



AGENDA FOR THE HEALTH AND WELLBEING BOARD

Members of Health and Wellbeing Board are summoned to a meeting, which will be held in Committee Room 4, Town Hall, Upper Street, N1 2UD on **14 January 2015 at **1.30 pm****.

**** Please note start time for this meeting**
Future meetings will commence at 1pm**

John Lynch
Head of Democratic Services

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Despatched : 6 January 2015

Membership

Councillors:

Councillor Richard Watts (Chair)
Councillor Janet Burgess
Councillor Joe Caluori

Clinical Commissioning Group Representatives

Alison Blair, Chief Executive, Islington Clinical Commissioning Group
Martin Machray, Director - Quality & Integrated Governance, Islington Clinical Commissioning Group
Dr. Gillian Greenhough, Chair, Islington Clinical Commissioning Group
Dr. Josephine Sauvage, Joint Vice Chair (Clinical), Islington Clinical Commissioning Group
Anne Weyman, Lay Vice Chair, Islington Clinical Commissioning Group

NHS England

Dr Henrietta Hughes, NHS England

Islington Healthwatch Representative

Olav Ernsten

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

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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 meeting held on 15 October 2014 1

B. Discussion/Strategy items

1. Primary care strategy and co-commissioning 5

2.	Response to "Better Health for London" - the report of the London Health Commission	13
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C.	Business items	Page
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3.	Health and Wellbeing Board - appointment of additional non-voting co-opted members	29
4.	Children and Families Prevention and Early Intervention and Prevention Strategy 2015 - 2025 and the Early Intervention Summit	35
5.	Islington Safeguarding Children's Board Annual Report 2013/14	87
6.	Pharmaceutical needs assessment	187
7.	Joint Health and Wellbeing Strategy priorities update - June to December 2014	355

D. Questions from Members of the Public

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

E. 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.

F. 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.

G. 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.

H. Confidential/Exempt Items for Information

I. Any other business

The next meeting of the Health and Wellbeing Board will be on 15 April 2015

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Agenda Item A5

London Borough of Islington
Health and Wellbeing Board - Wednesday, 15 October 2014

Minutes of the meeting of the Health and Wellbeing Board held at Committee Room 1, Town Hall, Upper Street, N1 2UD on Wednesday, 15 October 2014 at 2.00 pm.

Present: **Councillors:** Watts and Caluori
Officers: Dr. Gillian Greenhough, Islington Clinical Commissioning Group
 Dr. Josephine Sauvage, Islington Clinical Commissioning Group
 Martin Machray, Islington Clinical Commissioning Group
 Julie Billett – Corporate Director of Public Health
 Sean McLaughlin - Corporate Director of Housing and Adult
 Social Services
 Eleanor Schooling - Corporate Director for Children’s Services
 Emma Whitby – Healthwatch Islington

Councillor Richard Watts in the Chair

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

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

16 APOLOGIES FOR ABSENCE (ITEM NO. A2)

Apologies were received from Councillor Burgess, Anne Weyman, Olav Ernstzen, Dr Henrietta Hughes and Alison Blair.

Emma Whitby was present substituting for Olav Ernstzen.

17 DECLARATIONS OF INTEREST (ITEM NO. A3)

There were no declarations of interest.

18 ORDER OF BUSINESS (ITEM NO. A4)

The order of business would be as per the agenda.

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

RESOLVED:

That the minutes of the meeting of the Board held on 18 July 2014 be confirmed as a correct record and the Chair be authorised to sign them.

20 STRATEGIC PRIORITIES AND COMMISSIONING PLANS FOR 2015/16 (ITEM NO. B1)

The report included shared principles that the Board had seen before. Creating resilient individuals, families and communities was key as well as maximising outcomes and values.

The Peer Review in Adult Social Services had looked at commissioning and identified that there were not clear commissioning intentions across partners.

The Healthwatch review into Home Care had been postponed until the New Year. They had carried out work in partnership with Help on Your Doorstep and run pop-up stalls in markets to reach out to the public about their work.

RESOLVED:

That the Board note the approaches to commissioning for 2015/16

21 HEALTH & HOUSING UPDATE REPORT (ITEM NO. B2)

Sean McLaughlin, Corporate Director Housing and Adult Social Services presented the update to the Board.

In the discussion the following points were made:

- There were many causes of damp and it was different in each instance.
- At the Andover Estate bridges and conductivity were the issue and structural work was required. Advice had been given on good ventilation but communication could be an issue.
- The levels of investment in this area had been considerable and 99% of the required cavity wall work had been completed.
- The decisions on district heating systems would help with the process.
- Officers were looking at the HRA to see if further investment could be made.
- A heat map of the borough had been prepared looking at the worst areas of poor/hard to heat homes.
- It would be helpful for GP Practices to be notified of schemes of works so that they could relate this to patients coming in with LTC exacerbated by heating/damp issues.

RESOLVED:

That the report be noted.

22 **SAFEGUARDING ADULTS ANNUAL REPORT (ITEM NO. B3)**

Sean McLaughlin, Corporate Director Housing and Adult Social Services presented the report to the Board.

In the discussion the following points were made:

- The Safeguarding Adults report would also be going to Scrutiny Committee.
- The Board would be a statutory requirement under the new Care Act regulations.
- There was a growing awareness of the safeguarding adults agenda and Healthwatch would be visiting services and reporting back on that process.

RESOLVED:

That the report be noted.

23 **BETTER CARE FUND UPDATE (ITEM NO. B4)**

Sean McLaughlin, Corporate Director Housing and Adult Social Services presented the update to the Board.

In the discussion the following points were made:

- A national decision had been made to rerun the Better Care Fund process in more detail.
- The only different comment they had received was more detail on how the integration monies should be spent.

RESOLVED:

That the update be noted.

24 **PHARMACEUTICAL NEEDS ASSESSMENT (ITEM NO. B5)**

Julie Billett stated that there would be a formal 60 day consultation process with the final sign off taking place in January 2015.

In the discussion the following points were made –

- Members commended the document and noted that Islington had the highest number of independent pharmacies in the country.
- The CCG worked very closely with pharmacies and were looking to explore more avenues of working together.
- The local pharmacies service was highly valued and needed to be recognised.

Health and Wellbeing Board - 15 October 2014

- Qualitative research with residents had showed how much they valued the services pharmacies provided and it was essential the value of this services was highlighted.

RESOLVED:

That the Pharmaceutical Needs Assessment be agreed.

25

JSNA EXECUTIVE SUMMARY (ITEM NO. B6)

Julie Billett presented the JSNA summary. Members had seen a previous version and the updated document included wider determinants. She recommended that members look at the Evidence Hub for more detail on specific areas. This could be accessed via the Islington website.

In the discussion the following points were made –

- Members were keen to follow the trajectory of certain areas rather than looking at an overall view.
- Consideration should also be given to whether data on vulnerable adults was average for the country. It would be good to undertake benchmarking to assess where improvement might be needed.
- The Needs Assessment for vulnerable children might be an area the Board wanted to focus on more closely.
- Islington had fallen to the 4th highest borough in London for children living in poverty. Members queried whether this was due to a rise in middle class families moving to the borough.
- Areas such as child tooth decay rates could be reflective of an underlying trend of neglect so it was important that these were not missed.
- On Early Intervention and Prevention it was important that there were sufficient services at the start to support families.
- Islington had hit herd immunity on immunisation for the first time.
- The mental health data was significantly out of date and this needed to be investigated. Data from GPs may provide a good source of information in the future but coding issues could play a part in that process.
- It would be interesting to look at the survey data on Children and Young People in more details to do some local modelling.

RESOLVED:

That the Executive Summary be noted.

26

WORKPLAN (ITEM NO. B7)

The Chair reported that the Board may wish to consider revisions to the Board format to be less formal. Sean McLaughlin and Julie Billett would meet to discuss this.

RESOLVED:

That the work programme be noted.

MEETING CLOSED AT 2.45 pm

Chair

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Report of: Chief Officer, Islington Clinical Commissioning Group

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	14 th January 2015	Item	All

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SUBJECT: PRIMARY CARE STRATEGY AND CO-COMMISSIONING

1. Synopsis

In recent months a number of policies and publications have been released which inform the overall direction of primary care and require CCGs to think through future plans. This includes the policy of primary care co-commissioning to share problem-solving and decision-making on primary care issues across CCGs and NHS England. In addition the North Central London Primary Care Strategy is in its last year of the agreed investment programme so we are currently refreshing the strategy across the five CCGs. The strategy will align with our co-commissioning plans as they need to support what we are trying to achieve in primary care.

This report sets out the new context for primary care and updates the Board on progress with co-commissioning. It is an opportunity for the Board to discuss and comment on plans prior to their formal approval by CCG Governing Bodies.

2. Recommendations

The Board is asked to:

- **consider** and **comment on** progress on plans for primary care across North Central London including co-commissioning, in particular the role of the Board in any new arrangements for commissioning. Some questions for the Board have been indicated in the report but it would be helpful to have comments on the way forward for primary care in Islington more broadly.

3. Background

3.1 National and London Context

Over the past few months there have been some key policy announcements at a national and London level about how primary care is commissioned and delivered.

3.1.1 Co-commissioning

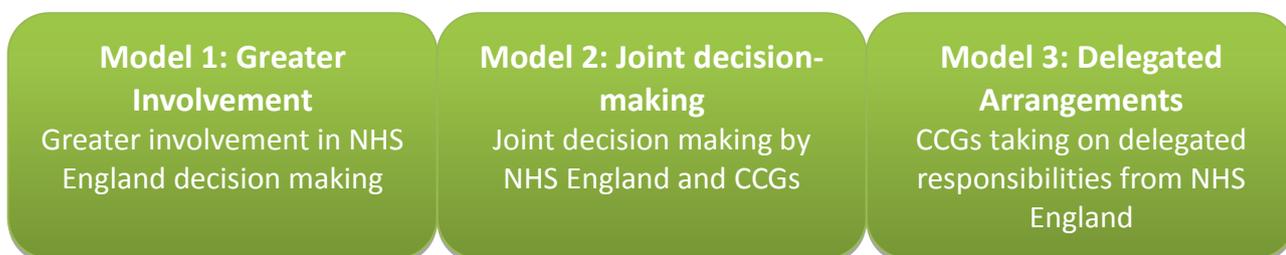
In May 2014, Simon Stevens (CE of NHS England) invited CCGs to come forward to take on an increased role in the commissioning of primary care services. The intention is to empower and enable CCGs to improve primary care services locally, in part through co-commissioning. The overall aim of primary care co-commissioning is to harness the energy of CCGs to create a joined up, clinically led commissioning system which delivers seamless, integrated out-of-hospital services based around the needs of local populations.

Some of the possible benefits from co-commissioning:

- Improved provision of out-of-hospital services for the benefit of patients and local populations;
- A more integrated healthcare system that is affordable, high quality and which better meets local needs;
- More optimal decisions to be made about how primary care resources are deployed;
- Greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services; and
- A more collaborative approach to designing local solutions for workforce, premises and IM&T challenges
- Co-commissioning is the beginning of a longer journey towards place-based commissioning

For this year, the scope of primary care co-commissioning is general practice services. The commissioning of dental, community pharmacy and eye health services is more complex than general practice with a different legal framework.

Through a national analysis of expressions of interest, it has become apparent that there are three main forms of co-commissioning CCGs would like to take forward:



NCL has expressed an interest in Model 2 Joint Decision-making in the first instance.

Further guidance about co-commissioning was published on 11th November (<http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc->

[cocomms.pdf](#)). It sets out in more detail how co-commissioning will develop in each of the models. For joint commissioning, we will need to establish a joint committee or a committee in common with NHS England. We have the option to pool investment funds. Joint committees could cover the following functions:

- GMS, PMS and APMS contracts (design, monitoring, actions)
- Design enhanced services
- Design of local incentive schemes
- Approve practice mergers
- Making decisions on discretionary payments.

We will agree membership as part of the approval process but can include others e.g. Healthwatch and Health and Wellbeing Board representation as non-voting attendees.

The national timetable for co-commissioning is as follows:

Co-commissioning form	Nov 2014	Dec 2014	January 2015	February 2015	March 2015	April 2015
Greater involvement	Take forward arrangements locally					
Joint commissioning	CCGs work with their membership and area team to consider and agree the preferred co-commissioning arrangement for 2015/16.		30 Jan: CCGs are invited to submit proposals to their regional office. <i>Please note that constitution amendments which relate solely to joint commissioning arrangements will also be accepted at this point.</i>	NHS England works with CCGs to review and approve their submissions.	Local Implementation by CCGs with their area team	1 April: Arrangements implemented and go-live
Delegated commissioning			5 Jan: CCGs are invited to submit proposals to england.co-commissioning@nhs.net During January, NHS England will work with CCGs to ensure that proposals are ready for sign off. <i>Please note that constitution amendments which relate solely to delegated commissioning arrangements will also be accepted at this point.</i>	16 Feb: Proposals are signed off by an NHS England Committee (likely to be the proposed new Commissioning Committee)	Local Implementation by CCGs and their area team	

The approvals process is designed to be straightforward to support as many CCGs as possible to implement co-commissioning by April 2015. We are required to implement a short proforma and request amendments to constitutions.

3.1.2 NHSE Five Year Forward View and the London Health Commission Report

Both of these reports published at the end of last year strongly focus on the need for a sustainable high quality primary care landscape.

The Five Year Forward View includes the following:

- Stabilise core funding for general practice and review how resources are fairly made available
- Give CCGs more influence over NHS budget – investment: acute to primary and community
- Provide new funding through schemes like the challenge fund
- Expand as fast as possible the number of GPs, community nurses and other staff
- Design new incentives to tackle health inequalities
- Help public deal with minor ailments without GP/A&E
- Potential new care models such as Multispecialty Community Providers and Primary & Acute Care Systems

The London Health Commission Report includes the following:

- Increase the proportion of NHS spending on primary and community services
- Invest £1bn in developing GP premises
- Set ambitious services and quality standards for general practice
- Promote and support general practices to work in networks
- Allow patients to access services from other practices in the same networks
- Allow existing or new providers to set up services in areas of persistent poor provision.

3.1.3 London Strategic Commissioning Framework for Primary Care

On 26th November the vision for high quality primary care for all patients in London is being launched for further engagement by NHSE with the support of CCGs. It covers specifications (service offers) based on the areas that patients and clinicians have identified as the most important:

Accessible care – better access primary care professionals, at a time and through a method that's convenient and with a professional of choice

Coordinated care – greater continuity of care between the NHS and other health services, named clinicians, and more time with patients who need it

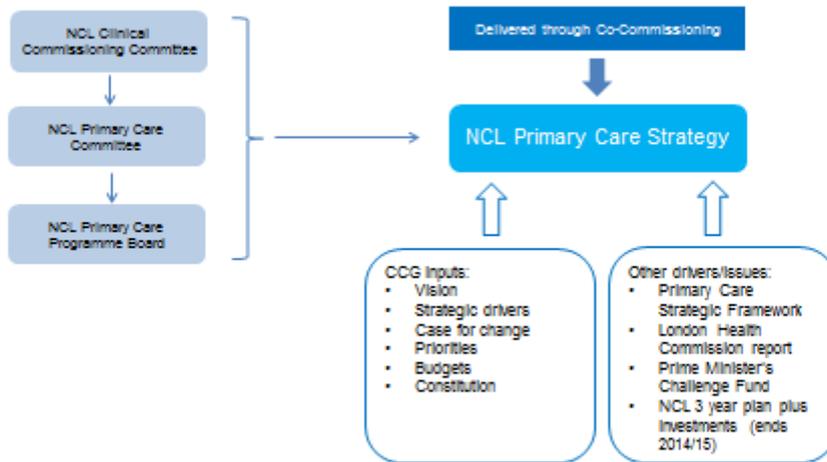
Proactive care – more health prevention by working in partnerships to reduce morbidity, premature mortality, health inequalities, and the future burden of disease in the capital. Treating the causes, not just the symptoms.

This will have significant workforce and financial implications. CCGs in London will need to work through how to take forward the framework from April over a period of time.

4. North Central London Primary Care Strategy

Due to this changing context and in view of the pressures on general practice locally and the variable quality in some parts of the patch, North Central London (NCL) needs a refocused primary care strategy. We have been working over the past three years on developing primary care infrastructure and improving quality and access in line with the NCL Strategy. This has involved investment of c£12m per year from our pooled CCG funds. This commitment was for three years up to 2014/15. We need to be clear how we want this work to progress from the end of this year.

NCL needs a new primary care strategy by January 2015



NCL has a strong track record in collaborative and mutually supportive working which will benefit the progression of the primary care development standards, and other initiatives such as co commissioning. As a starting point for refreshing the strategy have looked at local CCG plans and summarised our shared priorities for primary care development for NCL as follows:

- **Extending access to appointments.** This also includes work in making practices more productive and using information technology to enhance and improve patient care (e.g. interoperability, video consultations)
- **Ensuring GP provider collaboration and harnessing the benefits of working at scale** including development of GP networks to integrate with other services (pharmacy, CHS, Specialist) to deliver personalised care for patients with complex long term conditions
- **Reducing variability and increasing the quality** of the offer to patients, enabling all patients to have fuller and more equitable access to services
- **Improving patient experience** and having in place a range of methods to be able to engage and get feedback from patients
- **Closing the gap on expected and observed prevalence** for long term conditions, and more proactive care of people with chronic diseases
- **Promoting self-care**
- **Integrating care better** and ensuring that primary care plays a key part in successful delivery of integrated and coordinated care

- **Taking a strategic approach to primary care premises development** and where appropriate trying to improve premises where primary and community services are delivered from
- **Supporting the primary care workforce** through planning, education and training to help deliver our strategic ambition for the transformation of services.

Based on these themes it is proposed that we refresh our primary care strategy for April 2015. This will be a joint primary care strategy for NCL that will broadly cover the following:

- Vision for primary care in NCL
- Implementation of the Co-commissioning Framework
- Response to the London Health Commission
- Key objectives for primary care across NCL.

Questions for the Board

- *Are the shared priorities above the right ones for Islington?*
- *Bearing in mind the changing policy context, what opportunities are there for the HWBB to support the development of primary care locally?*

5. Co-Commissioning Primary Care in NCL

In June 2014, the five CCGs in NCL submitted our expression of interest in co-commissioning and since then we have been progressing local discussions on a joint commissioning model. We have been clear that any collective co-commissioning approach must mean that we can discharge that responsibility in a way that is better than now, and result in tangible patient benefits:

- The NCL Primary Care Strategy underpins the development of co-commissioning
- Gives CCG oversight of primary care development and how contributes to forwarding local strategic change
- More integrated decision-making
- Great consistency of outcomes and incentives
- Collaborative approaches to infrastructure developments (estate, workforce, IT).

We have identified some risks of co-commissioning which still need working through:

- Governance and handling of conflicts of interests: this will need careful and sensitive management. A national framework for conflicts of interest in co-commissioning is being published as statutory guidance in December 2014.

- Stakeholder and member views: Local CCGs need to continue to engage with their stakeholders and members to ensure they understand what we are proposing and what we are trying to achieve.
- Financial positions: Data on resources will need to be subject to transparent sharing and examination.
- Management costs: There will be no increase in running cost allowances and limited redistribution of NHSE resources under a joint commissioning arrangement.

The current approach in NCL is to set up a joint commissioning model over time with a shadow arrangement starting in April. This will give time to test out arrangements for decision making and membership as well as determine the resources needed.

Questions for the Board

- *Is the joint commissioning model the right one?*
- *What should be the functions of a joint committee?*
- *Who should be on the joint committee?*

6. Implications

6.1. Financial implications

The financial implications will be worked through as plans develop but it is not envisaged that any budgets and resources will be delegated from NHS England in a joint co-commissioning model. With regard to resources available for primary care investment which will be necessary for primary care to develop locally, we await clarification on sources of funding from London-wide and national policy initiatives but it appears likely that there will be opportunities. In addition NCL CCGs will need to make a decision about whether investment that has been available for the last three years to implement the NCL strategy will continue next year.

6.2. Legal Implications

Although not legal implications, CCGs will need to amend constitutions and approve terms of reference for the new co-commissioning arrangements which will require consultation with GP practice members.

The legal framework for co-commissioning is set out in the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012). The relevant NHS England duties are set out in the NHS Act (sections 1H, 13O and 13P, 83 and 91) and regulations. NHS England is able to enter into arrangements with CCGs, including delegated arrangements (section 13Z NHS Act).

CCGs and NHS England can establish joint committees (sections 13Z 14Z3 and 14Z9 of the NHS Act, as amended). The procurement requirements are set out in the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 and 'Substantive guidance on the Procurement, Patient Choice and Competition Regulations' issued by Monitor. CCGs must have due regard to 'Managing conflicts of interest: statutory guidance for CCGs'.

CCGs will need to amend constitutions and approve terms of reference for the new co-commissioning arrangements which will require consultation with GP practice members.

6.3. Equalities Impact Assessment .

As the plans for primary care progress, there will need to be consideration of the equalities impact.

6.4. Environmental Implications

N/a

Background papers: N/A

Final Report Clearance

Signed by



Julie Billett
Director of Public
Health

Date: 5th January
2015

Received by

.....
Head of Democratic Services

.....
Date

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Report of:

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	14th January 2015	Item	All

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SUBJECT: Response to *Better Health for London* – the report of the London Health Commission

1. Synopsis

This paper provides an overview of the London Health Commission’s final report – Better Health for London – and a commentary of the recommendations that are directed at HWB partner organisations in Islington. The report is intended to provide a synopsis of the key issues for the Health and Wellbeing Board and serve as the basis of a discussion by board members about the recommendations and how it wishes to respond.

2. Recommendations

The Health and Wellbeing board is asked to:

- Note the aspirations, ambitions and recommendations set out in the report of the London Health Commission “Better Health for London”.
- Discuss the implications of the report for Islington and potential areas for priority focus and action.
- Agree to convene a time-limited multi-partner working group to consider and respond to the recommendations of the LHC on behalf of Islington’s HWB.

3. Background

3.1. The London Health Commission was an independent inquiry established in September 2013 by the Mayor of London. The Commission was chaired by Professor the Lord Darzi and reported directly to

the Mayor. The Commission examined how London’s health and healthcare can be improved for the benefit of the population.

- 3.2. Extensive engagement was undertaken in the preparation of *Better Health for London* including: the views of more than 9,000 people; more than 50 roadshow and NHS-based events (at least one in every borough); 250 written evidence submissions received; and 9 oral hearing sessions.
- 3.3. On 15 October 2014, the London Health Commission published *Better Health for London* which, amongst other things, proposes measures to combat the threats posed by tobacco, alcohol, obesity, lack of exercise and pollution.
- 3.4. *Better Health for London* is set within an international context and compares London’s performance with a selection of ‘global cities’ from across the world. It ranks London as number 7 out of 14 comparable cities around the world in terms of health, wealth and education. To achieve the commission’s aspiration of being the world’s healthiest major global city, the report sets out 10 aspirations for London supported by 64 full recommendations (see appendix B):

Our aspirations for London Our ambitions for London

1	Give all London’s children a <u>healthy, happy</u> start to life	Ensure that all of London’s children are school ready at age five Halve the number of children who are obese by the time they leave primary school and reverse the trend in those who are overweight
2	Get London fitter with better food, more exercise and healthier living	Boost the number of active Londoners to 80% by supporting them to walk, jog, run or cycle to school or work
3	Make work a healthy place to be in London	Gain 1.5 million working days a year by improving <u>employee</u> health and wellbeing in London
4	Help Londoners to kick unhealthy habits	<u>Have</u> the lowest smoking rate of any city over five million inhabitants
5	Care for the most mentally ill in London so they live <u>longer, healthier</u> lives	Reduce the <u>gap</u> in life expectancy between adults with severe and enduring mental illness and the rest of the <u>population</u> by 10%
6	Enable Londoners to do more to look <u>after</u> themselves	Increase the proportion of people who feel supported to manage their long-term condition to top quartile nationally
7	Ensure that every Londoner is able to see a GP when they need to and at a time that suits them	General practice in London to be open 8am to 8pm and delivered in modern purpose-built/designed facilities
8	Create the best health and care services of any <u>world</u> city, throughout London and on every day	Have the lowest death rates in the world for the top three killers: cancer, heart diseases and respiratory illness; and close the gap in death rates between those admitted to hospital on weekdays and those admitted at the weekends
9	Fully engage and involve Londoners in the future <u>health</u> of their city	Year on year improvements in inpatient experience for trusts outside the top quintile nationally
10	Put London at the <u>centre</u> of the global revolution in digital health	Create 50,000 new jobs in the digital health sector

4. Themes and recommendations

3.6 Public health

Tobacco: Improvements have been made in recent years but smoking is still responsible for 8,400 deaths a year in the capital and 51,000 hospital admissions. Smoking tends to be higher among lower socio-economic groups, thereby contributing to health inequalities in the capital. There is evidence that the smoking ban has made a difference since its introduction in 2007, changing attitudes, stopping people starting smoking and saving lives and national efforts such as tax breaks for nicotine replacement products and legislation have also made a difference. The commission recognises the immense value of smoking cessation interventions and argues that they must continue to be supported and invested in. Given London's abundant green space (35,000 acres) compared with other comparable global cities, the commission argues that a smoking ban in parks and other public spaces owned by London's local and regional government could make a huge contribution to saving future lives (Recommendation 2). On illegal tobacco sales, the commission recommends a citywide coalition of local authorities, the metropolitan police, the London Fire Brigade, HMRC, trading standards, tobacco control alliances, crimestoppers, Public Health England (PHE) and the Mayor's Office for Policing And Crime (MOPAC) to coordinate action on the illegal sale of tobacco, map activity and share information (Recommendation 3).

Obesity: London is facing an obesity crisis with more than half of the adult population overweight or clinically obese. Although London performs better than England regionally on obesity rates, there is wide variation between the London boroughs. Obesity impacts both physical and mental health. The commission recommends the introduction of compulsory traffic light labelling in all London restaurants and cafes with more than 15 outlets nationally. GLA polling shows such an initiative is likely to prove popular with the public. There is evidence that traffic light labelling – as opposed to DRAs or calorie counting – works better at helping people identify healthy foods (Recommendation 4).

Alcohol: The commission recognises the role alcohol plays in the culture, economy and night life of London but also that alcohol-related hospital admissions and liver disease are rising. The commission's research shows that 'Binge drinking' has declined since 2009 but 'high risk' drinking is now concentrated in particular areas. The commission highlight research supporting a higher price per unit of alcohol in reducing deaths, illnesses, traffic fatalities, violence, crime, sexually risky behaviour and STIs and argues that London should follow the lead of cities like Newcastle and Liverpool which have introduced minimum unit pricing (MUP) using byelaws or voluntary agreements with vendors. Boroughs particularly affected should apply to the Secretary of State for Communities and Local Government to approve variations in licensing laws to enforce MUP in pilot areas. 50% of Londoners polled by the GLA supported MUP pilots. Such pilots could deliver substantial savings to the NHS in reduced hospital admissions. (Recommendation 5)

Taxation: The commission highlights the long history of employing taxation to reduce consumption of harmful substances and following the lead of other global cities around the world, argues that London boroughs should be given greater control over local taxation to incentivise healthy behaviours. (Recommendation 6)

3.7 Healthy workplaces

Whilst many Londoners are physically active, London lifestyles can contribute to sedentary behaviour. The commission argues that more needs to be done to make active travel easier for Londoners which would save lives and improve physical and mental health and wellbeing. The commission recommends a range of actions from employers, the Mayor, TfL and London boroughs. The commission highlights that despite significant potential gains to employers from workplace health schemes, that employers in the UK have less incentive to invest in employee health than in countries like the US or Germany (who pay for their staff's healthcare) because healthcare is provided by the NHS. The commission therefore sees a role for the Mayor, London boroughs and TfL in incentivising employers to promote health and healthy workplace schemes. (Recommendation 9)

3.8 Children's health

The commission recognise that healthy child development in the early years has huge importance for future health and happiness. London's children face particular challenges of extreme and concentrated poverty impacting on educational and health outcomes. The commission argues that parental learning programmes can ameliorate some of the impact of poverty and that a pan-London programme of evidence-based parenting support commissioned by health and care commissioners targeted from maternity to three years of age in the most vulnerable groups is needed. The programme would link midwifery, health visiting, Family Nurse Partnerships and would focus on supporting basic parenting skills (recommendation 13).

The commission also support the intervention by the Mayor in planning guidance to support local authorities to impose tighter controls on junk food businesses within 400m of schools (recommendation 14). The commission also recognises the importance of good health education and argues that more needs to be done by local authorities, the Mayor and the NHS working with Ofsted to capture information about the health of London's schools that would allow comparison around how health and wellbeing is supported. (Recommendation 15)

3.9 Health and care

The report's section on better care highlights the tension between universal and personalised care services. It contends that better care is personal care i.e., care that reflects the individual wants and needs of the person, including the design of their own care by patients (recommendation 18) and empowers both the individuals that use care and the professionals and providers who deliver it. It highlights the tension between personalisation and the principle of universality – that access to healthcare should be based on need, not ability to pay – as universal services have often meant care that is the same regardless of individual needs. The commission argue that different people want different things from their care and that people should be grouped into cohorts of similar need (e.g., older people, people with long-term conditions etc) and that the system in which care is provided be similarly arranged to provide for groups of similar individuals, in which people are treated as "...unique and complex, not as an ailment, condition, or piece of anatomy." In practical terms, the commission advocates more joint teams in the community, more joined up working, and more integration between health and social care. This could mean that, rather than referring people with multiple long-term conditions to an array of outpatient appointments with different hospital-based specialists, that there is a team of specialists based in the community providing specialist advice directly to patients and GPs. (Recommendation 17) (see diagrams and graphics pgs. 43-47)

3.10 Engagement and empowering people to take control of their own health

The commission contend that there is much to be gained from empowering Londoners to take greater care of their own health. Local and regional government, the health service, the voluntary sector, employers, schools and colleges, transport, and the wider public and private sector all have a role to play in providing the information and support required to empower Londoners to make better choices about their own health. But at the same time, there is an expectation that Londoners must also contribute to and take responsibility for improving their own health and that of their communities. The commission argues that the NHS has been poor historically at listening and responding to people's concerns and views and that the NHS must do more to actively engage with and seek out the views of people, especially London's diverse and hard to reach communities.(Recommendation 1). The commission advocates the promotion and implementation of shared decision making, care and support planning, education for self-management, personal health budgets and access to health records by health and care commissioners and the voluntary sector so that London becomes an exemplar in improving people's participation in their own care and treatment (recommendation 19). It also recommends that NHS England should develop a single Londonwide online platform to encourage and inform people about how they can actively participate in discussions and decisions about health, care and services, building on the NHS Citizen Initiative and the

Imagine Healthy London brand (recommendation 40) and recommends the Mayor create a Citizen's Health Panel to oversee the engagement and involvement of Londoners (recommendation 41).

3.11 GP services

The commission recognises that GPs play an invaluable role in the health system and as the main point of contact for most people using the NHS, must be at the heart of any system-wide attempt to improve the health of London. The commission also recognises the immense pressures on GPs in the capital from historical under-funding as a proportion of overall NHS spend, critical workforce challenges, poor access for patients, low satisfaction levels of London patients and the poor condition of many GP premises. Consequently, the commission recommends: a £1bn investment programme in GP premises over the next five years to modernise facilities (Recommendation 21) with investments led by a partnership of CCGs, NHS England, and local authorities exploring opportunities to include wider public services (such as employment, child care, libraries and education); an increase in the total proportion of London NHS spending dedicated to GPs and primary and community services and facilities (Recommendation 22), and ambitious new service and quality standards for GPs in London tailored to the population groups they serve (Recommendation 23). The commission also recommends GPs working in networks to provide a wider range of services and more convenient appointment times (recommendation 24), allowing patients to move freely between GP networks (recommendation 25) and arrangements allowing new providers to set up new GP premises in areas where there has been persistently poor provision (recommendation 26).

3.12 Mental health

Huge numbers of Londoners experience mental health problems, including children. People with a mental health problem are much less likely to receive treatment and are more likely to report poor satisfaction with treatment. People with severe and enduring mental health die more than a decade earlier than those without. The costs to healthcare and employment of not addressing mental health are also significant. The commission highlights that health and care commissioners need to do more to provide innovative support for young people suffering mental illness that utilises the technologies that are widespread among young people (recommendation 28), increase access to good psychological therapies and early intervention services within primary care (recommendation 29) and develop a pan-London multi-agency model of care for adult and child mental health patients in crisis (recommendation 30).

3.13 Better care for the homeless

There are large numbers of homeless people and people rough sleeping in the capital and funding cuts to the VCS and local authorities mean that numbers are rising. The homeless can expect to live almost half as long as the general population and tend to be beset by a host of complex inter-related health problems including mental illness, substance misuse and physical health problems. Low levels of education and the transitory nature of being a homeless person make the homeless less able to manage their own care. The commission recommends a pan-London approach to tackle homelessness, appointing a single integrated care commissioner led by NHS England (London) or one of London's CCGs that would work closely with local authorities and the health service (recommendation 31).

3.14 Data and information

The commission highlight the important role data analytics and health information can play not only in assisting people to manage their own health and wellbeing, but also the huge potential benefits to health professionals of good quality, up to date information in helping them deliver better, safer care and plan better services. 86% of people polled agreed the people involved in their care should be able to access and share information on them and their health when necessary. Despite the benefits the commission recognises the challenges. It highlights how NHS IT systems are "bewildering" and "complex"; that information governance regulations are often a source of anxiety and an excuse for inaction; and that

information is too often 'pushed' from above rather than 'pulled' from the frontline to improve the quality of care. The commission therefore recommends that Academic Health Science Networks (AHSNs), CCGs and NHS England should work together to create matched patient-level data sets and real-time information sharing to improve both care delivery and service planning, with robust safeguards for privacy and confidentiality (recommendation 42) and that Health and care commissioners should embrace advanced data analytics to better understand care needs and to commission higher quality care (recommendation 44).

3.15 Funding

The commission point out that the way CCG budgets are currently allocated in London does not accurately reflect needs and that this can be seen in the differences in surpluses and deficits between London's CCGs with a pattern of inner-London CCGs being over-funded and outer-London CCGs being under-funded. Acknowledging that reform of complex allocation formulae will take time, the commission stresses the urgency that many London CCGs face in needing to deliver 'whole-systems transformation programmes' now. To address immediate funding issues, the commission urges CCGs and Strategic Planning Groups (SPGs) to jointly commission with GPs, hospitals and other providers what patients need in a more intelligent way and where appropriate, follow the lead of CCGs in north-west London who have developed joint financial strategies reflecting inter-connectedness and promoting financial stability (recommendation 46). The commission also argues that gains could be made by improving long-term clarity about budgets and extending the time-horizons for strategic planning in London to allow commissioners and providers to invest in improving services (recommendation 47).

In order to deliver the recommendations of the commission including investment in and reform of general practice (recommendations 21-26) and new ways of commissioning and listening to people, the commission recognise that significant investment of time, energy and money is required. The commission argues that commissioners are best positioned to lead these changes and that a dedicated team should take them forward. The commission therefore propose that NHS England and CCGs should establish a shared London Transformation Fund for investment in strategic change, jointly managed by NHS England (London) and CCGs with investments agreed with sub-regional health economies (recommendation 48)

The commission argues that the way the NHS budget is currently distributed to care providers has advantages, but it also has drawbacks too, especially for the care of people with complex needs which can lead to duplication of similar services funded by separate organisations, gaps in provision, different service priorities and not enough of a focus on preventing people from becoming sick in the first place. One way other countries have sought to address these challenges is via capitated payment systems – where a single provider or consortium of providers working together are made accountable for the care needs of particular groups and are allocated the whole budget for these groups along with a single agreed set of quality outcomes. Such an approach carries risks for providers and to work requires data to calculate the capitated budget, joint working across health and social care to pool, procure and manage integrated care, the development of new care models and co-design with people who use services. Despite the risks and challenges, the commission recommends that NHS England should work with CCGs and local authorities to trial capitated budgets for specific population groups (recommendation 49).

The commission argues that one possible reason why care can sometimes be unresponsive to individual needs is that we pay for the NHS indirectly via taxes rather than as individuals who can take our custom elsewhere if unsatisfied. One area highlighted for poor performance London is maternity care where on measures of satisfaction with maternity care, London trusts scored lower than the national average in 41 out of 44 cases and where the maternal mortality rate is twice that of the UK. As a result, the commission recommends that NHS England should lead the trial and development of Personally Controlled Payments in London, starting with a pilot with 12.5% of payments for maternity care controlled directly by individual mothers (recommendation 50). This would mean that individuals would be able to decide whether or not a

hospital receives a portion of its income relating to their own care based purely on subjective experiences of care. Money would be non-transferable and would be reinvested by commissioners in the NHS.

3.16 The NHS Estate

The NHS is one of largest owners of land in London with an estate worth more than £11bn. Despite the scale of the estate, the quality is variable with 40% hospitals more than 30 years old and a large proportion of the GP estate unfit for purpose. Assessments of capital efficiency indicate NHS assets may be under used by around 15% (with the majority in acute hospital trusts) which if unlocked would be worth around £1.5bn. This would also have the added benefit of reducing running costs by around £200m annually. The causes of this inefficiency include fragmented and complex rules about decision making and funding of the NHS estate and the fact that there is no London-wide strategic overview of how land and associated issues should be managed to best help patients. Given that 80% of patient contacts with the NHS are in GP practices, and 70% of the assets are in hospitals, the Commission proposes prioritising improvements in these two parts of the NHS

Overhauling the GP estate in London: As set out in recommendation 21-26, significant investment is required by the GP estate in London. Going further, the commission recommends a closer link between funding of the GP estate and the quality to which it is maintained and recommends that NHS England should reform the rent reimbursement system for GP premises, offer modern facilities for all practices and require practices to comply with disability access requirements or accept new facilities (recommendation 51)

Overhauling the hospital estate in London: The commission advocates three steps: incentives to encourage more efficient use of capital; more options for Trusts for disposal of assets; more joined up planning across the NHS and with local authorities

- **Incentives:** because capital charges are low and asset price inflation is high, trusts have little incentive to use capital efficiently. This can lead to 'land banking' – holding on to surplus assets to hedge against future deteriorations in financial position. Incentives need to change to encourage efficient use of capital, investment in high-quality facilities and free up land for housing and other economic growth. Starting with derelict and unused buildings the commission recommends ending from 2016/17 the public subsidy through lower capital charges (3%) meaning trusts would need to pay the market cost of capital on these assets (8%) (recommendation 52). At the same time the commission argues that the current rules for retention of capital receipts can lead to inaction by NHS trusts and so in the future, trusts should automatically receive 50% of receipts with the remaining 50% needing to be agreed with HM Treasury and the Department of Health (recommendation 53).
- **Disposals:** more options for disposal should be open to trusts including the option of transferring assets for redevelopment and disposal with receipts reverting back to trusts (recommendation 54) and the ability for transformation programmes to apply for asset transfers across the public sector (recommendation 55).
- **Planning and coordination:** To address the gap in strategic capital planning the commission proposes that Strategic Planning and Capital Boards are developed by NHS commissioners, providers and local authorities and work in conjunction with NHS Property Services and Community Health Partnerships to ensure that estates planning and a comprehensive asset database are part of strategic planning (recommendation 56)

3.17 Systems leadership and governance

The commission recognise that the complexity of the change required from moving to more integrated care requires skilful leadership and leaders. It highlights the poor record of the NHS in London on diversity

amongst NHS leadership and senior management. As a result the commission recommends recruiting a wider range of NHS and social care professionals to the Darzi Fellowship Programme (recommendation 60)

The Commission recognise that better health cannot be delivered by the NHS in isolation and must be delivered in conjunction with local authorities and Public Health England. Nevertheless, it also recognises that greater coordination of efforts and action are required to deliver results, and as a result, proposes the appointment of a London Health Commissioner to champion health in the capital, supported by combining the London region of Public Health England and the GLA health teams; with the Mayor lobbying the Department of Health for the Commissioner to receive a significant budget from Public Health England (recommendation 61).

Whilst recognising that partnerships between CCGs and local authorities should remain the principal point for commissioning health and care services, the commission also recognises that at time improvements could be better made by multiple CCGs and local authorities working together across larger multi-borough geographies or even on the footprint of large acute hospitals that serve multiple boroughs. In such instances, the commission argues that NHS England (London region) should devolve more decision-making powers to CCGs and local authorities to allow them to collaborate, including through pre-existing SPGs where appropriate (recommendation 62).

To improve transparency of decision making in the NHS and ensure that leader's respond to feedback, the commission recommends new measures to ensure that London's health system includes representation of people who use services on decision-making committees, by holding meetings in public, and publishing meeting documents online (recommendation 63)

4. Implications

4.1. Financial implications

None identified.

Any financial implications arising need to be considered and agreed by the relevant Council departments and any other partners.

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

4.2. Legal Implications

Section 194 of the Health and Social Care Act 2012 ("the Act") established health and wellbeing boards and required each local authority to establish a board for its area comprising of key leaders from health and social care.

Section 195 of the Act imposes a duty on health and wellbeing boards to encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner so as to build strong and effective partnerships, which improve the commissioning and delivery of services across NHS and local government, leading in turn to improved health and wellbeing for local people and reduced health inequalities.

The report of the London Health Commission "Better Health for London" sets out a number of recommendations to support its agenda for improving the health and care of people living in London. In so doing it emphasises the need for greater co-ordination and partnership working to achieve the actions set out in the report and its recommendations. Local authorities and CCGs through health and wellbeing boards are expected to have a lead role in securing significant improvements in the health and care of people living in London and in helping to achieve the recommendations set out in the report.

4.3. Equalities Impact Assessment

None identified.

4.4. Environmental Implications

None identified.

5. Next steps

5.1 Once the bodies named in Better Health for London have set out their responses, the Mayor will convene and chair a group to prepare a unified delivery plan. This group should then continue to oversee progress in the implementation of the recommendations. To prepare our local response, it is recommended that the Board convene a time-limited group whose membership comprises those local organisations named in the recommendations to produce a comprehensive response for Islington.

6. Conclusion and reasons for recommendations

The Health and Wellbeing board is asked to:

- Note the aspirations, ambitions and recommendations set out in the report of the London Health Commission “Better Health for London”.
- Discuss the implications of the report for Islington and potential areas for priority focus and action.
- Agree to convene a time-limited multi-partner working group to consider and respond to the recommendations of the LHC on behalf of Islington’s HWB.

Background papers:

Better Health for London – report of the London Health Commission - <http://www.londonhealthcommission.org.uk/wp-content/uploads/Better-Health-for-London-report-revised-November-2014.pdf>

Attachments:

- Appendix A – Commission members
- Appendix B – Commission’s recommendations

Final Report Clearance

Signed by



Julie Billett
Director of Public Health

Date: 5th January 2015

Received by

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Report author:

Tel:

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APPENDIX A: COMMISSION MEMBERS

- Professor the Lord Ara Darzi, Chair, London Health Commission
- Lord Victor Adebowale, Chief Executive, Turning Point
- Colin Barrow, Executive Chairman, Alpha Strategic
- Sir Cyril Chantler, Chair, University College London Partners
- Professor Yvonne Doyle, Regional Director, Public Health England (London region)
- Len Duvall, Chair, Greater London Authority Oversight Committee and London Assembly Member
- Peter Ellingworth, Chief Executive, Association of British Healthcare Industries
- Dr Sam Everington OBE, General Practitioner and Chair of Tower Hamlets Clinical Commissioning Group
- Andrew Eyres, Chief Officer, Lambeth Clinical Commissioning Group
- Professor David Fish, Managing Director, University College London Partners
- Professor Chris Ham, Chief Executive, The King's Fund
- Professor Dermot Kelleher, Dean of the Faculty of Medicine, Imperial College London
- Sir Ron Kerr, Chief Executive, Guy's and St Thomas' NHS Foundation Trust
- Professor Sheila Leatherman, Research Professor, The University of North Carolina and Visiting Professor, London School of Economics
- Dr Andy Mitchell, Medical Director, NHS England (London region)
- Crystal Oldman, Chief Executive, The Queen's Nursing Institute
- Cllr Teresa O'Neill, Leader, London Borough of Bexley
- Dr Matthew Patrick, Chief Executive, South London and Maudsley NHS Foundation Trust and Clinical Director for Mental Health, NHS England (London region)
- Dr Anne Rainsberry, Regional Director, NHS England (London region)
- Nick Raynsford, Member of Parliament, Greenwich and Woolwich
- James Reilly, Chief Executive, Central London Community Healthcare NHS Trust
- Andrew Ridley, Managing Director, NHS North and East London Commissioning Support Unit
- Dr Caz Sayer, General Practitioner and Clinical Lead, NHS Camden Clinical Commissioning Group
- Dr Tim Spicer, General Practitioner and Chair of Hammersmith and Fulham Clinical Commissioning Group
- Dr Geraldine Strathdee, National Clinical Director for Mental Health, NHS England
- Dr Chris Streater, Managing Director, South London Academic Health Science Network
- Jeremy Taylor, Chief Executive, National Voices
- Professor Chris Welsh, Director of Education and Quality, Health Education England

APPENDIX B: RECOMMENDATIONS

1. Better health for all

- Recommendation 1: All health and care commissioners and providers should innovatively and energetically engage with Londoners on their health and care, share as much information as possible, and involve people in the future of services.
- Recommendation 2: The Mayor, Royal Parks, City of London and London boroughs should use their respective powers to make more public spaces smoke free, including Trafalgar Square, Parliament Square, and parks and green spaces.
- Recommendation 3: The Mayor should launch a fresh crackdown on the trafficking in and selling of illegal tobacco.
- Recommendation 4: London boroughs should introduce mandatory traffic light labelling and nutritional information on menus in all restaurant and food outlet chains in London, by using their byelaw and licensing powers.
- Recommendation 5: London boroughs afflicted by problem drinking should be supported if they choose to pilot a minimum 50p price/unit for alcohol through their byelaw and licensing powers.

- Recommendation 6: The GLA and London boroughs should include 'sin taxes' in their review of how London might manage devolved taxation powers, and if appropriate, make a case to central Government.
- Recommendation 7: The Mayor should invest 20% of his TfL advertising budget to encourage more Londoners to walk 10,000 steps a day, and TfL should change signage to encourage people to walk up stairs and escalators.
- Recommendation 8: The NHS, Public Health England, and TfL should work together to create a platform to enable employers to incentivise their employees to walk to work through the Oyster or a contactless scheme.
- Recommendation 9: The Mayor should encourage all employers to promote the health of Londoners through workplace health initiatives. The NHS should lead the way by introducing wellbeing programmes, including having a mental health first aider for every NHS organisation.
- Recommendation 10: London boroughs, the GLA and the NHS should work together to organise an annual Mayor's 'Imagine Healthy London' Day in London's parks, centred on an 'All-Borough Sports Festival' with health professionals offering health checks, and exercise and healthy eating workshops.
- Recommendation 11: London's professional football clubs should promote health in stadiums and local communities through club incentives and competition.
- Recommendation 12: The Mayor should accelerate planned initiatives on air quality in London to help save lives and improve the quality of life for all Londoners.

2. Better health for London's children

- Recommendation 13: Health and care commissioners should jointly develop a new model to improve support for parents of vulnerable children under three.
- Recommendation 14: The Mayor should use the 'London Plan' planning guidance to support local authorities in protecting London's children from junk food through tighter controls within 400 metres of schools and to promote access to healthier alternatives.
- Recommendation 15: Local authorities, the GLA and Public Health England should work with Ofsted to ensure more data is published on school health and wellbeing.
- Recommendation 16: Health commissioners and providers should launch a process to address the variation in quality of care for children and to propose actions to improve outcomes.

3. Better care

- Recommendation 17: Health and care commissioners should commission holistic, integrated physical, mental and social care services for population groups with similar needs, with clearly defined outcomes developed by listening to people who use services.
- Recommendation 18: Health and social care professionals should partner with people who use services to ensure that their voice is heard in designing and implementing improvements to care.
- Recommendation 19: Health and care commissioners and the voluntary sector should promote the implementation of shared decision making, care and support planning, education for self-management, personal health budgets, and access to health records so that London becomes an exemplar in improving people's participation in their own care and treatment.
- Recommendation 20: Health Education England, NHS England, and professional regulators should work together with the voluntary sector to develop education programmes for self-management of long-term conditions, which would enable more peer support and empower programme graduates to self-prescribe their own medication for their own condition.
- Recommendation 21: The Department of Health and NHS England should launch a five-year £1 billion investment programme in GP premises so that all Londoners are able to access care in modern purpose-built/designed facilities.

- Recommendation 22: Health commissioners should increase the proportion of total London NHS spending dedicated to GPs and primary and community services and facilities.
- Recommendation 23: Commissioners should set ambitious new service and quality standards for GPs in London, tailored to the different population groups of patients they serve.
- Recommendation 24: NHS England and CCGs should promote and support GPs working in networks to reduce professional isolation, to provide a wider range of services and to provide more appointments at more convenient times.
- Recommendation 25: NHS England and CCGs should allow patients to move freely within GP networks, so those registered with one GP practice are able to access services from other practices within the same network.
- Recommendation 26: NHS England and CCGs should put in place arrangements to allow existing or new providers to set up new GP services in areas of persistent poor provision in London.
- Recommendation 27: Health commissioners should improve specialist care by accelerating efforts to create centres of excellence for cancer and cardiovascular services, launching a new programme to review elective orthopaedic services, and ensuring London Quality Standards are implemented.
- Recommendation 28: Health and care commissioners should ensure that all Londoners have access to digital mental health support, in the languages that they speak, and using the latest technology.
- Recommendation 29: NHS England should strengthen the role of mental health in primary care, with a particular focus on timely access to psychological therapies and early intervention services, and on improving the capacity and capability of GPs to care for people with mental illnesses.
- Recommendation 30: Health and care commissioners should develop a pan-London multi-agency (including the police and ambulance service) case for change and model of care for child and adult mental health patients in crisis.
- Recommendation 31: Health and care commissioners should develop a pan-London, multi-agency approach to healthcare for the homeless and rough sleepers, with dedicated integrated care teams, and commissioned across the capital by single lead commissioner.

4. Maximising science, discovery and innovation to enhance economic growth

- Recommendation 32: The Department of Health, the Department of Business, Innovation and Skills, and the National Institute for Health Research should invest in an Institute for Digital Health and Accelerator for London, coordinated by MedCity and the AHSNs.
- Recommendation 33: London's AHSCs should support and help expand the Health Informatics Collaborative funded by NIHR to improve knowledge sharing for research purposes.
- Recommendation 34: The Department of Health, the Department of Business, Innovation and Skills, and the National Institute for Health Research should invest in an Institute for Dementia Research to bring together expertise in basic sciences, technology and social policy to address the dementia crisis.
- Recommendation 35: London's providers should work with the Health Research Agency and Clinical Research Networks to create a simple and unified gateway for clinical trials in London.
- Recommendation 36: Clinical Research Networks should establish a strategic clinical research office to increase late phase research/novel real world studies in smaller NHS Trusts and GP practices.
- Recommendation 37: NHS England should strengthen London's AHSNs by further consolidating and channeling all innovation and improvement programmes through them.
- Recommendation 38: AHSC/Ns should forge greater links with Commissioners to advise on the use of latest innovations for patient benefit and to support delivery by providers.
- Recommendation 39: AHSNs in the South East should continue to collaborate – specifically on systematic knowledge sharing to improve adoption of innovation – to make South East England a leading region internationally for the adoption of the latest healthcare technologies and innovations.

5. Making it happen

- Recommendation 40: NHS England should develop a single London-wide online platform to encourage and inform people about how they can actively participate in discussions and decisions about health, care and services, building on the NHS Citizen initiative and the Imagine Healthy London brand.
- Recommendation 41: The Mayor should create a Citizens' Health Panel to oversee the engagement and involvement of Londoners, ensuring the capital's existing expertise and community diversity is fully represented.
- Recommendation 42: AHSNs, CCGs and NHS England should work together to create matched patient-level data sets and real-time information sharing to improve both care delivery and service planning, with robust safeguards for privacy and confidentiality.
- Recommendation 43: The National Information Board should designate London as an incubator for innovative health information, providing investment and support.
- Recommendation 44: Health and care commissioners should embrace advanced data analytics to better understand care needs and to commission higher quality care.
- Recommendation 45: NHS England should fund and trial patient-reported outcomes measures linked to payments to London providers.
- Recommendation 46: London CCGs and Strategic Planning Groups should consider developing local initiatives to promote greater equity in financing the health and care system.
- Recommendation 47: NHS England should make clear the budget for the London Region of NHS England and for London CCGs for the duration of future spending review periods.
- Recommendation 48: NHS England and CCGs should establish a shared transformation budget for investment in strategic change, jointly managed by NHS England (London) and CCGs with investments agreed with sub-regional health economies.
- Recommendation 49: NHS England should work with CCGs and local authorities to trial capitated budgets for specific population groups, such as elderly people with long-term conditions.
- Recommendation 50: NHS England should lead the trial and development of Personally Controlled Payments in London, starting with a pilot with 12.5% of payments for maternity care controlled directly by individual mothers.
- Recommendation 51: NHS England should reform the rent reimbursement system for GP premises, offer modern facilities for all practices, and require practices to comply with disabled access requirements or accept new facilities.
- Recommendation 52: The Department of Health should end the public subsidy for hospital assets that are no longer used for the public good by raising capital charges from 3% (public dividend capital rate) to 8% (the market cost of capital) from 2016/17.
- Recommendation 53: The Department of Health should agree with HM Treasury that NHS Trusts in London routinely retain 50% of any capital receipts, with the remaining 50% agreed with the TDA and local commissioners, so that trusts have an incentive to dispose of surplus assets.
- Recommendation 54: The Trust Development Authority and Monitor should work with the GLA to establish an unused NHS buildings programme in London so that trusts are encouraged to transfer assets for redevelopment and disposal receipts would revert back to the trusts).
- Recommendation 55: Transformation programmes should be able to apply to a joint HM Treasury, Department of Health, and Department for Communities and Local Government committee for permission to transfer assets from the NHS to other parts of the public sector at District Valuer figures.
- Recommendation 56: NHS commissioners and providers and local authorities should create Strategic Planning and Capital Boards to ensure that estates planning and a comprehensive asset database are part of wider service planning.
- Recommendation 57: Health Education England should ensure that education and training funding continues to support choice, foster excellence, and secure higher quality care.
- Recommendation 58: NHS Trusts should be permitted to include affordable housing as part of wider site redevelopment plans, working in partnership with local authorities.
- Recommendation 59: Local Education and Training Boards, Health Education England and employers should shift more training to general practice, community and integrated care settings, and explore the creation of new hybrid health and social care roles.

- Recommendation 60: The London Leadership Academy and London LETBs should recruit a wider range of NHS and social care professionals to the Darzi Fellowship programme.
- Recommendation 61: The Mayor should appoint a London Health Commissioner to champion health in the capital, supported by combining the London region of Public Health England and the GLA health teams; the Mayor should request the Department of Health for the Commissioner to receive a significant budget from Public Health England.
- Recommendation 62: NHS England should further empower CCGs to work together – with their local authority partners – to improve care across multiple boroughs, by devolving further decision-making powers to strategic planning groups.
- Recommendation 63: London should be the most transparent region of England’s health and care system by including representation of people who use services on decision-making committees, by holding meetings in public, and publishing meeting documents online.
- Recommendation 64: Once all the bodies named in this report have set out their responses, the Mayor should convene and personally chair a group to prepare a unified delivery plan. This group should then continue to oversee progress in the implementation of the recommendations in this report.

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Report of: Assistant Chief Executive, Governance and HR

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	14 th January 2015	Item	All

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SUBJECT: Health and Wellbeing Board – Appointment of Additional Non – voting Co-opted Members

1. Synopsis

- 1.1 Section 194 of the Health and Social Care Act 2012 (“the Act”) required Councils to establish a Health and Wellbeing Board (“HWBB”) by 1 April 2013. The objective of the HWBB is to increase the local democratic legitimacy of NHS commissioning decisions and bring together the key NHS public health and social care leaders in each local authority areas to work in partnership.
- 1.2 This report proposes two additional non-voting co-opted members be included in the membership of the HWBB.

2. RECOMMENDATIONS

- 2.1 To recommend to the Council the inclusion of representatives of the following organisations as additional non-voting members of the HWBB:
 - i. The Camden and Islington NHS Trust (non-voting)
 - ii. The Whittington NHS Trust (non-voting)
- 2.2 To recommend to the Council the amendments to the HWBB’s Terms of Reference to reflect the new membership as set out in Appendix 1.

3. Background

- 3.1 Under section 194 of the Health and Social Care Act 2012 (“the Act”) the Council was required to establish a HWBB as a committee of the Council by 1 April 2013.
- 3.2 The HWBB is a committee of the Council. The statutory provisions concerning the required

membership and operation of the HWBB do not align smoothly with the existing legislation in relation to Council committees therefore the Local Authority (Public health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (“the Regulations”) modify some of the legislation relating to committees to remedy this.

4. The Islington Health and Wellbeing Board

- 4.1 HWBBs provide new opportunities for local government to work in partnership with the NHS and their communities to understand local need, and develop a strategy to address the issues that matter to most local people.
- 4.2 The HWBB has a duty to encourage integrated commissioning across NHS, public health and local authority services in order to improve efficiency, secure better care and, ultimately, improve health and wellbeing outcomes for the local community. The HWBB is responsible for the mutual obligation on the council and NHS commissioners to undertake a Joint Strategic Needs Assessment (JSNA) and produce a Joint Health and Wellbeing Strategy (JHWS) for the borough.
- 4.3 The HWBB contains members from other statutory organisations and officers as voting and non-voting members.

5 Membership of the HWBB

- 5.1 The Health and Social Care Act 2012 sets a core membership for HWBBs that must include:
 - at least one councillor of the relevant local authority (who may be the Leader)
 - the Director of adult social services
 - the Director of children’s services
 - the Director of public health
 - a representative of the Local Healthwatch organisation
 - a representative of each relevant clinical commissioning group (CCG)
- 5.2 The Council can appoint any other members it considers appropriate however it must consult the HWBB if doing so any time after the board is established.
- 5.3 The current membership of the Islington HWBB is set out in the terms of reference of the HWBB in the Appendix 1.
- 5.4 Regulation 6 modifies the Local Government and Housing Act 1989 (section 13(1)) to enable all members of Health and Wellbeing Boards or their sub-committees to vote unless the Council decides otherwise. This means that the Council is free to decide which members of the Board should be voting members.
- 5.5 Currently the Board has two non-voting members; the CCG Director of Quality and Integrated Governance, and the representative of the Local NHS Commissioning Board who are appointed as members of the Health and Wellbeing Board for all purposes, but without the power to vote. .
- 5.6 The Board is recommended to reconsider the extent to which it wishes to involve local providers of health and social care services. Previously, the Board’s membership has been limited and providers have been included in a wider stakeholder reference group. It is now

thought appropriate to offer membership of the Board to non-voting representatives of Camden and Islington NHS Trust and Whittington NHS Trust in order to involve them directly in its decisions and to give the Board a wider and more inclusive reach.

- 5.7 The terms of reference of the Health and Wellbeing Board set out in the Council's Constitution allow the Council to appoint additional persons to the Board provided it has first consulted with the HWBB. The HWBB is also entitled to appoint additional persons as non-voting co-opted members of the HWBB. It is proposed that the HWBB recommend the appointment of the additional members to the Council as non-voting.

6. Voting and Conflicts

- 6.1 The Regulations modify the Local Government and Housing Act 1989 (section 13(1)) so that all members of HWBBs are able to vote unless the Council, having first consulted the HWBB, directs otherwise. All members of the HWBB with power to vote will be subject to the Islington Members Code of Conduct; any members not empowered to vote will not.
- 6.2 In Islington all members of the HWBB have voting rights, apart from the CCG Director of Quality and Integrated Governance and the local NHS Commissioning Board representative.
- 6.3 It is proposed that the HWBB invite two of the large local NHS providers Camden and Islington NHS Foundation Trust and the Whittington Trust to join the HWBB as full non-voting members. The Regulations require that voting arrangements, including any variation to the provision that all members of the Board including non-councillor members may vote, must be agreed by the whole Council.
- 6.4 Because they will not be entitled to vote at meetings of the HWBB, the proposed co-opted members will not be required to adhere to the Members Code of Conduct. However they should nevertheless be required declare their interests at meeting of the HWBB and adhere to a protocol in respect of their conduct, and requirements in respect of confidentiality and access to information.

7. Implications

7.1 Financial Implications

There are no financial implications arising directly from this report.

7.2 Legal Implications

Regulations permit the Council, in consultation with Health and Wellbeing Board, to determine which members of Health and Wellbeing Board should be voting members (The Local Authority (Public Health, Health and Well-being Boards and Health Scrutiny) Regulations 2013 (SI2013/218), regulation 6, (modifying section 13 of the Local Government Housing Act 1989)).

The Council can use this flexibility to designate Camden and Islington NHS Foundation Trust and Whittington NHS Trust as non-voting members of the Board.

7.3 Resident Impact Assessment

There are no resident impact implications arising directly from this report.

7.4 Environmental Implications

There are no environmental implications arising directly from this report.

Background papers:

None.

Attachments:

Appendix 1 –Terms of reference

Final Report Clearance

Signed by

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Debra Norman
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Date

Received by

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Head of Democratic Services

.....

