Public Document Pack

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, **11 April 2016 at 7.30 pm.**

John Lynch
Head of Democratic Services

Enquiries to : Peter Moore
Tel : 020 7527 3252
E-mail : democracy@islington.gov.uk
Despatched : 1 April 2016

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

A.	**Formal Matters**	**Page**
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.	Order of business	
6.	Confirmation of minutes of the previous meeting	1 - 6

7.	Chair's Report The Chair will update the Committee on recent events.	
8.	Public Questions	
9.	Health and Wellbeing Board Update - verbal	
B.	**Items for Decision/Discussion**	**Page**
10.	Health Implications of Damp Properties Scrutiny review - witness evidence - verbal	
11.	Joint Strategic Needs Assessment	7 - 30
12.	Department of Health Consultation - Community Pharmacy in 2016/17 and Beyond	31 - 34
13.	Work Programme 2016/17	35 - 38

The next meeting of the Health and Care Scrutiny Committee will be on 16 May 2016

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

www.democracy.islington.gov.uk

This page is intentionally left blank

London Borough of Islington

Health and Care Scrutiny Committee - Monday, 7 March 2016

Minutes of the meeting of the Health and Care Scrutiny Committee held at on Monday, 7 March 2016 at 7.30 pm.

Present:	**Councillors:**	Klute (Chair), Andrews, Heather, Turan, Ismail, Nicholls and O'Halloran
Also Present:	**Councillors**	O'Sullivan and Kaseki
	Co-opted Member	Bob Dowd, Islington Healthwatch

Councillor Martin Klute in the Chair

183 **INTRODUCTIONS (ITEM NO. 1)**
The Chair and Members introduced themselves to the meeting

184 **APOLOGIES FOR ABSENCE (ITEM NO. 2)**
The Committee noted the apologies of Councillor Janet Burgess, Executive Member Heatth and Well Being who was unable to attend to present her update on the Health and Well Being Board.

185 **DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. 3)**
None

186 **DECLARATIONS OF INTEREST (ITEM NO. 4)**
None

187 **ORDER OF BUSINESS (ITEM NO. 5)**
The Chair stated that the order of business would be as per the agenda

188 **CONFIRMATION OF MINUTES OF THE PREVIOUS MEETING (ITEM NO. 6)**
RESOLVED:
That the minutes of the meeting of the Committee held on 18 January 2016 be confirmed and the Chair be authorised to sign them

189 **CHAIR'S REPORT (ITEM NO. 7)**
The Chair stated that he had attended the departure event for Dr.Gillian Greenhough, who is being replaced on the CCG by Dr.Jo Sauvage

190 **PUBLIC QUESTIONS (ITEM NO. 8)**
The Chair outlined the procedures for Public questions and filming and recording at meetings

191 **HEALTH AND WELLBEING BOARD UPDATE (ITEM NO. 9)**
No update was presented due to the absence of Councillor Burgess

192 **SCRUTINY REVIEW HEALTH IMPLICATIONS OF DAMP PROPERTIES WITNESS EVIDENCE (ITEM NO. 10)**
The Chair introduced residents of Alderwick Court, who were present to give evidence in relation to this item.

Ellis Turner, Environmental Health Officer from Environment and Regeneration Department.

The Committee were informed that Partners had been expected to be present but had not attended but that they would be invited to a future meeting. It was noted that Hyde Housing Association would also be attending a future meeting.

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

- Residents stated that there had been a number of health problems, especially in children as a result of the damp conditions at Alderwick Court suffering from asthma, bronchitis and other associated health problems. This also affected their attendance at school
- Hyde Housing Assocaition had told residents that where there is evidence of mould tenants should scrub their walls with bleach, however this is not acceptable or dealing with the fundamental problem of the dampness
- Residents felt that there were a number of problems with the block, which it is felt was not built to accommodate central heating etc. which included dampness in bedrooms, front rooms and in one case black mould spores had been found on a mattress in a child's room
- Adult residents also suffered medical problems from the dampness and these included abdominal problems and also the mental wellbeing of the residents concerned some of whom suffered from depression caused by their living conditions
- Residents also complained of no thermostat to control their central heating and that despite repeated requests Partners had still not rectified this
- Residents felt that there were a number of problems with the block including cold bridging, lack of ventilation, rising damp, and lack of insulation
- It was stated that an independent survey that had been undertaken in one of the residents flats and this had shown that 71% of the flat had dampness whereas the maximum should be 31%
- Reference was made to the fact that the Committee would be interested to see evidence of dampness having an effect on health. The Committee requested that ant of the evidence referred to by residents concerning a letter from UCLH, the evidence referred to relating to health studies in the USA and the evidence referred to by Environment and Regeneration should be circulated to Members
- Members were informed that this is not a problem confined to private sector or Housing Association properties and that a number of Council estates had dampness problems, particularly the Andover and Girdlestone Estates where the Council is intending to take remedial action
- Reference was also made to the fact that a recent project had been undertaken at Holly Park Estate to put in insulation and this report had been submitted to a previous meeting of the Committee
- Environment and Regeneration stated that they did have powers to enforce on Housing Associations remedial works and that dampness can be caused by a variety of reasons such as condensation, rising damp, defective rainwater goods, cold bridging, lack of thermal insulation, inadequate heating, lack of ventilation and poorly designed buildings
- It was also stated that Council officers were also working in a multi-disciplinary way with Health and Social Care and the Whittington and on a child, health and wellbeing strategy including more preventative work, grants and street surveys. Environmental Health also worked closely with the Energy Team and 2018 will see the introduction of new energy efficiency regulations and that this needed to be recognised and to force landlords to comply

- The view was expressed that dampness tended to aggravate existing conditions and that the Council had offered training to Housing Associations but this tended to happen when there had been non-compliance
- Members stated that the Council no longer accepted the advice that dampness is often related to lifestyle choices by residents but that the reasons for the dampness were now being focused on
- In response to a question Members were informed that there were better working relationships between departments than previously

RESOLVED:
That the information requested above in relation to evidence of links between health conditions and dampness be circulated to Members

The Chair thanked residents of Alderwick Court, and Ellis Turner for attending

193 **MOORFIELDS PERFORMANCE UPDATE (ITEM NO. 11)**

Ian Tombleson, Director of Corporate Governance and Tracy Luckett, Director of Nursing and Allied Health Professions, Moorfields NHS Trust were present and made a presentation to the Committee, copy interleaved.

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

- It was noted that there will be a CQC inspection at Moorfields on 02 May
- There had been more patient attendances than ever before in A&E and the Trust had achieved 97% being seen within 4 hours against the 95% target
- There had been no cases of MRSA or C difficile
- Results continue to be good with regards to the Friends and Family test with results consistently above 95%
- The Moorfields way, a cultural change project incorporating patient focus groups has been introduced
- Results of the staff survey were good except in the areas of bullying and harassment and this is being addressed by the Moorfields way approach and Moorfields is rated as one of the top 10 best places to work in healthcare, and one of only two hospitals to feature in the top 10
- Two new satellite stations have been established in 2015, one for Merton residents and the ocular oncology service, previously managed by Barts Health was taken over by Moorfields from 29 June 2015 and there had been a great improvement in the service
- Moorfields are likely to post a £2m underlying surplus against a £2m plan a similar figure to the previous year despite lower tariffs and tougher efficiency programmes
- Monitor risks ratings expected to remain strong at year end
- There is a new centre of excellence with an Institute of Opthalmology planned to create unique, state of the art, integrated ophthalmic treatment, research and education centre in Kings Cross/Euston area and Members requested that they be kept informed of developments in this regard on the preferred site of St.Pancras hospital
- In response to a question it was stated that the increase in the number of attendances at A&E had presented a number of challenges one of which is that some of the people attending did not really need to attend A&E and could have gone to see their GP. Work was going on with the CCG as to how GP's could work more effectively with Moorfields to limit attendance at A&E. In addition Moorfields were looking at different ways of triaging patients and managing patient flow
- Moorfields were looking to move towards 7 days a week working and staffing levels had increased

- In response to a question it was stated that when necessary referrals to other institutions such as UCLH and Queens Square were made

RESOLVED:
That Members be kept updated by Moorfields on developments with the proposed relocation to the St.Pancras hospital site

194 **WHITTINGTON HOSPITAL ESTATES STRATEGY UPDATE (ITEM NO. 12)**

Simon Pleydell, Chief Executive Whittington Hospital NHS Trust, was present and outlined the Whittington Estates strategy for the Committee.

