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ISLINGTON

Governance and Human Resources
Town Hall, Upper Street, London, N1 2UD

AGENDA FOR THE HEALTH AND CARE SCRUTINY COMMITTEE

Members of the Health and Care Scrutiny Committee are summoned to a meeting, which will be held on **23 November 2015 at 7.30 pm.**

John Lynch
Head of Democratic Services

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Despatched : 13 November 2015

Membership

Councillors:
Councillor Martin Klute (Chair)
Councillor Jilani Chowdhury (Vice-Chair)
Councillor Raphael Andrews
Councillor Gary Heather
Councillor Nurullah Turan
Councillor Rakhia Ismail
Councillor Tim Nicholls
Councillor Una O'Halloran

Co-opted Member:
Bob Dowd, Islington Healthwatch

Substitute Members

Substitutes:
Councillor Alice Donovan
Councillor Alex Diner
Councillor Jean Roger Kaseki
Councillor Jenny Kay
Councillor Alice Perry
Councillor Dave Poyser
Councillor Clare Jeapes

Substitutes:
Olav Ernstzen, Islington Healthwatch
Phillip Watson, Islington Healthwatch

Quorum: is 4 Councillors

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1.	Introductions	
2.	Apologies for Absence	
3.	Declaration of Substitute Members	
4.	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** members present at the meeting.

5.	Confirmation of minutes of the previous meeting	1 - 10
6.	Order of business	
7.	Chair's Report	
8.	Public Questions	

9.	Update Margaret Pyke Centre - to follow	
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The next meeting of the Health and Care Scrutiny Committee will be on 7 January 2016

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

www.democracy.islington.gov.uk

Director of Corporate Resources

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London Borough of Islington

Health and Care Scrutiny Committee - Monday, 19 October 2015

Minutes of the meeting of the Health and Care Scrutiny Committee held at on Monday, 19 October 2015 at 7.30 pm.

Present:	**Councillors:**	Klute (Chair), Chowdhury (Vice-Chair), Heather, Turan, Nicholls, O'Halloran and Ismail
Also Present:	**Councillors**	Janet Burgess
	Co-opted Member	Bob Dowd, Islington Healthwatch

Councillor Martin Klute in the Chair

139 **INTRODUCTIONS (ITEM NO. 1)**

The Chair introduced Members of the Committee and welcomed witnesses to the meeting.

The Chair also welcomed two new Members of the Committee, Councillors Ismail and O'Halloran, who had been appointed as new Members of the Committee to replace Councilllors Gantly and Hamitouche.

140 **APOLOGIES FOR ABSENCE (ITEM NO. 2)**

Councillor Andrews

141 **DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. 3)**

None

142 **DECLARATIONS OF INTEREST (ITEM NO. 4)**

None

143 **ORDER OF BUSINESS (ITEM NO. 5)**

The Chair stated that the order of business would be as per the agenda

144 **CONFIRMATION OF MINUTES OF THE PREVIOUS MEETING (ITEM NO. 6)**

RESOLVED:

That the minutes of the meeting of the Committee held on 14 September 2015 be confirmed and the Chair be authorised to sign them

145 **CHAIR'S REPORT (ITEM NO. 7)**

The Chair referred to the dispute between the Government and junior doctors over the renegotiation of their contracts and that there is a lot of anger amongst junior doctor over the proposals.

The Chair added that he attended a meeting on 25 September of the North Central London Joint Overview and Health Scrutiny Committee and discussions took place on possible changes as a result of a report from Carnell Farrar and that the JOHSC had requested more details to be presented to a future meeting of the Committee.

The Chair reported that there is projected to be a £400m defecit in the NHS trusts by 2020 and that 22% of the population accounted for the use of 64% of resources and too many people attended A&E when it is not necessary. All the 5 PCT's in North Central London were making efforts to reduce these attendances.

The Chair added that the JOHSC also discussed the out of hours/111 service contract and that they had requested that the service should be profiled to fit individual boroughs needs, as each borough is different and that there appeared to be more positive engagement on this.

The Chair also referred to the GP appointments scrutiny recommendations and that he would be meeting with the Executive Member Health and Wellbeing on the implementation of these, given the concerns expressed at the last meeting, and would report back to the next meeting.

146 **PUBLIC QUESTIONS (ITEM NO. 8)**

The Chair outlined the procedures for Public questions and the filming and recording of meetings.

A member of the Public asked a question in relation to the proposed closure of the Margaret Pyke centre and it was stated that she was concerned at this and that Central and North West London NHS Trust should prioritise women's services, especially the important area of contraception, and keep the Margaret Pyke Centre open. She added that the centre is valued by clients and if the centre were closed the valuable work on research and training would also be lost.

Discussion took place as to the tariffs system for the payment of GUM and contraception services and the fact that there had been a lack of consultation and engagement with staff or patients.

The Director of Public Health stated that she recognised the inconsistencies in funding in the GUM and contraceptive services and that consideration is being given to an integrated tariff across London and that no firm options were yet available for consideration on proposals for the future of the Margaret Pyke Centre. In addition consideration needs to be given to whether there needs to be a different delivery model for these services. The Director of Public Health added that she was continuing to have discussions with L.B.Camden and would be visiting the Margaret Pyke Centre the following day.

The view was expressed that Margaret Pyke is an internationally renowned centre and the building had been refurbished at extensive cost recently. Contraceptive services were a basic right for women and if the services were broken up they could not be delivered in the same way.

The Chair indicated that the Committee had heard a convincing argument that the Centre should be retained and that it did not appear that the only option available is to reallocate services elsewhere. It was added that any proposals would represent a significant service provision change and therefore any service change proposals should be referred back to Committee for consideration.

RESOLVED:

That any proposals for reconfiguration of services for sexual health and contraception in relation to the above be referred back to the Health and Care Scrutiny Committee for consideration

147 **HEALTH AND WELLBEING BOARD UPDATE (ITEM NO. 9)**

There was no update submitted to this meeting

148 LONDON AMBULANCE SERVICE QUALITY ACCOUNTS - PRESENTATION (ITEM NO. 10)

Peter Rhodes, Assistant Director of Operations, London Ambulance Service, was in attendance and made a presentation to the Committee, a copy of which is interleaved.

During consideration of the presentation the following main points were made –

- Approximately 25% of Londoners are not registered with a GP and there are significant health inequalities and variations in life expectancy
- The LAS is the only pan London provider working with 32 Trusts, 32 Clinical Commissioning Groups, operating in seven clusters, seven System Resilience Groups, five Urgent and Emergency Care networks
- Demand for services is increasing year on year and in 2014/15 there were over 1.7 million requests. Operating budget is £316m and has 5,000 staff, 71% of which are frontline
- There is a changing workforce with more graduates, women and a higher turnover of staff and expectations. Transformation is taking place with a management restructure of frontline staff and recruitment drives
- The LAS main contract is to provide emergency service and urgent care ambulance (999) contract and is commissioned by NHS Brent CCG on behalf of all the 32 CCG's across London
- It is an annual contract which runs between 1 April 2015 and 31 March 2016 and operates 24 hours a day, for 365 days per year and the contract value is £267m per annum
- The 3 main challenges are staffing where morale needed to be improved as well as increasing staff numbers. There is also an ever increasing demand on services and the LAS will need to continue to find new and innovative ways of managing demand. The culture and management style of the organisation also needs to change as evidenced by staff feedback and external surveys
- In terms of recruitment LAS are running a national and international recruitment campaign for frontline staff, targeting Australian paramedics and increasing the number of places available at UK universities. Approximately 820 staff will be recruited this financial year, which includes 150 new posts
- In terms of performance LAS reached 75% of Category A calls in just over 10 minutes in 2014/15 and are now reaching 75% of Category A calls in just over 9 minutes so far in 2015/16. LAS work closely with the CCG and all the Acute Trusts in North Central London to develop pathways and reduce patient wait times
- Most patients are conveyed to the Whittington (31%) followed by UCLH (22%)
- In response to a question it was stated that it is mainly young people that did not register with a GP and that they tended to go straight to A&E
- LAS stated that staff in the staff survey in 2014 had indicated that they were concerned about the culture of management and a lot of work has taken place on improving local management who were visible to staff. There is also a new Chief Executive who is well respected by staff
- It was noted that the 2015 staff survey is now currently taking place
- A Member enquired whether there had been any improvement in recruitment of BME staff and the LAS stated that they would provide these figures to Members following the meeting
- In response to a question it was stated that the loss of staff contributed to the reduction in the Category A responses in 2014 and that one of the reasons why staff had left the LAS is that other services outside London are offering higher pay rates which the LAS could not compete with and that this had also affected staff morale

- It was stated that the utilisation rate of staff is around 90/95% which is very high and staff worked 12 hour shifts and this is tiring for staff and is far too high
- LAS worked well with the 111 service and did not think the referrals made were generally unnecessary or unreasonable, however there is a need generally to reduce attendance at A&E
- In response to a question the LAS stated that it would be useful if schools and colleges could be targeted to encourage children to train to be paramedics, however this would involve additional resources, however Health Education England had been approached in order to increase funding and training to encourage more paramedics and it is also important to retain existing paramedics

RESOLVED:

That the LAS provide the Committee with the closing date of the 2015/16 staff survey and the recruitment details of BME staff to the service and whether there had been an improvement in this

The Chair thanked Peter Rhodes for attending and his presentation

149 **PROCUREMENT OF GP PREMISES - VERBAL (ITEM NO. 11)**

Eshwyn Prabhu, Islington Planning Department, Alan Keane and Jonathan Weaver, NHS England, Fiona Ernes and Islington CCG were present for discussion of this item and made a presentation to the Committee, copy interleaved.

