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ISLINGTON

Resources Department
Town Hall, Upper Street, London, N1 2UD

AGENDA FOR THE HEALTH AND WELLBEING BOARD

Members of Health and Wellbeing Board are summoned to a meeting, which will be held in Committee Room 1, Town Hall, Upper Street, N1 2UD on, **26 April 2017 at 1.00 pm.**

Lesley Seary
Chief Executive

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Despatched	:	18 April 2017

Membership

Councillors:
Councillor Richard Watts (Chair)
Councillor Janet Burgess MBE
Councillor Joe Caluori

Local NHS Representatives:
Angela McNab, Chief Executive, Camden and Islington NHS Foundation Trust
Simon Pleydell, Chief Executive, The Whittington Hospital NHS Trust

Islington Healthwatch Representative:
Emma Whitby, Chief Executive, Islington Healthwatch

Clinical Commissioning Group Representatives:
Alison Blair, Chief Executive, Islington Clinical Commissioning Group
Melanie Rogers, Director of Quality and Integrated Governance, Islington Clinical Commissioning Group
Dr. Josephine Sauvage, Chair, Islington Clinical Commissioning Group
Sorrel Brookes, Lay Vice-Chair, Islington Clinical Commissioning Group

NHS England Representative:
Dr Helene Brown, Medical Director, NHS England

Officers:
Julie Billett, Joint Director of Public Health Camden and Islington
Sean McLaughlin, Corporate Director Housing and Adult Social Services
Carmel Littleton, Corporate Director Children's Services

A.	**Formal Matters**	**Page**

1. Welcome and Introductions

2. Apologies for Absence

3. Declarations of Interest

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

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

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

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

*(a)Employment, etc - Any employment, office, trade, profession or vocation carried on for profit or gain.
(b)Sponsorship - Any payment or other financial benefit in respect of your expenses in carrying out duties as a member, or of your election; including from a trade union.
(c)Contracts - Any current contract for goods, services or works, between you or your partner (or a body in which one of you has a beneficial interest) and the council.
(d)Land - Any beneficial interest in land which is within the council's area.
(e)Licences- Any licence to occupy land in the council's area for a month or longer.
(f)Corporate tenancies - Any tenancy between the council and a body in which you or your partner have a beneficial interest.
(g)Securities - Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

This applies to all voting members present at the meeting.

4. Order of Business

5. Minutes of the previous meetings 1 - 12

- 25 January 2017
- 31 January 2017

B.	**Discussion/Strategy items**	**Page**
1.	Annual Public Health Report 2016/17	13 - 70
2.	Violence Against Women and Girls Strategy 2017-2021	71 - 100
3.	Wellbeing and Work Partnership Update	101 - 114
4.	Better Care Fund: 2016/17 review of achievements and 2017/19 planning requirements	115 - 124

C. Questions from Members of the Public

To receive any questions from members of the public.

D. Urgent Non-Exempt Matters

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

E. Exclusion of Press and Public

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

F. Urgent Exempt Matters

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

G. Confidential/Exempt Items for Information

H. Any other business

The next meeting of the Health and Wellbeing Board will be on 18 October 2017

Please note all committee agendas, reports and minutes are available on the council's website: www.democracy.islington.gov.uk

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London Borough of Islington

Health and Wellbeing Board - Wednesday, 25 January 2017

Minutes of the meeting of the Health and Wellbeing Board held at Committee Room 1, Town Hall, Upper Street, N1 2UD on Wednesday, 25 January 2017 at 1.00 pm.

Present: **Councillors:** Richard Watts (Chair) and Burgess

Dr. Josephine Sauvage, Chair, Islington Clinical Commissioning Group
Emma Whitby, Chief Executive, Islington Healthwatch
Simon Pleydell, Chief Executive, The Whittington Hospital NHS Trust
Jonathan O'Sullivan, Islington Deputy Director of Public Health
Lucy de Groot, Islington Clinical Commissioning Group
Carmel Littleton, Corporate Director, Children's Services.

Also Present:

Candy Holder, Head of Pupil Services
Mark Hendriks, Senior Joint Commissioning Manager,
Brenda Scanlon, Service Director, Housing and Adult Social Services.
Eve Davies, shadowing Councillor Watts.
Karen Lucas, Head of Housing Needs
Bal Heer-Matiana, Senior Public Health Strategist.
Angelina Taylor, Public Health Strategist.

Councillor Richard Watts in the Chair

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

The Chair welcomed everyone to the meeting and introductions were given.

122 APOLOGIES FOR ABSENCE (ITEM NO. A2)

Apologies for absence were received from Councillor Joe Caluori.

123 DECLARATIONS OF INTEREST (ITEM NO. A3)

None.

124 ORDER OF BUSINESS (ITEM NO. A4)

The order of business would be Item B4, B2, B3 and B1.

125 MINUTES OF THE PREVIOUS MEETINGS (ITEM NO. A5)

RESOLVED
That the minutes of the meetings held on the 3 and 19 October 2016 be agreed as a correct record and the Chair be authorised to sign them.

126 ISLINGTON JOINT HEALTH AND WELLBEING STRATEGY 2017-2020: CONSULTATION RESPONSES AND FINAL STRATEGY (ITEM NO. B1)

Jonathan O'Sullivan, Islington Deputy Director of Public Health, reported on the Joint Health and Wellbeing Strategy 2017-2020.

The following main points were noted in the discussion:-

- There had been just over forty written responses submitted on the consultation, and there had been seven engagement meetings with groups of key stakeholders.
- The responses gave a wide range of feedback and came from people with a variety of backgrounds and perspectives. It was considered that there had been a good mix and quality of feedback.
- The strategy had been enriched and improved by the responses given.

RESOLVED

1) That the findings and changes made to the Joint Health and Wellbeing Strategy following consultation be noted.
2) That the Joint Health and Wellbeing Strategy be approved.

127 TRANSFORMING CARE PROGRAMME AND THE AUTISM SELF-ASSESSMENT FRAMEWORK (ITEM NO. B2)

Mark Hendriks, Senior Joint Commissioning Manager, reported on the Transforming Care Programme and the Autism Self-Assessment Framework.

The following main points were noted in the discussion:-

- It was noted that there were currently four patients in Islington who had a learning disability and/or autism in an inpatient setting funded by the ICCG. The numbers had remained relatively constant over time, although in 2016 data collection represented a wider population than in previous years.
- The ICCG target for inpatient numbers by 2019 was four. This was considered realistic when taking into account a reduction in long-stay patients against specialist use when needed with shorter and more effective stays. It was accepted that this small performance against targets could be volatile.
- There was an aim to reduce the use of hospital beds and provide services that were not hospital centric.
- The North Central London TCP, consisting of five local authority CCGs, was working to transform the care within this context.
- Approximately 1% of the population were on the autistic spectrum with an increased diagnosis in young people.
- Services needed to be made more accessible for both adults and children and both services needed to work closely with each other.
- Joint reports in the future would be welcomed.
- The Autism Partnership Board, which was attended by a wide range of stakeholders, had drafted an Action Plan which identified gaps in provision and would look at how people could be supported.
- It was noted that the Finsbury dental service had specialised knowledge of autism and there could be value in directing patients to specialised care.
- It was noted that Councillor Burgess would be attending future meetings of the Partnership Board.

RESOLVED

1) That the Action Plan be circulated to the HWBB once finalised.
2) That a further report be submitted to the HWBB once the next self assessment had been completed.

128 **SPECIAL EDUCATIONAL NEEDS AND DISABILITIES REFORMS UPDATE (ITEM NO. B3)**

Candy Holder, Head of Pupil Services, presented a Special Educational Needs and Disability Reform Update.

The following main points were noted in the discussion:-

- The service was seeing an increase in the identification of young people with Special Education Needs and Disabilities (SEND);
- Links with schools to identify and assess young people were key to the delivery of the plan;
- The ability of identify young people with SEND had improved. A specialist team did carry out most diagnosis.
- Where needs could not be met then young people would then qualify for an assessment.
- Where a young person was not making progress then that would be a reason to reassess.
- Local plans were to be completed by April 2018.
- The local offer had been launched as a new-look website. The challenge had been to develop a user friendly on-line version of the local offer. Members of the Board were invited to look at the website and let the Head of Pupil Services know where it could be improved.

RESOLVED

That the progress be noted and a further update report be submitted to the HWBB in January 2018.

129 **ISLINGTON HOMELESSNESS STRATEGY: PROGRESS UPDATE (ITEM NO. B4)**

Karen Lucas, Head of Housing Needs, gave a presentation on the homelessness prevention strategy.

The following main points were noted in the discussion:-

- That the Board wanted to own the development of the new homelessness strategy,
- There was a need to prevent homelessness through effective partnership working. This could be possible by developing links with GPs/ Accident and Emergency Departments, mental health services and through schools to help prevent vulnerable people.
- The need to use mental health links and schools to identify vulnerable people.
- A number of children who were in accommodation in Waltham Forest were at Islington schools which caused difficulties for families.
- Lucy de Groot undertook to raise the above issues with the ICCG for consideration.
- Links with the justice system also needed to be developed.
- It was noted that Headteachers were often the first person for parents to approach when they were in housing difficulty and the Head of Housing Needs would be invited to speak to Headteachers about the strategy.
- That Councillor Janet Burgess be the Health and Wellbeing Champion in order that the strategy be developed with health and well-being in mind.

RESOLVED

1) That the presentation be noted;

2) That the Board owns the development of the new homelessness strategy, reflecting on the achievements of the previous strategy;
3) That the Board facilitate the development of stronger intelligence and joint response across health, social care and housing services in the North London region.
4) That there be a future update to the HWBB detailing demand on the housing services and the interaction with other public services.

130 WORK PROGRAMME (ITEM NO. B5)

RESOLVED that the Work Programme be noted.

131 UPDATE ON ISLINGTON SAFEGUARDING CHILDREN BOARD FUNDING ARRANGEMENTS (ITEM NO. B6)

Carmel Littleton, Corporate Director of Children's Services, reported that there was some dispute over who should be contributing funding to the Safeguard Boards. This was a national issue. NHS England considered that funding responsibility had been passed to the Islington CCG which they disputed. It was accepted that from April 2017 the position may become clearer.

The Committee noted that this was not an unusual position between the CCGs and NHS England.

This was a situation that required clarity and fairness and was unacceptable because of the implications.

The matter had been raised directly with NHS England.

RESOLVED
That a letter be sent regarding the matter to the Health Minster from the HWBB with a copy to the local MPs and the Children's Commissioner.

Meeting closed at 2.30 pm

Chair

London Borough of Islington

Health and Wellbeing Board - Tuesday, 31 January 2017

Meeting in common with the London Borough of Haringey Health and Wellbeing Board

Minutes of the meeting of the Health and Wellbeing Board held in Committee Room 5, Town Hall, Upper Street, N1 2UD on Tuesday, 31 January 2017 at 9.30 am.

Present: Councillors Richard Watts (Chair), Janet Burgess and Joe Caluori

Alison Blair, Chief Executive, Islington Clinical Commissioning Group
Sorrel Brookes, Lay Vice-Chair, Islington Clinical Commissioning Group
Emma Whitby, Chief Executive, Islington Healthwatch
Angela McNab, Chief Executive, Camden and Islington NHS Foundation Trust
Simon Pleydell, Chief Executive, The Whittington Hospital NHS Trust
Carmel Littleton, Corporate Director of Children's Services

Also Present:

Members of Haringey Health and Wellbeing Board:

Cllr Claire Kober, Chair of Haringey Health and Wellbeing Board
Cllr Jason Arthur, Cabinet Member for Finance and Health, LB Haringey
Cllr Elin Weston, Cabinet Member for Children and Families, LB Haringey
Dr Jeanelle de Gruchy, Director of Public Health, LB Haringey
Sharon Grant, Chair, Healthwatch Haringey
Sarah Price, Chief Operating Officer, Haringey CCG
Dr Peter Christian, Chair, Haringey CCG
Dr Dina Dhorajiwala, Vice Chair, Haringey CCG
Beverley Tarka, Director Adult Social Care, LB Haringey
Jon Abbey, Director of Children's Services, LB Haringey
Geoffrey Ocen, Chief Executive, The Bridge Renewal Trust

Other representatives:

Lesley Seary, Chief Executive, LB Islington
Finola Culbert, Director of Targeted and Specialist Children and Families Services, LB Islington
Brenda Scanlan, Interim Service Director of Adult Social Care, LB Islington
Jason Strelitz, Assistant Director of Public Health, LB Islington
Zina Etheridge, Deputy Chief Executive, LB Haringey
Charlotte Pomery, Assistant Director of Commissioning, LB Haringey
Tim Deeprose, Interim Director of the Wellbeing Partnership
Dr Helen Taylor, Clinical Director and Deputy Director of Strategy, Whittington Health
Stephen Lawrence Orumwense, Assistant Head of Legal Services, LB Haringey

Councillor Richard Watts in the Chair

132 FILMING AT MEETINGS (ITEM NO. A1)

The Chair referred those present to Item 1 as shown on the agenda and asked that they review the information on filming at meetings.

133 WELCOME AND INTRODUCTIONS (ITEM NO. A2)

The Chair welcomed everyone to the meeting and introductions were given.

134 APOLOGIES FOR ABSENCE (ITEM NO. A3)

Apologies for absence were received from Julie Billett (representative: Jason Strelitz), Sean McLaughlin (representative: Brenda Scanlan), Dr Jo Sauvage and Dr Helene Brown.

It was noted that Cathy Herman (Lay Member, Haringey CCG) and Sir Paul Ennals (Chair of Haringey LSCB) were not present.

135 NOTIFICATION OF URGENT BUSINESS (ITEM NO. A4)

None.

136 DECLARATIONS OF INTEREST (ITEM NO. A5)

None.

137 QUESTIONS FROM MEMBERS OF THE PUBLIC (ITEM NO. A6)

None.

138 UPDATE ON THE NORTH CENTRAL LONDON SUSTAINABILITY AND TRANSFORMATION PLAN (ITEM NO. B7)

Zina Etheridge, Deputy Chief Executive of Haringey Council, made a presentation to the Board providing an update on the North Central London Sustainability and Transformation Plan (NCL STP).

The following main points were noted in the discussion:

- The Board noted concerns with the lack of public and democratic engagement on the STP. It was commented that the STP had not been developed transparently and there was a level of scepticism about the plan as a result. It was therefore important that all local health and wellbeing partners had an opportunity to consider the STP in an open forum.
- The STP identified a financial gap in NCL NHS services of £876m by 2020/21; with an additional £300m gap in social care funding in the same time period. Given the scale of savings required, it was important to ensure that stakeholders gave sufficient focus to transformation and prevention, rather than short terms approaches to achieving sustainability. It was emphasised

that reducing demand for services would be essential to achieve savings of such a scale.

- The STP had been scrutinised by the NCL Joint Health Overview and Scrutiny Committee. This had identified several themes for scrutiny and challenges for the STP, including the need to further integrate social care and the wider health system.
- It was noted that the STP did not make specific reference to children's services. It was considered that further integration of children's and health services would allow more comprehensive early help services to be provided.
- The Board noted the strengths of the STP, which included the acknowledgement that care was best provided closer to home, and the recognition of the need to enhance primary care; however considered the lack of public engagement and democratic oversight was a challenge to the STP's legitimacy.
- The Board welcomed that the STP gave mental health conditions parity of esteem to physical health conditions.
- Concern was expressed regarding the capacity of the voluntary sector to deliver more community care. It was suggested that work would be required to build the capacity of the voluntary sector, which was not referenced in the STP.
- The STP identified urgent and emergency care as an area for transformation. The Board noted that the details of this transformation were yet to be confirmed, however indicated that a reduction in urgent and emergency care services would not be supported. It was suggested that an increase in urgent and emergency care capacity would be more appropriate.
- A&E services were often operating beyond capacity, with 318 patients visiting A&E at the Whittington the previous day, above the expected number of around 260. Work was needed to reduce the demand on A&E by treating patients in other areas of the health system. It was commented that patients presenting to A&E did not always require hospital admission, with the daily admission rate being as low as 42% on some occasions.
- The STP was a high level strategic document and delivery plans would be produced to detail how the STP would be implemented. This would provide a new opportunity to engage with the public and key stakeholders on the plans.
- It was commented that public engagement on the STP needed to be coordinated and consistent. It was queried when decisions would be made on the form of the engagement, and how engagement initiatives would be supported. In response, it was advised that this would be considered at the next meeting of the Wellbeing Partnership Delivery Board.
- The Board acknowledged that the STP did not detail the impact of service transformation on particular services. It was suggested that the implications of the STP needed to be known before meaningful public engagement could take place. It was also considered that public engagement should be an opportunity to co-design services with the public.
- It was advised that a communications and engagement lead had been appointed to improve the engagement process around the STP.
- It was advised that the governance arrangements around the STP had been altered recently and that Healthwatch was to be incorporated into the oversight group and the delivery group. It was advised that Healthwatch was developing principles of public engagement and it was suggested that these could be incorporated into an engagement plan.

RESOLVED:

That the update on the Sustainability and Transformation Plan and its implementation in North Central London be noted.

139 DEVELOPING THE WELLBEING PARTNERSHIP AGREEMENT (ITEM NO. B8)

a) Presentation on the Frailty Workstream

Dr Helen Taylor provided an update on progress with the Wellbeing Partnership's frailty workstream.

The following main points were noted in the discussion:

- The level of frailty in Islington and Haringey was increasing as the population aged. However, the needs of frail people were exacerbated by factors such as deprivation and unsuitable housing. It was suggested that addressing these factors could significantly increase patient wellbeing.
- Whilst high-dependency patients were already known to the health system, it was thought that there were a number of people living with long term conditions who would only be identified as being frail once they had a health crisis and presented to A&E. It was commented that frailty usually worsened after health crises and vulnerable people often did not regain their full independence. As a result the patient's demand for health and social care, particularly emergency care, tended to increase after a crisis. Frailty therefore had considerable costs to the individual and the health and care system as a whole. It was considered that treating frailty itself as a long term condition and intervening earlier would improve outcomes for vulnerable people and achieve savings for health and care services.
- A frailty index had been developed through the Wellbeing Partnership which allowed a person's frailty to be measured against 32 deficits. This was intended to be used as a pop-up system for GPs when assessing a vulnerable person's needs. The system would allow local agencies to assess levels of frailty and ensure that vulnerable people received appropriate support before they reached a crisis point.
- It was thought that there were 10,000 people across Islington and Haringey who were either mild, moderately or severely frail. Local services needed to consider what could be done to stop those who were mild or moderately frail from becoming severely frail. For example, it was suggested that there could be a case for providing specialist care or services to frail people if they were just below eligibility thresholds if it would stop their frailty increasing.

b) Discussion on the Wellbeing Partnership

Tim Deeprose, Programme Director, Haringey and Islington Wellbeing Partnership, led a discussion on how to further develop the wellbeing partnership.

- It was thought that agreeing data sharing arrangements would be essential to providing targeted and joined-up services.
- It was thought that agreeing system-wide objectives and performance indicators would promote integration and collaboration between services.
- It was thought that joint procurement and pooling budgets would help to achieve efficiencies and service integration; however it was acknowledged that there were technical difficulties associated with financial matters.
- It was suggested that a shared health and wellbeing strategy would be useful in establishing a joint vision for health and care across Islington and Haringey.
- It was suggested that some services could be joined and operate across organisational boundaries, or could operate with shared management

structures, however each organisation would need to consider the implications of this diligently.

- It was suggested that risks and concerns associated with joining services across organisational boundaries could be minimised by taking a cautious approach, focused on making one or two joint services work effectively and then expanding to other areas, rather than immediately integrating several services.
- The Board noted that agreement had already been secured through the CCG for a joint local arrangement across the two boroughs with a shared commissioning post.
- The Board considered the proposed governance structure of the Wellbeing Partnership, as set out in the agenda pack. The proposed structure was considered sensible, however it was commented that the Wellbeing Partnership was still relatively new and revision may be required as arrangements developed.
- The Board considered the barriers faced by the Wellbeing Partnership to date, which included information sharing and communication between different parts of the health and care system. It was commented that agreeing a governance structure would assist with resolving such barriers.
- The Board considered how democratic accountability could be ensured in the Wellbeing Partnership. In response, it was suggested that a light-touch partnership model requiring decisions to be made by its constituent organisations would not require additional democratic oversight, however a more developed partnership with budgetary responsibility would require democratic representation on decision-making bodies. It was thought that over the next 12 to 18 months democratic accountability would remain with the individual statutory organisations that made up the Wellbeing Partnership Board.
- It was thought that developing joint Health and Wellbeing Board arrangements between Islington and Haringey would ensure that the Wellbeing Partnership received oversight from both elected members and professional officers.
- It was queried whether the community reference group referred to in the draft governance structure would be one group, combining voluntary and community sector groups across Haringey and Islington or whether there would be two groups. The Board also considered the need to ensure that local organisations were included in any future commissioning arrangements.
- It was emphasised that partnership arrangements needed to develop within a relatively short timescale to ensure that benefits would be realised and to enable organisations to respond to the STP effectively. It was noted that the governing bodies of partner organisations would be asked to approve the Partnership Agreement in the spring. It was requested that a more detailed proposal for governance arrangements be reported to a future meeting of the Board.

RESOLVED:

That the report be noted.

140 HARINGEY AND ISLINGTON: TACKLING OBESITY TOGETHER (ITEM NO. B9)

Jeanelle de Gruchy, Director of Public Health and LB Haringey, introduced the report and made a presentation on a joint approach to tackling obesity across Islington and Haringey.

The following main points were noted in the discussion:

- Haringey and Islington faced similar challenges with over 1 in 3 children aged 10-11 classed as overweight or obese. It was emphasised that obesity had a significant impact on overall health outcomes and wellbeing.
- The Board considered joint approaches to tackling obesity across Islington and Haringey. It was explained that public health initiatives could not rely on individual willpower alone and it was important to create healthier environments to support residents in tackling obesity. For example, it was reported that Haringey Council had removed 'no ball games' signs from public spaces to encourage physical activity. The Board supported removing these signs in Islington also.
- The Board considered the need to create healthier food environments and noted the Sugar Smart campaign, developed in conjunction with the Jamie Oliver Foundation and Sustain, which aimed to increase awareness and reduce sugar consumption. The Board noted the proposal to undertake an audit of public buildings to review the food offer and develop a food standards policy and toolkit to ensure the provision of healthier options.
- The Board noted the Heathy Workplace Charter, which was a framework which recognised employee health and wellbeing initiatives. It was noted that Islington Council already offered several initiatives for staff including reduced price gym membership, running clubs, lunchtime walks, as well as providing showers to support physical activity.
- The Board was keen to develop anti-obesity initiatives at a cross-borough level, including Play Streets schemes. The Board considered the importance of 'making every contact count' by promoting health initiatives to the public at every opportunity. It was proposed that a high profile campaign should be launched to generate public interest; it was suggested that a campaign against a particular product may be effective.

RESOLVED:

That Haringey and Islington work together to:

(i) Create healthier food environments and reduce sugar consumption:

- To sign up to London's Sugar Smart Campaign and to agree a joint pledge to make healthier food more affordable and accessible for our residents.
- To encourage sign up to the Sugar Smart Campaign from our partners (including schools and community organisations).
- To undertake a snapshot audit of the current food offer in public sector facilities across both boroughs in order to understand the quality and nutritional value of food on sale to our residents.
- To develop a food standards policy and toolkit to work with providers to improve the food offer for all our residents.
- That all organisations on the joint board work towards Healthy Workplace Charter 'Excellence'.

(ii) Build capacity and knowledge within the wider public health workforce

- To promote Making Every Contact Count (MECC) within all organisations represented in the Haringey and Islington Health and Wellbeing Board.

(iii) Identify joint funding to increase levels of physical activity

- To support a joint Haringey and Islington bid for the Local Area Fund pilot.

141 HARINGEY AND ISLINGTON JOINT HEALTH AND WELLBEING BOARD - TERMS OF REFERENCE (ITEM NO. B10)

Stephen Lawrence-Orumwense, Assistant Head of Legal Services at LB Haringey, introduced the report which set out the terms of reference for a Joint Islington and Haringey Health and Wellbeing Board.

The Board agreed two minor amendments to the proposals as set out in the report. It was agreed that the committee should be a joint sub-committee of each borough's respective Health and Wellbeing Boards; and that voluntary sector representation should be added to the membership of the joint committee. It was proposed that the voluntary sector representative of LB Haringey's Health and Wellbeing Board could represent the interests of the voluntary sector across both boroughs, and it was agreed that Healthwatch Islington would liaise with the voluntary sector representative in regards to this.

RESOLVED:

That the following be recommended to the Council for approval:

(i) That the Haringey and Islington Joint Health and Wellbeing Board (i.e. a Joint Committee) be established to discharge on behalf of both boroughs the function of encouraging integrated workings between commissioners and providers of health and care in the two boroughs in so far as it relates to areas of common interest and for the purpose of advancing the health and wellbeing of their populations

(ii) That the Terms of Reference of the Haringey and Islington Joint Health and Wellbeing Board which is attached as Appendix 1 be approved.

(iii) That the Terms of Reference of the Health and Wellbeing Board be amended to permit when appropriate delegation of more functions to the Haringey and Islington Joint Health and Wellbeing Board.

142 DATES OF FUTURE MEETINGS (ITEM NO. B11)

To be agreed.

MEETING CLOSED AT 11.00 am

Chair

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Public Health Department
222 Upper Street
London N1 1XR

Report of: Director of Public Health

Health and Wellbeing Board	**Date: 26 April 2017**	**Ward(s): All**

Delete as appropriate		Non-exempt

SUBJECT: Annual Public Health Report 2016/17: The Economics of Prevention and the Role of the NHS

1. Synopsis

1.1 This is the Annual Public Health Report for 2016/17 of the Joint Director of Public Health for Camden and Islington. It is a statutory requirement that each Director of Public Health provides an independent of report of health and wellbeing in their area. The focus of this year's Annual Public Health Report is on the economics of prevention and on those prevention interventions that will help the NHS save money in the short term.

2. Recommendations

2.1 The Health and Wellbeing Board is asked to:

- note the content of the report; and
- consider the recommendations and issues raised within the report.