During consideration of the report the following main matters were raised –

- Members were informed that Whittington were trying to develop a strategy in partnership with the Mental Health Trust, other partners and the Council
- The Trust were endeavouring to a number of packages for development to deliver an integrated care strategy and that it is felt that this could be achieved by working from 8 hubs, from the 38 sites at present, which would be facilitated by improved IT. This would enable income to be generated to improve services and the estate that remained. It is hoped that proposals could be developed within the next 9/12 months
- It was stated that a number of NHS and partner organisations were looking to source capital from the private sector given the lack of funding available from Central Government, but this would not be a re-run of the problems caused by PPI and there would be no transfer of risk or liability
- In response to a question it was stated that there were no firm views at present on whether sites should be owned or leased and this would depend on the best use of maximising funding and resources of the estates
- A Member enquired whether there were proposals for a private patient hospital facility on the Whittington site and it was stated that there is vacant land on the site however no proposals would be put forward that did not benefit share with partners, the NHS and patients
- In response to a question about future consultation on proposals it was stated that the Trust were looking to develop a series of packages that could be consulted upon and there would be specific consultations around these and staff engagement
- The Trust stated that some of the facilities and accommodation for staff were not suitable at present and these needed to be improved
- A Member enquired as to progress with the new maternity wing at the Whittington and it was stated that NHS budget is around £25billion overspent and therefore there is no capital funding available. This is of concern to the Trust given safety concerns and it is looking to develop sources of funding within the Estates strategy
- Discussion took place around the future of the Northern Hospital and it was stated that if there are covenants on any of the premises to be disposed of this would need to be taken into consideration, however the Northern is not an ideal site for delivering services both in terms of staff and patients
- Members were informed that the Trust were determined to present proposals that would demonstrate benefits to the community and that it is important to be able to react to the changing working practices of staff such as District Nurses
- In response to a question as to the future of the Finsbury Health Centre it was stated that work would be undertaken with partners in respect of all sites to determine the best way forward and collaborative work would be undertaken

RESOLVED:
That the report be noted and Members be kept updated on any developments

The Chair thanked Simon Pleydell for attending

195 **GP APPOINTMENTS SCRUTINY REVIEW - 12 MONTH REPORT BACK (ITEM NO. 13)**

Alison Blair and Clare Henderson, Islington CCG, were present for discussion of this report and during consideration the following main matters were raised -

- The Chair stated that he was concerned that the report on progress had not actioned a number of the recommendations made by the Committee and that he had raised this with the Executive Member Health and Well Being who had stated that these would be addressed
- Islington CCG stated that in relation to the recommendation on establishing voluntary performance bench marks across the borough for provision of appointments that the CCG would raise this through the recently established Federation of GP's that has just been established once it becomes fully developed and through other methods of communication
- In relation to the patient management plans and allocation of a named GP recommendation, the CCG stated that the issue of care placements had been addressed, however this did not include children and this needed to be looked at. In relation to regular repeat appointments this issue still needed to be addressed
- The Chair referred to the recommendation on training for reception staff and it was stated that skills training did take place and whilst there were excellent reception staff expertise and good practice should be shared and that this was an issue that the CCG should raise with the Federation to achieve a more consistent approach
- In response to a question it was stated that publicity leaflets had been printed for GP surgeries in relation to the new Islington I hub service, where if there were no appointments at your own GP surgery an appointment could be made at the I hub
- In response to a question it was stated that the I hub had had a 'soft' launch in October and the ways of working were still being developed and as this is a pilot there will need to be an assessment of the data and success of the service to ascertain whether it will continue to be funded
- In response to a question it was stated that each GP practice had a patient group and feedback is obtained through these, Healthwatch and the Families and Friends Test. The CCG expressed the view that there is an expectation that any significant changes within a practice will be communicated to patients and it is hoped that if this is not happening the creation of the Federation will start to address some of these issues, however the CCG would be willing to investigate if notified where there were problems
- The Chair stated that he had had difficulty in accessing the most recent patient surveys on the website and the CCG stated that they would investigate this on the NHS England website

RESOLVED:

That the CCG take up the issues raised above and report back to the Committee at a future date

The Chair thanked Alison Blair and Clare Henderson for attending

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

RESOLVED:

That the work programme 2015/16 be noted

MEETING CLOSED AT 10.10p.m.

Chair

MEETING:	Islington Health Scrutiny
DATE:	7th March 2016
TITLE:	Update on Islington's Joint strategic needs assessment (JSNA)
LEAD DIRECTOR:	Julie Billett, Director of Public Health
AUTHOR:	Mahnaz Shaukat, Head of Health Intelligence
CONTACT DETAILS:	Mahnaz.Shaukat@islington.gov.uk Tel: 0207 527 3860

SUMMARY:

Joint Strategic Needs Assessments (JSNAs) are local assessments of current and future health and care needs, and should be produced through a continuous process of strategic assessment and planning. Their outputs, in the form of evidence and the analysis of needs, should be used to help determine what actions local authorities, the local NHS and other partners need to take to improve the health and wellbeing of the local population and reduce inequalities.

Local authorities and Clinical Commissioning Groups share an equal and explicit duty, through their local Health and Wellbeing Board, to prepare Joint Strategic Needs Assessments (JSNAs). Local areas are free to undertake JSNAs in a way best suited to their local circumstances – there is no template or format that must be used and no mandatory datasets to be included. The guidance makes it clear that the JSNA should be seen as an evolving process of understanding local needs and informing priorities, rather than a document to be produced at a single point in time.

Islington's JSNA consists of a series of factsheets that are hosted on the Islington evidence hub (see: http://evidencehub.islington.gov/Pages/HomePage.aspx). In 2015 all factsheets on the evidence hub were reviewed and updated and a high level executive summary of the JSNA, supported by more in-depth profiles and analysis, was produced. This executive summary, which is appended to this report, draws together the key messages from the intelligence gathered to date.

Going forwards, the JSNA will be updated on a rolling cycle, to ensure all factsheets are updated at least every three years, or sooner if one or more of the following triggers is met:-

- Significant policy change occurs in a particular area/topic, either nationally or locally, requiring a new needs assessment;
- Significant new intelligence and evidence, including data, emerges that requires consideration of more or different intervention(s);
- Significant service developments are proposed or implemented.