During consideration of this item the following main points were made –

- There are cost pressures in London however there are a number of initiatives to improve capacity and access to primary care
- There is an Islington I HUB pilot which has secured funding from PM Challenge Fund which will extend core GP hours in Islington, provide three physical hubs across the borough, with a single point of entry via a smart phone telephone interface, including clinical triage and be supported by digital information channels
- Islington has the lowest proportion of single handed contracts compared to other NCL boroughs. Since October 2014, 3 single hander GP practices have closed with a combined list of 4711. Capacity audits of neighbourhood GP practices during the consultation indicated that patients could re-register
- Islington is above the national average for FTE GPs per 1000 patients
- The average GP and Nurse FTE per 1000 patients combined across London is 0.75 and Islington is the highest in North Central London. This indicates that Islington provides sufficient clinical capacity for GP and Nurse FTE per 1000 patients
- The GLA estimates a projected increase of 41,500 (20%) over 15 years
- Growth varies by ward from 11% in Canonbury to 34% Bunhill however there is uncertainty as the actual number of homes or bedroom sizes are not known until planning permission is finalised
- Islington GP consultations are high at the start of life and from middle age increase sharply. Islington population aged 65-74 is expected to grow by 35% and aged 75+ by 39% from 2011-16
- Research has shown that someone living in the most deprived areas consults a GP as often as someone 20 years their senior in the least deprived areas
- There are a number of issues associated with Primary Care premises – Complex arrangements of tenure, where premises are improved and have rent increases this is picked up by the CCG to ensure alignment with strategy, Better Care for London recognised that across the capital up to 30% of

primary care premises are not compliant with the Equality Act 2010, strong focus from national bodies on how estates can be an enabler to service transformation

- From 1 October 2015 Islington CCG became a co-commissioner with NHS England which means that they both worked together to commission primary care
- Estate is a priority across North Central London CCG's who are working together to develop plans and Islington and Haringey are working on a joint strategy due in December 2015
- The strategic direction is to develop more local provision in the community so it is likely that there will be more co-location of primary care
- The recent Bunhill example showed how local planning could work and the project team included NHS England, L.B.Islington Public Health and Planning, NHS Property services, Islington CCG and the NEL Commissioning Support Unit
- The projected residential development and population increases arising from development over the next 15 years arises from developments particularly concentrated around Finsbury Park, Bunhill, Archway and Clerkenwell
- In the near future, the majority of development outside of, but adjacent to Islington, is planned in the Hoxton West ward, in the area north of City Road, and one development in the Hoxton East and Shoreditch wards, east of City Road
- There is a methodology used for options appraisal – public health maps of Islington, the City and Hackney wards, practices within one mile of the development, ratio of patients to GP's and nurses, space requirements, etc.
- The options available to cope with the recent decision for Bunhill population increase included – do nothing, grow existing practices within current premises, develop and improve existing practice premises, or relocate an existing GP practice into the City Forum development or commission new premises and a new contract
- In terms of the Bunhill development options appraisal there is an approval process in place and this was outlined, although this may not be suitable for other future developments
- The use of the Finsbury Leisure centre for the new GP premises is positive as it enables a co-location with a leisure facility with the stability of the Council being the landlord
- Members expressed concern that they would not like to see in future developers not being made to avoid their obligations to provide suitable premises and that it was important to develop a strategy with NHS England and the Planning Department to ensure that premises that are required are delivered at the right time and that any potential difficulties were identified at an early stage and there were no gaps in the process
- In response to a statement that GP's are independent contractors, it was stated that there were however levers that were in place to encourage them to change premises and that by having a competitive process GP's could be persuaded that this was a good idea
- It was stated that if there is significant population growth a new practice can be established and that the City Road development of 4000 additional patents, was not significant enough for this so the most viable option was to increase capacity at an existing practice. City Road practice were keen to expand and NHS England the Council were keen to work with them
- Reference was made to the previous item on the London Ambulance service where it was noted that 25% of Londoners were not registered with a GP and whether it was envisaged that this would increase. It was stated that it is hoped that new practices will pick up some existing residents who are not registered, however there is variable registration across London and whilst

they were looking at hotspots for non- registration it was a difficult problem to resolve

- It was stated that there is a constant churn of people in the borough and that NHS England were working with the Council to look at information on projected population growth and it would be important for them to work with Public Health and Planning to be aware of projected population growth
- Reference was made to the fact that there is often a limited amount of space to develop the capacity of GP surgeries in an inner London Borough such as Islington
- The Chair stated that it is hoped that Islington Planning would be able to deliver suitable premises through planning gain and in conjunction with an NHS needs assessment followed by NHS England seeking suitable providers

The Chair thanked all the witnesses for attending

150 **SCRUTINY REVIIEW - HEALTH IMPLICATIONS OF DAMP PROPERTIES - WITNESS EVIDENCE - VERBAL (ITEM NO. 12)**

Katie White, Andover TRA, Janet Manderson, Girdlestone TRA and Ken Kanu, Help on Your Doorstep were present for discussion of this item and gave evidence to the Committee.

Julie Billett, Director of Public Health was also present together with Damian Dempsey, Housing and Adult Social Services.

During consideration of the evidence the following main points were made –

- The Girdlestone Estate had been built in 1975/76 and 95% of the properties suffered from some sort of dampness problem
- The problems of dampness on the estate has led to instances of depression, respiratory problems, allergies, coughs and colds, and the issue affected flats on all levels not just the ground floors
- There had been constant issues with the Council in resolving these problems and tenants often gave up however major works were planned in the future and it was hoped that these would remedy the problems
- There seemed to be a number of causes of the dampness problems on the estate including leaks from central heating pipes, roofing, lack of DPC, balconies etc.
- There were also problems with leaks from the flat above the Community Centre, which was a leasehold flat and there had been ongoing problems with the Council and the leaseholder in resolving this issue which meant the Community Centre often cannot be used. Councillor Nicholls stated that he would investigate this issue with the TRA and the Housing Department
- The Committee were informed that a programme of works is being drawn up on the Girdlestone Estate and a pilot scheme would shortly be started with a rolling programme of major works commencing in 2017/18 for the rest of the estate, however there may still be the difficulty of accessing leasehold flats where there were central heating pipe problems
- The Andover TRA stated that there were not only problems in the new Andover blocks but the old blocks as well and may flats suffered from dampness problems
- There was poor communication by the Council when faults were reported and often tenants requested a report or feedback following a surveyors visit and this never happened and tenants often gave up and continued to live in damp conditions
- The Andover TRA stated that there were similar medical complaints of tenants to those at Girdlestone Estate, respiratory problems, coughs/colds, asthma,

especially in children, and tenants suffered depression, both caused by the problems and the difficulties in getting it rectified. Housing officers did not respond to e mails or enquiries and tenants never got feedback on visits and often problems remain unresolved or the dampness was just painted over

- It was stated that the pilot scheme on the Andover Estate is in relation to the new blocks
- The Andover Estate TRA also made reference to the problems that some tenants had experienced in relation to the installation of new kitchens and bathrooms and that this had caused condensation due to cupboards being placed in front of the air bricks
- In some flats the dampness was so bad children had to sleep in the sitting room
- The Housing officer stated that he did not consider that it was satisfactory if tenants had not received responses and he would contact the TRA to visit the estate and take up with officers the lack of responses issue
- The view was expressed that there were also problems on the New River Green and Elthorne Estates that had been picked up by Help on Your Doorstep in relation to dampness problems
- A number of vulnerable residents were affected by damp problems and 25% of those supported by Help on Your Doorstep are elderly. In addition there are families with young children that are affected and recurring medical themes are respiratory problems, allergies, infections, skin complaints and mental health problems
- Many residents also complained about the smell of damp in their properties and it lingering on their clothes and Help on Your Doorstep referred to a 93 year old woman that they were assisting and had been trying to rectify her dampness problems for 6 years and it was still ongoing
- In response to a question it was stated that the dampness problems in the old blocks were experienced on all floors. Councillor Heather indicated that he had visited the estate to see the problems and he felt that some of them were caused by a leaking water tank in the roof and he had discussed this with the surveying team
- The Committee expressed the view that there needed to be a systematic look at the problems on the Girdlestone and Andover Estates. Members were informed that there is a pilot taking place on the new blocks at the Andover and then major works would take place and similarly on the Girdlestone, however it appeared the old blocks on the Andover Estate, that were not scheduled for works needed further investigation
- The Committee requested that they receive six monthly updates on the progress of works on Andover and Girdlestone Estates, once they commence
- Help on Your Doorstep is an outreach/referral service that is a door knocking service for residents that refers residents on to a wide range of Council and other services, The service tried to focus on vulnerable residents and had identified a significant number of dampness problems and is the most common housing issue for residents
- Help on Your Doorstep stated that a common complaint from residents was that housing officers never responded to them and in the end they gave up and continued living in poor damp conditions. To date Help on Your Doorstep had identified 261 cases associated with dampness in the last 5 years
- Clients offered received multiple visits from surveyors and then did not get any feedback or work done and even on the occasions where work is carried out it is often superficial. Whilst it is recognised that dampness is often expensive to remedy it is also not pleasant for those residents having to live in damp properties
- The Committee were of the view that the evidence strongly seemed to suggest that there needed to be a better communications strategy with residents and

that where there were dampness problems copies of surveyors reports should be provided to tenants when they requested them and that this may well be one of the recommendations arising from the scrutiny review

- Reference was also made to the fact that a number of residents had communication problems as English was not their first language and that in such cases these should be sent to a relative of friend who could translate it for them
- Councillor Heather stated that he had experienced similar lack of communication issues with officers when reporting complaints and that the problems on the Andover Estate needed to be systematically assessed. In connection with the major remedial works on the Andover Estate, public meetings had been held and future meetings will be held with residents to keep them informed and discuss proposals
- In response to a question Help on Your Doorstep stated that they had information on the database in relation to the health problems suffered by residents that they assisted and Members requested that this should be circulated to Members, with names etc. anonymised

The Chair thanked Katie White, Jan Manderson and Ken Kanu for attending

151 **ANNUAL ADULTS SAFEGUARDING REPORT (ITEM NO. 13)**

Marian Harrington, Chair of the Adult Safeguarding Board and Elaine Oxley,Housing and Adult Social Services were present for discussion of this item.