Date

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Appendix 1

HEALTH AND WELLBEING BOARD

Composition

- Leader of the Council
- Lead Member for Health and Wellbeing
- Lead Member for Children and Families
- GP and Chair of the Islington Clinical Commissioning Group
- GP and Joint Vice Chair of the Islington Clinical Commissioning Group
- Lay Vice-Chair, Islington Clinical Commissioning Group
- CCG Chief Operating Officer
- Corporate Director of Housing and Adult Social Services
- Corporate Director Children's Services
- Director of Public Health
- Health Watch representative (one member)
- CCG Director of Quality and Integrated Governance (non-voting)
- Local NHS Commissioning Board representative (non-voting)

[Proposed new members:

- The Camden and Islington NHS Trust (non-voting)
- The Whittington NHS Trust (non-voting)]

The Board will be chaired by the Leader of the Council.

A deputy may be appointed in respect of each member who may attend the meeting subject to the agreement of the Chair.

The Council may appoint additional persons to the Board provided it has first consulted with the Board.

The Board shall be entitled to appoint additional persons as non-voting co-opted members of the Board.

Quorum

The quorum for a meeting of the committee shall be 4 members including one CCG representative, one councillor and a representative of Health Watch.

Terms of Reference

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Report of: Corporate Director Children's Services

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	14 January 2015	Item	All

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SUBJECT: Children and Families Prevention & Early Intervention Strategy 2015-2025 and the Early Intervention Summit

1. Synopsis

- 1.1 This paper presents the Children and Families Prevention and Early Intervention Strategy 2015-2025 for adoption by the Health and Wellbeing Board (HWB), which reflects the Health and Wellbeing Board's strategic priorities. It also references the recent Early Intervention Summit. The summit informed the final version of the strategy and brought partners together to further embed prevention and early intervention in the early years with some focused work on conception-3 years.

2. Recommendations

The Health and Wellbeing Board are asked to

- adopt the Children and Families Early Intervention and Prevention Strategy 2015-2025
- ensure that children and young people's needs are fully reflected in the JSNA to ensure commissioning and service planning and development responds to needs
- commit to actively champion and drive the agenda, committing to a long-term focus on early intervention and prevention

3. Background

Children and Families Strategy 2015-2025

Strategy rationale

- 3.1 Islington's Children and Families Strategy, developed by the Children and Families Board in consultation with a range of stakeholders, is an early intervention and prevention strategy in recognition of the growing body of evidence showing that investment in support that identifies and meets the needs of children and their families earlier is more cost-effective (in terms of human and financial cost for individuals, society and the public purse) than intervening later in a child's life or in the life of a problem. Identifying and preventing problems as early as possible must be the core business of services; whilst ensuring that when the need arises, targeted and specialist services are involved to help address problems early.
- 3.2 Islington's national profile as an early intervention leader is strong, having been selected as an Early Intervention Pioneer Place by the Early Intervention Foundation. However, this strategy sets out the challenge to continue to embed a focus on early intervention and prevention, working innovatively and in partnership to make best use of resources, and prioritising investment that will achieve critical outcomes for ensuring wellbeing at every stage of a child and young person's development and ultimately being ready for adulthood and parenthood, thus breaking the cycle of disadvantage.
- 3.3 The key strategic priorities will ensure we continue to stay focused on what is most important for securing the long term welfare of our children, young people and families:
- 1) Improving outcomes from conception to 19 through good and outstanding universal services
 - 2) Strengthening our early help support for children and families who have additional needs
 - 3) Supporting our most vulnerable children to be safe and thrive and to be able to overcome the challenges they face as they grow up
- 3.4 The strategy is set within a context of a challenging economic climate where huge savings to local authority funding have already been required and further reductions are needed over the next four years. Partnerships are key if we are to maintain effective services, avoiding duplication, and continue to improve outcomes for children through further alignment of resources and more formal joint commissioning arrangements. The Strategy is therefore a 10 year strategy to ensure we hold our nerve and embed a long term focus on early intervention and prevention.

Consultation Process

- 3.5 Islington's Children and Families Board held responsibility for developing the Children and Families Strategy in consultation with key stakeholders in the borough. Board members actively engaged their constituencies in the development of the strategy, including engagement of young people and families.
- 3.6 In addition, the strategy has also drawn on the key messages emanating from a range of work that has been undertaken by the partnership over recent years, including the recent early intervention summit (see below for more detail), the youth strategy review, the council's financial strategy, consultation with young people during the development of the child health strategy and the priorities identified as important to young people through the Youth Council elections. In addition the Youth Council were formally consulted on this strategy.

Number of consultation responses: 25

Partnership area	Number of responses
Voluntary Sector	6 - CYPVSF and also responses from individual organisations (Chance UK, Caspari Foundation, Islington Play Association) , Holloway Children's Centre Cluster, Early Intervention Foundation
Council:	14 - Family Support and Outreach Area Managers; Early Years; Targeted Youth Support; Family Information Service; Play, Youth and Post 16; Families First; Children's Partnership Commissioning Team; Schools Health and Wellbeing Team; Targeted and Specialist Children's Services; Strategy and Community Partnerships; Community Safety, Public Health
Safeguarding	1 - ISCB
Health	1 - CCG
Partnership Groups:	3 - Children and Families Board, Early Help Advisory Group, Children's Service Improvement Group

Key messages from the consultation

3.7 There was a unanimous commitment across all partners to a focus on early intervention and prevention and agreement with the strategy's Vision, Principles and Priorities. There were a number of themes that were common among a number of respondents:

(i) Language/tone

The strategy needed to be more empowering and less paternalistic in its language and tone, highlighting the strengths and capabilities of children, young people and families and the need to work in partnership with families to identify the right support to enable the family to address their needs and achieve positive progress and outcomes. The language of the strategy has been changed in light of this.

(ii) Role of partners

The consultation was a key opportunity for partners to further shape the strategy ensuring it captured the varied role and responsibility of all partners towards achieving our vision for children and young people.

Some of the feedback from the voluntary and community sector captured the need to more clearly articulate the important and unique role the VCS play in the community and the resources this sector can lever in. There was a need for the strategy to better reflect the current and potential opportunity for a strong partnership and collaboration between this sector and other partners.

Feedback from other partners, particularly health, has been extremely positive, due to the partnership recognising how crucial emotional and physical health outcomes are to wider outcomes.

The strategy has been amended to strengthen these messages.

(iii) Needs

Feedback generally highlighted that the needs assessment summary (key data and information drawn from the overall JSNA including the Vulnerable Children Needs Assessment) was comprehensive. However, there were a number of areas that were missing. These included the following areas: needs of young fathers; population churn; in-work poverty; children missing from home, care and education; sexually transmitted infections; youth offending and siblings.

These areas of need are now reflected in the strategy's needs assessment summary (Appendix D).

(iv) Outcomes

The outcomes have now been amended to better reflect the soft and hard outcomes the partnership believe to be important for the short and long term wellbeing of children and young people and to break the intergenerational cycle of disadvantage.

There is now a distinct section on parental outcomes to ensure we give significant focus to enabling parents to achieve outcomes important for the wellbeing of their children.

Feedback from the consultation indicated a need to focus on the very early years from conception to 3 years. Therefore the first developmental band has been broken up to identify key outcomes from conception to 3 and outcomes for 3-5 year olds. In addition, following feedback, each developmental band from conception to 19 overlaps to ensure children at the bottom and top of age bands do not get neglected and to show the fluidity of children's development.

Prevention and Early Intervention Summit – 20 November 2014

- 3.8 Islington's Early Intervention Summit in November, with a focus on the early years, and was an opportunity to bring partners together to reflect on the huge amount of work already taking place in the borough and to recognise the challenges and opportunities ahead.
- 3.9 The discussions and insights during the summit fed into the amended outcomes within the Children and Families Strategy and also reinforced the key actions for the first 4 years of the strategy.
- 3.10 The discussions at the summit are directly feeding into a refresh of Islington's Conception – age 3 approach across Islington, bringing together partners across the CCG and council, including education, public health, children's centres, social care, Whittington Health and the third sector, to ask how we can

prioritise those things that matter most in children's lives. Through this process partners will continue to be engaged to ensure developments make best use of the expertise, insight and resources across the partnership.

4. Implications

4.1. Financial implications

There are no direct financial implications arising from this report. The Children and Families Strategy has been developed alongside the financial strategy.

4.2. Legal Implications

There are no direct legal implications. Achieving an early intervention approach as set out in the strategy supports a range of statutory duties. This includes the requirements of the Working Together 2013 statutory guidance for early help, securing the wellbeing of children outlined in the Children Act 2004 and the duty for Health and Wellbeing Boards to encourage integrated working between commissioners of NHS, public health and social care services under the Health and Social Care Act 2012.

4.3. Equalities Impact Assessment

Early intervention seeks to address a range of inequalities to help all children and young people thrive and build resilience to factors that may disadvantage them. A focus on equalities runs throughout the entire strategy, from the Vision to ensure all children and young people have the best start in life, through the principles that underpin the work of the partnership and the Priorities that focus on what the Partnership will do to ensure children, young people and families get the right support to ensure their long term wellbeing and to achieve the very best outcomes.

4.4. Environmental Implications

There are no environmental implications arising from this report.

5. Conclusion and reasons for recommendations

An effective early intervention approach is beneficial for the health and wellbeing of Islington people.

Making a strategic shift to early intervention will require:

- Taking a long-term approach
- Strong 'whole-place' leadership to ensure the gains made through early intervention are not lost to national or local funding, management or political cycles;
- Taking a risk in funding prevention and early intervention approaches;
- Commissioning for early intervention and prevention across all health, education/employment, social care and other commissioning portfolios; and
- 'In-practice' activities to maintain a legacy that prevents problems and/or doesn't store up problems for the future such as collaboration with external partners such as schools and the third sector, and innovation and building the evidence.

The current Children and Families Strategy expires in March 2015. The Health and Wellbeing Board, as the formal body bringing partners together to improve the health and wellbeing of Islington's population, are asked to adopt the Children and Families Prevention and Early Intervention Strategy 2015-2025 which will underpin the focus of the Children's partnership over the next ten years.

Background papers:

Attachments: The Children and Families Prevention and Early Intervention Strategy 2015-2025

Final Report Clearance

Signed by

CM Blair

05/01/2015

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Date

Received by

.....

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Giving Children the Best Start in Life

Islington Children and Families Prevention and Early Intervention Strategy 2015-2025

Islington's Children & Families Prevention and Early Intervention Strategy 2015 – 2025

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Context

Economic recovery and its impact still seem far away. Families have less to live on and there may be more stress within them. Our children may find it harder to get work, buy their own home and face a higher cost of living than their parents. Some may need a little more support, some a lot more. This not only affects families on low incomes but people on middle incomes as well. As needs grow, there will be fewer local resources to support those needs.

Children and families need to be equipped to adapt positively to challenging life experiences at a time when there is intense pressure on public finances. Resilient children, families and communities can bounce back and thrive despite the challenges they face. Children, young people and their families can be supported in three broad ways:

- so that problems don't arise in the first place (**prevention**)
- so that problems are nipped in the bud (**early intervention**)
- so that something is in place for needs or problems that are serious, will not respond to early help or will endure (**specialist intervention / treatment**).

Whilst our aim is for children, young people and parents¹ to be confident and independent through their own personal resilience and the support of social networks, this isn't always possible without the support provided by a range of services including excellent universal services delivered by a variety of partners which are available to all (early years, health services, schools, play and youth provision), and effective accessible targeted services or specialist services, when needed. There is a growing body of research evidence that suggests that intervention as early as possible pays off, early in the life of a child and early in the life of a problem. It is therefore crucial we ensure the right balance of investment across universal, targeted and specialist services and work in partnership with family members to deliver services that respond to their needs and build on their strengths, to give the best chance of making a positive difference to children's lives and to break the cycle of disadvantage. The care system, mental health in-patient services and youth offending institutions are all examples of specialist form of intervention. We know that these services cost a great deal of money. If we can prevent the need for these services we will be improving children's lives as well as making financial savings.

During good economic times, policy makers put in place the social and physical infrastructure for early intervention. As the population grows and the effects of reduced public spending begin, the risk of that infrastructure disappearing mean that problems can be stored up for the future. As a community, we risk the ability of our children, young people and families to survive and thrive.

Our challenge is how can we, across the council, health system, schools, criminal justice system, business and employment services, and the third sector invest in support that prevent problems arising in the first place or get effective help to children, young people and parents when the problems first arise?

¹ The term parent will be used throughout the strategy to include parents/carers.

The case for early intervention and prevention

In early 2013, Islington was designated as one of 20 'Early Intervention Pioneer Places' by the [Early Intervention Foundation](#). This shows that our national profile as a leader in this area is strong. Islington will continue to make a step change so that we make early intervention a reality through all levels of local activity, from our governance structures and commissioning, development of strategies and business cases through to reviewing programmes and practice on the ground.

Our Early Intervention and Prevention Strategy is our 10-year approach to support how we work together in Islington to make early intervention and prevention our core business so that we:

- build resilience in children, young people, parents, carers and the community so that they become more self-sustaining;
- enable the impact of our investment on the lives of our children, young people and families to be seen and felt;
- continue to evaluate, develop and review how we commission for and deliver early intervention and prevention;
- make wise spending decisions and reduce duplication and costs to achieve long-term savings to society and public services

Early intervention and prevention is not a single one-off event; it is a process. It is cross-cutting and can involve multiple different factors rather than just one issue. For this reason, it requires a partnership approach. Meeting children and families' needs through early intervention will require partners to look beyond the national frameworks such as inspection and political/funding cycles. We need to embrace a local long-term strategic shift towards securing wellness and building resilience in the Islington population, hence our 10-year strategy.

What we do with children and young people will generate impact and savings for the adult population and the community. For example, social and emotional foundations in the early years, capable and confident parenting amongst vulnerable families, healthy lifestyles and good education experiences set during the primary and secondary school years can determine positive outcomes throughout the life course. It can also tackle the costly consequences of issues such as school exclusions and unemployment in later years.

We know that early intervention needs to be well-managed, particularly if families have multiple needs. . This requires a partnership approach that focuses on early intervention and services working together to secure long term well-being and resilience in the Islington population. Here, our approach to Early Help to prevent children and young people requiring expensive specialist services is important – a description of how early help services provide one element of early intervention is attached as *Appendix B*.

The challenge is to continue to support those currently in need while preventing the need for people to be supported intensively in the future. Although we are making good progress, we need to reduce the need for spend on acute and complex needs to enable better alignment of funding. Engineering a strategic shift of this kind when the pressures on public funding are intense is challenging. For the benefit of children, families and a thriving community, it is a long-term challenge we, across all areas of the children's partnership, must invest in.

The vital role of partnerships

We need to build on the work of the partnership to date to ensure we draw on the full range of resources, expertise and insight of all partners so we can better understand the needs of our children, young people and families, better identify and engage with those families who will benefit most from services, and provide co-ordinated services that effectively address needs early, to ensure the very best outcomes for our children, young people and families.

The strategy is set in the context of a very challenging economic climate which has seen unprecedented levels of central government cuts to local authority funding. During the last Children and Families Strategy 2011-15, Islington Council had to make savings of £112m. The next four year period looks as if a further £96m may have to be found which means that the council's overall budget would have been halved since 2010.

Although some areas such as schools and health currently have their budgets relatively protected, there isn't a lot of money for increased investment. A collective mixture of investment from partners such as the local authority, the health service, schools, the business and third sector could help.

It is for this reason that this strategy deliberately sets out a vision for the next ten years that places early intervention and prevention at its heart. If the partnership is not able to sustain sufficient investment and with the scale of cuts envisaged this could have a major impact on our: ability to support good and outstanding universal provision; capacity to provide early intervention and preventative services; and ability to contain expenditure. The outcome could be reactive services fulfilling only narrow statutory duties for children with greatest needs at increasing cost with worsening outcomes for children and families. This 10-year strategy will therefore be the foundation for the 2015-19 Children's Services Financial Strategy.

Partnerships are the key to being able to maintain effective services and continue to improve outcomes for children. There are key partnerships between the council and health services in supporting early intervention and prevention; and also with schools (who control 71% of the overall children's services budget in the local authority). Between 2011/12 and 2014/15 the Council's overall funding has reduced by 30% with a further 30% reduction expected over the next 4 years, whilst the overall funding for the individual school budgets and the Pupil Premium has increased by 39%. The partnership between the third sector, the council and other partners is also crucial to achieving better outcomes for children and young people. Third sector partners, including community groups and volunteers, perform an important role in reaching local communities and supporting families and it is important there is further collaboration across partnership which maximises the third sector's contribution, and its ability to lever in additional resource. Partnerships need to build on our achievements to date and encourage both the alignment of resources and more formal joint commissioning arrangements.

As well as the compelling social case in terms of improved health and well-being for children, young people and families, there is a strong economic case as described above for if we do not maintain effective early intervention and prevention services, we will be storing up problems and facing higher costs in future years.

Meeting the challenge requires a focused partnership approach. The Children and Families Board is the key strategic body for Islington in bringing key partners together.

About the Children & Families Board

The Children & Families Board brings partners across the community together in our children's partnership for the benefit of children, their families and the wider community by:

- using all of the services, workforce, finances and capital (resources) available to children, young people and parents so we can improve their lives in the best way possible
- enabling services and organisations to get support from other professionals to tackle the barriers children and families face and better meet their needs

Our role in improving children's lives is as a:

- Champion:** **for children and families**, leading the way in promoting fairness, addressing inequality, and ensuring all children and young people have the best possible life experiences and outcomes
- Catalyst:** bringing stakeholders together through shared vision and building effective partnerships to best meet need;
- Commissioner:** making best use of resources (including those specifically identified to tackle disadvantage) available through joint planning and commissioning ensuring cost effective delivery either in-house or through external providers.

The Children and Families Board develops the Children and Families Strategy in consultation with key stakeholders in the borough. The Strategy has been developed with the UN Convention of the Rights of the Child in mind. The Board has sought the views of young people and parents and the Youth Council have had an active role in shaping the strategy. In addition, the strategy has also drawn on the key messages emanating from a range of work that has been undertaken by the partnership over recent years, including the youth strategy review, the council's financial strategy, the development of the child health strategy and the priorities identified as important to Islington young people through the Youth Council elections.

The strategy is also formally agreed by the Islington Health and Wellbeing Board.

The Children and Families Strategy is closely aligned with key strategic priorities across the Council and the key partnership boards. Refer to *Appendix C*, Strategic priorities – relevant Extracts, for details of these strategic priorities.

The Islington Children and Families Early Intervention and Prevention Strategy sets out the Vision, Principles and Priorities that will drive the work of the Partnership for 2015-2025.

Refer to Appendix E, for a diagrammatic representation of Islington Children's Partnership arrangements.

The Children and Families Board, whilst ensuring children and young people are happy, healthy, thriving and safe, will lead a collective, co-ordinated and concerted shift by all partners towards investment in early intervention and prevention. This shift will result in a more equal Islington where children, young people and their families make the very best progress, achieve excellent outcomes and accomplish their ambitions. This shift will also realise improved value for money.

INSERT NAME, PARTNERSHIP AREA AND SIGNATURES OF CHILDREN AND FAMILIES BOARD MEMBERS FOLLOWING SIGN OFF

NOT OFFICIAL COUNCIL POLICY

Our Vision for children, young people and families in Islington

We want children and young people in Islington to have the best start in life.

By 2025 we want an Islington where they achieve the **outcomes that are important for ensuring wellbeing** at each broad developmental stage and are also able to make a successful transition to the next stage and break the intergenerational cycle of disadvantage. Whilst we acknowledge not all children start from the same point and some face a range of often complex challenges, our ambition is for all children to achieve the very best outcomes and for parents to have the capacity and confidence to provide the environment in which children can thrive. This means:

Parental outcomes

- Secure attachments and positive parenting
- Parents are managing and supporting their child's health and development
- Parents have self-belief and are capable and confident
- Positive family relationships and strong positive social networks

Child/young person outcomes Conception to 19, by developmental stage

1. Starting well:

In the early years: conception to 5 years (conception, early childhood and pre-school)

Conception to 3:

- Good physical and emotional maternal health
- Babies and young children:
 - have secure attachments and achieve optimum social and emotional development
 - have good physical health and achieve optimum physical development
 - achieve optimum communication and language development
 - are safe, are able to learn from experience and have the confidence to make positive and safe choices

3 to 5 years:

- Children have good physical and emotional health
- Children are ready for school
- Children are safe, are able to learn from experience and have the confidence to make positive and safe choices

2. Developing well:

In the primary school years: 4 to 11 years (childhood - school age)

- Children have good physical and emotional health
- Children have social and emotional capabilities including ability to problem solve, make decisions, form positive relationships and manage their feelings and behaviour
- Children are and feel safe, are able to learn from experience and have the confidence to make positive and safe choices
- Children achieve their full potential
- Children are ready for secondary school

In the secondary school years: 11-16 years (adolescence – school age)

- Young people have good physical and emotional health and are enabled to take more control of their health
- Young people have social and emotional capabilities, including confidence, creativity, good communication skills, resilience and determination, positive relationships and leadership skills, ability to plan and problem solve and manage feelings
- Young people are and feel safe, are able to learn from experience and have the confidence to make positive and safe choices
- Young people achieve their full potential
- Young people have ambitions realistic to their age and stage of development and understand the pathways that will help them achieve these

Entering young adulthood: 16 + years (young adulthood)

- Young people have social and emotional capabilities
- Young people have independent living skills
- Young people have stable, positive and respectful relationships
- Young people are and feel safe, are able to learn from experience and have the confidence to make positive and safe choices
- Young people are physically and emotionally healthy and are taking control of and managing their health well
- Young people achieve their full potential
- Young people are in appropriate education, training or employment that is line in with their abilities and aspirations

The Principles underpinning our 2015-25 Strategy

There are a number of important principles on which we are developing our strategy for children, young people and families. The main principle that underpins our aim and vision is:

- **Early Intervention and Prevention**

We believe that:

- investing to meet the needs of children and their families earlier is more cost-effective;
- identifying and preventing problems as early as possible should be the core business of services such as health, early years, housing and schools;
- when the need arises, targeted and specialist services should be involved to help resolve problems early, address the negative impact of disadvantage, and enable children and young people to have positive outcomes and break the cycle of disadvantage

The supporting principles to achieve our aim and vision are:

- **Good quality integrated Universal Services**

We believe that:

- a continued focus on the quality of integrated universal services, like GPs, schools, children's centres, early years, employment services, adventure play and youth services, will support children and families outcomes to be as good as, or better than, national performance.

- **Reducing Inequalities**

We believe that making Islington fairer involves:

- addressing child poverty;
- narrowing the gap in outcomes between groups in Islington and between Islington and those nationally;
- ensuring that the principles of fairness and social justice guide our priorities and actions, recognising and ensuring that characteristics that could result in inequality such as gender, race, disability, immigration status and sexual orientation do not create disadvantage

- **Think Family**

We believe that:

- *children's and adult's services should 'Think Child, Think Parent, Think Family'* so that we can meet the needs of family members earlier and work co-operatively to improve outcomes and reduce unnecessary costs.

- **From Participation to Co-production**

We believe that:

- children and families co-producing or co-designing the services they use, the support they need and influencing decisions that affect them is the foundation for responsive, good quality services; building on their strengths, developing their resilience, autonomy and self-sufficiency.

- **Connecting socially for a stronger community**

We believe that:

- opportunities should be available for children, young people and families of different backgrounds to connect socially and build friendships and support networks that are essential for a stronger, more cohesive community.

- **Innovation and evidence**

We believe that:

- all providers and commissioners across statutory, commercial and third sectors should invest in services with a strong evidence base. Partners should encourage a culture of learning and innovation to drive change where there is evidence that a particular approach isn't working. We should be innovative, encourage practitioners to tell us what works and monitor outcomes and evidence of impact to develop the evidence base where gaps are identified.

The impact of the 2011-15 Children and Families Strategy

In 2011, the Children and Families Board set out four key priorities. This is a summary of progress made on each of these to date, that also serves as a benchmark for our 2015-25 strategy:

Improving outcomes by 19 through outstanding health services, schools and children's centres

- The gap between the Early Years Foundation Stage outcomes in Islington and those nationally narrowed significantly between 2010 and 2012. Since then a new framework has been introduced and the gap in 2013 was 8 percentage points. In 2014 the gap reduced to 2 percentage points.
- Key Stage 2 results are up and above national but below London averages
- Key Stage 4 results are up and above the national and London averages
- School attendance at Primary is below national levels; and at Secondary is up, above national levels
- Attainment outcomes at 19 are up but below national and London averages
- Breastfeeding rates are up and above national averages
- Immunisation rates are up and above national averages
- Obesity rates are down but above national averages
- Teenage Pregnancy rates are down from 48.1 per 1000 (15-17yr olds) in 2009 to 30.1 per 1000 in 2012. This represents a 38% drop.
- Over 90% of Children's Centres are good or outstanding
- 89.1% of schools are good or outstanding, an increase since 2011. Islington is in the top 10% of LAs in the country on this measure

Ensuring play, youth and leisure opportunities for children and young people

- Completed major review of adventure play
- New commissioning arrangements for 6 voluntary sector adventure playgrounds has led to increase in free open access play of 41 hours opening per week in term time and 90 hours per week in holidays with a 24% increase in participation
- Completed major Youth Review
- Opened two major new Youth Hubs at Lift and Platform
- Outcomes-led approach to commissioning established, supported by the publishing in 2013 of a framework of the agreed outcomes for young people to be delivered through all youth work supported by the council;
- Co-production of youth work services established supported through a co-produced quality assurance framework against which the quality of youth work delivery is assessed by young people trained as young quality assessors
- Youth Council established to make decisions on all council investment in youth work services
- Participation rates in youth services has increased and is just under 20% for 2013-14

Transforming early intervention and prevention support for vulnerable children and families

- CAMHS maintained in all Children's Centres and Schools despite reductions in Early Intervention Grant and CAMHS Grant
- Selected as National Pathfinder for Community Budget for Families with Multiple Needs
- Established Families First, a new targeted family support service for 1,000 families with the first stage evaluation showing positive outcomes
- Established the Specialist Multi Agency Outreach Service to provide intensive support to prevent young people going into care; criminal justice system etc. including 83% prevention rate for LAC (4 years); 'Social Return on Investment' economic impact: for every £1 investment - saving of £2.57 within 1 year; £4.88 within 2 years; Saving of £970k p.a. on placement costs;
- Selected as Early Intervention Pioneer Place
- CCG selected as an Integrated Care Pioneer
- Established the First 21 months programme to provide better access to services and co-ordinated support across health and early years for parents from conception to end of child's first year.

Ensuring children are safe at home, school and in the community

- Ofsted Safeguarding and Looked After Children Inspection: all judgements were good or outstanding
- LAC numbers down by 5% over the last 3 years
- LAC outcomes are up at KS2 and KS4 and for attendance
- LAC health assessments; immunisations; dental checks up and above national rates
- Lower rates of child protection plans than London, nationally and statistical neighbours
- Re-offending down but above national rates
- First Time Entrants down but above national rates and higher than YOT Family²
- Serious Youth Violence down by 39% and Knife Crime down by 49% between 2011/12 and 2013/14
- Quality of YOS provision judged as poor through HMIP inspection
- Reduced avoidable delay in care proceedings

² Islington's YOT Family is made up of Lambeth, Southwark, Tower Hamlets & City of London, Camden, Hammersmith and Fulham, Hackney, Haringey, Wandsworth and Lewisham. The YOT Family average includes the Islington rate, whereas Statistical Neighbour averages exclude Islington figures.

Key messages from our needs assessment

Environmental factors

Islington is a borough of stark contrasts, containing pockets of significant wealth and many highly qualified people working in the borough and yet is one of the most deprived local authorities in the country. **Poverty** is widespread, not concentrated in particular parts of the borough. A significant number of children are living in overcrowded housing; workless households; and lone parent households. Poverty is strongly linked to inequalities in health (both physical and mental), educational achievement and the long term wellbeing of children, young people and parents.

Approximately 44% of all school children are eligible for **free school meals** in the borough.

Parental vulnerability factors

A significant number of children, young people and families require support to address a range of issues including **domestic violence, substance misuse, mental ill-health, parental dispute, parenting issues, unemployment, housing issues, and financial concerns, as well as involvement in antisocial behaviour and crime.**

Parents with disabilities, including parents with special educational needs, have additional needs and this can mean increased vulnerability for their children.

Given the background of some of the larger ethnic groups in Islington, there may be a significant number of girls and young women at risk of (or who have already undergone) **Female Genital Mutilation**.

Child/young person vulnerability factors

We have high levels of children and young people identified with **special educational needs and disabilities**.

The number of **young carers** in Islington is higher than the London and England averages and the impact for these individuals can be substantial.

Although the rate of **teenage pregnancy** is falling, the rate is higher than London and England. There needs to be continued focus on outcomes for young parents (mothers and fathers) as well as children of teenage parents.

Young people at risk of, who have been victim to **Child Sexual Exploitation (CSE)**, is a concern in Islington.

Islington has a higher rate of **missing children and young people**, compared to the national average. These young people are known to be at greater risk of CSE.

Despite seeing a year on year reduction in **first time entrants** to the criminal justice system, **repeat offending** is an area of concern in Islington. **Gang activity** is also an area of focus.

Health outcomes

Areas of particular concern for child health are **oral health** (high levels of tooth decay); **obesity** and **mental health**.

Although **emergency admissions for long term health conditions** such as asthma and epilepsy are falling, the rates remain above the London rate. Islington children also tend to stay in hospital longer than the national average.

Educational attainment and employment outcomes

Although the majority of children and young people achieve a high level of **educational attainment**, a proportion of our children do not achieve their potential. Whilst the **attainment gap** between children from low income families and others is relatively small compared with the national position, our aim is to reduce this gap further. This must start early with all children achieving a good level of development at end of early years foundation stage.

There is a strong link between **school absence** and educational attainment, so whilst our attendance rates are improving, this is still an area that needs focus.

The majority of young people remain in education at 16. However, we have a higher proportion of young people 16-18 not in education, employment and training (**NEET**) than the Central London average.

Qualification levels for 19 year olds is an area requiring focus given the growing gap in employment prospects for those with no or little qualifications compared to better qualified members of the population.

The size of our **looked after children** population has remained stable over recent years but the needs of this group are changing, with fewer unaccompanied asylum seekers and more children with complex needs. Outcomes for looked after children are not as good as for their non-looked after peers.

Building on resilience factors and addressing vulnerability factors

Whilst we know from the needs assessment that there are a number of vulnerability factors prevalent in Islington that can have an adverse effect on babies, children and young people, there are a wide range of outcomes that can ensure children and young people are resilient to the impact of vulnerability and risk factors. Over the next ten years the partnership aims to focus on supporting children, young people and parents to build on resilience outcomes as well as reduce risk factors, to ensure all children and young people have the best start in life. We aim to do this by focusing on 3 priorities.

Appendix D provides a more detailed summary needs assessment.

Our Priorities for the 2015-25 Strategy

We are reducing our key priorities from 4 to 3 to reflect our focus on universal, targeted and specialist levels of need and services. In our last strategy, we included a priority to ensure play, youth and leisure opportunities for children and young people. This work has been progressed significantly since the last strategy with the major reviews of adventure play and universal youth provision. The outcomes have been reported to the Children and Families Board and are briefly summarised on page 11. The important continued contribution of play and youth services is built into our three strategic priorities.

In order to continue to improve outcomes for children and young people in Islington supported through an early intervention and prevention approach, we are proposing the following three priorities

Priority 1: Improving outcomes from conception to 19 through good and outstanding universal services

Early intervention and prevention is at the heart of this priority from the earliest years through to adolescence. Through places such as health settings, early years, schools, play and youth services, we help children and young people become resilient by supporting them to develop the foundations, aspiration and social and emotional capabilities that are highly significant for good outcomes. We make safeguarding everyone's business and this helps ensure that children are safe at home, at school and in the community. A healthy start in life and good early child development, healthy lifestyles, academic and social successes, good emotional health and skills to prepare for adult life help children overcome challenges they may face from time to time.

Priority 2: Strengthening our early help support for children and families who have additional needs

Stable families where parents are able to meet their children's needs and provide good care for them are good for children, families and the wider community. Families facing many disadvantages (such as low income, poor health and housing, domestic violence, parental mental and physical ill-health, parental substance misuse) are at greater risk of outcomes such as unemployment, school exclusion, anti-social behaviour and offending, with a large cost to society and a continuing cycle of disadvantage. With high local rates of child poverty; supporting parents and carers into work that means they are better off (both financially and in terms of their broader well-being) is the best route out of poverty. Duplication and lack of co-ordination are a poor use of resources.

We need to further develop our system of early help for families with multiple needs, ensuring access to the right services and support, delivered at the right time, in places where people can use them. Interventions need to be co-ordinated and targeted to ensure they bring about sustainable change, are proportionate to risk and reduce the need for treatment or statutory services. This will help to reduce what we currently spend on specialist services and enable reinvestment into services that prevent problems arising in the first place and get effective help to children, young people and families when problems first arise.

Priority 3: Supporting our most vulnerable children to be safe and thrive and to be able to overcome the challenges they face as they grow up

Where children and young people experience trauma (including abuse and neglect), difficulties or stresses in their lives, we need to ensure that they have the effective support to overcome the odds and go on to achieve successful lives. For some children, particularly disabled children, children with special educational needs, looked after children and children with long-term conditions, we have to work in ways that builds their social and emotional skills, enabling them to better recognise their strengths, build resilience, respond to risks and challenges and take up opportunities that they recognise as important for their long term wellbeing

Related appendices

Appendix A provides a more detailed breakdown of the priorities and actions proposed over the next five years to support the strategy

How will we know whether our Early Intervention and Prevention Strategy is making a difference?

The Children and Families Board will monitor and review the effectiveness of the partnership in engaging with children, young people and families that builds resilience and addresses needs early.

The Board will monitor how well young people's outcomes compare with London averages to ensure our children and young people are doing as well as or better than their peers. The Board will make a concerted effort to drive better outcomes for children and young people who are more vulnerable and will monitor the extent to which we are narrowing the gap between these children and young people and their peers.

The Board will annually update its work programme to ensure it keeps a focus on monitoring what is most important and actively drives the work of all partners in line with the priorities.

NOT OFFICIAL COUNCIL POLICY

Priority 1: Improving outcomes from conception to 19 through good and outstanding universal services

Why is this important?

Early intervention and prevention is at the heart of this priority from the earliest years through to adolescence. Through places such as health settings, early years, schools, play and youth services, we help children and young people become resilient by supporting them to develop the foundations, aspiration and social and emotional capabilities that are highly significant for good outcomes. We make safeguarding everyone's business and this helps ensure that children are safe at home, at school and in the community. A healthy start in life and good early child development, healthy lifestyles, academic and social successes, good emotional health and skills to prepare for adult life help children overcome challenges they may face from time to time.

What will it take to do better through working together?

As a **Champion for children, young people and families**, we will:

- listen to what children, young people and parents tell us is important and using this to inform the way we work
- hold universal services such as health services, Children's Centres, schools, play and youth services to account through challenge where necessary;
- support services to be judged as good or outstanding
- ensure that children achieve their full potential and are ready to move into the world of work.

As a **Catalyst**, we will focus on:

- strengthening the partnership between early years, health, schools and the third sector to drive outcomes for babies and young children and ensuring children are 'school ready'
- working with the Schools Forum, Education Improvement Strategy Group and the Islington Community of Schools to collectively drive and invest in quality and standards and improve outcomes in all schools and early years settings, through a culture of continuous learning and improvement;
- working through the Safeguarding Children Board to ensure that our safeguarding services are co-ordinated and as effective as possible;
- working with the Children's Service Improvement Group to ensure that all health services are working together and with partners to improve health and other outcomes for pregnant women, children and their parents
- strengthening the partnership between the providers of the adventure playground service
- encouraging greater collaboration across the youth sector both through the youth hubs and by organisations partnering to bid for and provide services
- bringing the world of work and learning together as a strong partnership between local employers, training, employment and education services, to enable young people to be ready for future careers
- exploring pathways for learning from the innovation of colleagues to ensure all partners are able to respond quickly to local need and build a community of support for all children and families

As a **Commissioner**, our 2015-19 priority Actions will include:

1. remodelling health services and children's centres to ensure that services for families from conception to a child's first birthday are effective and integrated (First 21 Months initiative);
2. targeted work that promotes access to health care and reduces health inequalities;
3. supporting the provision of health services in universal settings such as early years and schools
4. developing a sustainable model and balanced offer for early years and childcare that makes best use of resources and assets in Islington;
5. maintaining essential early years, pupil and school services in partnership with schools;
6. maintaining 12 adventure playgrounds to enable children's social, emotional and physical development and securing a different service delivery model for council-run adventure playgrounds

7. working closely with schools to ensure the effective use of the pupil premium;
8. commissioning youth work providers to co-produce programmes with young people that focus on young people's social and emotional capabilities;
9. commissioning youth work that maximises the resources available through asset maximisation, entrepreneurial approaches and commercial activity
10. introducing new information technology to better enable universal services to identify and refer children with additional needs
11. ensuring the workforce is suitably skilled to deliver effective interventions

Priority 2: Strengthening our early help support for children and families who have additional needs

Why is this important?

Stable families where parents are able to meet their children's needs and provide good care for them are good for children, families and the wider community. Families facing many disadvantages (such as low income, poor health and housing, domestic violence, parental mental and physical ill-health, parental substance misuse) are at greater risk of outcomes such as unemployment, school exclusion, anti-social behaviour and offending, with a large cost to society and a continuing cycle of disadvantage. With high local rates of child poverty; supporting parents and carers into work that means they are better off (both financially and in terms of their broader well-being) is the best route out of poverty. Duplication and lack of co-ordination are a poor use of resources.

We need to further develop our system of early help for families with multiple needs, ensuring access to the right services and support, delivered at the right time, in places where people can use them. Interventions need to be co-ordinated and targeted to ensure they bring about sustainable change, are proportionate to risk and reduce the need for treatment or statutory services. This will help to reduce what we currently spend on specialist services and enable reinvestment into services that prevent problems arising in the first place and get effective help to children, young people and families when problems first arise.

What will it take to do better through working together?

As a **Champion for children, young people and families**, we will:

- listen to what children, young people and parents tell us is important and using this to inform the way we all work
- challenge services to deliver evidence-based early intervention and prevention, create a stronger evidence base, learn from what works locally and nationally and further develop a learning and improvement culture;
- promote services that focus on the most cost-effective way to prevent or address emerging issues of children, young people or their parents

As a **Catalyst**, we will focus on:

- working with partners to effectively address the needs of families with multiple needs and strengthen our partnership through our Early Help Advisory Group;
- working through the Education Improvement Strategy Group and Schools Forum on how best schools can contribute to this priority, particularly through the effective use of the pupil premium;
- ensuring effective early help services through the stronger families programme and Youth Justice Services Management Board.

As a **Commissioner**, our 2015-19 priority Actions will include:

1. maintaining the Community Budget for Families with Multiple Needs to:
 - enable parents to get pre-employment advice and support to improve the rate of parents in work;
 - enable parents to function without the need for continual support, strengthen their ability to address challenges and achieve greater independence;

- support and challenge the most troubled children and families where there are young people with very complex difficulties, who otherwise may continue to offend or need to be taken into care;
 - integrate the expanded Stronger Families Programme into the community budget model, ensuring we can improve outcomes for younger children, families affected by domestic violence and health problems
2. commissioning re-evaluation of early help and implement the recommendations that will further improve outcomes achieved through early help
 3. commissioning and implementing a new early help client database to give effective and efficient case recording and management oversight
 4. supporting provision of health care in the right place at the right time and empowering children, young people and parents to be more in control of children's health, reducing the need for hospital admission;
 5. ensuring effective integrated working with schools and other universal services through a 'Think Child, Think Parent and Think Family' approach using lead professional, early help assessment and the Team around the School/Team around the Child/Family arrangements, making best use of the Pupil Premium and other school resources.
 6. maintaining a portfolio of effective parenting support programmes and within this, considering the need to improve engagement of fathers and male carers;
 7. exploring the need for more effective programmes to enhance disrupted attachments in very early childhood (0-3years)
 8. reviewing our Family Support and Early Help Strategies;
 9. commissioning a co-ordinated network of providers to provide tailored contraception and sexual health support to avoid the use and costs of traditional sexual health services, unintended pregnancies and sexual health treatment;
 10. providing timely and targeted youth support and implementing our youth justice plan to reduce reoffending, address the factors that contribute to it and also identify and manage the risk of harm to others and vulnerability
 11. remodelling the young people's drug and alcohol service to improve early identification and prevention in universal and targeted services
 12. maintain and strengthen early help parental substance misuse services
 13. complete the development of a Parental Mental Health Service that delivers a coordinated offer of support and intervention across CAMHS, Adult Mental Health Services and Children's Centres, promoting resilience in users and the wider family
 14. ensuring the workforce is suitably skilled to deliver effective interventions

Priority 3: Supporting our most vulnerable children and young people to be safe and thrive and to be able to overcome the challenges they face as they grow up

Why is this important?

Where children and young people experience trauma (including abuse and neglect), difficulties or stresses in their lives, we need to ensure that they have the effective support to overcome the odds and go on to achieve successful lives. For some children, particularly disabled children, children with Special Educational Needs, looked after children and children with long-term conditions, we have to work in ways that builds their social and emotional skills, enabling them to better recognise their strengths build resilience, respond to risks and challenges and take up opportunities that they recognise as important for their long term wellbeing

What will it take to do better through working together?

As a **Champion for children, young people and families**, we will:

- listen to what children, young people and parents tell us is important and using this to inform the way we all work
- ensure children are protected from significant harm and diverted from offending, gang violence and child sexual exploitation (CSE)

- ensure children overcome difficult and harmful childhood experiences
- ensure that all children looked after by the Council have the lives we want for our own children
- find permanent families for children who cannot live at home
- recognise children with long term conditions as vulnerable

As a **Catalyst**, we will focus on:

- Supporting the Islington Safeguarding Children Board and implementing strong quality assurance and workforce development systems to ensure that our safeguarding arrangements for children at risk are as effective as possible;
- Multi agency working and sharing of intelligence to ensure a better understanding of the prevalence and impact of radicalization, and the conditions that make radicalization possible;
- ensuring strong commitment of the local authority as corporate parent, and an integrated approach to planning and delivering services through the Corporate Parenting Board to ensure the best possible outcomes for Looked After Children;
- working through the Disability Strategy Board to ensure that the SEND reforms make a positive impact on the health and wellbeing of children and young people with disabilities and their families
- working through the Youth Justice Services Management Board with relevant agencies and services to ensure that offenders have effective support to reduce re-offending and improve their health, education, training and employment outcomes;

As a **Commissioner** our 2015-19 priority Actions will include:

1. implementing the education, health and care plan to support children with special educational needs and disability and their families in a more integrated and effective way
2. reviewing our commissioning arrangements through the North London Efficiency programme and Adoption and Fostering Consortium, to stimulate efficient and effective support for children looked after by the Council
3. reshaping services for children with complex health needs, mental health needs and disability in order to ensure a seamless transition from children's to adult's services
4. ensuring that our core business is protecting children in the community and those who are looked after and makes a real difference to children's lives
5. multi-agency working and sharing of intelligence to ensure children at risk of sexual abuse, including CSE and/or gang involvement are supported and protected
6. working with the courts, ensuring permanency is achieved within a timescale that meets the child's needs
7. ensuring the workforce is suitably skilled to deliver effective interventions

Early Intervention and Early Help

Being an Early Intervention and Prevention Place demonstrates the contribution all partners make to shift from reactive spending towards early action that can result in building resilience, better outcomes and value for money.

Early intervention and prevention: Building resilience in individuals, families and communities so that they become more self-sustaining, protect children from harm provide stable and thriving environments resulting in less reliance on public services. There is a focus, however, on those that need direction and support and we, as an area, get in early and nip problems in the bud. Where this is not possible, we make early and authoritative decisions about permanent family based care.

Minimising risk of problems arising: The foundations for achieving the necessary outcomes and resilience at each life development stage such as good health, academic achievement and social and emotional capabilities. These tend to be the core business of universal services such as early years, health services, schools, play and youth services.

Key strategies: Children's Health Strategy; Child Poverty Strategy; Islington Safeguarding Children Plan

Early Help and Early Help Offer: our interventions, portfolio of evidence-based programmes, multi-agency systems and workforce to get in early and nip problems in the bud that keep children safe, supported and reduce the need for statutory services.

Key strategies: Early Help for Islington Families Strategy; Children's Health Strategy; Parenting and Family Support Strategy.

Ensuring children with needs or problems that are serious or will endure can still survive and thrive: interventions to help individuals or families to treat, cope with or avoid the damaging consequences of problems or issues. These tend to be the core business of specialist intervention or statutory services such as children's social care or in-patient health care.

Key strategies: CAMHS; Corporate Parenting Plan; Islington Safeguarding Children Board (ISCB) Plan

Strategic Priorities – relevant extracts

The Children and Families Strategy is closely aligned with key strategic priorities across the Council and the key partnership boards.

Islington Commitment

- Making Islington a place where people and families can thrive by
 - Doing everything we can to protect children from harm
 - Helping children and young people to grow up in stable environments where they are supported to reach their potential
 - Ensuring even the most vulnerable people can enjoy the borough and live happy, fulfilling lives
 - Supporting people to live healthy lives

Islington's Child Poverty Strategy

- Early intervention
- Improve life chances for children
- Sustainable employment for families
- Financial resilience

Islington's Child Health Strategy (LBI and CCG)

- Best start in life, prevention and early intervention
- Health services are high quality, cost-effective, clinically safe and deliver a positive experience of care
- All health services and partners working together to deliver care coordinated around the child or young person and the family for the:
 - acutely unwell child
 - those with long term conditions
 - those with mental health and emotional needs
 - those with special educational needs and/or disabilities

Health and Wellbeing Board strategic priorities

- Best start in life
- Improve mental health and wellbeing
- Preventing and managing long term conditions to extend both the length of life and quality of life and reduce health inequalities

Safer Islington Partnership Strategic Assessment

- Early intervention
- Violence against Women and Girls
- Tackling Gangs and Serious Youth Violence Strategy
 - Prevention and early intervention
 - Engagement and protection of young people at risk

Islington Safeguarding Children Board Plan

- Support the development of early intervention and oversee the review of its effectiveness
- Joint work with Adult services focusing on parents with learning difficulties and transition to adulthood
- Core business (child protection) focusing on domestic violence and neglect

Needs Assessment Summary

This summary provides key data and information about Islington's children, young people and families that has informed our Children and Families Strategy. More detailed needs assessment information on each of the below topics can be found in the Joint Strategic Needs Assessment (JSNA) on the Evidence Hub.

<http://evidencehub.islington.gov.uk/yourarea/jsna/Pages/default.aspx>

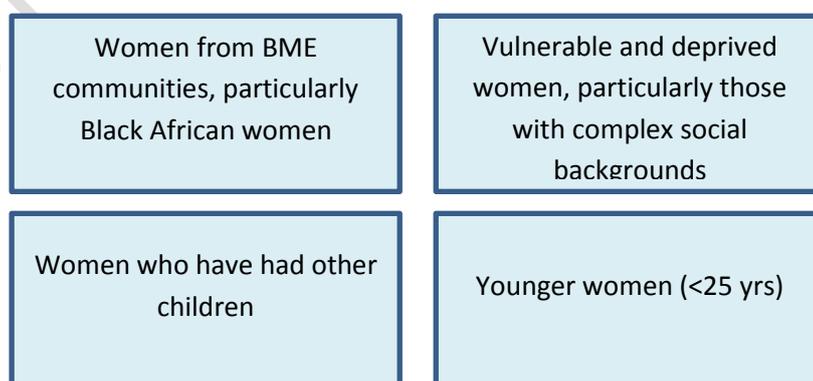
1. Local context

- Population size of 220,100. Islington is a small densely populated borough.
 - 2nd smallest borough in London in terms of geographical area
 - Highest population density in the country
- 14th most deprived local authority in country (2010 IMD - Index of Multiple Deprivation)
- 2nd most deprived based on IDACI (Income Deprivation Affecting Children Index)
 - Approximately 35% of children living in low income families
 - Almost 1/3 children in Islington live in a household where no one is working
 - 60% of families with dependent children live in social housing, compared to 20% nationally.
 - Most housing is in flats with no outdoor space; the borough has only 12% of its land designated to green space, significantly lower than the London average of 38%
 - 11% of households live in overcrowding (similar to London average)
 - Almost 30% of children and young people live in lone parent households – higher than national average.
- Approximately 43,500 0-19 yr olds living in 21,000 households.
- 66% of children and young people are from BME backgrounds, with a significant proportion with English not as their first language.

2. Early access to maternity services

The early stages of pregnancy are a key time in a baby's development and a mother's health. All women are encouraged to contact maternity services as soon as they are pregnant and especially before the 13th week (third month) of pregnancy. For the first quarter in 2013/14, 79% of women who gave birth in Islington were booked into maternity services before the 13th week. The average for 2012/13 (Q1-Q3. Q4 data not available) was 88%. This is below the target of 90%. Based on these figures, another 350-630 women would need to be booked into maternity services before the 13th week to meet the target.

Groups less likely to access maternity services before 13 weeks of pregnancy are:



3. Infant mortality (death of a baby before his/her first birthday, excluding still births)

- Islington's infant mortality rate is below comparators. However, infant mortality continues to be prioritised because of the link to deprivation.

4. A&E attendance

The rate of A&E attendance is highest for under 1s but is also high for under 4s. This is similar to other parts of London and higher than the national average. Approximately 25% of these attendances are avoidable, i.e. children do not require any treatment at A&E.

5. Breastfeeding

There is evidence that babies who are breastfed experience lower levels of gastro-intestinal and respiratory infection. Observational studies have shown that breastfeeding is associated with lower levels of child obesity and diabetes.

- In Islington breastfeeding initiation in 2012/13 (89.5%) is higher than those for London (87%) and England (74%) and are also higher than most boroughs with similar levels of deprivation (2012/13)
- Prevalence of breastfeeding at 6-8 weeks (2012/13) is 75%, higher than greater London (70%) and England (47%).

Islington's breastfeeding rates are likely to be high because of the local demographic profile; with more women from ethnic minority groups who are more likely to initiate and continue with breastfeeding.

Research shows that ethnicity, social background and education are identified in patterns in which women are less likely to initiate and continue to breast feed. Younger women are also known to be more likely to give their babies formula milk rather than breast feed.

6. Immunisations

Immunisation take up has been increasing and very few children are now not fully immunised. This is higher than London and similar to England.

7. Oral health

Oral health contributes to general wellbeing and allows people to eat, speak and socialise without discomfort and embarrassment. Severe tooth decay in children can cause pain, disfigurement, infections, sleep deprivation, school absence and reduced nutritional intake and growth. Psychological impacts are significant too, including impact on self-esteem and confidence.

- Levels of oral disease in Islington children are relatively high with around 30% of 5 year olds suffering from tooth decay

8. Childhood weight and obesity

Child obesity has strong impacts on physical and mental health and emotional wellbeing.

- 36% of 10 year olds are overweight or obese (2012/13) and this is higher than the national rate
- Overweight children are twice as likely to become overweight adults compared to healthy weight children.
- The annual cost in Islington of treating diseases relating to overweight and obesity (across both children and adults) was estimated at £68.8 million in 2007, increasing to £73.6 million in 2015.

Overweight and obesity varies by gender, age, ethnicity and socio-economic factors.

9. Education

Children's education plays an important role in social mobility, health and wellbeing.

- 57.8% of children are achieving a good level of development (GLD) at EYFS
- 82% of children achieved level 4+ in Reading, Writing and Maths at end of primary school in 2014 and the % who achieved the expected progress between Key Stage 1 and Key Stage 2 was above comparators.
- 63.5% pupils achieved 5 GCSEs A*-C inc English and Maths in 2013 – above 2013 national and at Inner London averages.
- Qualification levels of 19 yr olds in 2013 slowly improving but significantly below the London and national average.
- Islington has seen an improvement in attendance. However, more progress needs to be made in this area.
- Children with high absence rates achieve substantially less well than their peers.
- The attainment gap between Free School Meal (FSM) eligible pupils and the rest is relatively small compared with the national position. However, our aim is to reduce this gap further.
- Achievement in EYFS was higher for White British group than Black or Minority Ethnic (BME) group in 2013. However, White British attainment was lower at GCSE.

10. Unemployment and NEETS

- 14th most deprived borough. However, at the same time, Islington has a much higher % of people employed in high-level managerial or professional jobs (43%) than London (34%) and England (28%)
- Highly qualified people (43% of Islington working age people have degrees) also constitute an increasingly high % of the employed population (75%) (ONS 2011 Census), up by about 23% in the last 10 years, compared with 58% in London and 41% in England
- Employment prospects for those with no or lower level qualifications seem to be getting worse – this group (25% of the population) represents an increasingly small % of those employed. This pattern is consistent with London and England
- Approximately 8% (about 12,500 people) of the working age population is claiming sickness benefits – a higher % than in any other London borough (DWP, Feb 2014)
- Over 50% of Islington's sickness benefit claimants are claiming due to mental health problems
- Employment rate is around 20-22% for people with long term health problems or disabilities, compared with 69-71% for those without.
- The Islington BME employment rate is consistently lower than that for the white population (ONS APS to December 2013).

Parents

- 29% of families with child dependents are workless. This is the highest % in London
- Parents face challenges to moving into work (eg. high childcare costs, lack of skills or work experience).

- 41% of households with dependent children in Islington are lone parents. Over half of these are out of work (2011 Census).
- 59% parents claiming out-of-work benefits have been doing so for over two years and 32% have been claiming for more than five (DWP, November 2013).

NEET 16-24 year olds

- 260 young people (5%) aged 16-18 in Islington Not in Education, Employment or Training (NEET), higher than the Central London average (3.7%)
- Almost all 16 year olds are in learning; engagement begins to fall at 17 and drops further by 18
- 1,010 young people aged 18-24 (4%) claiming Job Seekers Allowance (May 2014 DWP figures).

11. Vulnerability factors – parent; child/young person; environmental

11.1 Parental Vulnerability Factors

11.1.1 Domestic violence

Prevalence

- 3,806 incidents of domestic violence were reported to police in 2012/13, compared with 3,954 in the previous year. There were 1,571 offences of domestic violence (i.e. where the police found a crime had been committed).
- Islington has the second highest rate of reported domestic violence offences in North London. This can be an indication of higher violence and/or greater confidence in reporting to the police.
- 973 children were involved in an assessment where domestic violence was identified (including domestic violence involving parent, child or other)
 - 867 identified the parent being at risk
 - 348 identified the child being at risk
 - 156 where other members of the household were at risk
- 85% of perpetrators in Islington are men
- 1,700 children were affected by domestic violence in 2013/14 (referrals to children's social care)
- Over the last 3 years, there have been on average 230 children each year in households that have been discussed at Multi-Agency Risk Assessment Conferences (MARACs)³

Impact

As some domestic violence goes unreported, it is difficult to precisely judge the prevalence of domestic violence in Islington, or how many children are affected by the issue. Although domestic violence is present in a high proportion of referrals to both specialist and targeted services, we can assume that the true number of families affected is likely to be higher.

The physical, psychological and emotional effects of domestic violence on children can be severe and long-lasting. Witnessing domestic violence and abuse between parents irrespective of whether it results in direct physical harm to the child can have similar long term consequences for a child to physical abuse that is targeted at the child. A growing body of literature shows that children who have been exposed to domestic violence are more likely than their peers to experience a wide range of difficulties: Behavioural, social and emotional problems (i.e. become aggressive and antisocial/depressed and anxious); cognitive and attitudinal problems (i.e. Slower cognitive development and find it hard to concentrate in school) and long

³ MARACs are regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies.

terms problems (i.e. More likely to become perpetrators (males) and victims (females) of domestic violence as adults).

There are a number of factors that may contribute to increases in future need:

- Welfare reform, unemployment and recession- Economic recession and high levels of unemployment may increase financial stress in relationships. Victims may feel unable to leave a partner on whom they are financially reliant.
- More victims may stay with the perpetrator because legal aid will not be routinely available in separation, divorce and child contact cases, or for non-British victims not on a spousal visa.

At risk groups include:

Women – nationally 80% of domestic abuse victims and similar in Islington

Transgender people – Up to 80% have experienced abuse in relationships

BME groups – populations from certain cultural backgrounds may be at risk of Female Genital Mutilation (FGM) or ‘honour’ based violence

11.1.2 Parental Alcohol and substance Misuse

Prevalence - parents

There were 234 Islington adults who were receiving alcohol treatment in 2012/13 who were living with children, compared to 320 assessments by Islington Children’s Services where parental alcohol abuse was recorded.

Given the high level of substance misuse in Islington, it is likely to be that there are sizeable numbers of children living in households where this is a problem.

- 319 young people with at least one contact for parental substance misuse in 2013/14
- 727 assessments were conducted where substance misuse was identified. Of these:
 - 354 were for parental drug misuse
 - 110 were for another member of the household’s drug misuse
 - 367 were for parental alcohol abuse
 - 70 were for another member of the household’s alcohol abuse

Impact

The misuse of drugs and/or alcohol may adversely affect the ability of parents to attend to the emotional, physical and developmental needs of their children in both the short and long term (Social Care Institute for Excellence, 2005). The lifestyle of families with a substance-misusing parent can also be associated with a lack of routine, as well as social isolation.

Physical Impact	Psychological Impact	Socioeconomical Impact
<ul style="list-style-type: none"> • Maternal substance abuse: exposure to harmful chemicals and infection • Unmet basic needs (eg. food, hygiene, safety) • Lack of care and supervision: elevated risk of physical harm (eg. accident, fire) • Physical abuse • Induced substance misuse 	<ul style="list-style-type: none"> • Loss of attachment with the parent • Verbal abuse • Feeling insecure and anxious (eg. fears about discovery, being taken away or a parent dying; unpredictable behaviour of the parent) • Family break-up 	<ul style="list-style-type: none"> • Reversal of roles • Difficulties at school (eg. bullying, problems with concentration) • Financial burden (eg. unemployment, money to pay for drugs, substantial debts) • Social stigma/isolation, damaged social skills

11.1.3 Parental Mental health

Mental health conditions are common, affecting at least one in four people at some point in their life and one in six adults at any one time.

Mental health conditions account for the single largest source of disability and ill health in the UK.

Prevalence - parents

Islington has a significantly higher level of mental ill-health need than London or England. 15% of adults are experiencing depression or anxiety disorders in any week.

Applying the prevalence of parental mental health problems found in a high quality, large national survey of children aged five to 16, to the Islington population would suggest there could be as many as 6,000 children aged 5 to 16 in Islington whose mothers who would be classed as at risk for common mental health problems. Given that Islington has a relatively high proportion of lone parent families (just below 30% of children live in lone parent families), this may be an underestimate.

- 475 young people had at least one contact for parental mental health in 2013/14

Of all the assessments carried out by Children's Social Care in 2013/14:

- 872 children had an assessment where mental health concerns were identified. Of these,
 - 700 (27.7%) involved a concern about parental mental health
 - 101 involved a concern about another member of household's mental health

Impact

Children of patients with severe and enduring mental illness can experience greater levels of emotional, psychological and behavioural problems than their peers.

The National Child Development Study (NCDS), a national longitudinal study continuing since 1958, suggests that mental health problems in childhood can have an impact in adult life, including qualifications and employment, relationships and family formation, health and disability.

It is anticipated that the levels of mental ill-health will increase over the coming years as the current climate of long term austerity causes more financial hardship, unemployment and fears of destitution.

Self-harm has a number of physical and psychological effects. While the physical effects of self-injury might be obvious and harmful, the psychological effects of self-mutilation are no less damaging

Physical

- Wounds or scars
- Infection
- Nerve damage
- Broken bones
- Hair loss or bald spots
- Injury caused by overdose or poisoning

Psychological

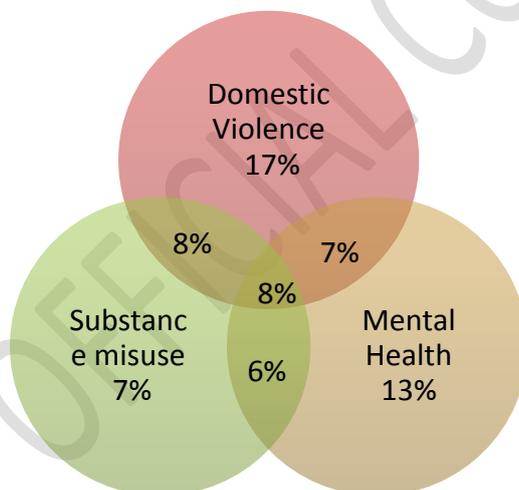
- Irritability
- Loneliness.
- Shame and guilt
- Stress and difficulty of lying to others / concealing about the self-injury
- Low self-esteem and self-hatred
- Depression
- Lack of control of self-harming behaviour

11.1.4 Key Parental Factors

The issues of domestic violence, parental mental ill-health and substance misuse have been identified as the most common features of families where harm to women and children has occurred.

Although a single issue such as mental illness may not detrimentally affect parenting capacity, there is considerable evidence that many parents also experience other difficulties (Cleaver and Walker with Meadows 2004; Velleman and Reuber 2007). It is the cumulative impact of combinations of factors that have been found to increase the risk of harm to children.

Intersection of key factors in Islington children's social care assessments, 2013/14



- 2/3 of assessments identified at least one of these three factors.
- 219 assessments identified concerns about all three factors
- 205 children (8%) were identified in assessments as being affected by all three factors.

11.1.5 Neglect

Prevalence

This is our biggest concern in Islington and is often affected by the three parental key factors, as listed above.

Of the assessments carried out by Children's Social Care in 2013/14:

- 47.5% of children (85) subject to child protection plans in 2013/14 were due to concerns regarding neglect.
- 763 young people with at least one contact to children's social care involved concerns about neglect (2013/14). Some had 2 or 3 contacts during the 12 month period.