RECOMMENDED ACTION:

The Health Scrutiny Committee is asked to:

- *Note and comment on Islington's JSNA executive summary and the process for its future development.*

This page is intentionally left blank

ISLINGTON

Joint Strategic Needs Assessment 2015/16

EXECUTIVE SUMMARY

September 2015

Table of contents

1.0 Islington's JSNA

A Joint Strategic Needs Assessment (JSNA) is a way local authorities, the NHS and other public sector partners work together to understand the current and future health and wellbeing needs of the local population and to identify future priorities. Local authorities and Clinical Commissioning Groups have an equal and explicit duty to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), through Health and Wellbeing Boards.

The JSNA is not just about health and personal social care services - it is also about the wider aspects of health and wellbeing including poverty, employment, education, housing and the environment. The purpose of the JSNA is to use the information gathered to identify local priorities and support commissioning of services and interventions that are based on need. This helps us achieve better health and wellbeing outcomes and reduce health inequalities in Islington.

JSNAs are a continuous process of strategic assessment and planning. Their outputs, in the form of evidence and the analysis of needs, should be used to help determine what actions local authorities, the local NHS and other partners need to take to improve the wellbeing of the local population and reduce inequalities.Islington's JSNA is a 'live' web-based resource, in the form of the Evidence Hub. In 2014 all the JSNA factsheets on the Evidence Hub were updated. This year's executive summary present's highlights from three key areas that have been updated this year, reflecting the HWBB priority areas; Children's health, mental health and the impacts of employment and health. The summary also includes the recurrent issues from 2014.

2.0 Islington's population

The population of Islington is living longer, growing and constantly changing. Women in Islington, in line with national picture, live longer than men. Life expectancy at birth for men in Islington is now 78.2 years, an increase of 4.8 years over the past decade (2011-13). However **life expectancy for men in Islington remains lower than England (79.4)** and is one of the lowest amongst all London boroughs. **For women in Islington life expectancy is 83.4 years and is similar to England (83.1).**

According to the latest estimates from the Greater London Authority about **224,600 people are living in the borough of Islington** (2015). Since the 2011 census, the population has increased by approximately 18,000 people (9%) and is predicted to rise to around 246,500 people by 2025.

The number of people moving in and out of the borough is also high. In 2014, an estimated 20,650 people moved into the borough and 21,640 moved out – about 10% of the population. Movement is particularly high in those aged 16-24 years old. Constant population churn impacts on the type of services that are provided and the way in which services are provided e.g. cervical screening or educational attainment if children and young families enter the borough and start school mid-way through an academic year.

Recent years have seen a small decrease in the number of births in Islington, and there are now **about 2,900 births a year**. The general fertility rate reflects this, as the 46 births per 1,000 women in Islington is lower than London (58 births per 1,000 women aged 15-44) and less than

the national average rate (62 per 1,000). However, over the next few years the birth rate is projected to slowly increase, reaching 3,150 births a year by 2020.

In terms of age, Islington's population is relatively young. In absolute numbers the largest age group are people aged between 20 and 39 years. This presents a significant opportunity for prevention of ill health as people under 40 are unlikely to have developed conditions that are the most significant contributors to death and disability in Islington. Though older people make up a relatively small proportion of Islington's population, in the next 10 years there is projected to be a 25% increase in those aged 80 years and older and a 20% increase in those aged 65 years and older. The percentage increase of children and young people in the borough is also predicted to significantly increase, especially in those aged 11-15 years old, which has implications for education and children's services.

Table 1: Islington estimated population by age and projected numbers, 2015 – 2025

Age group	2014	2024	Change (2014 to 2024)	% Change (2014 to 2024)
0-3	10,800	11,300	500	5%
4-10	16,000	17,900	1,900	12%
11-15	9,100	12,000	2,900	32%
16-19	8,900	10,100	1,200	13%
20-39	101,800	102,200	400	0%
40-64	58,000	68,800	10,800	19%
65-79	14,700	17,700	3,000	20%
80+	5,100	6,400	1,300	25%
Total	224,400	246,400	22,000	10%

Note: Numbers may not add up due to rounding
Source: © GLA 2014 Capped Population Projections – SHLAA

Islington's population is increasingly ethnically diverse. In 2001, 57% of Islington residents described themselves as White British. **In the 2011 Census, this had reduced to 48% describing themselves as White British,** with particularly high proportions of Turkish, Irish and Black African and Black Caribbean populations resident in Islington. Ethnicity also varies considerably by age in Islington. The younger population is more diverse compared to the older population, with **almost half of those aged under 25 from a black minority ethnic (BME) background** (45%) compared to one-in-five (20%) of the population aged 65 years and over.

This changing demographic picture has important implications for local health services since there are higher rates of some long term conditions in some BME communities; for example of heart disease and stroke, or of diagnosis of serious mental illness. Additionally, some behavioural risks, such as smoking, are more common in particular BME groups. These factors are often linked to significant socio-economic disadvantage and social exclusion.

In the 2011 census, there were 16,300 carers in Islington. Carers are themselves at significantly greater risk of both physical and mental ill health than the general population. With the ageing of the local population, together with increasing levels of long term conditions contributing to a relatively high level of disability in Islington, it can be expected that the number of carers in the borough will also increase.

What does this mean for Islington?
▪ The aging of the population in Islington over the next 10 years will lead to a growing number of people living with long-term conditions, indicating an increasing need for health and care services to identify and manage these long term conditions earlier and more effectively. It can also be expected that there will be an increase in the number of people living with multiple long term conditions.
▪ The increase in the older adult population will mean an increasing number of people with dementia, and with the increase in the over 80s, an increasing number of whom will also be physically frail.
▪ Work with local communities/specific population groups to improve understanding about how to improve the accessibility and reach of services.
▪ Raise awareness of the needs of carers and improve access to support and training for carers.
▪ Ensure that the commissioning and provision of services are culturally sensitive and provide equity of access responsive to a changing population with differing health needs.

3.0 Social, economic and environmental determinants

Many factors combine to affect the health of individuals and communities. Whether people are healthy or not is determined by a mix of genetic factors, their circumstances and environment, their lifestyle choices and their access and use of health services and other services that influence health (e.g. lifestyle change services, social care services). In the long term it is our circumstances and environment (which include factors such as how safe we feel in the environment in which we live, the physical condition of our housing as well as availability, job security, income and education levels) that have the strongest impact on health outcomes.

The Islington Employment Commission INSERT comments that last year's executive summary highlighted the impacts of all wider determinants on health and wellbeing. This year we have particularly focussed on employment and health.

3.1 Housing

The availability and quality of housing (e.g. accommodation that may be cold, damp or overcrowded) impacts on both physical and mental wellbeing. Homes in poor physical condition can put occupants' health and safety at risk, especially when they are children, older, ill or disabled people. In Islington, private rented homes are more likely to fall below the Decent Homes Standard and are less energy efficient than affordable homes. Living in overcrowded situations can also adversely affect health and wellbeing, particularly for children. As of May 2013 there were 5,089 households on Islington's housing register living in overcrowded housing (Islington Housing Strategy 2014-19).

The uncertainty that goes with living in temporary accommodation can have a negative impact on health and wellbeing. In Islington high house prices and private rents mean securing affordable housing is a key challenge for many households. The number of households placed in temporary accommodation has remained largely unchanged since 2007/08.

Islington has made greater use of the private rented sector in an environment of high house prices and where demand for social housing exceeds supply. In Islington, private rent is 40% of the average income; the fourth highest rent to income ratio in London. The combination of changes in benefits entitlements and rising private rents could result in many households being priced out of the rental sector. Key groups affected by these changes include those from low income households renting privately, and elderly or disabled households.