During consideration of the report the following main points were made –

- Under the Care Act 2014 the Council now has a statutory responsibility, through the Health and Care Scrutiny Committee to lead the Borough in safeguarding adults
- It was noted that physical abuse, financial abuse and neglect have remained the top three categories for several years and that the percentage of cases which were substantiated or partially substantiated has risen by 20% in the last year
- Islington has had its first serious case review for a number of years and an action plan is being worked on in order to address issues of concern. The case involved a discharge from hospital and measures had now been put in place to address these issues with care homes and Whittington and UCLH Trusts and relevant GP's
- In response to a question as to the interface between the Adults Safeguarding and Childrens Safeguarding Board, it was stated that there is an interface and there were teams in place to deal with the transition to adult services and there was a reciprocal arrangement for a member to be on the Boards. There is also shared learning and whole family training is being looked at
- The Chair stated that in view of the time limit for closing the meeting any questions to the Chair of the Adult Safeguarding Board would need to be submitted in writing for response

RESOLVED:

(a) That any questions be submitted in writing to the Chair of the Adults Safeguarding Board

(b) That the contents of the report be noted and to commend adult social services staff for their commitment to preventing abuse, where possible, and responding to concerns of abuse or neglect of vulnerable Islington residents

152 **WORK PROGRAMME 2015/16 (ITEM NO. 14)**

RESOLVED:

That, subject to the addition of the Healthwatch Work programme being added to the November meeting, the report be noted

The meeting ended at 10.30p.m.

Chair

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NHS
Islington
Clinical Commissioning Group

MEETING:	Islington Health and Care Scrutiny Committee
DATE:	23rd November 2015
TITLE:	Value Based Commissioning
AUTHOR:	Becky Kingsnorth, Head of Service Transformation
CONTACT DETAILS:	rebeccakingsnorth@nhs.net

1 Purpose of the report

Islington CCG is working with partner CCGs in North Central London to test a new approach to commissioning health services, which creates an increased focus on the outcomes achieved for people in Islington. The approach is called 'value based commissioning'. This short paper introduces Islington Health and Care Scrutiny Committee to this new approach, and provides details of work currently underway.

2 Recommendations to the scrutiny committee

The Scrutiny Committee is asked to NOTE this introductory paper and is invited to comment on this new approach to commissioning.

3 Intended impact of the report

The intention of the report is to keep one of the CCG's key stakeholders informed and engaged, to invite comment on the wider implications of developing this new approach to commissioning, and to continue to maintain transparency on the work of the CCG.

4 Contribution by community and professional partners to the report

There has been a high level of engagement over the past two years with patients, carers, clinicians, local providers, GPs and other stakeholders to discuss this

approach, define outcomes and agree how it could be introduced. This started with large workshops with this range of stakeholders in Autumn 2013, to identify what is important to people with diabetes, older people with frailty, and people living with psychosis. The projects have been led by the outputs from these workshops, which were used to define the outcomes we would focus on. The CCGs then carried out further work with specific local patient groups or networks to review and prioritise the outcomes. Each project continued with a series of design workshops, including service providers, patient and voluntary sector representatives to look at how services would need to be provided differently in order to achieve the selected outcomes.

While the CCG does not directly commission core primary care services, or social care services, there is the potential for these services to be involved in the changes. Local GP leaders have been at the forefront of our planning on value based commissioning. Where it is possible, we will use any additional services we commission from GPs, over and above core primary care, to ensure that they too are involved in delivering improved outcomes. Social care, for some groups in particular, has a very important impact on outcomes. Health and social care organisations will increasingly be asked to work together on achieving outcomes. Wherever possible, with agreement from our local authority partners, the same principle of linking payment to outcomes can be applied to social care services, but this may happen over a longer period of time.

5 Key issues, challenges and risks and their management - focusing on prevention, partnership working and reducing inequalities

CCGs currently commission most health services under a model known as ‘payment by results’. This means that we pay providers for each unit of activity they provide to a patient, such as an attendance at an outpatient clinic, an attendance at an Emergency Department, or provision of a diagnostic test. We commission slightly differently for the care that is provided outside of hospital (e.g. district nursing and other community nursing or therapy services). We have a single ‘block’ contract with community providers, which provides an overall amount of funding based on the amount of activity we expect to be provided, rather than paying for each unit of activity separately.

This current way of commissioning and reimbursing health services can make it difficult to encourage a shared focus across the health and care system on maintaining health and independence. Providers and the staff who work in different organisations often only see their part of the picture and it is left to the patient and family to link care together. We want to promote a system where different organisations are more aware of each other and their overall impact on outcomes.

5.1 About value based commissioning

Value based commissioning means changing how healthcare is organised, measured and reimbursed in order to improve the value of services. In a value based commissioning system, services delivered by a number of providers are organised around patients with similar sets of needs, to ensure that these needs are met in the most effective way.

We would like to bring about a significant shift in the extent to which organisations providing health and social care work together to focus on improving clinical outcomes for patients and supporting their independence. We are asking health and care organisations to work together, across boundaries, for patients with similar needs. As commissioners, we will support this approach by having a contract which describes the outcomes that we expect to be achieved. A proportion of payment for services will be linked to the outcomes that are achieved collectively by the range of providers involved in providing care for that group of patients.

We no longer want to pay providers just on the basis of the number of people who receive treatment, but for how well they manage to achieve the outcomes that have been defined by patients. Providers will still be paid for the patients that they treat, but commissioners will base a proportion of funding on the outcomes that are achieved.

5.2 Defining outcomes

Focusing on outcomes means focusing on the results of care for the individual, for example, whether a person with frailty has been enabled to live independently, or whether a person with diabetes feels able to manage their condition. For the projects that are underway (see below), we have worked with patients, carers, and clinicians to identify what it is important for each group of patients to achieve, and we have used this to define outcomes for a specific population group. These outcomes are

then prioritised and the way of measuring these outcomes is determined. It may be possible to measure the outcomes clinically, or by observing the results of care, but in many cases we need to ask patients themselves how they feel about the outcomes that have been achieved. This means a much greater focus on 'Patient Reported Outcomes'.

5.3 Current projects

A number of CCGs across the country are starting to develop value based contracts, but it is still a new approach. In Islington, we are working with Haringey CCG to develop a value based commissioning contract for care for people with diabetes, and we are working with Camden CCG to develop a value based commissioning contract for people living with psychosis. Haringey CCG is also developing a value based commissioning contract for older people with frailty, and Camden CCG already has a similar approach in place for people with diabetes.

6 Intended impact on reducing inequalities and improving health, wellbeing and value for money

The key aim of value based commissioning is to improve patient outcomes and experience by integrating care around the patient. In practice this means planning and organising care for particular groups within the population, for example people with frailty, people with diabetes or people with psychosis. An understanding of the different needs of the population must be considered with a focus on what patients need, rather than what organisations can provide. The model aims to enable people to be as independent as possible though care and support provided by the most appropriate person and in the most appropriate setting.

There are many benefits for patients and population groups of commissioning in this way, including enabling people to remain independent, faster recovery and maintaining physical and mental health and wellbeing. There are also financial benefits for providers and commissioners involved if outcome targets for population groups are achieved, as well as savings through efficiencies. The 'value' provided by healthcare is increased by increasing the outcomes achieved per pound spent. This is particularly important where we expect to see a growth in certain population groups.

7 What success looks like, measuring success and targets

Over the next year we would expect that for people with diabetes there will be a gradual move towards more health and social care services being brought together to be provided as an integrated model. We would expect that information will flow, with patient permission, more quickly and efficiently between, for example, hospitals and general practice. We will see more patients having a plan for care that they have been involved in and opportunities for patients to be supported by professionals to manage their condition. For people living with psychosis we will see an increasingly proactive focus on their physical health needs as well as their mental health needs, again with services brought together to be provided when the patient is already in contact with care, rather than offering multiple appointments in multiple settings, which can be difficult for a patient to navigate.

We will expect to see improvements in the outcomes that have been prioritised, over a period of five years. Where this will be measured through patient reported outcomes, we are developing new surveys to gather this information each year.

