Safeguarding Board Annual Report

SUMMIT/WORKSHOP

FEBRUARY 2015

Provider engagement event???

SUMMIT/WORKSHOP

SPRING 2015

Mental Health and Wellbeing Summit - Camden and Islington

FULL BOARD

15th APRIL 2015

1. NICE Guidance on Excess Winter Deaths

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