However, private rented homes are more likely to fall below Decent Homes Standard, and are less energy efficient than affordable homes. Work is also ongoing to increase the professionalism of landlords, encouraging them to improve the condition of their properties, particularly for vulnerable tenants, through the landlord accreditation scheme. Various teams in Islington provide advice and support to households who are renting privately, including assisting where tenants are experiencing harassment, illegally evicted, or in sustaining private rented tenancies.

3.2 Education

A good education is strongly associated with better health outcomes including life expectancy. Overall educational attainment at key stages for children going to Islington schools is improving and achievement was above the national average in 2013/14.

- 82% achieving level 4+ in Reading, Writing and Maths at Key Stage 2, compared to 79% nationally.
- 59.9% achieving 5+ A*-Cs including English and Maths at Key Stage 4, compared to 53.4% nationally.

In Islington, pupils who are eligible for Free School Meals have higher levels of attainment than the national averages for those eligible for Free School Meals, and the gap in attainment between pupils who are eligible for Free School Meals and their peers is narrower in Islington than the average across England.

Attendance at school improves the chances of educational attainment, and Islington schools have seen an improvement in attendance since 2007/08. Unauthorised absences in Islington secondary schools (2013/14) are now at 1.3%, similar to England (1.4%) and London (1.3%). Persistent absence amongst secondary school pupils was lower compared to nationally (3.4% vs 5.3%). However amongst primary school children persistence absence was higher in 204/15 compared to nationally (2.3% and 1.9%).

5.2% of Islington year 12-14s were n not in education, employment or training (NEET) in 2014/15, compared to 3.4% in London.

3.3 Employment

Being in good and secure employment has a positive impact on wellbeing whilst low quality and insecure jobs have a negative impact on both physical and mental health. Overall unemployment levels in Islington are lower than London, with 7.8% of the working age population unemployed (10,000 people). The highest levels of worklessness are in young adults aged 16-24 and social housing tenants. Groups with particularly high levels of unemployment in Islington include Black Minority Ethnic communities, those with learning disabilities and lone parents.

A large number of people claiming out of work benefits in Islington also do so because of long-term illness or other health conditions. Mental ill health accounts for the largest proportion of claims for incapacity benefits reflecting the high prevalence of mental ill health in the borough. Islington has the highest rate of claims for Employment and Support Allowance (ESA) or Incapacity Benefit (IB) of any London borough (7.9% of the working age population, compared to 5.5% across London). Though the rate of claims as a proportion of the working age population has fallen slightly since the turn of the century, the total number of ESA/IB claimants in Islington has remained virtually flat for at least 15 years. According to the latest figures, 12,820 Islington residents are in receipt of ESA or IB, equivalent to almost one in twelve of the working age population. More than half (53%) of the local ESA/IB cohort are claiming out of work benefits primarily due to a ‘mental or behavioural disorder’, while slightly under half (47%) are claiming primarily due to a physical health condition or disability

In Islington 4% of adults (18-69 years) in contact with secondary mental health services were in paid employment in 2013/14. This was lower than London (5%) and England (7%) and the 5th lowest in London, while it was one of the London local authorities with the highest mental ill health prevalence.

The gap in the employment rate for those people in contact with secondary mental health services and the overall employment rate in Islington (65%) is similar to London (64%) and England (65%). The smallest gap in London is 56%, achieved by Newham and Kensington and Chelsea.

The gap in the employment rate for those with long term condition and the overall employment rate in Islington (16%) is higher than London (11%) and England (9%).

In Islington **11%** of adults (18-64 years) with learning disabilities were in **paid employment** in 2013/14. This was **higher than London and England** and the **11th highest** employment rate **in London**.

3.4 Poverty

Poverty is a key determinant of poor outcomes in health and wellbeing. Islington is ranked the 5th most deprived borough in London (out of 33) and 14th most deprived in England (out of 354). Higher levels of deprivation are linked to numerous health problems (e.g. chronic illness and lower life expectancy) and unhealthy lifestyles (e.g. higher levels of obesity, smoking, drugs misuse). These factors mean that needs for health, social care and lifestyle services are higher amongst populations living in more deprived areas.

The impact that poverty (in terms of unemployment or low income) has on families with young children is particularly important. The emotional health of children is correlated with poverty, with particularly vulnerable children being those who are looked after, young offenders and children of parents with mental health problems. Disadvantaged experience in childhood strongly ties with poor health throughout life, and in Islington child poverty rates are very high at more than double the national average. Islington also ranks as the second most deprived area in England on the Income Deprivation Affecting Children Index (IDACI) with just under half of all children aged 0-15 years living in income deprived households. In 2012, 34.5% of children in Islington were living in low income families (over 13,000 children), compared to 18.7% nationally (this has replaced the child poverty measure).

According to the older people's deprivation index (IDAOPI), over two fifths (41%) of older people aged 60 years and over in Islington are income deprived compared to 18% across England.

What does this mean for Islington?

- A large scale, systematic and co-ordinated approach to reducing health inequality is needed that involves all partners and focuses on the wider socio-economic and environmental determinants and on family and individuals.
- Poverty is one of the greatest threats to health and wellbeing in the borough. Getting people into work and particularly those population groups that face persistent barriers to moving into work, should be a focus.
- Strengthen links between employment support services and local health provision to support people out of work due to ill health and those with a learning disability back into work.
- Support local business to create healthier workplaces for their staff to improve staff wellbeing and ultimately reduce sickness absence and absenteeism

1.0 4.0 Lifestyles and risk factors

Regular exercise, maintaining a healthy weight, reducing harmful levels of alcohol consumption and stopping smoking can prevent illness or at least delay it for many years. Unlike other factors such as age and genetics, poor lifestyle behaviours can be altered and in the medium term improve population health outcomes.

4.1 Smoking

The number of people who smoke has declined in Islington over the past few years. Overall smoking prevalence in Islington, based on the Integrated Household Survey, has reduced from 34% in 2005 to 22% in 2013. Current estimates are significantly different to that estimated for England (18%), but significantly higher than London (17%). Despite these improvements, smoking remains prevalent in key population groups including the Turkish and Irish populations and those living with long term conditions (including mental health). People from these groups may find it harder to quit and need more intensive support. Greater effort is therefore required to support people from these groups to stop smoking.

After an increase last year, the rate of smoking in pregnancy has fallen again in the past year to 8%, but is still above the London average.

4.2 Alcohol

Despite positive improvement in treatment outcomes the harm that alcohol causes remains high. Islington has seen an increase in **hospital admissions for alcohol-related conditions** of 22% in men & 19% in women in last 5 years. Similar trends were seen in London and England. Islington remains in the top 5 London boroughs for alcohol-related deaths and has the highest rate of alcohol-related hospital admissions in London.

4.3 Obesity and overweight

Almost 1 in 4 children aged 4-5 years old and 2 in 5 children aged 10-11 years old had excess weight in 2013/14. The proportion of children aged 4-5 years with excess weight in Islington schools has continued to show a slight decrease and is currently similar to the prevalence in England and London. The percentage of pupils aged 10-11 years who are overweight and obese has shown a rise in the last year and is similar to London but higher than England.

Just over 69,000 adults registered with an Islington GP are obese or overweight and approximately two thirds of adults with a chronic illness are overweight and obese. Obesity increases with deprivation, with those living in the fifth most deprived areas of Islington being 27% more likely to be obese compared to the Islington average.

What does this mean for Islington?