Impact

Neglect has far reaching consequences and can affect all aspects of a child's development. It can have negative, long-term effects on mental and physical development. It can affect children's behaviour, educational achievement and emotional wellbeing.

Poor nutrition, poor hygiene and a lack of parental supervision can result in faltering growth, the development of medical conditions or the exacerbation of existing medical conditions.

Neglect can have dramatic effects on children's mental health. The emotional impact of neglect can lead to young people committing anti-social behaviour, self-harm and suicide. Some young people may seek care and affection from other people, which can put them at increased risk of sexual abuse and exploitation.

11.1.6 Family Stability

Prevalence

Although the proportion of children living in lone parent families across the country is around a quarter, this is a snapshot of all children at a single point in time. Looking to the future, 48% of all children born today will not be living with both natural parents by the time of their sixteenth birthday (Benson, 2010). This is not just about couples who divorce – unmarried families account for 80% of all break-ups.

In Islington, just under 30% of children were living in households headed by a lone parent (ACYPP Profile 2013). On average, around three thousand children are born to Islington parents each year. The research suggests that around over 1,400 of these children will not be living with both of their natural parents by the time they are 16.

Excluding information requests, parental disputes were the third most common reason for a contact to Islington children's social care in 2013/14, with 781 contacts for 686 different children and young people.

Impact

Children with separated, single or step-parents are 50% more likely to fail at school, have low self-esteem, struggle to make friends and with their behaviour. They often battle with anxiety or depression throughout the rest of their lives. Children who experience family breakdown tend to leave school and home earlier and report higher levels of smoking, drinking and other drug use during adolescence and adulthood (Centre for Social Justice, 2013).

Family breakdown is a key driver of poverty, especially for women, and half of all single parents are living in poverty (Jenkins, 2008). However, financial pressures can put additional stress on relationships and increase conflict, so family breakdown can be both a driver and an effect of poverty.

11.1.7 Parental Offending

Prevalence

Criminal parents are among the strongest family factors predicting offending (Farrington, 2011).

In Islington, 1,600 children and young people were living in a household where offending occurred (2012/13). This may not include families where there is a young offender, although offences may relate to older siblings who live at the household, rather than parents.

In 2013/14 there were 343 young people with at least one contact relating to parental offending.

Impact

Children of prisoners have three times the risk of antisocial/ delinquent behaviour compared to their peers (Murray and Farrington, 2008). 65% of boys with a convicted parent go on to offend compared with 22% of boys whose parents are not offenders (Farrington and Coid, 2003).

However, whilst there is a strong correlation, poorer outcomes are not proven to be caused by parental imprisonment (Ministry of Justice and Department of Children, Schools and Families, 2007).

Children of prisoners face barriers to educational attainment. Inflexible visiting times and long-distance placements mean that parents often have to take children out of school to visit their incarcerated parent. Emotional damage, separation, stigma and feelings of shame also impact on educational attainment. Research has also found bullying of offenders' children is common and this can lead to a child behaving antisocially or playing truant from school (Loucks, 2004).

Children of offenders are a hidden population and therefore it can be difficult to get services to them.

11.1.8 Parents with Learning Difficulties and Disabilities

Prevalence

Islington Housing and Adult Social Services hold a register of adults with global learning disabilities (around 750 at the time of writing). However, details on whether each adult is a parent are not recorded consistently enough to provide a valid estimate of prevalence.

In Islington's GP registered population there are 710 adults recorded as having a learning disability. Applying the 7% estimate obtained nationally, we can estimate that in Islington there are 50 parents with learning disabilities. It must be noted that there is a wider group of parents with learning disabilities whose needs fall below the threshold for support services.

There were 91 children had assessments by Islington children's social care in 2013/14 where parental learning disability or difficulty was identified as a key factor, much higher than would be expected from the national estimates.

Impact

People with learning disabilities are more likely to have other disabilities or certain other health problems, including mental health problems (Royal College of Psychiatrists 2008).

Children born to parents with a learning disability are at increased risk of inherited learning disabilities and psychological and physical disorders. Children of parents with learning difficulties may suffer neglect as a result of a lack of parenting capacity combined with a lack of support (McGaw and Newman 2005). It is recognised that parents with learning difficulties and disabilities are more likely to require financial, practical and social support.

11.1.9 Female Genital Mutilation and harmful traditional practices

Prevalence

The report *Female Genital Mutilation (FGM) in Islington: A Statistical Study* (2012) suggests given the background of some of the larger ethnic groups there may be a significant number of girls aged 0 – 18 at risk of (or who may have already undergone) FGM.

Impact

There are a number of possible immediate and longer term physical health implications of FGM as well as psychological/psychosexual implications (i.e. depression, anxiety, substance misuse and / or self-harm).

11.2 Child / Young Person's Vulnerability Factors

11.2.1 Young carers

Prevalence

- According to the 2011 Census, in Islington, 3.2% of young people (1,800 people under the age of 25, an increase from 1,515 identified in the 2001 Census) were providing some level of unpaid care to another person. A number of studies suggest this could be an underestimate, particularly in terms of young carers from Asian communities, due to a range of cultural and language barriers.
- The proportion of young people providing unpaid care in Islington is higher than the averages for London and England where 2.7% and 2.5% of young people respectively provide care.
- 30% of young carers provide 20 or more hours of care per week and a significant minority over 50 hours.
- There were 100 children in need assessments completed in 2013/14 where the fact that the child / young person had caring responsibilities was highlighted as a key factor.

Impact

Factors affecting young carers (according to Islington Young Carer's Strategy 2012-15):

- Adult mental health
- Substance misuse
- Disabilities
- Limiting lifelong illness

Young carers are affected by:

- stress, anxiety and feelings of guilt, interrupted sleep and physical injury
- performing 'adult' tasks; exposure to significant physical and/or emotional changes; transition into adulthood
- missing school, falling behind with work, feel unable to confide in teachers. Some young carers report feeling isolated from their peers and being bullied. National research suggests that 27% of young carers (aged 11–15) miss school or experience educational difficulties and 68% of young carers are bullied and feel isolated in school.
- putting other people first and can feel undervalued.
- lack a working parent and home finances may well be affected by disability. Reliance on young carers often continues into adulthood and may restrict choices as an adult.

11.2.2 Sexually transmitted infections

There were almost 1,300 diagnoses of acute sexually transmitted infections in Islington among 15 to 24 year olds in 2012, equivalent to a rate of 43 per 1,000 population. This is higher than the England average (34 per 1,000).

11.2.3 Teenage pregnancies

Prevalence

- The teenage pregnancy rate in Islington has fallen almost half from the 1998 baseline of 58.3 conceptions per 1000 girls aged 15-17 to 30.1 in 2012.
- This is higher than the London rate of 26 and England rate of 28.
- There are 92 conceptions per year to women aged under 18 (2010-12).
- 67% of conceptions were terminated which is higher than the London and England average.
- Majority of conceptions under the age of 18 are unintended and in Islington almost two-thirds lead to an abortion.
- The gap between Islington and the England and London rates has narrowed over time.
- There were 19 live births to Islington mothers aged under 18 in each of the last 3 years reported, with a rate which is below comparators.

Looked after children becoming teenage parents

Children who have been in care are almost 2.5 times more likely to become teenage parents (SCIE, 2004).

There are some risk factors that make looked after children more vulnerable to teenage pregnancy (Haydon, 2003), which include:

- Social exclusion and early sexual experiences: low levels of self-esteem and their desire to be included in peer groups making them more likely to conform with pressure to engage in early or unwanted sexual activity; sex perceived as a way of receiving love and affection
- Personal experience of abuse: distorted understanding about sex, sexuality and interpersonal relationships
- Pregnancy as a positive choice: parenthood as an alternative way to demonstrate their maturity and worth; stability and a sense of purpose or direction in their lives

Impact

Being a young parent in an area of deprivation can increase the risks and disadvantage for parents and children including:

- 25% higher low birth weight
- 60% higher infant mortality rate
- 3 times higher rate of post-natal depression
- By age 30, 22% more likely to be living in poverty than mothers giving birth aged 24 or over.
- Young fathers twice as likely to be unemployed at age 30 – even after taking account of deprivation
- 11% of NEET young people are teenage mothers or expectant mother.

Evidence shows that young people who experience high levels of disadvantage and vulnerability are at increased risk of becoming pregnant at a young age, perpetuating the cycle of deprivation.

11.2.4 Mental Health

Prevalence

- There are estimated to be over 3,000 Islington children aged 5 to 17 with a mental health disorder.
- The proportion of boys aged 5 to 17 diagnosed with a mental disorder (14%) was twice the proportion of girls (7%). It is estimated there will be 430 more children in Islington with mental health problems by 2021.
- 222 young people had at least one contact for child's mental health in 2013/14

Rates of mental health problems among children increase as they reach adolescence.

Mental health problems were most prevalent in children with a Black origin (14.5%), compared to those with White (13%) and Other (12%) ethnic origins, and least prevalent in Asian children (9%). The majority of children aged 5 to 17 with a mental health disorder are from a White ethnic group (largest population group).

Self-harm

In 2013/14, there were 133 children's social care assessments where suspected or actual self-harm was flagged as a key factor.

The Islington rate for hospital admissions due to self-harm amongst 10 to 24 years olds has been below the England rate, but above the London and Statistical Neighbour averages, 3-year average. These rates reflect an average of around 100 hospital admissions each year.

Impact

The emotional well-being of children is just as important as their physical health. Good mental health allows children and young people to develop resilience to cope with problems they may face as they grow up. The National Child Development Study (NCDS), a national longitudinal study continuing since 1958, suggests that mental health problems in childhood can have an impact in adult life, including qualifications and employment, relationships and family formation, health and disability.

Self-harm has a number of physical and psychological effects. While the physical effects of self-injury might be obvious and harmful, the psychological effects of self-mutilation are no less damaging

11.2.5 Children with long term conditions

Prevalence

The rate of emergency admissions for asthma, diabetes and epilepsy amongst under 19s for Islington registered patients fell from 675.0 per 100,000 in 2011/12 to 313.0 per 100,000 in 2012/13. The data for the 2013 calendar year shows that the rate has continued to fall. The Islington rate is now below the England rate, although it remains above the London rate.

Around two thirds of these admissions each year relate to asthma, and the rate of emergency admissions due to asthma is higher for Islington than for London or England. Although the rates for diabetes and epilepsy are lower, Islington children tend to stay in hospital longer than the national average when they are admitted in an emergency for these conditions.

Risk factors for asthma:

- Family history of asthma
- Nasal allergies, hayfever or eczema
- Exposure to tobacco smoke before or after birth
- Prematurity
- Early viral respiratory infections
- More males suffer from asthma than females

- Poor air quality
- obesity

Impact

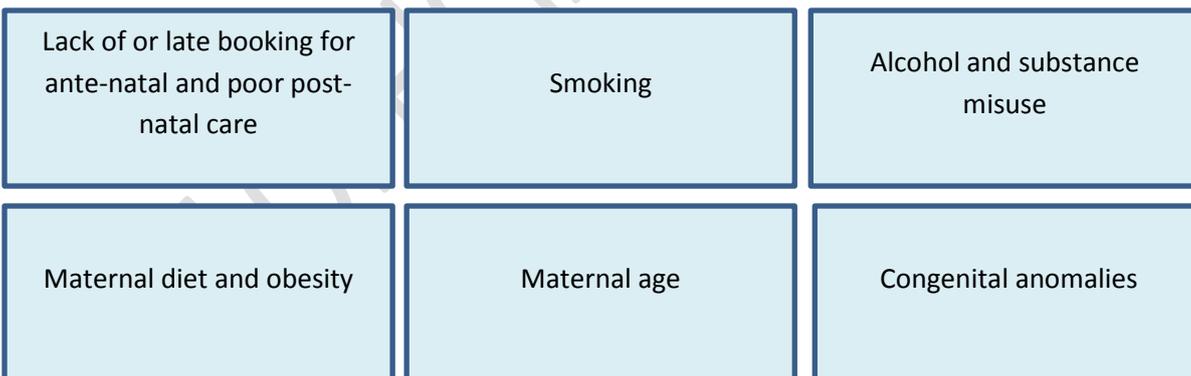
As well as the ongoing health risks due to these long term conditions, there are other effects on children and their families. Children and young people who have a long term condition are at risk of missing out on educational opportunities due to prolonged absences from school, either as a result of ill health or because of frequent attendance at clinics and hospitals

11.2.6 Children with Special Educational Needs and Disabilities (SEND)

Prevalence

- 24.5% of Islington school pupils have some form of Special Educational Needs, significantly above London and England (19%)
- Approximately 2500 (6%) disabled children in Islington in 2014
- Nationally evidence shows people with learning disabilities experience poorer health than non-disabled peers and have a higher risk of experiencing multiple comorbidities (additional condition occurring with a primary condition) including psychiatric disorders, and epilepsy
- Autistic Spectrum Disorder was the most prevalent need in 2013, followed by Speech, Language and Communication Needs and Moderate Learning Disabilities.
- Islington has a higher proportion of CIN with disability than statistical neighbours but similar to London average and lower than England average.
- In January 2014, around 5,800 children and young people aged under 19 in Islington had a Statement (843) or an additional educational need without a statement (5,080).
- There has been a slight rise in the number of children and young people with a statement over the past 5 years, equating to an average of 19 additional statements each year. However, there has been a slight decrease in the % of the total school roll compared to January 2013.
- About 75% of Islington pupils with statements are boys, similar to national picture.

Health determinants of SEN and disabilities include:



Impact

Pupils with SEND face barriers that make it harder for them to learn than other 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 and economic opportunities and transition to adulthood.

52% of child/children with a disability are living on low incomes, compared to the proportion in the whole population (39%).

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 SEND system from birth to 25, giving children and young people with complex needs and their parents, greater control in ensuring that their needs are properly met.

11.2.7 Children with life-limiting conditions

Prevalence

In 2009/10 there were 147 cases of children with life limiting conditions. This was broadly in line with the London average of 34.9, but above the England average of 32.2.

The prevalence of life limiting conditions was associated with higher levels of deprivation and strong association with ethnicity: South Asian, Black, and Chinese, Mixed & 'Other' populations were statistically significantly higher compared to the White population.

11.2.8 Alcohol and substance misuse

Prevalence

Limited information is available on the usage of alcohol by children. The Islington hospital admission rate for under-18s with alcohol specific conditions has fallen in recent years, and has decreased at a faster rate than the London and England averages.

- Estimated prevalence based on national rates of drug use would indicate about 1400 children are affected.
- 131 young people with at least one contact relating to the child's substance misuse in 2013/14

Of all the assessments carried out by Children's Social Care in 2013/14:

- 4.2% (114) involved a concern about alcohol abuse by the child
- 2.3% (61) involved a concern about drug misuse by the child
- 727 assessments were conducted where substance misuse was identified. Of these:
 - 110 were for child's drug misuse
 - 59 were for child's alcohol abuse

Impact

Young people who persistently abuse substances often experience an array of problems, including educational difficulties, health-related problems (including mental health), poor peer relationships, and involvement with the youth justice system.

11.2.9 Offending

Prevalence

- Islington has seen a year on year reduction in first time entrants to the youth justice system with an overall decrease of 69% in the rate of first time entrants since the baseline year of 2007, but the rate in other local authorities has reduced faster.
- The reoffending rate, based on offences on the Police National Computer, for Islington offenders has been higher than the rate for any of the borough's comparators throughout the last 4 years.

- Islington's Youth Offending Team (YOT) worked with 285 young offenders during 2013/14.
- 13% of Islington's offending population over the last 3 years (2011/12 to 2013/14) have been female. This is slightly lower than the London (15%) and England (19%) averages.
- Based on a data matching exercise in October 2014 there were 312 households with someone accused of a youth offence between August 2013 to August 2014. There were 673 siblings living within these households. (Please note this figure does not include families with young people who were no longer living in the borough eg. they were in custody)

Gang activity

There have been reductions in Serious Youth Violence, Knife and Gun Crime since 2011, which has been attributed to the targeted enforcement, prevention and engagement work that has significantly disrupted what were three of the main gangs in Islington.

In 2013/14, there were 594 contacts to Islington children's social care due to the child's criminal behaviour. There were 113 assessments completed where the child may have been at risk of harm because of involvement with gangs.

Impact

There is considerable overlap between the risk factors for youth offending and substance misuse, and also with the risk factors associated with educational underachievement, young parenthood, and adolescent mental health problems. Action taken to address these risk factors therefore helps to prevent a wide range of negative outcomes.

Educational attainment:

Being in education, employment or training (EET) is one of the most significant protective factors in reducing the risk of reoffending. The proportion of young people supervised by Islington YOT who are engaged in EET has increased in the last two financial years and is above the rates for the borough's comparator group.

Accommodation

A higher proportion of young offenders in Islington (99%) are in suitable accommodation at the time their disposal is closed, compared to the borough's comparators. The proportion of Islington young offenders in suitable accommodation has increased in each of the last two years, whilst nationally, and across London as a whole, the proportion has been falling.

11.2.10 Children missing from home or care

A child is defined as missing from home/care 'if their whereabouts are unknown, whatever the circumstances of their disappearance' (Pan London Child Protection Procedures 2014).

In 2013/14,

- 27 children and young people went missing from care
- 35 children went missing from home (of which 63% were females)
- It is thought that around a quarter of children and young people that go missing are at risk of serious harm, with particular concerns around risk of sexual exploitation.

11.2.11 Children missing from education

In Islington a child is deemed missing from education when 'a child of compulsory school age, who are not on a school roll, nor being educated otherwise (e.g. privately or in alternative provision) and who have been out of any educational provision for a substantial period of time (usually agreed as four weeks or more) and who is not receiving a suitable education' (Department for Education).

- In the 2013/14 academic year, there was an average of 3 cases of Children Missing Education (CME) each month.
- CME are at significant risk of underachieving, being victims of abuse, and becoming NEET (not in education, employment or training) later on in life.

11.2.12 Child sexual exploitation (CSE)

Prevalence

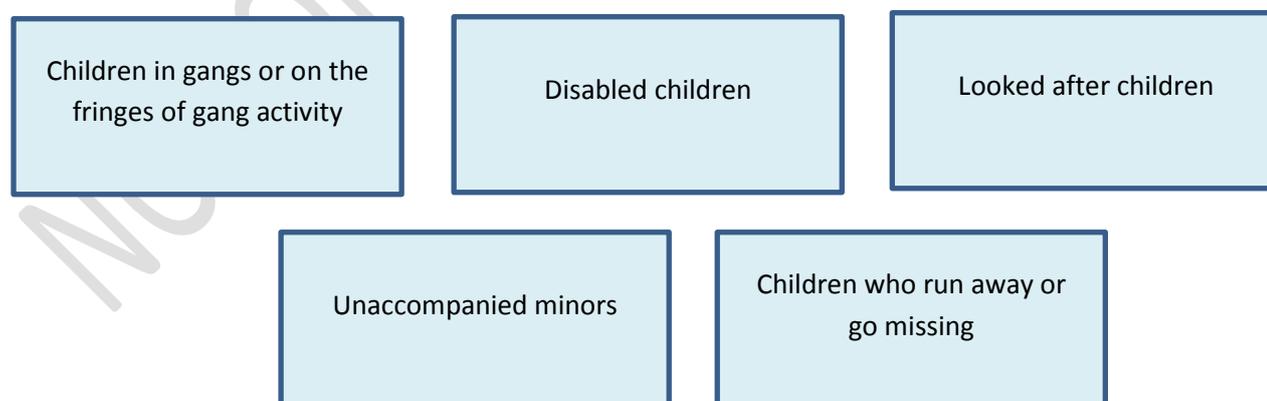
Child sexual exploitation is a type of sexual abuse in which children are sexually exploited for money, power or status. CSE is often hidden as victims may be confused or frightened and may not report it happening (NSPCC, 2013). Some young people are not even aware that they are being abused as they may be coerced into believing they are in a loving relationship, or that they are dependent on their abuser for protection (Sharp, 2011; Cockbain & Brayley, 2012; Child Exploitation and Online Protection Centre (CEOP), 2011).

- Referrals to children's social care rose from 3 in 2011/12 to 68 in 2012/13, to 96 in 2013/14. This is a significant rise in the number of CSE referrals and demonstrates the progress made in identifying and responding to CSE.
- However, as we know CSE is often hidden, we need to do more to identify children who are at risk or who are victim of CSE.

Of the assessments carried out by Children's Social Care in 2013/14:

- 2.9% of assessments identified concern about child sexual exploitation
- There were 77 young people where CSE was identified as a factor, leading to 68 Multi-Agency Planning (MAP) meetings (compared to 36 in 2012/13) to address concerns.
- 16 young people became looked after because of CSE in 2013/14.

Groups at increased risk of CSE include:



Impact

Impact on children and young people can include:

- Experiencing poor mental health
- Exhibiting higher levels of antisocial behaviour
- Increased likelihood of teenage pregnancy and substance misuse
- Educational underachievement

11.3 Economic and Environmental Factors

11.3.1 Poverty and low income families

Prevalence

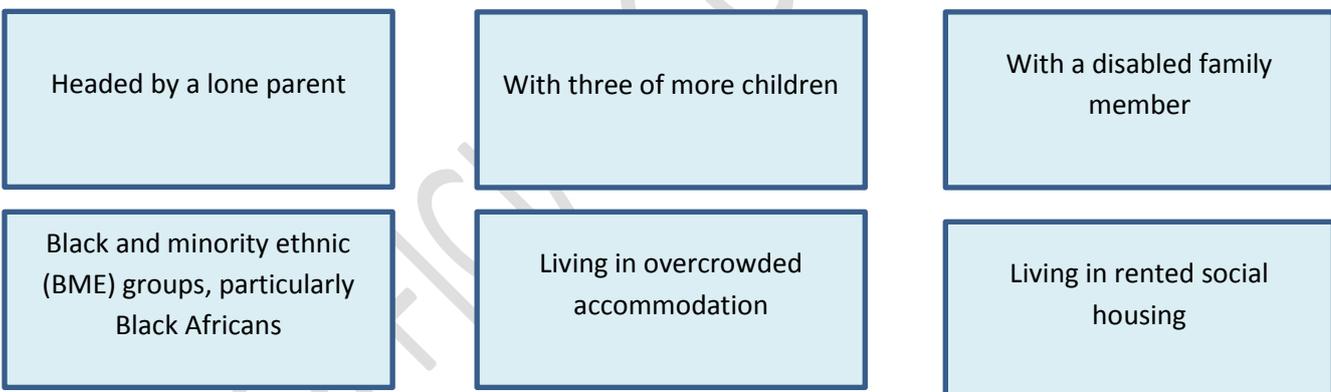
Islington has had the second highest proportion of children in low-income families in England each year from 2009 to 2012 (Tower Hamlets has the highest).

However, during this period, the proportion of Islington children in low-income families has fallen by almost ten percentage points, from 44 to 35%.

In 2012/13, approximately 4,600 in-work families with children received Working Tax Credit credits and Child Tax Credits (with approx. 8,300 children), as well as approximately 1,100 in-work families with children who received just the Child Tax Credits (with approx. 2,200 children).

A higher proportion of primary school age pupils in Islington are eligible for free school meals (FSM) compared to England as a whole. The proportion of Islington secondary school age residents who attend an Islington school that are FSM-eligible has increased over the last 3 years. Approximately 44% of all school children are eligible for FSMs in the borough.

Households over-represented in local child poverty figures are those:



Poverty is widespread across the borough with no clear spatial pattern. There is a strong correlation between those in poverty and those living in social housing.

Impact

The impact of welfare reform on child poverty is difficult to predict. However, the changes (ranging from the Household Benefit Cap, to reforms to disability benefits, to freezing annual inflation-based increases in the value of benefits) will reduce incomes for many workless families, especially those unable to move into work. This could entrench existing relative poverty and also increase levels of absolute and severe poverty.

The attainment of pupils who are eligible for Free School Meals:

Educational outcomes are lower for children from low income households and are affected by poverty from a very early age.

11.3.2 Population churn

Between 2009 and 2013 a greater number of families with children (of all age groups) moved out of the borough than moved into the borough.

Further work is being undertaken to establish the effects of population churn and the implications this has for cross borough work and for demand for services.

11.3.3 Housing at risk/temporary accommodation/overcrowding

Prevalence

- In July 2014, there were just under 6000 under 18 year olds living in an overcrowded household on the waiting lists to be rehoused by Islington's Housing service. This is approximately 13% of the resident population. There has been a slight fall in the number living in overcrowding compared to the same month in 2013.
- Just under 2000 Islington under 18 year olds were living in temporary accommodation, as of July 2014.
- There were over 1800 children were affected by the benefit cap in March 2013 and this has fallen by 61% to 700.

Fewer households were being affected by the cap in March 2014 due to the involvement of the local authority (Discretionary Housing Payments for example), amongst other factors. However, those still affected are amongst the most vulnerable and are often large families.

Impact

Poor housing conditions increase the risk of severe ill-health or disability by up to 25% during childhood and early adulthood. Mental health issues such as anxiety and depression have also been linked to overcrowded and unfit housing. Bad housing affects children's ability to learn at school and study at home. Overcrowding is linked to delayed cognitive development, and homelessness to delayed development in communication skills. The lower educational attainment and health problems associated with bad housing in childhood impact on opportunities in adulthood.

11.3.4 Homelessness

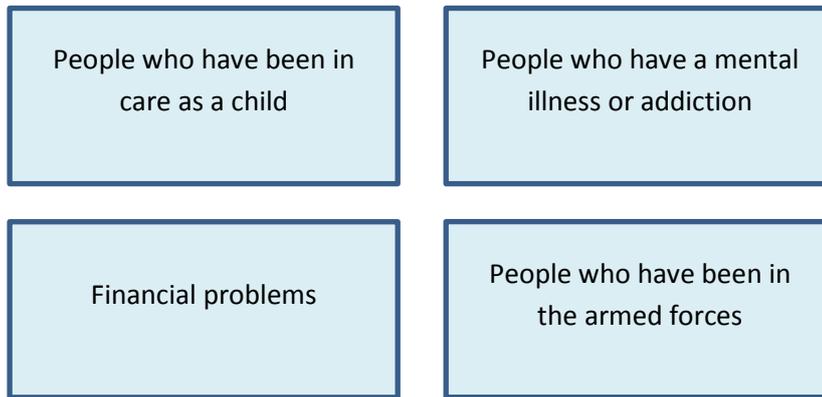
Prevalence

- Since the economic downturn in 2009 Islington has seen an increase in the numbers of people applying as homeless.
- 290 Islington households with dependent children or pregnant woman were accepted as unintentionally homeless and eligible for assistance in 2012/13. This represents a rate of 3.2 per 1,000 households, which is below the London average of 3.6 per 1,000.
- The main reason for which people in Islington make homeless applications is eviction by family or relatives.
- In 2011/12, 56% of households accepted as homeless had children or were expecting children.
- There has been a significant increase in the number of applications from young people, and from people with mental health issues.

Impact

Homeless children are three to four times more likely to have mental health problems than other children. Homeless children are two to three times more likely to be absent from school than other children due to the disruption caused by moving into and between temporary accommodation. Homeless children are more likely to have behavioural problems such as aggression, hyperactivity and impulsivity, factors that compromise academic achievement and relationships with peers and teachers.

At risk groups are:



Structural factors increasing the risk include:

- The impact of the welfare benefit system
- Shortage of affordable accommodation
- Unemployment
- Migration

Possible triggers include:

- Domestic violence
- Relationship breakdown
- Leaving home or care
- Unemployment
- Leaving institutions (e.g. hospital, prison)
- Lack of knowledge about benefits
- Getting into debt (particularly mortgage and rent arrears)

12 Children/young people in need of specialist and targeted services

The Department for Education define 'vulnerable groups' as 'disadvantaged groups', whilst Ofsted term vulnerable children among those who may need additional support or intervention in order to make optimum progress. There are a range of factors that make children vulnerable.

- Islington's Targeted and Specialist Children and Families Services have received around 12,000 contacts a year in each of the last five years (relating to 7,000 children a year). There were 6,422 different young people with a contact in 2013/14 (excluding information requests and Subject Access Reviews (SARs))
- Excluding contacts related to information requests, more than a quarter of the children for whom contacts were received in 2013/14 had at least one contact related domestic violence. The 'Other' reasons for contacts in 2013/14 cover 17 different reasons for contacts, including Child Sexual Exploitation (80 children) and harmful traditional practice, e.g. Female Genital Mutilation (23 children)
- Overall, 24% of these contacts progressed to a referral to children's social care, whilst 17% were referred to Early Help services.
- Most common referrals (over a quarter of cases) for early help in 2013/14 were for parenting issues, followed by housing issues, recorded in almost a fifth of all cases.

Children's social care assessments

Assessments were completed on over 2,400 children in 2013/14.

- The most common reasons for referrals to social care are abuse and neglect.
- Frequent parental characteristics are domestic violence, substance misuse and parental mental ill-health.
- The most common factor identified was where there were concerns that a parent (or carer) was subject to domestic violence.
- In 30% of these cases of suspected domestic violence there were also concerns that the child was also subject to domestic violence. On top of this, there are cases where the child may be suffering, or likely to suffer significant harm due to abuse (physical, emotional or sexual).

Children in Need

Children in need are defined as children with a disability or children where assessment shows they are unlikely to achieve a reasonable standard of health or development without provision of services

Islington has a higher rate of children in need (CIN) compared to statistical neighbours, Inner London and England. This could reflect that staff in partner organisations are well trained to identify child protection issues, are making appropriate referrals to children's social care, and so children are being kept safe.

- Islington had the 15th highest rate of CIN in the country, as at 31 March 2014.

Children on Child Protection Plans

- 179 children became the subject of a child protection plan in 2013/14.
 - 85 children (47.5%), this was due to neglect
 - 68 children (38.0%), this was due to emotional abuse
 - 25 children (14.0%), this was due to physical abuse
- The proportion of Islington children who became the subject of a child protection plan for a second or subsequent time fell between 2010/11 and 2012/13 to 10.4% but it rose in 2013/14 to 20.1%.

Looked After Children

- The number of children looked after by Islington fell between 2003/04 and 2008/09 and despite a rise between 2009 and 2013 the figure is now around 300 to 330 (similar to 2009 figure). The rate compared to the population is higher than statistical neighbours, inner London and England rates.
- 150 different children became looked after during 2013/14, although some of these children were looked after for more than one period during the year, so this reflects 158 periods of care.
- 54% of these children became looked after due to abuse or neglect, with the next most common needs being absent parenting (16.0%), family dysfunction (11.3%) and 'family in acute stress' (10.0%).

The majority of children looked after have needs other than for basic care and support with many exhibiting behaviours arising from attachment related issues or disorders.

- A higher proportion of Islington's looked after children population are placed out of the borough and more than 20 miles from home, compared to statistical neighbours, Inner London and England averages.
- There are more older young people (16+) becoming looked after
- There has been a fall in the number of unaccompanied asylum seeking children (UASC)

Educational achievement:

- Averaged out over the last 3 years, 52% of Islington children who had been looked after continuously for more than 12 months achieved level 4 or above in English and Maths (or Reading, Writing and Maths in 2013) at the end of Key Stage 2. This is higher than for looked after children

across the country but lower than their non-looked after peers (75%). Due to the change in the indicator in 2013, the comparator results are not available.

- Across the last 3 years, 18% Islington children who had been looked after continuously for more than 12 months achieved the benchmark of 5 A*-Cs GCSEs (or equivalent) including English and Maths. This is just below the Inner London average of 20%, but higher than the England average of 15%. Across the country as a whole, on average almost 60% of all pupils achieve of 5 A*-Cs GCSEs (or equivalent) including English and Maths so the attainment of looked after children at Key Stage 4 is lower than that of their peers.

Offending:

- A lower proportion of Islington's looked after children aged 10 to 17 who had been looked after for more than 12 months have been convicted or subject to a final warning or reprimand each year between 2009/10 and 2012/13 than the borough's comparators. The proportions reduced between 2009 and 2013 to 3.9% and were lower than England and Statistical Neighbour averages. Provisional data shows an increase in Islington 2013/14 to almost 10%.

Substance misuse:

- A higher proportion of Islington children who had been looked after for more than 12 months have been identified as having a substance misuse problem than the borough's comparators in each of the last 3 years. However, this may indicate that Islington has good processes in place to identify when a looked after child has a substance misuse problem.

School attendance:

- Local monitoring shows that in 2011/12, Islington school age pupils who had been looked after continuously for 12 months or more had absence levels of 5.0%. This is marginally higher than the Inner London and England averages (both 4.7%), but below the Statistical Neighbour average of 5.2%. However, only 5.7% of the Islington cohort were persistent absentees (pupils with an absence rate of 15% or more across the year). This is lower than the Inner London (6.0%), England (6.1%) and Statistical Neighbour (7.7%) averages.

Fixed term exclusions:

- 9.9% of Islington's school age pupils who had been looked after continuously for 12 months or more had a fixed term exclusion during the year. This is lower than the Inner London (13.0%), England (11.4%) and Statistical Neighbour (13.3%) averages. There were no permanent exclusions amongst Islington's school age pupils who had been looked after continuously for 12 months or more during the year.

Care leavers

Attainment:

- On average over the last 3 years the proportion of Islington's care leavers (children aged 19 who were looked after when they were aged 16) who were in education, employment or training has been in line with the borough's comparators. The percentage fall in 2012/13 actually represents a small number of young people. The difference was due to there being more young parents who were not in education, training or employment in the 2012/13 cohort compared to previous years. The number of young parents in the cohort was significantly higher than in previous years.

Accommodation:

- On average over the last 3 years, the proportion of Islington's care leavers (children aged 19 who were looked after when they were aged 16) who were in suitable accommodation has been in line with the borough's comparators.

Children of care leavers

- There is no local data available but research tells us that the children of care leavers are more than twice as likely to go into care themselves (Biehal *et al* 1995; Barn & Mantovani, 2007; cited by London Borough of Hounslow JSNA report, 2011).

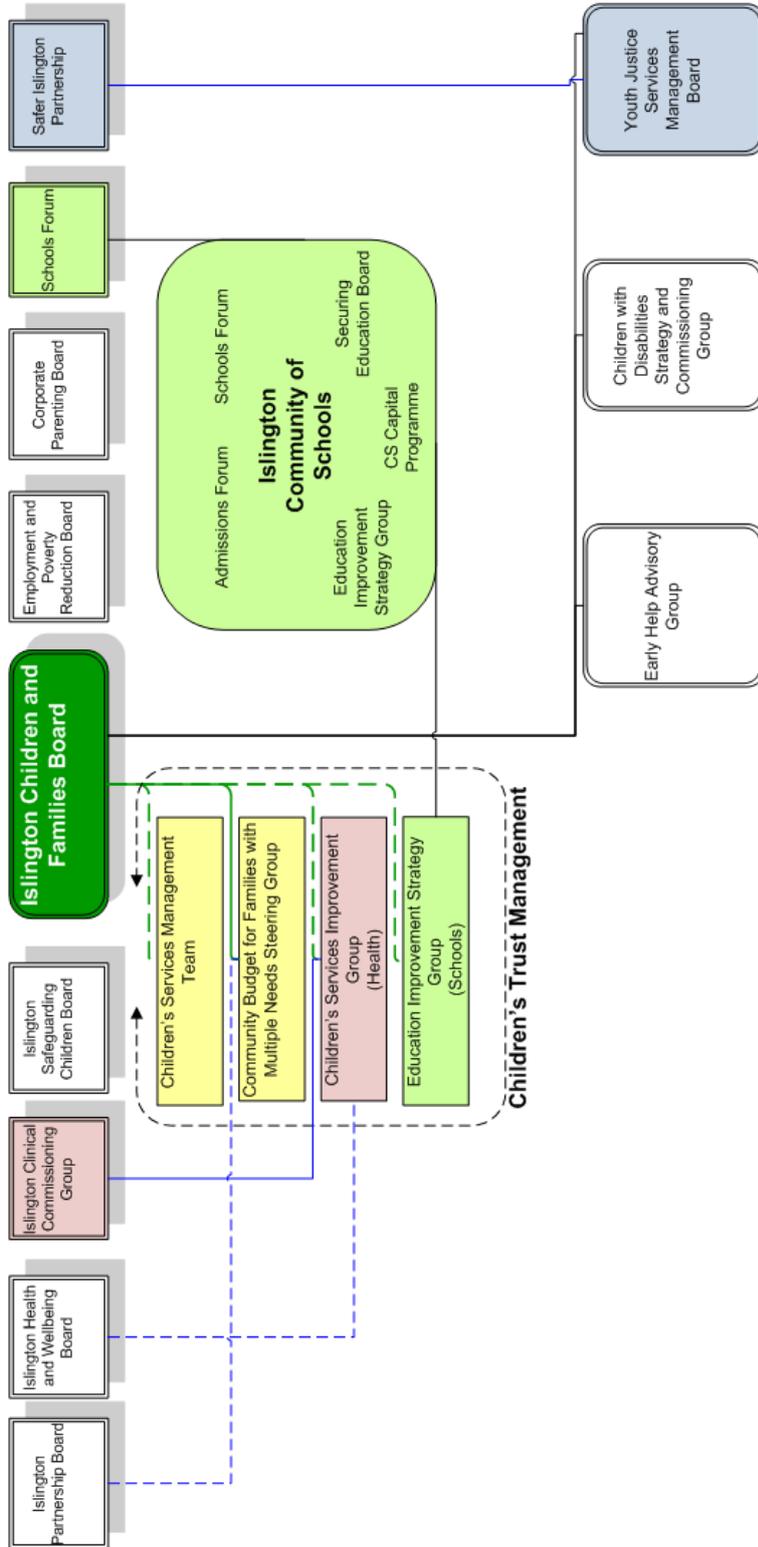
Sources:

Data and information used to produce this needs assessment summary has been taken from the following documents from the JSNA:

- Childhood immunisation fact sheet
- Childhood obesity factsheet
- Childhood oral health factsheet
- Child health strategy needs assessment
- Education and attainment fact sheet
- Early access fact sheet
- Infant mortality fact sheet
- Homelessness fact sheet
- Mental health fact sheet
- Special Educational Needs and Disability Needs Assessment
- Teenage pregnancy factsheet
- Unemployment and NEET fact sheet
- Vulnerable Children Needs Assessment
- Area Children and Young People's Partnership Profile 2014

Islington Children and Families Partnership

Islington Children and Families Partnership



Date: 7 August 2014
 Author: Nikki Ralph
 Strategy and Commissioning (Children's Partnership Development and Strategy)
 For queries, please contact 020 7527 8847

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Report of:

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	14.02.2015	Item	All

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SUBJECT: Islington Safeguarding Children’s Board Annual Report 2013/14

1. Synopsis

The Islington Safeguarding Children’s Board (ISCB) annual report is a statutory report prepared by the Independent Chair of the ISCB, Alan Caton, and provides a summary of the board’s work during the 2013/4 financial year. It finds that Islington partners are working in a co-ordinated way to promote the welfare of children and safeguard them from harm when necessary. It identifies that child neglect, domestic violence and the prevention child sexual exploitation are areas that will continue to be priorities in future.

2. Recommendations

The ISCB has a statutory duty to work with and influence strategic partners to ensure that children’s welfare and safety is a priority in Islington. The ISCB would like the Health and Wellbeing Board to note the report’ findings and in particular to consider the recommendations on page 59 of the report.

3. Background

This report comes to the Health and Wellbeing Board as proposed in the joint protocol between the board and the ISCB.

4. Implications

4.1. Financial implications

None identified

4.2. Legal Implications

Section 13 of the Children Act 2004 (“the Act”) requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area.

Section 14 of the Act sets out the objectives of LSCBs, which are:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the local authority, and

(b) to ensure the effectiveness of what is done by each such person or body for the purposes of safeguarding and promoting the welfare of children.

Section 14A of the Act imposes a duty on the Chair of the Local Safeguarding Children Board to publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. Paragraph 16 in Chapter 3 of Working Together to Safeguard Children 2013 requires that the Annual Report should cover the preceding financial year, that is should fit with local agencies’ planning, commissioning and budget cycles and that it should be submitted to the Chief Executive, Leader of the Council, the local Police and Crime Commissioner and the Chairman of the Health and Wellbeing Board.

4.3. Equalities Impact Assessment

None identified

4.4. Environmental Implications

None identified

5. Conclusion and reasons for recommendations

The ISCB Annual Report is a statutory report that comes to the board as agreed in the joint protocol

Background papers: None

Attachments:

Appendix 1 - ISCB Annual Report 2013/4

Appendix 2 - Executive Summary of ISCB Annual Report 2013/4

Final Report Clearance

Signed by

CM Blair

05/01/2015

.....

Date

Received by

.....

Head of Democratic Services

.....

Date

Report author:

Tel:

Fax:

E-mail:

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2013/14



Islington Safeguarding Children Board Annual Report 2103/14

Alan Caton, Independent Chair

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Section II: Chair's introduction

I am pleased to present the Islington Safeguarding Children Board (ISCB) Annual Report covering the period April 2013 to March 2014. I would like to thank my predecessor Ms Janet Mokades who stood down in September 2013. Janet's commitment and leadership in Islington resulted in a vibrant Board which has a culture of continuous learning, development, improvement and challenge.

This has been a challenging year for partners given their significant budgetary pressures but this report provides plenty of evidence of the commitment and determination among agencies and professionals to keep children and young people in Islington safe.

This report will highlight the effectiveness of child safeguarding and promoting the welfare of children in Islington. I do not intend to repeat here the content of the main body of the report, other than to briefly mention one of the new initiatives that has come to fruition in this reporting period which highlights effective multi-agency working;

In order to combat the abusive issue of child sexual exploitation, Islington CSE sub-group developed a strategy and action plan in June 2013 based on Promotion, Prevention and Protection of children being abused through sexual exploitation, since this time the sub-group has continued to develop and progress this work. In January 2014, Islington introduced the Multi Agency Sexual Exploitation meetings (MASE), in conjunction with the ***Pan London Operational Protocol*** which introduced the concept of MASE at its launch in February 2014.

This annual report articulates the difference we have made as a Board and the impact that those differences have had on children, young people and their families in Islington.

As a Board we continue to face a number of challenges as we strive to constantly develop front-line practice with a view to improving outcomes for all children and young people. These challenges are highlighted in this report and include;

- Ensuring that the views of children and young people are taken into account in all aspects of safeguarding.
- Ensuring that lessons learned from local and national case reviews and audits are embedded in local practice and improve the quality of the provision of services to children.
- Ensuring the effectiveness of safeguarding support for children living with domestic abuse. Islington has the second highest rate of reported domestic violence offences in North London and therefore continues to be of concern for many children and families.
- To continue to monitor and evaluate the impact of Early Help.

- Ensuring the Islington response to child sexual exploitation is identifying those children at risk of CSE at the earliest opportunity and evaluating the multi-agency response to keep children safe.

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

We have changed the style and content of this year's report to better reflect the LSCB's statutory duties and to make its approach more analytical and less descriptive. I commend this report to you and invite you to feedback your thoughts on how we can continue to develop and improve in order to keep the children of Islington safe.

Alan C Caton OBE

ISCB Independent Chair

Section III: Purpose of this report

1. Statutory duty

Legislation¹ compels Local Safeguarding Children Boards (LSCB/ board) to assure itself that local children are safe and agencies promote children's welfare in the way they work together. The board has a statutory duty² to annually prepare a report on its findings:

"The chair of the LSCB must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the Health and Wellbeing Board"

2. Remit of the report

This report follows the *Annual Report 2012-2013* (Mokades, 2013) published in autumn 2013 and covers the financial year from April 2013 – March 2014.

Section IV: provides an outline of the board's main objectives, how well it has achieved those objectives and what difference they have made. In doing so, the report reflects on successes but also identifies gaps in services. The report also outlines future challenges that need consideration.

For the first time, section headings are based on the statutory duties of the board as they are found in the *Local Safeguarding Board Regulations 2006* (Government, 2006). This should make it easier to see exactly what the board's duties were, and how well it met the expectation.

3. Audience

As stated in paragraph 1, the chair reports his findings to:

- The Chief Executive of Islington Borough Council, Lesley Seary;
- The Leader of Islington Borough Council, Cllr Richard Watts,
- London Police and Crime Commissioner, Mayor's Office for Policing and Crime (MOPAC)
- Chair of Islington Health and Wellbeing Board

¹ Children Act 2004

² Apprenticeships, Skill, Children and Learning Act 2009

It is hoped that board members will share it more widely with senior managers responsible for safeguarding children in their own agencies

Action 1: Board members to share this report with their own senior management teams / management boards. Individuals named in this paragraph and ISCB board members to consider the findings of this report and inform the Independent Chair of the actions they may consider necessary in response to these findings and actions reported

4. Methodology

In writing this report, contributions were sought directly from board members, chairs of sub-groups and other relevant partnerships. It drew heavily on the numerous monitoring reports presented to the board and subgroups during the year (see bibliography)

LSCB members were asked to give a summary of key achievements and challenges in 2013-4. Regrettably, not all board members responded to the invitation which inevitably led to some agencies being more comprehensively represented than others.

5. Approval process

The chair presented this report, in draft, to the ISCB on 16 September 2014 for oversight and commentary. Once the report has been finalised an executive summary will be prepared.

6. Publication of this report

The final version of this report will be placed on the ISCB website.

Section IV: London Borough of Islington, background and context

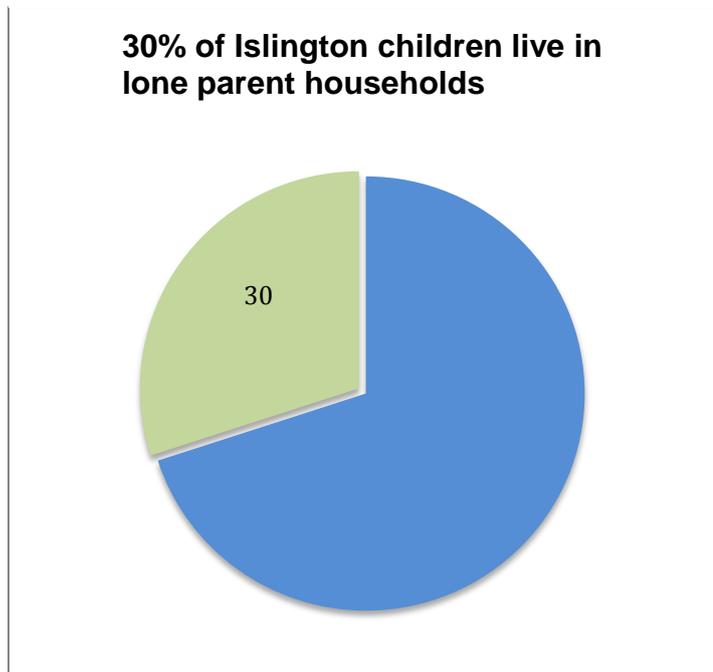
1. Demographics

With a population of 220 100, Islington is a small but densely populated inner-London borough. The borough has 43 500 children (0-19) living in 21 000 households. In geographical terms, it is the second smallest London borough but one of the most densely populated areas in the country. A mere 12% of the borough is designated as green space, compared to a London average of about 38%.

In 2010, the *Index of Multiple Deprivation* listed Islington as the 14th most deprived local authority in the country, whereas the *Income Deprivation Affecting Children Index* places it as the second most deprived area in the Country.

A third of Islington’s Children live in lone-parent household. Approximately 42% of children live in income deprived households. 60% of families with dependent children live in social housing, compared to 20% nationally. 11% of households live in overcrowding (similar to London average) (Children and Families Board, 2014)

Figure 1 - Children who live in lone parent household



Section V: Governance of ISCB

1. Independent chairing and leadership

During this financial year, the board saw a change in leadership. The ISCB expressed its gratitude to Ms Mokades who lead the board for 4 years until then end of August 2013, when she handed the chair over to, Alan Caton OBE who joined the ISCB after retiring from the Suffolk Constabulary.

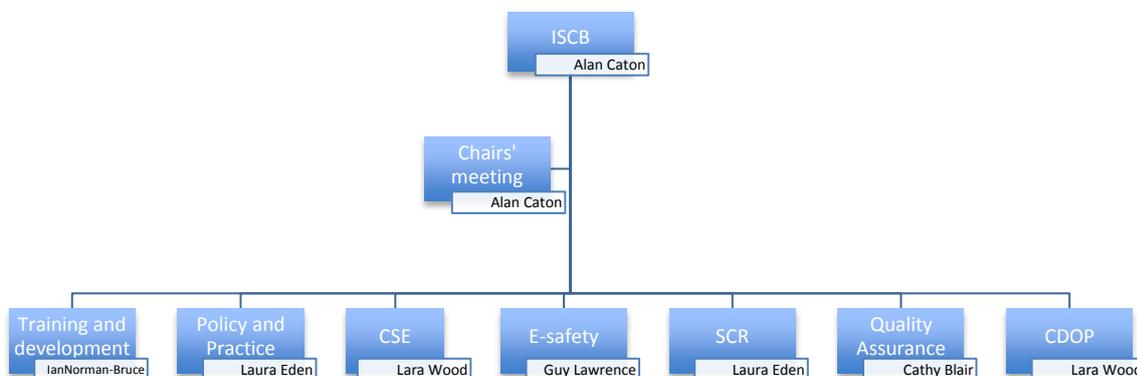
Working Together 2013 took effect in April of 2013, which now requires that Local Authority Chief Executives take over the responsibility from Directors of Children Services for overseeing the work of the board chairs. In Islington, the independent chair, chief exec, executive lead member for children and the DCS work closely together to promote the welfare of Islington’s children. Regular safe-guarding accountability meetings take place between the chair, elected members and other senior officers of the Local Authority.

2. Structure

The structure of the board and its sub-groups has not changed substantially during this year. The LSCB most recently reviewed its Terms of Reference in January 2012. In May of 2014 Mr Caton and board members considered the structure of the board, and decided to refresh some of the sub-group structures, reporting lines and terms of reference. Notably, the board will be more closely governed day-to-day by a smaller business group (currently the Chair’s meeting).

3. Sub-groups of the ISCB

Figure 2 - Board governance



2013):

Senior managers in the Local Authority chaired all subgroups. This brought about significant advantages in co-ordination and communication; providing such a number of senior managers also placed a significant burden on the Local Authority. There is the risk that domination by one board partner could potentially reduce the independence of the board.

Action 2: The ISCB would like to see that partners, especially s11 partners, take a greater lead in chairing and governance of the safeguarding board sub-groups. The board should continue to review its structure and governance.

3.1 Training and professional development subgroup

Key responsibilities of the subgroup are to:

1. Identify the inter-agency training and development needs of staff and volunteers
2. Develop and plan an annual training and development plan
3. Monitor and evaluate the quality of single and multi-agency training
4. Ensure lessons from Serious Case Reviews (SCRs) are disseminated
5. The work of this subgroup is discussed at

3.2 Quality assurance subgroup

Key responsibilities of the subgroup are to:

1. Develop agreed standards for inter-agency safeguarding work
2. Establish and maintain appropriate mechanisms and processes for measuring the quality of inter-agency safeguarding work
3. Contribute to the development of strategies to address any shortfalls in effectiveness
4. Monitor and evaluate the quality of safeguarding work within individual Board partner agencies
5. Contribute to the development of strategies for single agencies to address any shortfalls in effectiveness
6. Audit and review the progress of the implementation of recommendations of Serious Case Reviews conducted by ISCB

3.3 Policy and procedure subgroup

Key responsibilities of the subgroup are to:

1. Continually review and monitor ISCB's policies, practices and procedures

2. Plan the piloting of and / or introduce new working practices
3. Maintain an up-to-date knowledge of relevant research findings
4. Develop / evaluate thresholds and procedures for work with families

3.4 *E-safety sub-group*

Key responsibilities of the subgroup are to:

1. Be a central point of contact for guidance, advice and networking
2. Set out the roles and responsibilities of the E-Safety Safeguarding Lead Officers (ESLOs)
3. Raise the awareness of e-safety within the borough
4. Hold agencies to account, through the incorporation of the e-safety Strategy into their existing safeguarding policies
5. Ensure that agencies have robust procedures in place in relation to recognition, identification, reporting and appropriate response to e-safety issues

3.5 *Child Sexual Exploitation sub-group*

Key responsibilities of the subgroup are to:

1. Agree and monitor the implementation of a strategy and action plan to minimise harm to children and young people
2. Raise awareness of sexual exploitation within agencies and communities
3. Encourage the reporting of concerns about sexual exploitation
4. Monitor, review and co-ordinate provision and practice

3.6 *Child Death Overview Panel*

Key responsibilities of the subgroup are to:

1. Collect and analyse information about each death with a view to identifying any case giving rise to the need for an SCR
2. Review and respond to any matters of concern affecting the safety and welfare of children
3. Review and respond to any wider public health or safety concerns arising from a particular death, or from a pattern of deaths
4. Put in place procedures for ensuring that there is a co-ordinated response by the authority and its Board partners and other relevant persons to an 'unexpected child death

3.7 *Serious Case Review Subgroup*

Key responsibilities of the subgroup are to:

1. Plan and undertake reviews of cases where a child has died or has been seriously harmed in circumstances where abuse or neglect is known or suspected
2. Identify lessons from the reviews for inter-agency working and the work of individual agencies
3. Produce and monitor action plans arising from SCRs and evaluate the effectiveness of their implementation

4. Engagement and participation

4.1 *Frontline staff*

Good practice indicates that the boards should hear and consider the opinions of frontline staff directly. In the previous year the board has not done any work in this respect. Key professionals, e.g. the designated / named professionals in health, designated roles in education and the Principal Social Worker may have valuable contributions to consider.

Action 3: The board would like to receive an annual report, representing the views of front line practitioner about the robustness of safeguarding practices within their agencies from the Named Nurse(s) for Safeguarding, Designated GP, Designated Doctor, Designated Nurse, and Safeguarding Lead for Education and the Principal Social Worker

4.2 *Children and Families*

More work needs to undertake directly with children and families. There are audits as described in the section about Involvement of Parents and Children. The board has since had an away day and decided that, in principle, the board's focus should be to consolidate the information that individual agencies already gather from children and parent's in their operational duties e.g. views of children attending case conferences.

5. Progress against strategic priorities in the 2103/4 business plan

A full copy of the *ISCB Business Plan 2013/4* can be found in the Appendix. The key messages are:

5.1 *Priority 1: Develop early intervention and review its effectiveness (overarching priority)*

5.1.1 What we wanted to do

1. Further embedding and increase in number of CAFs

2. Launch of eCAF as CSC Referral tool
3. Implementation of Children's Services Contact Team incorporating Multi Agency Safeguarding Hub (MASH)
4. Increase number of parents helped into work through Parental Employment Partnership (PEP)
5. Diversion of CSC contacts to Early help services
6. Children's centres increase in reach to all families
7. Continued use of 3 Families First (FF) early intervention teams to identify and support

5.1.2 Evidence that we were successful

1. Decrease in the number of re-referrals to CSC 2013/16

The Quality Assurance subgroup audited repeat referrals into Social Care (9.4.3) and found that 50% of repeat referrals were unavoidable. The sub-group have implemented an action plan and more work will be undertaken to achieve this outcome by 2016.

2. Low number of repeat child protection plans comparable with Statistical Neighbours

The quality assurance sub-group examined the reasons why children became subject to child protection plans for a second time. Only in one case did they find that a child protection plan may have ended prematurely (9.4.6).

3. Decrease in the number of children per 10,000 with child protection plans

There is been a slight increase (3/10 000) of children who became subject to child protection plan this year but it remains considerably lower than statistical neighbours (45.5/10000 – see par. 9.2.3).

4. Increase in use of CAF

During this year, we have opened 547 CAFs, a 12% increase over the preceding year (discussed in par 9.2.1)

5. Decrease in contacts by other agencies to children's social care (CSC) from 13/16)

CSC received 36 more cases this year compared to last year, which is negligible. The board and partners will continue to efforts to decrease referrals (see par. 9.2.3)

6. Evaluation of Early Help to demonstrate impact on children

The LA is undertaking work with all partners to evaluate the impact of Families First (Early Help services) and there are positive reports about the impact it has on children. A more comprehensive discussion about Early Help can be found at par. 9.2.2.

7. Evaluation of parenting programmes to demonstrate impact on parents

This has not yet been evaluated.

8. CAF to be re-launched in connection with awareness raising of neglect

The Early Help Assessment (CAF) has been re-launched, as well as the Neglect toolkit.

5.2 *Priority 2: Evaluate the effectiveness of training (overarching priority)*

5.2.1 What we set out to do

1. Training and Professional Development Sub-group audits and evaluates delivery and effectiveness of single and multi-agency training
2. Implementation of the London safeguarding children board Training Impact Analysis process

5.2.2 Evidence that we were successful

1. Staff incorporate learning from training into their practice.

The board's training is informed by lessons from serious case reviews and local learning but the sub-group does not yet have sufficiently sophisticated tools to measure how staff incorporate training into their day-to-day practice. This should be developed as a priority (Action 7)

2. Percentage of staff reporting a positive impact from training

Post-course evaluations are overwhelmingly positive about the usefulness and quality of ISCB training.

5.3 *Priority 3: Parents with learning difficulties (joint work with adults)*

5.3.1 What we set out to do

1. Regular communication between Children and Families Board, Adult Safeguarding Board and ISCB
2. Parents with LD accessing parenting programme – Mellow Bumps and Mellow Babies.
3. Parents with LD accessing advocacy and parenting support.

5.3.2 Evidence that we were successful

1. Reduction in percentage of parents with LD who have children on CP plans

The board has not yet looked at data to understand the impact on children with learning disabilities.

2. Increase numbers of parents with LD accessing early help services

The board has not yet examined this data.

5.4 *Priority 4: Transition to adulthood (joint work with adults)*

5.4.1 What we set out to do

1. Monitor management of transitions
2. C&IFT early intervention team undertakes transitional work with CAMHS
3. Strengthened TYS-YOS operational links with Integrated Offender Management arrangements
4. Regular communication between Children and Families Board, Adult Safeguarding Board and ISCB
5. Development of a protocol between CLA,IF and Adults in relation to YP at risk of abuse within the family

5.4.2 Evidence that we were successful

1. Increased number of young people with mental health problems access adult services
2. Increased number of young people with Asperger's access adult services
3. Fewer young people leaving prison re-offend
4. Improved accommodation available for homeless 16 & 17 year olds
5. Young people's views are included in all decisions regarding their care plans
6. Increase number of young people joint worked with CAMHS and Adult Mental Health.
7. Identify young carers of people with mental health problems and offer early support/intervention.
8. Scope out services for parental mental health ensure whole systems approach
9. Scope out current training for staff on children/young carers – improve access to training.
10. Identify all young carers on C&I caseload. Target for services accordingly

The Board's work plan completes in 2015, there is still has a considerable amount of work to do for this particular priority. There is evidence that children are more involved in decisions about their care plans. CAHMS and CSC have also put in place arrangement for more co-working of cases,

5.5 *Priority 5: Domestic violence (core business)*

5.5.1 What we set out to do

1. DV identified in CAF
2. Continue work on Deep dive Audit Action Plan
3. Review use of DV risk assessment tools
4. Develop guidance to assess impact of ethnicity, culture, religion on DV
5. Monitor implementation of local VAWG strategy
6. Early intervention through use of CAF and LP
7. MARAC attendance expanded to include Early Years, Families First and TYSS
8. Increase identification of cases and actions to reduce risk
9. Development of referral pathways for young victims referred to MARAC

5.5.2 Evidence that we were successful

1. Increased identification of women and children living with DV and action taken to protect them
2. Increased number of women engage with services to protect their children
3. Women experiencing DV are aware of what services they can access
4. Increased number of children access support
5. Increase in numbers of young people age 16 – 17 as CIN due to DV

5.6 *Priority 6: Neglect (core business)*

5.6.1 What we set out to do

1. Promote the use of CAF to identify neglect
2. Implementation of the neglect toolkit
3. Training provided on use of toolkit across children's partnership
4. Awareness raising campaign about neglect to Islington professionals
5. Production of information sheet/leaflet
6. Multi-agency audit of CP plan neglect cases
7. Agencies produce Neglect and CAF implementation plans which includes identifying how staff awareness will be raised

5.6.2 Evidence that we were successful

1. Multi-agency audit demonstrates good understanding of indicators and impact of neglect and prompt action.

The board has undertaken a multi-agency audit of children on child protection plans for neglect; the summary findings are reported at par. 9.4.2

2. Increased numbers of CP plans for neglect
3. Increased numbers of CAFs where neglect is primary concern
4. Decrease in length of time spent on CP plans for neglect
5. Increase use of neglect toolkit

The Neglect toolkit has been launched successfully and there is evidence that it is being used by board partners to work with children who are at risk of neglect.

5.7 *Priority 7: Child protection*

5.7.1 What we set out to do

1. Monitor and evaluate implementation of SCR action plans
2. Monitor and evaluate implementation of action plans resulting from audits/inspections/ reviews
3. Review progress in improving engagement of fathers
4. Monitor impact of implementation of MASH

5.7.2 Evidence that we were successful

1. Reduction in re-referrals

The quality assurance sub-group examined the reasons why children became subject to child protection plans for a second time. Only in one case did they find that a child protection plan may have ended prematurely (9.4.6).

2. Reduction in length of time with a CP plan

On the whole, children in Islington do not remain subject to child protection plans for long (9.2.4)

3. Increase in numbers of fathers attending initial child protection conferences

Children's Social Services have achieved some success in this area and work is ongoing to include even more fathers.