8 Legal implications

Implementing this approach to commissioning has required consideration to be given to a new form of contract, which describes how organisations will work together to achieve outcomes. This will operate in addition to the NHS Standard contract, and has been developed by lawyers.

9 Resource implications

Our plans do not involve changing how much is being spent on health and care services. We are trying to link part of our payment to achieving outcomes rather than spending any more or less money overall. In the long term we hope that a more integrated approach to care provision will be more efficient and will allow us to meet increased demand for services.

10 Next steps

For the project relating to people with diabetes, we have undertaken a process to establish which organisation providing health and social care to our population would

be best placed to lead implementation of the new service model. Information about this process was provided on our website. We were looking for leadership from a provider with: experience of providing services for people with diabetes within Islington and Haringey; good links and relationships with other local providers and partners; experience of partnership working; and evidence that they already provide high quality care. For this project, Whittington Health has been identified as the preferred provider to lead the next stage of the project, and we are currently discussing the new contract with them.

For the project relating to people living with psychosis, we are currently undertaking the above process, to find an organisation to lead the next stage. Given the need, in this case, for specialist mental health expertise in addition to the range of experience described above, we have initially invited Camden and Islington NHS Foundation Trust, the current mental health care provider for both Camden and Islington CCGs, to participate in this process. We will be presenting the outcomes of this process to the Governing Bodies of each CCG in January 2016.

We are trying to build an outcome focus into how we commission a wide range of services. Through the projects for diabetes and older people with frailty we will see if the new type of contracting approach supports this focus on outcomes. We will evaluate as the work progresses and may look to roll it out more widely at a later stage.

healthwatch Islington

Work Plan 2015-16

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

Aim	Status	Notes
1. Investigate experience of mental health services for young adults.	Complete	Report published 2nd October 2015.
2. To support the development of community-informed Equality Objectives with Islington CCG	Complete	Hosted a joint session with local community organisations and CCG to discuss equality issues.
3. Raise awareness of Joint Strategic Needs Assessment to increase community input.	Complete	Co-hosted an event with Islington Refugee Forum and Public Health and encouraged small local organisations to submit data to the 'Call for Evidence'.
4. Gather the views and experiences of home care service users.	To be started	To gather case studies telling us about the experiences of those currently using home care services – most likely by developing a series of case studies of experiences.
5. To gather experiences of 'personalisation' within a range of care settings including nursing homes and sheltered housing.	In progress	First round of visits completed (care homes), further visits planned for November (mental health day services) and January (supported housing).
6. Raise awareness of on-line booking at GP appointments and find out about user's experiences of this.	In progress	On-line survey of local people's experiences of on-line booking, to be followed by a report in November.
7. Mystery shop services in relation to Healthcare Travel Costs	In progress	Initial planning meeting held, 'shopping' to take place in September and October, report to follow in November.

Aim	Status	Notes
8. Investigate Integrated Care from the service users' perspective.	Complete	We spoke to CCG partners and delivered a report of semi-structured reviews with users of this service.
9. Develop models for cross-borough working with other Local Healthwatch.	On-going	Delivered training to Deaf residents across 13 North East Central London boroughs which have resulted in service visits and recommendations across this area. Further training underway.
10. Develop a model for effective engagement of children and young people.	In progress	Discussing a potential plan for joint working with London Borough of Islington to ensure robust, supported involvement. Healthwatch Islingotn devising a training plan.
11. Keep our local community informed of policy relating to local services	Ongoing	Hosting a meeting on Whittington Health and hosted a meeting on the pilot programme to extend GP opening.
12. Look for opportunities to develop joint work with local voluntary sector partners.	In progress	Great input from local partners on our interpreting and mental health work and now leading a bid with nine local partners to gather views on access to primary, planned and unplanned care.
Follow up on previous work:		
13. Improve access to interpreting services within primary care.	In progress	Report on lack of access to interpreting published. Working with GP practices and the CCG to improve uptake.
14. Assess customer service in GP receptions.	Completed	Visits carried out showed positive feedback from our mystery shoppers, both adults and young people.
15. Making a complaint about services offered at local GP practices.	Completed	Some improvement in the information available at practices. Healthwatch has disseminated a leaflet on making complaints about health services to local libraries, community centres, voluntary organisations and health services.

Aim	Status	Notes
16. Clearer information for Deaf patients in local hospitals using British Sign Language.	In progress	Still chasing up actions from one local provider and have raised this with Care Quality Commission.

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ISLINGTON

HEALTH IN ISLINGTON: Key achievements

Cllr Janet Burgess

Presentation to Health Scrutiny
23rd November 2015

Life expectancy

- Since 2000-02, life expectancy has **increased** in Islington for both men and women.
- Life expectancy at birth for men in Islington is now 78.2 years, an increase of 4.8 years over the past decade. However life expectancy for men in Islington remains lower than England (79.4) and is **the 4th lowest amongst all London boroughs**.
- For women in Islington life expectancy is 83.4 years and is similar to England (83.1).
- In Islington the **difference** in life expectancy between people in the **best-off** and **worst-off** areas of the borough is **3.9 years for men** and **1.3 years for women** although this probably does not reflect the true scale of inequality in the borough.

Life expectancy at birth

Men	2000-02	2011-13	Percentage increase
Islington	**73.5**	**78.2**	**6.4%**
London	75.8	80.0	5.5%
England	76.0	79.4	4.5%

Women	2000-02	2011-13	Percentage increase
Islington	**79.1**	**83.4**	**5.4%**
London	80.8	84.1	4.1%
England	80.7	83.1	3.0%

Source: Public Health Outcomes Framework, 2015

Islington's Health and Wellbeing Board priorities

ISLINGTON

Ensuring every child has the best start in life

Preventing & managing LTCs to extend length and quality of life & reduce health inequalities

Improving mental health and wellbeing

Delivering high quality, efficient services within available resources.

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ENSURING EVERY CHILD HAS THE BEST START IN LIFE

ISLINGTON

Key achievements – Best start in life

- Infant mortality has fallen by 68% since 2003-05. In 2010-12, Islington had the **8th lowest rate of infant mortality** of all local authorities in England.
- The percentage of babies being **breastfed** at 6-8 weeks (86.1%) is better than England (73.9%).
- Islington has seen a **significant reduction in teenage pregnancy rates**, which have more than halved in five years. For the first time is lower than the London and England average.
- 53 Children's Centres have received **Healthy Children's Centre** status
- Joint **Child Health Strategy** focuses on implementation of an early intervention and prevention approach across all professionals and settings
- Islington continues to perform well in all childhood immunisations. 91.5% of children aged 2 years **immunised** against MMR, which the fifth highest rate in London. Significant improvement in the uptake of school aged immunisations in 2014/15, with Islington having one of the highest uptake rate of HPV immunisation in London.
- **School readiness is improving**.
- **Children's oral health has improved** but there is still more work to be done. In Islington the mean number of decayed, missing or filled teeth **decreased from 1.5 in 2007/08 to 1.3 in 2011/12.**

Key challenges – Best start in life

- **Child obesity is high but stable**
- **Almost 1 in 4 children aged 4-5 years old had excess weight** in 2013/14. The rate continued to show a slight decrease and is currently similar to England and London.
- **2 in 5 children aged 10-11 years old had excess weight** in 2013/14. There has been a rise in the last year and is similar to London but higher than England.
- To address obesity levels we need to collaborate with the community and voluntary sectors- youth clubs and independent housing/social care workers/troubled families to engage with the most vulnerable communities.
- The number of **children referred and assessed for autism has increased** from 47 to 119 between 2012/13 and 2014/15 (+153%). The implications across the range of health, education and adult services are very significant. In particular from a Best Start in Life perspective this has significant implications for early intervention in support for parents.

What is being done locally?

ISLINGTON

- **First 21 Months programme:** aims to improve early intervention in pregnancy and the first year. A particular focus is on improving access, communication and coordination between services.
- **Islington Healthy Children's Centre programme:** Being recognised as a Healthy Children's Centre means that the centre offers a good level of support for Islington's key health priorities for young children and families.
- **Antenatal and Postnatal Services** and the **Family Nurse Partnership** are services aimed at improving infant, child and maternal health.
- There is an established obesity care pathway for overweight and obese children and young people in Islington. Many services in Islington help to **prevent childhood obesity** as they specifically improve healthy eating and increase physical activity, including **free school meals** for all primary school pupils, the **Change4Life** campaign, and **Healthy Children's Centre Programme**.
- There are several multi-component and specialist **child weight management services** in Islington.
- Islington aims to reduce oral health inequalities by **increasing knowledge of key oral health messages**, **increasing the availability of fluoride,** and **increasing access to local NHS dental services**.
- Key programmes include **Community-based fluoride varnish programme, the Brushing for Life scheme**, and **First tooth First Visit Dental Referral Initiative** and **Healthy Children's Centre Programme.**
- Islington has a strong **teenage pregnancy prevention programme** encompassing sex and relationship education, advice and access to contraception services. Services provided are both universal and targeted to those young people who have particular vulnerabilities or needs.