- Supporting people to live healthier lives across the life course remains a priority. Programmes and services to support people to adopt healthier lifestyles should be delivered at sufficient scale and appropriately targeted in order to improve population health outcomes, and reduce health inequalities within the borough. Specific areas of focus include:

- **Tobacco**
  - Educate and prevent young people from starting smoking
  - Ensure smoking cessation services target high risk populations to quit.
  - Reduce second hand exposure
  - Regulate and enforce the laws on sale and display of tobacco products
- **Overweight and obesity**
  - To continue to commission and evaluate interventions that promote physical activity, both universal services and those targeted at population groups most in need e.g. people on low incomes, people with disability.
- **Alcohol**
  - Increasing awareness of alcohol locally through the provision of clear, sensible advice around what is low risk drinking and why this is important.
  - Approaches for the provision of identification (screening) and brief advice (IBA) and alcohol liaison models to be implemented consistently and at scale.
  - Proactive enforcement continues to be a key part of reducing alcohol harm by managing alcohol availability locally.
  - Building on work already occurring locally, to ensure there is a strong partnership approach to maximise alcohol harm reduction, including enforcement of licensing regulations, IBA and high quality treatment services.

5.0 Physical and Mental health

Cancer, cardiovascular disease (CVD), and respiratory disease remain the leading causes of premature deaths and all deaths in Islington, although death rates are declining across the population as a result of people living longer. Diabetes, high blood pressure and obesity are also prevalent conditions that, although frequently not recorded as the underlying cause of death, significantly contribute to early death; similarly, mental health conditions significantly increase the risk of early death in a number of conditions. The increasing number of deaths due to liver disease associated with obesity and excessive alcohol consumption is also of growing importance.

Promoting healthy lifestyle behaviours will help to prevent or delay many deaths caused by long term conditions. As well as prevention, earlier diagnosis of these conditions, facilitating lifestyle advice and behaviour change and earlier medical management help to reduce the longer term ill health and disability associated with these conditions, as well as preventable deaths. This represents the **closing the gap** challenge, increasing the proportion of long term conditions in the population that have been diagnosed in order to provide earlier and more effective help and care. Since 2010/11 the estimated prevalence of undiagnosed diabetes and COPD has dropped by 35% and 8 % respectively. Meanwhile it has increased by 2% for hypertension and 10% for coronary heart disease. There are about 26,000 people with undiagnosed hypertension (13% of the population aged 16 and over).

The long term conditions described below disproportionately affect people living in deprived communities. Older people and people with more than one long term condition are at significantly higher risk of poor quality of life. Nearly a third of all people with long-term physical conditions also suffer from depression or anxiety. This association is particularly strong for cardiovascular disease, diabetes and chronic obstructive pulmonary disease (COPD).

5.1 Cardiovascular disease

Early deaths (deaths before the age of 75) from cardiovascular conditions including coronary heart disease are declining, although cardiovascular diseases remain the second leading cause of death across all ages in the borough. The rate of early deaths remains significantly higher than London and England for both men and women in Islington. However, for the last six years, the rate of early deaths from heart disease has been falling at a faster rate than in England and London. This means that, although still higher than the England average, the inequalities gap in early CVD mortality between Islington and England has significantly narrowed and Islington is making significant progress in reducing early deaths from CVD.

5.2 Diabetes

The gap between the number of people with diagnosed diabetes and the number expected to have the disease in Islington suggests a significant number of undiagnosed cases (over 4,000 people) in Islington. Islington's prevalence gap for diabetes is significantly higher compared to the gap in London and England. High levels of excess weight amongst younger people is likely to increase the number of people developing diabetes in future, which will increase their risks of heart disease, stroke, kidney failure, blindness and amputations. A locally commissioned service, developed with GPs in Islington, aims to enhance the management of diabetes and those at risk of developing diabetes in primary care.

5.3 Respiratory disease

Respiratory diseases are important causes of ill health in Islington and of emergency admissions to local hospitals, particularly among older people, many of which are potentially preventable. The main impact associated with COPD in Islington is a significant reduction in the quality of life of people with COPD and their carers, and frequent hospital emergency admissions caused by exacerbations of the condition. The second highest rate of potentially preventable hospital admissions in Islington are as a result of COPD (second only to admissions for influenza and pneumonia). Many of these admissions could potentially be avoided through earlier diagnosis and better medical and lifestyle management; stopping smoking would prevent the majority of cases of COPD occurring in the first place. The COPD local enhanced service introduced in primary care and closer working with secondary care has resulted in emergency admissions for COPD decreasing by 14%. However, there are an estimated 4,000 cases of undiagnosed COPD in Islington. Higher levels of pollution in inner city areas like Islington will also contribute to respiratory disease morbidity in both children and adults and earlier mortality.

5.4 Cancers

Cancers are the leading cause of premature deaths (under 75) in Islington. The rate of early death from all cancers has been falling in the borough with a faster rate than England, decreasing the inequalities gap in early cancer mortality between Islington and England. Lung cancer is the largest contributor to early death amongst all cancers. The proportion of people who are alive after a diagnosis of prostate, breast, lung and colorectal cancer at 1 year and 5 years is generally similar compared to England. There is scope to further improve survival by increasing awareness, early detection and treatment. 5.5 Liver disease

Most liver disease is preventable and much is influenced by alcohol consumption and obesity prevalence, which are both amenable to public health interventions. During the last 3 year rolling period Islington has made progress in reducing the rate of deaths from preventable liver disease for persons under the age of 75 and rates are now similar to England and London.

5.6 HIV

With advances in treatment, HIV is now also considered a long term condition. In 2013 about 9 people per 1000 population aged 15-59 were diagnosed with HIV. This is the 6th highest prevalence rate in London. The majority of diagnosed HIV infections in the borough are in gay and bisexual men (71%). Although there continue to be a significant number of newly diagnosed infections each year, improved treatment and survival has led to a shift in the age distribution of. The impacts of poverty and of stigma and discrimination continue to be important issues associated with HIV. As with other long term conditions, there are also higher rates of mental health conditions among people living with HIV.

5.7 Mental health

Mental health conditions affect all groups in the borough, although the types and prevalence vary according to gender, ethnicity and age, and are influenced by a wide range of factors including family, early life experiences, social, economic and environmental determinants. It has been estimated that mental health conditions are the single largest cause of ill health and disability in the population aged under 65, and they continue to be an important cause among people aged 65 and over. Mental health conditions can intensify the effects of a physical illness and considerably raise the cost of physical health care. Rates of hospitalisation and early death

due to physical health conditions for those with mental health problems are up to three times higher than for others.

One-in-six adults in Islington (about 32,000) have been diagnosed in primary care with one or more mental health conditions, including common mental health disorders such as anxiety and depression (29,900), serious mental illness (3,385 people) such as schizophrenia and dementia (1030). Islington has the highest diagnosed prevalence of serious mental illness in the country and the highest diagnosed prevalence of depression in London.

In addition to the numbers already diagnosed, it is estimated that a significant proportion of mental health conditions go undiagnosed: among adults, there are an estimated 16,000 undiagnosed mental health conditions, and 1,760 among children and young people. This is less true of dementia, and in Islington, people with dementia are more likely to have received a diagnosis than anywhere else in London or nationally.

There are inequalities in the levels of mental health conditions between different groups in Islington and inequalities of access to services. Patterns vary between conditions and also with demographic factors such as age, sex, ethnicity and socioeconomic deprivation. There is an over-representation of people from black and ethnic minority groups with more serious mental illness, matching national trends. In general, the determinants of mental health are socio-economic; mental health conditions are highest in people and communities who are experiencing deprivation, disadvantage, financial hardship, exclusion or isolation and there is a strong inter-generational cycle of illness.