3. Background

3.1 The 2017 Annual Public Health Report seeks to demonstrate that, as the old adage says, "prevention is better than cure." The simple rationale for prevention is that it is better and cheaper to prevent problems before they arise. There is a strong evidence base which demonstrates this to be the case. Across the public sector, not just in health, there is an increasing interest in and emphasis on investing in prevention and early intervention. In health, a fundamental re-orientation of the system towards prevention in order to improve health outcomes, keep people independent and well, and reduce demand for reactive high cost services, is an essential part of the answer to the current challenges facing the health and care system and to its future sustainability

3.2 The NHS has a key and distinct role in prevention. Indeed, the case for the NHS to '*get serious about prevention*' was powerfully articulated in the NHS Five Year Forward View[1], published in 2014. The same case was set out in the Wanless Report 15 years ago[2], yet we have not seen a substantial rebalancing of the NHS away from 'health care' and its focus on sickness, towards health over the past decade. There are a range of factors, incentives and constraints in the current system which account for this failure to achieve a radical shift towards prevention. Not least is the short-term timescales for NHS planning, which the Five Year Forward View attempts to address, and a common perception that investment in prevention only delivers a financial return in the longer term.

3.3 The focus of this year's Annual Public Health Report is on the economics of prevention and on those prevention interventions that will help the NHS save money in the short term. This will not only reduce demand for more expensive, particularly acute, hospital care, but will make the system more sustainable, and when delivered at scale, will have a demonstrable impact on the health and wellbeing of residents, their families and wider communities. However, embedding prevention truly requires a whole system approach and should not be seen as something that any one part of that system can do alone. Local government, through its statutory responsibilities for improving the health of residents, has a crucial role to play, including but in no way limited to its public health responsibilities and programmes. The role of the voluntary and community sector in supporting people to live healthy, fulfilling lives and preventing demand for statutory services should also not be underestimated.

3.4 However, this report specifically focuses on those preventative interventions that are supported by evidence of delivering a return on investment to the NHS over the short term (within 5 years). It aims to create a shared understanding across the local health and care system about why, at a national level, Department of Health expenditure on prevention should be wider than the public health budget, and to build the case for a wider NHS role and investment in prevention. Many of these interventions described within this report are already being funded across Camden and Islington through the councils' public health grants, and with additional funding from NHS commissioners and providers in some cases. To achieve the significant up-scaling of programmes required across the whole system, in order to have a demonstrable impact, further investment into these preventative interventions, alongside organisational, cultural and behavioural change, is required.

3.5 What is presented here is in no way intended to be a comprehensive overview of all effective and cost effective prevention interventions that are or could be delivered by the NHS locally or by the wider system. We hope, however, that the evidence presented is the start of developing a more sophisticated understanding of return on investment to different parts of the health and care system, which is particularly relevant to the accountable care arrangements that are emerging locally across our health and care systems.

- **Chapter 1** explains the background to the economic modelling presented within the rest of the report, its strengths and limitations, and describes some of the challenges in using evidence, and specifically return on investment, across the health and care system.

[1] NHS. *Five Year Forward View*. NHS: October 2014.
[2] Wanless, D. *Securing Good Health for the Whole Population*. Department of Health: February 2004.

- **Chapter 2** looks at how investing in up-skilling our workforce in Making Every Contact Count (MECC) enables us to cost-effectively capitalise on the opportunities to support people to improve their health and is vital to embedding a culture of prevention and early intervention across the system.

- **Chapter 3** describes the return on investment for a selection of key evidence-based preventative interventions. Investing in these interventions and supporting residents to live healthier, independent lives will prevent the development or progression of long-term conditions, improve quality of life and deliver a clear return on investment to the NHS in the short term. These interventions include:

    - supporting people to quit smoking;
    - reducing falls;
    - supporting people to reduce their alcohol consumption;
    - supporting people to lose weight through weight management programmes;
    - reducing unwanted pregnancies through the use of long-acting reversible contraceptives.

- **Chapter 4** describes how promoting and protecting health and wellbeing within the workplace can reduce sickness absence and presentism, as well as improving staff engagement and wellbeing, resulting in a return on investment from increased productivity.

3.6 While most of the cashable savings to the NHS associated with the interventions covered in this report come from a reduction in hospital admissions over the short term, the impact will be more wide-reaching and longer term. Other societal and broader economic impacts of these interventions are important too, which are not captured and costed within the traditional health economics models, but will have a positive impact on residents' health and wellbeing. These wider impacts include, for example, households saving money on cigarettes or alcohol; preventing social isolation in older people resulting from a fall; and over time, reducing the significant wider social costs associated with unwanted pregnancies.

While this report focuses on the financial benefits from investing in prevention, value is not simply about money. Other key dimensions that need to be considered are quality, patient or resident experience, and particularly important from a public health perspective and directly aligned to each Health and Wellbeing Boards' priorities, is the targeting of inequalities. Above all, value represents the ability within available resources to meet the goals of local health services in improving the health and wellbeing of the population, and of local people and communities in managing and improving their own health.

4. Implications

Financial implications:

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

Legal Implications:

4.2 Section 3 of the Care Act 2014 is concerned with the promotion of integration with health services. Local authorities have duties under section 1 of the Care Act 2014 to promote well-being, and further duties in relation to prevention under the section 2 of the Act.

Environmental Implications

4.3 Some aspects of improving health and wellbeing will also lead to reduced environmental impacts. A reduction in smoking rates will lead to less cigarette litter, which has negative environmental impacts including toxic leachate. Reducing obesity and encouraging active travel may lead to increased rates of walking or cycling and reduced car usage. Scaling up access to contraceptives could have a long-term positive impact on the environment due to the potential reduction in population growth.

Resident Impact Assessment:

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

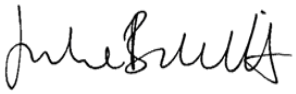
A Resident Impact Assessment has not been completed because it is not required in this instance. This report is presenting the evidence for why we should invest more in prevention. If the investment can be found to further invest in any of the interventions proposed, then resident impact assessments would need to be undertaken on a case-by-case basis.

5. Reasons for the recommendations:

5.1 The Health and Wellbeing Board is asked to consider the findings and recommendations of this report and to advise on how these can be taken forward to help ensure a radical upgrade in prevention, improve health and wellbeing, and reduce health inequalities.

Appendices: Annual Public Health Report 2017

Background papers: None.

Signed by: 

5 April 2017

Director Public Health — Date

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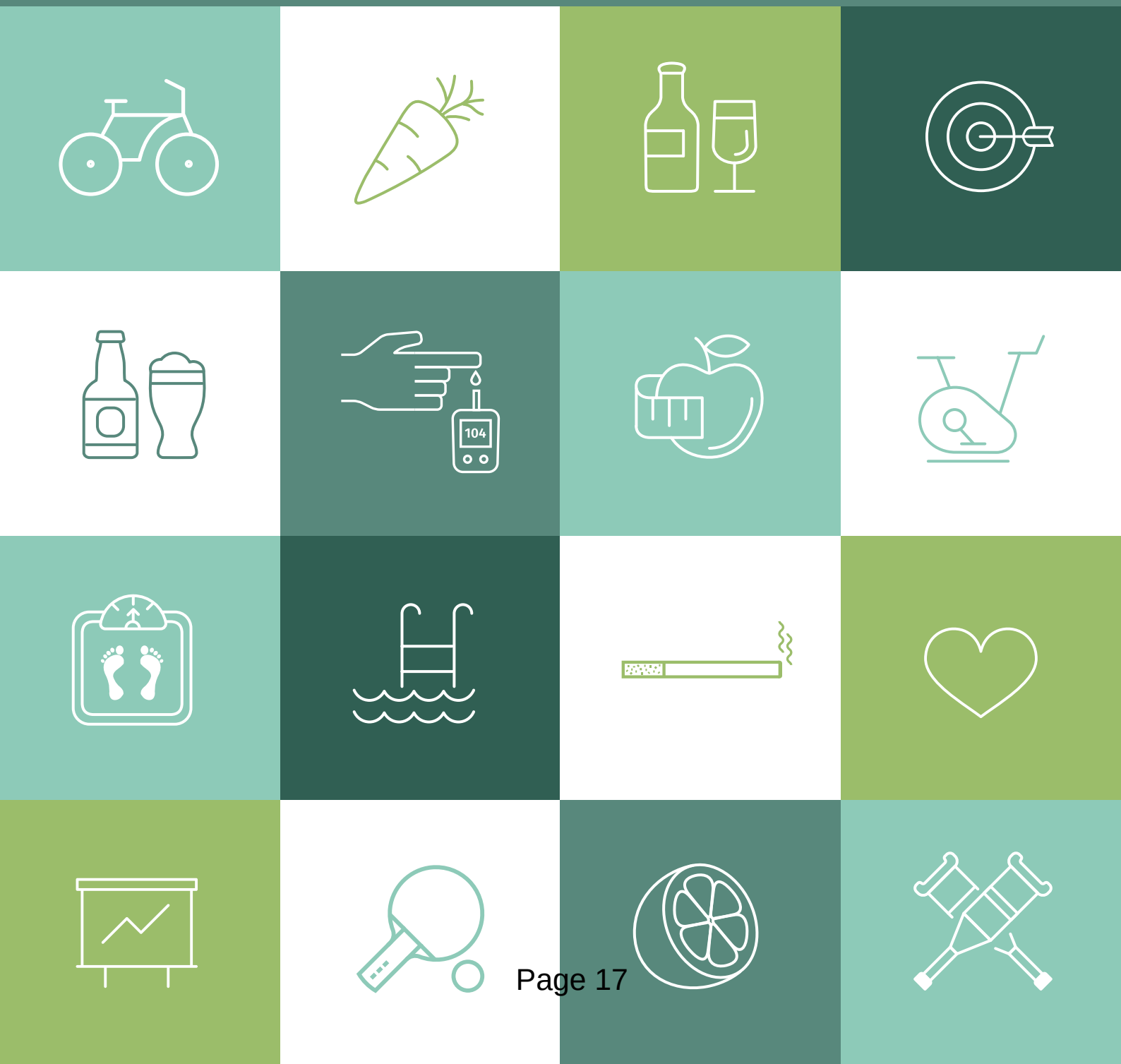
The economics of prevention and the role of the NHS

Annual Public Health Report 2016/17

ISLINGTON Camden



Contents

Foreword 6

Executive summary 10

Chapter 1:
Building the economic case for prevention in the NHS 14

Chapter 2:
A workforce for prevention: Making Every Contact Count 22

Chapter 3: Supporting residents, families and communities to make healthier choices 28

Chapter 4:
Creating healthier working environments 48

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Foreword

The health and care system is under growing pressure. The NHS, working with local authorities, needs to find ways to transform and make the system sustainable for the future. Investing in prevention is a key part of the answer, given that a huge burden of ill health in the 21st century is avoidable.

Advocating for investment in prevention within the health and care system is nothing new: Sir Derek Wanless made a clear and comprehensive case back in 2004.[1] Most recently, the NHS's Five Year Forward View calls for a 'radical upgrade in prevention and public health', in order to avoid spending billions of pounds in the future on avoidable illnesses and to improve health and wellbeing outcomes.[2]

While the NHS calls for a radical upgrade in prevention, Department of Health expenditure on public health has fallen, with cuts in the public health grant to local authorities. About 4% of the total healthcare budget is spent on prevention. Financial pressures within the NHS associated with a growing and ageing population, more complex health needs, new technologies and treatments and rising costs means that investment in prevention is more challenging. Our local health and care partnerships and strategies, the Wellbeing Partnership in Islington (jointly with Haringey) and the Local Care Strategy in Camden — retain a very strong and welcome focus on preventing poor health and improving outcomes for residents, aligned to the respective Health and Wellbeing Boards' priorities in each borough. There is also a strong expectation that prevention will be a key part of local Sustainability and Transformation Plans (STP) – five year, strategic plans for health and care transformation and integration that are being developed and implemented across larger geographies. Locally, Camden and Islington are part of the North Central London STP footprint. Given current pressures in the system, protecting existing investment in prevention and finding the additional investment needed to make a radical step change and a demonstrable impact on health and wellbeing, is proving to be the first challenge.

The bar for investing in prevention has always been higher than for treatment services. Indeed the current health care system in effect rewards providers for dealing with avoidable ill health and its consequences and complications by increasing funding for treatment services, at the expense of prevention and early intervention. Moreover, it is often assumed that the benefits of prevention, including any financial benefit to the health and care system, will only be seen over a long period of time, when financial challenges and pressures are very immediate. There is now a significant and robust body of evidence for public health and preventative interventions which show that they

1 Wanless, D. Securing Good Health for the Whole Population. Department of Health: February 2004.
2 NHS. Five Year Forward View. NHS: October 2014.

are highly cost effective and provide a return on investment.[3] The focus of this report is on those key preventative interventions that can return investment to the health service within 5 years backed up with robust evidence of effectiveness and economic modelling at a local level. The quality of evidence underpinning these calculations is often better than for many other interventions that the NHS funds, including many which are sometimes presented as cost-saving (often because of a lack of good economic evidence) but which may cost the system more money overall.[4]

Of course there is a collective responsibility for prevention that extends far beyond the NHS. As my previous Annual Public Health Reports[5,6] have discussed, so many of the factors and determinants that promote good health and wellbeing are out of the immediate control of the health system, such as housing, employment, education, and the built environment. As a place-based strategic leader and partner, local government through its very broad range of roles and responsibilities, and specifically through its public health functions and responsibilities, plays a vital role in prevention. This ranges from investing in primary prevention services, like smoking cessation support, to providing affordable, decent housing, from supporting older people to remain as independent as possible, through to using its regulatory and planning powers to shape the nature and quality of the environments in which we all live, work and play. Beyond local government, schools, business, the voluntary and community sector, and residents and communities themselves all have a key role to play in prevention. Furthermore, tackling the perverse incentives that exist across the health and care system and indeed across the wider public sector which mitigate against investment in prevention can only be done through a system-wide approach which moves us away from operating with siloed budgets for treatment and prevention.

The explicit focus of this report, however, is on the role of and the benefits to the NHS of prevention. It focuses on those interventions and programmes that, if invested in and delivered at sufficient scale, would have a demonstrable impact on the health and wellbeing of our populations over a short timescale. But a radical upgrade in prevention is about much more than just the money: it requires culture change across the whole system and behaviour change amongst health and care professionals so that prevention is placed at the heart of their clinical practice. The Helping Smokers Quit Programme run by the London Clinical Senate, an excellent example of

3 World Health Organisation. The Case for Investing in Public Health. 2014.
4 Imison, C et al. Shifting the balance of care: Great Expectations. Nuffield Trust: March 2017.
5 Camden and Islington Annual Public Health Report 2015. Healthy Minds Healthy Lives. Widening the focus on Mental Health. http://www.islingtonccg.nhs.uk/Downloads/CCG/BoardPapers/20150506/5.2.2%20Annual%20Public%20Health%20Report%202015.pdf (accessed March 2017)
6 Camden and Islington Annual Public Health Report 2013/2014. Widening the focus. Tackling health inequalities in Camden and Islington. https://www.islington.gov.uk//~/media/sharepoint-lists/public-records/publichealth/qualityandperformance/reporting/20142015/20140529wideningthefocustacklinghealthinequalitiesincamdenandislington (accessed March 2017)

this type of behaviour change embedded within clinical teams and across care settings, makes the powerful case that "helping people to stop smoking is the single highest value contribution to health that any clinician can make".[7] This type of change is vital if the system is to become sustainable - it is well recognised that doing less in the same way is not going to lead to a sustainable solution. Delivering evidence based interventions for the management of long term conditions (secondary prevention) will release cashable savings back into the NHS in the short term. Finding ways to embed prevention and support behaviour change and self-management in every clinical encounter and pathway, alongside a systematic re-orientation of the system and re-allocation of resources towards prevention is both necessary and supported by a strong economic evidence base.

Last but by no means least, it is important to acknowledge the commitment to and focus on prevention by our NHS partners across Camden and Islington, in particular Camden and Islington Clinical Commissioning Groups who have continued to prioritise investment into a range of preventative services, interventions and programmes locally. We should also recognise the success of some of our local providers in embedding prevention into their pathways of care, into their health and care settings and environments and through workforce wellbeing programmes.

Building on these strong local foundations, this report simply makes the case that further investment in prevention over and above the investment already in the system is needed in order to achieve a 'radical upgrade' in prevention and deliver a step-change in health outcomes and quality of life for residents.

Generating the localised evidence provided in this report is not straightforward, and I would like to thank Sarah Dougan and Samantha Warnakula for their work, and specifically the economic modelling, on which this APHR is based. I would also like to thank the other members of my team who supported the planning and creation of this report, as well as other colleagues.

Julie Billett
Director of Public Health,
Camden and Islington

7 London Clinical Senate. Helping smokers quit. (2016).

Executive summary

As the old adage says, “prevention is better than cure.” The simple rationale for prevention is that it is better and cheaper to prevent problems before they arise. There is a strong evidence base which demonstrates this to be the case. Across the public sector, not just in health, there is an increasing interest in and emphasis on investing in prevention and early intervention. In health, a fundamental re-orientation of the system towards prevention in order to improve health outcomes, keep people independent and well, and reduce demand for reactive high cost services, is an essential part of the answer to the current challenges facing the health and care system and to its future sustainability.

The NHS has a key and distinct role in prevention. Indeed, the case for the NHS to ‘get serious about prevention’ was powerfully articulated in the NHS Five Year Forward View,[8] published in 2014. The same case was set out in the Wanless Report 15 years ago,[9] yet we have not seen a substantial rebalancing of the NHS away from ‘health care’ and its focus on sickness, towards health over the past decade. There are a range of factors, incentives and constraints in the current system which account for this failure to achieve a radical shift towards prevention. Not least is the short-term timescales for NHS planning, which the Five Year Forward View attempts to address, and a common perception that investment in prevention only delivers a financial return in the longer term.

The focus of this year’s Annual Public Health Report is on the economics of prevention and on those prevention interventions that will help the NHS save money in the short term. This will not only reduce demand for more expensive, particularly acute, hospital care, but will make the system more sustainable, and when delivered at scale, will have a demonstrable impact on the health and wellbeing of residents, their families and wider communities. However, embedding prevention truly requires a whole system approach and should not be seen as something that any one part of that system can do alone. Local government, through its statutory responsibilities for improving the health of residents, has a crucial role to play, including but in no way limited to its public health responsibilities and programmes. The role of the voluntary and community sector in supporting people to live healthy, fulfilling lives and preventing demand for statutory services should also not be underestimated.

However, this report specifically focuses on those preventative interventions that are supported by evidence of delivering a return on investment to the NHS over the short term (within 5 years). It aims to create a shared understanding across the local health and care system about why, at a national

8 NHS. Five Year Forward View. NHS: October 2014.
9 Wanless, D. Securing Good Health for the Whole Population. Department of Health: February 2004.

level, Department of Health expenditure on prevention should be wider than the public health budget, and to build the case for a wider NHS role and investment in prevention. Many of these interventions described within this report are already being funded across Camden and Islington through the councils' public health grants, with additional funding from NHS commissioners and providers in some cases. To achieve the significant up-scaling of programmes required across the whole system, in order to have a demonstrable impact, further investment into these preventative interventions, alongside organisational, cultural and behavioural change, is required.

What is presented here is in no way intended to be a comprehensive overview of all effective and cost effective prevention interventions that are or could be delivered by the NHS locally or by the wider system. We hope, however, that the evidence presented is the start of developing a more sophisticated understanding of return on investment to different parts of the health and care system, which is particularly relevant to the accountable care arrangements that are emerging locally across our health and care systems.

Chapter 1 explains the background to the economic modelling presented within the rest of the report, its strengths and limitations, and describes some of the challenges in using evidence, and specifically return on investment, across the health and care system.

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Chapter 3 describes the return on investment for a selection of key evidence-based preventative interventions. Investing in these interventions and supporting residents to live healthier, independent lives will prevent the development or progression of long-term conditions, improve quality of life and deliver a clear return on investment to the NHS in the short term. These interventions include:

- supporting people to quit smoking;
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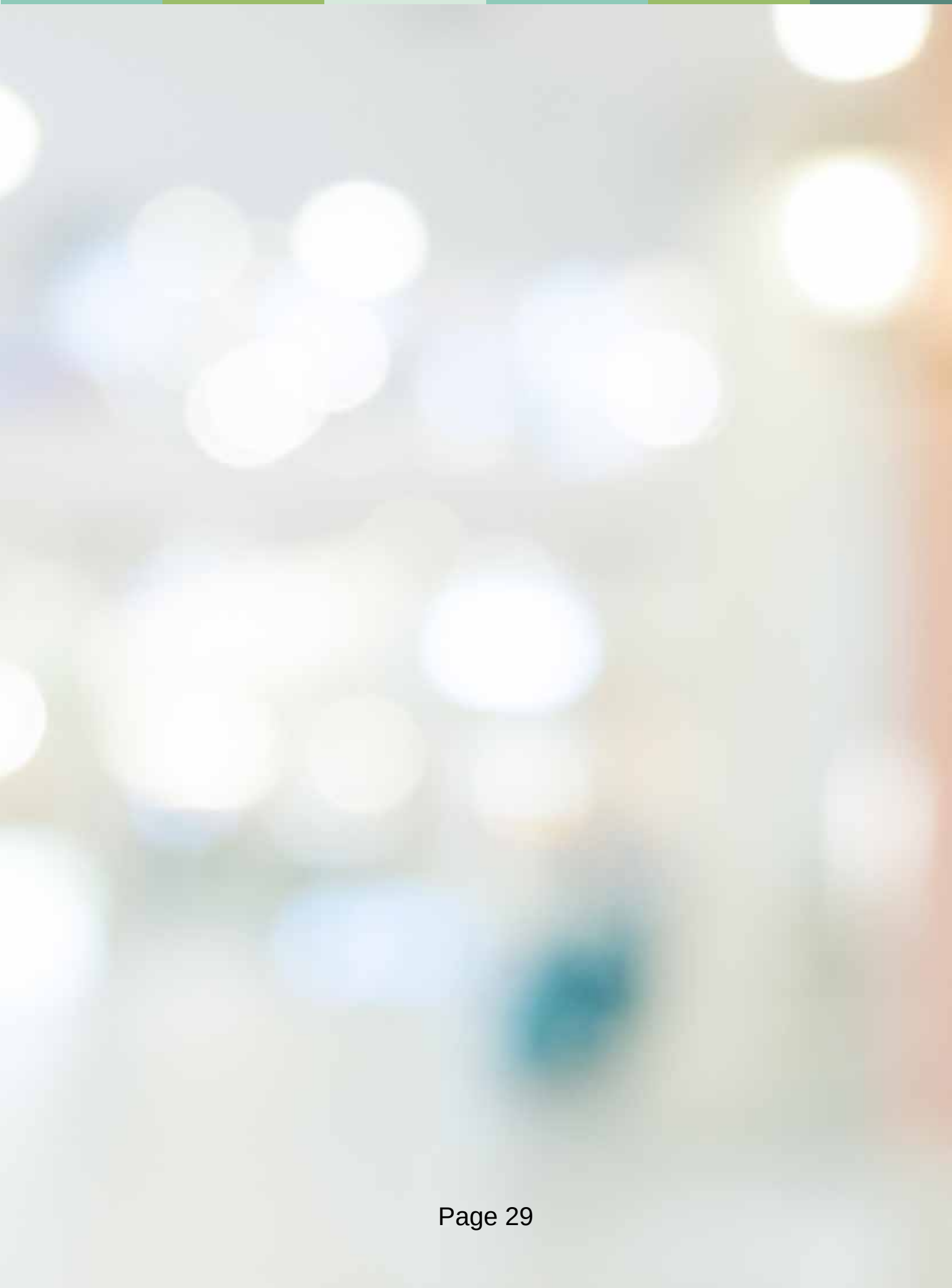
- supporting people to lose weight through weight management programmes; and
- reducing unwanted pregnancies through the use of long-acting reversible contraceptives.

Chapter 4 describes how promoting and protecting health and wellbeing within the workplace can reduce sickness absence and presenteeism, as well as improving staff engagement and wellbeing, resulting in a return on investment from increased productivity.

While most of the cashable savings to the NHS associated with the interventions covered in this report come from a reduction in hospital admissions over the short term, the impact will be more wide-reaching and longer term. Other societal and broader economic impacts of these interventions are important too, which are not captured and costed within the traditional health economics models, but will have a positive impact on residents' health and wellbeing. These wider impacts include, for example, households saving money on cigarettes or alcohol; preventing social isolation in older people resulting from a fall; and over time, reducing the significant wider social costs associated with unwanted pregnancies.

While this report focuses on the financial benefits from investing in prevention, value is not simply about money. Other key dimensions that need to be considered are quality, patient or resident experience, and particularly important from a public health perspective and directly aligned to each Health and Wellbeing Boards' priorities, is the targeting of inequalities. Above all, value represents the ability within available resources to meet the goals of local health services in improving the health and wellbeing of the population, and of local people and communities in managing and improving their own health.



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CHAPTER

Building the economic case for prevention in the NHS

Historically, funding in the health system has favoured treatment over prevention. However, there is a growing body of robust economic modelling — built on evidence of effectiveness and economic evaluation — which, when applied locally, shows that preventative initiatives can have a return on investment to the NHS even over the short term. This report makes the economic case for a greater focus on and prioritisation of prevention to save money. Doing this will not only reduce demand for expensive hospital care and make the system more sustainable, but delivered at scale, will have a demonstrable impact on the health and wellbeing of residents, their families and wider communities.

Much of the burden of ill health, poor quality of life and health inequalities is preventable; between 2013 and 2015, an estimated 23% (777) and 26% (828) of deaths were from preventable causes in Camden and Islington, respectively. The individual, social, and economic impacts of preventable ill health are extensive, and disproportionately impact on the poorest in society. The health and care system spends billions of pounds each year on treating illnesses and meeting care and support needs that are wholly avoidable.

The NHS has a key and distinct role in prevention, which is not just limited to delivering prevention as part of its treatment role - although obviously this is important. The NHS also has a key role to play as a major economic power in society, with massive population reach.

The box below summarises the various ways and levers through which the NHS contributes towards prevention and tackling inequality.

The role of the NHS in prevention

Impacts at an individual resident/ patient level:-

- Supporting behaviour change in people who are well but who are at risk of ill health, as well as in people who have one or more health conditions who are at risk of deterioration or developing other conditions (e.g. smoking cessation, alcohol screening and advice).
- Signposting and referring people to a range of our statutory and voluntary sector services and support to help maintain or promote health and wellbeing e.g. leisure services, befriending, money and debt advise, employment support.
- Ensuring the early identification, proactive and systematic management of long term conditions.
- Supporting patients and carers with self-management and self-care, empowering them to take actions for themselves and their families to maintain good physical and mental health, prevent illness and care for minor ailments and long term conditions.

Impacts as a "setting":-

- Creating health-promoting health care environments that support people to make healthier choices. For example, smokefree policies, providing a healthy food offer.