6. Objectives and functions of the LSCB

Legislation³ describes the objective of the LSCB as co-ordinating what is done by each person or body represented on the board for the purpose of promoting the welfare of children in the area and to ensure the effectiveness of what is done by each such person. Regulations⁴ set out the statutory functions to reach those objectives.

Previously, national guidance⁵ comprehensively described the duties of safeguarding board but when Working Together (2013) came in to force on 15th of April 2013, prescriptive guidance was much reduced, allowing boards to take a more 'local' approach to achieving its statutory objectives.

The rest of this chapter sets out the boards achievements under the heading used in the Safeguarding Board regulations.

7. Policy and procedure to promote welfare and safeguard children

LSCBs have a statutory duty to develop policies and procedures to support safeguarding work in their area. Boards were eagerly awaiting national guidance (Working Together to Safeguard Children) to reflect recommendations made by the Munro review⁶ which finally arrived in March 2013, taking effect at the beginning (15 April 2013) of the reported period.

The board's Policy and Procedure sub-group undertook a GAP analysis and developed an action plan that was overseen by the Policy and Practice subgroup.

London Borough of Islington Children Social Services took a leading role in revising the *Pan-London Child Protection Procedures* and the subgroup was an active participant in the feedback and consultation process (Policy and Practice, 2014).

Other work carried about the subgroup included:

1. Regularly updating the policy implementation check list
2. Finalisation of the ISCB Communication Strategy
3. Developing a protocol between ISCB and Islington Health and Wellbeing Board
4. Surveying staff's awareness of Islington Safeguarding Children Board policies:
5. Local Authority Designated Officer survey
6. Child Sexual Exploitation survey

³ The Children Act 2004, section 14(1)

⁴ Local Safeguarding Children Boards Regulations(2006)

⁵ Working Together to Safeguard Children (2010)

⁶ Munro Review of Child Protection (2011)

7. Harmful Traditional Practices survey
8. Developing and publishing an Escalation Policy
9. Launching reflective supervision guidance
10. Developing risk assessment guidance
11. Launching of a Neglect Tool Kit with supportive guidance and training for board partners

7.1 *Threshold for intervention and Early Help*

In response to Working Together 2013, the Policy and Practice subgroup oversaw development of comprehensive multi-agency guidance about Early Help Assessment and thresholds: *Local Assessment Protocol* and *Threshold document* (P&P Minutes, 2014.03.27). These documents have been published and incorporated into local training for the children's workforce.

7.2 *Other Initiatives*

7.2.1 *Islington's First 21 months programme*

Islington's First 21 months is a multi-professional integrated care approach to improving the community maternity and health visiting offer within children centres in order to and improve health and social outcomes for young families. It is set in context of, Islington's Joint Health and Wellbeing Strategy 2013-2016 priority of "Ensuring every child has the best start in life". Public Health are co-ordinating and implementing the programme in association with stakeholders including maternity, health visitors, primary care staff, GP's Children's Centres, Early Years, voluntary sector and parents. The aim of the programme is to support expectant parents and families, to access appropriate support systems and services as early as possible starting from conception up to the first year of a child life. The programme is also developing new ways of working, communicating and appropriate data sharing between professionals. These will be supported by improving interconnectivity and information governance.

The board received a presentation on *First 21 Months* in March 2014.

7.3 *Early intervention "pioneering places"*

Islington is one of the 20 Early Intervention "pioneering places" across the country. "Places" are selected on the basis of the strength of commitment among the local partnership to Early Innovation. (CCG Update, 2014)

7.4 *Training of the children's work force*

The workforce and development sub-group of the LSCB were responsible for key priority areas of the Islington Safeguarding Children Board's work plan. The sub-group is generally well-attended by a variety of agencies. It is unfortunate that the sub-group was without a dedicated chair for a significant part of the year, which negatively impacted on the work plan of the subgroup. Since then, a senior health manager had taken up the chair.

7.4.1 Attendance and impact of LSCB training

The ISCB has offered 1212 training places on 35 courses, which equates to 47 training days⁷. ISCB multi-agency training continues to be well attended and is generally oversubscribed. There is, however, considerable waste because of staff cancelling without sufficient notice (95 instances) to offer places to others or they simply do not arrive (196 instances). Some courses have gone ahead without full attendance. (Training and Workforce Subgroup, 2014).

⁷ Training days based on a single trainer per course, do not take into consideration administration and preparation of courses.

Figure 3 - Attendance of ISCB training

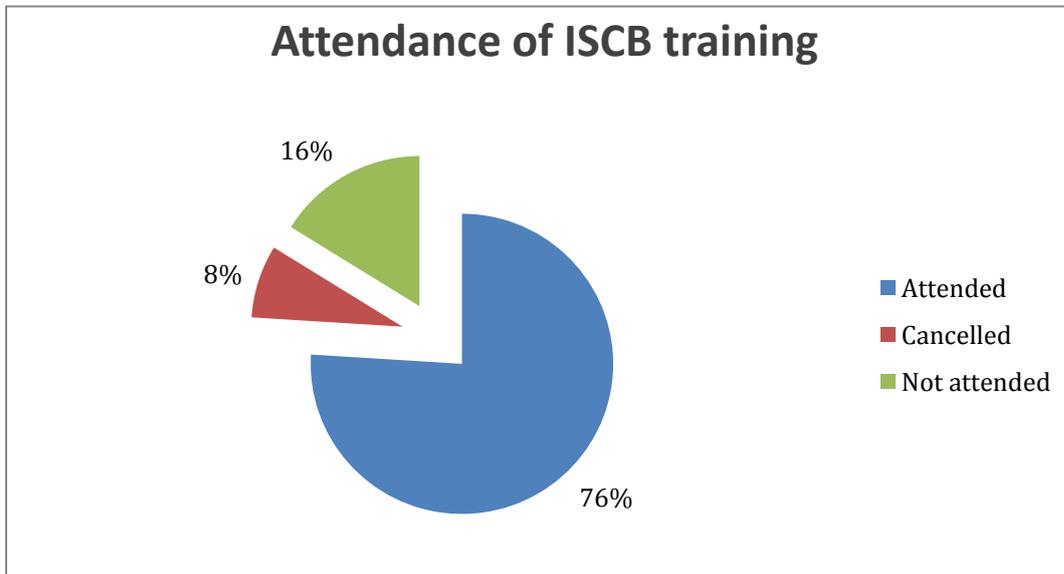


Table 1 - Training attendance

Sector	Bookings made	Attended	Not-attended	Cancelled
Not stated	108 (8.9%)	79 (6.5%)	19 (1.6%)	10 (0.8%)
Statutory	543 (44.8%)	398 (32.8%)	97 (8.0%)	48 (4.0%)
Private and voluntary	561 (46.3%)	444 (36.6%)	80 (6.6%)	37 (3.1%)
Total	1212	921 (76.0%)	196 (16.2%)	95 (7.8%)

Action 4: Board members to assure the ISCB that they have sufficient management mechanisms in place to ensure that staff members are identified and booked on relevant safeguarding training and that staff attend training that they have booked.

Action 5: Training and development sub-group to develop innovative ways to measure and understand the impact of training.

7.4.2 ISCB Training Audit (April 2013 to March 2014)

A Safeguarding Training Audit took place in April 2014. This audit examined the uptake and effectiveness of training programmes across the individual agencies. 36 services submitted returns, 23 returns from voluntary sector - a vast improvement on previous year's audit. Probation did not submit a return (Training and Workforce Subgroup, 2014).

At the same time, the Islington Safeguarding Children Board asked the sub-group to include a 'Deep Dive' Audit around domestic abuse training. It wanted to identify categories of staff who should complete domestic violence training and the number who had completed CAADA-RIC/Barnardos risk assessment training. Returns on this audit were only 27%, which is disappointing. This is a worrying return in light of the prevalence of domestic violence within referrals to social care and children on Child Protection Plans. It is also notable that a significant number of services working with young people did not give a return in light of the revised definition of domestic violence to acknowledge children under 18 as potential victims/ perpetrators. (Training and Workforce Subgroup, 2014)

7.4.2.1 Early Years

Overall compliance with safeguarding training remains high as a result of Ofsted monitoring and inspection. Training focuses on staff identifying concerns, liaising with Children's Services and domestic violence awareness Housing (HASS)

As reported in previous year's audit, there is still considerable work required with only 15% compliance reported in staff. The focus of safeguarding work remains within safeguarding adults at risk.

7.4.2.2 Health (Camden and Islington NHS Foundation Trust)

Compliance remains high and is monitored monthly via performance meetings and monitored by the Designated Nurse. Targeted training is delivered where necessary.

7.4.2.3 Islington Clinical Commissioning Group

Compliance remains high with mandatory child protection training reported on quarterly and monitored by the Designated Nurse and Islington CCG Child Protection Committee. Any areas of concern are monitored via contracts with NHS England (London). However, it is not clear if compliance of staff reported this year includes both independent contractors (G.P's, pharmacists, dentists etc.) and /or staff employed within the CCG.

7.4.2.4 Moorfields Eye Hospital

Compliance remains high. Focus on training is referring safeguarding concerns to appropriate staff member. Learning is supported by Trust intranet site and Named Nurse. External trainers are brought in to provide bespoke training, eg. domestic violence sessions. A confirmed pathway is in place for referring concerns and for the notifying of missed appointments.

7.4.2.5 Tavistock & Portman NHS Foundation Trust

Compliance is high with designated staff also trained in CAADA and or Barnardo's. Named Doctor and Named Nurse also provide support. Vulnerable children are flagged on recording systems and therefore clinical interventions are mindful of wider context of assessing risks.

7.4.2.6 Whittington Health NHS Trust

Compliance has increased dramatically over last year from a low base uptake. Awareness of need to undertake training has improved and a regular timetable of training occurs. Evaluations post training are positive and subsequent documentation and liaison with members of the Safeguarding Team are more timely and appropriate. Whittington Health has a large resource of Child Protection Specialists supporting staff across community and acute settings. A specific Safeguarding Children Intranet page supports the training.

7.4.2.7 Metropolitan Police

The audit only reported on police officers working in MASH (6 officers) and compliance is quite poor in this area. Other police departments working with children and families are not included in the audit. It is concerning that reported compliance is below the expected levels and police staff would benefit from training in a multi-agency context.

7.4.2.8 Schools & Young People's Services, Education Welfare Service

Good compliance is reported and supported by case audits, reporting of allegations and through dialogue with colleagues and partner agencies. The concern with these figures is that they represent establishments rather than numbers of staff trained. This can mean that potentially only a few members of the team within a school are trained.

7.4.2.9 Targeted and Specialist Children and Families Services (CSC, YOS/TYS and Families First)

Training levels remain below what is expected despite a concerted effort from managers to increase compliance. Staff turnover has impacted on the compliance levels with oversubscription of ISCB training meaning lack of availability of training courses.

7.4.2.10 Voluntary/Commissioned Sector

22 Private and voluntary agencies responded to the sub-groups audit, all of which reported very high levels of compliance. Most agencies worked intensively and specifically with children and it is therefore understandable and encouraging that they were well-trained. The board is aware that much more needs to be done to extend the reach of training into the voluntary sector.

7.4.3 Agencies that did not complete the audit.

7.4.3.1 Probation Service

An audit has been requested but not received.

7.4.4 Overview impact, effectiveness and quality of training and matters arising

It is apparent that the majority of agencies have robust processes in place for providing or accessing training. It is also encouraging that the training is supported through a variety of means, namely supervision and appraisals. It's regrettable that the sub-group was unable to implement a system for measuring the impact of training; this should be a future priority of the sub-group (Training and Workforce Subgroup, 2014)

7.4.5 Key actions arising from the training audit

1. Further work through the Training and Professional Development sub-group to support agencies to achieve compliance in safeguarding children training.
2. Membership of sub-group reviewed to reflect appropriate and effective representation. New chair of the sub-group appointed May 2014.
3. Attendance of a police service representative at the Training and Professional Development sub-group.
4. Encouragement of Probation service to complete next audit.
5. Develop and trial use of the Pan London Training Evaluation Toolkit from October 2014 as the key tool to measure effectiveness of training. Monitor implementation through the sub-group.
6. Address issue of lack of availability on ISCB training courses through developing revised booking systems and charging agencies for non-attendance.
7. Overturn decision made by ISCB to discontinue level 1 training within the ISCB. Audit demonstrated need to continue offering this course, particularly to meet needs of voluntary sector.

7.4.6 ISCB Safeguarding Training Programme 2014/15.

The following courses are delivered through the ISCB (Training and Workforce Subgroup, 2014):

- Introduction to Child Protection and Safeguarding (level 1)
- Foundation in Child Protection and Safeguarding (Level 2)
- Refresher and Updates (Level 3)
- Child Sexual Exploitation (Level 3)
- Domestic Violence (Level 3)

- E-safety (level 3)
- Parental Mental Health (level 3)
- Neglect (level 3)
 - a. Neglect in the Early Years
 - b. Neglect in the Middle Years
 - c. Neglect and Adolescents.
- Parental Substance Misuse (level 3)
- Designated and Named Person (level 4)
- Managing Allegations against staff – the LADO procedures
- E-CAF training

7.4.7 Forward plan

The Islington Safeguarding Children Board has decided to continue offering ISCB level 1 training due to demand from the voluntary sector.

From the next financial year, the course programme will be based on financial year; therefore September 2014's brochure will run for six months until April 2015.

The Training and Professional Development sub group will produce their annual report in May from 2015, aligning it better with the cycle of the Islington Safeguarding Children Board Chair's 2014/15 Annual Report .

7.4.8 ISCB Annual conference

The LSCB conference attracted more than 150 colleagues from across the children's workforce. The theme was Parental Factors: parental substance misuse, parents with Learning disability and parental mental health. The board commissioned eminent speakers and researchers who spoke with great understanding about their subject. Evaluations showed that the conference was both thought provoking and useful.

7.4.9 Child sexual exploitation (CSE) training

In 2013/ 14 Islington Specialist Private Fostering, Trafficking & CSE Social Worker offered advice and consultation to social workers, as well as providing training both internally and to partner agencies. As a result of this hundreds of staff across TSCFS, health, housing, targeted youth, youth offending, voluntary sector and the faith sector have received CSE awareness raising training. All training for designated staff includes a briefing on sexual exploitation. (CSE subgroup, 2014)

ISCB has run several CSE trainings for all agencies in terms of raising awareness following on from this it facilitated the running of four direct work tools days training sessions in 2013/14, which were targeted to TSCFS staff. Feedback from the awareness training was hugely positive and created a demand for further training focusing on direct work (CSE subgroup, 2014)

7.5 *Recruitment and supervision of the children's work force*

7.5.1 Staff turnover in Children Social Services

Since the previous year, there has been some turnover in the CSC workforce with increased dependency on agency staffing. Turnover is 15.5% across the targeted and specialist service, but caseloads are reasonable though increasing.

Churn in staffing within the CIN service has impacted on timescales for achieving timely assessments and has reduced the through put of work increasing the overall number of cases in the system (Quality Assurance subgroup, 2014).

7.6 *Allegations against persons who work with children*

The Local Authority Designated Officer⁸(LADO) prepared a thorough and comprehensive annual report to the board for scrutiny in July 2014 (LADO, 2014). It covered the period 1st April 2013 to 31st March 2014 and focused data gathered from referrals as well as work undertaken to raise awareness of the LADO role and its associated procedures.

Working Together 2013 has not changed the threshold criteria for allegations against staff, but the reporting requirements have been tightened up with all agencies now having to report all allegations to the LADO within 1 working day.

Referrals numbers were similar to last year, maintaining the rapid increase that occurred in 2011/12. Likewise, referrals were characterised by a variety of professionals and agencies. The most likely explanation for this trend was an investment in raising awareness with partner agencies.

7.6.1 What we wanted to achieve in 2013/4

7.6.1.1 Raising awareness

⁸ LADO role provides “advice and guidance to employers and voluntary organisations, liaising with the police and other agencies and monitoring the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process.” (Working Together 2013, Chapter 2, section 4)

In conjunction with NHS England we've shared local guidance with GP's, opticians, pharmacists and dentists and we've included a reference to the LADO procedures in the CCG's HR policies. More work needs to be done about whistleblowing policy in the CCG.

Whittington Health has undergone introduction training on dealing with allegations against.

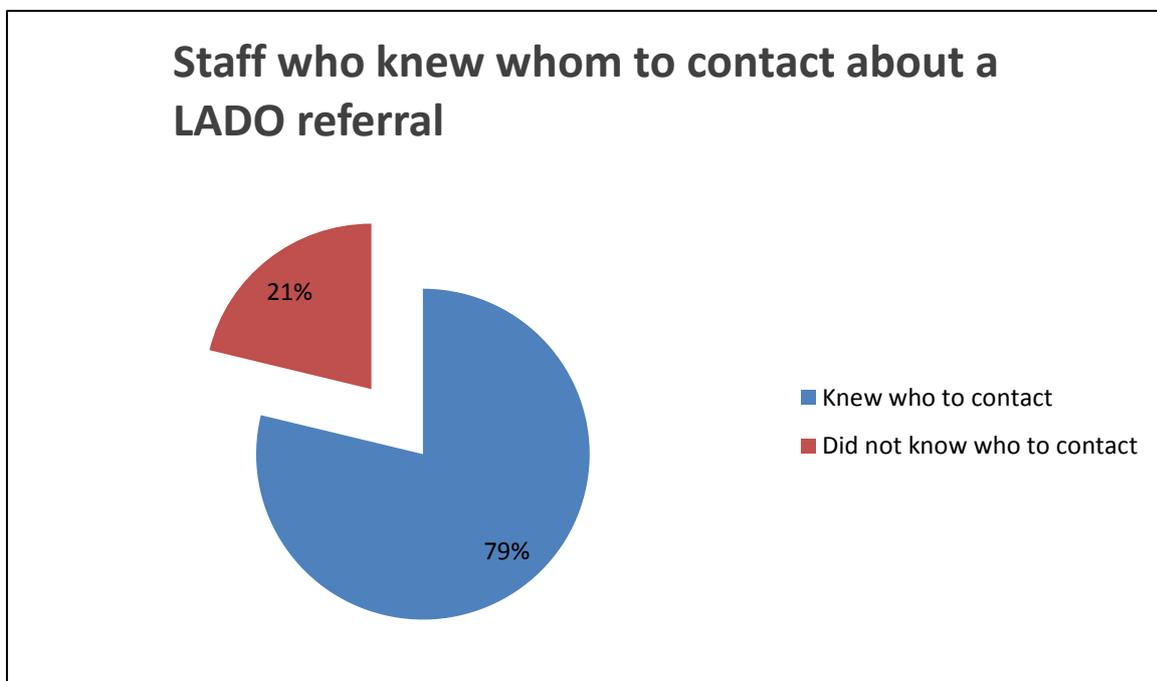
The absence of a voluntary sector champion on the LADO steering group has reduced awareness raising efforts within the voluntary sector.

The LADO has attended the faith forum and promoted the LADO procedures and duties. The faith schools are maintained except for the Christian school, all receive the information on LADO procedures and this is all included in designated training.

This year has seen a number of allegations involving the police force and it has identified a need for further liaison with the Independent Police Complaints Commissioner to shore up compliance with the board's allegations procedures.

7.6.1.2 LADO survey

Figure 4 - LADO survey



Local procedures have been cascaded to board partners and publicised on the website and the boards policy and practice subgroup survey randomly tested staff knowledge of procedures in Whit-

tington health, children’s services, early years, play and youth, housing and adult social care, police, Camden and Islington Mental Health Trust, supplementary schools and Islington’s CCG.

Results were encouraging - most staff could say to whom they should report a concern but only a tiny minority realised the procedures apply equally to allegations in private life matters. Fewer than half of those surveyed knew a report should be made within one working day.

7.6.2 LADO Steering group

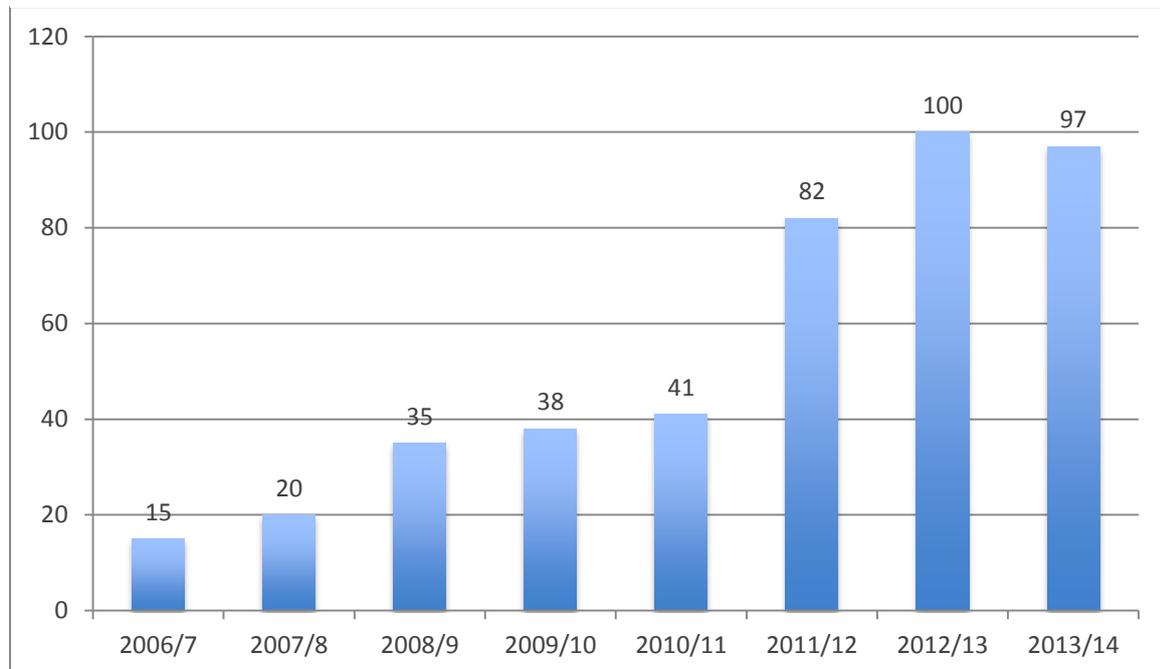
The LADO has continued to chair the termly Steering Group. Meetings were multi-professional and well attended with representatives from Fostering, Education, Early Years, Health, Housing, Faith Sector, Voluntary Sector, Police, Children’s Services Human Resources as well as the Child Protection Co-ordinators who Chair the Strategy Meetings.

The Board has facilitated two training sessions that were very well received and a number of organisations changed their policies and procedures as a result. We will continue to run these sessions twice a year.

7.6.3 LADO Referrals

The majority (73%) of referrals were allegations against staff in their professional capacities; the re-

Figure 5 - LADO referrals 2006-2014



maining 27% related to Private life matters.

Two cases in the year have resulted in a referral being made to the *Disclosing and Barring Service* (DBS) to recommend that the professional is barred from working with children (LADO, 2014).

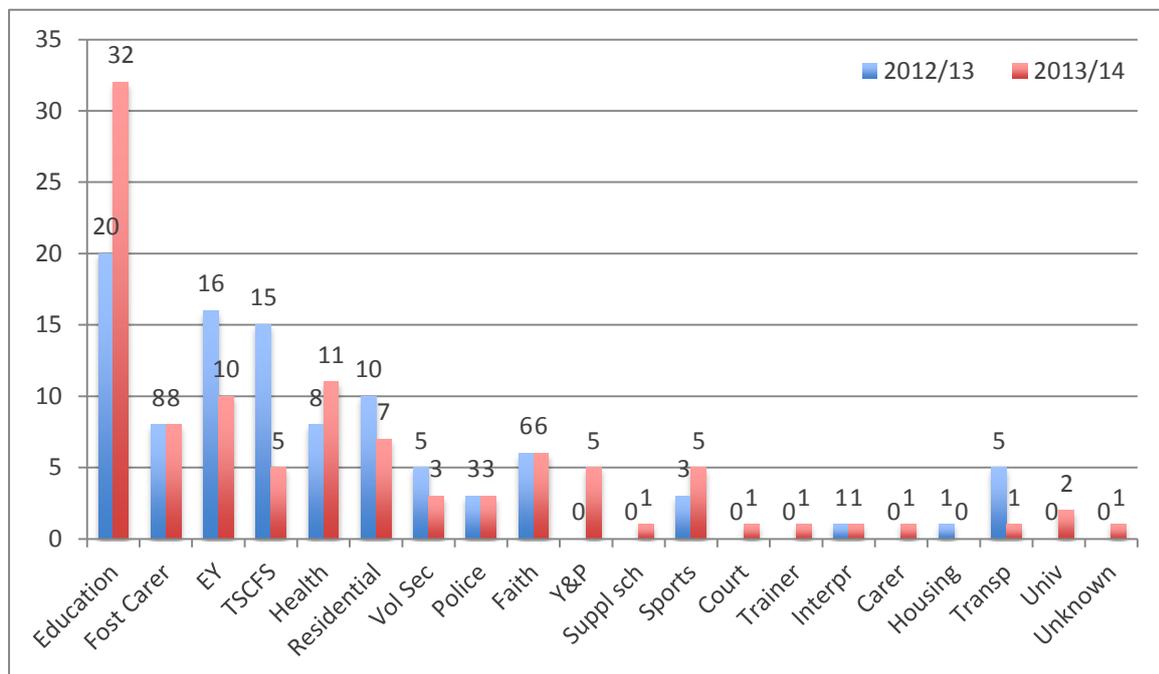
7.6.4 Conclusion and Recommendations

Referral rates remain high by comparison to earlier years because of the LADO’s persistent efforts to support agencies (practice meetings, and providing advice, consultation and training) in increasing their confidence and expertise in the area.

Throughout London referrals to the LADO range from 40 to 150 per borough per year. In the main high numbers of referrals to the LADO are in boroughs where there is a full time LADO post, lower numbers of referrals relate to boroughs which do not have a separate LADO post and incorporate the duties within the Child Protection Co-ordinator role. Islington is now in the position of receiving high numbers of referrals to the LADO but the borough does not have a solely designated person in

Figure 6 - Allegations by sectors, 2012/3 vs 2013/14

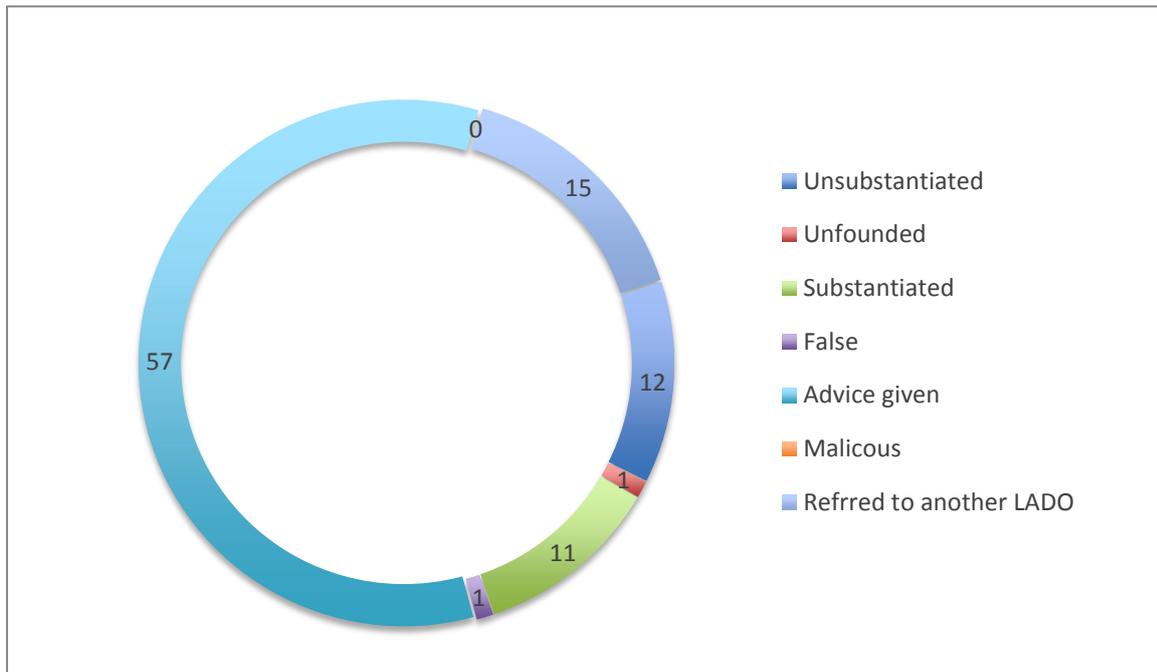
this role.



Action 6: Board Members to assure the Chair that they have suitable mechanisms in place through the Senior Named Officer structure to identify matters that need to be referred to the LADO

LADO referral numbers are small and one should show caution in reading too much into them, however, there appears to be an increase in the number of referrals from education staff and a decrease in the number of referrals regarding TSCFS staff. Referrals from Whittington Health, Primary Care

Figure 7 - Outcomes of LADO referrals



Services, CGG and Camden and Islington mental health trust seem low considering the size of these organisations.

Further work for the year 2014-2015 for the LADO and the designated leads on all agencies (Eden, 2014):

1. Raising awareness with Whittington Health, CCG, primary care services, Camden and Islington mental health trust, Voluntary sector, supplementary schools and the Sports sector.
2. Amend procedures to include what employers records need to cover, especially where an allegation does not meet LADO criteria.
3. Consideration of a referral form for LADO referrals.
4. Create and implement a Risk Assessment Template for employers to use.
5. An audit of unsubstantiated cases and advice only cases to assess whether there are any themes.
6. Links with groups that run extra-curricular activities for children
7. Undertake a self-assessment against the *Department of Education Self-Assessment Tool for Allegations*.

8. Ensure that commissioned services cover allegations management within their contracts.

7.7 *Safety of privately fostered children*

Minimum Standards⁹ require that:

“The local authority reports annually to the Chair of the Area Child Protection Committee (or its successor body, the Local Safeguarding Children Board) on how it satisfies itself that the welfare of privately fostered children in its area is satisfactorily safeguarded and promoted, including how it co-operates with other agencies in this connection.”

The board received a report (Private Fostering Report, 2014) from the LA’s specialist private fostering social worker in May 2014 (ISCB, 2014).

Since the board’s last private fostering update on 16th May 2013, the Specialist Social Worker for Private Fostering (SSWPF) and the Private Fostering Multi-Agency Task Group have been implementing the 2013 - 2014 Private Fostering Strategic Plan to raise awareness and target specific services and community faith groups.

Ofsted published a report in respect to private fostering in January 2014: ‘Private Fostering: better information, better understanding’ and the LA was mindful of these recommendations in preparing Private Fostering Strategic Plan for 2014 - 2015.

7.7.1 *Work undertaken during 2013/14*

The SSWPF has completed the majority of tasks contained within the 2013 - 2014 strategic plan, mostly in relation to raising awareness in TSCFS, partner agencies, faith groups and the larger community, e.g. Islington Faith Forum, Interfaith Week Organisers, the North London Central Mosque, youth workers, general practitioners, schools, the Whittington Hospital and UKBA.

The SSWPF has updated all the private fostering publicity materials which has been issued under the auspices of the board.

Within CSC, there was a good practice via dedicated Private Fostering Panel, consultations and joint working with social work colleagues.

⁹ Standard 7, National Minimum Standards for Private Fostering 2005

Policy writers from the *Department of Education* visited Islington in September 2013 and they were impressed with the work undertaken in Islington. They were particularly interested in Islington, particularly about the collaborative work with the School Admissions Team and the Service Level Agreement with the Home Office. They commended Islington for having a dedicated Social Worker to raise the profile of private fostering.

Islington hosted the *British Association for Adoption and Fostering* (BAAF) National Conference on Safeguarding the Welfare of Privately Fostered Children in January 2014. At the conference Ofsted highlighted findings from their inspection report 'Private Fostering: better information better understanding'. The headline finding was a national decline in the identification of privately fostered children, which chimed with experiences in Islington. They emphasized that the quality of collected data prevents benchmarking against other authorities / areas, especially in areas with language schools that reported unusually high numbers of privately fostered children.

The majority of those making referrals are professionals. Yet, despite vigorous campaigns, notifications in Islington declined from 4 (2012/3) to just 2 in 2013/4. This is against the backdrop of existing private fostering arrangements, which has since declined to just 3. The report assured the board that for legitimate reasons these children were no longer privately fostered. In one case the Local Authority identified a child at risk of harm and invoked statutory procedures to protect him.

Action 7: LA to assure the board that they have responded to the national inspection finding that identified that local areas have a poor understanding about the underlying reasons that explain the decline in private fostering numbers. All Board Members to assure the chair that they have robust mechanisms in place for identifying and referring private fostering arrangements to the LA.

7.7.2 Quality Assurance of private fostering casework

Private fostering cases are regularly reviewed by the Private Fostering Panel which scrutinises assessments of and arrangements for privately fostered. There were some concerns about the timeliness of private fostering visits but data is unreliable because of the small numbers involved.

The Islington Safeguarding Children Board Quality Assurance sub-group considered the information and stated that:

"Compared to 31 March 2013 (and in common with other areas) there has been a large reduction in privately fostered children, we now have only 3 arrangements. This is due to the lack of newly identified arrangements as 3 children turned 16; one child was looked after, three went home and two moved out of the borough during the year.

"Universal services need to exercise further vigilance to identify private fostering arrangements; the specialist social worker will need to continue awareness-raising within universal services. (Quality Assurance subgroup, 2014)

7.8 Co-operation with neighbouring children's services authorities

The Local Authority and board sub-groups chairs were actively involved in the development of *Pan-London Child Protection Procedures*.

8. Communicating and raising awareness

A key board duty is to communicate the need to safeguard and promote the welfare of children in Islington, and to make agencies aware of how this can be achieved.

The P&P subgroup is chiefly concerned with the ISCB communications strategy and awareness raising. (P&P Minutes, 2014.03.27). In the last year they focussed on the review and development of promotional materials (Policy and Practice, 2014):

1. Domestic Violence leaflets and posters
2. A Domestic Violence information card
3. Child Sexual Exploitation cards for parents and young people
4. Child Sexual Exploitation leaflets for parents and professionals
5. Safeguarding deaf and disabled children leaflet
6. Missing children leaflet
7. Strengthening families information
8. Feedback booklet for children and young people to Child in Need meetings

Copies of all documentation are posted on the ISCB website and attempts are made to achieve a wide distribution through partner agencies. Leaflet provision to housing estates and community centres has been particularly active. Agencies have been requested to monitor the availability of leaflets in local sites. A comprehensive distribution list has been compiled which is being kept under regular review, however, anecdotal feedback from front line practitioners indicates that there are issues with the dissemination of information therefore there will be a stronger focus on this aspect for the next year (Policy and Practice, 2014)

The ISCB website has been kept under review and has been regularly updated with new information. The menu was restructured to be more coherent and several new pages were added to reflect changes in the responsibilities of safeguarding children boards and new initiatives; these included Neglect and Children Looked After (Policy and Practice, 2014).

The Neglect toolkit has been added to the website and has been launched in all designated officer and CAF training. The toolkit was presented to the Children's Services Conference and the Head Teachers Forum. The Children's Services Contact Team refers partners to the toolkit (Policy and Practice, 2014).

The ISCB newsletter is produced three times per year with input from member agencies; attempts are made to achieve as broad a distribution as possible in order to reach a wide audience. The newsletter serves a vehicle for publicising recent events concerning safeguarding children, new initiatives and changes in policy and practice. It also includes some basic facts and figures concerning the child protection system in Islington. Whilst this appears to be well received it is felt that there could be more focus on evidencing the impact of the work of the ISCB and partners and outcomes for local children and young people, therefore, this will be a priority consideration for the forthcoming issues. (Policy and Practice, 2014)

9. Monitoring the effectiveness of what is done by the authority and the board partners

9.1 Quality Assurance

9.1.1 Quality Assurance subgroup Annual Report 2103/4

The Quality Assurance subgroup focusses on monitoring the effectiveness of the authority and board partners; the sub-group chair presented a thorough and comprehensive annual report for scrutiny to the board on 15th of July 2014 (Quality Assurance subgroup, 2014). Their work plans were ambitious and focussed, in the main, on scrutinising core data of the child protection system.

The report highlighted notable improvement during the preceding year, but also identified a few areas for improvements.

9.1.1.1 Improvements

1. Very good information sharing between agencies
2. Children do not fall through the net of services between early help and statutory children in need services
3. Greater consistency in threshold for child protection enquiries preventing families being drawn into the statutory process
4. Mental health trust is better at identifying parents and their children
5. Early help services are effective and reaching the right families
6. Agencies are able to challenge one another when there is disagreement
7. Increased use of the Common Assessment Framework
8. Quality of practice in Islington's residential children's home has improved
9. The Children's Services Contact Team (CSCT) and Multi Agency Safeguarding Hub (MASH) are working effectively
10. Care proceedings are taking less time so decisions for children in court are more timely
11. Good multiagency attendance at child protection meetings
12. Child protection issues are resolved in a timely manner

13. Care proceedings to protect children, avoid drift
14. Good parental engagement in the child protection process
15. Improved identification and protection of children at risk of sexual exploitation
16. Improved participation of GP at child protection conferences
17. Authoritative decision making is ensuring younger children are provided with permanent alternatives where their family are unable to care for them
18. Preventative work is reducing the number of CLA despite requirement to look after more aged 16+
19. Improved process and commitment to interagency audit

9.1.1.2 Areas for improvement

1. Improve software to support the consistent recording and management oversight of Early Help
2. Improve quality of CAF used as an early help assessment outside of Families First
3. Improve and increase those undertaking Lead Professional role outside of Families First
4. Distinguish when CAF is used as request for service and early help assessment
5. Improve consistency of practice in Disabled children's social work
6. Improve quality and review of Children in Need (CIN) plans in Children's Social Care (CSC)
7. Continue to improve the timeliness of single assessment
8. Improve Retention of Social Work staff within the CIN service
9. Improve attendance at parenting programmes especially fathers
10. Increase range and scope of multi-agency audit

9.2 Core data about the child protection system

9.2.1 CAF outcomes

The use of the Common Assessment Framework (CAF) has been developed so that it can be used as a Request for a Service, or an Early Help Assessment. 547 new CAFs have opened during the year, a 12% increase on last year. Unfortunately it is not yet possible to identify how many of these CAFs were completed solely as a request for service and how many were an Early Help Assessment.

Action 8: Whilst it is positive that Early Help Assessments are being used, it is important that we can identify, where e CAF is being used, how many are early help assessments and how many are requests for service. The board would like to see that universal services increasingly take on the duties of lead professional when required to do so.

9.2.2 Early help services

Last year's report (ISCB Annual Report, 2013) introduced *Families First* as a developing Early Help initiative in Islington that has already shown promising results. This year, the LA has built on that success. They received 199 (1006) more referrals than last year and worked with 325 more families (1158). There was a 22% reduction in Early Help Assessments

The board heard that 84% of families showed improvement in keeping children safe, especially for those with the highest levels of unauthorised absence.

Overall, the evaluation of Families First indicated that it was having an impact in supporting families to sort out problems. On entry to Families First, approximately 62% of full intervention families had 2 or more problems and this reduced to approximately 30% of families with 2 or more problems when they exited the service.

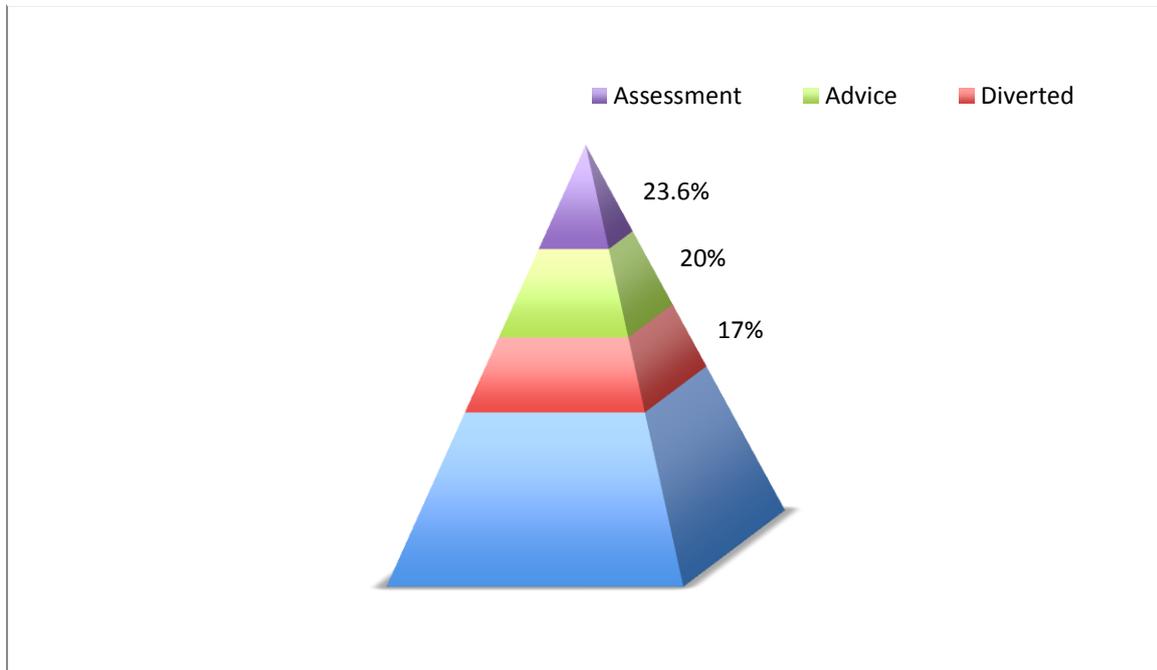
The range of parenting programmes has provided a good reach to vulnerable families. More needs to be done to engage fathers; a specific parenting programme is being run to engage teenage parents.

9.2.3 Referral to children's social care

Children's Services have established a single point of contact, Children's Services Contact Team (CSCT), for all requests for service at Targeted and Specialist levels. The Multi Agency Safeguarding Hub (MASH) is located in the same team. CSCT received 11,724 contacts during the year, which is a very small increase over preceding year (36 cases). As expected, Welfare Reforms meant that more referral were made about financial hardship.

23. 6% of contacts lead to statutory assessments, which is an increase of 1. 8% (or 218 additional assessments). It was thought that an increased awareness of child sexual exploitation, and Early Help services more effectively identifying children in need of protection through the neglect tool kit is the reason for this. 17% contacts were diverted to a targeted service and 20% received information or advice. Remaining contacts were enquiries about access to records, statutory checks form other agencies (CAFCASS, probation etc) or where no further action were required.

Figure 8 - Contacts



By far the majority of contacts with CSCT come from the police (29.3%), a substantial number of which do not progress to assessments, followed by schools (16.7%).

Action 9: Data shows that a substantial number of police referrals to CSCT do not lead to action by Targeted or Specialist services, MPS should review whether the BRAG rating is being correctly applied.

The board heard that thresholds were generous and did not act as a barrier or delay in the provision of services, however, scrutiny of the data shows that half of CSC assessment end in No Further Action. If early help assessments were more robustly conducted in advance of a contact being made with CSCT the right service could be targeted earlier and it will improve the support provided to the family and reduce caseloads within CSC (Quality Assurance subgroup, 2014)

Working Together 2013 requires LAs to abolish Initial and Core Assessments and provide a Single Assessment instead. 62% were carried out within 45 days. The LA's audit showed that child in need cases now have child in need plans in place and the quality of these plans are improving.

Action 10: The Board, through the Quality Assurance subgroup, needs to ensure that statutory assessments are being completed within a timely manner and that SW are using appropriate discretion when extending assessments.

9.2.4 Child Protection meetings and multi-agency working

84.5% of all Strategy Discussions led to S47 enquires, of these 40.7% led to an Initial Child Protection Conference. That is in line with the England (45%) and London (41%) averages. The number of strategy discussions and child protection investigations (Section 47 enquiries) have increased by 100; Islington have a higher rate of Section 47 enquiries than their statistical neighbours and the conversion rate to initial child protection case conference is now equivalent to statistical neighbours (Quality Assurance subgroup, 2014).

Since 01 Apr 2013, 57.6% of all Initial Child Protection Conferences were held within 15 working days. There were 36 additional initial child protection case conferences during the year.

At 31 March 2013 38/10,000 children were subject to protection plans compared to 34/10,000 at 31 March 2014 which is well below the average of statistical neighbours (45.5 / 10,000). Children under 1 year old were proportionally over-represented in child protection numbers, followed by children aged 1-4. Children do not remain on child protection plans for long, although this year children subject to plan for 2 years or more increased from 5.7% to 7.7%.

39% of families with child protection plans had DV as a contributory factor a decrease of 17% on the previous year, followed by mental health 15% overall and substance misuse 16% overall.

Action 11: Initial Case Conferences should take place no later than 15 working days after the initial strategy discussion. CSC and the CAIT should assure the Board that SW managers and CAIT officers are exercising appropriate discretion in extending child protection enquiries beyond this time-scale.

9.2.5 Working with families

Mothers attended 79% (last year 82%) and fathers 68% (last year 54%) of Child Protection Conferences they were invited to (Quality Assurance subgroup, 2014). Parents' views indicate positive views about the child protection process and parents have stated that they felt included and heard.

9.2.5.1 Number of child protection plans during 2013

Month	Number with CPP	Population under 18 years	Number with CPP per 10,000 Islington under 18
Mar-09	138	33,692	49 SN* (41)
Mar-10	132	33,743	53 SN* (33)
Mar-11	112	33,743	52 SN* (33)

Mar-12	141	34,297	46 SN*(41)
Mar-13	117	34,297	34
Mar-14	137	36,700	37

9.2.5.2 Categories of risk in child protection plans

Category	Mar-09	Mar-10	Mar-11	Mar-12	Mar-13	Mar-14
Emotional	58	46	43	58	48	62
Neglect	75	79	61	70	60	64
Physical	4	7	4	6	6	10
Sexual	1	0	0	7	3	0
Multiple Categories	1	0	0	0	0	1
Total	138	132	112	141	117	137

9.3 *Islington's Looked After Children.*

The Board received a report from the LA about CLA. (CLA Report, 2014)

The Local Authority's rate of children looked after is higher at 84 per 10,000 compared with statistical neighbours at 75 /10 000. There has been a 30% decrease in Children Looked After since 2005 but numbers have stabilised in the last three years. On average 13 new children and young people become looked after each month, though this masks peaks of 21 and troughs of 6 in any year. (CLA Report, 2014)

As a result of a higher than average number of children subject to Care Orders, a review of thresholds for commencing care proceedings and a retrospective examination of care proceedings cases ending in supervision orders suggest that legal proceedings could not have been avoided (LAC Report, 2014)

9.4 *Audits and evaluations*

9.4.1 Section 11 audit

The Section 11 safeguarding audit¹⁰ was done in 2012 by Board members, and the quality assurance subgroup continued to monitor agencies' progress against their action plan. (Quality Assurance subgroup, 2014)

9.4.2 Multi-agency audit: neglect

In November 2013, a multi-agency audit of 10 children previously subject to a child protection plan for neglect was undertaken as part of the Safeguarding Children's Board (ISCB) quality assurance arrangements (Quality Assurance subgroup, 2014).

There was engagement with the audit from; children's social care, adult mental health services, schools, police, early years, probation, adult substance misuse, Whittington Health.

Most cases (7) were graded as good while 3 required improvement. No cases were graded as inadequate. The board was pleased to see that the audit indicated improvements in practice.

The audit included feedback from parents, who said that they were kept fully informed and understood the child protection process. They also all reported that they were given the opportunity to be heard in meetings.

The audit confirmed the following good practice

1. Consistent evidence that assessments included parental history and considered the impact this had on parental capacity.
2. Examples of good information sharing and agencies working together.
3. Evidence of effective use of care proceedings to safeguard children, when risks were too high and change was not being affected under CP plans.
4. Sharing of information in child protection cases by the police, including gathering and sharing of information between different CAIT teams when the family is transient.
5. Evidence of Child Protection Conferences occurring within timescales and conference minutes and child protection plans being distributed.
6. Attendance at Child Protection Conferences by key professionals is high and there is evidence of their positive contribution to the decisions and planning for the child

¹⁰ Self-assessment against standards in Section 11 of the Children Act 2004 – duty to safeguard and promote the welfare of children

7. All cases had contingency plans in place whilst they were in the Child Protection process and this contingency plan was effectively implemented on a number of cases in which children subsequently became CLA.
8. Whittington Health supervision on CP cases was carried out in line with procedures; cases had actions plans following supervision.

The following needs strengthening:

1. Some assessments lacked the voice of the child.
2. There was evidence of the use of Children Social Care chronologies in most cases and these had been used to inform safety planning for some children. Agencies outside CSC did not always maintain their own chronologies of significant events
3. Information in education files is inconsistent. Education holds a separate file for children with additional safeguarding and welfare needs however the information in these files was limited.
4. Most core group meetings occurred on time and key agencies attended the meetings. The quality of the recording of core group meetings was variable and agencies did not consistently receive core group minutes. Contributing agencies did not have a consistent way of recording core group minutes.
5. Supervision and management oversight was variable across agencies. There was a lack of evidence of reflective supervision on social work files and some gaps in timeliness. Police supervision is timely but the quality of this is variable with some being more process driven. There is evidence of police supervision tackling key issues such as drift on cases and lack of key documentation being on file.
6. Most agencies had reasonable recording of the key information on their files. This was not consistent either across agencies or by different professionals within agencies. There were particular gaps in the recording of some education files where schools were not recording communications with the child and family.
7. All agencies found it challenging to work with distracting parents. These cases showed evidence of drift and that the professionals found it difficult to challenge effectively and maintain the focus on the child. Agencies were able to identify drift in the child's plan but they then struggled to be proactive and robust in challenging this effectively.
8. There was evidence of additional quality assurance activity on half of the CSC files but no evidence of this within other agencies files.

9.4.3 Repeat Referral Audit (Children's Social Care)

20 cases were audited, 10 were repeat referrals within 6 months and 10 were repeat referrals within 12 months. The audit concluded that 50% of the re-referrals could not be avoided with the benefit of hindsight. In those cases where the referral could have been avoided, the main reason related to repeat domestic abuse. The findings of the audit and recommendations were progressed during the year by children's social care (Quality Assurance subgroup, 2014).

9.4.4 Winterbourne View Hospital review

The Quality Assurance sub-group reviewed the requirements arising from the Winterborne View enquiry which identified systemic failings in the public sector approach to commissioning and monitoring of vulnerable adults and some children with disabilities. Seven Islington children had been identified as meeting the review criteria:

1. Five were placed in residential provision funded through the Joint Agency Panel and two were in in-patient psychiatric care.
2. The five children in residential care were all Looked After and subject to the regulations governing review and visiting. One of these children had moved on to adult services. The two children in psychiatric provision had also moved on.
3. The sub group were satisfied that the four remaining children received suitable support and scrutiny by LA.

9.4.5 Audit of RiO (Mental Health Trust)

Following the findings of the Ofsted /CQC inspection of joint work in Adult and Children's services an audit of RiO records was completed in June 2013. The audit wanted to check that progress was reviewed and that the consistency of recording children's details in the Mental Health Trust has improved. A total of 40 cases were randomly selected for the audit.

In the main, staff asked about children during assessments and recorded the information on the risk assessment. The audit showed there are pockets of excellent recording practice, although there is still room for improvement in the consistency of recording. Further awareness raising and guidance has been issued to staff and a re-audit will be completed to ensure standards are maintained and consistency continues to improve (Quality Assurance subgroup, 2014).

9.4.6 Repeat Child Protection Plans (Children's Social Care)

A large proportion of child protection plans are made either pre-birth or when children are in their infancy. There is therefore always the potential for children from the most vulnerable families to once again be subject to a child protection plan at a later stage in their childhood (Quality Assurance subgroup, 2014)

The majority of children subject to repeat CP plans fell within the category of neglect, in some instances the presenting issue was emotional abuse, some children had moved between the categories of neglect and emotional abuse. In long term neglect and emotional abuse cases it could be argued that an alternative to a child protection plan could have been considered. Nevertheless, in view of the relatively small numbers of children subject to a child protection plans at any one time and bearing in mind they will always be from the most vulnerable families, it may not be unreasonable for there to be repeat plans in certain cases.

Repeat plans also raise concern about whether previous plans were ended prematurely. However, in this report there is only evidence of CP plans ending too soon in one case due to lack of robust challenge to parents in the situation and their being significant gaps in the risk assessment. When CP plans were ended children's cases did remain open to CSC and families were offered intervention on a CIN basis. Not all families were willing to engage on a CIN basis and when they did the timescales that these cases remained open for varied, a step down meeting did not always take place when the CIN process ended. There is a step down procedure in place for cases moving from CIN plans to targeted services (Quality Assurance subgroup, 2014).

Repeat plans raise concern about capacity for parents to change, particularly where mental health and substance misuse are the primary issues. A repeat plan will be evidence in itself that prognosis is poor and may be the pre-cursor to Family Proceedings. These cases will need to continue to be under strict scrutiny by the quality assurance sub-group.

9.4.7 Looked After Children Placed at a Distance (Children's Social Care)

The Quality Assurance subgroup subcommittee examined the effectiveness of work with looked after children given the concerns about placing children at a distance from the borough. It is widely acknowledged that children placed at a distance are more vulnerable than those who are placed closer to home. There was good understanding expressed about the reasons that children were placed at a distance and decision making was at a senior level for these placements, children's plans are independently reviewed and visits are in excess of statutory minimum (Quality Assurance subgroup, 2014). The LA surveyed of 29 children who live out of borough and:

- 25 yp agreed or strongly that they were happy living outside London/ Islington
- 29 agreed or strongly agreed that they are happy in their current placement
- 20 said that it made no difference that their social worker was in Islington
- 29 agreed or strongly agreed that they feel safe in the area they live in
- 24 yp said that their placement was making a positive difference to their life

9.4.8 Involvement of Parents and Children

The Quality Assurance sub-group examined a survey carried out by the social care complaints manager of parents whose children had been subject of a child protection enquiry, which had not ended in a child protection conference. The families who responded reported a positive experience and most welcomed the intervention. Given that there were a limited number of respondents it was difficult to draw firm conclusions. One recommendation was that families should be given an alternative contact for use when their social worker is not in the office (Quality Assurance subgroup, 2014)

9.4.9 Scrutiny of Safeguarding Quality Assurance Mechanisms within member agencies

The Quality Assurance subgroup has a rolling programme to review arrangements for assuring the quality of safeguarding practice in Whittington Health, Early Years, Early Help, and CANDI were scrutinised during the year. In 2013, a requirement has been introduced for all Health members of ISCB to share with ISCB any information and feedback from CQC inspection which have included child safeguarding (Quality Assurance subgroup, 2014)

9.4.10 Audit of Cases within Children with Disabilities Service (Children's Social Care)

A sample of 20 open cases were randomly selected to include a mix of personal characteristics of the children e. g. age, ethnicity, sibling, and also a mix of the legislative and regulatory context under which the service is delivered e. g. child in need, child with protection plan, child looked after.

The audit found no child to be unsafe. The overall quality of work and outcomes for the cohort was spread across the range of grades with the vast majority being 'good' or 'adequate'(room for improvement) in equal numbers. There was some consistency of findings across the cohort. These included strengths in relation to up-to-date recording, compliance with statutory processes, engagement with children and young people and family members and aspects of partnership working in Islington. Areas for development included quality and timeliness of assessments, use of advocates and independent visitors as well as clarity about concurrent delivery and synergy of health plans associated with the child's disability and social care plans. Seven cases were deemed 'good' with eight requiring improvement one was outstanding and four inadequate.

9.4.11 Unannounced Service Review of Children in Need

Social Care had an unannounced service review in June 2013, which reviewed the CSCT, and CIN service. 41 cases were audited, 15 staff were met.

The unannounced independent review provided evidence of good practice within CSC, it confirmed that progress had been made in areas identified within the Ofsted inspection and confirmed that children are as safe as they can be in cases examined. The new MASH and CSCT was deemed to be working effectively and thresholds were assessed as clear and generous. The challenge is for CSC to address the variability in practice and to drive improvement in supervision. Following the review CSC implemented and completed an action plan against the findings (Quality Assurance subgroup, 2014).

9.4.12 Child sexual exploitation Children Services Audit

This audit was undertaken to measure if Islington was following *Pan London Child Protection Procedures* including the *Safeguarding Children Abused through Sexual Exploitation supplementary procedures*. The audit sample mainly pre dated the *Pan London Sexual Exploitation Operational Protocol* and therefore performance was not measured against it (CSE subgroup, 2014).

The audit looked at 20 randomly selected cases, which were referred for CSE in 2013/4.

In conclusion this audit found that a wide range of agencies were able to identify children at risk from CSE and then make appropriate referrals to CSCT, which were responded to in a timely manner with work undertaken in line with CP procedures to safeguard children. Many, but not all, children and young people who become victims of CSE have additional vulnerabilities which increases the likelihood of them being targeted. These vulnerabilities will mean that they will continue to be potential targets of CSE which is why medium to long-term specialist intervention is necessary in many cases. Since this audit was undertaken the protocol is now in place and the next steps will be measuring the effectiveness of agencies work in relation to this (CSE subgroup, 2014)

9.4.13 LADO Survey

See section: LADO survey

9.4.14 The Impact of audit work.

It is difficult to establish the direct impact of audits and reviews in the short-term but evidence suggests that by focusing on a particular area the LSCB can influence levels of practice awareness of the issues associated with that area.

Action 12: Islington Safeguarding Children Board to undertake more multi-agency audits in the following year. ISCB partners to consider adding additional capacity to undertake quality assurance audits on behalf of the board.

9.5 Child Sexual Exploitation

In July 2014 the board received an annual report from the chair of the Child Sexual Exploitation subgroup (CSE subgroup, 2014). The sub-group has been working closely with the police, CSC and key partner agencies on the development of Multi-Agency Sexual Exploitation meetings (MASE). Islington implemented MASE in January 2014, in conjunction with the *Pan London Operational Protocol* which introduced the concept of MASE at its launch in February 2014

MASE focused on identification of hot spots, through gathering key intelligence, looking at connections between young people through the gangs matrix and incident reports. It gathered information

from key agencies such as CSC, police, schools, health, voluntary sector, TYS/ YOS and other relevant agencies. It is therefore a strategic meeting that share information and intelligence with a key focus on establishing a detailed overview of the profile of CSE in Islington and to use that information to target services, resources and enforcement, disruption and prevention actions.

Islington was the second highest (in London) in terms of Child Sexual Exploitation reports to the police reports for Child Sexual Exploitation which is evidence of the impact effective awareness raising has on the identification of the issue.

There has been focused work with areas that link to CSE, such as missing children, gang affiliated families and Children Looked After. This work has resulted in the identification of possible or actual CSE cases increasing from 68 to 96 children / young people. This is a significant increase in the number of cases of children/young people identified as at risk of Child Sexual Exploitation.

At the end of the year, four children were subject of Child Protection Plans as their parents have been unwilling to parent in a way that didn't leave them at risk of harm e.g. reporting them missing.

The police are now debriefing children who regular go missing to assist in the early identification of those at risk of child sexual exploitation.

The CSE sub group commissioned an audit of the CSE cases in 2013/14, please see: Child sexual exploitation Children Services Audit

Also see [Child sexual exploitation \(CSE\) training section](#) for information about work force development in this area.

9.5.1.1 MisUnderstood

MisUnderstood is a partnership between the University of Bedfordshire, Imkaan, and the Girls against Gangs project to address young people's experiences of gender inequality. The partnership has been funded by the Esmée Fairbairn Foundation, Trust for London, and the Samworth Foundation, to deliver a three-year programme of work on peer-on-peer abuse: teenage relationship violence, peer-on-peer exploitation, and serious youth violence (CSE subgroup, 2014).

At the end of the audit process the MsUnderstood Partnership will produce an audit report outlining;

1. Strengths in local response
2. Points for local development
3. Gaps in local response
4. Recommendations for local site support.

The project will provide the Islington Safeguarding Children Board with a report in December 2014.

9.6 Missing from care

Missing¹¹ from care report has been received by the board (Missing from Care, 2014)

In January 2014 the Government released Statutory Guidance on children who run away or go missing from home or care. This has informed the amended (currently draft) guidance on *Children Missing from Care, Home and school* in the *Pan London Child Protection Procedures 2014*. (

A risk assessment is completed where there are risks that a child or young person may go missing. Missing from Care (MFC) meetings take place within a maximum of 48 hours of a child or young person going missing. The board is assured that there is robust senior management oversight and the Director of Children's Services inform elected members of any child who have been missing for 5 days or more. Safety plans for children are reviewed on a regular basis.

The CLA service response to children missing from care has improved. There is greater adherence to the procedure, better risk management and safety planning, a greater awareness of the importance of this across the service and good senior management oversight. Safe and well checks are completed by the police on all Children Looked After. However, there is need to focus on ensuring a more effective response to help reduce the frequency of missing episodes for some of the most complex young people. (Missing from Care, 2014)

9.7 Domestic Violence

Islington has the second highest rate of reported domestic violence offences in North London. 3,806 incidents of domestic violence were reported to police in 2012/13. That is a 23% increase in reported domestic violence offences in 2012/13 compared with the previous year. This can be an indication of higher violence and/or greater confidence in reporting to the police.

60% of perpetrators and 57% of victims are 16-35 years old, with almost half of those being 16-25 year olds. Perpetrators are most like to be men (85%).

Welfare reform such as the benefit cap and paying universal credit to one partner could make victims more likely to stay with their abuser if they cannot afford to move. The economic recession and higher levels of unemployment may increase financial stress in relationships.