ISLINGTON

PREVENTING AND MANAGING LONG-TERM CONDITIONS (LTCS) TO ENHANCE BOTH LENGTH AND QUALITY OF LIFE AND REDUCE HEALTH INEQUALITIES

Key achievements - LTCs

ISLINGTON

- 46% reduction in early deaths from **heart disease** over the past 10 years. This is a faster reduction compared to London (40% reduction) and England (37%). However, the rates remain higher than the national and London averages.
- Since 2001-03, **premature cancer mortality has fallen** substantially but the rate is still **higher than England**.
- **Premature mortality from respiratory disease has fallen** and the rate is now **similar to England.**
- Islington had the lowest late diagnosis rate of HIV in the country in 2011-13.
- **Over half** of adults in Islington are overweight or obese (54%). This percentage is **lower** than the London and England averages. 62% of Islington residents participate in the recommended level of physical activity (over 150 minutes of physical activity per week). This percentage is **significantly higher** than the London and England averages
- Referrals rates into **adult weight management services** are increasing.
- In 2014 Islington was the top performing London Borough for **Health Checks**, and ranked 2nd out of 152 Local Authorities in England.
- Pioneer Status leading to a more **integrated approach** to health and social care within the borough with the aim of improving people's experience of care and their health and wellbeing outcomes.

Key challenges - LTCs

- In 2013 Islington had the **2nd highest** prevalence of smoking in London, with higher than London and England.
- In 2012/13 Islington had a **1.5 times higher smoking quit rate** (1,295 per 100,000) than the national average (868 per 100,000). However, the number of smoking **quitters is falling** – reversing this trend is a key challenge for Islington.
- **Cancer screening uptake in Islington is lower than the London and England** averages and increasing uptake remains a challenge.
- Although statistically similar to England, Islington's rate of **alcohol specific deaths, deaths from chronic liver disease and alcohol related deaths are all some of the worst in London**. Generally, in Islington, these rates have declined over the last five years, although these declines are not, statistically, significant.
- We continue to have **significantly worse admissions** to hospital as a result of alcohol, and the rates have increased in Islington over the last five years.

What is being done locally? (LTCs)

ISLINGTON

- **NHS Health Checks programme:** designed to prevent heart disease, stroke, diabetes and kidney disease by identifying and treating people at high risk through targeting 35-74 year olds. During the Health Check individuals are also offered lifestyle advice.
- **Cardiac rehabilitation** is available for most people with acute coronary syndromes, post revascularisation, newly diagnosed angina, heart failure, established stable angina, and to aid recovery following valve and other cardiac surgery.
- **Cancer screening** aims to detect early stage cancers or pre-malignant disease. Currently, three national cancer screening programmes for **breast, bowel and cervical cancer** are offered to eligible populations in Islington.
- As part of an initiative launched in 2010 GPs continue to be incentivised to deliver a **Locally Commissioned Service** (LCS). The LCS aims to find patients with undiagnosed COPD; support patients living with COPD to self-manage; manage patients with severe COPD and those admitted to hospital; review the medications prescribed to COPD patients.
- **Closing the prevalence gap**. This Locally Commissioned Service (LCS) requires GP practices to identify those people on their practice register that are at greater risk of certain conditions, including diabetes, and inviting them in for tests.

What is being done locally? (Older People)

ISLINGTON

Primary care:

- **Over 75s Health Check LCS**: This LCS works towards reducing the gap between diagnosed and undiagnosed prevalence for a number of long term conditions including diabetes, chronic kidney disease, hypertension, CVD, atrial fibrillation, dementia and depression.
- **Vaccination Programme**:
- **Other Locally Commissioned Services:** LCSs are delivered by GP practices across Islington. These services aim to improve the care of conditions such as diabetes, Chronic Obstructive Pulmonary Disease (COPD) and Coronary Heart Disease (CHD) through; education, earlier diagnosis and the enhanced clinical care of patients with LTCs as well as improving the experience of patients.

Community services:

Seasonal Health Interventions Network (SHINE), the Well Winter Campaign, the Dementia Navigator Service, Community rehabilitation, and Falls prevention services.

What is being done locally? (Lifestyles)

Islington has a number of initiatives which encourage adults to be physically active:

5 outdoor gyms

- 20 walking routes
- 3 walking clubs

- Free cycle training courses
- Cycling routes through residential streets

Over 100 clubs, leisure centres, parks, and other venues to do more than 60 sports and other types of physical activity

- The **Islington Smokefree Alliance** has brought together a wide range of organisations that have a common aim in reducing smoking prevalence. Membership includes the Fire Service, Environmental Health, Trading Standards, Education, City and Islington College and the NHS. The Islington Alliance has a 10-year strategy which aimed to address the wider determinants that support smoking.
- The **Islington Food Strategy** was re-launched in November 2014 involving over 25 local partners and stakeholders. The vision for the action plan was agreed as 'Eating Well Together: Making Healthy Choices the Easy Choices', focusing on four themes: Building a healthy start, healthy choices for children's and young people's appetites, supporting a healthy environment and connecting through food.
- Islington topped the **Good Food for London league** table for the 4th year in a row reflecting the borough's high level of participation in key healthy and sustainable food initiatives. The nine food issues covered by the league table are: UNICEF UK Baby Friendly Initiative, community food growing; London Living Wage, Fairtrade food, Food for Life in schools, sustainable fish, animal welfare, healthier catering and local food partnerships.

What is being done locally? (Alcohol)

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- **Developing and implementing the licensing strategy**
- **Awareness raising**

HAGA provide training in Identification and Brief Advice, as well as awareness raising at community events. Don't Bottle it Up is an online tool that allows an individual to work out what level of risk they are at as a result of their drinking, and access personalised advice about alcohol harm reduction

- **Treatment**

There are a number of treatment services in Islington as well as voluntary agencies providing support to people to reduce or stop their drinking. These are split across four tiers, depending on need.

- **Tier 1 services** include information and advice as well as initial **brief interventions** delivered in a range of community settings.
- **Tier 2 services offer assessment, brief interventions, safer drinking models and harm reduction**. These are focused on people with lower levels of need and are offered at CASA (Islington Community Alcohol Service) and at PCADS (the Primary Care Drug and Alcohol Service).
- **Tier 3 services provide structured treatment offering key working, care planning and goal setting**, psychosocial interventions, community detoxification, and relapse prevention. Entry into these services is through CASA who arrange referrals to other services depending on need. Providers include ISATS (Islington Specialist Alcohol Treatment Service), PCADS and Change and Recovery at 28B.
- **Tier 4 services offer detoxification and rehabilitation at residential centres.**

ISLINGTON

IMPROVING MENTAL HEALTH AND WELLBEING

Key achievements – Mental Health

- An estimated 15% of 5-16yr olds experience MH conditions (higher than England), with higher levels of investment than London or England. Addressing prevention and earlier intervention is key to improving MH. To address this CAMHS are now part of schools pastoral care teams and as a result of partnership working schools are now one of the biggest referrers into the service.
- Mental Health Promotion services include free **Mental Health awareness training**, **Mental Health First Aid training** and **mental health champions programme**. In 14-15, 48 MH awareness workshops reached over 800 people and 32 new champions were recruited.
- The number of people accessing psychological therapies through **IAPT reached the national target of 15%** of people with depression and/or anxiety using the service (4654 people) by March 2015. Approaching **50% of patients were moving towards recovery**, which is close to 'gold standard' outcomes for this type of service.
- 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 of iCope.
- Islington had a **large decrease** in the suicide rate between 2001-03 and 2011-13: it is now not significantly different to London or England. There are, though, significant risk factors in the local population.
- The 2015 **Annual Public Health Report "Healthy Minds, Healthy Lives: Widening the Focus on Mental Health"** emphasises the broad range of determinants and consequences of poor mental health in Camden and Islington. The report argues that mental health is everybody's business and summarises the high economic, personal and broader health benefits of achieving better mental health.

What's being done locally?

Mental Health (MH) services in Islington cover services for children and young people (CAMHS), services for adults of working age, older people's MH services and alcohol and substance misuse. The national and local strategies of dealing with mental health inequalities aim to:

- **Tackle stigma and discrimination** by encouraging people to recognise poor mental health and seek help at an early stage
- **The mental health and resilience in schools** (MHARS) project began in January with four Islington schools taking part to develop a resilience framework for implementation across the borough
- Programmes to **improve the physical health of those with mental health problems**
- **Mental health promotion** includes MH First Aid and Youth MH First Aid training (MHFA/YMHFA), the Mental Health Champions project, and the Direct Action project which focuses on children and young people
- **Primary care** (Improving Access to Psychological Therapies (IAPT)
- **Secondary care**, including an Assessment and Advice Team, Crisis Resolution and Home Treatment Team, and acute mental health inpatient services.
- A **review of suicide prevention pathway** in Camden and Islington is proceeding. A wide variety of stakeholders, including those directly affected by suicide, have taken part in the review, building up a full picture of current support networks and possible gaps in service provision.

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Challenges for the coming year

- Increasing the number of smokers who successfully quit
- Addressing the high levels of alcohol related admissions
- Improving the physical health of those with mental health problems
- Increasing the number of people with LTCs who are in employment
- Tackling social isolation in vulnerable groups, such as older people, MH and LD
- Addressing parental mental health in the early years and building resilience

ISLINGTON

Islington Adult Social Care Local Account

2014/15

The Adult Social Care Plan

- The Adult Social Care Plan 2015-2019 outlines how we will support the Council to deliver Corporate Plan *Towards a Fairer Islington.*

- We will make sure that our most vulnerable residents continue to receive good quality care and support. We will ensure that adults at risk are safeguarded from abuse and neglect.