Impacts at a wider societal or population level:-

- As a major local employer, particularly of non-medical staff and through offering "good employment", for example, offering London Living Wage, apprenticeships and job opportunities for people who face particular barriers to work.
- As a healthy employer, supporting the physical and mental health and wellbeing of its workforce.
- As a commissioner and procurer of services from third parties and by ensuring fair conditions and social value are procured and maximised through its supply chain.

It is important to recognise and acknowledge that so many of the factors and determinants that promote good health and wellbeing are out of the immediate control of the health system and therefore prevention truly requires a whole system approach. For determinants such as housing, employment, education, and the built environment, local government plays a vital role in prevention, not only through delivery of specific services but also through its regulatory and planning powers to shape the nature and quality of the environments in which we all live, work and play. Beyond local government, schools, business, the voluntary and community sector, and residents and communities themselves all have a key role to play in prevention.

When thinking about prevention, it can be helpful to describe it as a series of different levels – wider determinants, primary, secondary and tertiary **(figure 1)**. The short term benefits of prevention are through secondary and tertiary prevention, essentially by helping to prevent further deterioration and ill-health in people who already have disease. These interventions generally deliver net cashable savings to the NHS by reducing hospital admissions, in addition to improvements in health and wellbeing for the individuals concerned. Effective secondary prevention requires both early diagnosis of disease and for health professionals (and others) to be encouraging and supporting patients who already have disease and their carers to change their behaviours including supporting self-management and self-care. Crucially, there is a role for every health professional in supporting secondary prevention, including hospital doctors, nurses, GPs, pharmacists, and allied health professionals (e.g. physiotherapists), as well as others within the public and voluntary sectors.

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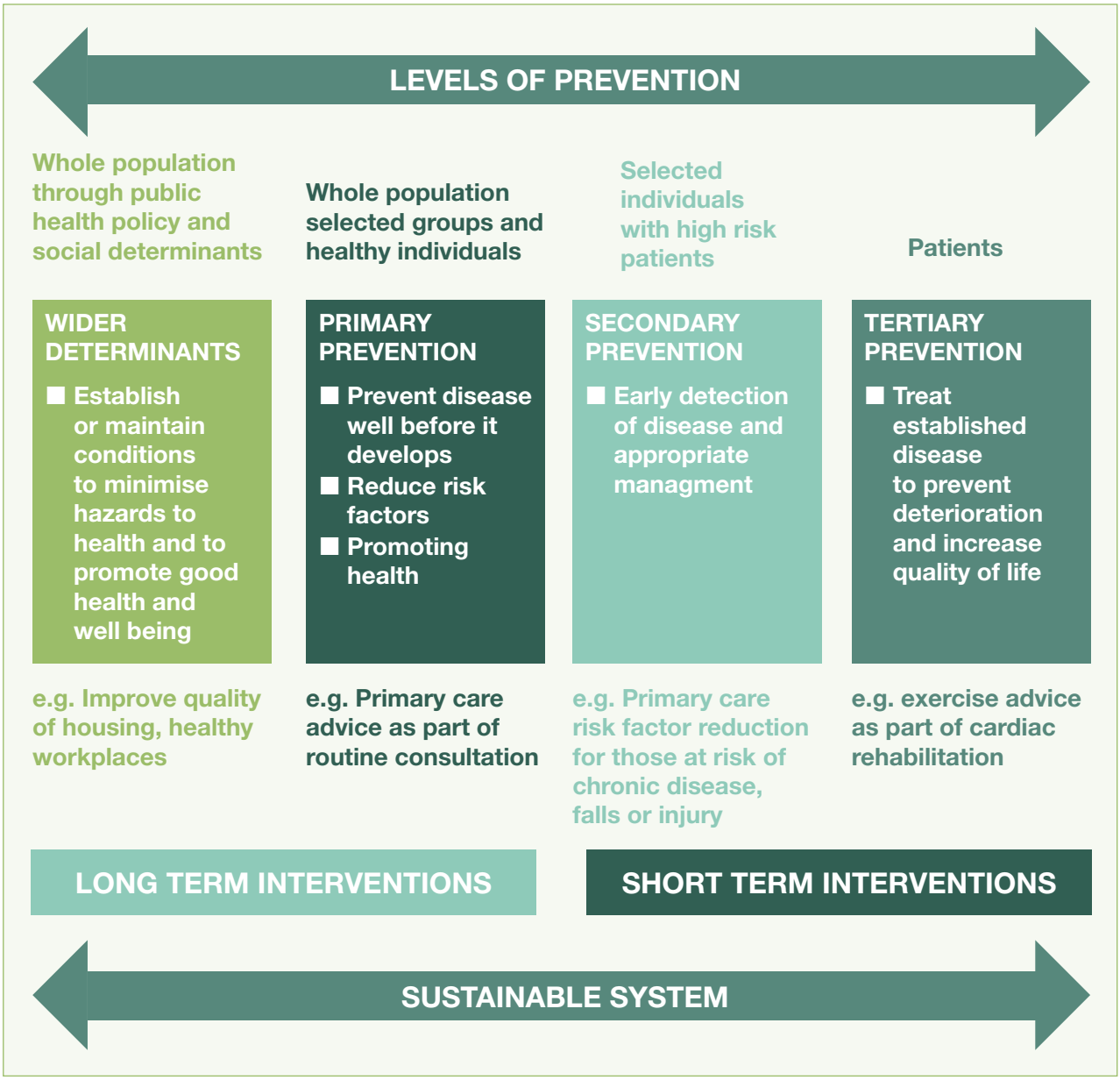
CHAPTER

Figure 1: the levels of prevention



While most of the cashable savings to the NHS associated with the interventions described in this report come from a reduction in hospital admissions over the short term, the impact will be more wide-reaching and longer term than this for the reasons set out below. Some of these additional health and financial impacts may not be felt for years or even decades:

- By systematically encouraging, supporting and providing targeted services focused on positive behaviour change, the NHS can play a key role in primary prevention, as well as in secondary prevention. This will result in cost-savings to the NHS over the medium to longer term from a reduction in 'high risk' behaviours.

- Not all of the savings from secondary prevention will be captured over the short term as the risk reduction for some adverse events can take longer. For example, stopping smoking will reduce a person's risk from cardiovascular disease within a year of quitting, but it takes five years for a reduction in lung cancer risk.

- Other societal and broader economic impacts of these interventions are important too, which are not captured and costed within the traditional health economics models, but will have a positive impact on residents' health and wellbeing. These include for example, households saving money on cigarettes or alcohol; preventing social isolation in older people resulting from a fall; and over time, savings to the welfare system from a more economically productive population.

It is important to understand that the weight of evidence used to generate economic modelling is substantial and includes research studies demonstrating evidence of effectiveness as well as economic evaluations. Owing to its focus on shorter-term cashable savings, there is an obvious absence of interventions relating to children and young people and other key interventions (e.g. HIV testing to reduce late HIV diagnoses) in this report. This emphasises the need to be planning and considering benefits and returns over a longer time period, which would help to ensure financial sustainability over the medium and longer terms. A recent systematic review has identified public health interventions that yield a return on investment in the medium and long term (table 1), some of which are already being implemented locally (e.g. 20mph zones).

Table 1:

Public health interventions that deliver a return on investment in the medium to long term (adapted from Masters et al., 2017)

Time over which intervention will return investment	Intervention category	Brief description of the intervention	Where the investment returns
Medium term (between 5 and 20 years)	**Evidence for local level intervention:**		
	Workplace wellbeing	Workplace health promotion for firefighters	NHS
	Physical activity	Improved cycling and walking infrastructure	
		Bike and pedestrian trails	
	High blood pressure	Home blood pressure monitoring for hypertension diagnosis and treatment	
	Education programme	Wellness and disease prevention programme	
	Young offenders	Multisystematic therapy with serious young offenders	NHS and wider public sector
	Road safety	20 mph zones	
	Alcohol	Therapeutic services for alcoholism	
	Oral health	Water fluoridation	Wider public sector
	Evidence for national level intervention:		
	Vaccination	Hib vaccination	NHS
	Nutrition	Sugar sweetened beverage tax	
		Eliminating tax subsidies for advertising of nutritionally poor food to children	

Long term (20 years or more)	**Evidence for local level intervention:**		
	Smoking cessation	Stop smoking services	NHS
	Education programme	Intensive early education programme for socially deprived families (preschool and school age programmes)	NHS and wider public sector
		Intensive early education programme for socially deprived families (extended intervention)	
		Preschool education programme for socioeconomically deprived children	
	Young offenders	Multisystematic therapy with serious young offenders and their siblings	
	Alcohol	Therapeutic services for alcoholism	NHS and wider public sector
	Evidence for national level intervention:		
	HIV	HIV/AIDS prevention	NHS
	Vaccination	Measles vaccination	
		Hepatitis B vaccination	
	Road safety	Campaigns	
	Tobacco	Programmes to reduce consumption	
	Heart disease	Programmes to reduce rates of coronary heart disease	
	Children	Parenting programmes for the prevention of persistent conduct disorders	NHS and wider public sector
Lifetime	**Evidence for local level intervention:**		
	Substance misuse	Supervised injection facilities	NHS and wider public sector
	Evidence for national level intervention:		
	Substance misuse	Needle exchange	Wider public sector
	HIV	Counselling, testing, referral and partner notification services	
		Expanded HIV testing	NHS
	Contraception	Family planning services	
	Nutrition	Folic acid fortification of grain	Human capital
	Vaccination	MMR vaccination	NHS and wider public sector
		Hib vaccination	

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CHAPTER

Additionally, the economic evidence presented here only considers the interventions which return savings to the NHS. There are other important interventions to improve health and wellbeing, which would be potentially cost saving to other parts of the public sector system, including local authorities and the Department for Work and Pensions (DWP), for example. The evidence is more limited in some of these areas, and developing a more robust evidence base for these types of interventions, as well as for interventions to achieve medium to longer term savings, should be a priority. Consideration of who invests in which interventions within the public sector and who gets the financial return (or more negatively, where a cost shunt occurs when services or interventions are reduced or stopped) will also become more important as individual organisations' budgets become more constrained. With full appreciation that this is a very complex system, better recognition and understanding of the impacts of organisational decisions across the whole public sector system will be pivotal in working together to improve the health and wellbeing of residents, and ensuring that we do not inadvertently widen health inequalities through individual organisational actions or decisions. More whole system population health approaches in which the new models of accountable care systems and partnerships are grounded, seek to mitigate these risks and move beyond organisational interests and silos.

Robust economic evidence, and specifically evidence of a return on investment, is both complex and challenging to produce. Typically, we see a relationship between the size of the reported gains and the strength and quality of the underpinning evidence: more robust modelling generally reports smaller economic gains. Being mindful of this and critically appraising the evidence on which investment decisions are being made will only become more important as the financial deficit grows across the health and care system. If the system truly wants to make evidence-based decisions and achieve planned savings then there needs to be a more sophisticated understanding and use of more robust evidence across the board. This is equally important for disciplines which do not have a strong evidence base, as for those that do, otherwise these areas will be continually disadvantaged when investment decisions are made because of a relative, perceived lack of return.

Finally, while this report focuses on the financial benefits from investing in prevention, value is not simply about money. Other key dimensions, which will certainly be more important from the perspective of our residents and that need to be considered are quality, access and patient or resident experience. Clearly the targeting and reduction of inequalities is also a key dimension when considering value and population benefits. Above all though, value represents the ability within available resources to meet the goals of local health services in improving the

health and wellbeing of the population, and of local people and communities in managing and improving their own health.

Key References

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02
CHAPTER

A workforce for prevention: Making Every Contact Count

Our local public sector workforce is one of our greatest assets for prevention and early intervention. NHS and other public sector staff have thousands of daily interactions with patients and residents and so are ideally placed to cost-effectively support people to improve their health and wellbeing and to access the right services at the right time.

We know we will be successful across Camden and Islington when…

…every member of the local public sector workforce, including all parts of the NHS, is a champion for prevention and taking proactive steps to close the health and wellbeing gap in the local population.

A key way we can ensure that residents are appropriately supported and directed towards preventative services that might benefit them, is by equipping our workforce with the knowledge, skills and confidence to support people to make healthier choices, and to embed this approach and holistic way of working into their everyday working practice. These would include interventions to address particular health behaviours (e.g. smoking, alcohol) and those that address the social determinants of health (e.g. debt, employment, housing). Doing this, at scale, will help increase engagement in the wide range of preventative services on offer locally and generate savings over both the shorter and longer term.

We can achieve this is by up-skilling staff to Make Every Contact Count (MECC). With competence in promoting self-care and prevention in their daily working lives, staff will be able to capitalise on the opportunities within their teams, with their patients and through other contacts to:

- support people to improve their health;
- identify and refer those who would benefit from the help and support of another service to improve their health and wellbeing, encompassing a social prescribing approach to make best use of the range of services, support avenues and assets to help people stay healthy, well and independent;
- embed and nurture a culture of prevention and early intervention across the system.

MECC is a whole system approach to reducing health inequalities and it helps to generate savings to the NHS and to the wider public sector by capitalising on the thousands of conversations that staff are already having each and every day across the system: the marginal cost of talking to someone about behaviour change within these conversations, which can last as little as 30 seconds long, is very small. The expectation is that from these thousands of conversations, some will move patients and residents a step closer to making healthier

choices, while others will go on to seek support from preventative services, with some of those going on to make positive changes as a result. MECC is therefore a personalised and cost effective way of raising awareness of health and wellbeing services across large numbers of people, and increasing demand for and take up of preventative services which provide direct cost-savings to the NHS and the wider system.

> One of the strengths of Making Every Contact Count has been the engagement of key services and organisations across Camden and Islington which has helped to ensure the training is relevant, accessible and useful to staff. With different styles of working and learning, we have managed to develop the training in a way that it meets a wide range of needs.
>
> **Islington CCG Staff member**

What is MECC?

MECC is central to how we can better support residents and patients to get the help they need earlier. Often when people are asked for help on issues that are outside the remit of their immediate role, staff do not always know what advice to give, nor do they feel comfortable giving it. In fact, our workforce, through their routine and daily contact with residents and patients, are ideally placed to spot needs and opportunities to help and encourage people to take positive steps to improve their own health. MECC training is about helping staff to spot those opportunities in the thousands of conversations they are already having with residents locally, having the confidence and skills to raise issues appropriately, and signposting to further support for issues related to:

- Money worries
- Debt and fuel poverty
- Getting the right job
- Housing
- Stop smoking services
- Physical activity and healthy eating
- Mental health and sensible drinking

and more

02
CHAPTER

What is MECC?

Importantly, MECC is not about staff becoming experts in all of these issues, but about having the knowledge, skills and confidence to have a brief conversation, when the opportunity presents itself in a way that respects residents' preferences and circumstances.

MECC should not be viewed as an isolated training intervention or programme on its own, but as a key component of the wider organisational and cultural changes necessary to support an increased focus on helping people stay healthy and well, rather than just treating ill health. MECC should also be seen as part of a continuum of approaches supporting behaviour change.

Workplace wellbeing programmes that support and promote employee wellbeing (see chapter 4), as well as 'environmental' changes, such as smoke-free hospitals or changing the food choices available in public buildings, are important and positive organisational influences on effective MECC implementation at scale.

> MECC training is very applicable to my work and will be beneficial to our housing clients - **Reception Centre Manager, Islington Council**

> The MECC training is very informative, and builds your confidence to support others
>
> **Sheltered Housing Manager, Camden Council**

MECC in Camden and Islington

During 2016, Camden and Islington Councils launched MECC programmes across the two boroughs. The MECC programme consists of three elements: a short introductory e-learning course, which helps all staff recognise opportunities and the various needs of residents, understand the basics of brief advice and provides knowledge on where to signpost people for further support. The second element is a face-to-face training offer, which builds on the short e-learning course by focusing on behaviour change techniques and is especially relevant for frontline staff members, who regularly work with residents and who would benefit from more focused training to equip them with the skills to enable them to deliver MECC confidently and consistently. The final element focuses on supporting implementation of MECC by having MECC champions who promote MECC by encouraging others to take part in the training and embed the skills into their everyday practice. This will help ensure sustainability of the programme.

Our local MECC training in Camden and Islington is fully accredited by Royal Society of Public Health (RSPH) and is available to all council staff as well as to staff in the NHS, voluntary and community sector and the emergency services.

To date, over 900 staff from a wide range of public sector services and the voluntary sector have received either e-learning or face-to-face MECC training. Staff have reported that the training has helped them make a positive difference to residents. There are opportunities now to expand this programme much more widely across both boroughs, including into all of our local NHS providers. Implementing MECC at scale will help deliver short term savings to the NHS by encouraging people who are already ill to change their behaviours (secondary prevention), as this is where we can achieve cost-savings within a five year period — by improving their health and reducing emergency hospital admissions. Clearly, there will also be wider benefits in the medium to longer term by helping people to stay healthy and well, and with them becoming more engaged in looking after their own health and wellbeing.

Further information is available at:
www.camdenmecc.org.uk
and **www.islingtonmecc.org.uk**

02
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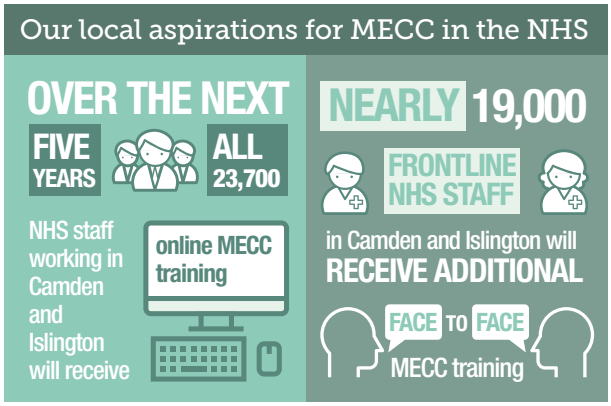

Prevention in action:

One training participant explains how MECC helped her signpost a client she was supporting for housing needs.

"I had gone to visit a young mum who I'd recently placed in temporary accommodation. She told me how she felt powerless to get a job because of having young children and no qualifications. I told her about Camden's Employment team and gave her their contact details. The next time I visited she had received information about a local college and the crèche facilities available, which led to her enrolling on a course."

Recommendations

1. We collectively aspire and commit to training up all of our staff through e-learning and, additional investment permitting, front line staff with face-to-face training. We will do this by embedding MECC into organisational training programmes, and targeting key services. To achieve short term financial savings to the NHS through prevention, this means that there needs to be a specific focus on front-line health professionals

2. 'MECC Champions' should be established within different organisations to advocate and promote MECC within their teams and services. To provide very visible leadership for our aspirations around creating a workforce for prevention, we ask that every board and senior management team has at least one MECC champion.

3. MECC is a key prevention priority within North Central London's STP and for the Healthy London Partnership at a London level. We will work collaboratively with partners to build upon, share, and use existing materials and learning to ensure cost-effective delivery and greatest impact.

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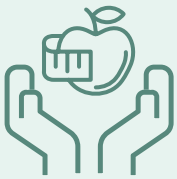
> Making Every Contact Count is key to really breaking down those barriers between health care, social care and other council services, most people just need advice and support on improving their health and quality of life, whoever provides it and all services across NCL should be doing that.
>
> **Royal Free London NHS Foundation Trust**

03
CHAPTER



Supporting residents, families and communities to make healthier choices

Supporting our residents to make healthier choices is vital, not only to extending life expectancy, but also for improving quality of life and preventing avoidable ill health and disability. This includes among people with long term conditions, to prevent deterioration and the development of other long term conditions. There is clear economic evidence that investing more to support Camden and Islington residents to stop smoking, reduce alcohol intake, lose weight and reduce unwanted pregnancies, as well as doing more to prevent falls, can result in net cashable savings to the NHS even within five years, a relatively short timeframe for prevention.

We know we will be successful when…

…our residents, families and communities are supported to look after their health: smoking and drinking less, eating more healthily, and being more active, as well as looking after their sexual health and mental health and wellbeing.

…there are far fewer hospital admissions from preventable causes such as smoking, alcohol, and falls, and reductions in associated ill health and early deaths.

The interventions described in this chapter have been identified on the strength of economic analysis demonstrating that they should save the NHS more than they cost over the next five years, using a return on investment methodology, and where benchmarking demonstrates there is scope to increase existing levels of activity within these areas in Camden and Islington. The analyses have not included longer term health impacts and other, non-NHS benefits, and so the overall benefits described in this chapter are likely to understate the full impacts of the selected interventions.

Although the analysis has a focus on savings within the NHS, as we set out in Chapter 1 of this report, many of the interventions cannot be carried out by the health service acting alone and are likely to best be realised by partnership action. For example, wider local and national tobacco control strategies which encompass multi-partnership working on education, prevention, treatment and smoke-free policies are important factors in individuals deciding to engage with stop smoking interventions.

Interventions which are multi-sectoral in their impact will also be particularly understated using these economic models and timescales, and are especially important when considering the needs of children and families, people with mental health conditions or other vulnerable groups, and older people. These are also important groups where collective action across partners can promote more effective use of resources and better experience and outcomes for residents. For similar reasons, interventions

in the development of conditions where outcomes are generally of a longer duration are also not captured, which means a short term focus may mean longer term 'opportunity costs' for future health service needs and resources. Some of these interventions are listed for reference in Chapter 1.

These interventions therefore represent only a subset of interventions that have been shown to be cost-beneficial or cost-effective in preventing or intervening early in health problems. Much wider programmes of partnership action are necessary to drive significant and lasting change, engaging individuals and families, communities and wider society in active change to promote better health and reduce health inequalities. It is particularly important that across the health and care system and particularly in areas such as mental health, children, maternity, long term conditions and primary care, that we continue and develop the local track records of partnership action for prevention and early intervention.

Supporting people to quit smoking

Smoking is the single greatest contributor to the health and wellbeing gap in Camden and Islington. People living in our most deprived communities are much more likely to smoke, and therefore die prematurely (before 75). Supporting people to quit smoking saves the NHS money by reducing smoking-related hospital admissions in the short term. Although our local stop smoking services perform well and benchmark favourably against other areas, helping around 40% of service users to achieve a "four-week quit", fewer than 1% of smokers are estimated to quit for a year or more using NHS stop smoking services in Camden and Islington each year. With investment, there is plenty of scope to up-scale services and deliver a bigger return on investment to the NHS, as well as reducing the burden of preventable ill-health from smoking.

Smoking increases the risk of developing serious health conditions like cancer and cardiovascular disease, and contributes to around one-in-six premature deaths among our residents. Almost half of all long-term smokers die of a smoking-related illness. Women who smoke during pregnancy have an increased risk of miscarriage, stillbirth and delivering babies with low birth weight.

Collectively, the harmful effects of smoking on health place a significant burden on the NHS due to the costs associated with GP consultations, prescriptions for drugs and treatment of smoking-related illnesses within our hospitals. Disability associated with smoking – related conditions also places a significant burden on adult social care, such as vascular dementia. Tobacco use affects not only smokers and their families, but also has multiple impacts across society, including loss of workforce productivity as a consequence of poor health, the cost of clearing cigarette litter from our streets, and smoking-related fires which require emergency service call-outs.

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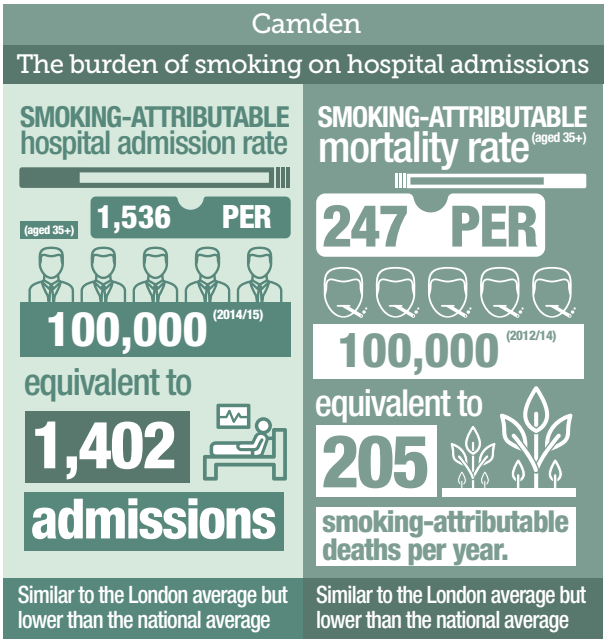
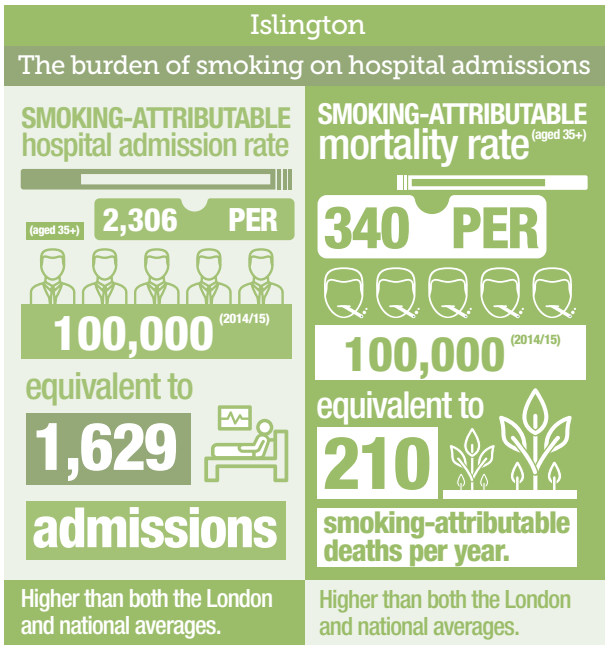
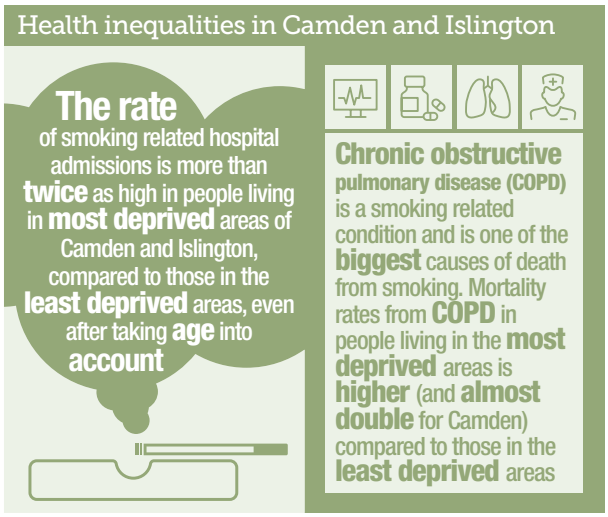
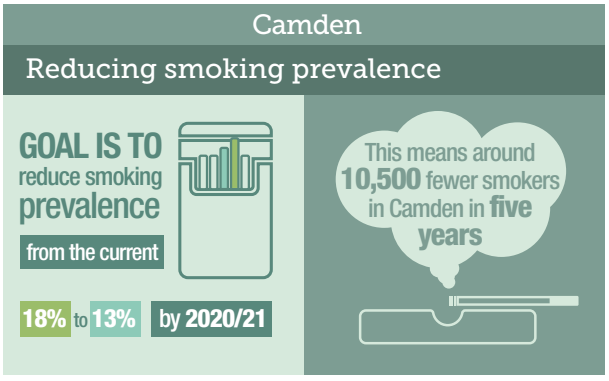




The number of people who smoke in Camden and particularly, in Islington, has remained stubbornly stable since 2010, even though prevalence has been steadily decreasing nationally. Camden and Islington's Tobacco Control Strategy 2016-2021 lays out a bold ambition to significantly reduce the prevalence of smoking in Camden and Islington over the next few years. This will involve all parts of the system supporting people to quit smoking, including in secondary care. Up-scaling access to and engagement in stop smoking services is needed, as well as offering smokers a range of options to support them to quit smoking; for example, through the use of digital apps for those who do not want to see a health professional, increasing support in the community through upskilling the voluntary and community sector to provide support, and providing more specialist addiction support for those with highly addictive smoking behaviours. All these options will be available to smokers across Camden and Islington as part of the newly commissioned stop smoking service, as well as through new forms of support being developed through the London Association of Directors of Public Health's Smoking Cessation Transformation programme.