¹¹Definition: "if their whereabouts are unknown, whatever the circumstances of their disappearance." (Children Missing from Care, Home and school in the Pan London Child Protection Procedures 2014 – Draft)

More victims may stay with the perpetrator because legal aid will not be routinely available in separation, divorce and child contact cases, or for non-British victims not on a spousal visa.

Estimates are that domestic violence costs Islington almost £26 million per year, with the highest cost to physical and mental health services (£7.7 million). However, there are huge costs to criminal justice, social services, housing and refuges and civil legal services (Children and Families Board, 2014)

9.7.1 IRIS project

In 2013 Islington CCG agreed funding for the “IRIS “project in all Islington GP practices and pharmacies. The project will commence in 2014 and will provide training and advocacy support for GPs and pharmacists to facilitate the identification, management and referral of victims of Domestic Violence. (CCG Update, 2014)

The IRIS project will be evaluated over the 2 years by ICCG and also by the CLAHRC (Collaboration for Leadership in Applied Health Research and Care), which will look at the possible mainstream implementation of the IRIS model in general practices throughout the UK. (CCG Update, 2014)

It is anticipated that the IRIS project will facilitate GP involvement in MARAC which is an identified gap (CCG Update, 2014).

9.7.2 The Home Safe Project.

The Home Safe: Domestic Violence (DV) Prevention Education Programme for Schools was introduced as a pilot project in the London Borough of Islington in 2004 and based within the Social Inclusion Unit of Cambridge Education@Islington (the London Borough of Islington’s education partner at the time). The Programme was initially funded through the Safer Islington Partnership, steered by the Islington Domestic Violence Partnership Team and Cambridge Education @ Islington (2004 – 2010). (Home Safe, 2014)

The Programme was set up to meet the aims of the Islington Domestic Violence Strategy, which include recognising the needs of and giving support to children and young people affected by domestic violence. Further, to promote a culture of human rights and non-violence within the school setting based on the principles of gender-equality, as outlined in the Mayor’s current VAWG prevention strategy. Although the key focus is on DV prevention, the programme also addresses wider, interconnected gender-based violence issues in order to contextualise the extent and prevalence of DV in our society, as reflected in the statistics below. (Home Safe, 2014)

9.8 *Children missing from home*

Children Social Care prepared an annual report for the board about children who are missing from home.(Missing from home, 2014). Children who run away are from all sections of society, and when children go missing from home or care it may be related to a safeguarding issue. It is thought that

approximately 25 per cent of children and young people who go missing are at risk of serious harm. There are particular concerns about the links between children running away and the risks of sexual exploitation.

TSCFS formed a multi-agency steering group and agreed an action plan on how to target children missing from home and school. Some of the actions undertaken in the year 2013-2014 include:

During April 1st 2013 to May 2014 the total number of children who were reported to TSCFS as missing was 47; this is almost 50% lower than what was reported last year according to the data. However of the 47 children who were reported as missing, there were 62 different incidents, these figures showed trends in some young people absconding on more than one occasion and over varying frequencies. The data provided numbers of young people reported missing and the number of different times they absconded.

Last year it was reported that 82 children were reported missing from home, but for the same period 2013-14 there is a 43% reduction. We need to ensure this is an accurate picture and this reduction is due to less children absconding, and not because how data is recorded on our different data system (Missing from home, 2014)

9.9 Children Looked After / Permanence planning

The CLA population remains stable at 307 children compared to 310 last year. Islington have 84 per 10,000 CLA compared to 75 for SN. Audits have concluded that the right children are looked after by the local authority (Quality Assurance subgroup, 2014).

Overall decrease of 31% in CLA since 2005, the decrease in the numbers of CLA demonstrates the effectiveness of early intervention, alternative solutions to becoming looked after and the timeliness of permanent solutions for those who do become looked after, for example, adoption, special guardianship, rehabilitation home.

There has been an increase of 3% of newly looked after children who are required to be placed outside of the borough. The LA assured the Quality Assurance subgroup that children are appropriately placed outside of the borough given their needs and reflects an increase of children who are at risk of sexual exploitation and need out of borough placements to help reduce their gang association. There has been 100% increase (25 children) in the use of residential care for children, largely due to the complexity of their needs. As most residential care is outside of London, this also explains the increase in numbers of those placed outside of the borough. Out of borough placements are kept under strict review and decisions are made at head of service level.

39 children under 1 year were looked after during the year, this is proportionately the largest age group which demonstrates the effectiveness of early identification and intervention. At the end of

March 2014 74% of children were looked after through a court order because they were suffering or likely to suffer significant harm.

9.10 External inspection findings

9.10.1 Inspection of Lough Road Children's Home

Ofsted had their annual unannounced inspection on 1st October 2013. Inspectors rated the services as Good for 'overall effectiveness', 'outcomes', 'management and leadership' and 'safeguarding' and 'quality of care'. This is an improvement in the quality of care rating, which was previously adequate (Quality Assurance subgroup, 2014)

10. Participating in the planning of services

10.1 Working with other boards

The LSCB Chair continues to attend and update the Children and Families Partnership Board on LSCB activity. This year, the boards have refreshed their working protocol to ensure that suitable governance arrangements are in place. Similar arrangements are in place with the Islington Health and Wellbeing Board and the Adult Safeguarding Board.

During the next reporting cycle the Islington Safeguarding Children Board will want to renew the protocol between itself and the Safer Islington Partnership board to ensure that protocols and procedures are in place that ensure that children are at the heart of cross-cutting agendas such as domestic violence and harmful traditional practices.

Action 13: Safer Islington Partnership and Islington Safeguarding Children Board to refresh the protocol and procedures between them to ensure that children' welfare is the primary consideration in their work plans.

10.2 Membership, attendance and participation

The LSCB has a membership pack available for all new board / sub-group members which is reviewed as part of the annual reporting/business planning cycle and further documents will be made available as required.

10.2.1 LSCB attendance of agencies / represented sectors.

Key to the effectiveness of the LSCB is regular attendance by members (see appendix)

All required agencies attend the board regularly and have formed as strong partnership to carry out board business. In future the board will want to be more strategic in its approach and deepen its scrutiny function.

10.2.2 Participation in the work of the board

The active participation by the LSCB's members in the agenda and activity of the Board could be said to demonstrate effectiveness of the strategic leadership of the safeguarding system in terms of understanding their part in the safeguarding system. One way to gauge this is through the involvement in the LSCB agenda by members.

10.3 Challenge and response to challenge

The LSCB independent chair, Alan Caton meets regularly with Eleanor Schooling (DCS), Cathy Blair, the Director of TSCFS, and Lesley Seary, Chief Executive. Alan Caton also attends the Children and Families Partnership Board to update them on the work of the LSCB.

11. Serious Case Reviews

There have been no serious case reviews during the year. (Quality Assurance subgroup, 2014).

11.1 Management Review of Child D

A management review was undertaken concerning a very young child who was physically abused by her mother's boyfriend. The circumstances did not meet the threshold criteria for a serious case review. The learning centred on the following (Quality Assurance subgroup, 2014):

1. Increased use of CAF, lead professional and multi-agency risk assessments in cases on non-engagement with young people who have a history of non-engagement/missed appointments with a range of services. Development of professional curiosity and improved management oversight of cases.
2. Exploring and challenging the impact of religious beliefs on parenting. Understanding of the role and responsibilities of agencies particularly FNP and Children Centres. Clarity of transfer of cases between agencies 'step-up and step-down'.
3. Implementation of the *London Child Protection Procedures*, including in the cases of unborn children where they should be the focus.
4. Ensuring that Single assessments include a risk assessment.

11.2 Management Review of Child E

This report focused on lessons to be learnt from an analysis of multi-agency involvement with Child E who died after a fall from a balcony at her home, which was on the 11th floor of a block of flats. She had a diagnosis of autistic spectrum disorder.

The board co-ordinated a multi-agency management review of the circumstances to discover what lessons could be learned. The main lesson in this case related to how agencies involve housing and ensure that they communicate need and risk appropriately. A housing policy was created in light of the findings and an extensive action plan was overseen by the Quality Assurance subgroup (Quality Assurance subgroup, 2014).

12. Child Death Overview

In its 6th year of working, Child Death Overview Panel continues to be well attended by a core group of professionals from health, social care and the police. Additional members from other services

(e.g. Education, Housing, Community Children's Nursing Team and the Life Force Team) are invited to attend depending on the cases being discussed.

In 2013-14 there were 13 deaths of Islington residents under the age of 18 years. The average for the previous 5 years being 14.4 deaths/year with a range of 9 to 19 deaths.

The Panel discussed 8 deaths in 2013-14 of which 3 were identified as having modifiable factors¹²— The issues that were identified as contributing to these deaths and the actions that were undertaken were:

- Co-sleeping with a child who was a Sudden Unexpected Death in Infancy – reminders to all health visitors about advice on co-sleeping
- Housing issues in a child with additional needs – a new policy was written for re-housing families who have children who are physically able but at risk in their home environment
- The importance of safety netting and advising families of red flags when seeing children in a Walk in Centre – further training of the GPs in the Walk in Centre on relevant paediatric clinical issues was completed

Away from the individual cases examples of what the Panel also looked at were the cost of funerals for babies, children and young people; the End of Life policy used by Whittington Health; child deaths in families where the parents are related, a practice seen more often in some ethnic groups; and reviewed its own processes in light of the new Working Together 2013 which have been carried into the next year. In addition there have been exploratory discussion about how we might work with neighbouring boroughs to share good practice and learning, and this too has been taken into the next year with a new chair form public health.

¹² A modifiable factor is defined as having “contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.”

Section VI: Resources and Capacity

1. Budget

	12/13	13/14
INCOME		
Carry over from previous year	5 453.00	38 370.00
London Borough of Islington	118 754.00	118 754.00
Islington PCT / CCG	33 456.00	11 500.00
Probation	2 000.00	2 000.00
Other grants, reimb & contributions		28,271.72
Munro grant	31 882.00	
Metropolitan Police	5 000.00	
CAFCASS	1 100.00	
Subtotal	197 645.00	198 895.72
EXPENDITURE		
Staff:		
Salaries, 2.5 staff	122 148.00	147 546.42
Training / conferences	575.00	8.33
Travel	290.00	172.10
Agency		6 241.25
Sub-total	123 013.00	153 968.10
Board courses:		
Hire facilities	2 187.00	1319.75
External trainers / e-learning	900.00	853.00
Refreshments	2 806.00	262.50
Printing (leaflets, newsletter)	4 012.00	5 032.00
Sub-total	9 905.00	7 467.25
Board Expenses:		
Chair		
SCRs		
Annual conference		
Board development		
Sub-total	24 599	8 469.77
Office expenses:		
Stationary	1 758.00	768.45
Sub-total	1 758.00	768.45
Total expenditure	159 275.00	170 673.57
Carry over / shortfall	38 370.00	28 222.15

Action 14: The board should review the financial contributions of members so that they do not disproportionately fall on a small number of agencies.

Section VII: Conclusions

This report has provided an assessment of the effectiveness of local arrangements to safeguard and promote the welfare of Islington's children. It has evidenced that safeguarding activity is progressing well locally and that the Islington Safeguarding Children Board has a clear consensus on the strategic priorities for the coming year as articulated in the ISCB Business Plan 2013-2015

The ISCB has worked well in fulfilling its statutory functions under the revised Working Together to Safeguard Children (2013). Statutory and non-statutory members are consistently participating towards the same goals in partnership and within their individual agencies.

Throughout the year the Board has continued to review its structure and governance arrangements, with changes being made to the sub-groups to enhance a wider partnership contribution.

There are robust arrangements in place to evaluate the effectiveness of our local approach to Early Help showing timely responses to child care concerns.

We have more work to do:

We need to raise the profile of the LSCB with the wider communities of Islington. Along with our ongoing communications strategy, we will be appointing new lay members.

We need to facilitate new ways of getting feedback from the public and frontline staff on 'what works' and what could be done better or differently.

Public services will continue to be operating in an environment of financial constraint, which looks to be even more challenging in future years, as a Board we must continue to ensure the safety of children is not compromised

Partner agencies need to ensure their in-house safeguarding training arrangements are effective and consistent with the ISCB Training Strategy. In addition the Board needs to develop more sophisticated means to effectively evaluate the impact of training.

Our response to children affected by neglect, child sexual abuse and child sexual exploitation in terms of identification and interventions needs to be constantly reviewed and improvements made where necessary.

Our response to families affected by domestic violence needs to remain a high priority. Islington has the second highest rate of reported domestic violence offences in North London and therefore continues to be of concern for many children and families

We need to strengthen our approach to understanding e-safety as the advancements in social media technology have created new negative opportunities for children and young people to harm each other by 'cyber bullying'

The Board has done well to monitor and evaluate the effectiveness of safeguarding within Islington with the limited resources that have been made available. This work needs to be kept constantly under review to ensure our monitoring and evaluation functions are properly resourced to be able to help inform the Board of what difference it is making to keep children safe in Islington

The ISCB Sub Groups will be the main drivers for ensuring the business plan is implemented. The plan will be regularly reviewed at main LSCB meetings and kept under regular review in the Sub-Groups

We are confident that Islington Safeguarding Children Board partner agencies will continue to:

- identify and act on child protection concerns,
- work effectively to share information appropriately,
- collectively make decisions about how best to intervene in children's lives where their welfare is being compromised, and
- collectively monitor the effectiveness of those arrangements.

Core child protection procedures are well imbedded in Islington, which allow agencies to have a clear reference point to undertake single and multi-agency work. We are confident that these ensure children are best protected from harm and their families offered the right support when they most need it. Our local policies and procedures also enable the right decisions to be made about the safe recruitment, induction and supervision of frontline staff, as well as respond to allegations against staff.

Our learning culture has been enhanced by a programme of undertaking multi-agency case audits. These give a valuable insight into the child protection system and how single agency service delivery and working together impacts on outcomes for children.

Our aim year on year is to make sure that children in Islington are best protected from harm. This can only be achieved through ensuring the right systems are in place, that agencies work well together for each individual child and family and we develop our learning culture. We need to be constantly reflecting whether children in the area are safe and, if not, what more can be done to reduce incidents of child maltreatment and intervene when children are at risk of suffering significant harm. We will continue to raise awareness within our local community that safeguarding children is everybody's business

Section VIII: Summary of actions

Action 1: Board members to share this report with their own senior management teams / management boards. Individuals named in this paragraph and ISCB board members to consider the findings of this report and inform the Independent Chair of the actions they may consider necessary in response to these findings and actions reported

Action 2: The ISCB would like to see that partners, especially s11 partners, take a greater lead in chairing and governance of the safeguarding board sub-groups. The board should continue to review its structure and governance.

Action 3: The board would like to receive an annual report, representing the views of front line practitioner about the robustness of safeguarding practices within their agencies from the Named Nurse(s) for Safeguarding, Designated GP, Designated Doctor, Designated Nurse, and Safeguarding Lead for Education and the Principal Social Worker

Action 4: Board members to assure the ISCB that they have sufficient management mechanisms in place to ensure that staff members are identified and booked on relevant safeguarding training and that staff attend training that they have booked

Action 5: Training and development sub-group to develop innovative ways to measure and understand the impact of training.

Action 6: Board Members to assure the Chair that they have suitable mechanisms in place through the Senior Named Officer structure to identify matters that need to be referred to the LADO

Action 7: LA to assure the board that they have responded to the national inspection finding that identified that local areas have a poor understanding about the underlying reasons that explain the decline in private fostering numbers. All Board Members to assure the chair that they have robust mechanisms in place for identifying and referring private fostering arrangements to the LA.

Action 8: Whilst it is positive that Early Help Assessments are being used, it is important that we can identify, where e CAF is being used, how many are early help assessments and how many are requests for service. The board would like to see that universal services increasingly take on the duties of lead professional when required to do so.

Action 9: Data shows that a substantial number of police referrals to CSCT do not lead to action by Targeted or Specialist services, MPS should review whether the BRAG rating is being correctly applied.

Action 10: The Board, through the Quality Assurance subgroup, needs to ensure that statutory assessments are being completed within a timely manner and that SW are using appropriate discretion when extending assessments.

Action 11: Initial Case Conferences should take place no later than 15 working days after the initial strategy discussion. CSC and the CAIT should assure the Board that SW managers and CAIT officers are exercising appropriate discretion in extending child protection enquiries beyond this time-scale.

Action 12: Islington Safeguarding Children Board to undertake more multi-agency audits in the following year. ISCB partners to consider adding additional capacity to undertake quality assurance audits on behalf of the board

Action 13: Safer Islington Partnership and Islington Safeguarding Children Board to refresh the protocol and procedures between them to ensure that children' welfare is the primary consideration in their work plans.

Action 14: The board should review the financial contributions of members so that they do not disproportionately fall on a small number of agencies.

Section IX: Glossery of terms

ABE	Achieving Best Evidence
AMASS	Adolescent Multi-Agency Specialist Service
BME	Black and Minority Ethnic
C&IFT	Camden & Islington Foundation Trust
CAF	Common Assessment Framework
CAIC	Child Abuse Investigation Command
CAIT	Child Abuse Investigation Team
CAMHS	Child & Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CFAB	Children and Families across Borders
CiN	Children in Need
CLA	Children Looked After
CMHT	Community Mental Health Team
CP	Child Protection
CPP	Child Protection Plan
CPS	Crown Prosecution Service
CQC	Care Quality Commission
CSC	Children's Social Care
CSCT	Children's Services Contact Team
CSE	Child Sexual Exploitation
CSU	Community Safety Unit
CSV	Community Service Volunteers
DBS	Disclosure and Barring Service
DV	Domestic Violence
ECPB	Executive Corporate Parenting Board
EET	Education, Employment and Training
EIP	Early Intervention and Prevention
ESLOs	E-Safety Safeguarding Lead Officers
FGM	Female Genital Mutilation
FIP	Family Intervention Project
FISS	Family Intervention Specialist Service
FNP	Family Nurse Partnership
FOSS	Family Outreach Support Service
GP	General Practitioner
HASS	Housing and Adult Social Services
ICDOP	Islington Child Death Overview Panel
ICS	Integrated Children's System
IRO	Independent Reviewing Officer
ISCB	Islington Safeguarding Children Board
IYSS	Integrated Youth Support Services
LADO	Local Authority Designated Officer
LAS	London Ambulance Service

LBI	London Borough of Islington
LGID	Local Government Improvement and Development
LP	Lead professional
LSCB	Local Safeguarding Children Board
MAP	Muti-Agency Plan
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MI	Motivational Interviewing
MPS	Metropolitan Police Service
NEET	Not in Education, Employment and Training
NFA	No Further Action
Ofsted	Office for Standards in Education, Children’s Services and Skills
PCP	Person Centred Planning
PCT	Primary Care Trust
PEP	Parental Employment Partnership
PEPs	Personal Education Plans
PPD	Public Protection Desk
PRU	Pupil Referral Unit
QA	Quality Assurance
R&A	Referral and Advice
SCR	Serious Case Review
SEN	Special Educational Needs
SIP	Safer Islington Partnership
SMART	Specific, Measurable, Achievable; Realistic, Timely
SN	Statistical Neighbour
SPOC	Single Point of Contact
TAF	Team around the Family
TYS	Targeted Youth Services
UKBA	UK Border Agency
VAI	Voluntary Action Islington
YJS	Youth Justice System
YOS	Youth Offending Service
YPDAS	Young People’s Drug and Alcohol Service

Section X: Bibliography

ASC Update, 2014. *ASC Update ISCB Prioroties*, s.l.: s.n.

CCG Update, 2014. *Update on prioroties*, London: s.n.

Children and Families Board, 2014. *Islington CYPEarly Intervention and Prevention Strategy (draft)*. London: s.n.

CSE subgroup, 2014. *Annual Report to the ISCB from Child Sexual Exploitation Subgroup 2013-2014*, London: ISCB.

Home Safe, 2014. *Report, Home Safe: DV prevention and anti-bullying in schools*, s.l.: s.n.

ISCB Annual Report, 2013. *ISCB Annual Report April 2012 - March 2013*. s.l.:s.n.

ISCB, 2014. *ISCB Minutes*. London: ISCB.

LAC Report, 2014. *Corporote parenting report 2013-204*, s.l.: s.n.

LADO, 2014. *Annual Report to the ISCB, Local Authority Designated Officer: 2013-2014*, London: London Borough of Islington.

Minutes, P., 2013.07.25. *P&P Subgroup*. s.l.:s.n.

Missing from Care, 2014. *Report to ISCB, Missing from care 2103/4*, s.l.: s.n.

Missing from home, 2014. *Report to the ISCB: Children missing from home*, s.l.: s.n.

P&P Minutes, 2013.07.25. *P&P subgroup*. s.l.:s.n.

P&P Minutes, 2014.03.27. *P&P subgroup*. London: s.n.

Policy and Practice, 2014. *Report to the ISCB: Policy and Practice subgroup*, s.l.: s.n.

Private Fostering Report, 2014. *Report to the ISCB on Private Fostering*, London: Islington Borough Council.

Pupil Services Update, 2014. *Update on ISCB prioroties*, s.l.: s.n.

Quality Assurance subgroup, 2014. *Annual Report to the ISCB, Quality Assurance Subgroup: 2013-2014*, London: ISCB.

Training and Workforce Subgroup, 2014. *Annual Report to the ISCB, Training and Workforce Development Subgroup 2013-2014*. Lonodn: ISCB.

Section XI: Appendixes

Islington Safeguarding Children Board

Business Plan

2013 – 2015



Islington Safeguarding Children Board

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1. Chair's Introduction

Islington is in the forefront of the move to early intervention. As it develops, the ISCB needs to develop ways of measuring its impact on the lives of children and young people. At the same time, we will need to retain a sharp focus on those groups and areas of work where we identify the highest level of risk.

Good training equips staff and volunteers to do their difficult work effectively. The ISCB will continue to evaluate the uptake and impact of training on safeguarding practice.

In order to allow sufficient time to embed new initiatives and to maintain synergy with local strategic plans, this business plan will cover a two year period with a mid-way report on progress to be included in the next annual report.

2. 2013/2015 Priorities and Objectives

ISCB's 2013/2015 priorities will reflect the changes in Working Together 2013, the priorities of the 2011–2015 Islington Children & Families Partnership's strategy, and the areas identified for further development in ISCB's 2012/13 Annual Report.

ISCB's overarching priorities are to:

- Develop early intervention and review its effectiveness
- Evaluate the effectiveness of training

We will continue to focus on:

Joint work with Adult services focusing on:

- Parents with Learning difficulties
- Transition to adulthood
- Core business (child protection) focusing on:
 - Domestic violence
 - Neglect

ISCB's overall objectives are to:

- Co-ordinate local work
- Raise awareness
- Develop policies and procedures
- Monitor and evaluate practice and identify lessons to be learnt

These objectives relate to all priorities.

OVERARCHING PRIORITIES			
<p>Early Intervention and the impact of early help including families that are hard to engage</p>	<ul style="list-style-type: none"> • Further embedding and increase in number of CAFs • Launch of eCAF as CSC Referral tool • Implementation of CSC contact team incorporating Multi Agency Safeguarding Hub (MASH) • Increase number of parents helped into work through Parental Employment Partnership (PEP) • Diversion of CSC contacts to Early help services • Children's centres increase in reach to all families • Continued use of 3 Families First (FF) early intervention teams to identify and support 	<ul style="list-style-type: none"> • Decrease in the number of re-referrals to CSC 2013/16 • Low number of repeat child protection plans comparable with Statistical Neighbours • Decrease in the number of children per 10,000 with child protection plans • Increase in use of CAF • Decrease in contacts by other agencies to children's social care (CSC) from 13 – 16 • Evaluation of Early Help to demonstrate impact on children • Evaluation of parenting programmes to demonstrate impact on parents • CAF to be re-launched in connection with awareness raising of neglect 	<ul style="list-style-type: none"> • Fewer neglected children • Low number of families accessing early intervention services are referred to Children's Social Care • Increased number of parents in employment • Children are helped at an early stage reducing need for involvement with higher tier services. • Streamlined access to safeguarding services and clear multi-agency understanding of thresholds
<p>Effectiveness of training is evaluated</p>	<ul style="list-style-type: none"> • Training and Professional Development Sub-group audits and evaluates delivery and effectiveness of single 	<ul style="list-style-type: none"> • Staff incorporate learning from training into their practice 	<ul style="list-style-type: none"> • Managers report improvement/changes in practice following attendance at training

ated	<ul style="list-style-type: none"> and multi-agency training Implementation of the London safeguarding children board Training Impact Analysis process 	<ul style="list-style-type: none"> Percentage of staff reporting a positive impact from training 	
SPECIFIC PRIORITIES			
Core business (child protection)	<ul style="list-style-type: none"> Monitor and evaluate implementation of SCR action plans Monitor and evaluate implementation of action plans resulting from audits/inspections/ reviews Review progress in improving engagement of fathers Monitor impact of implementation of MASH 	<ul style="list-style-type: none"> Reduction in re-referrals Reduction in length of time with a CP plan Increase in numbers of fathers attending initial child protection conferences 	<ul style="list-style-type: none"> Children will be safer at home, at school and in the community
Joint work with adult services focusing on:			
Transition to adulthood	<ul style="list-style-type: none"> Monitor management of transitions C&IFT early intervention team undertakes transitional work with CAMHS 	<ul style="list-style-type: none"> Increased number of young people with mental health problems access adult services Increased number of young people 	<ul style="list-style-type: none"> More successful transitions and fewer cases where things go wrong at this stage

	<ul style="list-style-type: none"> • Strengthened TYS-YOS operational links with Integrated Offender Management arrangements • Regular communication between Children and Families Board, Adult Safeguarding Board and ISCB • Development of a protocol between CLA,IF and Adults in relation to YP at risk of abuse within the family 	<p>with Asperger's access adult services</p> <ul style="list-style-type: none"> • Fewer young people leaving prison re-offend • Improved accommodation available for homeless 16 & 17 year olds • Young people's views are included in all decisions regarding their care plans • Increase number of young people joint worked with CAMHS and Adult Mental Health. • Identify young carers of people with mental health problems and offer early support/intervention. • Scope out services for parental mental health ensure whole systems approach • Scope out current training for staff on children/young carers – improve access to training. • Identify all young carers on C&I case-load. Target for services accordingly. 	<ul style="list-style-type: none"> • A seamless service from CAMHS to Adult mental health services prevents young people from slipping out of services • Improve quality of life for children who live with parents with a mental health problem. • Better working practices between CAMHS and Adults to ensure the best possible interventions for children and their carers. • Identifying those who may be vulnerable to mental health problems and offer early support intervention to minimise future impact and improve life chances. • Systems which are joined up
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			<p>and work not being duplicated across various organisations.</p> <ul style="list-style-type: none"> • Staff who are confident and equipped to work with young people and offer best service.
Parents with learning difficulties	<ul style="list-style-type: none"> • Regular communication between Children and Families Board, Adult Safeguarding Board and ISCB • Parents with LD accessing parenting programme – Mellow Bumps and Mellow Babies. • Parents with LD accessing advocacy and parenting support. 	<ul style="list-style-type: none"> • Reduction in percentage of parents with LD who have children on CP plans • Increase numbers of parents with LD accessing early help services 	<ul style="list-style-type: none"> • Parents with LD will be able/are equipped and supported to keep their children safe • Parent’s with LD accessing universal and targeted services for themselves and their children.
Domestic violence (DV)	<ul style="list-style-type: none"> • DV identified in CAF • Continue work on Deep dive Audit 	<ul style="list-style-type: none"> • Increased identification of women and children living with DV and action 	<ul style="list-style-type: none"> • Fewer children are exposed to DV • Reduction in numbers of children

	<p>Action Plan</p> <ul style="list-style-type: none"> • Review use of DV risk assessment tools • Develop guidance to assess impact of ethnicity, culture, religion on DV • Monitor implementation of local VAWG strategy • Early intervention through use of CAF and LP • MARAC attendance expanded to include Early Years, Families First and TYSS • Increase identification of cases and actions to reduce risk • Development of referral pathways for young victims referred to MARAC 	<p>taken to protect them</p> <ul style="list-style-type: none"> • Increased number of women engage with services to protect their children • Women experiencing DV are aware of what services they can access • Increased number of children access support • Increase in numbers of young people age 16 – 17 as CIN due to DV 	<p>with CP plans exposed to DV</p> <ul style="list-style-type: none"> • Reduction in numbers of young people age 16 – 17 affected by DV
Neglect	<ul style="list-style-type: none"> • Promote the use of CAF to identify neglect • Implementation of the neglect toolkit • Training provided on use of toolkit across children’s partnership 	<ul style="list-style-type: none"> • Multi-agency audit demonstrates good understanding of indicators and impact of neglect and prompt action. • Increased numbers of CP plans for neglect 	<ul style="list-style-type: none"> • Professionals recognise and act on early indicators of neglect. • Fewer children exposed to damaging effects of neglect

	<ul style="list-style-type: none">• Awareness raising campaign about neglect to Islington professionals• Production of information sheet/leaflet• Multi-agency audit of CP plan neglect cases• Agencies produce Neglect and CAF implementation plans which includes identifying how staff awareness will be raised	<ul style="list-style-type: none">• Increased numbers of CAFs where neglect is primary concern• Decrease in length of time spent on CP plans for neglect	<ul style="list-style-type: none">• All professionals are aware of and able to use the Neglect Toolkit to assess levels of need and support early intervention and referral processes.
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1. Islington Safeguarding Children Board members

Page 164 Cllr Joe Caluori	Lead Member for Children	London Borough of Islington	Joe.caluori@islington.gov.uk
4Adams, Ross	Programme Manager	Chance UK	Ross.adams@chanceuk.com
Askew, Catherine	Assistant Chief Office	London Probation Trust - Camden and Islington	Catherine.askew@london.probation.gsi.gov.uk
Bailey, Alva	Head of Community Safety	Islington Council	Alva.Bailey@islington.gov.uk
Blair, Cathy	Director, Child Protection	Islington Council	Cathy.blair@islington.gov.uk
Brooks, Patrick	Community Involvement Officer Camden & Islington	London Ambulance Service	Patrick.brooks@lond-amb.nhs.uk
Campbell, Gerry	Borough Commander	Metropolitan Police	Gerry.campbell@met.police.uk
Chapman, Jane	Designated Nurse - Child Protection	NHS North Central London (Islington)	jane.chapman@nclondon.nhs.uk

2013/15 Action Plan

Eden, Laura	Service Manager Safeguarding and Quality Assurance	Islington Council	Laura.eden@islington.gov.uk
Fisher, Steve	North Central London LIT	UK Border Agency	Steve.fisher@homeoffice.gsi.gov.uk
Foulkes, John	DCI	CAIC	John.foulkes@met.pnn.police.uk
Friedberg, Melissa	ISCB Manager	Islington Safeguarding Children Board	Melissa.friedberg@islington.gov.uk
Gilby, Maria	ISCB Co-ordinator	Islington Safeguarding Children Board	Maria.gilby@islington.gov.uk
Hackett, Dee	Director of Operations	Whittington Health	Dee.hackett@nhs.net
Humphery, Sarah	GP	Health	sarah.humphery@nhs.net
Kenway, Penny	Head of Early Years foundation stage	Children's Services	Penny.kenway@islington.gov.uk
Luckett, Tracy	Director of Nursing	Moorfields Hospital	Tracy.luckett@moorfields.nhs.uk
Mokades, Janet / Alan Caton	Independent Chair	Independent	Janet@janetmokades.co.uk Alan.caton@islington.gov.uk

Norman Bruce, Ian	Head of Targeted Services	Cambridge Education @ Islington	ian.norman-bruce.camb-ed@islington.gov.uk
O'Shea, Barrie	Head teacher	Duncombe Primary School	success@duncombe.islington.sch.uk
Odling-Smee, Patrick	A D Housing and Adult Social Services	Islington Council	Patrick.odling-smee@islington.gov.uk
Oxley, Elaine	Head of Safeguarding Adults	Islington Council	Elaine.oxley@islington.gov.uk
Plant, Colin	Director Integrated Care	Camden & Islington Foundation Trust – Mental Health	Colin.Plant@candi.nhs.uk
Schooling, Eleanor	Director, Children's Services	Islington Council	Eleanor.schooling@islington.gov.uk
Watts, Richard Cllr	Lead EM	Islington Council	Richard.watts@islington.gov.uk
Wheeler, Tony Dr.	Consultant Community Paediatrician	Whittington Health	tony.wheeler@nhs.net
Yilkan, Zafer	Service Manager	CAFCASS	Zafer.yilkan@cafcass.gov.uk

2. Islington Safeguarding Children Board Attendance

Name	Title	Agency	May	Jul	Sep	Nov	Jan	Mar
Adams, Ross	Programme Manager	Chance UK	A	√	√	√	√	√
Askew, Catherine	Acting Assistant Chief Officer	London Probation	X	X	√	√	√	√
Bailey, Alva	Head of Community Safety	Islington Council	√	√	√	√	A	√
Blair, Alison	Chief Officer	CCG			√	A	√	A
Blair, Cathy	Director TSCFS	Islington Council	A	√	√	√	√	A
Brooks, Patrick	London Ambulance Service	London Ambulance Service	A	A	√	√	√	A
Calaminus, Paul	Chief Operating Officer	Cam & Isl NHS MH & SCTrust	√	√	A	√	√	A

Caluori, Joe	Lead Member for Children	Islington Council	√	√	A	√	√	A
Campbell, Gerry	Borough Commander	Police	X	X	√	√	√	D
Caton, Alan	ISCB Chair	ISCB	√	√	√	√	√	√
Chapman, Jane	Designated Nurse Child Protection	CCG	√	√	√	√	√	√
Corbett, Anne	Headteacher	Richard Cloudesley School				D	√	√
Eden, Laura	Service Manager S&QA	Quality and Safeguarding	A	A	√	√	√	√
Fisher, Steve	North London LIT	UK Border Agency	Attend when required					
Foulkes, John	DCI	CAIC	√	A	√	√	D	√
Friedberg, Melissa	ISCB Manager	Board manager	√	√	L	L	L	L
Gilby, Maria	ISCB Coordinator	Board	√	√	√	A	√	√

2013/15 Action Plan

Griffiths, Stephen	Voluntary Representative	CYProject	√	X	X	X	√	X
Holder, Candy	Head of Pupil Services	Islington Council						√
Humphery, Sarah	GP		√	A	√	A	√	√
Kenway, Penny	Head of Early Years Service	Islington Council	√	√	√	√	√	√
Luckett, Tracy	Director of Nursing	Moorfields Hospital	√	√	√	D	√	√
Mattair, Lynn	Interim Board Manager	ISCB			√	√	√	√
Mokades, Janet	Independent Chair	Independent	√	√	L	L	L	L
Norman-Bruce, Ian	Head of Targeted Services	Camb-ed@islington	A	A	A	A	L	L
Odling-Smee, Patrick	AD Housing and Adult SC	Islington Council	√	D	A	L	L	L
O'Shea, Barrie	Headteacher	Duncombe Primary School	√	√	√	√	√	√
Oxley, Elaine	Safeguarding Adults Development Manager	Islington Council	√	√	D	A	√	X

Page, Sam	Director of Operations Women, Children and Families	Whittington Health	√	√	√	√	√	√
Schooling, Eleanor	Director, Children's Services	Islington Council	√	√	√	√	√	A
Steph Sollossi	Independent Consultant – Safeguarding	Whittington Health				√	A	L
Vanessa Lodge		NHS England				X	A	X
Watts, Richard	Councillor	Islington Council	√	L	L	L	L	L
Wheeler, Dr, Tony	Consultant Community Paedia- trician	Whittington NHS	√	√	√	√	√	√
Yilkan, Zafer	Service Manager	CAFCASS	√	√	√	√	√	X

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Islington Safeguarding Children Board

Annual Report 2013–2014

Executive Summary

Islington Safeguarding Children Board
3 Elwood Street
London N5 1EB

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1. Introduction

This executive summary presents the key points from Islington Safeguarding Children Board's (ISCB) 2013 - 2014 Annual Report. The full report and plan can be accessed on the ISCB website www.islingtonscb.org.uk

ISCB's objectives and functions are to:

- Co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area
- Ensure the effectiveness of what is done by each such person or body for that purpose
- Develop and agree thresholds, policies and procedures
- Communicate and raise awareness of safeguarding and child protection
- Monitor and evaluate the effectiveness of practice to safeguard children
- Contribute to the planning of services and ensure participation by parents and children
- Undertake functions related to child death
- Undertake Serious Case Reviews as necessary

2. Effectiveness of safeguarding - Delivery of ISCB priorities 2013/14

There is evidence that outcomes for children are improving in Islington as a result of the work done by the children's partnership and the ISCB.

The 2013/15 Business Plan identified the following priorities:

2.1 Development of early intervention

- This is a continuing priority from the preceding year and some outcomes have already been reported in the 2012/3 Annual Report.
- The board examined repeat referrals to Children's Social Care and found that 50% of repeat referrals were unavoidable.
- During this year, we have opened 547 Early Help Assessments, a 12% increase over the preceding year.
- LA and partners evaluated the impact of Families First (Early Help services that shows positive impact on the outcomes for Islington' children.
- The CAF has been launched as the local Early Help Assessment alongside the neglect toolkit.
- Under 1 year olds proportionally the largest group in LAC population which is an indication of successful early intervention.

2.2 Evaluate the effectiveness of training (continue from 2012/3)

- Lessons from serious case reviews and local learning have been incorporated in the board multi-agency training.
- Post-course evaluations are overwhelmingly positive about the usefulness and quality of ISCB training.
- The board has increased the number of training opportunities for board partners and demand for training places has remained high.
- 1212 training places were offered on 35 courses (47 fulltime training days)
- During this year, the board has begun a training audit which will report in 2014/5. Alongside the training audit the board needs to develop more sophisticated ways to understand and evaluate the impact of training.
- Parents with learning difficulties early intervention.

2.3 Parents with learning difficulties and transition to adulthood (joint work with adults)

- Annual multi-agency conference about influence of learning disabilities on parenting capacity.

2.4 Domestic violence (core business)

- Implement recommendation from management review to train and use CAADA-RIC assessment of domestic violence
- Islington CCG secured funding for the IRIS project (training and advocacy support for GPs to facilitate early identification, management and referral)
- Level 3 domestic violence training
- Produced Domestic violence posters and cards to raise awareness
- Continuation of the Home Safe: Domestic Violence (DV) Prevention Education Programme for Schools.

2.5 Neglect (core business)

- The Neglect toolkit has been launched successfully across the children's partnership and early indications are positive about both its utilisation and usefulness.
- A multi-agency audit of neglect cases graded 70% of cases as good .
- Care proceedings were effectively used where risk was high and changes were not made in a suitable timescale.
- Parental history was consistently considered in relation to parenting capacity and risk assessment.
- Good multi-agency attendance at case conferences.

2.6 Child protection

- At a rate of 38/10 000, children who became subject to child protection plan this were considerably lower than statistical neighbours (45.5/10000).
- On the whole, children in Islington do not remain subject to child protection plans for long
- The quality assurance sub-group examined the reasons why children became subject to child protection plans for a second time. Only in one case did they find that a child protection plan may have ended prematurely.
- More father have attended case conference this year, and work continues in this area.

3. Progress on other key work

3.1 Children looked after (CLA) and care leavers

- Looked after children rate (84 /10000) is higher than statistical neighbours (75/10000) but a review of thresholds have shown that care proceedings were issue appropriately. CLA population have remained stable.
- Very slight increase (3%) of LAC who were placed away from the authority, but reason were well understood and ratified by senior managers.
- 74% of children were looked after as part of a court directed care plan.

3.2 Child sexual exploitation (CSE)

- Established a Multi-Agency Sexual Exploitation (MASE) meetings in partnership with the Police and other agencies.
- MASE has begun early work on identification of hot spots.
- Effective awareness raising around child sexual exploitation (Islington second highest in London to report potential exploitation to the police)
- Efforts to link CSE, gang-affiliated families, LAC and missing children have identified additional 28 children who may be vulnerable.

3.3 Private fostering

- Work undertaken by a dedicated specialist private fostering social worker.
- Despite new publicity material and consistent awareness raising, private fostering number have decreased this year.
- Collaborative work between the specialist social worker and the schools admission team were highlighted as good examples of practice by policy writers of Department of Education.

3.4 Child death overview panel (CDOP)

- The total numbers of deaths was 13, higher than the preceding year but slightly below average of 14 deaths per annum for a 5 year period
- None of the deaths were the subject of a serious case review
- Panel discussed 8 deaths in 2013/4 , in three cases the panel identified modifiable factors including: a change in housing policy, co-sleeping and the importance of safety netting.

3.5 Local Authority Designated Officer (LADO)

- The LADO has management and oversight of individual cases where allegations are made against people who work with children.
- In 2011/12, 82 allegations were referred to the LADO, 100 in 2012/13 and 97 in 2013/14
- This maintains the marker increase in referrals that began in 2011/12
- Seventy three percent of referrals related to an allegation in the workplace
- Twenty seven percent of referrals were related to an issue in private life that raised concern as to an individual's future suitability to work with children
- The majority of cases received advice only; in 15 cases the allegations could not be substantiated and in 11 cases there were sufficient evidence to substantiate the concerns.
- The LADO made referrals to the DBS on two occasions.

3.6 ISCB annual conference

- The theme of the conference held in June 2013 looked at the influence of parental factors on safeguarding: parental substance abuse, parents with learning disabilities and parental mental health. 150 professionals attended and their feedback was overwhelmingly positive.

4. Multi-agency inspections and audits

4.1 Training Audit

All board partners were asked to audit how well they met the expectation to train staff in safeguarding and at the appropriate level:

- Improved response compared to the previous year, especially from the voluntary sector.
- Deep Dive audit around domestic abuse training. Unfortunately only 27% of agencies completed that part of the audit.
- Overall compliance with train was good, but in some agencies such as the police and housing compliance was variable.

4.2 Winterbourne View Hospital Review

- The board reviewed the requirements arising from the Winterbourne review and identified 7 children that fit the criteria. No concerns were reported.

4.3 Involvements of parents and children

- Undertook a survey of parents whose children had been subject to child protection enquiries; those who responded reported positively about their experience and saw the purpose of the intervention.

4.4 Audit of cases in the children with disabilities service

- No concerns were noted in a sample of 20 selected cases. Overall quality of work was considered to be equally spread between good or adequate. Recommendations included more synergistic delivery of health plans in parallel with care plans, involving advocates and independent visitors.

4.5 Unannounced service review of children in need

- Evidence of good practice was found within Children 'Social Care. The MASH was deemed to be working effectively, without thresholds deemed generous and clear. There was some variability in practice and a requirement to continue the improvement drive of supervision.

4.6 Child Sexual Exploitation Children's Services Audit

- Audit undertaken to measure how well Pan London Child Protection Procedures and CSE supplementary procedures were embedded. Audit found that a wide range of agencies could identify a risk of CSE and knew how to make appropriate referrals.

5. Child protection data

Number of children with Child Protection Plans

Month	Number with CPP	Population under 18 years	Number with CPP per 10,000 Islington under 18
Mar-09	138	33,692	49 SN* (41)
Mar-10	132	33,743	53 SN* (33)
Mar-11	112	33,743	52 SN* (33)
Mar-12	141	34,297	46 SN*(41)
Mar-13	117	34,297	34
Mar-14	137	36,700	37

* Statistical neighbour

Category of Abuse

Category	Mar-09	Mar-10	Mar-11	Mar-12	Mar-13	Mar-14
Emotional	58	46	43	58	48	62
Neglect	75	79	61	70	60	64
Physical	4	7	4	6	6	10
Sexual	1	0	0	7	3	0
Multiple Categories	1	0	0	0	0	1
Total	138	132	112	141	117	137

6. 2013/15 priorities and objectives

- Early intervention and the impact of early help, including families that are hard to engage
- Joint work with adult services focusing on:
 - Parents with learning difficulties
 - Transition to mental health services
- Core business including:
 - Neglect
 - DV

7. Conclusion

The ISCB has worked well in fulfilling its statutory functions under the revised Working Together to Safeguard Children (2013). Statutory and non-statutory members are consistently participating towards the same goals in partnership and within their individual agencies.

Throughout the year the Board has continued to review its structure and governance arrangements, with changes being made to the sub-groups to enhance a wider partnership contribution.

There are robust arrangements in place to evaluate the effectiveness of our local approach to Early Help showing timely responses to child care concerns.

We have more work to do:

- 1 We need to raise the profile of the LSCB with the wider communities of Islington. Along with our ongoing communications strategy, we will be appointing new lay members.
- 2 We need to facilitate new ways of getting feedback from the public and frontline staff on 'what works' and what could be done better or differently.
- 3 Public services will continue to be operating in an environment of financial constraint, which looks to be even more challenging in future years, as a Board we must continue to ensure the safety of children is not compromised
- 4 Partner agencies need to ensure their in-house safeguarding training arrangements are effective and consistent with the ISCB Training Strategy. In addition the Board needs to develop more sophisticated means to effectively evaluate the impact of training.
- 5 Our response to children affected by neglect, child sexual abuse and child sexual exploitation in terms of identification and interventions needs to be constantly reviewed and improvements made where necessary.

6 Our response to families affected by domestic violence needs to remain a high priority. Islington has the second highest rate of reported domestic violence offences in North London and therefore continues to be of concern for many children and families

7 We need to strengthen our approach to understanding e-safety as the advancements in social media technology have created new negative opportunities for children and young people to harm each other by 'cyber bullying

The Board has done well to monitor and evaluate the effectiveness of safeguarding within Islington with the limited resources that have been made available. This work needs to be kept constantly under review to ensure our monitoring and evaluation functions are properly resourced to be able to help inform the Board of what difference it is making to keep children safe in Islington

Core child protection procedures are well imbedded in Islington, which allow agencies to have a clear reference point to undertake single and multi-agency work. We are confident that these ensure children are best protected from harm and their families offered the right support when they most need it. Our local policies and procedures also enable the right decisions to be made about the safe recruitment, induction and supervision of frontline staff, as well as respond to allegations against staff.

Our aim year on year is to make sure that children in Islington are best protected from harm. This can only be achieved through ensuring the right systems are in place, that agencies work well together for each individual child and family and we develop our learning culture. We need to be constantly reflecting whether children in the area are safe and, if not, what more can be done to reduce incidents of child maltreatment and intervene when children are at risk of suffering significant harm. We will continue to raise awareness within our local community that safeguarding children is everybody's business

8. Budget 12/13

Income

Carry over from previous year	5 453.00	38 370.00
Carry over from previous year	5 453.00	38 370.00
London Borough of Islington	118 754.00	118 754.00
Islington PCT / CCG	33 456.00	11 500.00
Probation	2 000.00	2 000.00
Other grants, reimb & contributions		28,271.72
Munro grant	31 882.00	
Metropolitan Police	5 000.00	
CAFCASS	1 100.00	
Subtotal	197 645.00	198 895.72

Expenditure

Staff:		
Salaries, 2.5 staff	122 148.00	147 546.42
Training / conferences	575.00	8.33
Travel	290.00	172.10
Agency		6 241.25
Sub-total	123 013.00	153 968.10
Board courses:		
Hire facilities	2 187.00	1319.75
External trainers / e-learning	900.00	853.00
Refreshments	2 806.00	262.50
Printing (leaflets, newsletter)	4 012.00	5 032.00
Sub-total		
Board Expenses:		
Chair		
SCRs		
Annual conference		
Board development		
Sub-total	24 599	8 469.77
Office expenses:		
Stationary	1 758.00	768.45
Total expenditure	159 275.00	170 673.57
Carry over / shortfall	38 370.00	28 222.15

9. List of actions

Action 1: Board members to share this report with their own senior management teams / management boards. Individuals named in this paragraph and ISCB board members to consider the findings of this report and inform the Independent Chair of the actions they may consider necessary in response to these findings and actions reported

Action 2: The ISCB would like to see that partners, especially s11 partners, take a greater lead in chairing and governance of the safeguarding board sub-groups. The board should continue to re-view its structure and governance.

Action 3: The board would like to receive an annual report, representing the views of front line practitioner about the robustness of safeguarding practices within their agencies from the Named Nurse(s) for Safeguarding, Designated GP, Designated Doctor, Designated Nurse, and Safeguarding Lead for Education and the Principal Social Worker

Action 4: Board members to assure the ISCB that they have sufficient management mechanisms in place to ensure that staff members are identified and booked on relevant safeguarding training and that staff attend training that they have booked

Action 5: Training and development sub-group to develop innovative ways to measure and understand the impact of training.

Action 6: Board Members to assure the Chair that they have suitable mechanisms in place through the Senior Named Officer structure to identify matters that need to be referred to the LADO

Action 7: LA to assure the board that they have responded to the national inspection finding that identified that local areas have a poor understanding about the underlying reasons that explain the decline in private fostering numbers. All Board Members to assure the chair that they have robust mechanisms in place for identifying and referring private fostering arrangements to the LA.

Action 8: Whilst it is positive that Early Help Assessments are being used, it is important that we can identify, where e CAF is being used, how many are early help assessments and how many are requests for service. The board would like to see that universal services increasingly take on the duties of lead professional when required to do so.

Action 9: Data shows that a substantial number of police referrals to CSCT do not lead to action by Targeted or Specialist services, MPS should review whether the BRAG rating is being correctly applied.

Action 10: The Board, through the Quality Assurance subgroup, needs to ensure that statutory assessments are being completed within a timely manner and that SW are using appropriate discretion when extending assessments.

Action 11: Initial Case Conferences should take place no later than 15 working days after the initial strategy discussion. CSC and the CAIT should assure the Board that SW managers and CAIT officers are exercising appropriate discretion in extending child protection enquiries beyond this timescale.

Action 12: Islington Safeguarding Children Board to undertake more multi-agency audits in the following year. ISCB partners to consider adding additional capacity to undertake quality assurance audits on behalf of the board

Action 13: Safer Islington Partnership and Islington Safeguarding Children Board to refresh the protocol and procedures between them to ensure that children' welfare is the primary consideration in their work plans.

Action 14: The board should review the financial contributions of members so that they do not disproportionately fall on a small number of agencies.

10. Glossary of Acronyms

ABE	Achieving Best Evidence
AMASS	Adolescent Multi-Agency Specialist Service
BME	Black and Minority Ethnic
C&IFT	Camden & Islington Foundation Trust
CAF	Common Assessment Framework
CAIC	Child Abuse Investigation Command
CAIT	Child Abuse Investigation Team
CAMHS	Child & Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CFAB	Children and Families across Borders
CiN	Children in Need
CLA	Children Looked After
CMHT	Community Mental Health Team
CP	Child Protection
CPP	Child Protection Plan
CPS	Crown Prosecution Service
CQC	Care Quality Commission
CSC	Children's Social Care
CSCT	Children's Services Contact Team
CSE	Child Sexual Exploitation
CSU	Community Safety Unit
CSV	Community Service Volunteers
DBS	Disclosure and Barring Service
DV	Domestic Violence
ECPB	Executive Corporate Parenting Board
EET	Education, Employment and Training
EIP	Early Intervention and Prevention
ESLOs	E-Safety Safeguarding Lead Officers
FGM	Female Genital Mutilation
FIP	Family Intervention Project
FISS	Family Intervention Specialist Service
FNP	Family Nurse Partnership
FOSS	Family Outreach Support Service

10. Glossary of Acronyms continued

HASS	Housing and Adult Social Services
ICDOP	Islington Child Death Overview Panel
ICS	Integrated Children's System
IRO	Independent Reviewing Officer
ISCB	Islington Safeguarding Children Board
IYSS	Integrated Youth Support Services
LADO	Local Authority Designated Officer
LAS	London Ambulance Service
LBI	London Borough of Islington
LGID	Local Government Improvement and Development
LP	Lead professional
LSCB	Local Safeguarding Children Board
MAP	Muti-Agency Plan
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MI	Motivational Interviewing
MPS	Metropolitan Police Service
NEET	Not in Education, Employment and Training
NFA	No Further Action
Ofsted	Office for Standards in Education, Children's Services and Skills
PCP	Person Centred Planning
PCT	Primary Care Trust
PEP	Parental Employment Partnership
PEPs	Personal Education Plans
PPD	Public Protection Desk
PRU	Pupil Referral Unit
QA	Quality Assurance
R&A	Referral and Advice
SCR	Serious Case Review
SEN	Special Educational Needs
SIP	Safer Islington Partnership
SMART	Specific, Measurable, Achievable; Realistic, Timely
SN	Statistical Neighbour

10. Glossary of Acronyms continued

TAF	Team around the Family
TYS	Targeted Youth Services
UKBA	UK Border Agency
VAI	Voluntary Action Islington
YJS	Youth Justice System
YOS	Youth Offending Service
YPDAS	Young People's Drug and Alcohol Service

Islington Safeguarding Children Board

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Report of: **Director of Public Health**

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	15 January 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 draft PNA was approved prior to consultation at the HWB meeting in October 2014, and the mandatory consultation period ran from October to December 2014. The attached consultation report details the consultation responses received, and how these responses have been or will be addressed within the final PNA. This consultation report is also included as an appendix in the PNA.

Unfortunately, not all of the information required in order to address all of the comments received from NHS England was available at the time of preparing this report to the HWB. The outstanding amendments to the PNA that are required in order to fully respond to all comments received during the consultation are clearly highlighted in the attached consultation report. Consequently, the attached version of the PNA is a near final version. The Islington PNA will be finalised once the outstanding data are received from NHSE in early January 2015. In order to meet the statutory deadline for publication of Islington's PNA by 1st April 2015, it is recommended that approval of the final PNA, incorporating these final few amendments, is delegated to the Chair of the HWB.

2. Recommendations

The Health and Wellbeing Board is asked to:

- NOTE the report on the PNA consultation and how the draft PNA has been amended to respond to the comments received;
- NOTE the outstanding changes required to the PNA, contingent on receipt of final pharmacy details and opening hours information from NHS England; and
- DELEGATE responsibility for approval of the final PNA to the HWB Chair.

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.

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.

The draft PNA was approved prior to consultation at the HWB meeting in October 2014, and the mandatory consultation period ran from October to December 2014. The attached consultation report details the consultation responses received, and how these responses have been or will be addressed within the final PNA. This consultation report will also be included as an appendix in the final PNA.

In total, feedback was received from four individuals and eight organisations during the consultation period. The organisations that submitted a response were: the Local Pharmaceutical Committee, NHS England, Islington Clinical Commissioning Group, Breathe Easy Islington, and three pharmacies. In general, respondents agreed with the conclusions and recommendations described in the draft PNA. The attached consultation report groups the responses received under the following four themes/areas:-

- Accuracy of the pharmaceutical list and data shown
- Current and future provision of pharmaceutical services
- Final assessments of pharmaceutical services
- General comments.

In order to be able to respond fully to all of the comments received from NHS England, further information is required from NHS England relating to accurate pharmacy details and opening hours. NHS England have indicated they will provide this information by early January 2015. Consequently, the attached PNA is a near final version. In order to meet the statutory deadline for publication of Islington's PNA by 1st April 2015, it is recommended that HWB members comment on this 'near final' version of the PNA, and delegate approval of the final PNA, incorporating the final few outstanding amendments, to the Chair of the HWB.

4. Implications

4.1. Financial implications

None identified

Any improvement recommendations and the delegation of authority should not cause a pressure for the council and should be carried out, if applicable, within available resources.

4.2. 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 following a period of public consultation.

4.3. Equalities Impact Assessment

As this is a needs assessments, equalities were included in assessing pharmacy services. Protected characteristics were also considered, as required by the regulations.

4.4. Environmental Implications

The report will be available online, with printed versions only on request, as required by the regulations.

5. Conclusion and reasons for recommendations

The Health and Wellbeing Board is asked to:

- NOTE the report on the PNA consultation and how the draft PNA has been amended to respond to the comments received;
- NOTE the outstanding changes required to the PNA, contingent on receipt of final pharmacy details and opening hours information from NHS England; and
- DELEGATE responsibility for approval of the final PNA to the HWB Chair.

Background papers: None

Attachments:

Appendix 1 - Islington Pharmaceutical Needs Assessment

Appendix 2 - Islington Pharmaceutical Needs Assessment Consultation Report

Final Report Clearance

Signed by



23 December 2014

.....
Date

Received by

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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. Table 1.1 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 and PPV 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.
Supervised consumption service	Necessary service	<ul style="list-style-type: none"> Access is limited on Sundays, throughout the borough. On weekdays, five pharmacies provide the service outside of standard working hours (9am-7pm).
Needle syringe exchange service	Necessary service	<ul style="list-style-type: none"> Access is limited on Sundays, throughout the borough.
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.

Interim report

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 two pharmacies in Islington which are dispensing appliance contractors.

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

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 2013 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. Pharmacists dispense medicines in dosette or blister packs to help patients take medicines at the correct time.
Vaccination service	The scheme aims to deliver 'flu vaccination to key population groups during September – January of each year, as well as a pneumococcus polysaccharide vaccine (PPV); commissioned until the end of March 2015.

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 or NHS England, but 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).

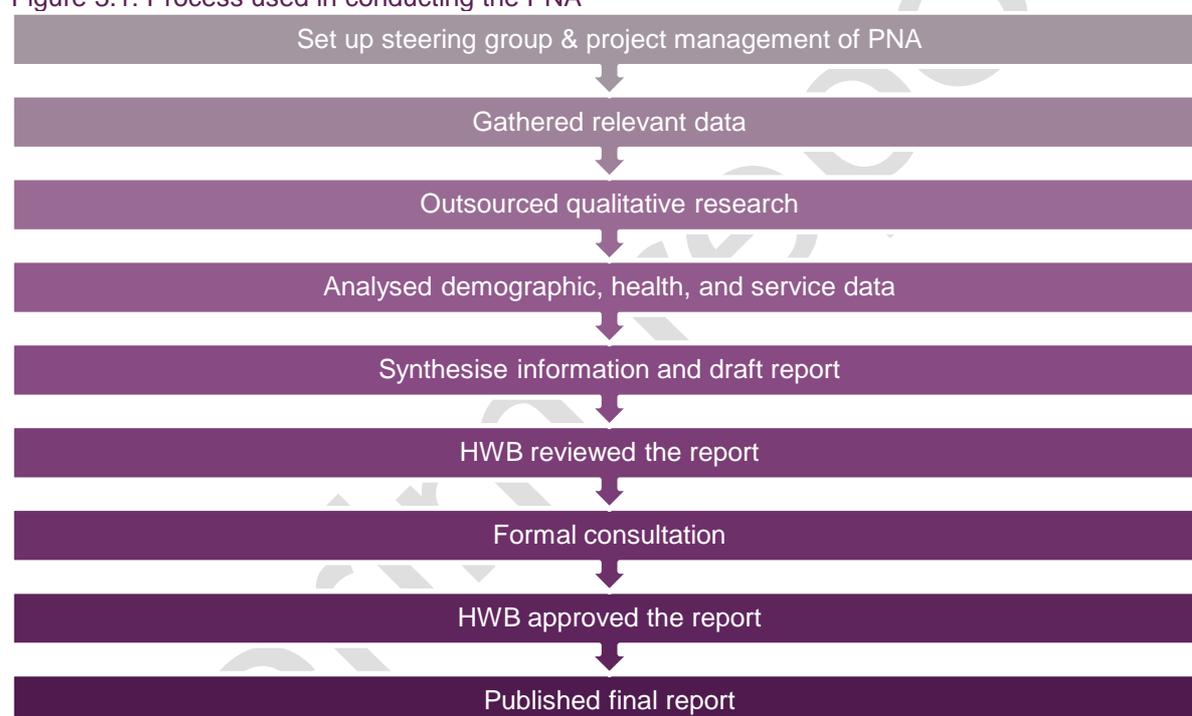
A mixture of methods and data were used in making the assessment of each type of pharmacy services, including engagement with local residents through dedicated qualitative research. This has included:

- 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.

¹⁰ A long term condition is a health problem that cannot be cured but can be controlled by medication or other therapies.

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 truly reflects the needs of Islington residents. A list of consultees specifically requested to take part is listed in Appendices D and E.

3.3.1. 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.

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 212,000 people live in Islington.

Map 3.1: London boroughs showing Islington's location, 2014



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 36 GP practices, 20 general dental practices, 45 community pharmacies and three main hospitals serving the Islington population, as well as other community based services. More information on service provision is given in Chapter 5.