- We will work to the principles that are described in the Corporate Plan, namely:
  - Early intervention and prevention: moving services to address problems before they become too ingrained to manage
  - People-centred services: we will develop person-centred policies and services, rather than systems or process-led approaches, with more multi-agency, multi-disciplinary teams, pooled budgets and joint working across Islington and within the Council.
  - Co-production: we will work together with service users as equals to develop policy and services and adopt the Co-production concordat approach used in “Making it Real”.
  - Strong partnerships: All public sector organisations in the borough are facing cuts and so the importance of working together in the interest of residents has never been greater.
  - Making every contact count: residents facing multiple disadvantages are in contact with many services, so it is essential that we make every contact with them count and avoid people having to negotiate their way through complex systems.
  - Employment focussed: Supporting people into employment should be at the heart of everything we do.

Social Care In Islington

In 2014/15 Islington offered 3820 residents a social care service (including both service users and carers). All data given is 2014/15 unless otherwise stated.

Headline demographics are:

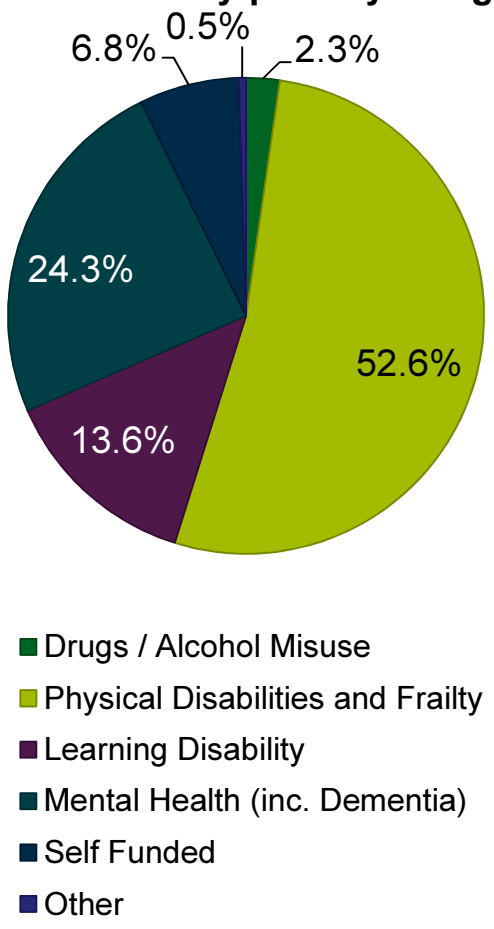
- 46% are male, 54% are female
- 44% are under 65, 23% are over 85.
- 31% are from BAME Groups.
- At least 51% of service users are single, separated, divorced or widowed.

The proportion of service users receiving a service to address a physical disability or frailty increases dramatically amongst the over 65s – however, it is the largest primary category for all service users aged over 40.

Islington has the highest diagnosis rate for Dementia in London and the 5th highest in England.

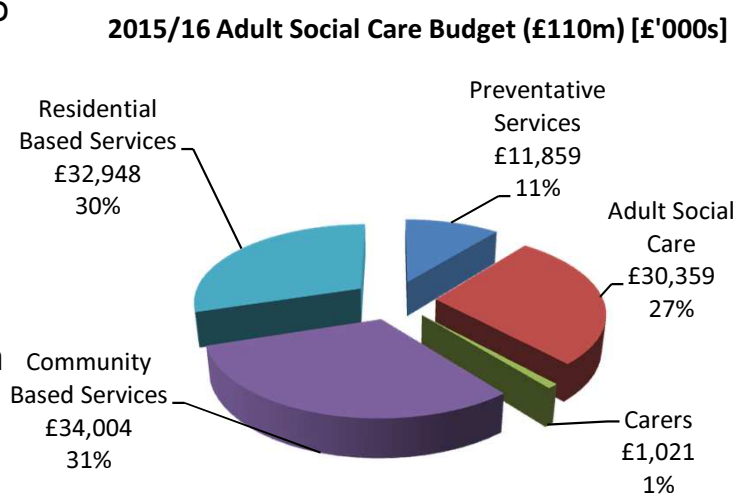
The numbers of adults with learning disabilities who require services is expected to increase as people transition from Children's Services.

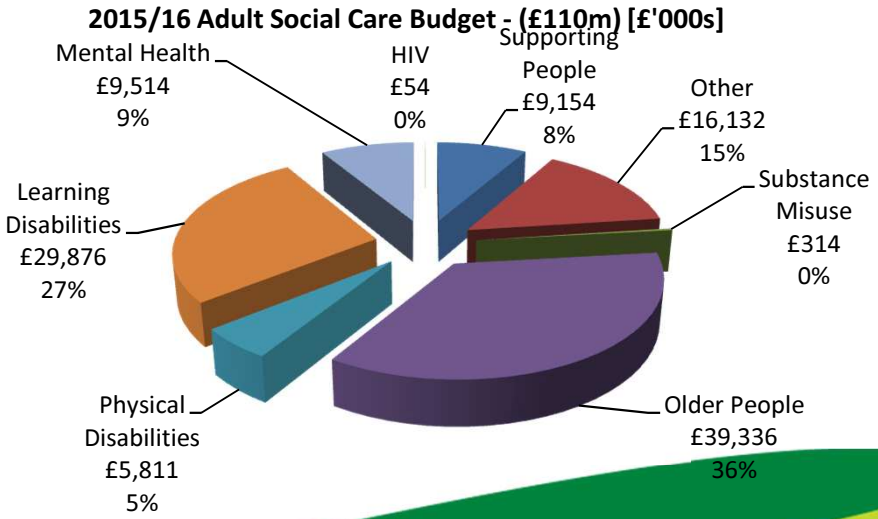
Service users by primary category



Adult Social Care Finances

- During the period 2011-2015 Islington Council has had to close a net budget gap of c£150m.
- Adult Social Care has contributed £31m to the £150m during this period.
- The department has made savings of £6.8m in 2014/15 and has plans in place to facilitate the delivery of £10.5m savings in 2015/16.
- Adult Social Services 2015/16 Gross Budget - £110m
  - 30% of the total budget is on residential and nursing care.
  - In 14/15 on average 702 people received this care – only 18% of those receiving an eligibility tested social care service
  - Very small proportion of the overall number of people receiving support from adult social care when preventative and community based services are also considered
- Estimated savings target of £20m approximately over the next 4 years.





Newly Integrated Adult Social Care Teams

- Streamlining access to social care and community health services.
- A social care and therapy ‘urgent response’ function – providing a same day response for new referrals.
- Established two multi-disciplinary locality teams aligned to Islington CCG’s four localities. The teams are fully integrated made up of health and social care professionals.
- Introduce a new role leading on delayed transfers of care to support and monitor hospital discharges.
- The principles of the new model are:
  - Person centred, coordinated care
  - Strength based assessments
  - Promoting independence
  - Flexibility
  - Maintaining continuity of care
  - Cutting out inefficiencies

Further Integration with Health

ISLINGTON

Ambulatory Emergency Care (AEC)

AEC provides a safe alternative and an improved experience for patients, who can receive the treatment they need in a fast and flexible way, rather than going into the hospital system.

Total attendance in AEC has risen from 750 in April 2014 to 1300 in July 2015 which has dramatically reduced the pressure on hospital emergency departments, significantly reduced the length of stay of patients in wards and freeing up capacity within the hospital. Total admissions to emergency departments actually decreased by 2.29%

Integrated Community Ageing Team (ICAT)

ICAT aims to; a) deliver person-centered, integrated care to residents of care homes, b) advocate for this vulnerable group and enable equality of access to existing community services and c) increase their time spent at home with better support and advanced care planning.

From May 2013 to July 2015 admissions to the Whittington from care homes dropped from 42 to 17.

Intermediate Care

A new model of care has been adopted that supported the delivery of community intermediate care and rehabilitation as port of an integrated service with social services, with co-located teams, a single point of access for referrals and advice and shared screening of referrals.

Successful pilots of integrating pharmacist and physiotherapist support into the re-ablement team have been completed and taken forward within the team.

Improved Mental Health Services

- A successful Primary Care Mental Health Service pilot in 2014/15 is being developed into full service from Camden and Islington NHS Foundation Trust (C&I) across the whole Borough. The pilot ran with five GP practices and will be rolled out to all other practices over the coming 12 months.
  - Service user feedback has been overwhelmingly positive and the service provides patients with an opportunity to access expert mental health care close to home. This offers a unique opportunity to engage with people who traditionally find it difficult to access services or are uncertain about accepting support.
  - Teams of mental health consultants, nurses and psychologists will work alongside GPs and other primary care professionals – often within individual practices.
  - The development of this project has been strongly tied into the development of integrated health and social care teams in primary care more generally as part of the Islington Integrated Care Pioneer Programme.
  - The pilot has produced a 68% reduction in secondary care referrals and a 26% reduction in Occupied Bed Days (OBD) in mental health acute wards.

- Work has also begun at developing an Integrated Practice Unit (due to start next April) – to improve the physical and mental health of people with psychosis in the borough.
  - Co-produced, value-based outcomes have been developed in order to create parity of esteem for people living with psychosis and physical health problems.
  - 20% of the funding will be outcomes based.
  - 3504 Islington residents will benefit from the new service.

Safeguarding

ISLINGTON

- The Care Act 2014 came into effect. New categories of abuse have been recognised in the Act: modern slavery, domestic violence and self-neglect.