A reduction in smoking prevalence across both boroughs will deliver cashable savings to the NHS through a decrease in smoking-attributable hospital admissions over a five year period. In addition to these direct healthcare savings, health inequalities could be reduced through upscaling the targeting of disadvantaged groups, including people with serious mental health problems, people with learning disabilities, specific BAME groups with higher rates of smoking, and people from the most deprived communities.



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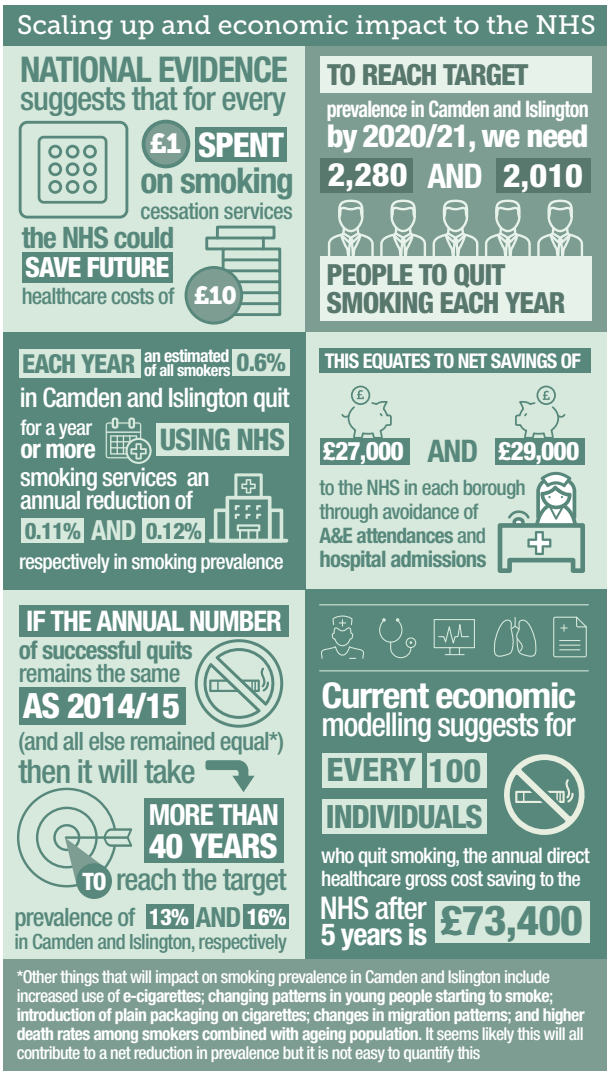

Prevention in action:

Camden and Islington NHS Foundation Trust's smokefree hospital policy

Camden and Islington Foundation Trust have had a smokefree hospital policy and nicotine management policy since 2015. There are no designated smoking areas in the Trust and no staff-supervised or staff-facilitated smoking breaks for service users. Nicotine replacement therapy (NRT) is available to inpatients 24 hours a day to support them to abstain whilst using the service or to stop altogether. Staff are trained to deliver evidence-based smoking cessation interventions. A smoking cessation care pathway supports people to address their nicotine dependence when they leave hospital or as they move across services.

Prevention in action:

Case study of an Islington stop smoking service user

Joe (not his real name) started smoking at 14 and by age 40 he was a heavy smoker. Since his late 20s he had been diagnosed with cancer twice and had tried to stop smoking three times, but without success. When he got his third cancer diagnosis, he decided to try again. Whilst undergoing chemotherapy treatment, his GP referred him to the Islington specialist community stop smoking service. Even though he had tried Champix three times before without success, he went on the medication again, not really expecting to ever give up. However, his advisor did not give up on him, and with their support, he managed to stop completely.

Having stopped smoking for the first time in over 25 years, he started noticing the benefits straight away. He made sure to keep to a healthy diet, as he was concerned about putting on weight. His swimming improved dramatically. He felt free from smoking which had been dominating his life and he had more time on his hands. He started showing up to his appointments on time, finishing his chores at home and taking better care of himself. When his cancer treatment finished, he planned to start voluntary work and was determined never to go back to smoking. He says that going to see the stop smoking advisor 'has saved his life'.

Reducing the harms of alcohol use

Alcohol has an important and positive role in British culture and is used widely in our society and family life. Locally the alcohol drinks market plays a significant part in the night time economy, contributing to employment and economic development. The vast majority of people enjoy alcohol without causing harm to themselves or others.

However excessive alcohol consumption can have a detrimental effect on nearly all parts of the body, and the associated health problems cause a significant burden on the NHS, as well as on the wider public sector. People with alcohol misuse problems often face multiple additional challenges such as unemployment, homelessness or housing issues, multiple drug use and involvement with the criminal justice system.

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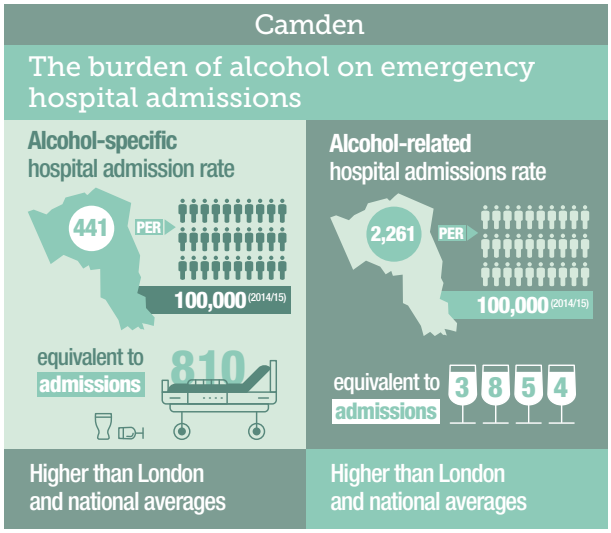
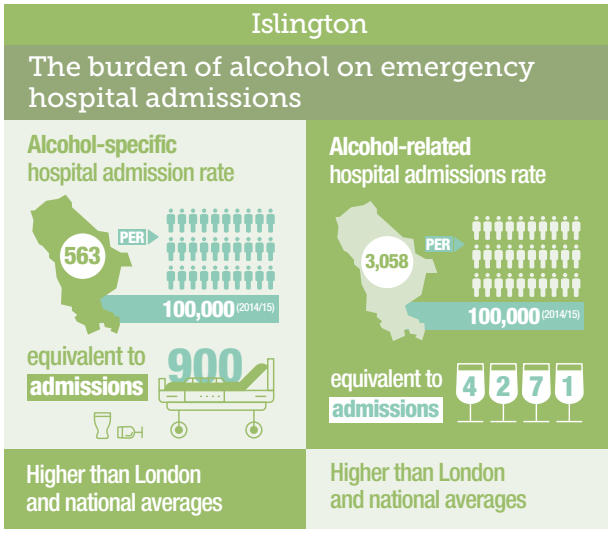




Across both Camden and Islington, reducing alcohol consumption and the associated harmful effects is a strategic priority for both Health and Wellbeing Boards, and a range of different interventions and levers are being used to achieve this, using a whole systems approach. In terms of the NHS, there is good national and local evidence that savings can be achieved in the short term (within 5 years) from alcohol screening, alcohol liaison, and alcohol assertive outreach teams. While all of these interventions are currently being delivered to some level in Camden and Islington, there is still potential to scale these up significantly given the high levels of alcohol-related harm within the boroughs.

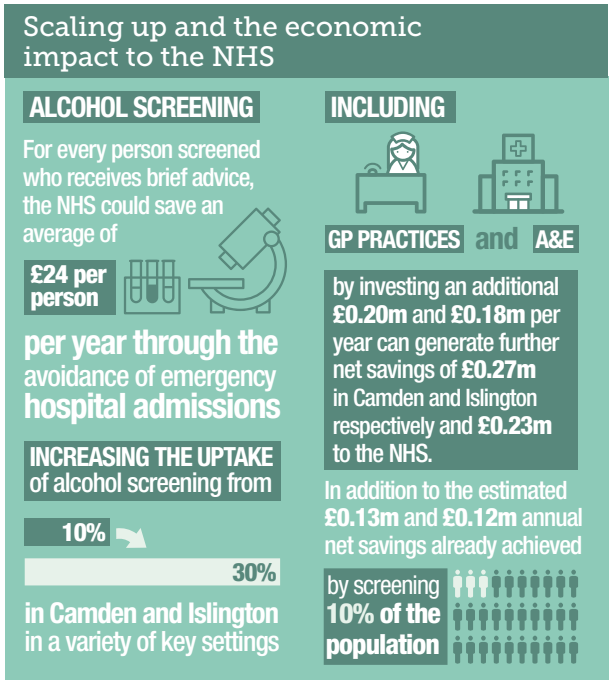
In addition to delivering cashable savings in terms of avoiding hospital admissions, and specifically repeat admissions, increasing the scale of delivery of these three interventions can also help to close the health and wellbeing gap locally by targeting high risk and dependent drinkers from those groups that suffer the highest levels of harm.

Alcohol interventions in Camden and Islington

Alcohol Screening: Camden and Islington adults are currently screened for their alcohol intake through either NHS Health Checks, or as newly registered patients with their GP practice.

Alcohol liaison services: Alcohol liaison teams, including in-hospital liaison nurses, target people with repeat hospital admissions and visits to A&E due to alcohol related problems. These services are already in place at the Whittington, UCLH and Royal Free. In Camden, alcohol liaison services are also able to refer potential clients to the Assertive (Alcohol) Outreach Team (AAOT).

Assertive (Alcohol) Outreach Teams: Assertive community treatment models have been shown to be effective in improving retention and engagement in treatment and improved clinical outcomes for people who misuse alcohol. This model seeks to support clients to engage with a range of support services, helping them reduce their alcohol intake and increase their social connections, leading to a positive impact on health, wellbeing, and self-management. Camden's AAOT is CCG funded and part of the wider Integrated Camden Alcohol Service (ICAS).



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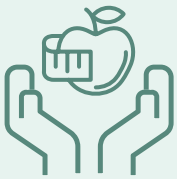

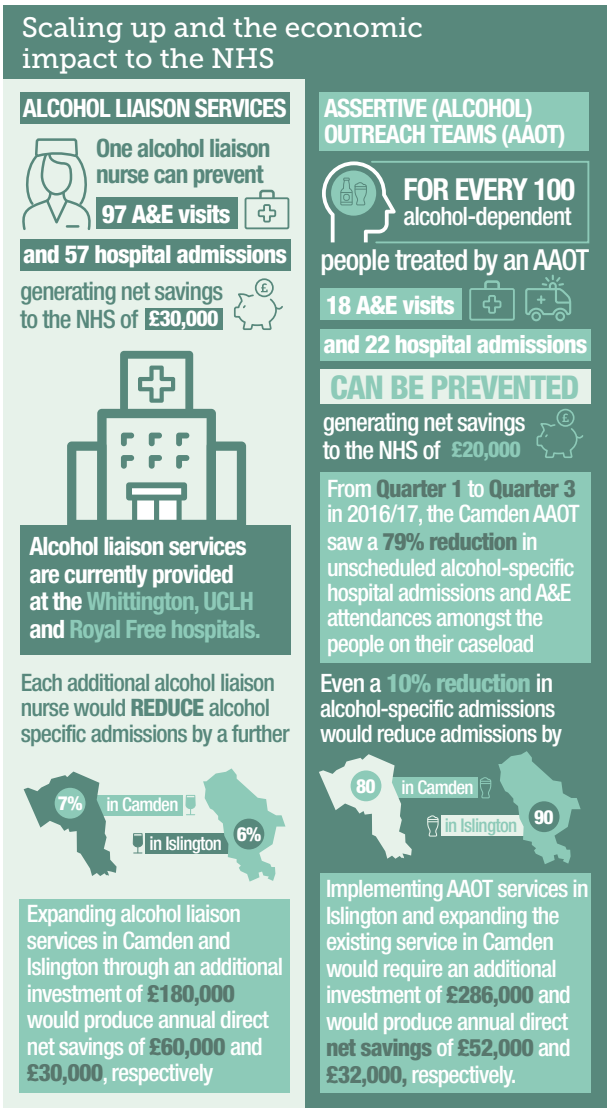

Finally, it is important to appreciate that the economic modelling of the benefits in reducing alcohol consumption captures only a small part of the possible impact on the system (by looking at hospital admissions). Given the wide-ranging impact of alcohol, there would also be other savings across the system which would return to other public sector bodies and may include for example, the ambulance service, the police, the criminal justice system, costs related to anti-social behaviour and domestic violence, as well as wider costs associated with homelessness, unemployment, and lost productivity.

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Prevention in action:

Case study of an AAOT patient

When Alex (not his real name) was referred to the AAOT he had been admitted 10 times in the last 6 months for alcohol-related seizures and was experiencing seizures almost daily. Alex suffered from depression and was also in a violent relationship. He was drinking 3-4 litres of 9% cider per day in order to manage his depression and seizures.

AAOT began working with Alex in November 2015 following his assessment. He was keen to stop drinking and worked with his keyworker to cut down very slowly to reduce the risk of seizures. It was suggested to Alex that if he could regularly attend the pre-detox group and his 1:1s that it would be a positive start to assess his commitment to his recovery. He was given a timetable, clear goals, and advised that if he felt able to do any more, it would all support and prepare his application for rehab.

Alex excelled all expectations. He attended every pre-detox group, every 1:1 at the Integrated Camden Alcohol Service (iCAS) site and his hostel. He attended SMART Groups every week, AA and recovery peers every week.

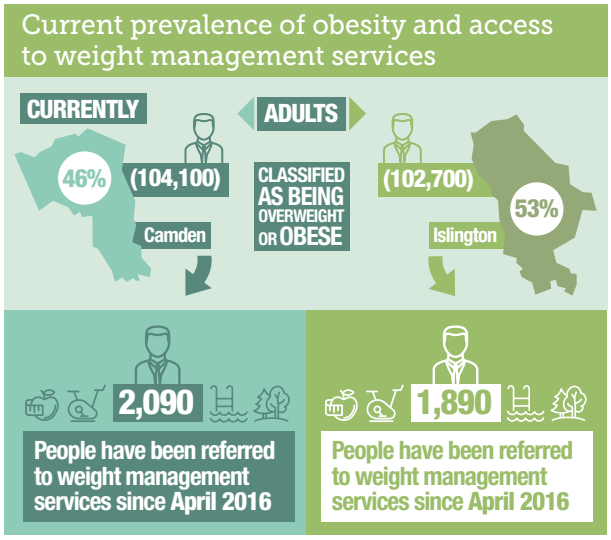
Through this intensive work with Alex, during his time prior to detox (4 months) his presentations and admissions to hospital reduced to only two. Alex remains in rehab and reports that 'his life has changed for the better' and that he was 'doing really well and working hard'.

03
CHAPTER

Supporting overweight and obese individuals to lose weight

Over recent decades, the environment we live in has made it ever easier for people to be less physically active and to consume more calories. A major consequence of our environment has been the rising public health challenge of overweight and obesity; this has significant implications for health, social care and the economy. Early intervention and prevention are very important because once established, obesity is difficult to treat. Supporting overweight and obese individuals towards moderate weight loss (5-10% loss of body weight) through weight management programmes can save the NHS money in the short-term, through a reduction in obesity-related complications and associated treatment costs.

Compared to individuals with a healthy weight, people who are overweight or obese have an increased risk of many serious health conditions including high blood pressure, type 2 diabetes, cardiovascular disease, mental illness, osteoarthritis and cancer. The treatment of obesity and related complications places a significant financial burden on the NHS due to the cost of diagnostics, prescriptions, surgery, and GP consultations, as well inpatient and outpatient care. The impact of obesity, however, is not limited to the direct financial burden on the NHS; there are much wider economic consequences through, for example, working days lost and welfare payments. Furthermore, individuals who are overweight or obese may suffer adverse social consequences such as discrimination, social exclusion and loss of or lower earnings.



Both Camden and Islington Health and Wellbeing boards have made it a strategic priority to reduce the prevalence of obesity; this requires a whole systems approach, using all levers available to support people to have the healthiest lives possible. Long-term commitment and action is required at every level, from the individual to society, and across all sectors. At a population level, it is changes to the environment and supporting healthier physical activity and food choices which will have the greatest impact on rates of obesity. However, at an individual level, the strongest evidence of effectiveness and cost effectiveness is for weight management programmes.

Weight management services aim to have a life-long impact by promoting healthier lifestyles and helping people to sustain these changes. However, in the short-term (five years), these services can also generate returns on investment to the health and care system through avoidance of treatment costs for obesity-related health conditions (e.g. type 2 diabetes). Therefore, the upscaling of existing weight management services (including integrated physical activity and wellbeing activities) in Camden and Islington will generate additional short-term savings to the NHS. In addition to these direct health care savings, health inequalities could also be reduced by targeting those population groups who are more likely to be overweight or obese, such as people from Black and South Asian minority ethnic groups, or people living with a physical and mental health problem.

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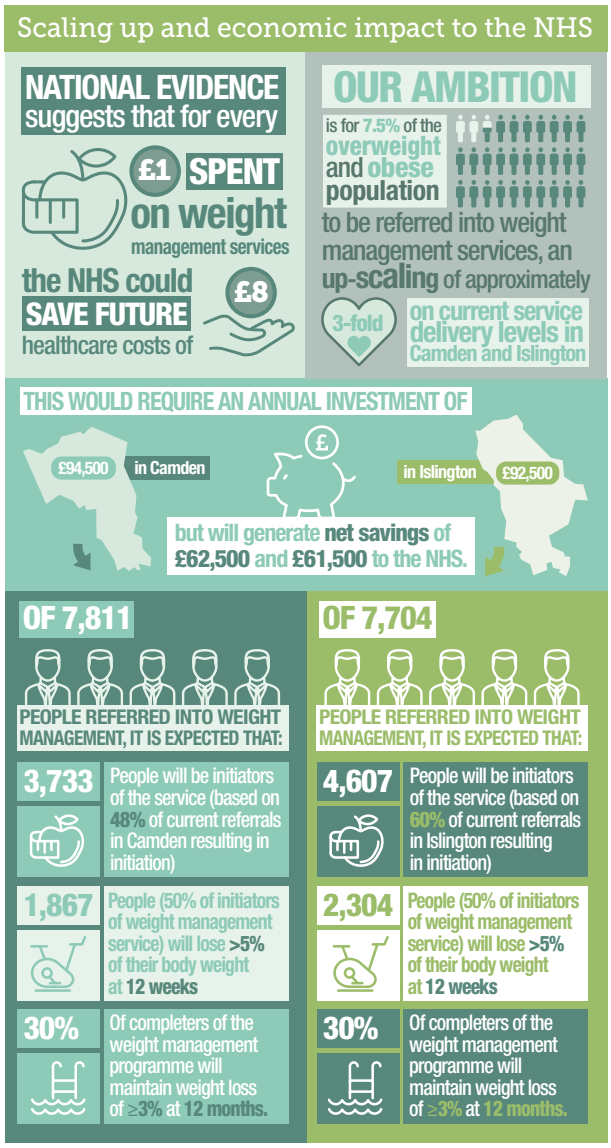

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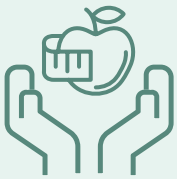


Prevention in action:

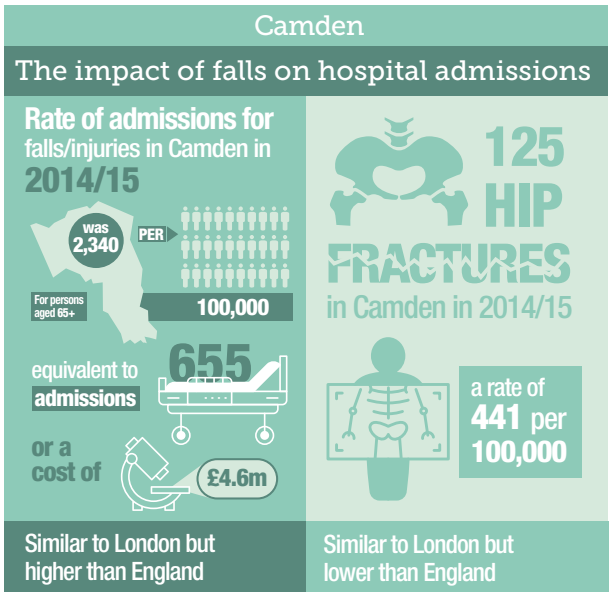
Testimonial from a resident enrolled in a local weight management programme

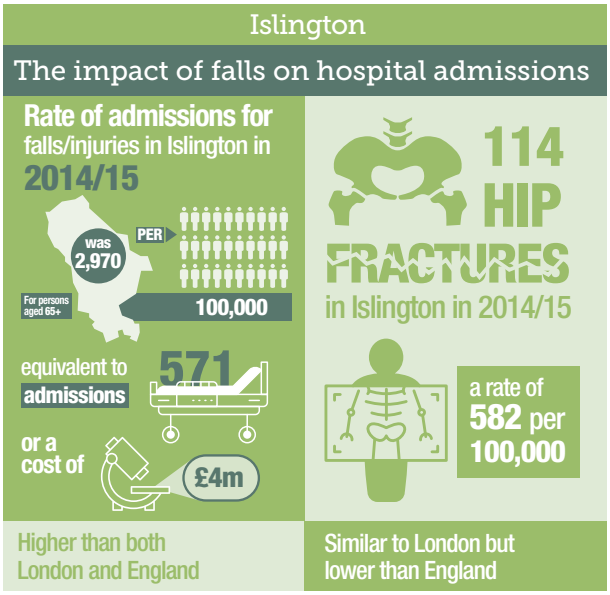
"I am incredibly grateful for my time in the programme. In the span of just 12 weeks I have lost 6 kilos. But even more importantly than the weight loss I have been supported on my journey of building better habits. I have absolute confidence that I can continue the great habits sparked by this programme. I now exercise four times a week, which is a major improvement over my sedentary lifestyle before this programme. I have also greatly increased my vegetable intake and reduced my sugar intake. Through these changes I feel healthier and more confident. I had tried many times to get myself into good sustainable health habits over the years and failed. This programme gave me the tools to finally move towards a healthy lifestyle that will last."

Preventing falls

Falls are a common and serious problem for older people, and a significant cause of injury, ill health, decreased confidence and mental wellbeing, functional limitation and premature death. Falls are the single largest cause of emergency hospital admissions among older people. Across England, approximately 30% of people over 65 years of age living in the community fall each year, increasing to 50% of people over 80 years of age. Falls are also very costly to the health and care system: they result in a heavy burden on both social care services and the NHS, with approximately 20% of falls requiring medical attention and 95% of hip fractures occurring as a result of a fall.

Among older people, Camden and Islington both have a significantly higher rate of falls resulting in serious injury compared to the national average. Preventing falls is a key component of improving the overall health of the older population given the impact it has on people's independence, and related to that, their confidence and ability to be able to get out and not become socially isolated at home. As the population ages, the number of falls and their impact on health and wellbeing, as well as demands on and costs for the public sector, are likely to increase unless sustainable and effective falls prevention interventions are delivered at scale.





Prevention in action:

Role of wider public sector partners in prevention of falls

Islington have been recently named as one of five pilot sites across London to roll out Safe and Well checks with the London Fire Brigade Service as part of the initiative "Fire as a health asset". A Safe and Well visit is a person-centred home visit carried out by Fire and Rescue Services. The visit expands the scope of previous home checks made by the London Fire Brigade. In addition to reducing the risks of a fire, they will aim to reduce health risks such as falls, loneliness and isolation which will also reduce unplanned hospital admissions and help people to stay in their own homes safely and for longer.

Safe and Well visits are part of ongoing work on understanding how people move into and between services, and any barriers that hinder this. This includes the vital role of the voluntary sector in both preventing falls through programmes such as exercise for older people, and the response for people who have had a fall through programmes such as those that reduce social isolation. One of the key risk factors for falls is frailty, and the Haringey and Islington Wellbeing

continued...

continued...

Partnership is looking at ways to explore using the electronic frailty index to identify the most vulnerable using information already in GP clinical systems. This then enables an earlier offer of possible interventions, including falls prevention, to enable residents to remain independent and socially engaged. Other key aspects include the role of housing and housing-related services which can help to make homes safer, for example by fitting hand rails or reducing trip hazards. Many organisations in both the statutory and non-statutory sectors are contributing to this work, and we are working together to scope provision across community and healthcare settings to inform the development of a shared understanding of how services work together and where we could do better. This will help to ensure adherence to NICE standards and quality statements, and facilitate people's access to prevention and treatment services, and seamless transfer between services.

Across Camden and Islington it should be possible to reduce falls-related hospital admissions by 10%, through providing multifactorial interventions combining regular strength and balance exercise, modifications to people's homes, vision assessment, and regular review of medicines. There is good evidence to suggest that these multifactorial interventions are effective in reducing the rate and risk of falls. Work is currently underway to scope the feasibility of a single falls pathway across primary, secondary and tertiary services in Camden and Islington. In particular, the pathway will target those at increased risk at falling, for example those over 65 who have fallen previously. Recurrent falls occur in 60–70% people who fall, and economic analysis suggests that preventing repeat falls is cost saving to the NHS.