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:

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

¹¹ Greater London Authority (2013). <http://data.london.gov.uk/datastore/package/daytime-population-borough>

¹² <http://evidencehub.islington.gov.uk/Pages/HomePage.aspx>

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, in turn, 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

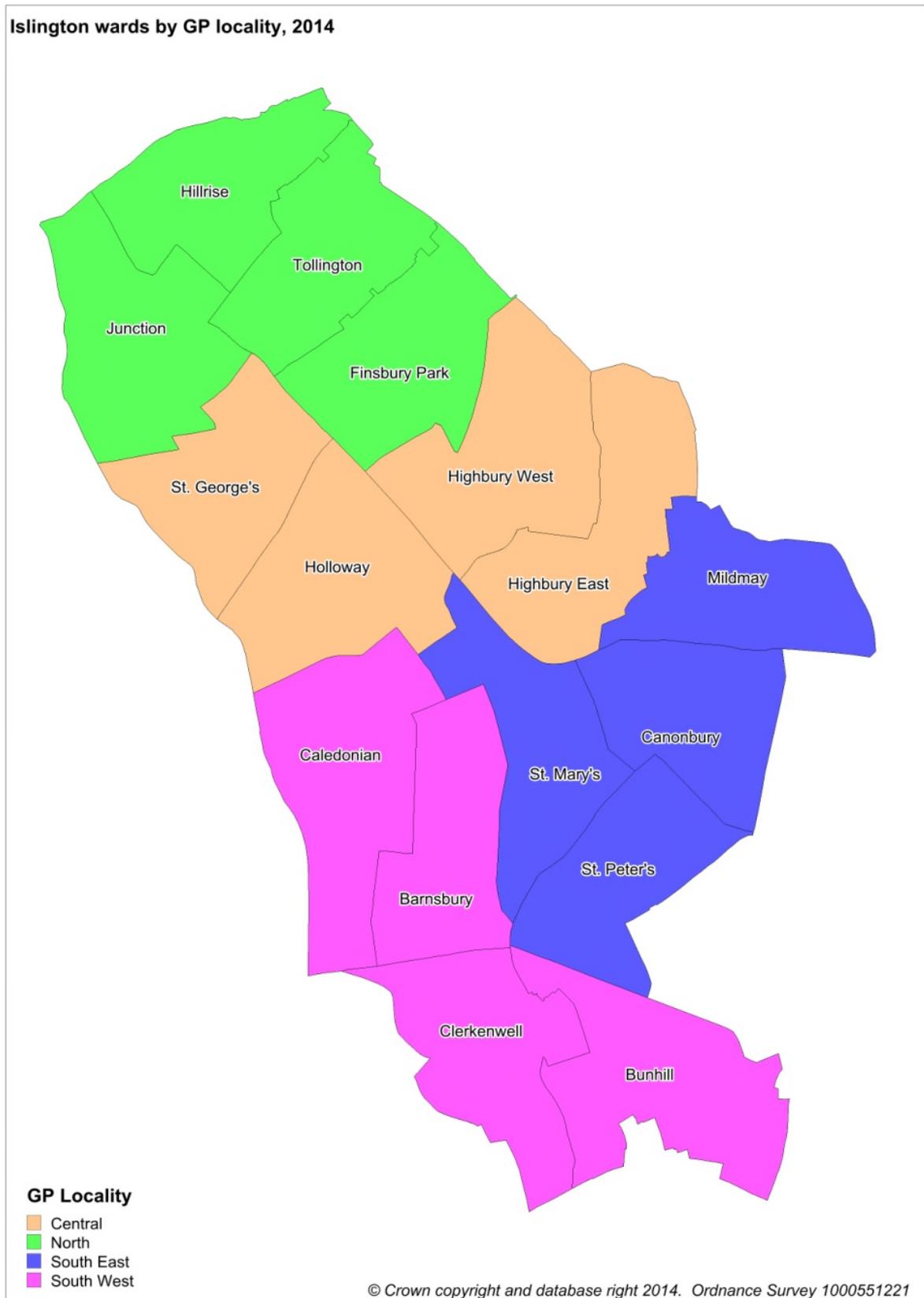
The resident population of Islington's localities varies, due to the varying population density between areas. The table below shows the resident population, using the 2011 Census findings. As a comparison, the GP registered population is also shown.

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 217,000 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 239,200 by 2024, an increase of 10%¹⁷. This compares to a 10% increase in London. This compares to a 9% increase in London. The largest percentage increase is expected in people aged 60-69, with numbers in this group predicted to rise by 19% (2,400 people). The expected population rise in people aged 30-39 accounts for the largest change in terms of numbers of residents, with an estimated growth of 6,600 people. Expected population growth varies slightly by geographical area from 8% in the Central locality to 13% in the South West locality.

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

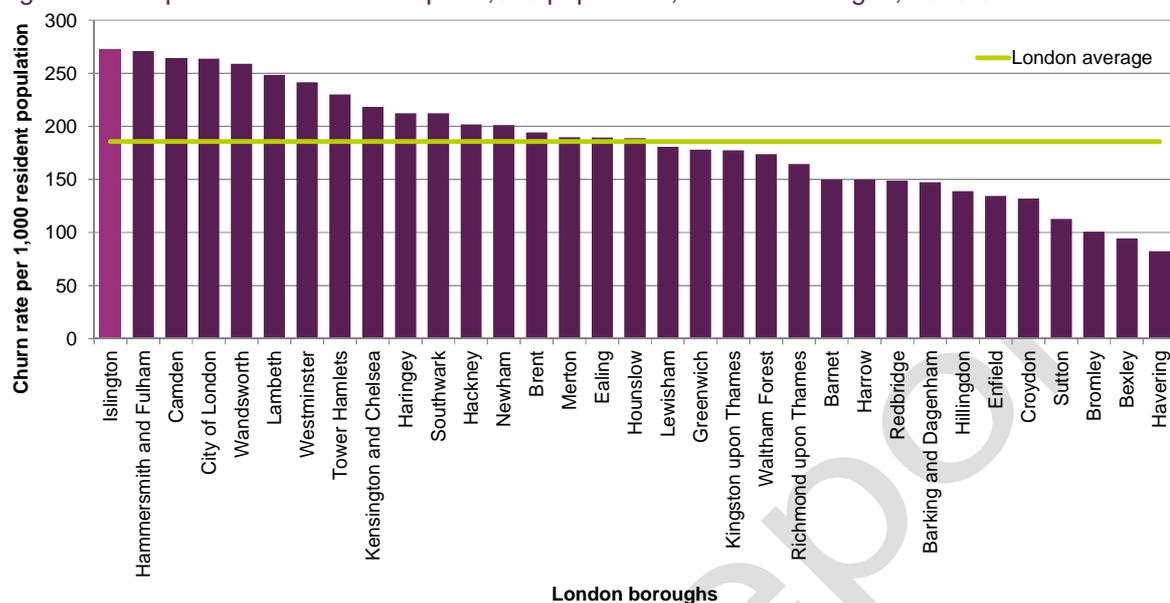
Source: GLA, 2014

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

¹⁷ GLA 2013 Round Demographic Projections SHLAA-based ward projections, 2014

year (**Error! Not a valid bookmark self-reference.**). There are more people moving into Islington than leaving the borough, increasing the population size.

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.

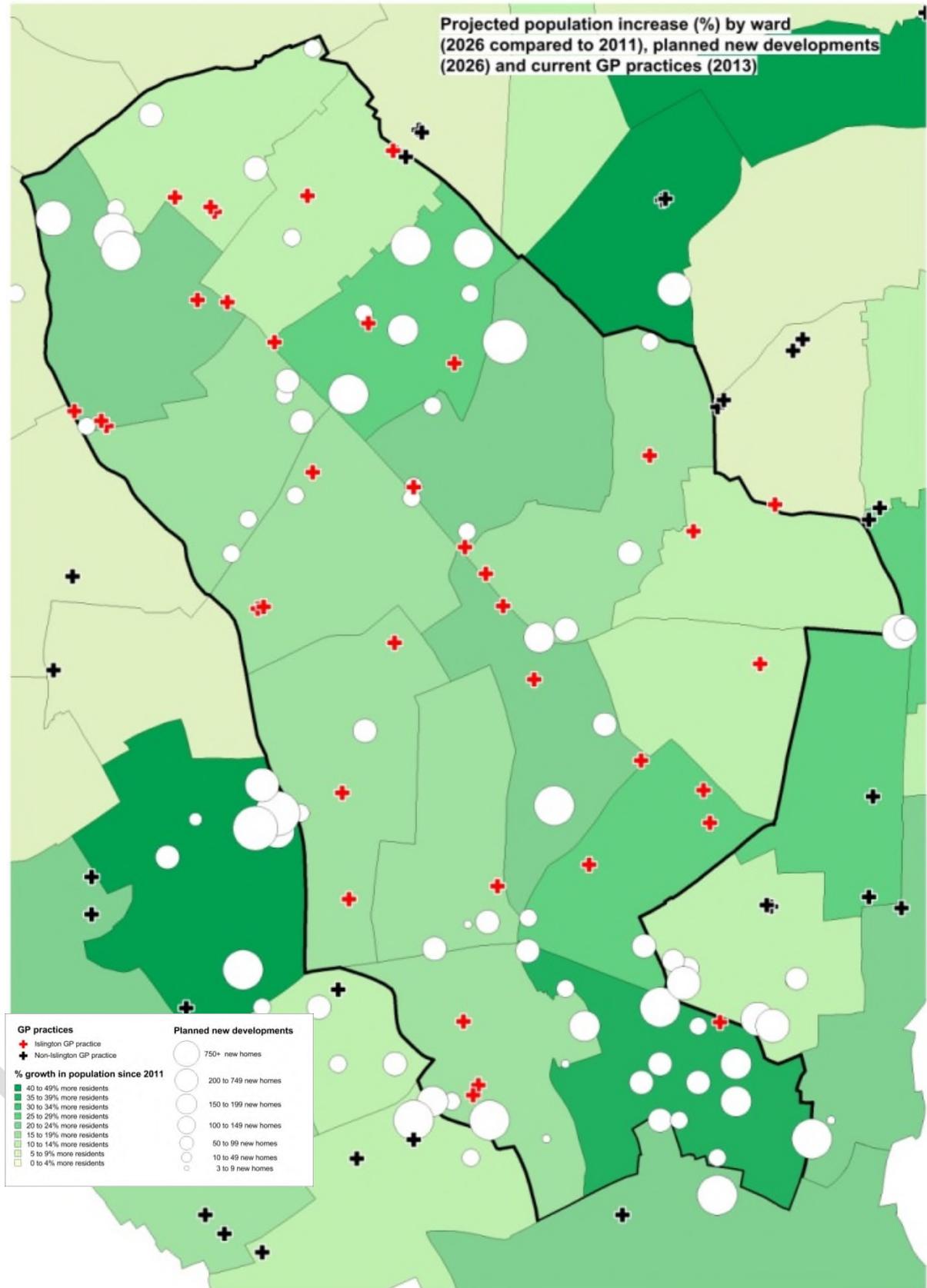
Residential development and the population increases arising from development are particularly concentrated around the Finsbury Park and King’s Cross areas, Barnsbury, Bunhill, Archway and Clerkenwell. There are no projected residential developments in Canonbury between now and 2026.

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.

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

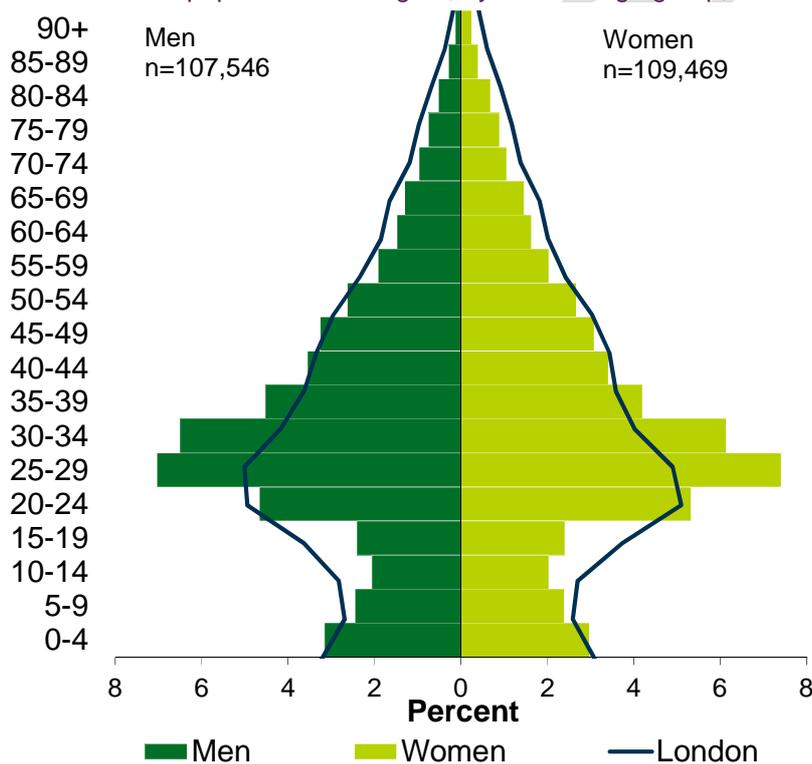
4.2.2. Daytime population

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.

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

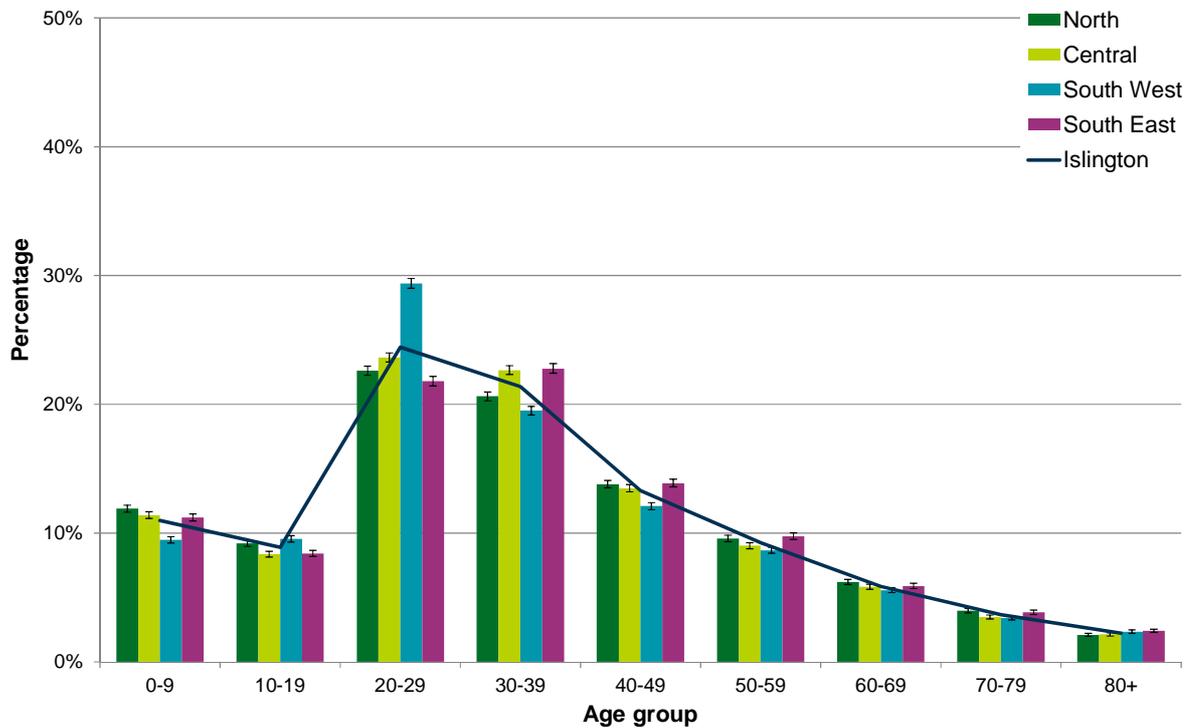


Source: GLA, 2014

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.

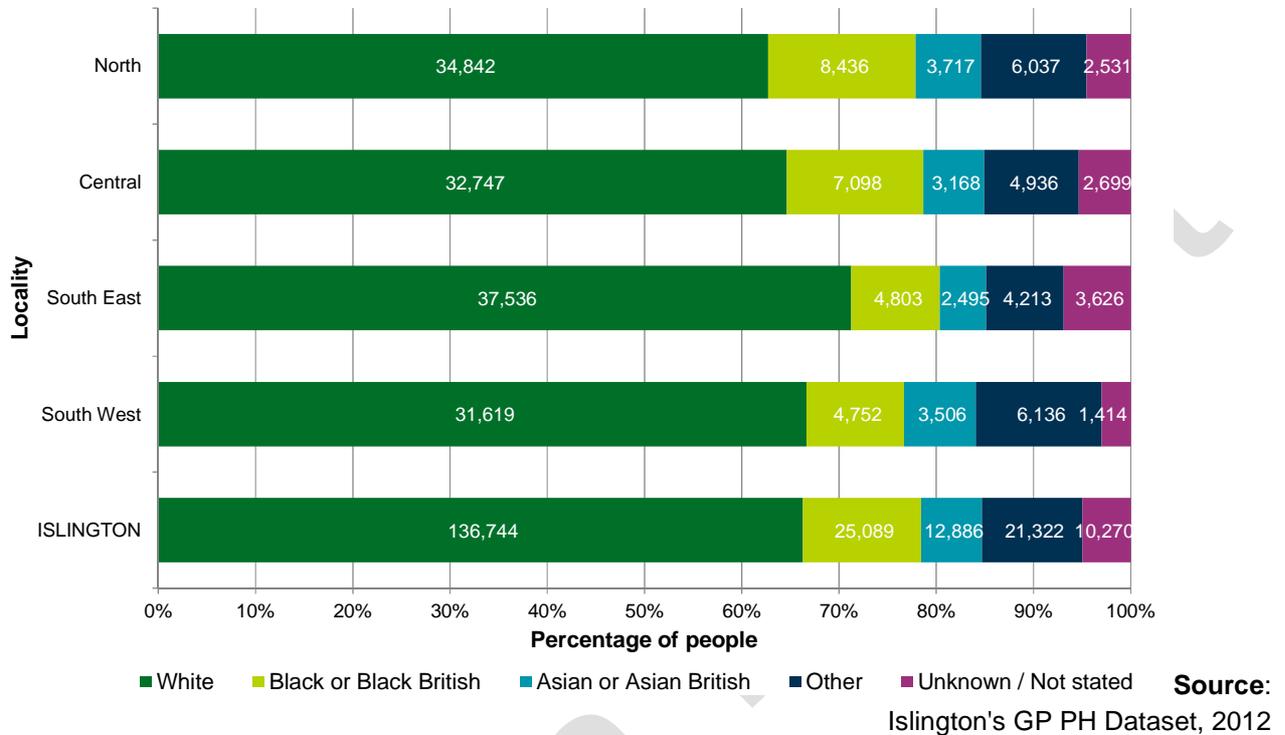
Generally the age structure of the BME groups is younger than the white population across all localities; 46% of children and young people aged 0 to 24 years are from a BME background compared to 20% of the population aged 65 years and over (

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

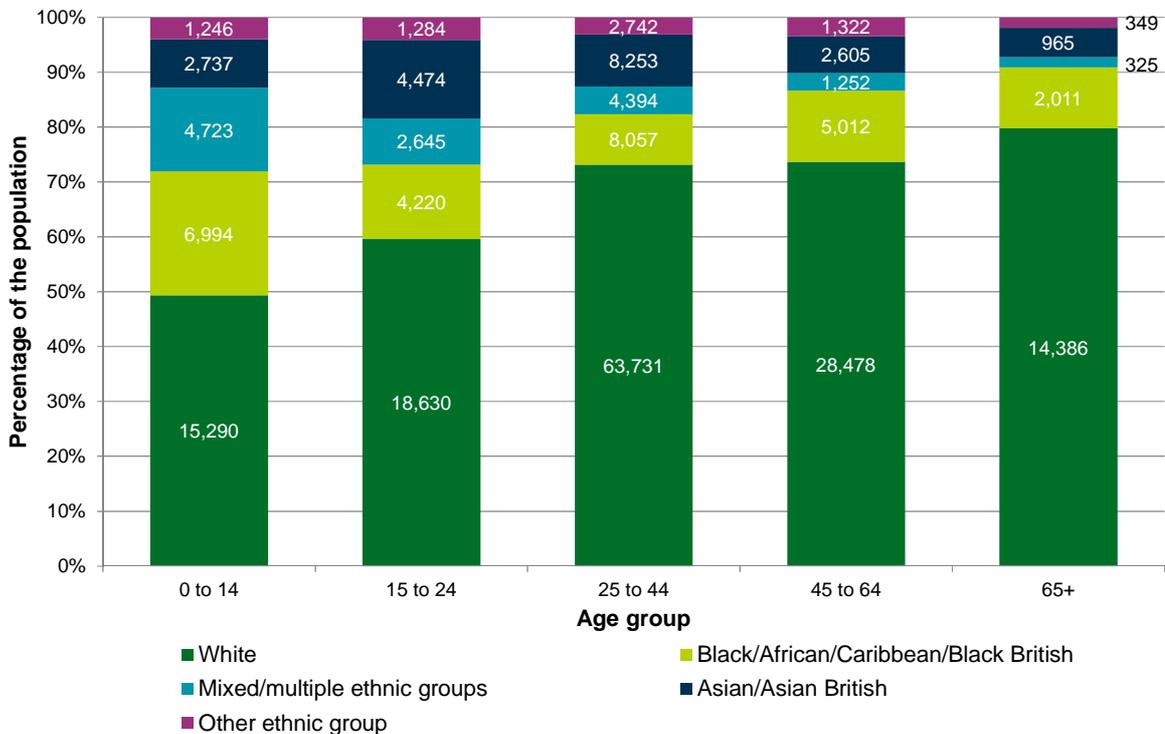
'Other Black' groups expected to grow by 31% and 30% respectively, while White are expected to grow by only 7% between 2011 and 2021.

Figure 4.4: Percentage breakdown of GP registered population by ethnicity, Islington localities, September 2012



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



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.

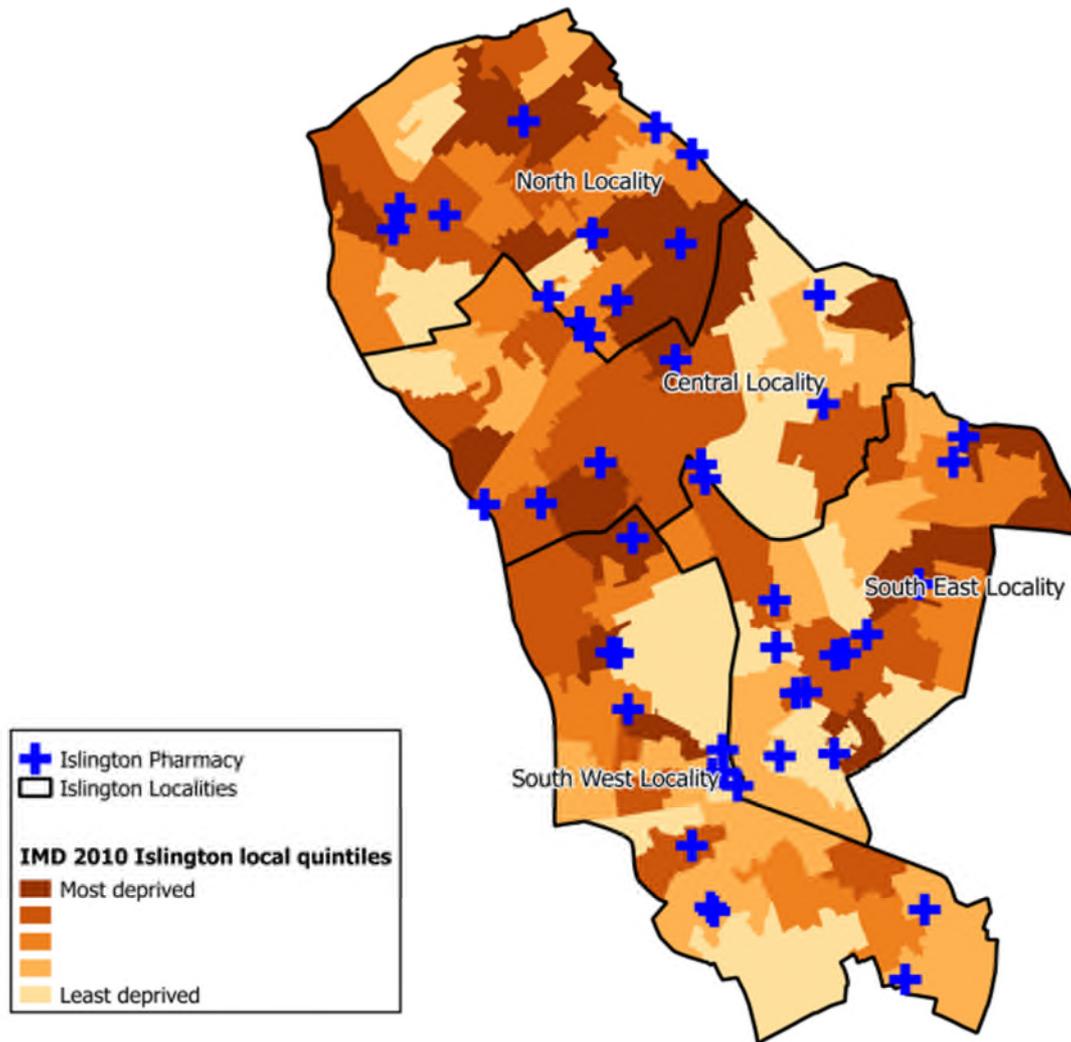
Across all localities, there are clear inequalities in the burden of long term conditions by deprivation: 31% of those living in the poorest areas are living with a diagnosed long term condition compared to those in the richest areas. After controlling for other risk factors such as age and ethnicity, 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)

Map 4.2: Level of deprivation by small area, Index of multiple deprivation, Islington, 2010



Source: Department for Communities and Local Government, 2011

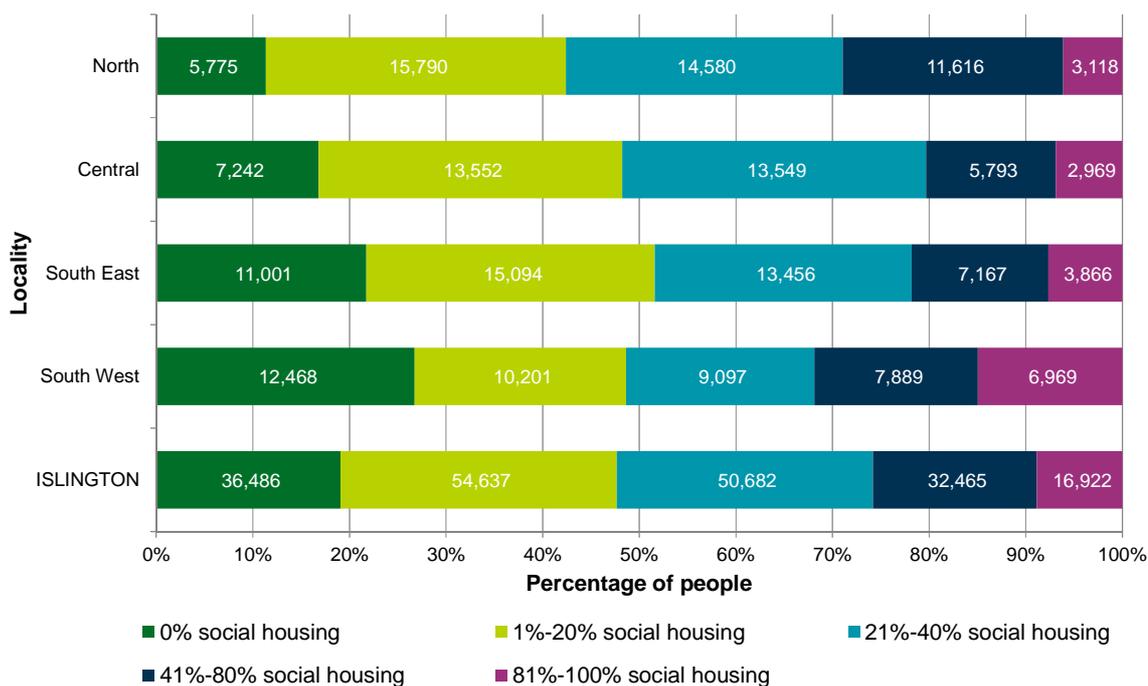
The most deprived people in Islington are more likely to be living with poor health compared to the more affluent. Among people diagnosed with one or more long term conditions, more deprived people are living with multiple long term conditions than affluent people. This is likely to reflect the complex 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.

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, 2011

Note: 26,119 patients were resident outside of the borough, and were not 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 in Islington.

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.

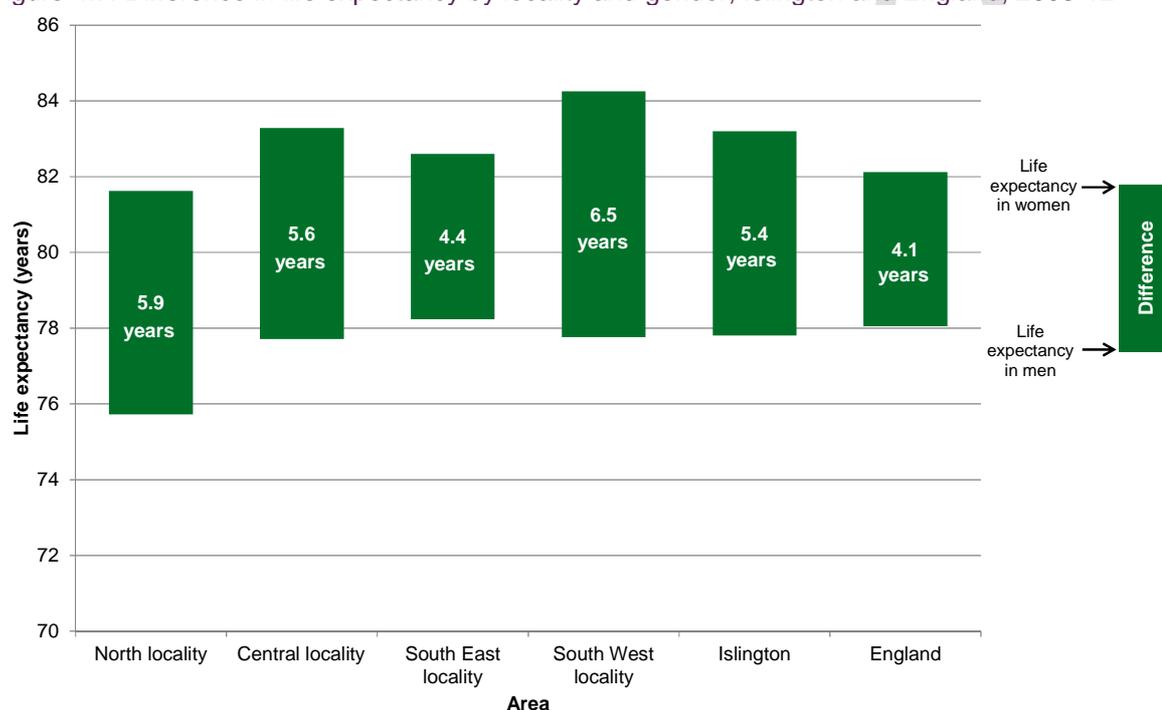
There are signs the gap in life expectancy may be increasing, however the more affluent residents may have experienced greater improvements in life expectancy over time than the most deprived. Furthermore, the improvements in life expectancy do not seem to have been shared equally across the population, 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

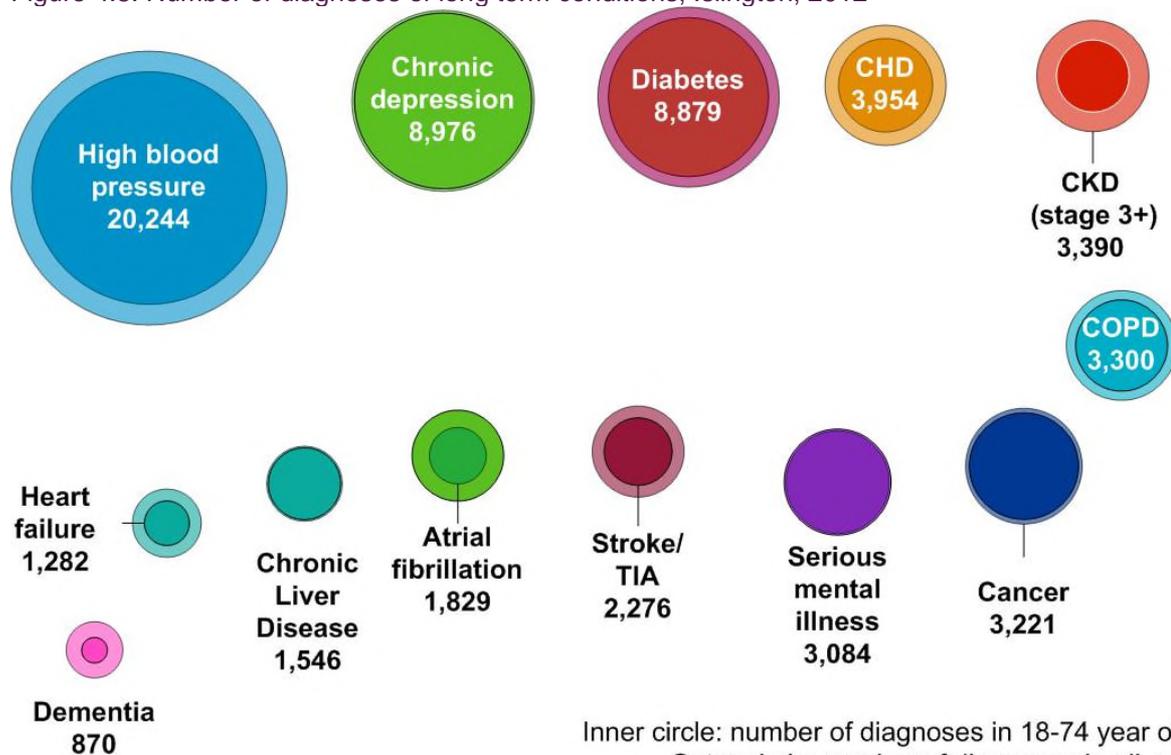
4.4. Prevalence of long term conditions

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.

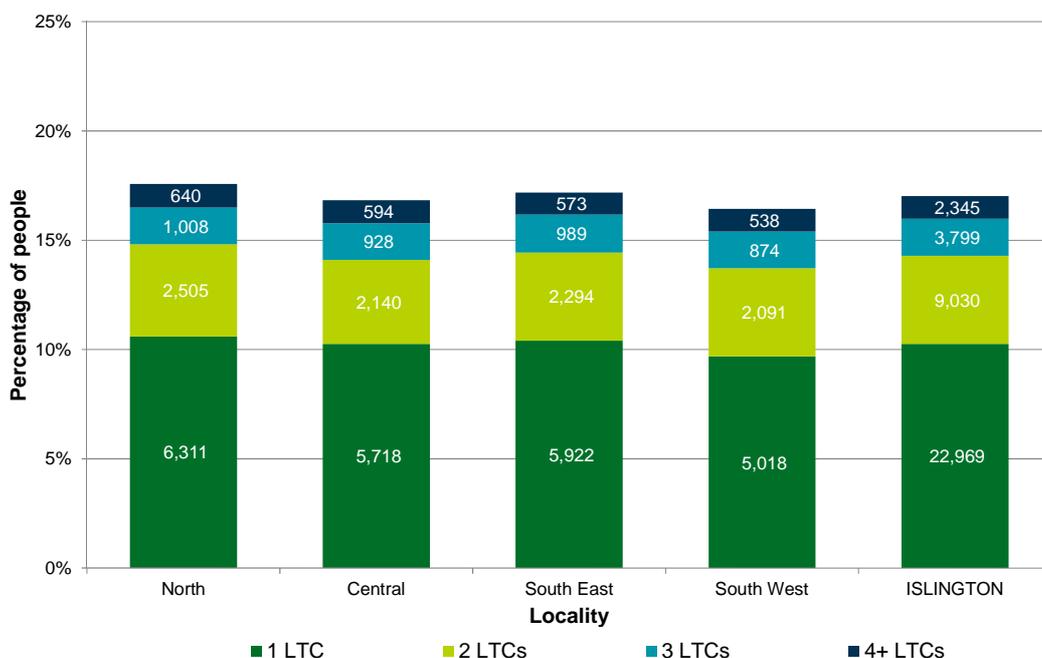
4.4.1. Comorbidities

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%	3312	6330
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%

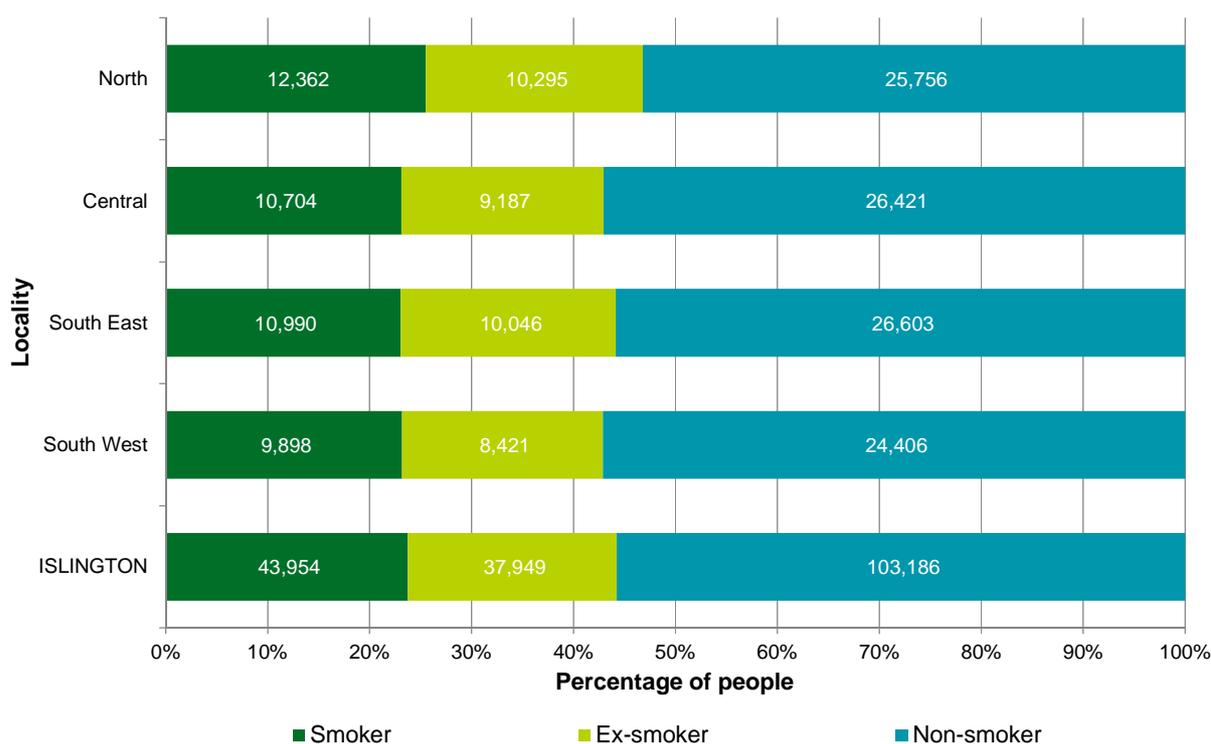
The variation by locality in the recording of alcohol and BMI needs to be considered when interpreting the data shown in the next sections, as low levels of recording can lead to under-reporting of the prevalence of these risk factors.

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.

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:

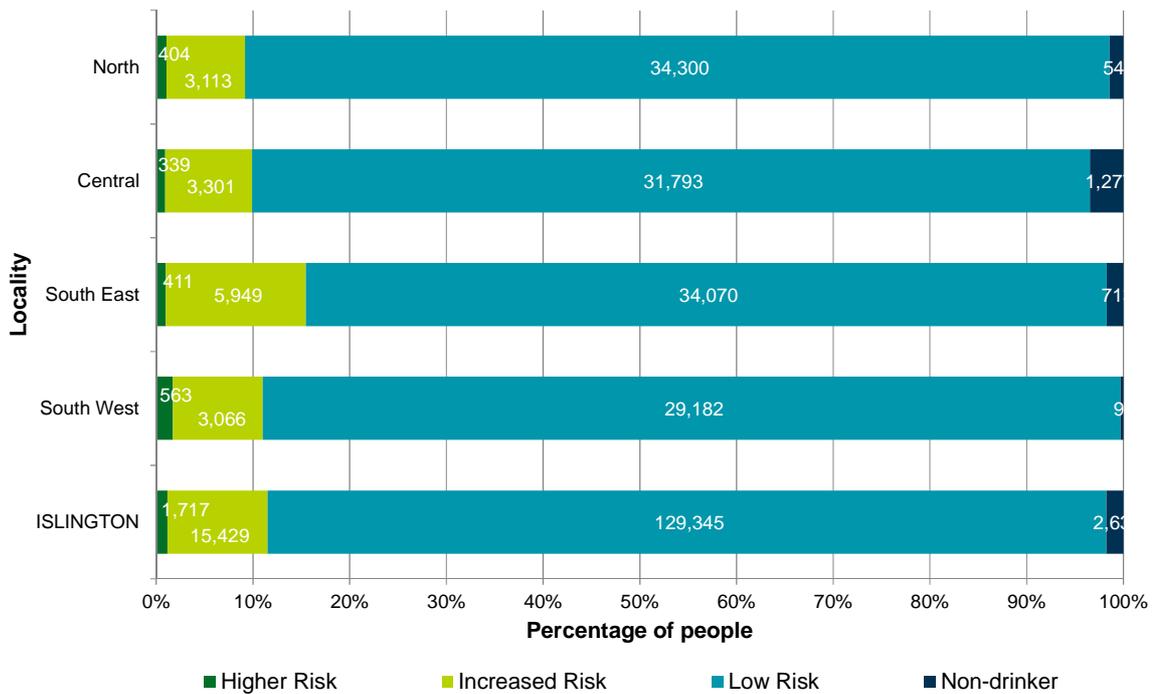
- Male who drink regularly more than 3-4 units a day (but less than higher risk levels)
- Female who drink regularly more than 2-3 units a day,

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.

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 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.

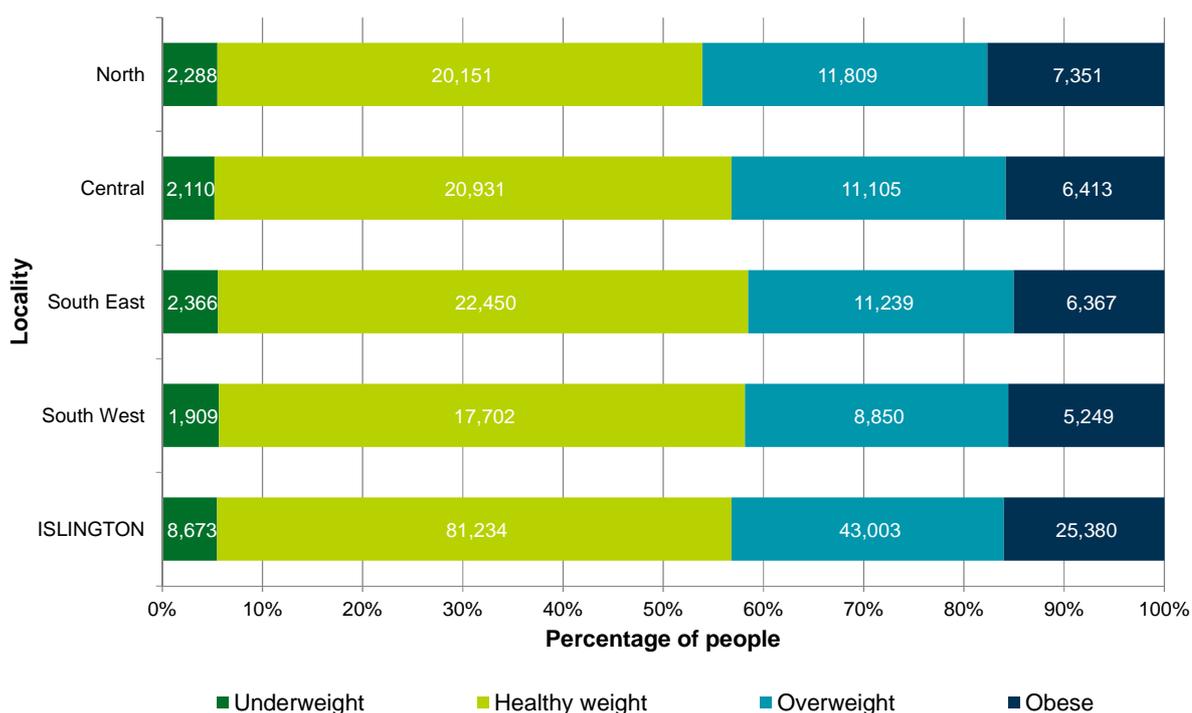
Alcohol-specific admissions are significantly higher amongst Islington men (887 per 100,000 population) compared to both London and England (529 and 506 per 100,000 population respectively). For women, the alcohol-specific admission rate (272 per 100,000) is also significantly higher compared to London 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 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 (63%) are still higher than the national average (50%); 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 1,424 people accessing HIV care in Islington in 2013. The rate of Islington residents accessing HIV care is significantly higher in Islington (8.5 per 1,000 population) compared to both London and England (5.7 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 6.0 per 1,000 in 2002 to 8.5 in 2013) as people are living longer with the virus and more people are diagnosed.

Of those in treatment, 84% are men and about 69% were infected through sex between men (983 people), with a further 353 people infected through sex between men and women (25%). Most people in treatment were White (959, 67%) followed by Black-African (231, 16%).

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.

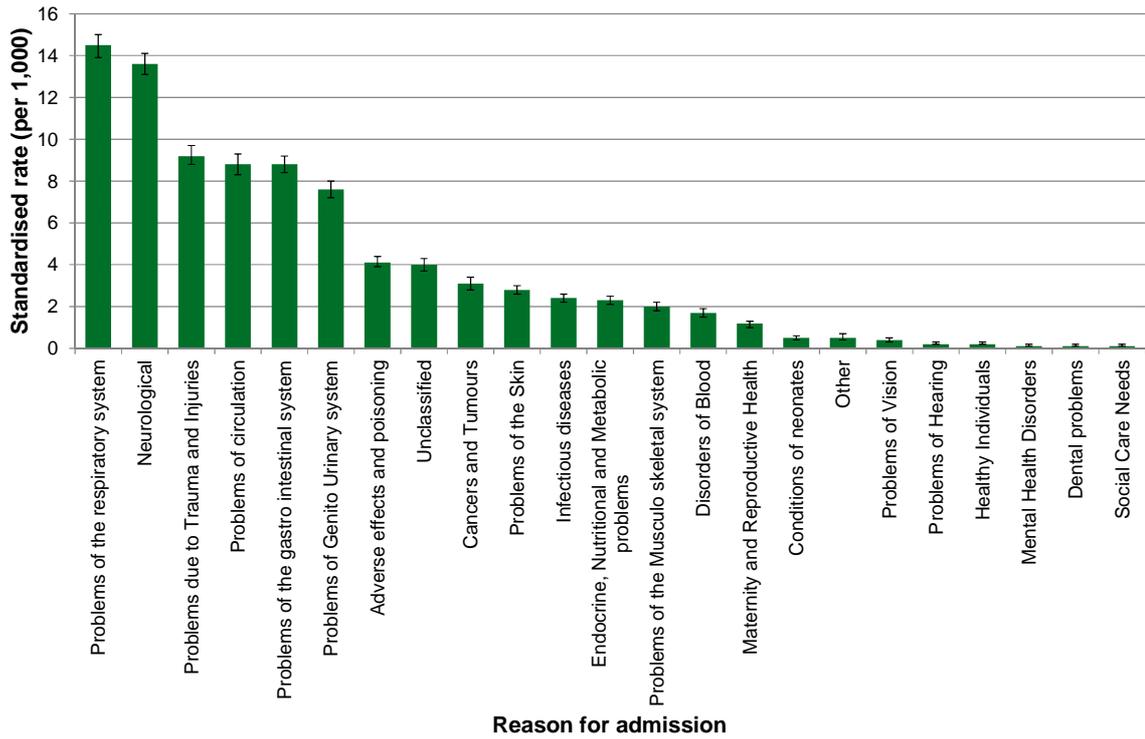
4.8. Hospital admissions

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

Interim

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.

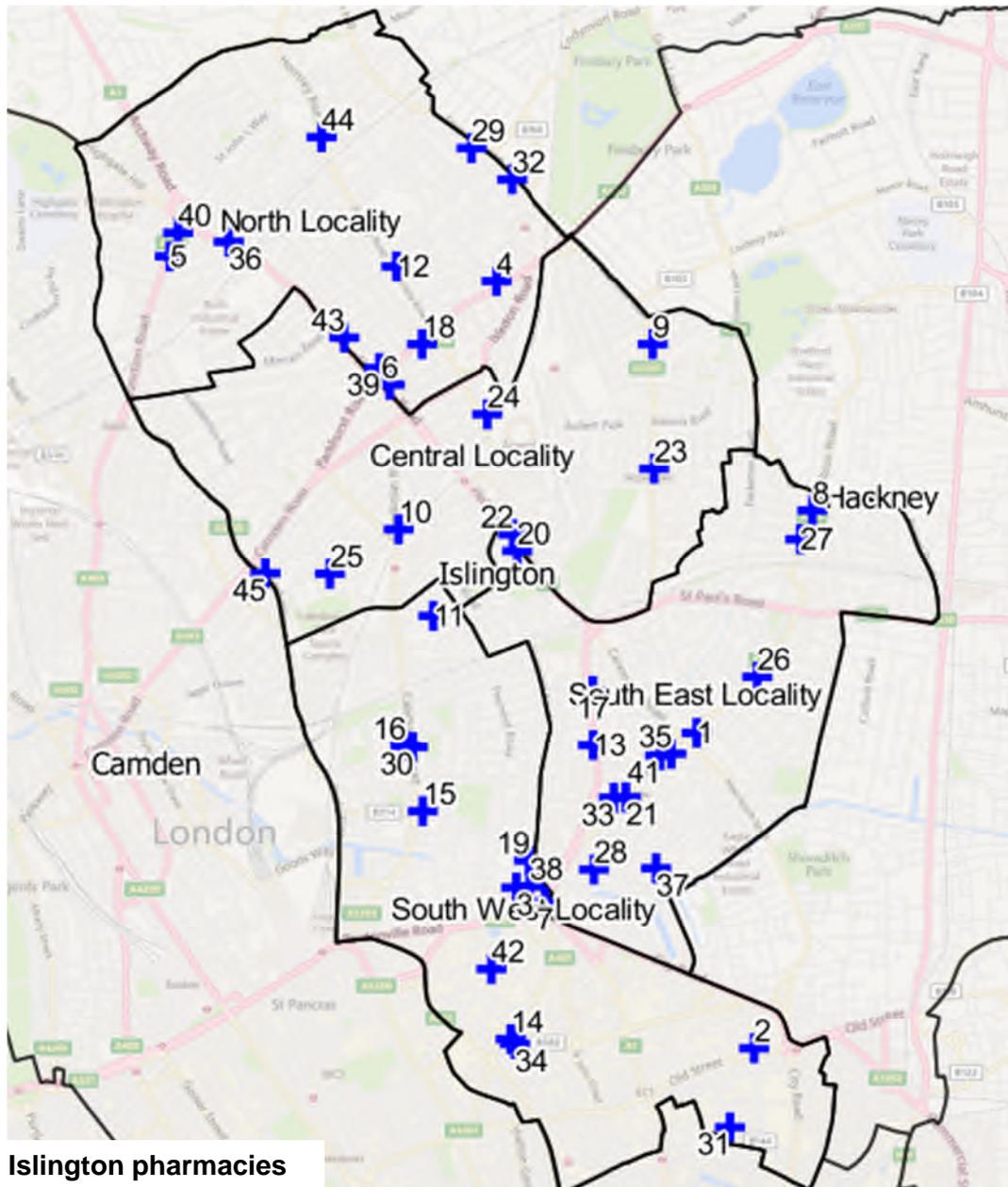
Information on pharmacy opening hours and service provision are based on information provided by NHS England. A survey of pharmacies was undertaken in September to verify this information, to which 28 (62%) pharmacies responded.

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 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. The combination of a large number of pharmacies, particularly clustered around the high traffic areas like high streets and transport links, as well as the option of using pharmacies outside of Islington means that there are a range of pharmacies available to local residents and patients registered with Islington GP practices.

Map 5.1: Islington pharmacies, October 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

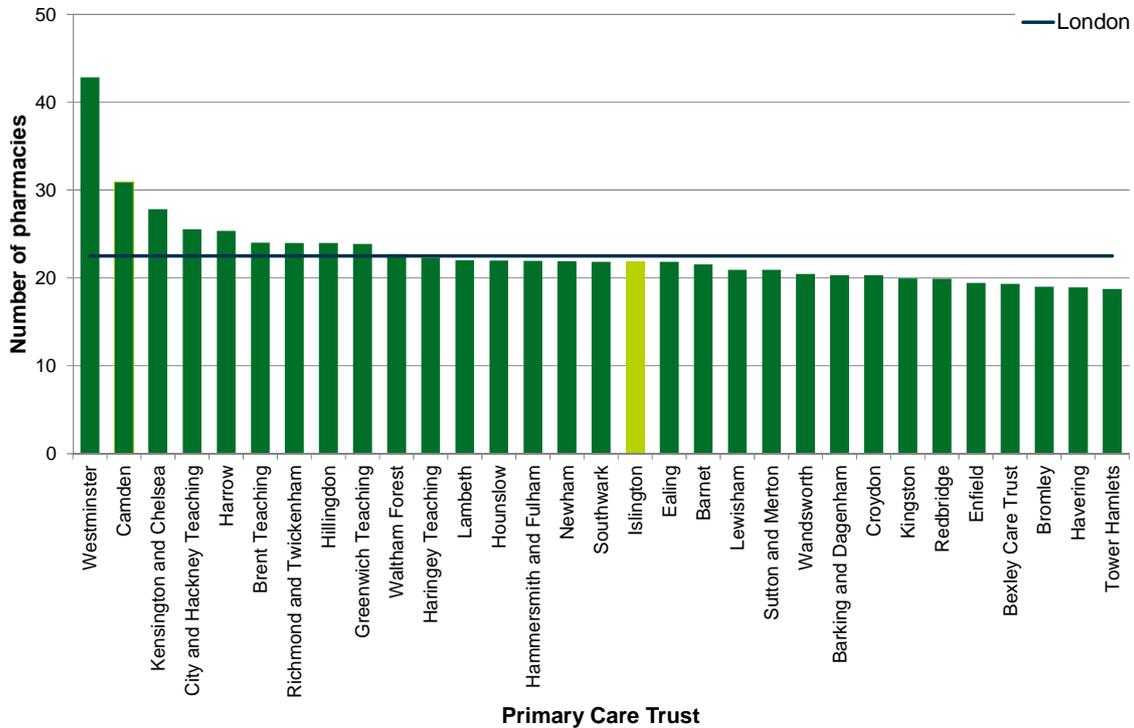
Table 5.1: Number of pharmacies by Islington ward and locality, and the number of pharmacies per 100,000 population.

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

There are no exclusively mail order or internet-based pharmacies based in Islington, but residents do use mail order pharmacies and local pharmacies do also offer an internet-based service. A full list of pharmacies in Islington can be found in Appendix A.

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, aside from those on a 100 hour contract. 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 October 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 36 (80%) 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. One pharmacy is open after 7pm, Islington Pharmacy, which is open until 11pm.

On Sundays there are four pharmacies (9%) 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 shown 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 Care UK; patients calling the NHS Out of Hours service will be referred to Care UK'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 is one pharmacy 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 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.

Alignment with GP opening hours

Future changes to GP services may change the need for pharmacy services. The GP contract for 2015/16 will include a commitment to increase online services for patients, including an increase in access to online appointments. This may change the way in which patients interact with their GP, and therefore the way in which they need to access pharmacies for prescriptions.

Plans to extend GP opening hours may also change the demand for pharmacy services – nationally there are plans to introduce seven-day, 12 hours a day, opening hours at some GP practices. If GP practices in Islington start to follow these opening hours it may increase the demand for access to pharmacy services outside of existing opening hours.

In both instances, it is hard to predict the impact of changes at this point, so this is something that should be monitored, to see if demand for evening or weekend access to pharmacies increases, and whether this is naturally met by the existing community pharmacy network.

Alignment with dental practice opening hours

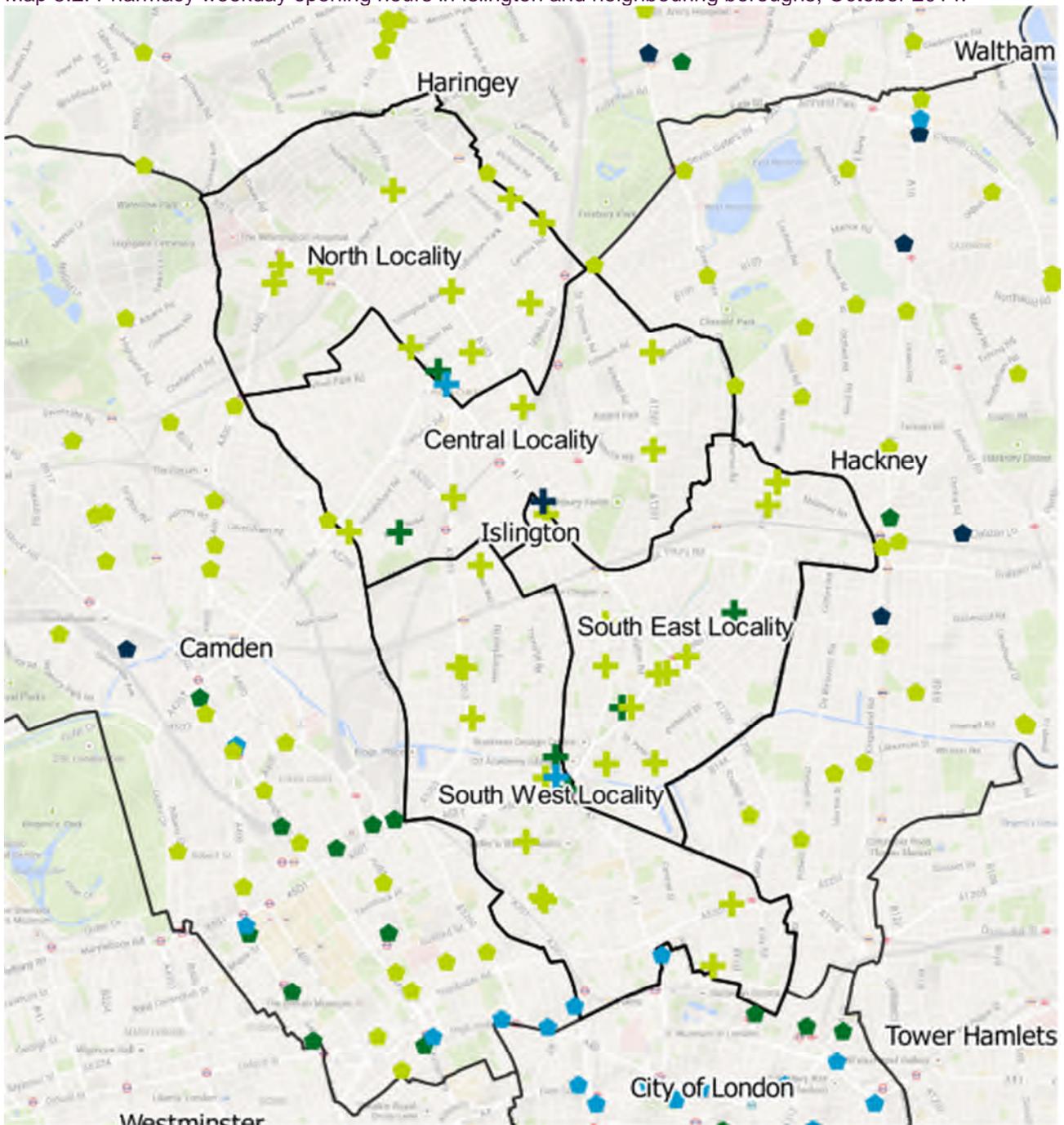
Section to be added at the request of NHS England.