- Deprivation of Liberty Safeguards applications surged. In spite of this, the Safeguarding Adults Team managed to turn around most applications within timescales.

- The Safeguarding Adults team delivered training to 1876 people (an 18% increase on the previous year).

Key statistics:

- 1165 alerts about possible adult abuse or neglect (no change on last year)

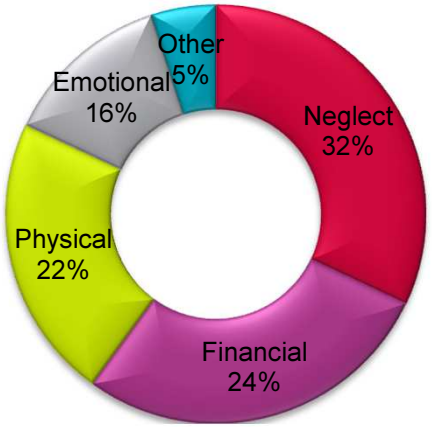
- 573 investigations about suspected adult abuse (an increase of 12% on last year)

- 1100% increase in deprivation of liberty safeguard applications

- In 98% of cases where we agreed abuse took place, we took action. In the remaining 2% of cases, we did not take action because the adult did not want us to do anything.

- Our actions either removed or reduced the risk of harm in 97% of cases

Safeguarding Alerts by type



Making it Real

ISLINGTON

The Making It Real programme has led on embedding co-production into the delivery of social care in Islington and developing more personalised services. The programme is due to come to an end in March 2016 having already successfully delivered the following outcomes:

- Developed the skills and confidence of a diverse range of Experts by Experience who are increasingly lead on the delivery of the programme
- Embedded personalisation and co-production across our frontline services.
- Helped introduce a new strengths-based approach to assessment
- Co-produced engaging personalisation training programmes for staff that are co-facilitated by Experts by Experience and council officers and supported the Islington Personal Budgets Network to deliver peer support and training events to over 400 people
- Made direct payments easier to manage by providing people with pre-paid cards
- Trained staff in plain English and introduced a new online service directory that improves staff and the public's access to information about local care and support services
- Established a new forum to learn from complaints, compliments and suggestions based on principles of co-production
- Developed a simple Personal Assistant register for direct payments employers and self-funders

Challenges for 15/16

The challenge will be continuing to improve outcomes for residents in Islington who use adult social care in the context of a very difficult financial position. This involves:

- Delivering savings that have as low an impact on the quality of services delivered as possible, in line with the Council's budget plans.
- Continuing to develop joined-up health, care and support services with NHS partners, including the CCG, Whittington Health and Camden and Islington NHS Trust
- Ensuring that family carers are supported to continue in their caring role where they choose to do so, as well as improving outcomes for family carers in Islington.
- Working with providers to develop a market of care in Islington that is best suited to the needs of our residents.
- Enabling people to stay as well and independent in the community as possible, through the development and promotion of prevention services that are open to all.

ISLINGTON

ANDOVER ESTATE

November 2015

UPDATE REPORT ON THE DAMPNESS / CONDENSATION WORKS PILOT WORKS.

Recommendations on the way forward to the rest of the similar type units

Figure 1Balconies above bedroom and hallway and pitched roof above the living room to the ground floor flat entrance. Elevation of a typical four storey block with individual garages behind.

1 ANDOVER ESTATE

The pilot works concentrated on some of the ground floor units to Todds Walk which are considered the worst effected flat units, being those with condensation and dampness within the ground floor units to the four storey blocks which have individual garages. The pilot works were completed in December 2014.

These one bedroom units particularly suffer because:

a) The garages are unheated, they have poor levels of insulation and the wall dividing them with the flat behind is a solid masonry wall. Condensation occurs to the various flat cupboard walls and bathroom adjacent to the garages.

b) Windows are only located to only one elevation of these units resulting in the absence of cross flow of ventilation from front to back.

c) Mechanical ventilation ducts to the internal bathroom originally discharged through the rear garage and are inefficient, ineffective mainly caused by the inordinately long route that the ducts cover.

d) Condensation and its effects occurs to and is most prevalent underneath the front first floor flat balcony roof and double pitched roof areas to the habitable bedroom, living room and hallway of these flats. This is where cold bridging is noticeable and where insulation was found to be minimal. In many instances the external balcony insulation has either decayed, broken down or it has been removed and where it is present, it does not cover the full balcony surface area.

e) Various building external defects that require addressing to the masonry, roof coverings, gutters, pointing, flashings and finished external ground levels compromising the Damp Proof Course.

Figure 2 Typical four storey block- with individual garages at ground floor level. These back directly onto the ground floor one bedroom flat units.

2 UPDATE REVIEW OF THE PILOT WORKS

The “Pilot” phase was carried out to attempt to resolve the known condensation and dampness problems and also uncover and identify and highlight any other problems or areas that could be developed further, improved upon and subsequently resolved. A period of monitoring would take place and changes ascertained that needed to be implemented. Therefore following on from the initial pilot works we have re- looked at various areas and matters that we will be doing differently now and report on our findings to date. It was recognised at the review stage that the pilot did not go far enough.

Most of the pilot flats have been re-visited during the interim at some stage which has assisted in helping us to compile this report. We have also had the experience of working with our voids team on an empty property at number 2, Todds Walk. The existing defects period for our pilot scheme ends in December and it is our intention

to re- visit all flat units when this expires with the contractor to check further on the works completed and also pick up any defects found.

We have re-assessed and re-evaluated the areas of risk, the processes, the design, and the various products, with a view to achieve the best solutions for the benefit of any proposed future works. Furthermore we have also identified issues with the existing heating and cold water supply systems which are now proposed to be renewed.

We are not aware of instances of mould growth that has re-occurred to areas that were insulated but we now recognise that we did nod not go far enough

In one instance mould growth had returned within the living room to a wall area where we had not insulated in-spite of them being cavity walls and insulation provided between the cavity walls in recent years to this same wall.

This is then complicated by the fact that the living room door was not present, the bedroom and more importantly the bathroom doors did not close fully. The bathroom mechanical fan was also switched off. There was not mould growth present to any of the other rooms of this flat

It is clear that the pilot has given us a greater understanding of the various issues involved.

a) The council have a delivery plan to address these issues correctly starting with the External and communal cyclical repair works which will pick up on the considerable areas of external repairs, defects and improvements necessary to the fabric of the building. These include defects to the main roof, balcony roof coverings all to be renewed, lower roof slopes Roof works: renewal of type of felt and battens, expansion joints, windows, doors, rainwater pipes, gutters, overflows, above ground drainage, concrete/ masonry cracks/ repairs, re-pointing, re-rendering. These elements will be fully tackled importantly first to prevent dampness to the structure which could contribute to and exacerbate any condensation issues.

b) The proposed Decent Home Bathrooms, WCs, and kitchens that were missed from last time, works programme is to be incorporated with the proposed condensation and dampness remedy works and thee are proposed to be completed together within each flat at the same time.

c) Further to this we are working co-operatively with our new build team and we are mindful of the various initial feasibility options being considered and the impact and consequences of how this will fit in with the above mentioned proposed measures and vice versa.

3 DESIGN CHANGES/ IMPROVEMENTS REQUIRED GOING FORWARD

We have now re-assessed what is considered necessary and completed the following pre works processes:

- External and internal surveys have been undertaken now to the whole building envelope to address various defects/weaknesses/ faults i.e. general repairs, masonry, defects, roofing defects, plumbing leaks,.

- We have thoroughly reviewed the design of the proposed condensation/dampness works to take into account all possible potential areas of cold bridging for the various types of properties together with LBI Building control and the leading trade suppliers/ manufacturers.

- The working drawings have been revised to meet the improved design amendments. The existing plans now show changes to meet with the revised specifications.

Thermal insulation:

Whilst there is now a noticeable change to the insulation levels within all the properties where works were carried out on the pilot, there are still various further measures required that are necessary to be undertaken to improve the building performance and living conditions within. Some areas to the walls are vulnerable with the potential for condensation and mould growth to migrate to those previously un-insulated areas.

Internally: to improve the thermal performance of the flat units, changes have been made to the insulation materials provided their specification and their fixing methods. The proposal in order to minimise resident disruption and timescale is now to use a universal system within each room and area within the flat rather than the various types used on the pilot. The insulation material will be fixed direct to backing surfaces without the use of battens which will save considerable time and cost.

The insulation will now be fitted to the garage side to the rear wall of the bathroom, bedroom and the kitchen. Some enforcement may be required where access to garages is not forthcoming.

All of the exposed external living room, bedroom and hallway wall surfaces will now be insulated as opposed to the partial wall works to just the drop down concrete beams as was carried out within the pilot and will also include insulation to windows and front entrance/garden door reveals.

Externally: Insulation will now be fitted to the sloping living room roof void from the outside in lieu of internally to the living room ceiling thus reducing resident disruption and disturbance to the internal 'Artex' finishes to ceilings which contain an element of asbestos. A further consequence of will be a reduced overall cost. The detail to the balcony skirting will be amended to also include insulation on all up-stands.

Ventilation:

Required to improve air circulation and remove excess moisture produced.

Internally: The Mechanical Ventilation to the kitchens and bathrooms has been reviewed and further changes have been made to the product, its mode of ducting and its route to improve performance. Having worked closely with the industry manufacturers we have now specified a mechanical fan that is a reasonable cost to supply and fix, runs 24 hours continuously in an extremely quite fashion and is cheap to run using minimal electricity.