Scaling up and economic impact to the NHS

Nationally, falls are estimated to cost the NHS more than **£2.3 billion** per year, with additional costs seen in other community settings and services.

Savings from falls prevention interventions will be seen in:

- Emergency admissions **(35% savings)**
- Social care **(14% savings)**
- Primary and community care **(50% savings)**

Camden

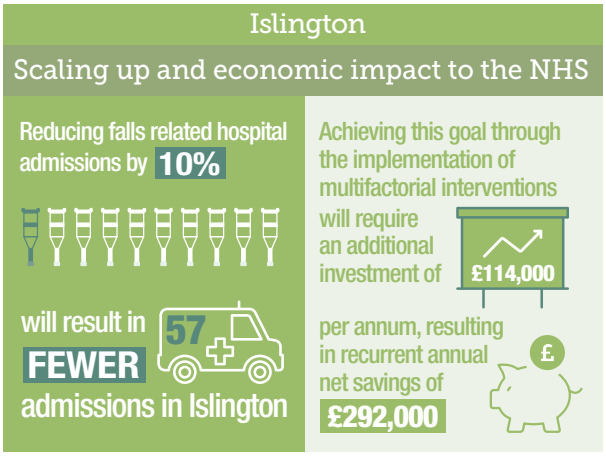
Scaling up and economic impact to the NHS

Reducing falls related hospital admissions by **10%**

will result in **FEWER** admissions in Camden **66**

Achieving this goal through the implementation of multifactorial interventions will require an additional investment of **£124,000**

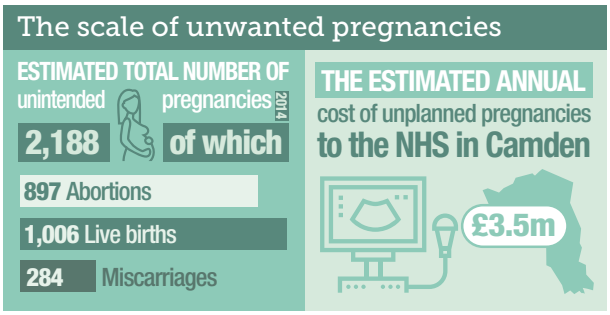
per annum, resulting in recurrent annual net savings of **£341,000**

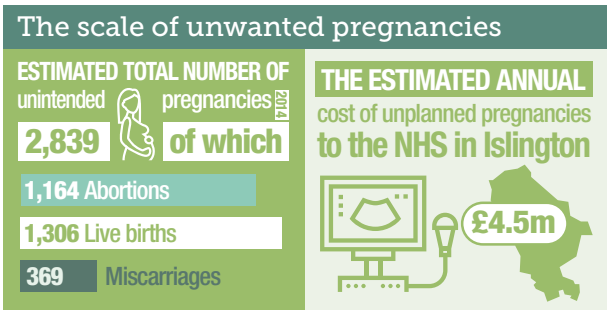


Reducing unintended pregnancies

Births resulting from unintended or closely spaced pregnancies are associated with adverse maternal and child health outcomes, such as delays in accessing prenatal care, premature birth, and negative physical and mental health outcomes for children. Providing access to and promoting the use of contraception is an important part of reducing unwanted and unplanned pregnancies, and can generate savings to the NHS in the short-term, through the avoidance of community and hospital costs for managing unplanned pregnancies. Reducing unwanted pregnancies also obviously has much wider social and economic benefits beyond the NHS.

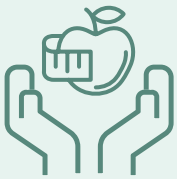
National evidence indicates that of all unintended pregnancies, 41% end in abortion, 13% in miscarriage and 46% in live birth.





The rate of abortion among women aged 15-44 years is just below the national average in Camden, but it is significantly higher in Islington. Importantly, repeat abortions are common, particularly among younger women: three out of ten women aged 15 to 24 years who had an abortion in 2015 in Camden and Islington had previously had an abortion, and four out of ten women of any age who had an abortion in 2015 in Camden and Islington had previously had an abortion.

While not all unplanned pregnancies can be prevented, the promotion of more effective contraceptive methods can reduce the number. Long acting reversible contraception (LARC) is the most effective form of contraception;



and whilst putting patient choice and woman-led decision making at the centre of our local approach, the priority in Camden and Islington is to upscale the use of LARC, to meet individuals' needs and circumstances. This will involve primary care, maternity and abortion services and services for early pregnancy loss, working in partnership with secondary care services – combining universal approaches with targeting of groups with greater vulnerability or disadvantages. This new integrated approach would need to be complemented by training and skills development among relevant professional groups to help promote the benefits of LARC in preventing unintended pregnancy, together with awareness-raising and promotion in the community.

LARC has been an important part of programmes to reduce teenage pregnancy within more disadvantaged groups. More recently, local sexual health services are closely linked into initiatives for women who have experienced, or are at risk of, repeat removals of their children into care, to offer them pathways for access to LARC, such as through the PAUSE programme in Islington or Brandon Reach in Camden.

Upscaling the uptake of LARC would deliver cashable savings in the shorter term to the NHS through avoidance of maternity costs, miscarriage, abortions and mental health problems related to unwanted pregnancies. More widely and in the medium to longer term, public sector savings would also be achieved in education, housing, social services and welfare costs.

Prevention in action:

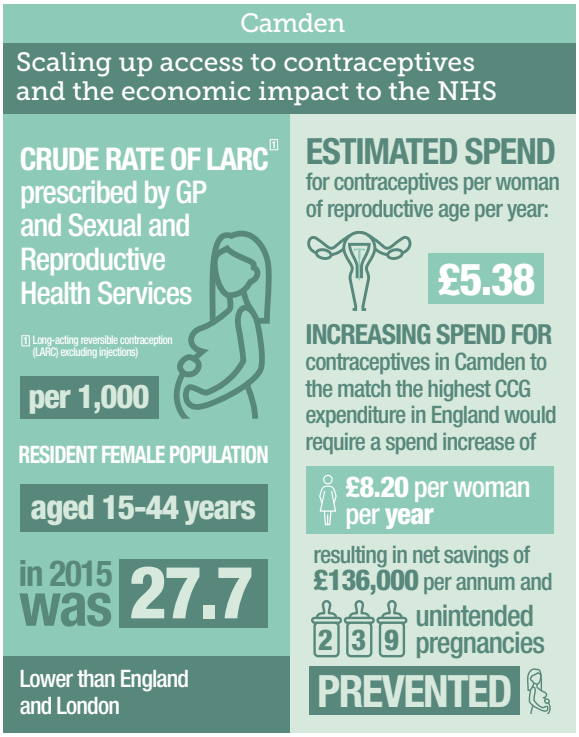
Local services to prevent unwanted pregnancies

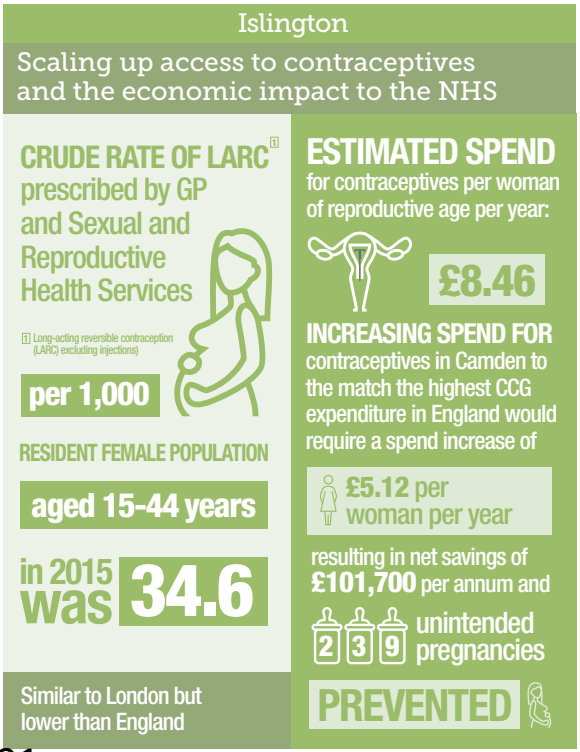
The PAUSE programme is an innovative programme offered in Islington designed to address the needs of women who have had or are at risk of having multiple children removed into care. PAUSE aims to intervene at a point when women have no children under their own care, creating a space to support women to reflect and develop new skills and responses. This "space" is facilitated by requiring participants to take LARC if they agree to be part of the PAUSE programme.

Brandon Reach in Camden provides similar services for young parents under twenty five who have had a child removed from their care. Brandon Reach provides confidential and flexible services in an outreach format, meeting with clients wherever they feel most comfortable.

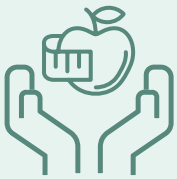
Case study

Bella came to Brandon Reach shortly after her final hearing. She was very distressed and struggling to understand everything that had happened. Over the course of therapy she shared horrendous experiences of abuse and violence both in her childhood and in her intimate relationships. Her initial coping strategy with the loss of her child was excessive alcohol and drug use and "one night stands". Intimate relationships often served as a way of numbing the pain she felt and she spoke about finding it hard to "be alone" as it meant sitting with the loss and trauma. Relationships and her sexual health and wellbeing were part of our conversations throughout the process of therapy. Bella became a regular user of our contraceptive service, initially having regular checks and then accessing contraception (the contraceptive pill and then later on the implant). Her contraceptive journey reflected her therapeutic journey; as she came to understand herself better in relationships she felt more able to be assertive about her own desires and needs (including the use of contraception and being adamant that she did not want another child, when her ex-partner was pressuring her to).





03
CHAPTER



Recommendations

1. We will work collectively across the system to make the case for and secure the additional investment needed to radically upscale these programmes and interventions. Given the cost-savings that can be generated, these interventions could potentially become part of local QIPP and CIP programmes (NHS savings plans for commissioners and providers). This will enable us to better support residents to make healthier choices and make a demonstrable impact on health and wellbeing outcomes, including health inequalities across Camden and Islington.

2. We will also look at how we can work better together to get more out of our current investments and delivery of these services. This could be, for example, by establishing or strengthening provider networks to share learning and best practice, by ensuring behavioural interventions are embedded within care pathways; and by using our commissioning levers to ensure that providers are focused on delivering preventative interventions (e.g. abortion services and LARC).

3. We will make best use of also make best use of NCL Prevention Board, part of the STP, to work with partners across the health and care system in NCL and London to share learning, best practice and where appropriate, to do things across a larger geography. This would include across a wider spectrum of interventions, including mental health, children, maternity, long term conditions and primary care and building on and developing actions for longer term, multi-sectoral prevention and early intervention.

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04
CHAPTER

Creating healthier working environments

Without employees who are well and at work, the NHS, as well as other public sector organisations and local businesses, cannot deliver high quality and safe services. There is a solid evidence base which shows that investing in workplace wellbeing can deliver a return on investment to the NHS by reducing absences and increasing staff retention. In light of the growing pressures on public sector services, including the NHS, the health, wellbeing and resilience of staff will only become increasingly important, in order to both sustain the system and to enable change and service transformation to happen.

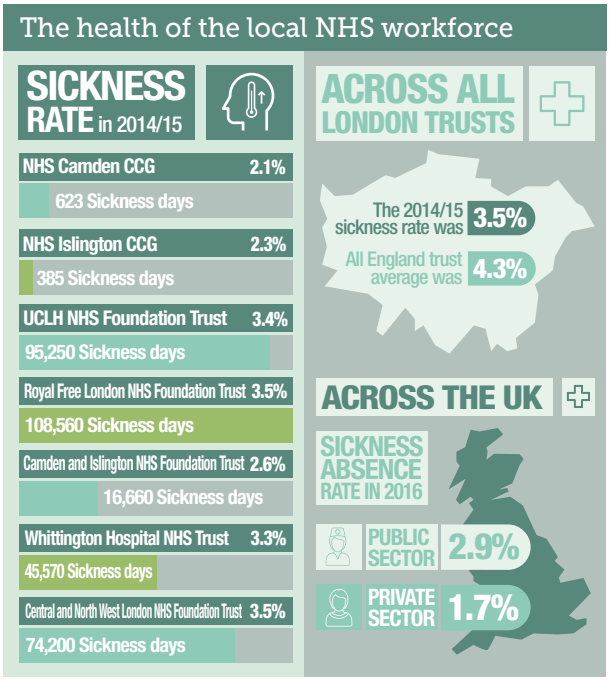
We know we will be successful when…

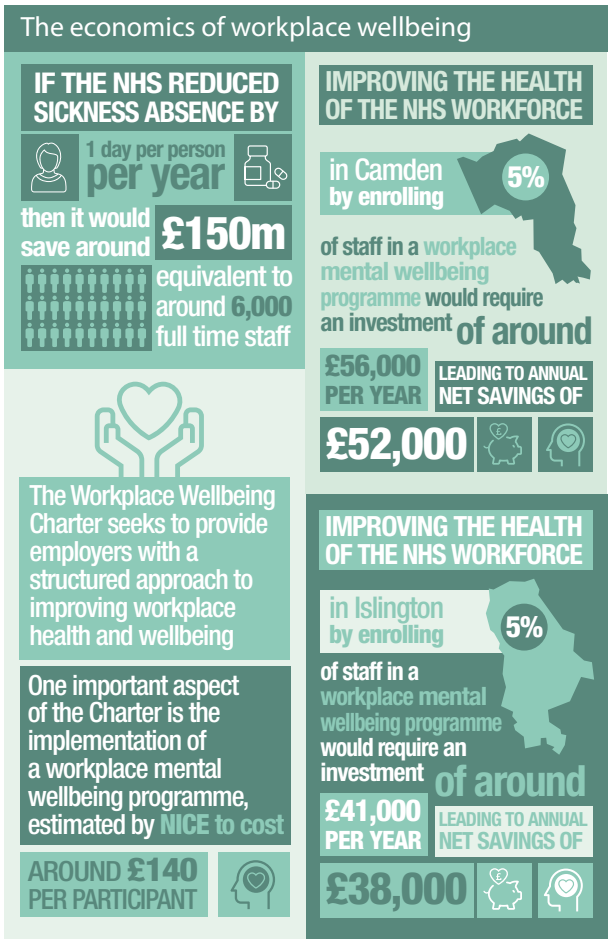
…across Camden and Islington those working locally become healthier, through increasing levels of active travel, supporting positive mental health wellbeing, supporting employees to quit smoking and to eat more healthily, all leading to reduced absences and increased productivity.

In 2015, Public Health England estimated the annual cost of sickness absence to the NHS was £2.4bn. The benefits of a healthier workforce to the NHS of investing in staff health and wellbeing go beyond productivity and cost savings. They include:

- improved patient safety and experience
- improved staff retention and experience
- reinforced public health promotion and prevention initiatives
- setting an example for other industries to follow.

Even small reductions in sickness absence can deliver large savings. Investing in the health and wellbeing of staff can also help the NHS improve the productivity of staff, making further savings by positively impacting on the overall health, wellbeing and happiness of the workforce and reducing rates of presenteeism. Additionally, keeping employees happy, healthy and in work has wider impacts on the health and life chances of their families, communities and wider society.





Staff retention rates also improve when people feel their employer cares about their health and wellbeing, resulting in lower recruitment costs, improved team cohesion and better working environments. Locally, as is the case across London, the NHS experiences some significant problems in recruiting and retaining elements of its health workforce, and keeping staff healthy and at work in the first place is one way of tackling this.

04
CHAPTER

Improving the health and wellbeing of staff has been a focus within the NHS over the past couple of years, following the influential Carter Review which highlighted workplace wellbeing as a key enabler of operational productivity and performance. In London, the London Healthy Workplace Charter has been developed to support employers, and in 2016/17 a health and wellbeing Commissioning for Quality and Innovation (CQUIN) payment, which provided a direct financial incentive for trusts to invest in the health and wellbeing of their staff, was introduced by NHS England. While there has been progress in improving workforce wellbeing across the NHS locally, there are still opportunities to look at what is working well, learn from good practice, and to implement effective interventions consistently and at scale across all NHS organisations to have a demonstrable impact on workforce wellbeing.

Across Camden and Islington we want to ensure that all NHS organisations, as well as the two local authorities, attain at least the 'achievement' standard of the London Healthy Workplace Charter, and ideally to reach the 'excellence' standard to ensure that the health and wellbeing of staff is central to the organisation's culture and values. In doing this, we can continue to build on the progress made in hospitals — the largest NHS employers — in implementing the 2016/17 CQUIN.

Prevention in action:

improving workplace wellbeing at the Whittington

COPY TO FOLLOW

London Healthy Workplace Charter and our progress locally

The London Healthy Workplace Charter provides a framework for action to help employers build good practice in health and work in their organisation. The Charter supports all types of employers, large and small, from the public, private or voluntary sectors. Using the self-assessment framework, an organisation can find out what it is already doing that fits into the ethos of the Charter as well as where it might need to improve. The framework reflects best practice and is endorsed nationally by Public Health England

Some of the standards in the Charter include encouraging staff to be more

PHYSICALLY ACTIVE
Including promoting active travel to work

HEALTHIER EATING
Providing information about healthy eating and user-friendly eating facilities

MENTAL HEALTH
Providing information and training on mental health and wellbeing

WORK LIFE BALANCE
Through flexible working policies

There are three award levels which organisations can work towards

COMMITMENT
THE ENTRY LEVEL
For organisations that have recently started the process

ACHIEVEMENT
THE INTERMEDIATE LEVEL
For organisations that have a more advanced and comprehensive approach to employee wellbeing

EXCELLENCE
THE ADVANCED LEVEL
For organisations that demonstrate that health and wellbeing are systematically embedded in their corporate culture and values

ACHIEVEMENTS LOCALLY

Camden and Islington Foundation Trust, Camden Council and Camden CCG are at commitment level and are working towards achievement.

University College London Hospital (UCLH), Central Northwest London (CNWL) NHS Foundation Trust, Royal Free London NHS Foundation Trust and Islington CCG are all at achievement level

Islington Council is currently at achievement level and working towards excellence.

The Whittington Hospital is already at excellence level.

UCLH have been awarded 'achievement level' on the London Healthy Workplace Charter. The trust has made several changes to benefit their staff's health and wellbeing, including:

- Revised their smoking policy to include a ban on vaping within their premises
- Changes to their smoking policy
- People are not allowed to smoke outside the hospital building
- Regular mental health awareness workshops for staff
- Improved communication to staff on the offer available to improve their physical activity

> Working through the Healthy Workplace Charter really helped us to focus our efforts. The charter provides a straightforward framework to gauge how you're currently doing and then to be clear about what more is needed. The action plan tends to write itself! We are part way through our journey and having achieved the achievement level, we know we're part way there and what we need to be excellent. It's motivated us in our efforts to get the top award - **CNWL NHS Foundation Trust**

04
CHAPTER

Recommendations:

1. Many NHS organisations across Camden and Islington have already attained the achievement level of the London Healthy Workplace Charter. We should support and encourage the others who have yet to reach this standard to invest in doing so to not only improve the health and wellbeing of their staff, but to also achieve cost-savings within the short term.

2. While we should celebrate the success of organisations in attaining achievement level, we should aspire for excellence in all of our organisations to ensure that the health and wellbeing of staff are embedded into our corporate cultures and values. Investment in this area has been shown to demonstrate a clear return on investment so makes financial sense. Even with no or little additional investment we could work better together to share materials, learning and resources. As large local employers, local authorities and NHS organisations have a key role to play as champions and exemplars for other employers and business.

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ISLINGTON Camden

ISLINGTON

Children Services
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Report of: Director of Youth and Community Services, Children's Services

Health and Wellbeing Board	**Date: 26 April 2017**	**Ward(s): All**

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SUBJECT: Violence Against Women And Girls Strategy 2017-2021

1. Synopsis

1.1 The Violence against Women and Girls (VAWG) Strategy for 2017-2021 addresses the following issues: domestic violence and abuse, rape and sexual violence, forced marriage, honour based violence, gangs and peer on peer abuse, trafficking, prostitution, female genital mutilation and sexual exploitation. This kind of violence has a serious detrimental impact on the health and wellbeing of the wider local community. This affects men, women and children, not only in relation to the significant costs of the services needed but also the issues of health inequalities that develop as a result of the violence. Exposure to violence as a child has particularly negative impacts, not only increasing the risks of involvement in future violence but of substance misuse, poor mental health and chronic illness in later life.

2. Recommendations

2.1 To note this VAWG Strategy as the final version produced and adopted by London Borough of Islington and its' VAWG Strategic Board partners. It was formally launched on 8 February 2017 at Islington Town Hall.

2.2 To discuss and explore how the Health partners can contribute to and complete the VAWG Action plan that supports the work of the VAWG Strategy.

2.3 To ensure that the correct members of the Health and Wellbeing Board and its partner agencies are represented at the VAWG Strategy Board.

2.4 To discuss if the Health partners can contribute financial resources to the assist the delivering of the DVA services within the Health sector.

2.5 To ensure that the Health and Wellbeing Board fulfils its obligations around the Three Priorities in the Islington's Joint Health and Wellbeing Strategy 2017-2020 and ensure joined up working with the VAWG Strategy.

3. Background

3.1 The VAWG Strategy is a refresh of the previous strategy developed in 2011 and will be a continuation of the work that has already started in Islington.

It is important that the Health and Wellbeing Board support the work as the Violence Against Women and Girls agenda needs the highest possible strategic profile and effective partnership working as there is major health, economic and social consequences of violence. A significant risk is that there is currently under reporting of domestic violence and abuse and VAWG issues particularly from health colleagues and agencies. This is evidenced by the Domestic Violence multi-agency risk assessment conference (MARAC) and the number of low referrals being made within the health sector where there is significant under-reporting.

3.2 The strategy was drafted as a joint initiative and produced by its VAWG Strategic board partners and all the necessary comments, consultations and feedback into the strategy took place over a 12 month period. The members have included the statutory, voluntary and community sector, as well as health partners from the Clinical Commissioning Group (CCG), Public Health, Whittington Hospital Safeguarding Team and the Family Nurse Partnership.

3.3 In relation to implementing the VAWG Strategy there might potentially be some costs. These have not been fully scoped yet as the partners are still developing their different actions around the top five priorities as stated in the Strategy and we are yet to receive a response from health colleagues.

There are some existing services in place that will continue. These include:

- A domestic violence and abuse advocacy service for women and men from 16 years plus
- Domestic violence and abuse refuge provision for women and children
- A Black, Asian, Ethnic Minority and Refugee VAWG/Capacity Building Service
- A domestic violence and abuse adult perpetrator service
- A rape and sexual violence service
- Female genital mutilation support services
- Harmful practices work around forced marriage and honour based violence cases
- The Integrated Gangs team at Islington Police Station (including support for girls)
- The Pan London Ascent Project providing counselling and other DV support services
- A specific support model for GP practices and pharmacies in Islington arounds support, identification and referral pathways for domestic violence and abuse clients/patients/victims and perpetrators called the IRIS model.

These are alongside the existing frontline and operational services that agencies and organisations will continue to provide to its service users as part of its core services.

Additional funding bids are being explored to help support and deliver some of these additional VAWG strands. We have been successful in two DCLG bids for 2017-18 to deliver a Latin American Women's Aid Refuge for women and children; and also to work with Camden, Haringey and Enfield around complex needs of women experiencing domestic violence and abuse, mental health and substance misuse.

Furthermore, a funding bid was submitted on 1 March 2017 for the Transformation Fund which is a new one-off national fund released by the Home Office to support VAWG services. If successful this will greatly enhance the work of VAWG services to be delivered in Islington. Otherwise, it would be advisable to carry out joint commissioning activity between Health, the council and other partners to help deliver some of these key services.

3.4 The work will enable all staff to have an improved knowledge and understanding of VAWG issues, how cross cutting and multi-agency the strands are and their roles and responsibilities in addressing this. Health and Wellbeing Board members are asked to consider the work areas and how they can influence these strands in their sector.

In particular, it is suggested that the Health and Wellbeing Board members and their partners consider the following:

- Funding a skilled post, namely an 'Independent Domestic Violence Advocate' (IDVA), to be recruited to the Whittington Hospital to support staff and clients on matters related to domestic violence and abuse.

  Specialist DVA support has previously operated in the Whittington and led to an increase in health referrals to MARAC etc. as well as being highly successful in other hospitals, namely the Royal Free, UCLH and Barnet Hospital to name a few.

  Most clients will approach health services in the first instance before any disclosures are made to any other agency, including the police. Therefore, this first point of access needs to be available and supportive to increase referrals and improve safety for all.

- In order to aid our profile and understanding of DVA and VAWG we need more data from our health partners and the police. This would include data on:
  - Violent crime, including age standardised rate of emergency hospital admissions for violence
  - Rate of violence against the person offences
  - Sexual violence

- To understand and place/fund additional resources where there are complexities of cases where there are overlapping issues for victims and perpetrators around; mental health, domestic violence and abuse and substance misuse. There are a high proportion of these cases that are marginalised and falling through the gaps and if not supported earlier on, are having an increasing impact on resources when they have increased to being high risk.

- How to ensure there is an integration of services that provide a seamless approach.

In relation to other VAWG areas:

- To fund FGM services, provide training for all health staff on identification and referrals and understanding their obligations and mandatory duties.

- To support all rape and sexual abuse victims and ensure that they are referred to the relevant Islington support services.

- To explore funding a specific Independent Sexual Violence Advocate (ISVA) post within the hospital, to support all victims

- To join up work with young people and gangs, especially young girls that experience additional issues around VAWG.

- To ensure that all staff within all the health sector partners receive specific DVA and VAWG Training that is in addition to Safeguarding Training.

- To link in with a range of commissioned cycles and services so there is joined up working taking place and clear partnership working, strategically and operationally.

4. Implications

Financial Implications:

4.1 None at this stage. Financial implications regarding the request for additional funding from health partners to support the delivery of the VAWG strategy are to be discussed.

Legal Implications:

4.2 There are no implications arising directly from the recommendations; however members of the Health and Wellbeing Board should be aware of the new domestic violence and abuse best-practice guidance 2016, established by the National Institute for Health and Care Excellence (NICE). Despite this not being mandatory it is recommended that the practice toolkit is adopted by organisations providing services to those who experience domestic violence and abuse. The Guidance sets out a quality standard to improve health and improve safeguarding.

Environmental Implications:

4.3 There are no significant environmental implications from the priorities for action outlined in the report beyond those associated with standard office usage, namely energy, water and material use and waste generation.

Resident Impact Assessment:

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

A Resident Impact Assessment was completed on 1st February 2017 and the summary is included below.