Table 5.2: Summary of pharmacy weekday opening hours, by locality and ward, October 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, October 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

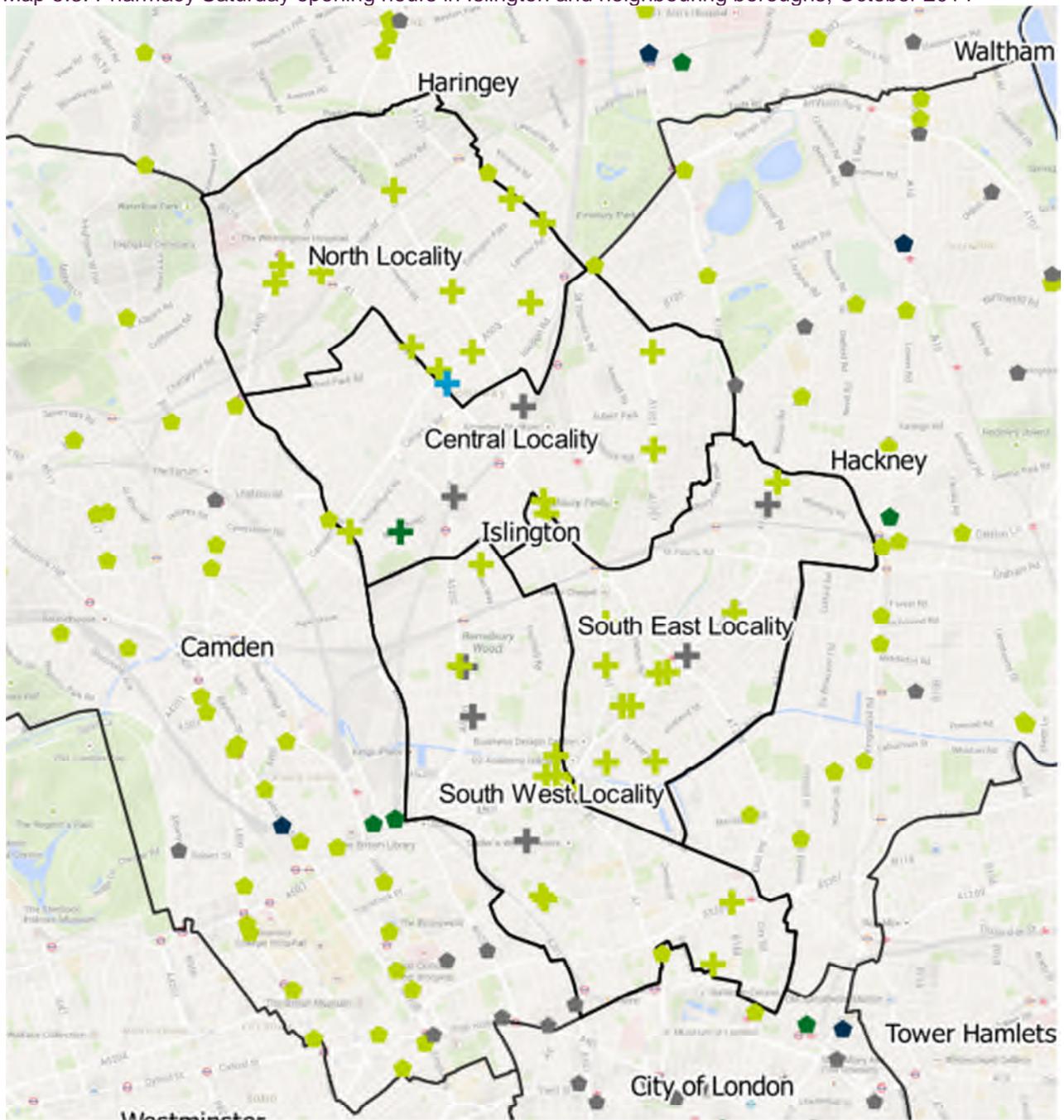
Source: NHS England, 2014

Table 5.3: Summary of pharmacy Saturday opening hours in Islington, by locality and ward, October 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	2	0	0	0	2
	Clerkenwell	2	0	0	0	1
	South West Total	10	0	0	0	3

Source: NHS England, 2014

Map 5.3: Pharmacy Saturday opening hours in Islington and neighbouring boroughs, October 2014



Islington Saturday opening hours

- + Extended Hours: Open before 9am and after 7pm
- + Standard Hours: Open between 9am and 7pm
- + Early Hours: Open before 9am
- + Cbsed

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

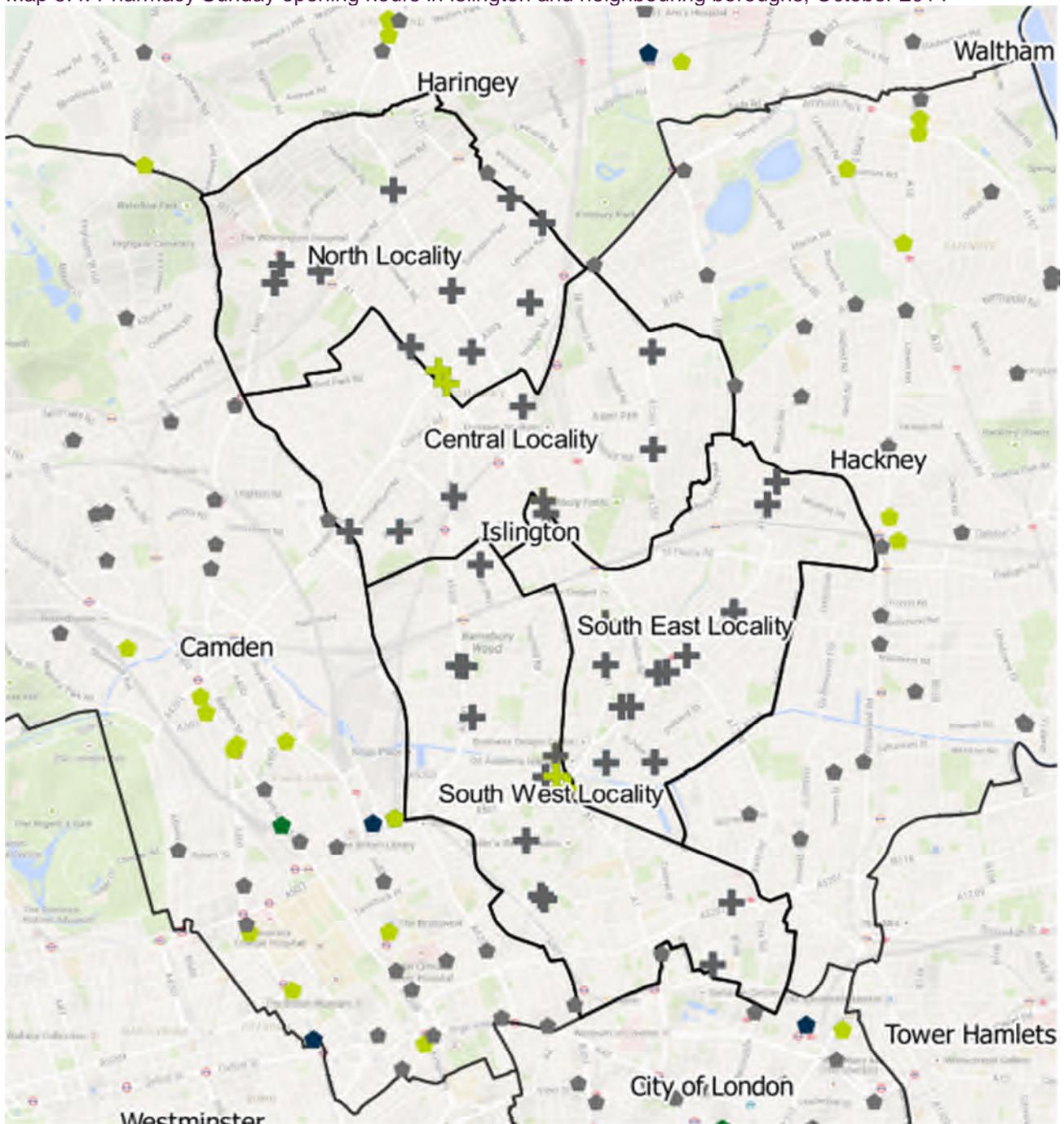
Source: NHS England, 2014

Table 5.4: Summary of pharmacy Sunday opening hours in Islington, by locality and ward, October 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	0	0	0	0	1
	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	0	0	0	0	14
South West	Barnsbury	2	0	0	0	2
	Bunhill	0	0	0	0	2
	Caledonian	0	0	0	0	4
	Clerkenwell	0	0	0	0	3
	South West Total	2	0	0	0	12

Source: NHS England, 2014

Map 5.4: Pharmacy Sunday opening hours in Islington and neighbouring boroughs, October 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 easily. The number of pharmacies available in Islington, and their proximity to transport links, suggests that residents in most areas of the borough have a choice of pharmacies to use. 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, but could use pharmacies in neighbouring boroughs.

Access at weekends is limited, with four 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. If GP opening hours change, the demand for evening or weekend access to pharmacies should be monitored, to ensure that the population are still adequately served.

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, the provision of pharmacies in Islington is adequate for the current and future needs of the population, but some additional capacity at weekends may be desirable. This need could be met by extending the opening hours of existing pharmacies.

5.2. Essential services

In this section, the provision of essential services is assessed using the distribution of pharmacies, their opening hours, and the provision of dispensing services, as these factors are the most important in determining the extent to which the current provision of essential services meets the need of Islington's population.

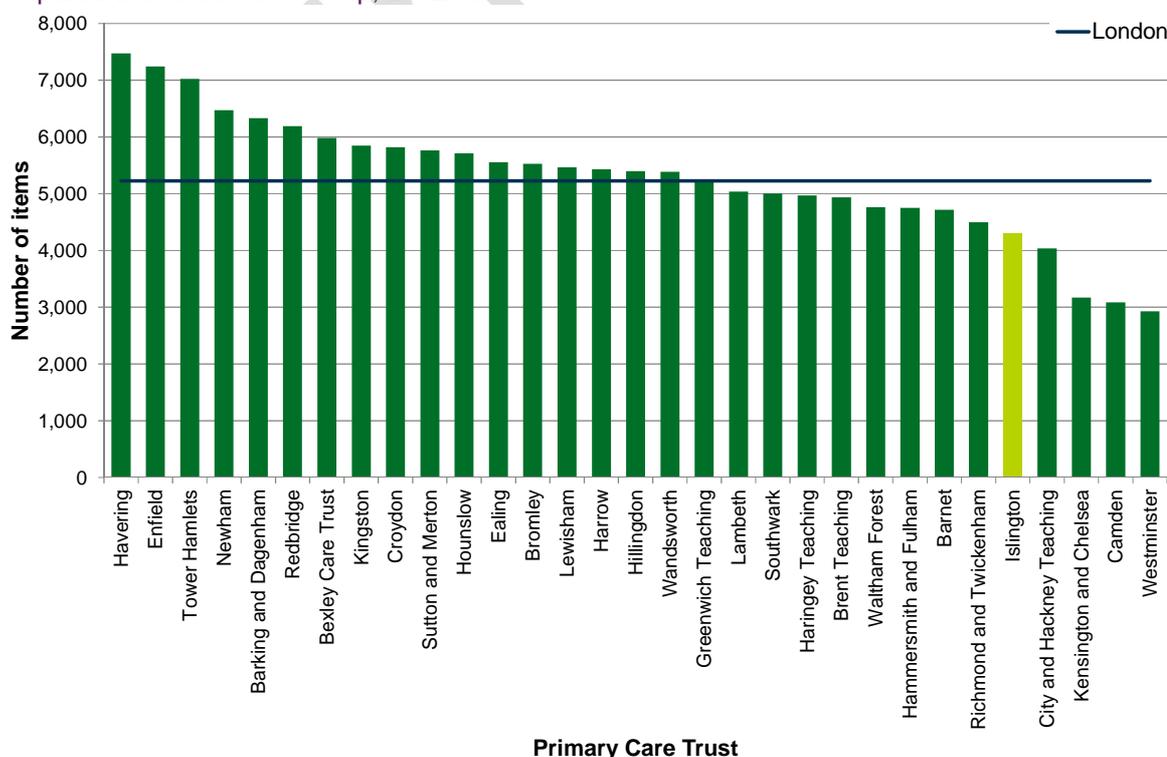
Essential services are the services provided by all pharmacy contractors: the dispensing of medicines and appliances, promotion of healthy lifestyles, and safe disposal of unwanted medicines, repeat dispensing, signposting patients to other sources of support and care, and supporting self-care. All 45 pharmacies in Islington must provide these services as a part of their contract so in order to assess the service provision. Pharmacies must also ensure that clinical governance arrangements are met, as set out in the Regulations.

5.2.1. Dispensing services

Pharmacies in Islington dispensed an average of 4,299 items per month in 2012/13, compared with an average of 5,225 across London and 6,628 per month in England as a whole (Figure 5.2). This is the fifth lowest dispensing rate of all London boroughs.

Just over 2.4 million items were prescribed by Islington GPs in 2013/14, and over 2 million (83%) of these items were dispensed by pharmacies in Islington.

Figure 5.2: Average number of items dispensed per month, per pharmacy, Islington pharmacies compared with ONS Peer Group, 2012/13



Source: HSCIC, 2014

Table 5.5: The total dispensing by GP practices in each locality and the average number of items per pharmacy, per month, by locality, 2013-14 and 2014 year to date.

Locality	April 2013 - March 2014			April 2014 - October 2014		
	Total Items Dispensed	Number of pharmacies	Number of items per pharmacy	Total Items Dispensed	Number of pharmacies	Number of items per pharmacy
North	673,692	12	4,678	396,258	12	4,717
Central	591,586	7	7,043	354,023	7	7,225
South East	608,995	13	3,904	361,361	13	3,971
South West	538,081	13	3,449	327,571	13	3,600
Islington	2,412,354	45	4,467	1,439,213	45	4,569

Source: NHS Business Services Authority, 2014

The data in Table 5.5 are provided as an indicator of dispensing by locality. These dispensing figures are published at GP Practice level, so may not represent the number of items dispensed by pharmacies each locality. However, as an indicative measure, they are compared here against the number of pharmacies in the locality. The data show that the rate of dispensing per pharmacy, per month, is highest in the Central locality, and lowest in the South West locality. The Central locality is the only locality with a dispensing rate above the London and England averages.

The South East and South West localities have the highest anticipated increase in population over the coming years (Section 4.2.1), so their lower rates of dispensing per pharmacy suggest that there is capacity within the local area to accommodate an increase in population. Furthermore, the proximity of pharmacies across the borders - particularly in the south of Camden, which has a number of housing developments planned, and the City of London - suggest that not all new Islington residents will necessarily use Islington pharmacies.

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 figures, October 2014, indicate that for Islington, 5.1% of all items were repeat prescriptions (Table 5.6). The proportion of dispensing that is repeat dispensing varies between localities, from 1.6% to date in 2014-15 in the Central locality to 11.8% in the South West locality. Rates of repeat dispensing and electronic repeat dispensing are increasing in Islington CCG and are monitored via the NHS England Medicines Optimisation dashboard. The CCG's prescribing advisors are working with GP practices and pharmacies to increase uptake, and the roll out of EPS2 will facilitate increased uptake through automation of the paper-based process. This work to increase uptake will improve patient choice within the localities, as well as improving the level of convenience for patients.

Table 5.6: Breakdown of repeat dispensing, by locality, 2013-14 and 2014 year to date.

Locality	April 2013 - March 2014			April 2014 - October 2014		
	Total Items Dispensed	Items Repeat Dispensed	% Repeat Dispensed	Total Items Dispensed	Items Repeat Dispensed	% Repeat Dispensed
North	673,692	17,920	2.7%	396,258	9,797	2.5%
Central	591,586	4,756	0.8%	354,023	5,675	1.6%
South East	608,995	32,128	5.3%	361,361	18,889	5.2%
South West	538,081	57,090	10.6%	327,571	38,765	11.8%
Islington	2,412,354	111,894	4.6%	1439,213	73,126	5.1%

Source: NHS Business Services Authority, 2014

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 the end of 2014, or soon thereafter. 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 5.7). The roll out of EPS2 across Islington's GP Practices and pharmacies will help to improve the choice for patients, increasing the number of sites where they can receive an electronic prescription.

Table 5.7: 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%
July 14	212,488	8,922	4.2%
August 14	196,335	13,716	7.0%
September 14	208,376	19,389	9.3%
October 14	223,001	21,734	10%

Source: NHS Business Services Authority, 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 5.8, and mostly fall in the immediately neighbouring boroughs. The number of neighbouring pharmacies fulfilling prescriptions for Islington patients serves to highlight the level of choice available to Islington patients and residents.

Table 5.8: Top ten pharmacies most frequently used outside of Islington.

Pharmacy	Address	Post code	Borough
DH Roberts Chemist	147 Fortess Road	NW5 2HR	Camden
Boots UK Limited	29 North Square	N9 0HW	Enfield
Santa's Pharmacy	182 Stroud Green Road	N4 3RN	Haringey
Park Pharmacy	286 Seven Sisters Road	N4 2AA	Hackney
Boots UK Limited	31-32 The Mall	E15 1XD	Newham
Aura Pharmacy	21 Brecknock Road	N7 0BL	Camden
Pitchkins & Currans	Unit 2 45-47 Elgin Avenue	W9 3PP	Westminster
Boots UK Limited	82-84 Kingsland High St	E8 2NS	Hackney
Safedales	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. These are discussed in section 5.5.7.

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, and this service will show increasing benefits for residents as the CCG works with GP practices and pharmacies to increase the use of EPS and repeat dispensing. 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 the lower rate of dispensing in the South East and South West suggests that 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 in this area. The data also suggests that overall there is capacity to meet an increase in demand arising from the 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. Each of the essential services directly help to support the JHWB's goal of preventing and managing long term conditions by providing access to both medicines and advice and support on their use, and can also contribute to the goals of ensuring that every child has the best start in life, and improving mental health and wellbeing. 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),
- People with, or at risk of, cardiovascular disease and regularly being prescribed four or more medicines, added as a target group from 1 January 2015.

In 2014/15, at least half of all MURs in a year needed to be delivered to people from these target groups. As of 1 January 2015, people with, or at risk of, cardiovascular disease and regularly being prescribed at least four medicines will be added as a target group, and the target will increase to at least 70% of MURs being delivered to these target groups in 2015/16. 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 5.10). 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. 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.

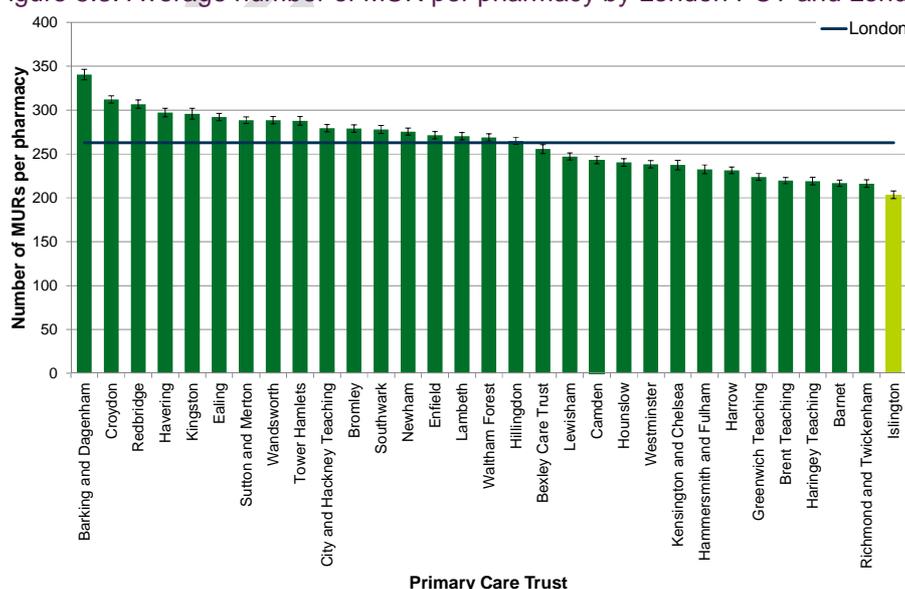
Data on MURs provided by pharmacies for 2013/14 show that 9,348 MURs were carried out by 41 (91%) pharmacies in Islington (Table 5.9). On average, 203 MURs were carried out per pharmacy in Islington; the lowest in London (Figure 5.3). These data show that the average number of MURs per pharmacy in each of Islington’s localities are either lower than, or similar to, the London average. This suggests that there is capacity within each of the localities for pharmacies to accommodate an increase in residents; again this is most significant for the South East and South West localities which see the highest concentration of housing developments. 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.

Table 5.9: 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

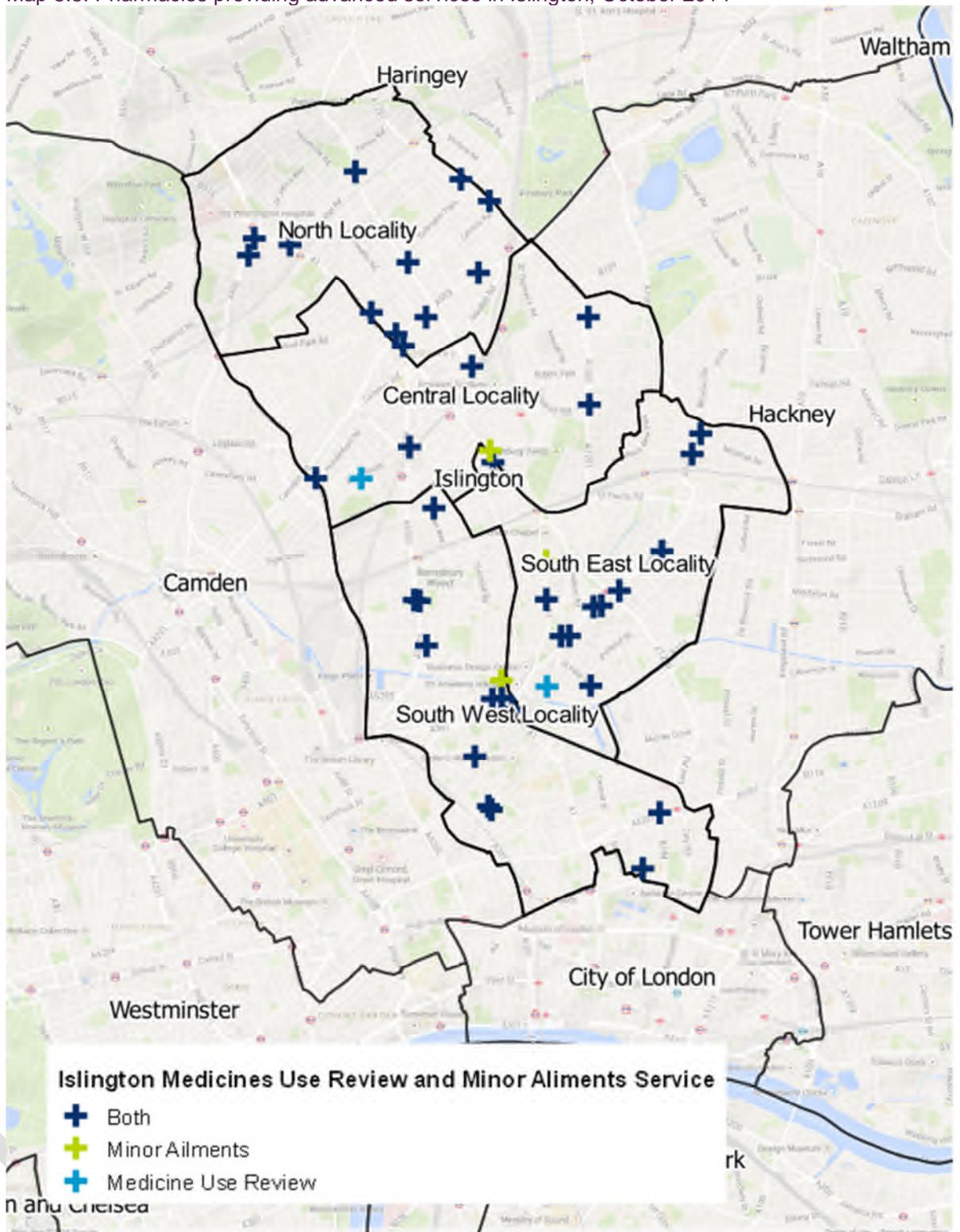
Source: PSNC, 2013/14

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, October 2014



Source: NHS England, 2014

Table 5.10: 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	11	1	0	0	11	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	10	0	1	1	10	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	12	0	0	0	10	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; which is one of the JWB's priorities. 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 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 weekdays 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)

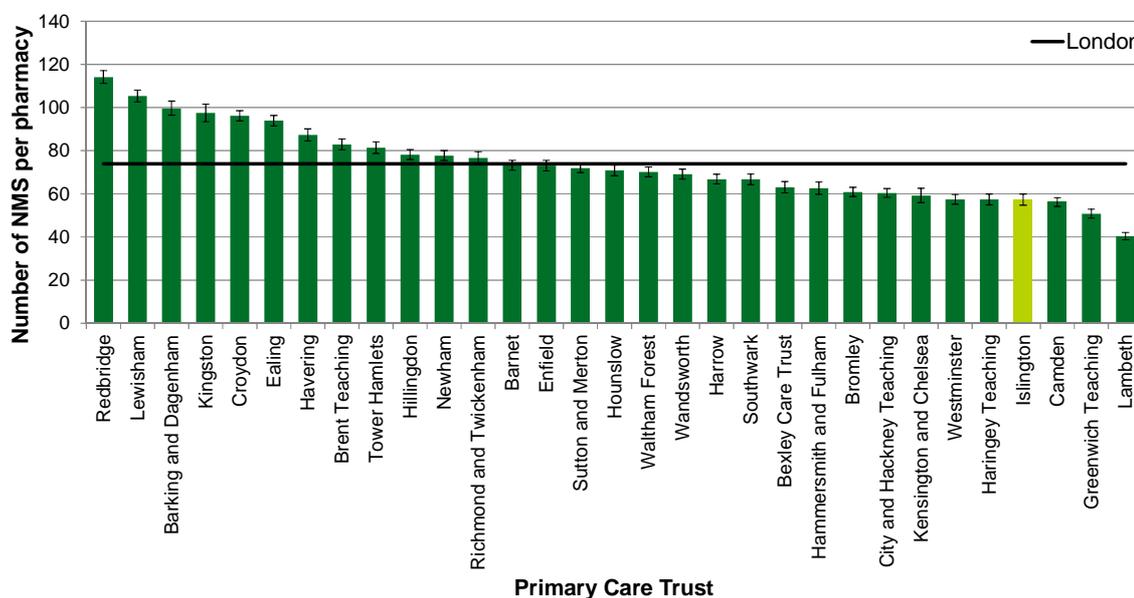
The NMS was introduced in 2011 and supports patients with long term conditions when a new prescription medicine is introduced. It aims to improve adherence to new medication, focusing on people with specific conditions:

- 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, and after an extension to March 2015, NHS England have recently confirmed an extension for 2015/16.

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.

Figure 5.4: Average number of new medicines services per pharmacy, London PCTs and London, 2012/13



Source: HSCIC, 2014

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>

NHS England data on the number of pharmacies providing the service was incomplete; based on a survey of pharmacists carried out in September 2014, we are now aware of 36 pharmacies currently providing the service and there may be more. We will use 2012/13 performance data for this needs assessment as it is considered more accurate, however this data is only available at borough level – not at pharmacy or locality level – so more detailed analysis is not possible. 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).

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 the MUR, NMS contributes directly to the JHWP goal of preventing and managing long term conditions by improving the adherence to medication; where relevant it can also help to meet the other JHWP goals, by helping to children's start in life and improving mental health and wellbeing. Improving adherence, and therefore reducing the number of avoidable GP and hospital appointments, also makes indirect advances on each of these goals, as well as for the general health and wellbeing of the population by freeing up healthcare resources.

We are validating service data provided by NHS England for 2013/14, so are unable to comment on current service gaps. However, 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 and can contribute to the JHWB goal of managing long term conditions, 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.

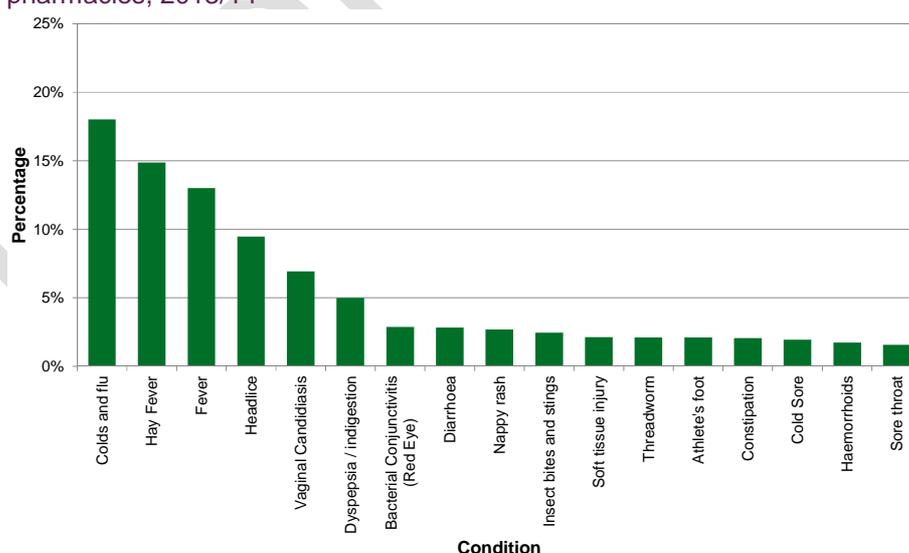
In Islington, 42 (93%) of pharmacies offer the MAS. In the North, Central and South East localities one pharmacy offers the service before 9am, while the Central and South East localities have pharmacies offering the service after 7pm (Table 5.12). On Saturdays, 39 pharmacies offering this service were open, with 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 5.11). The mostly frequently diagnosed ailments are colds and ‘flu (18%), hayfever (15%) and fever (13%) (Figure 5.5).

Table 5.11: 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 no recorded condition.

Table 5.12: 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	0	1	0	0	0	1	0	0	0	0	2
	St George's	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Central Total	5	0	1	0	4	0	0	0	2	0	0	0	0	6
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	3	0	0	0	2	0	0	0	1	0	0	0	0	3
	South East Total	10	0	1	1	10	0	0	0	2	0	0	0	0	12
South West	Barnsbury	1	0	0	3	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	10	0	0	3	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 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 and therefore freeing up healthcare resources.

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. Pharmacists dispense medications in dosette or blister packs, to help patients to take the correct dosage at the correct times. 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. MRD contributes to JHWB goals by supporting patients to prevent or manage long term conditions, as well as indirectly through the reduction in unscheduled service use.

The service offers good coverage from Monday to Saturday, with a number of pharmacies open in each locality offering patients a choice of pharmacies in most instances. However there is more limited access on Sunday; it should be reviewed to see if there is demand for more pharmacies offering the service on Sundays.

There are slightly fewer pharmacies providing the service in the South 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 (for both pharmacy and GP providers) 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 33 pharmacies will deliver the service. This high level of provision ensures that there is good coverage across each of the localities: 12 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, offering patients greater choice.

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, as well as GP practices, 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.
Health promotion campaigns run by Public Health	Local Authority Public Health departments can run health promotion campaigns in addition to those run by NHS England.

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.

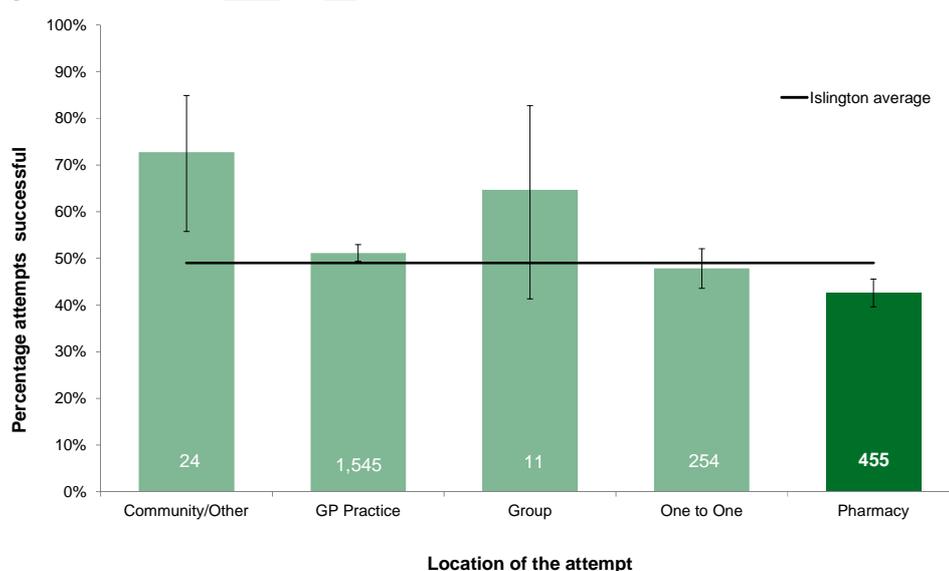
The majority of pharmacies (26 out of 30) are open for standard hours on weekdays; 28 pharmacies offer the service on Saturdays, and one of these pharmacies is open before 9am with the others all open between 9am and 7pm. On Sundays four pharmacies are open and offering stop smoking services.

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; 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 GP Practices (51%) had significantly higher successful quit rates. Quit rates in community settings may be higher because they 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. Pharmacy quit rates will also be influenced by the higher level of deprivation seen in their smoking cessation client population, discussed in more detail later in this section.

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).

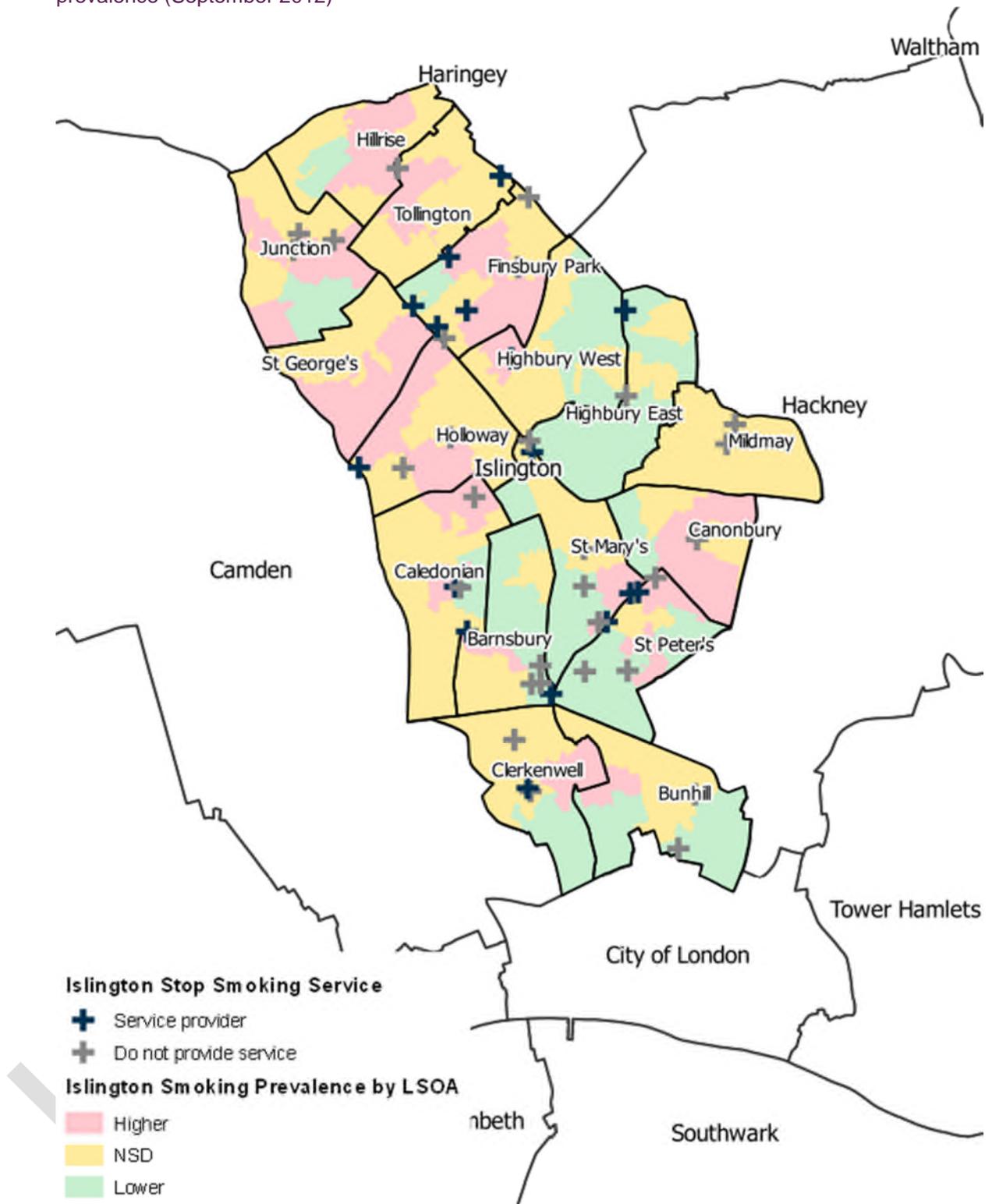
Figure 5.6: Success of quit attempts, by setting of the attempts, Islington's registered population aged 16+, 2012/13



Source: Islington Stop Smoking Service, 2013

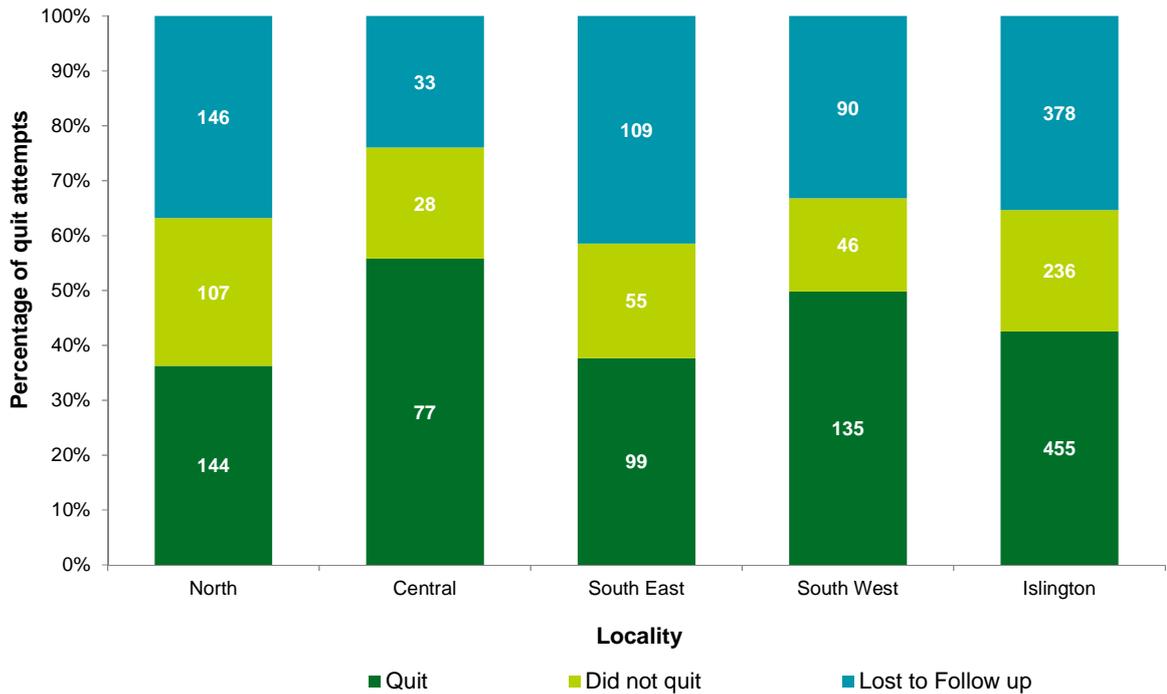
Note: Chart represents attempts rather than individuals, so individuals may appear more than once.

Map 5.6: Islington pharmacies providing Stop Smoking Service (October 2014), and smoking prevalence (September 2012)



Source: NHS England, 2014

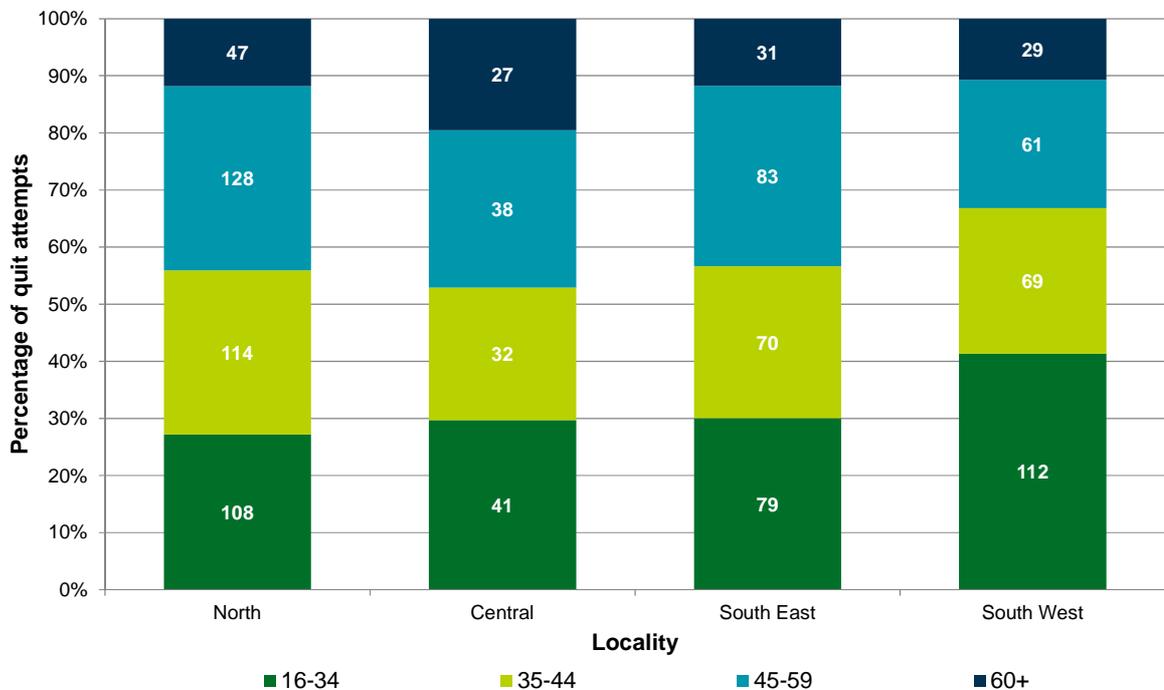
Figure 5.7: Outcome of quit attempts at Islington pharmacies, by locality and outcome, Islington, aged 16+, 2012/13



Source: Islington Stop Smoking Service, 2013

Note: Chart represents attempts rather than individuals, one individual may contribute more than one attempt.

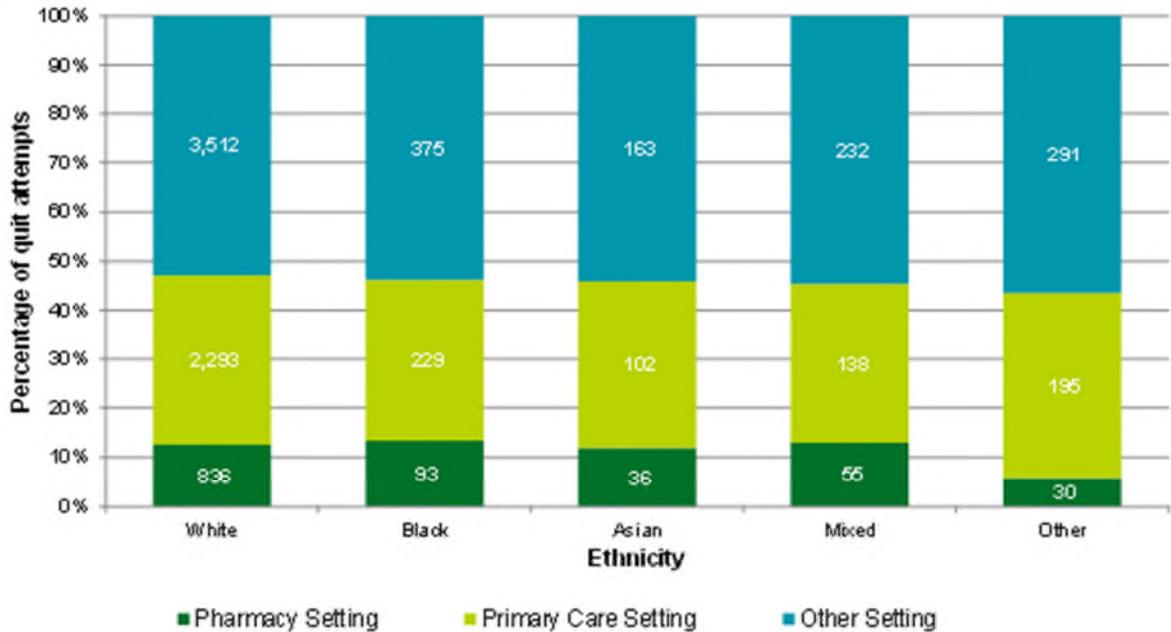
Figure 5.8: Percentage of quit attempts, by age and locality of pharmacy service attended, Islington, aged 16+, 2012/13



Source: Islington Stop Smoking Service, 2013

Note: Chart represents attempts rather than individuals, one individual may contribute more than one attempt.

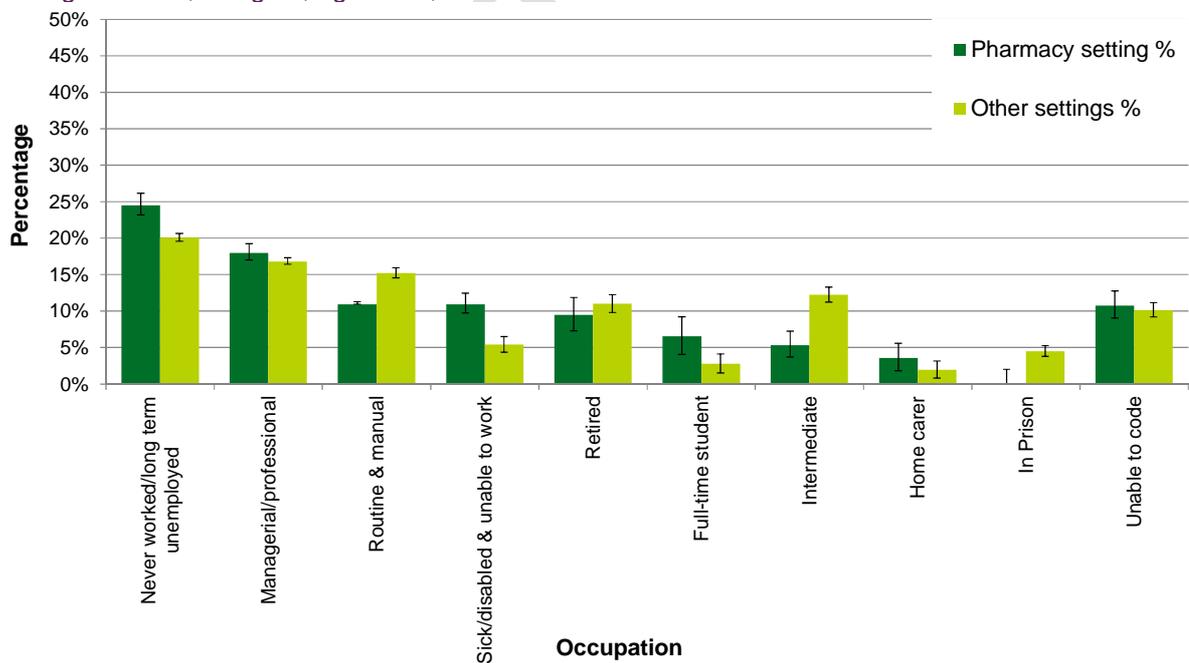
Figure 5.9: Percentage of quit attempts, by ethnicity of the user and type of service, Islington, people aged 16+, 2012/13



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**. Given the links with long term conditions, and the higher prevalence among people already diagnosed with long term conditions, smoking cessation helps to meet the JHWB goals of preventing and managing long term conditions, as well as improving mental health and wellbeing. Pharmacies have the second largest number of quit attempts compared to other settings, however, pharmacies could be providing more quits. Between pharmacies, GP practices, and community settings patients are able to choose from a wide range of settings for smoking cessation support.

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%.

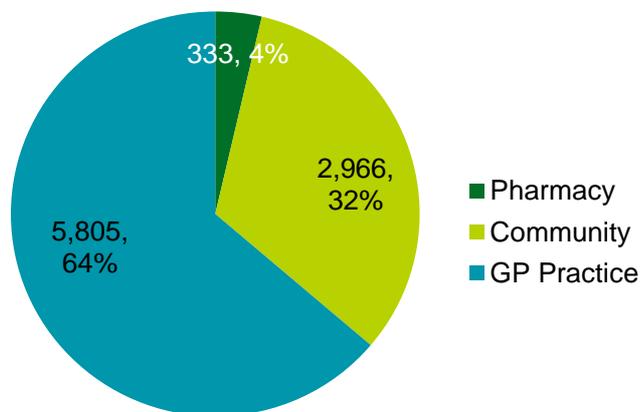
Two pharmacies in Islington provide NHS Health Checks (4% of pharmacies in the borough). One is located in the North locality and the other in the South East (but close to the heart of the borough). Both pharmacies in Islington providing NHS Health Checks are open standard opening hours Monday to Saturday 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.

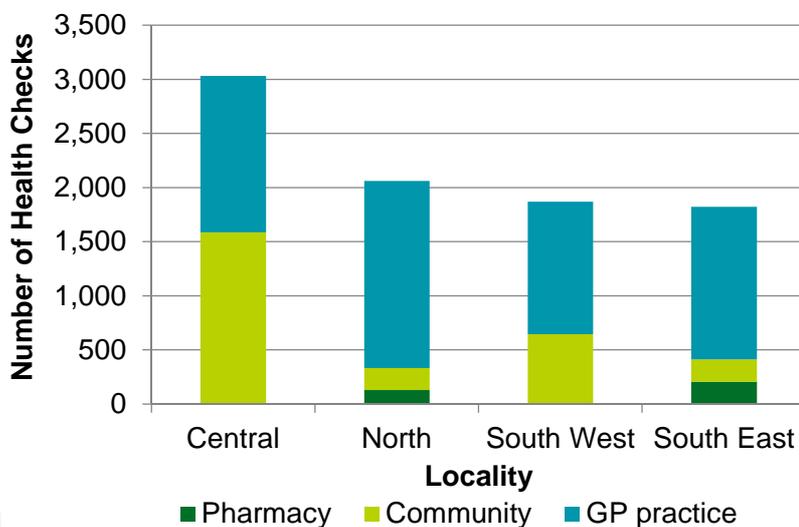
Figure 5.11: Number and proportion of NHS Health Checks provided, by provider type, Islington, 2013/14



Source: Camden and Islington Public Health, 2014

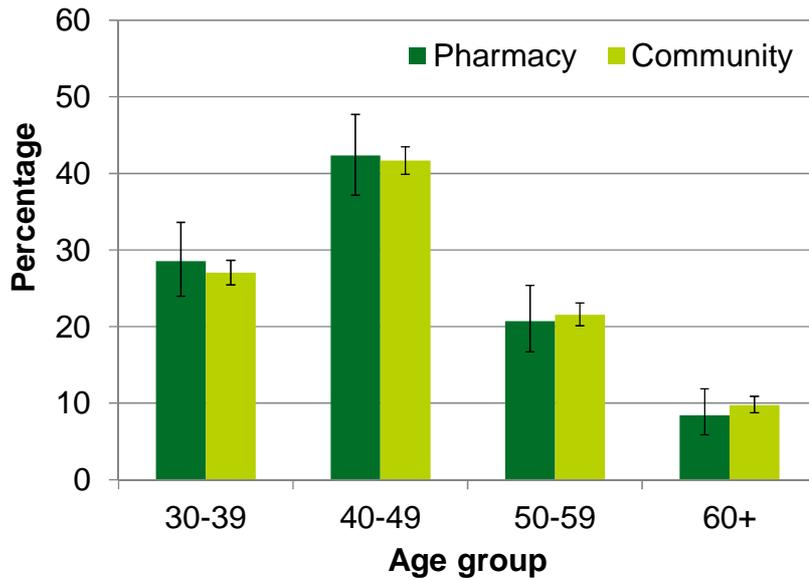
Note: Health Checks for GP practices cover the time period July 2013 to June 2014. Health Checks for pharmacies and community settings cover the financial year 2013/14.

Figure 5.12: Number of NHS Health Checks provided by provider type and locality, Islington, 2013/14



Source: Camden and Islington Public Health, 2014

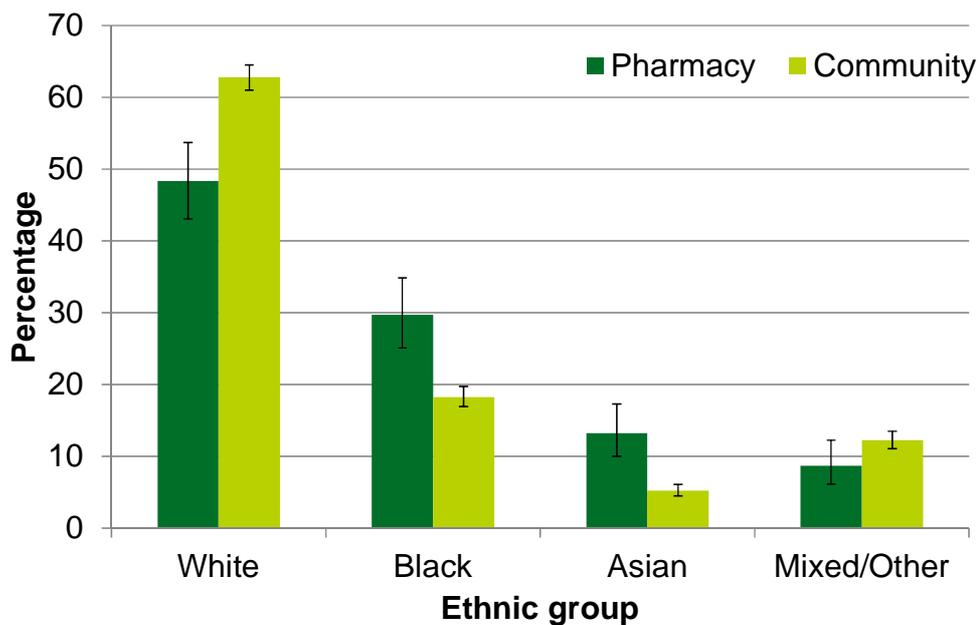
Figure 5.13: Proportion of NHS Health Checks by age group and provider type, Islington, 2013/14



Source: Camden and Islington Public Health, 2014

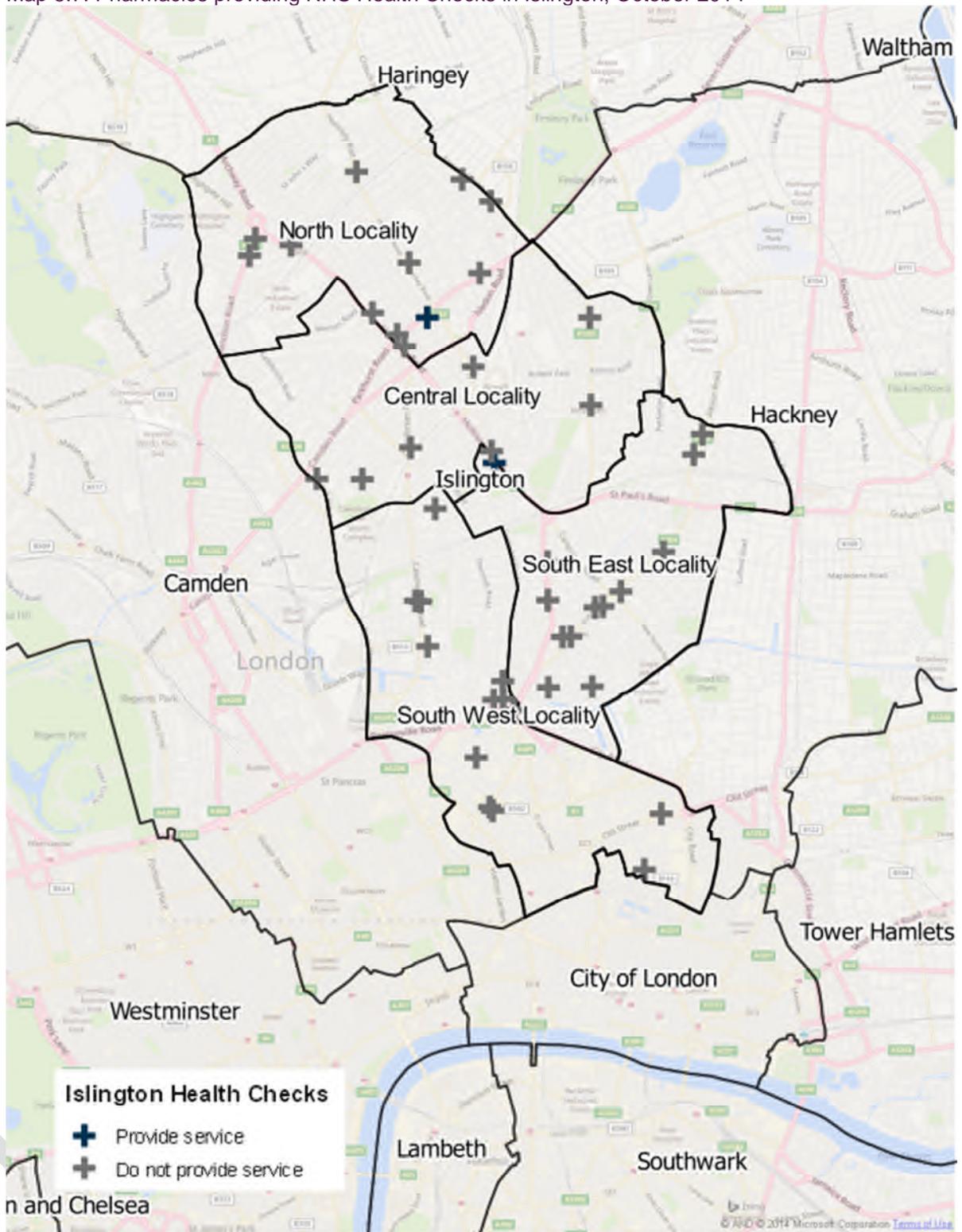
The largest group of people receiving Health Checks at pharmacies were of White ethnicity (48%), reflecting Islington’s population structure overall. Thirty per cent of Health Checks were received by people of Black ethnicity, while 9-13% were received by people of Asian and Mixed/Other ethnic groups. 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, October 2014



Source: NHS England, 2014

CONCLUSION ON NHS HEALTH CHECKS

Based on the information presented, NHS Health Checks are a **relevant service**. They can help to meet the JHWB goal of preventing and managing long term conditions by reducing the number of people living with undiagnosed long term conditions, particularly with health check offers being targeted at those thought to be at highest risk. 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, but patients can also have their health check at GP practices or at a range of community settings. This indicates sufficient choice of venues. Both pharmacies delivering Health Checks are closed during weekday evenings and on Sundays; but there may be availability at other providers.

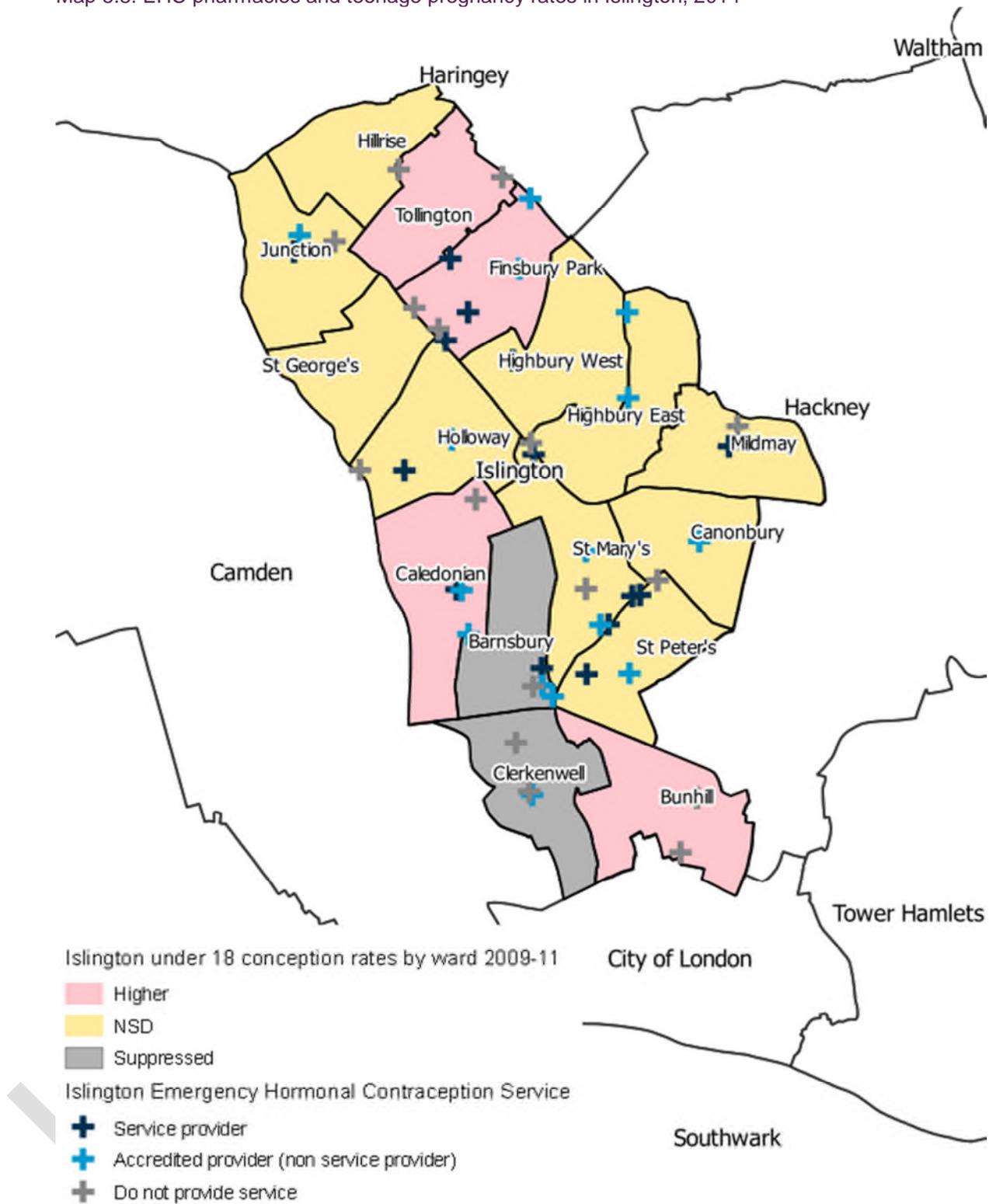
There is an appetite among residents for more information on specialist services that pharmacies provide, including NHS Health Checks.

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 locally commissioned 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 26 (58%) 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 LCS.

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 for confidentiality reasons, we are only able to provide demographic information for the number of EHC uses.

Map 5.8: EHC pharmacies and teenage pregnancy rates in Islington, 2014



Source: NHS England, 2014

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 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.

CONCLUSION ON EHC

The EHC service provided in accredited pharmacies is a **relevant service** as it improves access to this service in the borough, and supplements the standard offer of EHC. Pharmacies provide an alternative setting to sexual health clinics and GP practices through 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 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 three pharmacies open for extended, early or late hours on weekdays and 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 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.