Permanent ventilation is also to be provided to ventilate the garden doors which are not currently ventilated.

Externally::Additional air vents are to be provided to the lower level sloping roof voids.

Heating System:

We have since the pilot commissioned a report from our mechanical engineers which recommended that the heating system radiators and pipe work which are original and date back to the 1978 are overdue for replacement it was found to be in poor condition with some radiators showing signs of leaks.

The living room radiators are fed from buried 15mm copper pipework within the concrete floor screed to both the hallway and living room that has no corrosion/mechanical protection.

The proposed works to affected properties will require the removal of the radiators/pipework to allow the installation of thermal insulation of the walls to reduce heat loss, condensation and maintain a stable temperature within the property; it was recommended by our engineers that at this stage the heating system is replaced in its entirety and the new radiators are positioned on internal un-insulated walls where possible and with new surface run pipework.

The majority of the boilers in the ground floor properties were replaced around 2004-2006 with Ideal boilers which are now having performance problems. Although these are under 15 years old we have been advised to replace them at this stage as they are reaching near the end of their economical service life.

These works were not done to the pilot flats but are now being proposed for flats of this type going forward.

Water Storage Systems:

The hot and cold water Elson storage tanks are now over 30 years old, they have inadequate insulation and in most cases the lids are unsealed with open tops causing condensation within the compartment/property (the units do not comply with part L of the current Building Regulations).

The pipework within the cupboards containing the tanks is also un-insulated and there are signs of heavy condensation due to lack of insulation and defective ball valves. The recommendation received in a report from our mechanical engineers is to replace the Elson tanks with a fully insulated cylinder, an insulated plastic cold water storage tank at high level including controls and wiring upgrade. This was also not done to the pilot flats but is being proposed for flats of this type going forward.

4 FURTHER PROPOSALS FOR UPCOMING WORKS

Access for the external works, type and operations have been fully reviewed with scaffolding design, mode of operation and the cost valued engineered.

There has been recognition that any existing mould growth present within the flats including other rooms and cupboards that are not being worked on i.e. kitchens, this will need to be addressed straight away and fully removed and that these areas are treated from the outset.

Electrical/Carpentry works:

Plugs, switches, light fittings, doors frames, architraves, skirting's and window reveals/trims have all been taken into consideration as part of the design and will require altering. There is also a requirement to reduce some areas of the ground levels externally to the living room extension.

Timescale:

The programme together with phasing has been prepared to deliver the works earliest to the worst affected blocks first with this order being kept as we move around the estate. We are also endeavouring to reduce to the minimum the overall timescale of works taken to complete the works within each type of flat. The areas to be worked on and detailing have increased significantly particularly in relation to the insulation, carpentry decoration and heating/water services works which will increase the timescale.

Delivery:

It needs to be clearly explained to the residents that high levels of labour will be working within their flats at a simultaneous and considerable disruption to the residents. Equally the contractor needs to provide sufficient technically skilled labour resources, manage the scheme well from start to finish and be flexible and responsive in approach in view of varying residential requirements. The resident liaison team was very good on the pilot and a similar standard will be required going forward.

Welfare: The client and contractor are to make further provision for protection, providing storage and the security of resident's goods/furniture and safely moving these items particularly where they are excessive or bulky. Working in occupation is

very difficult; we may need to ensure residents have a room free at all times for the contractors to work in thus working on a single room at a time to various flat together before sequencing with another room afterwards in the same fashion. Cardboard storage boxes were provided on the pilot and this aspect worked well and the practice continued on the rest of the scheme. We did not put furniture into storage which we may have to in some cases now.

Resident profiling:

The importance of early resident profiling and pre-surveys of residents' needs and requirements in advanced will speed up the future works particularly if residents have any Occupational Therapy (OT) or environmental requirements i.e. adapted bathrooms or special needs. The good news is that the OT preliminary identification process for the estate has already taken place as part of our surveys. There is a need to ensure that all properties with multiple occupancy are highlighted as there is generally more furniture in these. Environmental matters and response times to dealing with these matters are also going to be addressed in advance of works.

Respite: The use of alternative temporary respite facilities for some residents during the daytime is still considered desirable for the success of the scheme and at present this remains currently unresolved although various options are being considered. a number of properties on the estate have elderly residents, babies and young children. It was mentioned in the pilot review that works ideally in certain circumstances should not take place after 4:00 pm to allow for a good daily clean and for children returning home from school.

Consultation:

The processes have been reviewed and the plan is to keep all residents and interested parties regularly updated and informed by various measures throughout the scheme.

Cost:

The intention is for the Term Contractor to manage the contract with the works being let out to a specialist contractor under a competitive tendered basis cost per unit will be higher than pilot due to the increased level of works.

Scaffold:

The scaffold access design method has been re-evaluated to reduce cost and prevent un-necessary delay.

Risk:

We have undertaken a risk analysis for both risk avoidance and management including for contingencies and are currently in the process of compiling a risk register.

5 CONCLUSION

Following on from the Pilot we have re-visited flats, consulted further and importantly listened to our residents and their representatives including Councillors, contractors, industry experts, specialist, manufacturers, suppliers, Building Control Officers, internal departments including the new build team, our day to day repairs contractor, Health and Safety officers and other interested parties.

The cyclical works will deal with properties which are suffering with condensation being indirectly contributed to from various external repair sources and defects leading to leaks and damp penetration which would undoubtedly contribute significantly to the condensation problems within the properties.

The levels of moisture content in the air within the flats will reduce significantly with the proposed improved mechanical and passive ventilation provision.

The heating system is being renewed which will make the flats more economical to heat and much warmer.

Improvements to the thermal performance of the building enclosure will eradicate cold bridging and also reduce the amount of heat loss to the outside which will in turn help maintain the internal surface temperature. However it should be acknowledged that we are working to the constraints of an existing building design/building materials used, and this will not perform to the higher standards and requirements of a new build. We are governed by restrictions on ceiling heights, door thresholds and exposed concrete balconies.

Education on how to avoid condensation should be provided to residents Lifestyle is a major consideration and factor in the success of the scheme. The remedying of external defects, additional provision of thermal insulated exposed walls and ceilings, improved heating, mechanical/passive ventilation and water storage coupled with the previously installed double glazing and cavity wall insulation will not solve condensation problems if the flat units are not heated and ventilated in a reasonable manner. Sound household management is considered paramount. Fuel poverty remains a concern if the heating provision is not used. Any overcrowding of units could also tilt the balance.

To assist in this area the Council is in the process of producing new advisory advice in the form of a leaflet on this whole area. Further to this the residents should be advised on how to best operate and manage the heating and ventilation within their flat units.

We see that the whole package of measures proposed is massive opportunity to improve the current living conditions of the residents and make a difference to welfare. We would be strongly relying on the performance of a reliable contractor to deliver the scheme

Jim Matthews,

Senior Project Manager/Surveyor
November 2015.

HEALTH SCRUTINY COMMITTEE
WORK PROGRAMME 2015/16

19 MAY 2015

1. Membership, Terms of Reference and Dates of Meetings
2. Work Programme 2015/16 and prioritisation of scrutiny topics
3. 11/Out of Hours service specification
4. Islington CCG Annual report
5. Scrutiny Review – Patient Feedback – Draft recommendations
6. Health and Wellbeing Board - update

02 JULY 2015

1. Drug and alcohol misuse – Annual Update
2. Camden and Islington Mental Health Trust Quality Account
3. Whittington Hospital defecit
4. Islington Healthwatch Annual Report
5. Scrutiny Review – Health Implications of Damp Properties – Approval of SID
6. Work Programme 2015/16
7. Health and Wellbeing Board – update

14 SEPTEMBER 2015

1. NHS Trust – Whittington Hospital – Performance update
2. Scrutiny Review – Health Implications of Damp Properties - Presentation
3. 111/Out of Hours service
4. Work Programme 2015/16
5. Hospital Discharges
6. Health and Wellbeing Board – update

19 OCTOBER 2015

1. London Ambulance Service – Performance update
2. Scrutiny Review – witness evidence
3. Annual Adults Safeguarding report
4. Work Programme 2015/16
5. Procurement of GP premises
6. Health and Wellbeing Board - update

23 NOVEMBER 2015

1. Scrutiny Review – Health Implications of Damp Properties - witness evidence
2. Work Programme 2015/16
3. Presentation Executive Member Health and Wellbeing
4. 111/Out of Hours service – Draft service specification and consultation responses
5. Healthwatch Work Programme
6. Health and Wellbeing update
7. Update Margaret Pyke centre
8. Value Based Commissioning

07 JANUARY 2016

1. NHS Trust – UCLH – Performance update
2. Scrutiny Review – witness evidence
3. Work Programme 2015/16
4. Health and Wellbeing Board - update

08 FEBRUARY 2016

1. Child Protection in Islington – Annual Update
2. Scrutiny Review – Draft recommendations
3. NHS Trust – Moorfields – Performance update
4. Work Programme 2015/16
5. Health and Wellbeing Board - update

11 APRIL 2016

1. Scrutiny Review – Final report
2. Scrutiny Review – GP Appointments – 12 month report back
3. Work Programme 2015/16
4. Health and Wellbeing Board – update

16 MAY 2016

To be determined

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