Domestic violence and abuse and violence against women and girls disproportionately affect women, although some men are affected as well. It is claimed that 1 in 4 women experience some form of domestic violence and abuse; this cuts across all classes, sexuality, faiths, ages and ethnic communities. Recent work has highlighted that there are certain communities, such as Black minority ethnic and refugee (BMER), Lesbian gay, bi-sexual and transgendered (LGBT) and people with disabilities that experience additional barriers to reporting incidents and barriers to accessing services. It is with these concerns that the equalities and diversity issues need to be addressed. The Domestic violence and abuse definition has lowered the age to 16 years from 18 years so younger teenagers can be supported appropriately.

All the issues under VAWG also disproportionately affect women in the same way as highlighted for DVA. Although men can be affected, the issues of patriarchy, power and control tend to prevail around VAWG. This will have a direct impact on the residents within Islington, for all communities of women, children, men and boys.

5. Reasons for the recommendations:

5.1 The Health and Wellbeing Board is asked to consider how health partners can address some of the gaps in services to increase VAWG disclosures by all patients and clients that they support. This would support the onward referral to support services and the prevention of escalation of high risk cases to potential homicide cases. This is in line with the Health and Wellbeing Strategy priorities and will help this board fulfil some of the priorities outlined in this VAWG strategy.

Appendices: VAWG Strategy 2017-2021

Background Papers: None

Signed by: 

11 April 2017

Director of Youth and Community Services Date

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Violence against Women and Girls (VAWG) Strategy

2017 - 2021

Contents page

Topics	Pages
Foreword	3-4
1. Introduction	5-6
2. What is VAWG? - Definitions and the national context	7-10
3. VAWG in Islington - Current picture - Case studies	11-13
4. Priorities for action	14-15
5. Action planning	16-20
6. Islington services	21
7. Measuring impact	22
Appendices: i: Glossary of terms	23

Foreword

Councillor Andy Hull, Executive Member for Community Safety, Islington Council

Violence against women and girls (VAWG) in all its forms is completely unacceptable. One of my top priorities is to ensure that the council, together with our partners, is fully committed to preventing and tackling it. We aim to make our borough a fairer place. That also has to mean making it a safer place for everyone who lives here, especially in their own homes.

Violence against women and girls affects all communities, involves men and boys, and can feed into a wider cycle of violence. It is not a stand alone issue but rather one that is inherently connected to other serious social challenges that we face in the borough. The majority of young people caught up in gangs in Islington, for instance, have experienced domestic violence as children. It therefore requires a joined-up and coordinated response, involving the council, the police, the voluntary and community sector, other partners and the wider community. I am proud that this strategy has been developed in that spirit of partnership.

Our vision is for Islington to lead the way as a borough in which no form of VAWG is tolerated and where victims and their children know how and where to get the help they need. The implementation of the strategy will be underpinned by a robust action plan that will secure real change for our residents. All the organisations and individuals involved will be held to account to ensure that we deliver.

This VAWG strategy builds upon what has been achieved since we published its last iteration in 2011. It sets out our partnership approach and redoubles our commitment to intervene as early as possible to support survivors, children and their families to stay safe, report crimes and rebuild their lives. We know that exposure to VAWG early on in life has long term consequences and we recognise that domestic violence and abuse is the most reported form of VAWG in the borough. This is why we are committed to increasing the support for young people to help them understand and build healthy relationships. We also recognise that this is not only about physical violence and we need to do more to respond to the devastating impact of psychological abuse and coercive control, which is more of a problem than many realise.

Reporting incidents and accessing support is difficult for everyone, and we know that some communities and those with complex needs may experience additional barriers. This is why we are pleased to be continuing the close work between statutory services and the voluntary and community sector to meet the needs of Islington's diverse community.

We all have a responsibility to help put an end to VAWG and I thank everyone involved in formulating this strategy for their continued dedication to preventing all forms of VAWG in our borough, safeguarding our residents and supporting survivors to recover. It is vital work in which I hope we will all play our part.

Detective Chief Superintendent Catherine Roper Borough Commander, Camden & Islington Boroughs

Any violence is unacceptable, and my policing teams and I are committed to supporting all victims and robustly managing offenders to make it clear that such acts will not be tolerated in our incredible borough of Islington.

This strategy focusses on the tackling of violence towards women and girls, and how the local partnership can prevent, educate and tackle any such behaviour which makes someone feel unsafe. Everyone has a right to feel safe inside and outside their homes, and have the confidence to live their lives without the threat of violence or abuse. Where violence is committed towards women and girls, there will be young boys and men who will be affected too. The damage that can be done to anyone involved in any such cycle of violence and aggression is immeasurable, and will impact upon people for the rest of their lives.

Through this partnership, I want to encourage people to come forward and to trust us to help them. I do not want anyone to feel alone or that there is no help available. There is help – and I guarantee that together we can find a way to support anyone who is a victim, and also their families. I know this is difficult, but the more we know then the more we can do. We will also help anyone who needs support to stop acting with violence and anger. Together we are committed to intervene early, and to help people live their life as they have a right to – safely, happily and with dignity.

I am proud to support this strategy, and will tirelessly work with partners across Islington is order to achieve our goal of ending violence against women and girls

1. Introduction

The purpose of this strategy is to set out our continued integrated approach to stop Violence against Women and Girls and improve the health and wellbeing of individuals and families who experience domestic violence and abuse, controlling and or coercive behaviour in the borough of Islington. It aims to build on our existing successful partnerships and to further increase public awareness and assist local communities, individuals, and family members to tackle domestic violence and abuse in the home and in their relationships.

Our aim is to promote a 'zero tolerance' approach to violence against women and girls and to ensure that through our service provision and delivery we offer a range of education and support services to assist. We know through our work previously and through research that domestic violence and abuse is still a very under-reported crime and that victims worry that making a complaint or speaking out may make the situation worse for themselves or for others often within the home. This means that we must ensure that what we offer is widely known and those affected can feel confident that when they come forward an appropriate array of provision is available. This approach is a priority for us as;

7 women a month are killed by a current or former partner in England and Wales.[1] This is testament to the fact that abuse and violence can escalate to the most serious extremes if no-one intervenes effectively.

2.1MILLION people suffer from some form of domestic abuse in the UK each year, with 100,000 of these considered to be at high and imminent risk of being murdered or seriously injured as a result of domestic abuse[2].

Women are much more likely than men to be the victims of high risk or severe domestic abuse. 27% women have experienced domestic abuse in some form within their lifetime[3]. 95% of people referred to Multi Agency Risk Assessment Conference (MARAC) or accessing an Independent Domestic Violence Advocate (IDVA) service are women.[4]

130,000 children in the UK live in homes where there is high-risk domestic abuse[5]. 62% of those children are directly harmed by the perpetrator of the abuse, in addition to the harm caused by witnessing the abuse of others.[6]

2.3 years: On average high-risk victims live with domestic abuse for 2.3 years before seeking help, and 85% of victims sought help five times on average from professionals in the

[1] ONS (2015), Crime Survey England and Wales 2013-14. London: Office for National Statistics.
[2] http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171776_352362.pdf
[3] The Crime survey for England and Wales 2014
[4] Safe Lives (2015), Insights IDVA National Dataset 2013-14. Bristol: Safe Lives.
[5] Safe Lives (2015), Getting it right first time: policy report. Bristol: Safe Lives.
[6] Caada (2014), In Plain Sight: Effective help for children exposed to domestic abuse. Bristol: Caada.

year before they got effective help to stop the abuse.[7] Domestic Violence and Abuse has a higher rate of repeat victimisation than any other crime.[8]

Our strategy builds upon what has been achieved since 2011 and sets out our priorities for tackling domestic violence and abuse over the next four years. Our previous strategy promoted partnership working to ensure that staff are continually skilled in identifying domestic violence and abuse and guided the partnership in the development of a wide range of services to support survivors and children and this remains a priority.
We aim to identify victims and offenders at an earlier opportunity and work together to intervene effectively to prevent violence from escalating and to tackle re-victimisation. We need to offer more joined up and co-ordinated support to young people within the borough. We need to build positive healthy relationships and address the risks posed by the rising trend of the inappropriate use of technology and social media which in the last two years has seen rapid acceleration.

Whilst the partnership acknowledges and supports the VAWG principles held by central Government and London Mayor's Office of Policing and Crime (MOPAC) it is worth noting that we want to whole heartedly include children and young people within our strategy and our delivery plan. In Islington we are committed to keeping children and young people safe and Domestic Violence and Abuse is one of our three priorities for the Islington Safeguarding Children's Board underpinning our work for 2017 and going forward.

This VAWG Strategy does not stand alone - the themes and issues are interwoven in other strategies and areas of work across the partnership. For example, our Child Sexual Exploitation Strategy 2016, Early Help Strategy 2015-2025 and our Youth Crime Strategy 2015.

In order to identify and prioritise our work we have consulted widely and listened to feedback from our residents, partners and children and young people[9] and the 5 areas were identified -

prevention and early intervention

- **the provision of effective services**
- **a strong partnership response**
- **addressing perpetrator behaviour**
- **responding to the complex pressures on individuals**

[7] Safe Lives (2015), Insights IDVA National Dataset 2013-14. Bristol: Safe Lives.
[8] Home Office, July 2002
[9] Please see the VAWG Strategy Consultation Report 2015 for more details.

2. Definition of Violence against Women and Girls (VAWG)

The term “Violence against Women and Girls (VAWG)” is both a form of discrimination and violation of human rights. Islington has adopted the definition set out in the Mayor’s strategy on Violence against Women and Girls.

The United Nations defines Violence against Women and Girls; “as any act of gender-based violence that results or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, that is directed at a woman because she is a woman or acts of violence which are suffered disproportionately by women.”

These include the following:

- **Domestic violence and abuse**
- **Coercive and controlling behaviour**
- **Sexual violence including rape**
- **Female Genital Mutilation (FGM)**
- **Forced marriage**
- **Crimes in the name of “honour”**
- **Stalking**
- **Prostitution and trafficking**
- **Sexual exploitation**
- **Girls and gang violence**

For the purpose of our work Islington adopts the government definition of Domestic Violence and Abuse:

“ any incident or pattern of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality”

This includes:

- Controlling behaviour is a range of acts designed to make a person dependant by isolating them from sources of support, depriving them of the means needed for independence, resistance and escape, and regulating their everyday behaviour
- Coercive behaviour is an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim
- This definition also includes so called “ honour” based violence, female genital mutilation and forced marriage, and is clear that victims are not confined to one gender or ethnic group

Islington approach to men and boys within VAWG

This strategy is focused on the needs of women and girls and is a deliberate response to the disproportionate impact of VAWG crimes on women and girls. This does not mean that men are never victims of, for example, rape, forced marriage, sexual exploitation or domestic violence and abuse, or even that women are not sometimes perpetrators. Just over a fifth (22%) of domestic offences in Islington in 2016 involved a female perpetrator.

The term violence against women and girls can be accompanied by concern about the exclusion of men and boys from services and a lack of recognition that men and boys can

experience these forms of violence and abuse. We recognise the gendered nature of these forms of violence and abuse (that women and girls are more likely to experience); therefore, the responses we are developing are based on the understanding that women and girls **disproportionately** experience these forms of violence and abuse.
This definition also helps us to understand that some VAWG areas are gender specific such as Female Genital Mutilation (FGM). It is important that men and boys are included in all aspects of the strategy, particularly our prevention and awareness raising work.

The partnership is committed to increasing reporting rates and providing support and appropriate services for male and Lesbian, Gay, Bi-sexual and Transgender (LGBT) victims. We will therefore work to ensure that agencies develop clear pathways to support all victims of domestic violence and abuse. We also see high levels of domestic violence and abuse where the perpetrator is a family member of the survivor and not an intimate partner - 23% of relationships known are familial, with the suspect being a son, daughter, grandchild, brother, sister, cousin, uncle or other family member of the survivor and this is addressed within our plan.

We know that children are affected by domestic violence and abuse, and that early childhood experiences of living in a family setting where violence and abuse occurs will have negative impact on a young people's wellbeing and development later in life. We are committed to addressing the links between domestic violence and abuse and trauma in childhood. Where known at least 25% of the young people believed to be in a gang or affiliated to in Islington have suffered domestic violence and abuse in their past. We will continually work with schools to address aggressive and often angry behaviour in young men to assist them in understanding that domestic violence and abuse is not normalised behaviour.

'I just thought it was normal to argue and fight – sometimes it got physical. It's what I saw at home as I grew […] It was scary when I was smaller, but then I got strong and I realised that I could make people listen to me that way. I didn't know how to talk to people to sort things out – girls, friends, family. I didn't know any different" (Tom*, 17).

National and legal context

In 2010 Government published its "Call to End Violence against Women and Girls" which has detailed through a series of action plans ways to address domestic abuse across all agencies and local authorities. The new National Ending Violence Against Women and Girls Strategy 2016-2020 underpins our work to understand and better support the needs of BAME, LGBT and disabled women who are also survivors of VAWG[10]. Safeguarding practices across London have also been supported by the Pan London Violence against Women and Girls Strategy published in 2014 which "outlined a bold and ambitious approach, making London a national and global leader in seeking to end VAWG"[11].

* Not his real name
[10] https://www.gov.uk/government/publications/strategy-to-end-violence-against-women-and-girls-2016-to-2020
[11] https://www.london.gov.uk/sites/default/files/gla_migrate_files_destination/Pan-London%20Strategy%20on%20Violence%20against%20Women%20and%20Girls%202013_17_1.pdf

VAWG is prevalent both in Britain and globally. According to the Crown Prosecution Service (CPS) there has been an increase of 'violent crime offences against women' but there is still an under reporting. In 2015 an estimated 1.4 million women experienced some form of domestic violence and abuse in the UK, whilst 31% young women aged 18-24 reported having experienced sexual abuse in childhood.

According to a survey commissioned by the Mayor's Office for Policing and Crime, which sought the opinions of 8,000 Londoners, only 39% of respondents to the survey agreed that London is a safe place for women and girls. Additionally Transport for London (TfL) commissioned research found that 15% of women had experienced some form of unwelcome sexual behaviour on public transport. In the 'Draft Police and Crime Plan for London 2017-2021 – Consultation Document', MOPAC have stated it is a goal to reduce violence against women and girls in London and change the culture that enables this to happen, empowering women and girls to take control and be treated equally. MOPAC have published a refreshed London Violence against Women and Girls Strategy 2017 – 2021. The refreshed Strategy will set out shared commitments to investing in services to support survivors while also addressing wider prevention and criminal justice service issues that undermine our ability to address repeat victimisation and offending.
In 2015, the National Troubled Families programme was expanded to include domestic violence and abuse in the wider set of problems families may be experiencing. In 2014, the Care Act was also expanded to include new duties to support vulnerable adults experiencing domestic violence and abuse. This acknowledges the risk posed to older and vulnerable people and helps those working with them to recognise abuse. The extension of the definition of domestic violence and abuse in 2013 to include young people aged 16 and 17 has helped increase awareness that young people in this age-group experience domestic violence and abuse, encouraging more of them to come forward and access the support they need.[12]

Alongside the Domestic Violence, Crime and Victims Act 2004, the Serious Crime Act 2015 and the Care Act 2014, there is a strong framework supporting the VAWG work. This has included the introduction of coercive control offences for domestic violence and abuse cases. As well as the introduction of the criminalisation of Forced Marriage and the mandatory reporting of child female genital mutilation cases by teachers, health professionals and social workers; as well as the use of FGM Protection Orders. There was also the introduction of the Modern Slavery Act 2015 which can be used to address the cross border issues around Trafficking.

The Domestic Violence Disclosure Scheme - known as Clare's Law – was rolled out nationwide in 2014. It gives members of the public a 'right to ask' police where they have a concern that their partner may pose a risk to them or where they are concerned that the partner of a member of their family or a friend may pose a risk to that individual. Domestic Violence Protection Orders (DVPOs) and Domestic Violence Protection Notices (DVPNs) were rolled out across England Wales in 2014. DVPOs are a new civil order power that fills a "gap" in providing protection to victims by enabling the police and magistrates courts to put in place protective measures in the immediate aftermath of a domestic violence and

[12] https://www.gov.uk/government/news/new-definition-of-domestic-violence-and-abuse-to-include-16-and-17-year-olds--2

abuse incident where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions.

The Anti-Social Behaviour, Crime and Policing Act 2014, made it a criminal offence to force someone to marry. Forcing someone to marry is now a criminal offence in England and Wales. The Government remains focused on prevention and increasing support and protection for victims and those at risk of becoming victims. It has published several important pieces of guidance for public authorities including the multi-agency statutory guidance on dealing with Forced Marriage (2014). We need to examine how all agencies can work more effectively together to safeguard against forced marriage and 'honour' based crimes and prosecute perpetrators. Including increasing the use of 'Forced Marriage Protection Orders' for victims.

In 2014, the Forced Marriage Unit dealt with approximately 1,300 cases of forced marriage (FM), of which 79% were female, 21% male and 11% involved minors. It is estimated that between 2010-2014 there were 11,000 cases of so called 'honour' crime recorded by Police UK forces and approximately 12 'honour' killings are carried out every year. Disturbingly, these figures do not reflect the full scale of the abuse, with many more cases unreported.

Control and Coercion in the context of domestic violence and abuse: using section 76 of the Serious Crime Act 2015

A new offence of controlling or coercive behaviour in intimate relationships has been created by Section 76 of the Serious Crime Act 2015. The aim of this act is to provide the means to take action in situations where key aspects of a person's life are controlled by their partner – their finances, where they go, who they see, how they dress etc. Proving coercion requires a different approach to evidence gathering. It is about establishing a pattern of behaviour rather than proving individual incidents took place.

CEDAW

The Convention on the Elimination of all Forms of Discrimination against Women recommendation 19 on violence against women particularly asks "states to consider family violence and abuse, forced marriage, dowry deaths, acid attacks and female circumcision as prejudices and practices that may justify gender-based violence as a form of protection or control of women."

3. Violence against women and girls in Islington: our current picture

What we do know is that:

- Domestic violence and abuse is the most widely reported form of VAWG.
- Rates of domestic violence and abuse have been increasing over time in Islington, as elsewhere, rates were60% higher in 2015/16 than in 2011/12.
- During 2015, Islington police recorded 2,260 Domestic Violence and Abuse offences with 2,100 female survivors living in Islington.
- Domestic violence and abuse affects all groups of women, but younger age, poor health, deprivation and unemployment are associated with higher rates.
- The impact on children and young people is considerable: over 1,000 (over 50%) assessments are made annually by children's social care in Islington as a result of domestic violence and abuse.
- 221 Domestic Violence MARAC referrals were made in Islington in 2015/16
- Islington has higher levels of sexual offences than the London average - those aged 16-29 are at highest risk. This could be because it is better reported.
- Harmful Practices including honour based violence and female genital mutilation (FGM) are underreported across the country and this is replicated In Islington.
- Fewer perpetrators are being brought to justice across London. In Islington the detection rate for domestic violence and abuse offences has fallen from 53% in 2010/11 to 39% in 2015/16/
- Every year, the specialist domestic violence and abuse services in Islington work with over 1,500 women experiencing domestic violence and abuse.
- Islington is a richly diverse borough with a well-established voluntary and community sector. We are only able to meet the needs of our diverse population through a positive relationship with community partners.

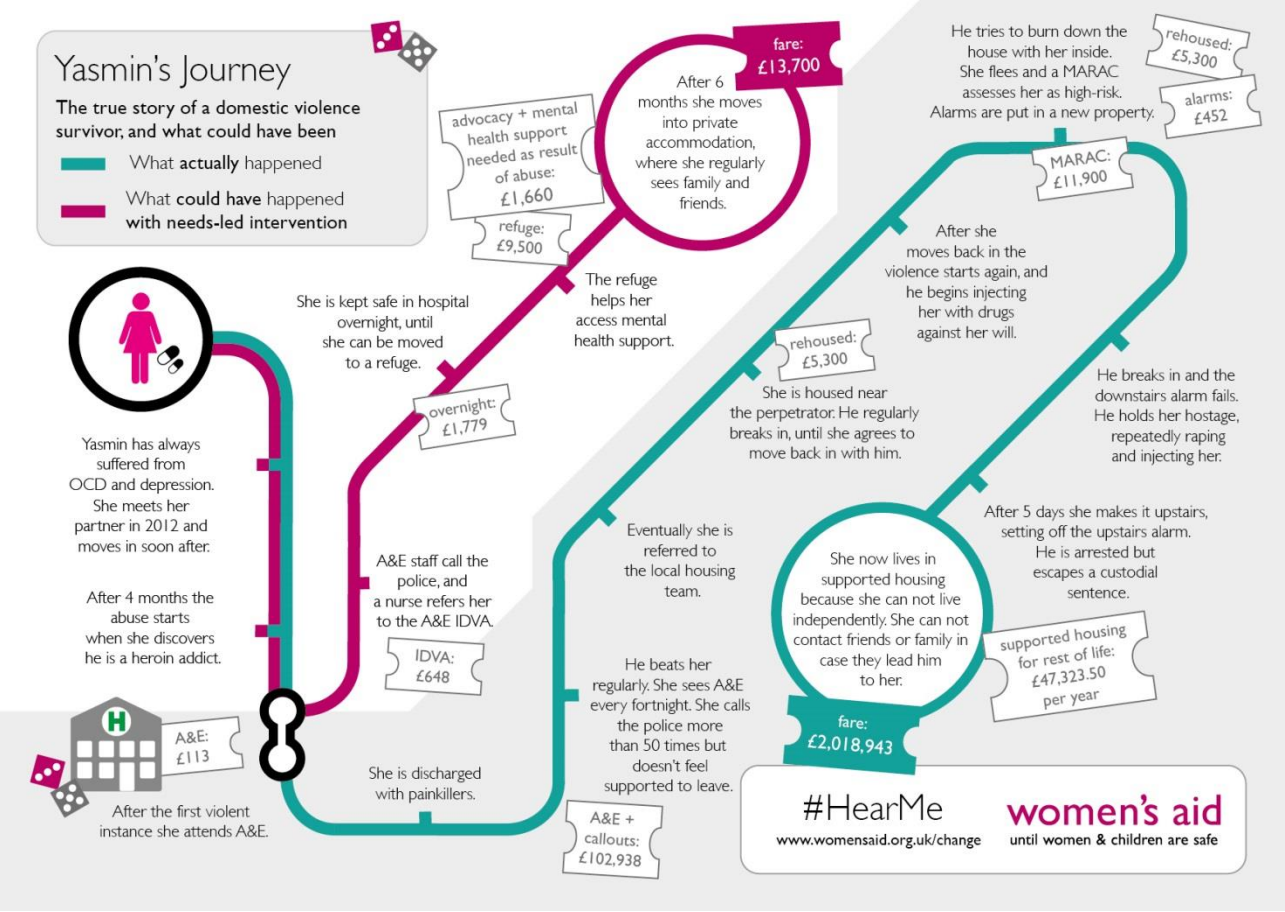
Case studies

Carly*[13], 35

Carly has been homeless or unstably housed for many years, and is a chaotic alcohol, heroin and crack user. She also suffers from depression and Personality Disorder. She has two children – both are in the care of a family member outside of London. Carly was physically abused as a child and has had a number of abusive boyfriends whilst living on the street. Some have stolen from her, others have been physically violent and one forced her to sell sex to pay for their drugs.

The hostel in which Carly was staying referred Carly to the Domestic Violence MARAC as they were concerned about the high risk posed by her increasingly violent boyfriend. The Domestic Violence MARAC discussed Carly's case and made housing and other support recommendations. The police also undertook a visit to Carly with an Independent Domestic Violence Advocate (IDVA) to let her know of the support options and encourage her to report the abuse she was experiencing.

Carly is now living in supported housing and receiving support from a local service who work with clients like Carly who have complex needs and require intensive interventions. She has sustained her tenancy for a year and is now accessing support services to help her to recover and build an independent life off the streets and free from abuse.



Reproduced here with permission from National Women's Aid: https://www.womensaid.org.uk/our-approach-change-that-lasts/

[13] Not real name

Bêrî*[14], 23

Bêrî arrived in the UK from Turkey at the age of 19; unknown to the authorities this was through a forced marriage. Bêrî has a 2 month old baby and was referred to a specialist (Black Asian Minority Ethnic Refugee) BAMER Domestic Violence and Abuse Support and Capacity Building service by a Children's Centre. The Children's Centre also contacted the council's Children's Services about the risk to the child.

Bêrî disclosed that she has experienced ongoing physical, emotional, verbal, sexual and financial abuse from the perpetrator and his mother. She was not allowed to leave the home alone and was prevented from learning English which meant that Bêrî was very isolated and could not tell anyone about the abuse.

The BAMER Domestic Violence and Abuse service supported Bêrî to move into a refuge. The service also helped her access legal support including injunctions to keep her safe from the perpetrators and to address her immigration status. The case was also reported to the Forced Marriage Unit for investigation. Bêrî and her daughter are living in another borough where Bêrî has a supportive cousin and the BAMER Domestic Violence and Abuse Service continue to support her.

[14] Not real name

4. Priorities for action

Following wide consultation and our internal review of activity we have identified our priority actions for 2017-2021. These are:

- **prevention and early intervention - raising awareness and increasing social intolerance**

We consider this a priority as domestic violence and abuse has a huge negative impact on outcomes later in life. Intervention, particularly in early childhood, can prevent individuals developing a propensity for domestic violence and abuse. In our Early Help and Family Support Strategy 2015-2025, Domestic violence and abuse is identified as a key issue to tackle through our work with children, young people and families. Awareness and education around forming positive relationships and safeguarding young people in their use of social media and technology is crucial in addressing harmful behaviours that may lead to violence. It has become apparent when we have looked at our young people who have joined gangs or have come to the attention of the police and our Youth Offending Service that violence within the home is often an ordinary feature of their lives and this cannot be seen as normal for young people growing up in our borough.

- **the provision of effective services - vulnerable children and adults are at the heart of our response**

We consider this to be a priority as it is essential that victims and children caught up in domestic violence and abuse in all its forms, including emotional and psychological abuse to receive a prompt and appropriate service to support them and meet their needs. We need to ensure that we are clear about what we offer to the people of Islington and that it is local, accessible and responsive to their needs. We aim to ensure that victims are not passed around between services and to work together to coordinate support and address gaps in our service provision. Whilst we accept that for many community support through church and religious centres as well as age appropriate services will be what people seek. We want as a partnership to ensure we know what is available so we can build on developing other provision where needed to link and work collaboratively.