Three-fifths of Islington's pharmacies offered supervised consumption services in 2013/14. Service provision ranged from 43% of pharmacies in the Central locality to 81% in the South East. 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 5.13).

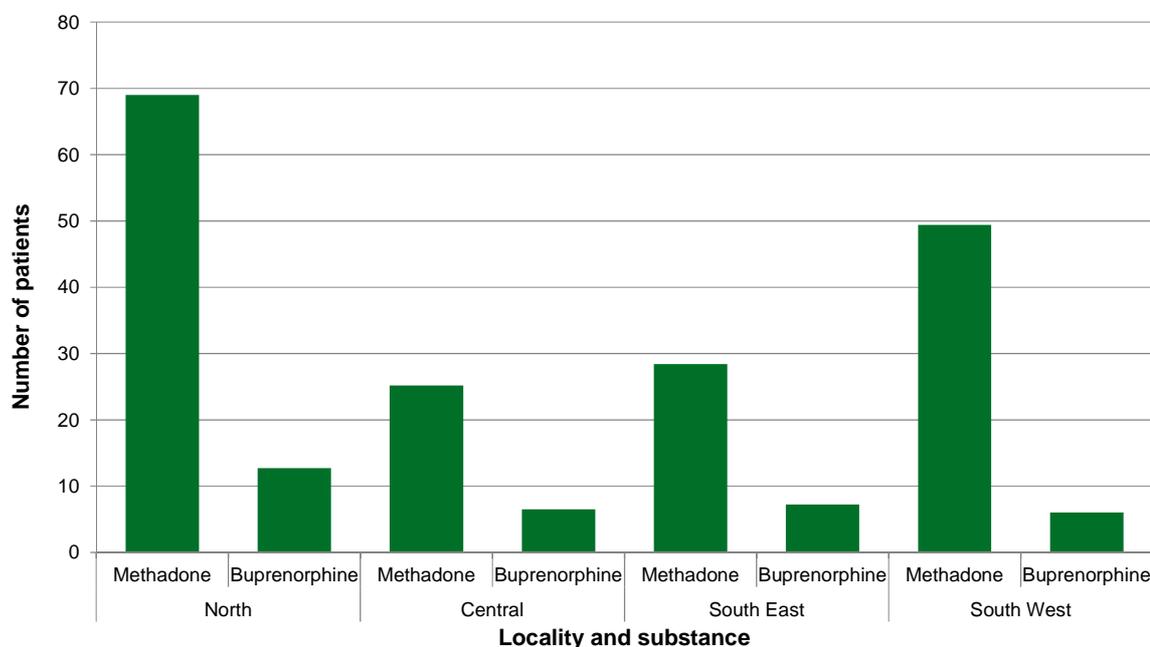
Table 5.13: Percentage of pharmacies offering supervised consumption service and average registered service users by locality, Islington, 2013/14

Locality	Providing service	Total pharmacies	% providing service	Monthly average number of patients registered with pharmacies	% total resident population registered with pharmacies
North	9	15	60%	82	0.2%
Central	3	7	43%	32	0.1%
South East	9	11	81%	36	0.1%
South West	6	12	50%	55	0.1%
Islington	27	45	60%	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.

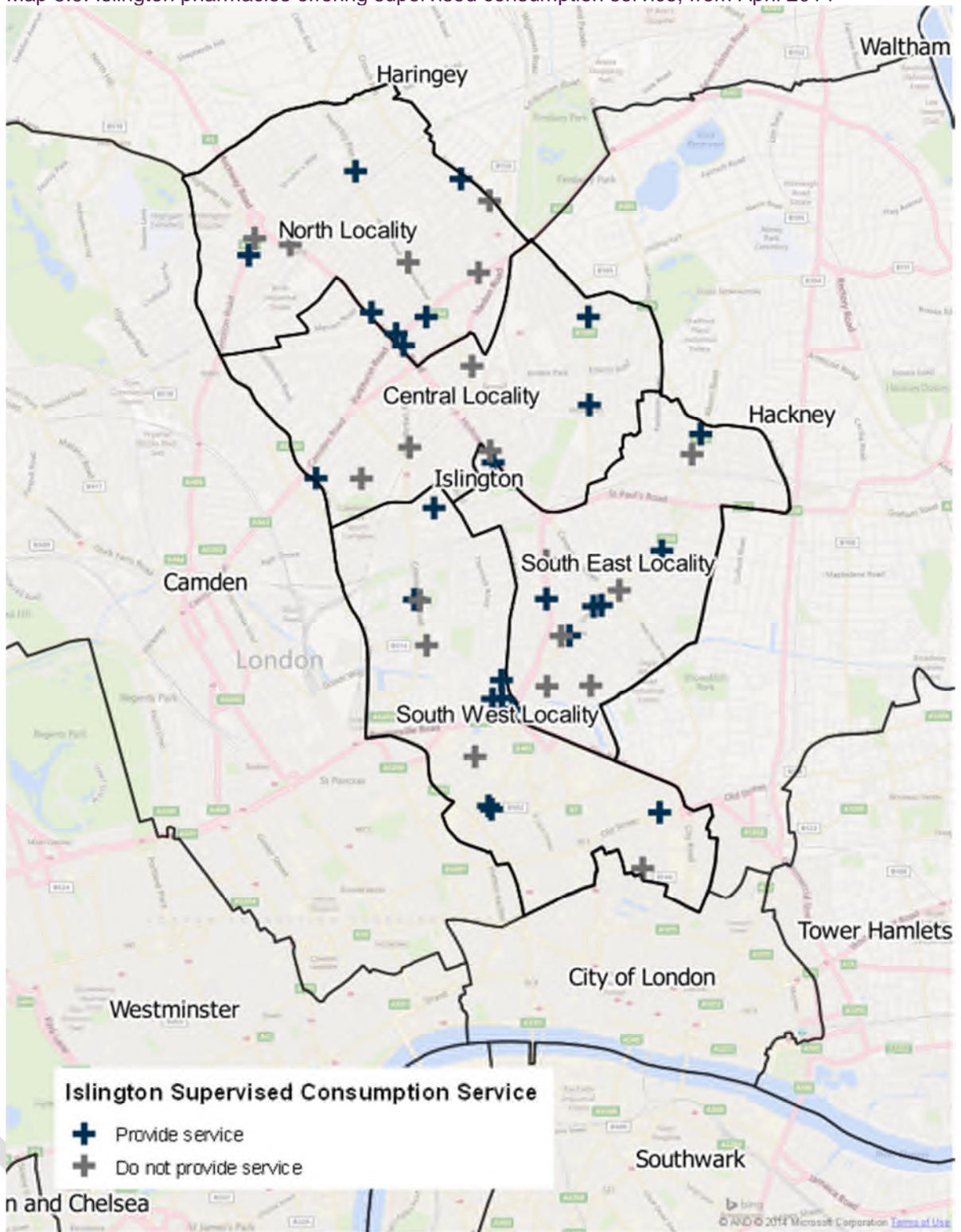
In 2013/14 there were an average of 172 clients (84% of the treatment population) receiving Methadone and 32 (16%) receiving Buprenorphine in Islington each month. There was no significant variation in the type of drug by locality (Figure 5.15).

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

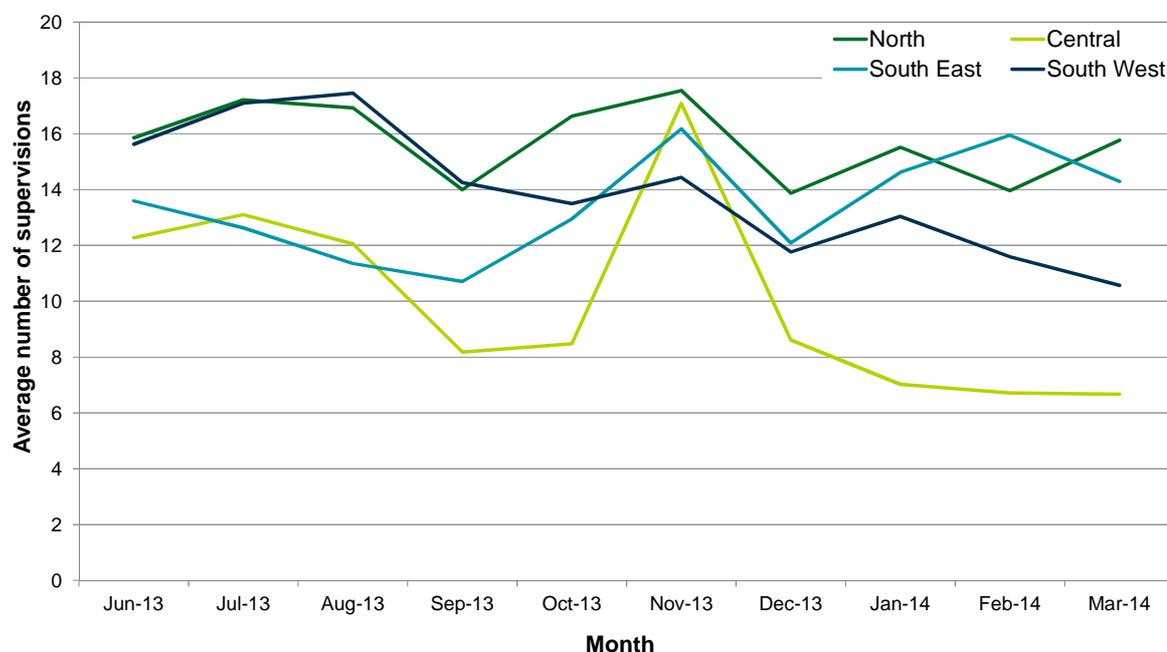
Map 5.9: Islington pharmacies offering supervised consumption service, from April 2014



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; 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.

One in four of Islington's pharmacies offered needle exchange services in 2013/14. Service provision ranged from 33% of pharmacies in the North locality to 50% in the South West (Table 5.14). 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.

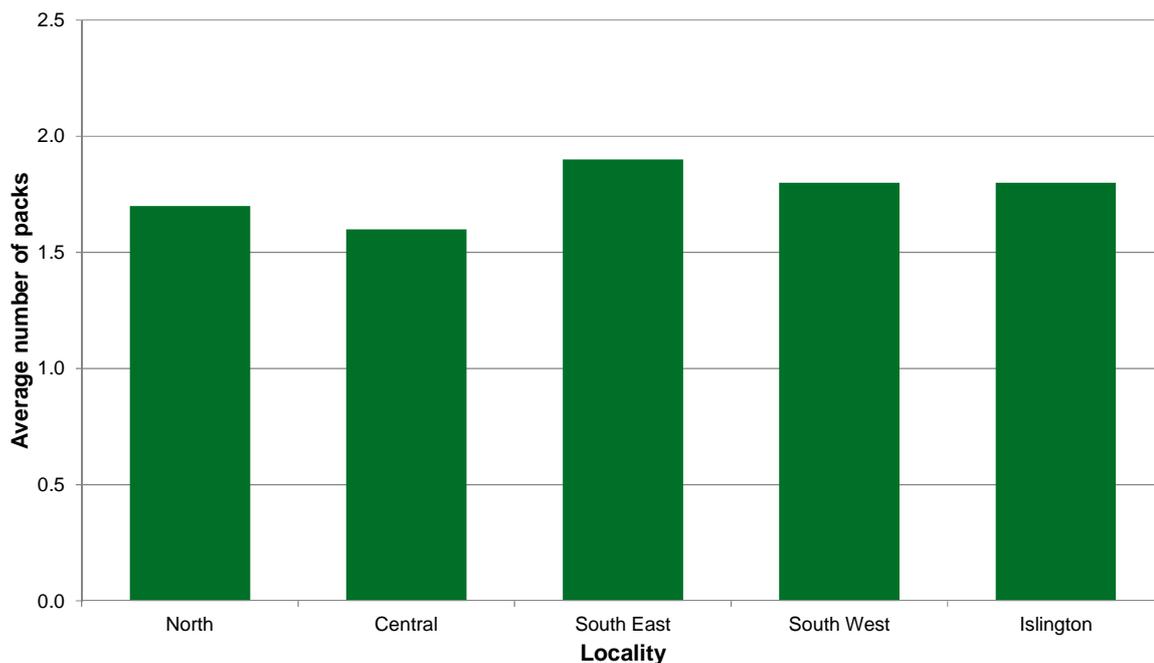
On average the 981 people used the needle exchange service each month over the course of the year (

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%).

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

Table 5.14: 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	15	33%	431	0.8%
Central	3	7	43%	132	0.2%
South East	4	11	36%	133	0.3%
South West	6	12	50%	285	0.5%
Islington	18	45	40%	981	0.5%

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. The service can contribute JHWB goals of preventing and managing long term conditions, as well as providing support to improve the mental health and wellbeing of clients. 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), 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.

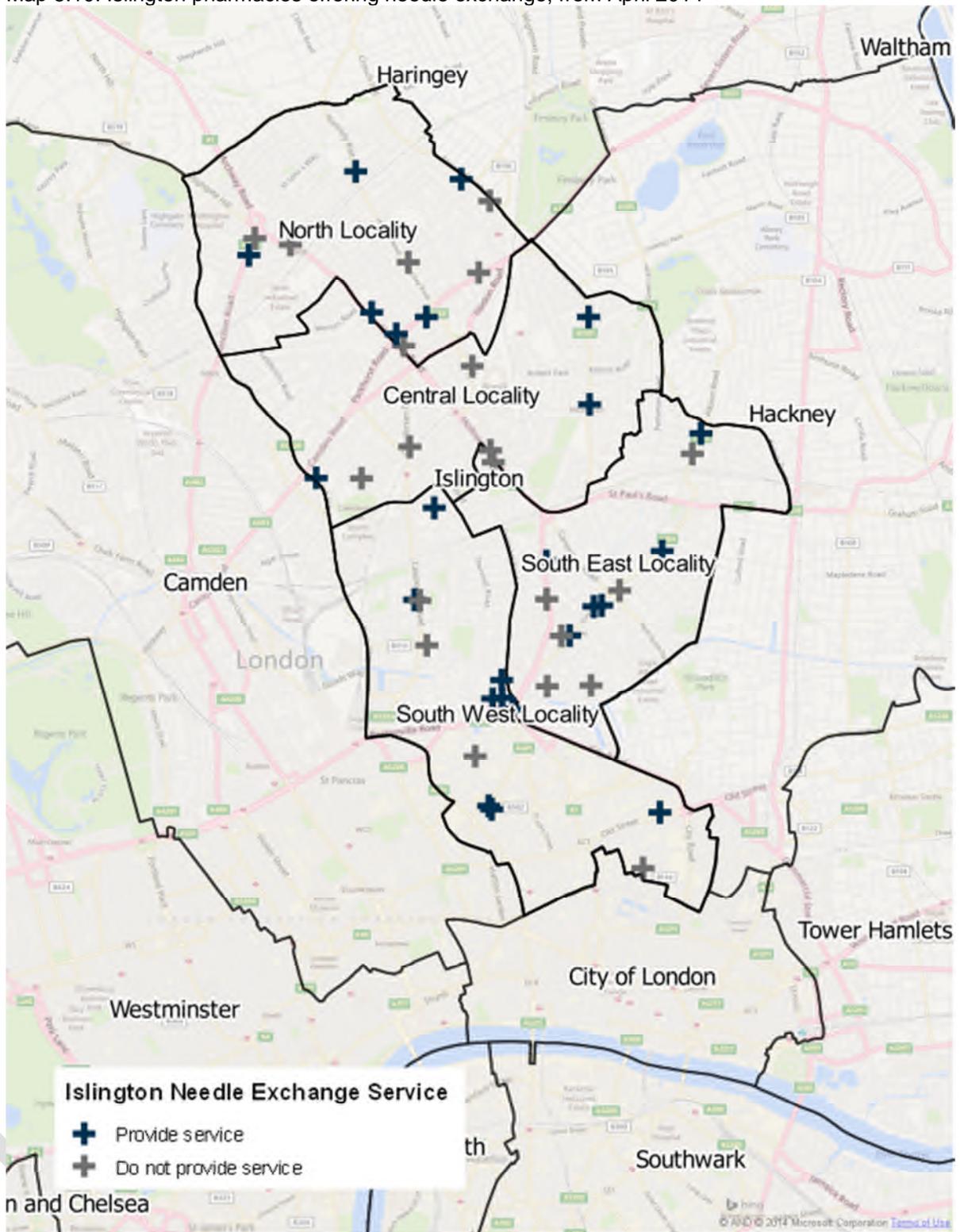
Needle exchange services

- **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, 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 in existing pharmacies.

Interim

Map 5.10: Islington pharmacies offering needle exchange, from April 2014



Source: NHS England, 2014

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 prevent and manage long term conditions, one of the JHWB goals, as well as 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 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.

5.5.7. Health promotion campaigns run by Public Health

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 PUBLIC HEALTH PROMOTION CAMPAIGNS

We conclude that Health Promotion campaigns are a **relevant service** as they provide additional information about local services targeted to the needs of the local population.

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 5.15 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 5.15: 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 5.15 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 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. 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

7.1. 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.

7.2. 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.

7.3. 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.

Interim report

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	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	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										
	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								
	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		

Note: This table is based on data provided by NHS England. All pharmacies were contacted to verify the information, and information has been updated where necessary.

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	Yes		
	St Peter's Pharmacy	N1 8JR	Yes	Yes	Yes		Yes	Yes		Yes				
	Turnbolls 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	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				
	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									

Note: This table is based on data provided by NHS England. All pharmacies were contacted to verify the information, and information has been updated where necessary.

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

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/>

providing more pharmacy services, or through opening more pharmacies. It should also take account of likely future needs.

- 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.

Interim report

Appendix D: Consultation report: plan and implementation

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.7.1 lists the organisations invited to consult on the PNA.

Table D.7.1: 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 in the report?
2. Has the information included in the report 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, including the needs of the individual localities?
5. Do you think the PNA accurately reflects the pharmacy provision throughout Islington, including the individual localities?
6. Do you think 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 pharmacy services which could be provided for residents, but have not been identified as a gap?
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. as, or on behalf of, a pharmacy?
 - c. as a member of another health or social care profession?
 - d. as, or on behalf of, a Health and Wellbeing Board?
 - e. as, or on behalf of, NHS England?
 - f. as, or on behalf of, an LMC?
 - g. as, or on behalf of, an LPC?
 - h. as, or on behalf of, an NHS trust?
 - i. as, or on behalf of, a Healthwatch organisation?
 - j. as, or on behalf of, another organisation?
 - k. as, or on behalf of, another business or trader?

Appendix E: Consultation report: responses

This chapter provides a summary of the consultation for Islington's PNA and the comments received.

Consultation process

The draft PNA was approved by Islington's HWB on 15 October 2014. Following approval, it was published for consultation on 20 October 2014, and closed on 19 December 2014.

The draft PNA and information about the consultation process was available online at the dedicated consultation page: www.islington.gov.uk/PNAconsultation. The consultation questions took the form of an online survey, with questions targeted for organisations or residents. For example, pharmacists were asked to comment on the draft PNA, as well as confirm their opening hours and the services they offer, while residents were only asked to comment on the PNA and complete optional equality monitoring information. Paper versions of the consultation questions and the report were available on request. The full list of questions is available in Appendix D.

An invitation to reply to the consultation, the draft PNA, and supporting documentation was sent to all organisations stipulated in the requirements, as well as to other key stakeholders. In addition, the consultation was publicised to Islington residents. Of the organisations covered in the requirements, the following were asked to respond:

- Camden and Islington Local Pharmaceutical Committee
- Islington Local Medical Committee
- Islington pharmacy contractors
- Healthwatch Islington
- Royal Free London NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- The Whittington Hospital NHS Trust
- Central and North West London Foundation Trust
- Moorfields Eye Hospital NHS Foundation Trust
- Camden and Islington NHS Foundation Trust
- NHS England
- Islington Health and Wellbeing Board
- Neighbouring HWBs (Camden, City of London, Hackney and Haringey)

Advertising the consultation

The PNA consultation was advertised through multiple channels. Where possible, individual emails were sent to consultees and organisations and invited to respond. This included the mandatory

organisations listed above, as well as other local health groups such as the Local Dental and Optical Committees, and the Health Scrutiny Committee. The consultation was also advertised on the Islington Council and CCG website, Islington CCG GP newsletters, voluntary sector newsletters, Twitter, focus group participants from the qualitative research undertaken by OPM, and other bulletins including a bulletin for Carers in Islington and the Council's eBulletin to residents. It was also presented to LPC members at their AGM in November 2014 by the Director of Public Health.

Responses to the consultation

In total, feedback was received from four individuals and eight organisations during the consultation period. The organisations that submitted a response were: the Local Pharmaceutical Committee, NHS England, Islington Clinical Commissioning Group, Breathe Easy Islington, and three pharmacies. In general, respondents agreed with the conclusions and recommendations described in the draft PNA. The PNA Steering Group reviewed the responses and discussed the changes to be made to the report before its final publication.

The LPC, NHS England, and the Clinical Commissioning Group made comments on the Consultation draft, highlighting areas of the text that required amendments to ensure that services were defined accurately and to avoid ambiguity around conclusions and recommendations. NHS England's response also highlighted a number of areas where conclusions need a more explicit reference back to the Schedule 1 requirements to ensure that the PNA clearly met the guidelines. These changes have been incorporated in the final report.

Specific comments and suggestions on how to improve services have been collated into themes, and described in Table E1. The Steering Group believes that each of the comments on the draft report have been met by the final draft of the PNA.

Table E1: Analysis of PNA consultation responses

Section of PNA	Response to consultation	Comment from PNA Steering Group	Decision to amend PNA?
Accuracy of the pharmaceutical list and data shown			
Chapter 5	<p>Camden and Islington LPC reflected concern that the Pharmaceutical List supplied by NHSE is not accurate for Islington and neighbouring boroughs. NHS England have also made similar comments.</p> <p>One pharmacy suggested that the verification of pharmacy data to check the data supplied by NHS England was only carried out late in the process drafting the PNA.</p>	<p>The Steering Group received the Pharmaceutical List for Islington from NHS England in July 2014, as well as those in neighbouring boroughs. Members of the Steering Group felt that the list contained errors relating to opening hours and the services provided.</p> <p>To ensure the accuracy of the assessments included in the PNA, the LPC organised a data verification exercise with local pharmacies in September 2014. Updated information was included in the draft PNA, and any other corrections received during the consultation period were also included. NHS England has since committed to provide updated information in January 2015, following review of the opening hours included in the draft, which will be incorporated into the final version of the PNA.</p> <p>In addition, the qualitative research described in section 5.6 included a specific questionnaire for pharmacies and pharmacists in the Islington area which asked for comments and suggestions on ways in which services could be improved. These findings have been included when making the final assessments.</p>	<p>Yes - the PNA SG accepts these comments. Pharmacy provision information, including opening hours, will be amended once the final pharmaceutical list is received from NHS England.</p>

Section of PNA	Response to consultation	Comment from PNA Steering Group	Decision to amend PNA?
Chapter 5	One pharmacy requested that more data was included about access to cross-border services as these should be considered when making market entry decisions.	The Steering Group also requested information about the provision of services in the neighbouring boroughs, but these lists were not received in full from NHS England and so it was not possible to include this information in the draft PNA. The PNA for each of the neighbouring boroughs would however include this information, if necessary to reference.	Yes - the PNA SG accepts these comments. Once an accurate list is received from NHS England, this information will be amended for the final version.
Section 5.1.1	There was one request to show pharmacies by ward, as well as transport links across Islington and neighbouring boroughs.	The maps currently show the major roads and the London Underground, Overground, and National Rail stations. The maps showing opening hours for weekday and weekends also show pharmacies in neighbouring boroughs, by opening hours. A map with pharmacies plotted with ward boundaries is provided (map 5.6), showing smoking prevalence by ward. Showing the transport links in any more detail, and showing the pharmacies along with ward boundaries, would serve to make the maps harder to read in most instances.	No – the PNA SG does not agree with the proposed change.

Section of PNA	Response to consultation	Comment from PNA Steering Group	Decision to amend PNA?
Sections 5.1 – 5.5	Pharmacies in neighbouring boroughs and their opening times, which are shown in maps 5.2, 5.3, and 5.4 for weekdays, Saturday, and Sunday respectively.	At the time of producing the consultation draft we had not received complete information on the Advanced and Enhanced services being provided by pharmacies in neighbouring boroughs, so have not included neighbouring pharmacies in these maps.	Yes - the PNA SG accepts this comment. Maps will be amended once the final list is received from NHSE.
Current and future provision of pharmaceutical services			
Sections 5.2 – 5.5	Two pharmacies suggested that there should be more information about the services pharmacies would be willing to provide.	Data of this type is out of scope of the PNA, but are taken into account in other areas of work.	No – the PNA SG does not agree with the proposed change.
Section 5.1	The importance of pharmacy services being open at a similar time to primary care out of hours GP services was reiterated.	Accessible pharmacy services with opening hours matching those of other services is already highlighted in the report, as is the importance of raising the awareness of late and extending opening pharmacies.	Yes – the PNA SG will be amended the section to include information on GP opening hours as well as other relevant services.

Section of PNA	Response to consultation	Comment from PNA Steering Group	Decision to amend PNA?
Sections 5.3 – 5.5	Standardised service specifications for commissioned services, on a London-wide level, were also mentioned, as these could potentially help provide better outcomes, particularly for the MAS.	Standardised service specifications are also out of scope of the PNA, but the request has been noted by the PNA Steering Group; the CCG have already requested amendments to the scheme but this was postponed pending future commissioning decisions related to the scheme.	No changes necessary.
Final assessments of services			
Section 5.3	<p>Medicines Use Review:</p> <p>One pharmacy recommended that the service specification creates an inherent gap in service provision by including the length of time a patient must have used a pharmacy in order to be eligible for the service.</p>	<p>The MUR service specification is set nationally. The specification requires that the patient must have been using the pharmacy for the previous 3 months. Most patients receive their repeat prescriptions on an 8 week cycle therefore a minimum 3 month period known to the pharmacy seems reasonable to maximise the impact from the MUR and avoid multiple MURs. The PNA SG feels that the 3 month rule is broadly appropriate for regular customers. However, our boroughs have very high transient population with a huge difference between daytime and resident populations, different from the national picture. However, there may be scope for the removal of the 3 month rule for prescription interventions where a Pharmacist spots an issue and intervenes. This would be an appropriate change given the unique dynamics of our populations.</p>	No changes necessary.

Section of PNA	Response to consultation	Comment from PNA Steering Group	Decision to amend PNA?
Section 5.3	MUR / NMS: Joint working between secondary care and pharmacies in Islington could improve MUR and NMS provision by linking discharge MURs from hospital into the community.	The value of MURs and NMS on discharge from hospital is well-recognised and there is already a recommendation in the MUR service specification for patients discharged from hospital to have an MUR within 4-8 weeks. Improving integrated care and secondary care referrals to community pharmacy are ongoing priorities. CCGs in North Central London are collaborating to develop a 'Commissioning for Quality and Innovation' (CQUIN) or equivalent award system for Trusts that support frail and vulnerable older people on discharge to receive their medicines in an efficient and supported way and refer patients to their community pharmacy for an MUR or NMS. A recently published toolkit from the Royal Pharmaceutical Society to support efficient referrals to community pharmacy will be utilised (http://www.rpharms.com/unsecure-support-resources/referral-toolkit.asp). A domicillary MUR service would be even better from as it helps the patient understand their new medication regime and gives assurance that any old medicines will be removed, hence reducing the chances of the patient taking the wrong (old meds), improving safety and potentially reducing medication related hospital admissions.	No changes necessary.

Section of PNA	Response to consultation	Comment from PNA Steering Group	Decision to amend PNA?
Section 5.4	Flu vaccination: One pharmacy suggested that achievement in pharmacies could be compared to that in GP practices in Islington.	Comparing vaccination achievement in pharmacies against GP Practices is not possible. GP Practices have a defined list of patients, and therefore it is possible to track the proportion of patients who have received a vaccination. The same is not true of pharmacies as people are not 'registered' at a pharmacy. With pharmacies providing 5% of vaccinations comparing them directly against GP Practices would be unfair.	No – the PNA SG does not agree with the proposed change.
Section 5.5	<p>NHS Health Checks:</p> <p>One pharmacy suggested that a review of the NHS Health Checks service was carried out, and the outcomes considered before recommending that the number of NHS Health Checks carried out in pharmacies was increased. The same pharmacy also stated that the service should not be constrained by IT requirements and be easy for patients to access.</p> <p>One pharmacy recommended that</p>	Pharmacies are one component of a wider approach to delivery of health checks across Camden. This wider model is currently being reviewed, with the intention of developing a new approach to provision over the next 12 months. Whilst this is occurring we do not want there to be a break in provision of current service offered through pharmacies. As such the intention is to continue with the current provision for now but to develop the approach in line with the findings of our wider review.	No changes necessary.

Section of PNA	Response to consultation	Comment from PNA Steering Group	Decision to amend PNA?
	an increase in the number of pharmacies providing NHS Health Checks or the anti-coagulation service would support better access to care.		
General comments			
All	The statements made in the PNA draft about raising awareness of opening hours, what services pharmacies provide would be greatly welcomed, and would have a positive effect for residents and the health benefits.	We welcome the comments on opening hours, and the steering group will ensure work continues to improve awareness of pharmacy provision in Islington.	No changes necessary.

Appendix F: Islington GP Locality profiles

The Islington GP Locality Profiles are available on the Evidence Hub, to reduce the size of this file:

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

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Appendix G: Opening hours [CD1]

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	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

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

Note: This table is based on data provided by NHS England. All pharmacies were contacted to verify the information, and information has been updated where necessary.

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	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

Note: This table is based on data provided by NHS England. All pharmacies were contacted to verify the information, and information has been updated where necessary.

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	18:00						
	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

Note: This table is based on data provided by NHS England. All pharmacies were contacted to verify the information, and information has been updated where necessary.

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	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

Note: This table is based on data provided by NHS England. All pharmacies were contacted to verify the information, and information has been updated where necessary.

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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	09:30	18:00		■	■	■	■	
	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	14:00		■	■	■		
	FN508	Tumbulls 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	Closed							
	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

Note: This table is based on data provided by NHS England. All pharmacies were contacted to verify the information, and information has been updated where necessary.

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	Turnbulls 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

Note: This table is based on data provided by NHS England. All pharmacies were contacted to verify the information, and information has been updated where necessary.

Appendix H: Bibliography

Adult obesity and overweight profile 2012: http://www.islington.gov.uk/publicrecords/library/Public-health/Quality-and-performance/Profiles/2012-2013/%282013-01-21%29-Obesity_Profile_FINAL_JULY_2012v.04_redacted.pdf

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/>

Islington Census Demographics profiles:
<http://evidencehub.islington.gov.uk/Demographics/census/Pages/default.aspx>

Estimating population growth from urban development in and around Islington 2014

Health and Wellbeing Strategy 2013-16: <http://www.islington.gov.uk/services/social-care-health/health-in-islington/Pages/publichealthservices.aspx>

Islington GP Locality profiles 2014:
<http://evidencehub.islington.gov.uk/wellbeing/Healthsettings/Pages/default.aspx>

Mental health profile 2013:
<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	LARC	Long Acting Reversible Contraception
AUR	Appliance Use Review	LBI	London Borough of Islington
BAME	Black, Asian and Minority Ethnic	LCS	Locally Commissioned Services
BMI	Body Mass Index	LPC	Local Pharmaceutical Committee
CCG	Clinical Commissioning Group	LPS	Local Pharmaceutical Service
CHD	Coronary Heart Disease	LTC	Long Term Condition
CKD	Chronic Kidney Disease	MAS	Minor Ailments Scheme
COPD	Chronic Obstructive Pulmonary Disease	MSM	Men who have sex with men
CPPE	Centre for Pharmacy Postgraduate Education	MUR	Medicine Use Review
DAC	Dispensing Appliance Contractors	NHS	National Health Service
DBS	Disclosure and Barring Service	NHSCB	National Health Service Commissioning Board
DH	Department of Health	NMS	New Medicine Service
EHC	Emergency Hormonal Contraception	NRT	Nicotine Replacement Therapy
ESPLPS	Essential Small Pharmacies Local Pharmaceutical Services	ONS	Office for National Statistics
GLA	Greater London Authority	PCT	Primary Care Trust
GP	General Practice or General Practitioner	PGD	Patient Group Directions
HLP	Healthy Living Pharmacy	PH	Public Health
HWB	Health and Wellbeing Board	PNA	Pharmaceutical Needs Assessment
HSCIC	Health and Social Care Information Centre	SAC	Stoma Appliance Customisation
IDASS	Islington Drug and Alcohol Specialist Services	SLA	Service Level Agreement
JHWS	Joint Health and Wellbeing Strategy	STI	Sexually Transmitted Infections
JSNA	Joint Strategic Needs Assessment	VCS	Voluntary and Community Sector
LA	Local Authority		

Appendix E: Consultation report: responses

This chapter provides a summary of the consultation for Islington's PNA and the comments received.

Consultation process

The draft PNA was approved by Islington's HWB on 15 October 2014. Following approval, it was published for consultation on 20 October 2014, and closed on 19 December 2014.

The draft PNA and information about the consultation process was available online at the dedicated consultation page: www.islington.gov.uk/PNAconsultation. The consultation questions took the form of an online survey, with questions targeted for organisations or residents. For example, pharmacists were asked to comment on the draft PNA, as well as confirm their opening hours and the services they offer, while residents were only asked to comment on the PNA and complete optional equality monitoring information. Paper versions of the consultation questions and the report were available on request. The full list of questions is available in Appendix D.

An invitation to reply to the consultation, the draft PNA, and supporting documentation was sent to all organisations stipulated in the requirements, as well as to other key stakeholders. In addition, the consultation was publicised to Islington residents. Of the organisations covered in the requirements, the following were asked to respond:

- Camden and Islington Local Pharmaceutical Committee
- Islington Local Medical Committee
- Islington pharmacy contractors
- Healthwatch Islington
- Royal Free London NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- The Whittington Hospital NHS Trust
- Central and North West London Foundation Trust
- Moorfields Eye Hospital NHS Foundation Trust
- Camden and Islington NHS Foundation Trust
- NHS England
- Islington Health and Wellbeing Board
- Neighbouring HWBs (Camden, City of London, Hackney and Haringey)

Advertising the consultation

The PNA consultation was advertised through multiple channels. Where possible, individual emails were sent to consultees and organisations and invited to respond. This included the mandatory

organisations listed above, as well as other local health groups such as the Local Dental and Optical Committees, and the Health Scrutiny Committee. The consultation was also advertised on the Islington Council and CCG website, Islington CCG GP newsletters, voluntary sector newsletters, Twitter, focus group participants from the qualitative research undertaken by OPM, and other bulletins including a bulletin for Carers in Islington and the Council's eBulletin to residents. It was also presented to LPC members at their AGM in November 2014 by the Director of Public Health.

Responses to the consultation

In total, feedback was received from four individuals and eight organisations during the consultation period. The organisations that submitted a response were: the Local Pharmaceutical Committee, NHS England, Islington Clinical Commissioning Group, Breathe Easy Islington, and three pharmacies. In general, respondents agreed with the conclusions and recommendations described in the draft PNA. The PNA Steering Group reviewed the responses and discussed the changes to be made to the report before its final publication.

The LPC, NHS England, and the Clinical Commissioning Group made comments on the Consultation draft, highlighting areas of the text that required amendments to ensure that services were defined accurately and to avoid ambiguity around conclusions and recommendations. NHS England's response also highlighted a number of areas where conclusions need a more explicit reference back to the Schedule 1 requirements to ensure that the PNA clearly met the guidelines. These changes have been incorporated in the final report.

Specific comments and suggestions on how to improve services have been collated into themes, and described in Table E1. The Steering Group believes that each of the comments on the draft report have been met by the final draft of the PNA.

Table E1: Analysis of PNA consultation responses

Section of PNA	Response to consultation	Comment from PNA Steering Group	Decision to amend PNA?
Accuracy of the pharmaceutical list and data shown			
Chapter 5	<p>Camden and Islington LPC reflected concern that the Pharmaceutical List supplied by NHSE is not accurate for Islington and neighbouring boroughs. NHS England have also made similar comments.</p> <p>One pharmacy suggested that the verification of pharmacy data to check the data supplied by NHS England was only carried out late in the process drafting the PNA.</p>	<p>The Steering Group received the Pharmaceutical List for Islington from NHS England in July 2014, as well as those in neighbouring boroughs. Members of the Steering Group felt that the list contained errors relating to opening hours and the services provided.</p> <p>To ensure the accuracy of the assessments included in the PNA, the LPC organised a data verification exercise with local pharmacies in September 2014. Updated information was included in the draft PNA, and any other corrections received during the consultation period were also included. NHS England has since committed to provide updated information in January 2015, following review of the opening hours included in the draft, which will be incorporated into the final version of the PNA.</p> <p>In addition, the qualitative research described in section 5.6 included a specific questionnaire for pharmacies and pharmacists in the Islington area which asked for comments and suggestions on ways in which services could be improved. These findings have been included when making the final assessments.</p>	<p>Yes - the PNA SG accepts these comments. Pharmacy provision information, including opening hours, will be amended once the final pharmaceutical list is received from NHS England.</p>

Section of PNA	Response to consultation	Comment from PNA Steering Group	Decision to amend PNA?
Chapter 5	One pharmacy requested that more data was included about access to cross-border services as these should be considered when making market entry decisions.	The Steering Group also requested information about the provision of services in the neighbouring boroughs, but these lists were not received in full from NHS England and so it was not possible to include this information in the draft PNA. The PNA for each of the neighbouring boroughs would however include this information, if necessary to reference.	Yes - the PNA SG accepts these comments. Once an accurate list is received from NHS England, this information will be amended for the final version.
Section 5.1.1	There was one request to show pharmacies by ward, as well as transport links across Islington and neighbouring boroughs.	The maps currently show the major roads and the London Underground, Overground, and National Rail stations. The maps showing opening hours for weekday and weekends also show pharmacies in neighbouring boroughs, by opening hours. A map with pharmacies plotted with ward boundaries is provided (map 5.6), showing smoking prevalence by ward. Showing the transport links in any more detail, and showing the pharmacies along with ward boundaries, would serve to make the maps harder to read in most instances.	No – the PNA SG does not agree with the proposed change.

Section of PNA	Response to consultation	Comment from PNA Steering Group	Decision to amend PNA?
Sections 5.1 – 5.5	Pharmacies in neighbouring boroughs and their opening times, which are shown in maps 5.2, 5.3, and 5.4 for weekdays, Saturday, and Sunday respectively.	At the time of producing the consultation draft we had not received complete information on the Advanced and Enhanced services being provided by pharmacies in neighbouring boroughs, so have not included neighbouring pharmacies in these maps.	Yes - the PNA SG accepts this comment. Maps will be amended once the final list is received from NHSE.
Current and future provision of pharmaceutical services			
Sections 5.2 – 5.5	Two pharmacies suggested that there should be more information about the services pharmacies would be willing to provide.	Data of this type is out of scope of the PNA, but are taken into account in other areas of work.	No – the PNA SG does not agree with the proposed change.
Section 5.1	The importance of pharmacy services being open at a similar time to primary care out of hours GP services was reiterated.	Accessible pharmacy services with opening hours matching those of other services is already highlighted in the report, as is the importance of raising the awareness of late and extending opening pharmacies.	Yes – the PNA SG will be amended the section to include information on GP opening hours as well as other relevant services.

Section of PNA	Response to consultation	Comment from PNA Steering Group	Decision to amend PNA?
Sections 5.3 – 5.5	Standardised service specifications for commissioned services, on a London-wide level, were also mentioned, as these could potentially help provide better outcomes, particularly for the MAS.	Standardised service specifications are also out of scope of the PNA, but the request has been noted by the PNA Steering Group; the CCG have already requested amendments to the scheme but this was postponed pending future commissioning decisions related to the scheme.	No changes necessary.
Final assessments of services			
Section 5.3	<p>Medicines Use Review:</p> <p>One pharmacy recommended that the service specification creates an inherent gap in service provision by including the length of time a patient must have used a pharmacy in order to be eligible for the service.</p>	<p>The MUR service specification is set nationally. The specification requires that the patient must have been using the pharmacy for the previous 3 months. Most patients receive their repeat prescriptions on an 8 week cycle therefore a minimum 3 month period known to the pharmacy seems reasonable to maximise the impact from the MUR and avoid multiple MURs. The PNA SG feels that the 3 month rule is broadly appropriate for regular customers. However, our boroughs have very high transient population with a huge difference between daytime and resident populations, different from the national picture. However, there may be scope for the removal of the 3 month rule for prescription interventions where a Pharmacist spots an issue and intervenes. This would be an appropriate change given the unique dynamics of our populations.</p>	No changes necessary.

Section of PNA	Response to consultation	Comment from PNA Steering Group	Decision to amend PNA?
Section 5.3	MUR / NMS: Joint working between secondary care and pharmacies in Islington could improve MUR and NMS provision by linking discharge MURs from hospital into the community.	The value of MURs and NMS on discharge from hospital is well-recognised and there is already a recommendation in the MUR service specification for patients discharged from hospital to have an MUR within 4-8 weeks. Improving integrated care and secondary care referrals to community pharmacy are ongoing priorities. CCGs in North Central London are collaborating to develop a 'Commissioning for Quality and Innovation' (CQUIN) or equivalent award system for Trusts that support frail and vulnerable older people on discharge to receive their medicines in an efficient and supported way and refer patients to their community pharmacy for an MUR or NMS. A recently published toolkit from the Royal Pharmaceutical Society to support efficient referrals to community pharmacy will be utilised (http://www.rpharms.com/unsecure-support-resources/referral-toolkit.asp). A domicillary MUR service would be even better from as it helps the patient understand their new medication regime and gives assurance that any old medicines will be removed, hence reducing the chances of the patient taking the wrong (old meds), improving safety and potentially reducing medication related hospital admissions.	No changes necessary.

Section of PNA	Response to consultation	Comment from PNA Steering Group	Decision to amend PNA?
Section 5.4	Flu vaccination: One pharmacy suggested that achievement in pharmacies could be compared to that in GP practices in Islington.	Comparing vaccination achievement in pharmacies against GP Practices is not possible. GP Practices have a defined list of patients, and therefore it is possible to track the proportion of patients who have received a vaccination. The same is not true of pharmacies as people are not 'registered' at a pharmacy. With pharmacies providing 5% of vaccinations comparing them directly against GP Practices would be unfair.	No – the PNA SG does not agree with the proposed change.
Section 5.5	<p>NHS Health Checks:</p> <p>One pharmacy suggested that a review of the NHS Health Checks service was carried out, and the outcomes considered before recommending that the number of NHS Health Checks carried out in pharmacies was increased. The same pharmacy also stated that the service should not be constrained by IT requirements and be easy for patients to access.</p> <p>One pharmacy recommended that</p>	Pharmacies are one component of a wider approach to delivery of health checks across Camden. This wider model is currently being reviewed, with the intention of developing a new approach to provision over the next 12 months. Whilst this is occurring we do not want there to be a break in provision of current service offered through pharmacies. As such the intention is to continue with the current provision for now but to develop the approach in line with the findings of our wider review.	No changes necessary.

Section of PNA	Response to consultation	Comment from PNA Steering Group	Decision to amend PNA?
	an increase in the number of pharmacies providing NHS Health Checks or the anti-coagulation service would support better access to care.		
General comments			
All	The statements made in the PNA draft about raising awareness of opening hours, what services pharmacies provide would be greatly welcomed, and would have a positive effect for residents and the health benefits.	We welcome the comments on opening hours, and the steering group will ensure work continues to improve awareness of pharmacy provision in Islington.	No changes necessary.

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Report of: **The Director of Public Health**

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	14 Jan 2015	Item	All

Delete as appropriate	Exempt	Non-exempt
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SUBJECT: Update on progress against the Joint Health and Wellbeing Strategy priorities: June 2014-December 2014

1. Synopsis

1.1 This paper sets out an update on activities and progress on the three Health and Wellbeing Board (HWB) priorities, specifically in relation to the Joint Health and Wellbeing Strategy. The three priorities are: (1) ensuring every child has the best start in life; (2) preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities; and (3) improving mental health and wellbeing. The updates that follow are for the period between June 2014 (when the last update on priorities came to the Board) and December 2014.

2. Recommendations

The health and wellbeing board is asked to:

- NOTE progress against the Health and Wellbeing Board's three priorities;

3. Background

3.1 This update focuses on activities and progress on the three Health and Wellbeing Board priorities, and is framed within the context of the Joint Health and Wellbeing Strategy and the specific outcomes set out in that document. It is not intended to provide a comprehensive overview of all of the work currently underway across the borough that contributes towards the delivery of these three priorities, but instead highlights some of the significant developments in the last six months. The three HWB priorities are:

- ensuring every child has the best start in life;

- preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities;
- improving mental health and wellbeing.

4. Priority 1: Ensuring every child has the best start in life

4.1 Early intervention and prevention summit

The Strengthening Early Intervention and Prevention Summit, held in November, brought together more than sixty local partners across the CCG and council, including education, public health, children's centres, social care, and Whittington Health, as well as national experts in Early Intervention. It provided an opportunity to take stock of achievements to date and showcase the excellent work taking place across the borough, and to recognise and begin to plan for the challenges ahead. This is feeding into a refresh of the Conception to age 3 approaches across Islington, and the final draft of the Children and Families Strategy 2015-25.

4.2 Joint child health strategy

The joint Islington CCG and Islington Council Child Health Strategy has been finalised. The strategy focuses on implementation of an early intervention and prevention approach across all professionals. The strategy has been informed by a Children and Young People's Health Needs Assessment carried out by Public Health.

4.3 First 21 months

Four Children's Centre cluster sites have received additional funding as learning pilots under the First 21 months programme with some useful learning beginning to emerge from the projects. Three Children's Centres have improved their health rooms to ensure they meet minimum standards. By the end of the year all Children's Centres providing clinical services will have suitable equipment and spaces. A report has gone to the CCG with specific recommendations on improving IT connectivity for health staff in Children's Centres. Implementation of the proposals will begin early next year. A model of change and principles of practice have been developed and will be used as the basis for procuring a baseline evaluation of the programme. A needs assessment of parenting class provision during pregnancy is underway and will inform future development of an evidenced based inclusive programme offered to all prospective parents.

4.4 Child weight management

Childhood overweight and obesity continues to be a challenge in Islington. In 2013/14 almost a quarter of reception year pupils (23%, about 440 pupils) were overweight or obese. Among Year 6 pupils, the equivalent figure was more than a third (38%, about 600 pupils). The proportion of Year 6 pupils who are overweight (including those who are obese) is higher than the national average and has increased since 2012/13.

115 children and young people in Q1 & Q2 completed Tier 2 child weight management programmes to support them to eat more healthily, be more active and become more confident. The service is doing particularly well at engaging teenagers, which is unusual for this type of programme.

The Tier 2 service (for overweight children) is working well, but recruiting children and young people to Tier 3 programme (for obese children) continues to be a challenge

4.5 National Child measurement programme (NCMP)

The 2013/14 National Child Measurement Programme was completed with a participation rate of 93% and 94% for reception and year 6 children respectively, an increase from 2012/13.

4.6 Healthy Start

The Healthy Start scheme in Islington continues to distribute vitamins from children's centre bases and Health Centres. The number of Children's centres now on board has increased by six to 13 Centres, taking the total number of distribution points in the borough to 23. The distribution is being piloted in the extra 6 sites until March 2015, when the monitoring data will be reviewed. If the analysis is positive then all the sites will continue with universal distribution.

A recent Children's Centre parent survey shows that both awareness and interest in Healthy Start has increased. Awareness has increased from 49% in 2013 (525) to 71% (791) in 2014. Interest in Healthy Start has increased from 74% in 2013 (667) to 84% this year (884).

4.7 Breastfeeding

Data on breastfeeding prevalence at 6-8 weeks are not available, due to the challenges in re-establishing the data flows for maternity and breastfeeding indicators between providers. A meeting with providers and NHS England took place in September and Q2 data showed an improved coverage, with 94.6% coverage (just missing the 95% coverage for data to be considered valid).

4.8 Health visiting

An Islington Health Visiting Steering Group has been set up to oversee the smooth transition of commissioning responsibility for Health Visiting from NHS England to Local Authorities in October 2015. An Integrated Governance Framework has been set up between NHS England and LBI to allow co-commissioning of the service between now and October 2015.

4.9 Oral health

In 2013/14, the Islington community-based fluoride varnish programme delivered a total of 13,578 fluoride varnish applications to 3-10 year olds. The provider exceeded the annual target by 13%. Over 10,500 fluoride toothpaste and toothbrush packs were distributed to parents of young children through the Brushing for Life scheme. 129 Islington dental staff received training in prevention, including child behaviour management.

Procurement is now underway for the joint Camden and Islington oral health promotion service. The invitation to tender will go out in February and the new contract will be awarded in July. This new service will seek to build on the success of oral health promotion model that has been implemented in Islington, and integrate within this the latest evidence-based interventions.

4.10 Teenage pregnancy

Despite improved working with UCLH and midwifery liaison, UCLH maintain their position that it cannot share with Whittington health about eligible teenagers, due to reasons of confidentiality. This has been escalated to the GP lead on Islington CCG, who leads on the UCLH contract. This is also being pursued by the Director of Commissioning through the Clinical Quality review Group.

5. Priority 2: preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities.

5.1 Integrated Care

During the past few months, the Pioneer Programme (Islington CCG and Islington Council's integrated health and social care programme) has been ensuring that all work on LTCs is aligned to the local vision for Integrated Care, specifically the "test and learn" projects and the resulting locality offer for 2015/16.

- **Pathways:** Diabetes, COPD, and heart failure pathways are being aligned to the integrated care programme. An Integrated Care commissioning manager has sat on each pathway steering group and is actively involved in the test and learn projects, aiming to improve the patient journey and experience by improving integration between secondary, community and primary care services.
- **Inter-agency working in localities:** The new locality offer is drawing LTC management further into a locality based approach linking into mental health, enablement, district nursing and social services. A programme of "Test and Learn" service development has been instigated to determine the best model for inter-agency working which will then be rolled out across the borough from April 2015 – eight GP practices are currently engaged in the work with named representatives from mental health, community nursing and social services.
- **Self-care/self-management:** This workstream aims to empower patients with LTCs, providing them with the skills to manage their care during the bulk of the time that is not managed directly by outside agencies. The Self Care working group is due to reconvene in January 2015 after a hiatus due to a loss of lead staff members and reduced capacity within the CCG. Most recently, self-management resources have been developed for Somali, Turkish and Bengali patients with diabetes.
- **Training:** Work on the pathway includes upskilling of primary care workforce through training and education and an increase in capacity in order to allow greater repatriation of patients into the community – linking to the Workforce workstream. Since July 2014, training has included:
 - Insulin management education sessions
 - LTC Nurse champion programme for generalist primary and community nursing
 - Ongoing Year of Care training for all Islington GPs and practice nurses
- **Contract innovation & Integrated Care:** This has seen the introduction of Value Based Commissioning (VBC) approach to the diabetes workstream (in collaboration with Haringey CCG), shifting the emphasis to ensure that patients' own outcomes are treated as the main function of the pathway while also including clinical and process indicators to measure success. Outcomes are built around agreed patient goals e.g. "I want to be able to do the things I want to do", "I want to feel in control of my condition", etc. In addition to diabetes care, a VBC approach is also being developed for mental health and frail elderly services. This project is supported by a new contracting approach to commission these pathways, hopefully, provide a model for future commissioning.
- **IT:** Interoperability workstreams feed directly into the pathway work for LTCs as well as self-management and specialist community nursing management, since increased access to shared records across agencies, and ultimately with patients themselves, will improve management and outcomes for patients with LTCs.

- **Integrated Digital Care Record & Patient hand-held record:** Two key milestones achieved over the last few months are that the Pioneer IT team submitted their Department of Health 'Technology Fund 2' bid (and are awaiting the outcome) and that Procurement have published the tender document for the Integrated Digital Care Record (IDCR) and Patient Held Record (PHR). In addition, there have been a number of engagement activities with stakeholders including residents to understand what is wanted from a joined up service between health and social care in order to inform the IDCR. The main theme was that residents thought health and social care should already be sharing information; people spoke of the distress of having to repeat their story particularly at times of crisis. Body and Soul and Age UK have been commissioned to speak with their clients about the Patient Held Record. Shortly, service users will be recruited to sit on both the Integrated Care IT Steering Group and Design Service User Group as regular members.

5.2 Long-term conditions locally commissioned services

Islington CCG have just launched their Long term conditions locally commissioned service (LCS). This combines the most effective elements of each of their previous LCSs (COPD, Diabetes, Closing the Prevalence Gap and Over 75s Check), aiming to provide a more integrated and person-centred experience, particularly for those people with multiple long term conditions.

5.3 NHS Health Checks

- The NHS Health Checks programme has continued to perform very well in Islington. Between 1st April 2014 and 30th September 2014, Islington ranked as the top performing London Borough for delivering Health Checks and ranked 2nd out of 152 Local Authorities in England. During this period, 6,343 health checks were offered and 4,052 were delivered; an uptake rate of 64%.
- Health checks are key to lowering people's risk of developing four common but often preventable diseases: heart disease, stroke, diabetes and kidney disease. The programme aims to identify people at high risk of CVD early and to provide appropriate intervention to manage and their risk.
- In addition to GP surgeries, health checks have been delivered in a range of settings to increase uptake amongst population groups at greater risk e.g. people living in social housing or areas of high deprivation, unemployed people and carers.
- Islington has seen a 34% reduction in deaths from cardiovascular disease (CVD) over the past 6 years, and the NHS Health Checks programme is thought to have made a contribution to this decline by targeting those at the highest risk of CVD. Now in the 5th year of programme implementation, we are focussing on ensuring that Islington residents identified as being at high-risk of developing CVD receive appropriate support to reduce their risk.
- Islington's NHS Health Checks Steering Group was shortlisted for Team of the Year at the Heart UK annual awards in November 2014 for their successful collaborative work on the development and improvement of the service.

5.4 Cancer

- **Pharmacy cancer awareness campaign:** Public Health has recently completed a cancer awareness campaign within community pharmacies, aiming to increase public awareness of the signs and symptoms of cancer and to encourage appropriate GP presentation. Twenty-three pharmacies took part in the campaign over six months. This generated 2,080 conversations about cancer of which nearly 10% (204) of the conversations resulted in a pharmacist advising the customer to see their GP because of their symptoms. Of those customers who completed a feedback questionnaire (n= 107), 84% said they felt

comfortable talking about cancer in the pharmacy, a similar number felt that raising awareness of cancer was something pharmacies should do and 75% indicated they knew more about cancer than they did before they came to the pharmacy that day. We are now considering how to embed the success of the campaign and support community pharmacy to continue to raise awareness of cancer and screening programmes.

- **Primary care facilitator:** A dedicated primary care facilitator continues to support Islington GP practices on the early diagnosis of cancer. To date, 86% of practices in Islington have had initial sessions with the facilitator and 22 follow-up meetings have taken place with 11 practices since the start of the project. In addition to the sessions at practices, the facilitator offered 'Talk Cancer' training to Health Care Assistants and reception staff - with the aim of providing staff with the skills and confidence to talk about cancer in their current roles and to increase knowledge of cancer and screening programmes - staff from nine practices attended this training. The primary care facilitator has also presented a session at the three locality patient participation groups in Islington to raise awareness of cancer symptoms, discuss cancer prevention and screening programmes, and discuss having effective consultations with GPs. A community-based session with Somali elders was also developed and completed in collaboration with Manor Gardens Health Advocacy Project.
- **Raising public awareness:** Public Health have been providing a locally focussed boost to the national 'Be Clear on Cancer' campaigns by developing blogs, news items and distributing resources to community organisations, Council facilities and public spaces. The campaigns aim to improve earlier diagnosis of cancer by increasing awareness of the key cancer symptoms and encouraging people to talk to their GP.
- **De-commissioning GP bowel cancer screening locally commissioned service:** Despite this locally commissioned service running for 2 years, the uptake of bowel cancer screening in Islington had increased no more than the London average so in September, the decision was taken to de-commission this service from April 2015. Work will continue to be done with practices to encourage bowel cancer screening and uptake levels will be monitored closely to ensure there is no drop-off of screening levels.

6. Priority 3: Improving mental health and wellbeing

6.1 The number of people accessing psychological therapies through the local IAPT service is due to reach the national target of 15% of those with common mental health problems (4656 people) by March 2015. A slight dip over the summer months is not unusual due to staff changes and patient holidays. Health Equity Audits of the services show that historically under-represented groups, such as men, people living in deprived communities and people from Black Caribbean groups, are now well represented amongst service users. This is achieved through targeted initiatives to promote awareness and to tackle stigma and discrimination associated with mental health.

6.2 Programmes designed to improve understanding and awareness of mental illness and encourage early identification continue to operate locally through the provision of mental health awareness training, the mental health champions' project and the direct action project. The aim of these services is to increase early access to IAPT, and specifically to target hard-to-reach communities and young people. In the first half of 14-15, mental health promotion services have recruited 16 new mental health champions, delivered 20 mental health awareness workshops and provided Mental Health awareness training to 170 individuals, including a group of Islington Council

members in November. Training has focussed on front line staff such as housing workers and teachers.

- 6.3 A new cross-borough suicide prevention steering group met for the first time in September and agreed the briefing documents for a review of suicide prevention pathways across Camden and Islington. The brief was informed by an eight-year suicide audit of 151 suicides in Islington during this period. This project is currently out for tender and the pathway review is due to commence in 2015. The outcome of this review will inform a new suicide prevention action plan. Islington Mental Health and Poverty Networking Forum have been commissioned to deliver a second workshop on suicide prevention in 2015 to raise awareness of current issues and share good practice. It is likely that this workshop will cover both Camden and Islington services.
- 6.4 The Public Health led mental health and resilience in schools project (MHARS) continues to work closely with the schools health and wellbeing team, school improvement, CAMHS, Educational Psychology and a number of other partners. The next phase of this work begins in January when 5 local schools with interesting ideas to pilot, will develop new approaches to increasing pupils' and staff emotional resilience through whole school systems. The MHARS framework will be developed and the school interventions evaluated with the help of UCL Partners, with the aim of all schools then learning from the development of good practice.
- 6.5 Public Health has worked closely with colleagues in joint commissioning to provide knowledge and intelligence in a number of areas in 2014-15. The current reviews of both talking therapies and day opportunities for people with mental health problems are supported by public health intelligence. Information was also provided for the crisis care review which has since developed into the Camden and Islington Crisis Care Concordat Local Action Plan. This fulfils the standards laid down nationally for crisis care.
- 6.6 Public health has also been providing health intelligence support to a new local programme of value-based commissioning, which has resulted in the development of an agreed cross-borough (Camden and Islington) model for an Integrated Practice Unit (IPU) for people living with psychosis. 2015 will see this model implemented locally. The Value Agenda moves the focus towards achieving patient outcomes, and away from volume and activity, which is how most healthcare services are currently commissioned. The IPU outcomes are holistic, focussing on physical as well as mental health care, and aiming to tackle the very wide life expectancy gap that currently exists for those with serious mental illness. Public health has led on defining the physical health outcomes within the unit.
- 6.7 The Annual Public Health Report for 2015 will focus on mental health, giving the opportunity for reflection on the cross-cutting nature of mental health in terms of both the determinants and the consequences of mental illness as well as some insight into the interconnectivity of wellbeing and health. The report will demonstrate that the widely agreed need for "parity of esteem" for mental health is starting to become a local reality. The report will also contain a chapter on the physical health of people with mental illness, noting progress made (such as the agreement to implement smoke-free wards at Highgate mental health centre) as well as recommendations for further action to improve the treatment and mortality gap.

6.8 Islington Clinical Commissioning Group has made a number of new investments in 2014/15 supporting improved mental health and wellbeing. They include:-

- Procurement of a new community development worker service from Hillside clubhouse. This service will identify and address inequalities in mental health and address some of the barriers faced by people from excluded communities.
- A new contract for Dementia Navigators which has been awarded to Camden & Islington Foundation Trust
- New long-term conditions matrons working with people with serious mental illness to address poor outcomes from physical illness.
- Implementation of a smoke free site at Highgate mental health centre
- A new parental mental health service to support the families in need agenda
- A pilot primary care mental health service based in general practice began in June. The overall aim of the service is to increase the access of mental health clients within GP care to physical health care assessment, specialist physical and mental health support and relevant non statutory organisations. The service will be based within GP practices included in the pilot, and provide consultation and advice to GPs as well as direct care.

6.9 The opening of the new recovery college by Camden and Islington NHS foundation trust offers people with mental illness in Islington a new opportunity to take forward their own recovery and so prevent some of the secondary consequences of mental illness.

7. Implications

7.1. 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

7.2. Legal Implications

Section 193 of the Health and Social Care Act 2012 inserted new section 116A into the Local Government and Public Involvement in Health Act 2007, which imposes a duty on the Council and the CCG to produce a joint health and wellbeing strategy for meeting the needs identified in the joint strategic needs assessment.

7.3. Equalities Impact Assessment .

This paper provides an update across a wide range of programmes and services being delivered in support of the LTC Health and Wellbeing Board's priority. Consequently there is no separate EIA relating to this report. Reducing health inequalities is an underpinning principle across the Board's three priority areas, and the report identifies the ways in which the interventions, services and programmes described are being tailored and targeted to reduce health inequalities.

7.4. Environmental Implications

None identified

8. Conclusion and reasons for recommendations

The Board is asked to:

- NOTE progress against the Health and Wellbeing Board's three priorities.

Background papers:

Attachments:

Final Report Clearance

Signed by



Julie Billett
Director of Public
Health

Date: 5th January
2015

Received by

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