This year there has been a considerable focus on improving care for people in mental health crisis following a national crisis care concordat. A local action plan has been developed in response by key partners including Camden and Islington Foundation Trust, the Local Authority, Islington CCG, the Metropolitan Police and the London Ambulance service. Key achievements to date include increased staffing within the mental health crisis teams, a new website including an 'I need help now' button, the review and clarification of partnership working arrangements between police and partners and a pilot of user held crisis cards. This work compliments the focus on recovery that exemplifies care for people with enduring mental health problems.

People with mental health conditions have substantially higher levels of physical illness than others, including cardiovascular and respiratory conditions and diabetes. Lifestyle factors such as smoking, weight and, in depression, alcohol intake, increase the risk of developing physical health conditions. The long-term impact is a major reduction in life expectancy. People in contact with specialist mental health services have a mortality rate 3.6 times that of the general population.

Suicide in Islington has reduced steadily over the last 10 years to a rate of just under 10 per 100,000 population, very slightly above rates for London and England.

It is estimated that 78% of people with dementia in Islington receive a diagnosis, the highest rate in London and 5th highest in England. Timely diagnosis ensures access to services which support people to live well with dementia.

The stigma still attached to mental health disorders and the discrimination that accompanies this, make mental health a complex and challenging public health problem.

What does this mean for Islington?

- There are a significant number of people living with a long term condition but who have not yet been diagnosed. The Health Checks Programme is a vital part of action to address this key need, as well as to identify risks earlier. Islington's closing the gap local enhanced service, which aims to find undiagnosed long term conditions should continue and be evaluated.
- Programmes raising awareness of signs and symptoms of long term conditions including cancers and COPD should be targeted at deprived communities to encourage early presentation.
- Implement strategies and programmes that encourage people with long term conditions to self-manage and stay independent.
- Improve lifestyle and medical management of long term conditions, of those at significant risk of long term conditions, to improve quality of life.
- The strong link between physical health and mental health underlines the importance of the movement towards models of care that address both mental and physical health together.
- All those with a physical long term condition should be offered screening and help for depression.

6.0 The best start in life: children and young people and their families

There is clear evidence of the importance of giving children the best start in life, and there are a range of early interventions (starting not only in pregnancy, but pre-pregnancy) that are effective in achieving better long term outcomes and reducing inequalities. Although the majority of children and young people in Islington live healthy lives, there are high levels of vulnerability and disadvantage. Groups particularly at risk of poorer outcomes, in childhood or later on in adulthood, include: children living in poverty, young carers, children with disabilities, looked after children, young offenders, children with mental health conditions, children exposed to domestic violence and children of parents with long term mental health problems including personality disorder, or problem alcohol and substance misuse.

6.1 First 21 months

Interventions that address inequalities early on tend to demonstrate the best and most cost effective impacts on narrowing the gaps between groups. This is the underpinning basis for Islington's First 21 Months priority. Key indicators of health and wellbeing include:

- Early access to maternity services (booking by 12 weeks plus 6 days) to ensure women and their partners receive timely care and support through pregnancy, including early identification of health or social problems that may require extra support. Although early access has improved, Islington's two major maternity services remain below the 90% target, achieving 79% in Q1 2013/14. Earlier and more effective referral systems are needed, as well as promotion of the early access message into the community.

- Immunisation rates have significantly improved, including MMR and pre-school boosters. By Q3 2013/14, Islington achieved 98% uptake for the vaccinations among one-year old children, above the London (89%) and England (94%) average.

- Exclusive breastfeeding provides a significant level of protection against the future risk of childhood obesity. Initiation rates of breastfeeding in Islington are higher (90%) than London (87%) and England (74%). By 6-8 weeks the rate is 75%, but still remains higher than London and England.

- The Family Nurse Partnership is demonstrating good short-term outcomes for teenage parents and their babies, particularly with breastfeeding, immunisations at 24 months, smoking reduction and hospital admissions.

- Although there are significant risk factors in the population, particularly those linked to deprivation, data for 2010-12 show that the rate of infant mortality is significantly lower than England (2.2/1000 live births; 20 deaths) and the rate of low birth weight babies is similar to England (3%; 79 infants). The perinatal mortality rate (6.2/1000 births; an average of 14 stillbirths and 5 neonatal deaths per year) is also similar to England. The rates have reduced over the previous ten years, though the numbers are too small for these differences to be statistically significant.

- Childhood obesity rates remain high in both Reception and Year 6 children in Islington, increasing the risk of long term health problems for these children. Excess weight in children is further covered in section 0.

Mental health conditions in children and young people are estimated to be 36% higher than the national average, with more than 3,700 children and young people aged 5-17 experiencing a mental health condition during any one week. This estimate is primarily based on national survey data which is now close to 10 years old, and there is a key need for a new national survey. There are also about 1,500 children and young people under 18 in treatment for mental health conditions (5.9% of children in Islington).Mental health conditions in childhood, particularly if untreated, are an important risk factor for mental health problems in adulthood. Schools and Children's Centres are increasingly important sources of referrals to CAMHS services.

Admissions for asthma and some other long term conditions have been much higher for Islington children and young people compared to their national counterparts. This is being addressed through steps to improve medical management and self-care in community and primary care settings.

What does this mean for Islington?

- There is a need for maternity services to improve early access.
- A strong preventive and early intervention offer in pregnancy and the early years is important to reduce long term inequalities.
- Promoting exclusive breastfeeding, healthy eating, physical activity and access to weight management support to children and their families continues to be important to reduce high levels of obesity and excess weight.
- Access to effective services for conditions such as asthma or mental health problems in community and primary care settings will help to improve outcomes.

6.2 Children and young people with Special Education Needs and disabilities

The best available estimates for children and young people with disabilities come from special educational needs (SEN) data. However, not all children with disabilities and long term life limiting conditions have SEN, and further work is being done to estimate local numbers. Over one-in-five Islington pupils have a SEN, significantly above London and England (16% and 15%, respectively). In January 2015, around 5,100 children and young people aged under 19 in Islington had a statement or Education, Health and Care (EHC) Plan (917) or had additional educational need without a statement or EHC Plan (4,238). There has been a slight rise in the number of children and young people with a statement or EHC Plan in Islington over the previous seven years, equating to an average of 32 additional statements or EHC Plans each year.

Among children and young people with a statement or EHC Plan, an Autistic Spectrum Disorder was the most prevalent primary need in 2015, followed by Moderate Learning Disabilities and Speech, Language and Communication Needs. Prevalence of SEN needs varies by gender and ethnicity. About 75% of Islington pupils with a statement are boys, which is similar to the national picture. Some ethnic groups were more likely than the general Islington population to have a statement for certain specific types of SEN, for example, Black Caribbean children and children from a mixed ethnic group were around twice as likely to have a statement or EHC Plan

for Social, Emotional and Mental Health difficulties than the general population of children and young people.

Pupils with a SEN or disability face barriers that make it harder for them to learn than most pupils of the same age. People with SEN also face poorer outcomes than their peers in terms of educational achievement, physical and mental health status, social opportunities, and transition to adulthood. Evidence shows that nationally, people with learning disabilities are less likely to lead healthy lifestyles compared with the general population, with unhealthy diets and low levels of physical activity among people with learning disabilities contributing to poorer health outcomes.