- **a strong partnership response - coordinated community**

We consider this a priority as Islington has a wide range of organisations and individuals committed to supporting victims, and working with those families where domestic violence and abuse is prevalent. We want to build on our collaborative working practices and extend it within our service delivery. We aim to look at ways to co-locate our services and build on our successful existing partnerships such as MASH (multi-agency safeguarding hub) in borough and work with other partners. One of the main drivers for updating our strategy was recognising that as individual services we all offer approaches to victims and the children often caught up in the domestic violence and abuse but collectively we can

reach so many more people and collectively we can make more of a difference to their lives.

- **addressing perpetrator behaviour - make victims safer and reduce reoffending**

We consider this to be a priority to ensure that children, young people and families affected by domestic violence and abuse are well informed about the legal and protective measures available to them. We also consider that where it is safe to do so we want to work in a holistic way with all family members and look at engaging perpetrators in programmes designed to reduce harm and future offending. We consider that for a wide range of people they would, with the right approach be able to change their attitudes and behaviour to domestic violence and abuse. We will promote ways for information about previous offences to be shared to allow people to make informed choices about their relationships which will reduce the risks young people face. We consider that in Islington we should offer a balanced approach offering intervention if needed and supporting criminal sanctions where appropriate.

- **responding to the complex pressures *on individuals* – support with wider issues**

We consider it a priority to understand the complex pressures that people in the borough are under that prevent them from exiting abusive relationships or leaving households where domestic violence and abuse is taking place. We recognise that for many the perpetrator will be a loved one, and the Perpetrator may be caring for them or the victim is dependent on the perpetrator for their care. The partnership aims to work better with our colleagues in housing and adult services to support residents to manage limited resources such as housing, finances and access to benefits to prevent people feeling that they have no option but to remain in violent situations. We want to give all people freedom to make choices where they haven't been able before.

We also aim to work much closer with young people to actively understand the pressures they experience. We will promote safeguarding behaviours that reduce inappropriate use of social media and skill up our young people to recognise the softer subtle signs of domestic violence and abuse such as sexting, body shaming and sending sexual images. We also aim to ensure that children are not harmed in domestic violence and abuse situations and that parents act appropriately to safeguard children in their care to avoid these risks.

Islington recognises that there is a high human cost as well as financial cost to services. Islington also recognises that some communities can experience barriers to accessing support or the right services. These include; Black Minority Ethnic Communities (BME), Lesbian, Gay, Bi-Sexual and Transgender (LGBT), disabled communities, Travellers and Refugee and Asylum seekers. Our commitment will ensure that we work to reduce the impact on communities and continue our commitment to provide accessible services and address the gaps that exist.

5. Partnership VAWG action plan

Priority 1: prevention and early intervention – raising awareness and increasing social intolerance

Action
1.1 Ensure the delivery of a coordinated training and education campaign across Islington that clearly articulates our zero tolerance towards any domestic violence and abuse and / or harmful practices and all VAWG areas. This includes identifying training needs (levels) for professionals', community groups and faith groups, Islington Safeguarding Children's Board and Safeguarding Adults Board to work together to set expectations for training and practice.
1.2 Ensure that all multi agency front line practitioners receive training to develop the appropriate skills and knowledge to identify, respond and support domestic violence and abuse and the wider VAWG practices e.g. sexting and on line exploitation, Female Genital Mutilation (FGM) and so-called 'honour based violence' and other Violence against Women and Girls (VAWG) areas.
1.3 Identify an earlier response by using appropriate screening tools consistently across the partnership to identify risks and ensuring all partners are aware of what is available in Borough around VAWG and can signpost in an effective, timely way. Continue maternity and health visiting screening of all women and girls, to promote Safe lives DASH form, the Barnardo's Matrix young people's tool and develop FGM tools.
1.4 Use VAWG data better to intervene earlier and to understand and address the trends in the borough. This includes interfamilial violence, the relationship between gangs and serious youth violence and poor patterns in early childhood. We will develop a collective partnership data scorecard which will use to check our progress and inform our work.

Priority 2: the provision of effective services - vulnerable children and adults are at the heart of our response

Action
2.1 Continue to deliver appropriate support using a wide range of gender and culturally sensitive services with clear referral pathways for survivors /victims, professionals, friends and families, with a particular focus on increasing age-appropriate services. Recognising that all services have a role to play – from universal to specialist, highlighting the importance of the role that the voluntary and community sector play to address the diversity of need in Islington.
2.2 Ensure that the 'safe spaces' in the borough already established for those at risk of gangs and hate crime are gender and culturally sensitive and able to support those fearing domestic violence and abuse and sexual violence.
2.3 Support everyone in Islington to be aware of what is available to respond to domestic violence and abuse and VAWG services, knowing where to get help. We will maintain an up-to-date service directory and clear pathways for universal, community based and specialist services.
2.4 Include clear expectations in new contracts that domestic violence and abuse is identified and responded to appropriately by commissioned services including early help, youth services, adult services, mental health, sexual health and substance misuse.
2.5 Provide trauma-informed services to minimise the harm caused by domestic violence and abuse. This includes specific commissioned services such as the National Society for the Prevention of Cruelty against Children (NSPCC) Domestic Abuse Recovering Together (DART) programme as well as trauma-informed universal, targeted and specialist services for families.
2.6 Ensure any barriers are challenged and removed so that everyone receives the level of service and support they require. We will focus on any inequality or discrimination reported to ensure that everyone has an inclusive voice through equal participation, consultation and service user engagement at all levels. Including engagement with all partner services within Islington.

Priority 3: a strong partnership response - coordinated community

Action
3.1 Ensure that Children Service's 'front-door' is strengthened in practice by specialist domestic violence and abuse and VAWG expertise to assist with signposting and timely and appropriate referrals to specialist services; whilst providing specific support for women and their children.
3.2 All partners to review their policies and practices around VAWG issues to ensure that if clients present with these, the right information, offer of service provision and other signposting or referral pathways are universally offered across the borough
3.3 Develop a joint commissioning approach for a comprehensive range of interventions across the spectrum of domestic violence and abuse services to address the gaps identified in our comprehensive mapping exercise in 2016.
3.4 Continue to monitor and review the partnership contribution to successful outcomes in our domestic Violence MARAC and wider service delivery, and hold to account those agencies who do not deliver through our partnership governance arrangements.
3.5 Develop a communication plan that covers both organisations and the community as a whole that promotes and supports a 'zero tolerance' approach to violence against women and girls in Islington.

Priority 4: addressing perpetrator behaviour - make victims safer and reduce reoffending

Action
4.1 Evaluate and review our current offer for perpetrator support programmes to ensure that we have an effective approach to working with those perpetrating abuse. Provide support to those perpetrators identified as willing or open to change to address the cycle of domestic violence and abuse. We will explore different approaches to work specifically with those young males from age 7 years that are beginning to show signs of aggressive or harmful behaviours.
4.2 Ensure that the criminal justice system works for Islington in response to VAWG cases. We will strengthen the relationship between the police, Crown Prosecution Service (CPS), courts, prison and probation services to ensure perpetrators are effectively processed while victims are fully supported.
4.3 Support victims to access the appropriate criminal and civil sanctions and processes to reduce reoffending and further victimisation. We will share knowledge and support local and national initiatives to prevent offending i.e. use of the domestic violence disclosure scheme (Clare's Law), the use of domestic violence protection notices and orders, Forced Marriage Protection Orders, Modern Slavery and stalking legislation, amongst others.
4.4 The partnership will work with all communities to ensure the message of zero tolerance around unacceptable practices and violence against women and girls is strengthened across the borough.

Priority 5: responding to the complex pressures on individuals – support with wider issues

Action
5.1 Economic and environmental • Recognise the pressures put on those living in abusive situations, especially as housing and benefit pressures increase and housing moves are less available. • We will support residents to escape economic dependency by maximising their income and supporting them to secure gainful employment. We will also raise awareness of changes to welfare and benefits, and advertise these in receptions, clinics, with partners. • We will develop clear housing pathways and offer earlier support to identify realistic housing options.
5.2 Age-related pressures for younger and older people • Ensure a consistent offer across primary and secondary education and youth provision to support young people to develop healthy relationships and challenge the normalisation of sexual violence and peer-on-peer abuse. This includes universal and targeted offers as part of Personal Social and Health Education, Healthy Schools, Targeted Youth Support and Youth Offending Service interventions. • We will explore digital opportunities to reach young people in ways that work for them.
5.3 Housing • Evaluate and review the current housing options in the light of the huge decline in the availability of affordable housing the council faces. • To develop clear housing pathways and offer earlier support to identify realistic housing options; ensure the sanctuary scheme is one element of a package offering support and protection to clients experiencing domestic violence and abuse, who wish to remain in their homes. • To provide information around Reciprocal arrangements and action against perpetrators where tenancies are in their name. • To scope and review policies to see where VAWG cases can be picked up under the current legislation to support clients.
5.4 Other pressures • Recognise the impact of disability on vulnerability and the ability to exit abusive relationships/situations. We will take a strategic approach to multiple and complex needs. • We will also ensure our services are aware of and able to respond to cultural and religious pressures, especially around forced marriage and those with no recourse to public funds, and those at risk of FGM and other harmful practices.

6. Islington services

In Islington we have a range of universal, community-based and specialist services and interventions to prevent and address domestic violence and abuse. These are provided by a number of different organisations across the partnership, from health, local authority and criminal justice agencies and a variety of specialist voluntary and community sector organisations. These services work with individuals and families at different points in their journey to prevent domestic violence and abuse, keep individuals and families safe and to support recovery.

Services include: healthy relationship programmes in schools, Independent Domestic Violence Advocacy (IDVAs), adult and children's social work and safeguarding, recovery group work for parents and children, (FGM) clinics, housing support and a Domestic violence and abuse refuge, and a range of culturally-specific services.

What next?

The 2016 VAWG Needs Assessment and Service Mapping showed that we need to do more at an earlier stage to prevent domestic violence and abuse from taking place. We want to do more to support young people to address trauma they may have witnessed in their lives and address harmful attitudes and behaviours early on. We also want to do more to support lower-risk cases to avoid escalation and limit the harm. These two areas will be a focus of delivery for the *'prevention'* and *'provision'* priorities in this strategy.

- We will continue to commission Domestic Violence and Abuse services (for women and men)
- We will continue to work in partnership with all of our partners so we can improve agency responses to provide appropriate and accessible services
- We will continue to work with the community in Islington
- We will continue to prioritise safeguarding as an issue for children and vulnerable adults
- This strategy will be translated into a detailed action plan in order to deliver these objectives

7. Measuring impact

It is important to us to ensure we are getting it right for everybody in Islington and that it continues to be a safe borough in which to live and work. As individual services we collect performance information on our work but to collectively ensure that we are making a difference we will devise a set of performance indicators agreed by the partnership to measure Violence against Women and Girls, including domestic violence and abuse and the impact we are having. These will be reviewed quarterly by a range of strategic partnership boards such as the Islington Safeguarding Children's Board and our Safer Islington Partnership (SIP).

Alongside the national picture, including the difficulties of being able to gather accurate VAWG data, the local picture is the same. Islington holds some data mainly around domestic violence and abuse. We know that we need to gather further VAWG data in the borough to be able to understand the prevalence in the borough, to understand the local picture and then be able to act to reduce harm towards women and girls who are at risk. The key themes identified under each priority will be delivered through a detailed partnership action plan that will include a performance monitoring framework. This will be subject to regular scrutiny at the VAWG Strategic Board. This close monitoring, alongside new risks or opportunities identified, will allow for changes to this strategic approach as required.

This strategy will be formally reviewed in 2020; however the action plan will be monitored closely as described above.

Appendix i: Glossary of terms

Types of VAWG[15]	
Domestic Violence and Abuse	A pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, psychological, physical, sexual, financial and emotional abuse. In extreme cases this includes murder. Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.
Female Genital Mutilation	Involves the complete or partial removal or alteration of external genitalia for non-medical reasons. It is mostly carried out on young girls at some time between infancy and the age of 15. Unlike male circumcision, which is legal in many countries, it is now illegal across much of the globe, and its extensive harmful health consequences are widely recognised.
Forced Marriage	A marriage conducted without valid consent of one or both parties, where duress is a factor.
“Honour” based violence	Violence committed to protect or defend the ‘honour’ of a family and/or community. Women, especially young women, are the most common targets, often where they have acted outside community boundaries of perceived acceptable feminine/sexual behaviour. In extreme cases, the woman may be killed.
Prostitution and trafficking	Women and girls are forced, coerced or deceived to enter into prostitution and/or to keep them there. Trafficking involves the recruitment, transportation and exploitation of women and children for the purposes of prostitution and domestic servitude across international borders and within countries (‘internal trafficking’).
Sexual violence including rape	Sexual contact without the consent of the woman/girl. Perpetrators range from total strangers to relatives and intimate partners, but most are known in some way. It can happen anywhere – in the family/household, workplace, public spaces, social settings, during war/conflict situations.
Sexual exploitation	Involves exploitative situations, contexts and relationships where someone receives ‘something’ (e.g. food, drugs, alcohol, cigarettes, affection, protection money) as a result of them performing, and/or another or others performing on them, sexual activities. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the person’s limited availability of choice resulting from their social/economic and/or emotional vulnerability. Girls involved in or connected to gangs are at risk of sexual exploitation by gang members.
Stalking	Repeated (i.e. on at least two occasions) harassment causing fear, alarm or distress. It can include threatening phone calls, texts or letters; damaging property; spying on and following the victim.

[15] MOPAC: https://www.london.gov.uk/sites/default/files/vawg_strategy.pdf

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ISLINGTON

Chief Executive's Department
Town Hall, Upper Street,
London N1 2UD

Report of: Deputy Director of Public Health

Health and Wellbeing Board	**Date: 26 April 2017**	**Ward(s): All**

Delete as appropriate	~~Exempt~~	Non-exempt

SUBJECT: Islington Wellbeing and Work Partnership – Update

1 Synopsis

1.1 This paper provides an update on the progress and developments of Islington's Wellbeing and Work Partnership[1], which is run jointly between Islington Council and Islington CCG (in partnership with JobcentrePlus). The purpose of the partnership is to promote and coordinate borough-wide efforts to improve employment and health outcomes for residents with a long term condition or disability.

1.2 The paper builds on two previous reports to the Board related to this work. The first of these, in July 2015, made the case for establishing a partnership to focus local efforts on the links between health and employment, and how that might be accomplished. The second, in January 2016, provided an update on progress and gave highlights from the work.

1.3 This report considers progress and achievements of the partnership over the last year, gives a sense of its future areas of focus, and highlights some of the important changes in the wider health and employment landscape.

2 Recommendations

2.1 To note progress over the last year in improving the links between the local health and employment systems through the Wellbeing and Work Partnership, including signs of a culture shift beginning to take place.

[1] Previously known as the 'Health and Work Programme'. Following the announcement of a new DWP Work and Health Programme, it was decided to a name change was necessary to clearly distinguish our local efforts from national policy.

2.2 To note the areas where activity will be focused over the next 6 to 12 months, in pursuit of the partnership's longer term objectives: the IPS / supported employment trial; a prototyped employment retention service; a new peer mentoring project; a review of locally commissioned employment support services; and an outcomes and learning framework.

2.3 To note the added value of the partnership beyond these specific areas of work, in supporting collaboration and connections across the local health and employment systems; including sharing information about important changes in the local and national landscape.

2.4 To advise on any further steps needed to achieve the aspiration for significant 'system change' in relation to health and employment, in order to improve health and employment outcomes for local residents.

3 Background

3.1 Previous reports to the Health and Wellbeing Board have set out the context and rationale for establishing the Wellbeing and Work Partnership (July 2015) and given an update on early progress and achievements (January 2016).

3.2 In summary, the goal of the partnership is to improve employment and health outcomes for local residents with a long term health condition or disability (and reduce costs to the public purse) by developing, testing and learning from potential solutions to a set of identified 'system failures'. The full partnership objectives are set out in Appendix 1.

3.3 This paper provides the Health and Wellbeing Board with a further update on the partnership's progress and its future focus and opportunities. This distinguishes between areas of concrete, resourced activity either planned or underway, and areas where the partnership generates wider added value.

4 Progress and plans in key areas of partnership activity

IPS supported employment trial

4.1 Following initial discussions in 2015, it was agreed that NHS England would support (and largely finance) a trial of supported employment in Islington, to test the effectiveness of the key principles of IPS (Individual Placement and Support) in primary and community care. There then followed an in-depth period of local engagement to design a service trial, involving both local service users and clinical staff.

4.2 During this design phase, the council procured a small pilot service – called Working Better – to build our understanding of how to offer an employment service within a health setting. This was funded by DWP and provided by Remploy, running in six Islington GP surgeries between September 2015 and September 2016. Overall, 95 people were referred to Working Better via their GP, with 59 taking up the employment support offer. Around half cited mental health as their primary condition. By the end of the pilot, six clients were in employment, six were referred to adult learning, seven took up benefits advice and four started volunteering.

4.3 Beyond the hard outcomes, Working Better generated real value from engaging health care professionals in employment issues and the support available locally. It also enabled a range of technical and cultural issues arising from closer integration of health servcies and employment support to be identified and worked through. For instance: language and communication issues; information governance; and referral and feedback processes.

4.4 Building on Working Better, the CCG, council and NHS England agreed the design and specification of the IPS supported employment trial. Camden & Islington Mental Health Foundation Trust were appointed as the lead provider in summer 2016 and the service went live in January 2017. A large communications and mobilisation effort has taken place, leading to 30 out of 33 GP surgeries in Islington signing up to the trial. There have already

been over 100 referrals, which is ahead of target. The trial will take referrals for 18 months, with the aim of engaging 1000 patients: 500 receiving the service and 500 in a control group.

4.5 A key element of the trial is to develop a greater understanding of how IPS principles can be adapted to primary and community care settings (building from its established evidence base in secondary mental health servcies). This includes, crucially, how to integrate employment specialists with the relevant clinical teams and clinical pathways. A formal assessment to review the fidelity of the service to IPS principles is planned for September 2017.

4.6 The service is being tested through a randomised controlled trial (RCT), with a full evaluation being conducted by the Behavioural Insights Team. Interim results from the RCT should be available from around February 2018 (to help inform future commissioning and service design plans). To reiterate, eligibility for the trial is not related to benefit status, participation is completely voluntary, and no personal data will be shared with DWP.

Employment retention prototype

4.7 During the course of developing the IPS supported employment trial, it became very clear that there was a gap in early help for people at risk of losing their job. This was identified by both patients and clinicians as a major missed opportunity to support people to return to work *before becoming unemployed* and – hopefully – before the negative affects of unemployment on health and well-being take hold. At present, in general, the health care system is focused on providing medical certification for periods of sickness absence, while the employment support system is heavily weighted towards people who are already long-term unemployed.

4.8 Local analysis found that over 2,000 Islington residents have been issued with seven or more Fit Notes over the last two years. Research has shown that the longer a person is off work sick the more likely they are to lose touch with the labour market (and suffer the associated negative impacts on health and wellbeing). In response, over the last year we have forged a relationship with Shaw Trust, the national disability charity, who were keen to work with a local area to develop a model of employment retention support, closely linked to health care services.

4.9 The result of this relationship is that Islington Council and Shaw Trust have agreed to jointly design, test and assess the impact of a new preventative model of intervention to support people in employment but currently on sick leave to return to work and improve their health and wellbeing. Shaw Trust are providing over £300,000 to enable this prototype to be developed and tested, including to fund two employment retention specialists who will provide the support (based in local GP surgeries). The support will aim to blend employment coaching, wellbeing support and (where agreed by the client) engagement with the employer. The service is due to start in April 2017 and will be known as ‘Get Back on Track’.

4.10 To date, four Islington GP surgeries have signed up to host the service and refer patients: Amwell Group Practice, Junction Medical Practice, Mitchison Road Surgery, Ritchie Street Group Practice. The referral process will be linked to the issuing of FitNotes, so that when someone is signed off work (for more than four weeks) they will be offered the option of being referred to an employment retention specialist. The aim is that support will be offered to 500 people over a two year period.

4.11 To assess its impact, information is being collected on the employment and wellbeing outcomes of users on entry and exit from the service (with consent). We hope to be able to compare performance with the national Fit for Work service (and have designed ‘Get Back on Track’ to enable this). However, unlike the IPS supported employment trial, there is not an existing well-evidenced model of employment retention support to work from. It is for this reason that we are seeking to iteratively prototype the service, with an explicit ‘test and learn’ phase at the start. This will involve collecting detailed feedback from everyone involved and adapting both processes and the intervention itself in response.

Review of locally commissioned health-focused employment support.

4.12 There are a handful of local employment support services which are commissioned via joint arrangements between the council and the CCG (along with some in-house service delivery). This includes Mental Health Working, Islington Aftercare (for people in contact for substance misuse issues), the Community Access Project (for residents with a Learning Disability), and the council's iWork service. These services operate alongside those funded or delivered by DWP, plus new initiaitves like the IPS supported employment trial and the employment retention prototype.

4.13 The Council would like to better understand how all these services are working together as a system. As such, the joint commissioning team has begun a review of our supported employment services across the borough. This review will improve our understanding of the kind of support that works best for residents and the resources that it takes to help someone to find, and keep a job. It will aim to be concluded by the end of September 2017.

4.14 The purpose of the review will be to inform future commissioning intentions for how local resources are used to promote employment and health outcomes for residents with a long term condition or disability. It will take into consideration early findings and learning from the IPS supported employment trial and employment retention prototype.

Service-user led peer mentoring project for employment

4.15 The involvement of residents with lived experience of health-related unemployment has been an integral part of the partnership over the last year. In particular, one of the experts-by-experience involved in the partnership has developed an idea for one-to-one peer mentoring that connects a resident who is out of work with a long term condition or disability with someone with a similar experience who is in employment. The target group would be individuals not currently committed to seeking employment, but who are interested in talking it through and finding out more from someone with relevant personal experience.

4.16 This idea has been developed and refined through desk-based research, plus discussions with voluntary and community organisations in Islington, other experts by experience, and the Wellbeing and Work Partnership delivery group. Specifically, the objective has been to find a VCS partner organisation who would be prepared to test out the concept. Following a number of conversations, the most promising partner is Single Homeless Project (SHP), who already deliver a range of support to residents with complex needs.

4.17 SHP have agreed in principle to develop the project and are in the process of seeking funding options to build on their existing local service offer. The expert-by-experience is now supporting SHP as they develop their funding application and he will remain in contact with them if and when they move into a planning and delivery phase. The aim is that the project is externally evaluated, with learning fed back to the partnership in a manner to be agreed.

Health and employment outcomes and learning framework

4.18 From its inception, the partnership has sought to identify ways to assess the impact of its activity and to track progress in improving health and employment outcomes (both in relation to specific services and for the local population as a whole). These efforts have been hampered by gaps or inconsistencies in data collection, as well as the absence of links between relevant health and employment data at an individual level.

4.19 The IPS supported employment trial has developed a core set of data items to be collected for participating individuals, covering both work and wellbeing related outcomes. The aim is that this is now used in future for locally commissioned or delivered employment support services, to enable better and more comparable assessment of performance.

4.20 To date, less progress has been possible in connecting employment and health data sets, to look at the intersections between these two issues at an individual or population level. This has hindered attempts to develop an outcomes framework for the partnership as a whole.

Therefore, a framework has been designed around a set of proxy measures, which monitor progress against three of the partnership core areas of focus:

- Workforce development and awareness raising amongst health care professionals and employment coaches of the links between work and wellbeing;
- Improved referral processes and quality of employment support services;
- Engaged employers who are committed to supporting and recruiting staff with physical and mental disabilities.

4.21 Appendix 2 provides more deail on these metrics, including their rationale and the frequency and resource required to monitor them.The proposed metrics do not capture all of the relevant local activity, nor do they explain all of the interactions between activities and outcomes. However, while partial and indirect, the framework will provide insight into the contribution of key partnership activities to the main goal of improving employment and health outcomes for residents with a long term health condition or disability.

5 Wider added value of the partnership

5.1 Summarised in section 4 of this paper are the areas of resourced activity being undertaken through the Wellbeing and Work Partnership, though these do not comprehensively address all the stated objectives of the partnership[2]. While these objectives remain an accurate articulation of the partnership's long-term goals, the conclusion of a recent review of it's role and impact was that it made sense to distinguish between concrete, additional activity (i.e. part 4 of this report) and its wider value in: connecting key individuals across local organisations; joining up related activity; capturing and sharing learning; and embedding co-production with local residents and service users.

5.2 As such, this section of the report highlights some key aspects of this wider added value, including to underpin efforts to mainstream progress from earlier stages of the partnership. It is also worth noting here feedback that highlights the beginnings of a culture shift locally around health and employment (related to the partnership's activities). For example, it has been reported that staff in the council's iWork service now have a greater understanding and awareness of the health issues faced by their clients. Simialrly, there is now greater engagement of local health care providers and professionals with employment issues.

Mainstreaming the links beween local health and employment services

5.3 A key contribution to that last shift has been the work to provide information to health care professionals about the health and wellbeing benefits of employment, the detrimental impact that long term unemployment can have, and the local support available for people wanting to gain or maintain employment.

5.4 This has taken place through a programme of meetings and presentations to clinical teams in a range of settings (in total, 18 sessions reaching over 200 staff). In addition, the development of the IPS supported employment trial (and soon the employment retention prototype) has provided health care professionals with a trusted and accessible service to refer patients to.

5.5 From participating in the partnership, local health colleagues have been sharing (and gaining) insight into the challenges of embedding and integrating employment support services into the local health system. This increased knowledge and awareness has led to commissioners considering how employment fits with wider strategies and including

[2] See Appendix 1 – Wellbeing and Work Partnership Objectives

employment support within the scope for service transformation programme such as the Haringey and Islington Musculoskeletal and Diabetes programmes.

5.6 In parallel, steps have been taken to improve the quality of local employment support for people with health conditions and disabilities. For instance, the Employability Practitioners' Network (comprising employment coaches from across the borough) has held practical sessions to equip people with greater knowledge and awareness of presenting condition, as well as techniques and extra support options to draw upon.

5.7 In addition, the council is in the process of reviewing its employment and skills strategy, following these functions being moved from the Chief Executive's department to Children's Services. This review will draw on the lessons and learning from the partnership to ensure that these services take proper account of the needs of residents with a health condition or disability – and the range of support available locally.

5.8 Taken together, this has been important early work to develop the infrastructure and foundations for long term change in how health and employment services work together locally to improve outcomes for local residents and patients.

Focusing employer engagement activity to health and disability issues

5.9 Over the last year, efforts have intensified to generate a new focus on health and disability in the council's employer engagement activity. In addition to the brokerage of jobs with specific employers, work has gone in to getting key strategic partners – like the BIG Alliance, the Timewise Foundation and the Islington Business Board – to focus on health, disability and employment.