Effective ante- and post-natal care, smoking, alcohol and substance misuse, maternal diet and maternal age are important determinants of SEN and disability. Families with a child with a SEN or disability are more likely to live in poor housing, in unemployment and poverty, and face social isolation and discrimination; these are also associated with poorer health and educational outcomes.

Well-co-ordinated planning and advice makes a positive difference to young people's futures. Early identification and assessment can help to significantly improve mental and physical health, educational attainment, and employment opportunities, and interventions early in primary and secondary school and during the years leading into adulthood can improve health outcomes. High quality teaching and well trained teaching assistants and support staff are important factors in raising educational outcomes. Giving parents control through providing information, inclusion in planning and strategic development, and good multi-agency co-ordination can also improve outcomes for children and young people with SEN and/or disabilities.

The Children and Families Act (2014) introduced a new, single system from birth to 25 for all children and young people with SEN and their families. The Act extends the SEN system from birth to 25, giving children, young people and their parents greater control and choice in decisions and ensuring needs are properly met. It takes forward the reform programme including:

- replacing old statements with a new birth- to-25 education, health and care plan
- offering families personal budgets
- improving cooperation between all the services that support children and their families, particularly requiring local authorities and health authorities to work together.

What does this mean for Islington?

- The new SEN system will be less adversarial for parents, focus more on outcomes and extend rights from 0-25 (instead of 5-19 as present).
- The number of children and young people with SEN and disability is unlikely to change as a result of the SEN Reforms however the levels of attainment, attendance, and exclusions of this cohort are expected to show improvement, which improves long term life outcomes.
- All staff across Children's Services, schools and health partners who work with children and young people with Special Education Needs and disabilities will need to work differently as a result of the reforms.

7.0 Vulnerable groups

7.1 People with learning disabilities

The events at Winterborne and the subsequent report by the Confidential Inquiry into premature deaths of people with learning disabilities highlighted the responsibilities that public services have to ensure that people with learning disabilities receive equitable and accessible care and support. National data show that people with learning disabilities are three more times likely to die early compared to others, and as a result their life expectancy is up to 20 years less than the general population. Some of the difference may be accounted for by higher rates of specific health issues including coronary heart disease, respiratory disease and epilepsy, however many of these deaths are potentially preventable through a mix of earlier diagnosis and better and more responsive management of health conditions.

In spite of these stark inequalities, life expectancy for people with learning disabilities is increasing, this is in part due to rising numbers of young people with complex needs surviving into adulthood as well as longer life expectancies amongst adults with learning disabilities.

There has been an increase in the number of people with learning disabilities who have received health checks in Islington, but improving the delivery of preventative interventions and earlier identification and management of physical health issues in people with learning disabilities remain important.

What does this mean for Islington?

- Ensuring prevention and treatment services are accessible and able to meet the needs of people with learning disabilities in order to improve outcomes and reduce inequalities.

7.2 Vulnerable children

Although the majority of children and young people are healthy and achieve well there is a proportion of children and young people who need support from the local authority. The reasons are complex but often result in the neglect and abuse of children and young people. Each year, contacts to children's social care are made relating to concerns about over 7,000 children and young people. The majority of social care involvement is related to three key parental factors; domestic violence, parental mental-ill health and substance misuse.

Children who have witnessed or experienced domestic violence, whose parents have mental health issues and/or suffer from substance misuse are more likely to suffer from a range of difficulties including behavioural, social and emotional difficulties which also remain prevalent into adulthood.

Domestic violence

Islington's rate of domestic violence offences is the second highest in North London, which can be an indication of higher violence, or of greater confidence in reporting incidences to the police. Domestic violence can affect anyone, but women, transgender people and people from BME groups are at higher risk than the general population. The estimated cost of domestic violence is almost £26 million in Islington, with most of the cost being borne by physical and mental health services (£7.7million).

National estimates of domestic violence applied to the Islington population suggest that there are over 11,000 young people aged under 25 have witnessed domestic violence at some point in their lives.

Parental mental health

As many as one in four children aged 5-16 have mothers who may be at risk for common mental health problems, which would equate to around 6,000 Islington children.

Substance misuse

As many as 3,000 children aged under 16 in Islington may be living in a household where a parent misuses drugs. Additionally, it is estimated that over 9,000 children aged under 16 in Islington are living in a household where a parent drinks at hazardous or harmful levels.

The health services provided to vulnerable children including looked after children, young people who offend and young carers in Islington are good. High proportions of Islington children who have been looked after for 12 months or more are up to date in their healthcare e.g. immunisations, oral health check-ups and annual health assessments. .

What does this mean for Islington?

- Ensure health services and partners work together to deliver person centred care for children and young people
- Continue to ensure targeted health interventions for vulnerable children

8.0 Next steps

Through the development of the Health and Wellbeing board stakeholder engagement plan, timetabled opportunities to explore communities', service users' and patients' views on findings from the JSNA and their local health and wellbeing issues will be used to inform the on-going development of the JSNA.

FURTHER INFORMATION & FEEDBACK

The updated JSNA can be accessed at: http://evidencehub.islington.gov.uk/yourarea/jsna

For further information or comments, emails us: publichealth.intelligence@islington.gov.uk

This page is intentionally left blank

ISLINGTON

Public Health
Municipal Offices, Upper Street

Director of Public Health

Meeting of:	**Date**	**Agenda item**	**Ward(s)**
Health Scrutiny	11 April 2016		All

Delete as appropriate	~~Exempt~~	Non-exempt

SUBJECT: Department of Health Consultation – Community Pharmacy in 2016/17 and Beyond

1. Synopsis

1.1 The paper provides a summary of the Department of Health (DH) "Community Pharmacy in 2016/17 and beyond" consultation[1]. The paper outlines the consultation proposals and some preliminary reflections on how they may affect Islington residents including both health and wider social considerations. The paper will also outline how the CCG and Public Health will work with the Lead Member for Health and Social Care to develop a response to the consultation along with key stakeholders including the Local Pharmaceutical Committee (LPC) ahead of the consultation period ending on 24 May 2016.

2. Recommendations

2.1 The Committee is asked to note the paper for information.

3. Background

3.1 The Department of Health has recently published a consultation which proposes an extensive review of community pharmacy services. The DH focus of these changes is to 'place community pharmacy at the heart of the NHS' in line with proposed far-reaching changes to the primary care landscape.

3.2 The aims of the proposals are to:

1. Integrate community pharmacy and pharmacists more closely within the NHS, optimising medicines use and delivering better services to patients and the public.
2. Modernise the system for patients and the public – making the process of ordering prescriptions and collecting dispensed medicines more convenient for members of the public by ensuring they are offered a choice in how they receive their prescription.
3. Ensure the system is efficient and delivers value for money for the taxpayer.
4. Maintain good public access to pharmacies and pharmacists in England.

[1] Department of Health's "Community Pharmacy in 2016/17 and beyond" consultation. Available at: https://www.gov.uk/government/publications/putting-community-pharmacy-at-the-heart-of-the-nhs

The more detailed questions are listed at Appendix 1.

What do the proposals mean for the health of Islington residents?

3.3 Islington has a diverse resident population, with larger proportions of both younger people and minority ethnic groups than the overall London population. Islington also has one of the most deprived populations in the country, with the North locality being particularly deprived. Over 38,000 residents have a diagnosed long term condition, many have more than one condition, and it is estimated that the prevalence is actually much higher, with around 45,730 more long term conditions undiagnosed in the population. It is well recognised that encouraging prevention, early diagnosis, proactive long-term management and supporting self-management is key to helping improve the health and wellbeing of Islington residents with long-term conditions and community pharmacy have a central role in that.