5.10 Internally, there is agreement that the council will work towards becoming a Disability Confident employer and will review its recruitment processes to encourage a higher level of successful applications from candidates who declare that they have a long term condition or disability. Measures will include addressing induction and in-work support through mentoring as well as the staff forum. Islington Council already has Healthy Workplace status at 'achievement' level and is now working towards the status of 'excellence'.

5.11 Council officers are also exploring how social value legislation can be used more proactively to influence our contractors to support our health and employment objectives, through their own recruitment practises but also in supporting employment outcomes for service users.

Co-production (via a group of experts-by-experience)

5.12 The active involvement of service users and residents with lived experience has become an established part of the partnership. Experts-by-experience participate as equals in the core partnership meetings, as well as contributing to specific projects. For example, residents with lived experience have played a key role in developing both the IPS supported employment trial and the employment retention prototype, while also contributing to the information and awareness raising sessions with health care porfessionals. As mentioned above, one of the experts by experience involved in the partnership has developed the peer mentoring idea and provided strong leadership to make it happen.

6 Developments in the external landscape

6.1 While the focus of the Wellbeing and Work Partnership has been making an impact in Islington, it has always been critical to stay connected to the wider health and employment landscape (and, where possible, to influence its developments). Over the last 18 months, since the partnership began, there have been a number of important developments, both locally and nationally, which have shifted its operating context.

6.2 Following intense lobbying from London local government, with Islington at the forefront, the DWP has agreed to devolve £79m to four sub-regional groupings of boroughs along with the

responsibility for commissioning the Work and Health Programme (WHP). The procurement of the WHP is under way, with the programme due to 'go live' by March 2018 (with Islington part of the central sub-region). London has agreed to co-finance the programme with an additional £72m of European Social Fund resource.

6.3 The WHP will differ from the current Work Programme in a number of important ways: it will be voluntary for those with a health condition or disability; it will have higher unit funding; and it will have a less aggressive payment by results model. Sub-regional commissioning and smaller contract sizes will also make it more possible to integrate the provider with other local services, including health services.

6.4 The development of the Sustainability and Transformation Plans (STPs) has increased the focus on employment within discussions about the future of the NHS. The North Central London STP has a focus on employment as part of its prevention ambitions, which seeks to address both the role of the NHS as an employer itself and on improving employment outcomes for patients.

6.5 In addition, employment has been identified as an area of focus for the Haringey and Islington Wellbeing Partnership. An information sharing session has taken place between borough officers covering local employment-related activity. At the regional level, colleagues involved in our local partnership have been inputting into the employment element of the Mayor of London's *Thrive* initiative, aimed at improving mental health in the capital.

6.6 There are some crucial aspects of the health and employment systems experience by Islington residents which are determined by national policy. In particular, the rules and processes attached to the benefits system. In October 2016, the DWP and the Department of Health published a green paper on health and work[3]. This stated the government's commitment to ensuring that disabled people and people with long-term health conditions have equal access to labour market opportunities and are given the support they need to prevent them from falling out of work and to progress in the the workplace.

6.7 The green paper did not set out detailed proposals, but soughts views on a wide range of issues including how to integrate health and employment support, the expectations of employers to recruit and retain people with a disability or health condition, and the need for a broader culture change across society. The paper did reiterate the commitment to invest £115 million to test new models of health-focused employment support. There were not detailed proposals on changes to the work capability assessment, but it did invite views on how the process could be improved. The Islington partnership did submit a co-ordinated response and the government is now in the process of reviewing those responses.

6.8 Finally, in the last month NHS England has published an update to the Five Year Forward View. This reiterated the importance of employment as a key factor contributing to good health and well-being and also highlighted the Islington IPS supported employment trial:

> "*We are working in partnership with the Work and Health Joint Unit (a partnership between DWP and DH) to test new ways to improve the integration of and access to health and employment support to help people get and stay in work. As part of this we are supporting three trials involving around 12,000 people in Islington, the West Midlands and Sheffield City Region. These trials apply well-evidenced approaches derived from Individual Placement and Support – a model that helps people with severe mental illness return to work – to help people with more common physical and mental health conditions get and*

[3] *Work, health and disability: improving lives*: https://www.gov.uk/government/consultations/work-health-and-disability-improving-lives

stay in work. These randomised control trials will report interim findings in 2018 and final results in 2020, providing a strong evidence base on which to consider wider roll-out"[4].

7 Implications

7.1 Financial implications

7.1.1 None identified. This paper provides an update across a range of activites being undertaken by local organisations in support of the Health and Wellbeing Board's priorities. Any plans or strategies derived or agreed in relation to this report draw on existing resources and therefore do not create a budget pressure for the Council or the CCG.

7.1.2 The IPS supported employment trial and the employment retention prototype draw on external resources. However, these are time limited and so further consideration will be needed if these services are are to be sustained. It is hoped that, over the medium term, the work outlined in this paper would lead to reduced demand for public services in Islington.

7.2 Legal Implications

7.2.1 Section 195 of the Health and Social Care Act 2012 requires the Health and Wellbeing Board to encourage integrated working. Specifically section 195 (1) provides that the Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.

7.2.2 Section 195(4) further provides that the Health and Wellbeing Board may encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health-related services in its area to work closely together. "Health-related services" means services that may have an effect on the health of individuals but are not health services or social care services.

7.3 Resident Impact Assessment

7.3.1 Public bodies must, in the exercise of their functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). Consistent with this obligation, the Wellbeing and Work Partnership seeks to support activities aimed at addressing the disadvantage faced by residents with a disability in the labour market.

7.3.2 An Equality Impact Assessment was carried out for the IPS supported employment trial. As part of this trial – and the employment retention prototype – information will be collected on those participating in these services (including their outcomes). This will enable an assessment of which groups of residents with a health condition or disability are accessing support and achieving positive outcomes. This will point towards the need for any targeted action if it is identified that any specific population sub-groups are being missed out or significantly under-represented.

7.4 Environmental Implications

7.4.1 There are no significant environmental implications from the Wellbeing and Work Partnership beyond those associated with standard office usage, namely energy, water and material use and waste generation.

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[4] Next Steps on the Five Year Forward View https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf (p.44)

8 Conclusion and Reasons for Recommendations

8.1 To note progress over the last year in improving the links between the local health and employment systems through the Wellbeing and Work Partnership, including signs of a culture shift beginning to take place.

8.2 To note the areas where activity will be focused over the next 6 to 12 months, in pursuit of the partnership's longer term objectives: the IPS / supported employment trial; a prototyped employment retention service; a new peer mentoring project; a review of locally commissioned employment support services; and an outcomes and learning framework.

8.3 To note the added value of the partnership beyond these specific areas of work, in supporting collaboration and connections across the local health and employment systems; including sharing information about important changes in the local and national landscape.

8.4 To advise on any further steps needed to achieve the aspiration for significant 'system change' in relation to health and employment, in order to improve health and employment outcomes for local residents.

Background papers: None

Appendicies:

- Appendix 1 – Partnership Objectives Framework
- Appendix 2 – Outcomes and Learning Framework

Final Report Clearance:

Signed by	 ……	5 April 2017 …….....
	Jonathan O'Sullivan, Deputy Director of Public Health	Date

Report author: Graeme Cooke, Head of Strategy and Change
Tel: 020 7527 8742
E-mail: graeme.cooke@islington.gov.uk

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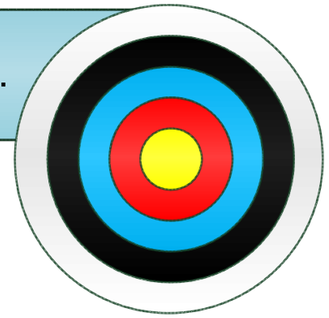
Wellbeing and Work Partnership

The aim is to improve employment outcomes for local residents with a health condition or disability..



"My doctor is positive about employment and can point me to someone who can help"

Support and encourage HCPs to integrate employment as part of helping patients to get and stay healthy. (Lea Ashman)

"I am offered help with work and well-being issues when I go through assessment processes"

Embed a stronger health and employment element in local benefit assessment processes, such as the FitNote and WCA. (Harvey Nicholls)

"I am contacted quickly, by the right organisation, after accepting an offer of employment support"

Establish a clear pathway from health services into local employment support. (Jimmy Flynn)

"Local commissioners work together to plan and buy support which works for me"

Develop a local commissioning strategy for health-focused employment support. (Jess McGregor)

"I get great support to find and keep work I enjoy and that benefits my health"

Improve the quality of health-focused employment support, with stronger links to local health services. (Jimmy Flynn)

"New types of employment support are being tested which could work better for me"

Test new models of health-focused employment support - e.g. supported employment trial. (Matt Stafford)

"I have a fair shot at getting and keeping the jobs that are available locally"

Promote more diverse recruitment and retention strategies among local employers. (Mina Scarlett)

"I have access to more and better jobs because of public sector commitment"

Increase recruitment and retention of disabled people in (or via) the public sector. (Mina Scarlett)

"We have much greater insight into the connections between health and employment locally"

Improve the collection and analysis of local health and employment data.
(Mahnaz Shaukat)

"We are actively engaging with the local people who matter"

Inform, persuade and mobilise key local actors - residents, professionals and employers.
(tbc)

"We can tell if local employment support is effective, and for whom"

Common assessment tools & outcome measures across local health-focused employment support.
(Mahnaz Shaukat)

"We are seeking change with, and alongside, local disabled people at every stage"

Active involvement of local residents with lived experience in designing, testing and reviewing solutions. (Rose Yorke Barker)

Addressing systemic challenges. A co-design approach. Learning what works. Changing the culture

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Table 1. Proposed metrics to monitor progress against three of the work and wellbeing partnership objectives

	Metric	Baseline	Suggested frequency	Comments
Health care professionals and employment coaches have and improved understanding of the relationship between health and work and are confident in discussing the benefits of work with their patients	1. Proportion of fit notes issued by GPs with ammended duties/adaptation/phased return to work/altered hours or workplace adaptations as advice.	7% (2015)	Annual	Workforce development and awareness raising amongst healthcare professionals, IPS trial and the upcoming job retention pilot should lead to an increase in employment status recorded and potentially fit notes issued with amended duties/adaptation/phased return as opposed to not fit for work. This would require a search set up from GP practice systems and run every quarter/annually. Can be met within current GP IT contract from September 2017. Extraction prior to this would require a budget of £1-2K.
	2. Proportion of the registered population with employment status recorded within the last 2 years.	11% (2015)	Quarterly	
Staff have a clear offer of employment support for their patients and know how and where to make referrals to support Islington residents with a disability/long term condition into employment	3. Proportion of all referrals to employment support services from health care professionals.	TBC	Quarterly	Clear referral pathways and awareness of employment services amongst healthcare professionals should increase referrals into the services. Data for indicators 3-6 would be available for council provided services only in the first instance. A new database is currently in development to capture these data. Over the next 6-12 months we would work with externally commissioned providers to include their data too. Data could potentially also be made available by condition/disability.
	4. Proportion of all clients referred to employment support services with long term health issues/disability accessing and engaging with employment support services.	TBC	Quarterly	
	5. Proportion of residents with long term health issues/disability accessing employment support services supported into paid work.	TBC	Quarterly	
	6. Proportion of residents with long term health issues/disability accessing employment support services health issues supported into volunteering/education.	TBC	Quarterly	
Workplaces/employers are committed and confident to supporting and recruiting staff with physical and mental disabilities.	*Number of ring fenced/carved jobs for people with a mental health or disability*			Discussions' regarding the measurement of this objective is ongoing.
	Number of employers signing up to being disability confident			

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ISLINGTON

Adult Social Services,
7 Newington Barrow Way,
London, N7 7EP

Report of: Corporate Director of Housing and Adult Social Services

Health and Wellbeing Board	**Date: 26 April 2017**	**Ward(s): All**

Delete as appropriate		Non-exempt

SUBJECT: Better Care Fund: 2016/17 review of achievements and 2017/19 planning requirements

1. Synopsis

1.1 The Better Care Fund is the only nationally mandated integration policy across health and social care. The Better Care Fund was first announced as part of the Government's Spending Review in 2013. Since 2015, this fund has acted to enable integration across health and social care.

In Islington, the Better Care Fund has operated as a key enabler for integration. This has included maintaining investment for Adult Social Care into services that benefit health and to protect Adult Social Care services. The Better Care Fund has also facilitated the transformation across health and social care through the Islington Integration Programme to deliver outcomes for local people.

In 2017, the requirements and funding allocations for the Better Care Fund have been developed to reflect the changes in the NHS planning processes and also the pressures across health and social care. The aim of this report is to summarise the implementation journey of 2016/17 and the planning requirements for 2017/19.

2. Recommendations

2.1 That the achievements of integrated working in 2016/17 are noted including areas of improvement of services.

2.2 That the planning principles for 2017/19 are noted and that a further update report is received by the board in October 2017 that includes the final arrangements for Islington for 2017/19.

3. Background and 2016/17 Better Care Fund achievements

3.1. Announced in 2013, the Better Care Fund has acted to bring together health and social care budgets to enable person centred care. Nationally, in the first two years of the Better Care Fund, the total amount pooled has been £5.3bn (2015/16) and £5.8bn (2016/17).

The aim of the Better Care Fund is to promote joint working between health and social care. It is recognised nationally that there is no one way to integrate care. In Islington, the Better Care Fund has been an extension of the integrated working which is established in the borough. In addition to the Better Care Fund, Islington has over £50 million in pooled budgets across health and social care for adults and children.

Islington has utilised the Better Care Fund to further enable and support the joint work in progress through the Integrated Care Programme. The Better Care Fund priorities locally are:

- Locality Offer across community, social care and mental health services to support primary care capacity;
- Enhancing primary care capacity;
- IT and inter-operability to ensure patient information can be shared across integrated services and along care pathways;
- To meet demographic pressures in social care, and across health and care services for older people and people with learning disabilities;
- To maintain social care eligibility;
- To incentivise providers to support integrated care.

3.2 The progress of the Better Care Fund has been managed through the Islington Integrated Care Programme. This programme is aligned to the wider Wellbeing Partnership across Haringey and Islington and the Sustainability and Transformation Plan. The Islington Integrated Care Programme Board over the past 3 years (of the 5 year national programme) has strengthened partnership working; identified opportunities for integrated care and has overseen whole systems integration initiatives particularly in the areas of care closer to home.

Key achievements in 2016/17 that were enabled by the Better Care Fund include:

- **Protection of Adult Social Care:**
  The Better Care Fund, alongside existing pooled budgets between health and social care, has supported investment into frontline services such as social care services that benefit health (core social care offer of assessment, care management and reablement); Carers funding (Carers funding, assessment and carers breaks) and disabled facilities grant (home adaptations for independent living). The fund has also been used to support demographic pressures and substantial growth in NHS funded Continuing Healthcare for people with Learning Disabilities and older people. This resourcing has enabled local people to live more independently, and return to the community in a timely way when accessing hospital services.

- **Universal coverage for people with complex needs through locality Integrated Health and Social Care Networks:**
  Islington CCG and Council alongside GP practices developed extended health and care teams to support networks of practices, to provide an integrated response to those patients most at risk of admission who would benefit from a more joined up response. This model is now available across the borough. This model of care includes regular meetings of health, care, housing and voluntary sector professionals to directly discuss patient care. These networks will be aligned into the wider GP locality working through the Care and Health Integration Networks.

  Evaluation of service user experience completed by Healthwatch through interviews indicated that service users experienced coordinated care.

- **Workforce to join up health and social care:**
  The Islington Community Education Provider Network was established and developed an integrated care training programme to enable a skilled workforce that delivers care with dignity and compassion, is motivated to make a difference and is rewarded for its efforts.

- **Development of improved models of community based rapid response services:**
  Islington health and care is working with Haringey health and care to further develop and align models of care for community based rapid response services. The ambition is to offer an urgent response to people in the community within 2 hours in a consistent way for people who are at risk of attending hospital and do not require an ambulance. This development forms part of wider programme of work to improve intermediate care services.

- **National status as an Integrated Personalised Commissioning site and Extension of Personal Health Budgets**
  Islington in November 2016 was awarded national status as a leading site to bring together health and social care for complex individuals (adults and children's) as a site for integrated personalised commissioning. This programme includes developing innovative approaches to deliver care planning and personal budgets as required. A key enabler of this work has been Islington's progression in personal health budgets which is now available to people with multiple sclerosis.

Appendix 1 shows the Islington performance against the nationally set whole systems metrics for the Better Care Fund. These metrics on the whole show that Islington performed near to or better than projections once demographic growth were accounted for across the system. Islington performs better than similar boroughs for these metrics.

These local achievements will be shared with wider partners through the Wellbeing Programme and the Sustainability and Transformation Plan throughout 2017/18.

4. Planning requirements for 2017/19

For 2017/19, there are a number of changes to the arrangements for the Better Care Fund. These developments are to ensure alignment to the NHS planning processes and to reflect social care funding arrangements. A summary of these key changes are set out below:

a. Two year planning horizon and alignment to the Sustainability and Transformation Plan:
The Better Care Fund plan is now to be set over two years to align to NHS planning processes which have changed through the introduction of Sustainability and Transformation Plans. The Better Care Fund now also includes a requirement to ensure that financial planning and direction aligns to the local Sustainability and Transformation Plan.

b. **Refinement of reporting requirements:**
The 2017/19 Better Care Fund has been refined to reduce the number of national reporting requirements from 8 to 4. The planning guidance states that the conditions are now:

- Plans jointly agreed
- NHS contribution to adult social care is maintained in line with inflation
- Agreement to invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care
- Managing transfers of care (this is a new condition to ensure people's care transfers smoothly between services and settings)

Beyond these conditions, local areas have flexibility on how the Fund is used but need to agree how the fund will improve performance in Delayed Transfers of Care, Non Elective Emergency Admissions, admissions into residential and care homes and effectiveness of reablement.

c. Introduction of the Improved Better Care Fund:
The main change to the fund is the Improved Better Care Fund which includes local authority social care grant funding, This comes from two sources: the Adult Social Care Precept (funded through local council tax) and the additional funding announced through the Spring Budget. The Spring Budget includes an allocation over 3 years and will be provided directly to councils via a Section 31 grant.

The planning guidance advises that this funding does not replace the NHS minimum contribution for Adult Social Care. The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. The Improved Better Care Fund arrangements will need to be agreed locally. The government has set out broad conditions on the use of these monies.

- The grant is to be spent on Adult Social Care and used for the purposes of meeting Adult Social Care needs, reducing pressures on the NHS - including supporting more people to be discharged from hospital when they are ready - and stabilising the social care provider market.

- The local authority must:
    - pool the grant funding into the local Better Care Fund, unless the authority has written Ministerial exemption;
    - work with the relevant Clinical Commissioning Group(s) and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and
    - provide quarterly reports as required by the Secretary of State.

Final technical guidance will be released from central government to further define the requirements for the Improved Better Care Fund which will enable Islington to finalise local plans in conjunction with Islington Clinical Commissioning Group.

d. Opportunity to 'Graduate' from the Better Care Fund:
The Government has set out an ambition that all areas will be able to work towards graduation from the Better Care Fund. This is to allow local determination and devolution where local systems are at appropriate maturity to act without central programme management. In 2017/18, a number of areas (6-10) will test the graduation process before this is offered more widely to other areas.

To finalise the planning for 2017/19, Islington Council and Islington Clinical Commissioning Group will work in partnership to develop detailed plans following the final release of planning guidance from the Government. A follow up report will capture this information for the October meeting of the Islington Health and Wellbeing Board.

5. Implications

Financial Implications:

5.1 The Better Care Fund for 2015/16 pooled budget between Islington Clinical Commissioning Group and Islington Council was £18.388m. In 2016/17 this was increased to £18.410m. This includes funding streams such as the Disabled Facility Grant of £1.318m which is an existing national scheme providing home adaptations to support independent living.

Financial Arrangements for 2016/17

Scheme Name	Financial Amount
16.01 Protection of Adult Social Services	£7,732,000
16.02 Reablement	£1,200,000
16.03 Carers	£246,000
16.04 Care Act	£663,000
16.06 Risk Pool	£1,200,000
16.07 IT	£600,000
16.08 Out of Hospital Services	£5,452,000
16.09 Disabled facilities Grant	£1,318,000
Total	**£18,411,000**

For the next planning phase for the Better Care Fund 2017/19, the financial implications as set nationally are captured below. This includes the existing allocations for the Better Care Fund and the increased through the Improved Better Care Fund. The utilisation of these funds for specific schemes will be refined following the release of further technical planning guidance. Due to the late allocation and policy guidance from central government, the 2017/18 allocation of funding is indicative and may be subject to change.

	2017-18 £m	2018-19 £m	2019-20 £m
Minimum fund contribution for Better Care Fund	17.09	17.40	17.73
Disabled Facilities Grant (*subject to inflation)	1 .318*	1 .318*	1.318*
Council Tax Precept	2.20	TBC	0
Original Improved Better Care Fund	1.30	5.20	4.50
Additional ASC Funding announced in spring 2017 Budget (One-off Funding)	6.07	3.70	1.83

Legal Implications:

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

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

Environmental Implications

5.3 The Better Care fund work has some minor environmental implications; the extended evening and weekend hours by staff will result in an increase in energy usage, whilst a new rapid response service will result in extra journeys, contributing towards emissions and congestion. However, the digitisation of care records will reduce the need for physical paper copies and will enable remote working

Resident Impact Assessment:

5.4 The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good

relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding. No specific RIA has been carried out in relation to this report; impacts on residents will be assessed in relation to specific schemes.

6. Reasons for the recommendations:

6.1 The Health and Wellbeing Board is asked to note the joint work across health and care services in Islington to develop integrated care for local people through the Better Care Fund, note the performance against plan assumptions.

Signed by:

18 April 2017

Corporate Director of Housing and Adult Social Services Date

Appendices

- Appendix 1 – Performance for Better Care Fund Metrics

Background papers: None

Report Author: Marisa Rose, Integrated Care Pioneer Programme Director, Islington CCG
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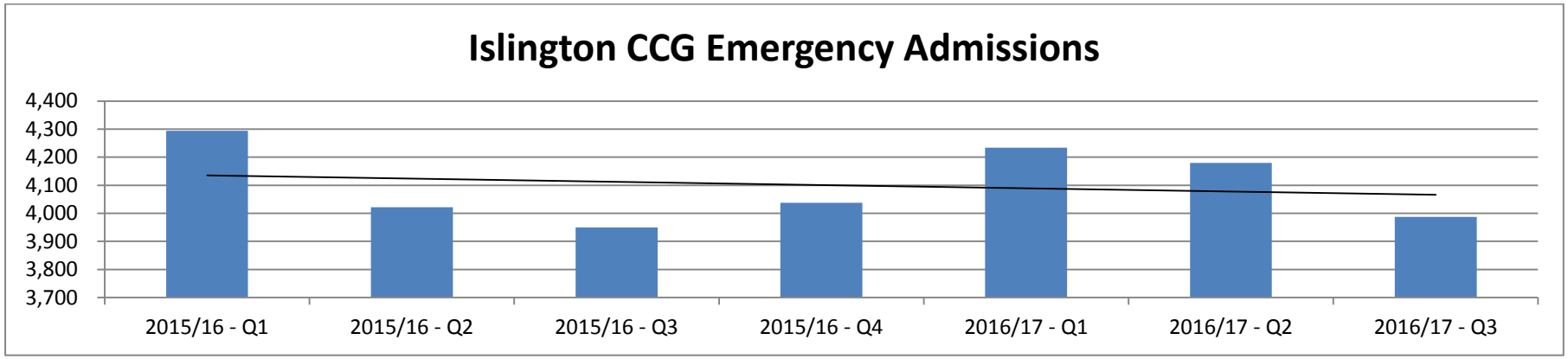
APPENDIX 1
Performance for Better Care Fund Metrics

Objective	PI No.	Indicator	Frequency	Estimated Year End Total	Target 2016-17	On/Off target	Same period last year	Better than last year?	Comments
Support older and disabled adults to live independently	ASC1	Delayed transfers of care (delayed days) from hospital per 100,000 population aged 18+	Q	**783.2**	685.8	**Off**	540.8	**No**	The current performance for Delayed Transfers of Care is not in line with the target. There is evidence that this is due to greater acuity of need especially with an aging population and demographic growth. This trend is borne out by national data from August 2010 to January 2017 (source – NHS England), which shows a steady increase in delays year on year The main reason for delays in Islington are due to limitations in access to further NHS services and delays in setting up nursing or residential care packages. Delayed Transfers of Care are closely monitored by managers at all levels both within health and social care with actions developed and monitored.
	ASC2	Percentage of people who have been discharged from hospital into enablement services that are at home or in a community setting 91 days after their discharge to these services	Q	**91.4%**	92%	**Off**	89%	**Yes**	Anticipated end of year performance is 91.4% which is slightly below target. Islington's performance in comparison with other areas has been above average and, while benchmarking data will not be available until Autumn 2017, it's anticipated that performance will continue to be above average when compared to similar authorities.

Support those who are no longer able to live independently	ASC4	Number of new permanent admissions to residential and nursing care	M	**139**	105	**Off**	133	**No**	The number of nursing and residential admissions is estimated to have increased this year compared with 2016/17, from 133 to 139. The target of 105 admissions for 2016/17 was based on an outdated methodology which did not account for all nursing and residential admissions during the year. Therefore, the target was unrealistically low. Population projections indicate an increase in those aged 85 and over from 2300 in 2015 to 3000 in 2025, which has the potential to cause additional pressures on services during the next ten years. Currently, around 50% of older adults admitted to permanent nursing and residential care are aged 85 and over. To address these demographic pressures, new processes have been developed and work is ongoing between health and social care to ensure that patients are discharged back to their own home. These measures include improvements to the intermediate care pathway.

Reporting source: London Borough of Islington

Performance for Better Care Fund Metrics



FiscalYear	FiscalQuarter	Activity
2015/16	Q1	4,294
2015/16	Q2	4,022
2015/16	Q3	3,950
2015/16	Q4	4,037
2016/17	Q1	4,234
2016/17	Q2	4,180
2016/17	Q3	3,987

Comments

The number of emergency admissions for 2016/17 (Q1-Q3) is 12 401 in comparison to 12 226 for 2015/16 (Q1-Q3). This performance is better than the target set at 14 057 for 2016/17 (Q1-Q3). The target is higher than the previous year's performance as demographic and non-demographic growth is included. This indicates that less people were admitted to hospital than expected.

Reporting source: Islington Clinical Commissioning Group

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