3.4 Public Health completed a Pharmacy Needs Assessment for Islington[2] in 2015. With 45 pharmacies overall, Islington has a similar rate of community pharmacies per 100,000 residents to the London average (21 pharmacies). One of the pharmacies in Islington is on a '100 hour' contract, providing coverage early in the morning and late at night. There is at least one pharmacy in most of the borough's wards, and three of the localities have a late opening pharmacy.

3.5 In 2012/13, Islington pharmacies dispensed on average 4,299 prescriptions per month, meeting the current threshold for the NHS's Establishment payment of £25,000 per year (received by all pharmacies dispensing 2,500 or more prescriptions a month). The average number of items dispensed per pharmacy in Islington is lower than most other boroughs. The low average per pharmacy suggests that current demand for essential services is being met and there would be capacity, on average, to meet any increased demand for prescriptions that might arise over the next few years as a result of inward migration and an increase in the prevalence of long term conditions. However, this lower average prescription rate also makes Islington pharmacies at higher risk of being negatively impacted by the Consultation proposals.

3.6 In addition to dispensing medicines, Islington pharmacies play a key role in the delivery of various locally commissioned services (LCSs) for both Public Health and the CCG eg stop smoking, substance misuse, NHS Health Checks and contraceptive services. An increasing number of Islington pharmacies are part of a growing nationally-approved network of Healthy Living Pharmacies (HLPs) whose aim is to provide a one-stop shop of key preventive behavioural change and health and wellbeing advice services, easily accessible to the public.

Impact on Islington pharmacies and wider socio-economic considerations

3.7 The general thrust of the proposals - improving the care of patients by making much better use of the expertise, accessibility and acceptability of community pharmacists - appears to be widely accepted and welcomed by all quarters, including and perhaps, especially by pharmacists themselves. The LPC strongly endorse their key role to play in the transformation of the healthcare delivery model by identifying health problems, managing existing conditions, and promoting healthy lifestyles, all at the heart of the community.

3.8 However the proposals also present risks to Islington pharmacies, particularly for the sustainability of many of them as small and medium sized enterprises (MSE) and therefore, the associated effects to the immediate communities they serve as local employers and the general economic vibrance of local high streets. Camden and Islington LPC estimate that approximately one third to half of pharmacies might close in Islington.[3]

Next steps

3.9 Public Health and the CCG are planning to establish a task and finish group to consider the implications of the consultation, develop a response in conjunction with the Lead Member for Health and Social Care and consider how we develop local mitigation to funding reductions. The group will include key

[2] Islington Pharmaceutical Needs Assessment 2015. Available at: http://www.islington.gov.uk/publicrecords/library/Public-health/Quality-and-performance/Reporting/2014-2015/(2015-03-25)-IslingtonPNA_FinalDraft.pdf

[3] Email correspondence from Y Parmar, CEO, Camden & Islington LPC. 29 Feb 2016.

stakeholders affected by the Consultation, especially the LPC. Local mitigations to the funding reductions might include potential collaborative working on bids for the proposed NHS Pharmacy Integration Fund and considering additional commissioning opportunities. The work will also help inform development of the CCG's local integrated Medicines Optimisation strategy incorporating developments to place community pharmacy at the heart of the NHS.

4. Implications

4.1 **Financial implications: to be added when received**

4.2 **Legal Implications: to be added when received**

4.3 **Environmental Implications: to be added when received**

4.4 **Equality Impact Assessment:**
A Resident Impact Assessment will be completed as part of the consideration of any consultation submission.

5. Conclusion and reasons for recommendations

5.1 The Department of Health's consultation proposes an extensive review of community pharmacy services to place community pharmacy at the heart of the NHS. Proposals include changing and developing new models of care, utilising the many skills of the nationally growing pharmacy workforce and providing even greater integrated support and medicines optimisation for the local population. While these aims are widely welcomed given the high levels of health need amongst Islington residents, there is concern at the possible negative socio-economic impacts of closures to local high street pharmacies. Public Health and the CCG will work with the Lead Member for Health and Social Care to develop a response to the consultation along with key stakeholders including the Local Pharmaceutical Committee (LPC) ahead of the consultation period ending on 24 May 2016 and to consider how we develop local mitigation to subsequent funding reductions.

5.2 The Committee is asked to note the work planned to develop a response to the consultation and subsequent follow-up for Islington.

Appendices

Background papers:

Final report clearance:

Signed by:

Director of Public Health Date: 31 March 2016

Received by:

Head of Democratic Services Date

Report Author: Dr Liz Brutus, Assistant Director Public Health
Tel: 020 7527 1078

Email: liz.brutus@islington.gov.uk

Appendix 1

Department of Health Consultation – Community Pharmacy in 2016/17 and Beyond
List of consultation questions

The aims of the proposed changes are to:

1. Integrate community pharmacy and pharmacists more closely within the NHS, optimising medicines use and delivering better services to patients and the public.
2. Modernise the system for patients and the public – making the process of ordering prescriptions and collecting dispensed medicines more convenient for members of the public by ensuring they are offered a choice in how they receive their prescription.
3. Ensure the system is efficient and delivers value for money for the taxpayer.
4. Maintain good public access to pharmacies and pharmacists in England.

As such, the questions for the consultation are outlined below:

Bringing pharmacy into the heart of the NHS

- What are your views on the introduction of a Pharmacy Integration Fund?
- What areas should the Pharmacy Integration Fund be focussed on?
- How else could we facilitate further integration of pharmacists and community pharmacy with other parts of the NHS?

Modernising the system to maximise choice and convenience for patients and the public

- To what extent do you believe the current system facilitates online, delivery to door and click and collect pharmacy and prescription services?
- What do you think are the barriers to greater take-up?
- How can we ensure patients are offered the choice of home delivery or collection of their prescription?

Making efficiencies

- What are your views of the extent to which the current system promotes efficiency and innovation?
- Do you have any ideas or suggestions for efficiency and innovation in community pharmacy?
- What are your views of encouraging longer prescription durations and what thoughts do you have of the means by which this could be done safely and well?

Maintaining public and patient access to pharmacies

- What are your views on the principle of having a Pharmacy Access Scheme?
- What particular factors do you think we should take into account when designing the Pharmacy Access Scheme?

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. Healthwatch Work Programme
5. Health and Wellbeing update
6. Update Margaret Pyke centre
7. Value Based Commissioning

18 JANUARY 2016

1. NHS Trust – UCLH – Performance update
2. Scrutiny Review – Health implications of Damp Properties
3. Margaret Pyke Centre – Update
4. 111/Out of Hours service
5. Work Programme 2015/16
6. Health and Wellbeing Board – update
7. GP Appointment update

07 MARCH 2016

1. Scrutiny Review – Health Implications of Damp Properties – witness evidence
2. NHS Trust – Moorfields – Performance update

3. Work Programme 2015/16
4. Health and Wellbeing Board – update
5. GP Appointments Scrutiny Review – 12 month report back
6. Whittington Estates Strategy

11 APRIL 2016

1. Scrutiny Review – Health Implications of Damp Properties – witness evidence
2. Work Programme 2015/16
3. Health and Wellbeing Board – update
4. Joint Strategic Needs Assessment

16 MAY 2016

1. **Scrutiny Review – Health Implications of Damp Properties – Final Report**
2. **Margaret Pyke update – Results of consultation/progress on transformation**
3. **111/Out of Hours service – update from Chair**

Other items to be determined

This page is intentionally left blank