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ISLINGTON

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

AGENDA FOR THE HEALTH AND CARE SCRUTINY COMMITTEE

Members of the Health and Care Scrutiny Committee are summoned to a meeting, which will be held in Committee Room 4, Town Hall, Upper Street, N1 2UD on, **6 July 2017 at 7.30 pm.**

Lesley Seary
Chief Executive

Enquiries to	:	Peter Moore
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Despatched	:	28 June 2017

Membership

Councillors:
Councillor Martin Klute (Chair)
Councillor Jilani Chowdhury
Councillor Gary Heather
Councillor Michelline Safi Ngongo
Councillor Nurullah Turan (Vice-Chair)
Councillor Troy Gallagher
Councillor James Court

Co-opted Member:
Bob Dowd, Islington Healthwatch

Substitute Members

Substitutes:
Councillor Alice Perry
Councillor Clare Jeapes
Councillor Satnam Gill OBE
Councillor Angela Picknell

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

Quorum: is 4 Councillors

A.	**Formal Matters**	**Page**
1.	Introductions	
2.	Apologies for Absence	
3.	Declaration of Substitute Members	
4.	Declarations of Interest	

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

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

In both the above cases, you **must** leave the room without participating in discussion of the item.
If you have a **personal** interest in an item of business **and** you intend to speak or vote on the item you **must** declare both the existence and details of it at the start of the meeting or when it becomes apparent but you **may** participate in the discussion and vote on the item.

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

This applies to **all** members present at the meeting.

5.	Order of business	
6.	Membership, Terms of Reference	1 - 6
7.	Confirmation of minutes of the previous meeting	7 - 14
8.	Chair's Report	

	The Chair will update the Committee on recent events.	
9.	Public Questions	
10.	Health and Wellbeing Board Update	
B.	**Items for Decision/Discussion**	**Page**
11.	Scrutiny Topic 2017/18	
12.	Camden and Islington NHS Trust - Performance update	
13.	Annual Public Health Report	15 - 68
14.	Draft recommendations - IAPT Scrutiny Review	69 - 84
15.	Work Programme 2017/18	85 - 86

The next meeting of the Health and Care Scrutiny Committee will be on 14 September 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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ISLINGTON

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

Report of: **Corporate Director - Resources**

Meeting of	**Date**	**Ward(s)**
Health and Care Scrutiny Committee	06 July 2017	All

Delete as appropriate		Non-exempt

SUBJECT: HEALTH AND CARE SCRUTINY COMMITTEE - MEMBERSHIP, TERMS OF REFERENCE AND DATES OF MEETINGS

1. Synopsis

1.1 The Committee is asked, to note the Committee's terms of reference and their meeting and working arrangements.

1.2 Scrutiny Committees carry out reviews of the council's policies, performance and practice and look at how external organisations conduct their business to ensure local, accountable and transparent decision making and shape future policy and practice.

2. Recommendations

2.1. To note dates of meetings of the Health and Care Scrutiny Committee for the municipal year 2017/18, the membership appointed by Council on 11 May 2017.

3. Background

3.1. The Health and Care Scrutiny Committee is established under the terms of the constitution of the London Borough of Islington.

3.2. The membership of the Health and Care Scrutiny Committee is attached below. The quorum is four councillors.

3.3. In addition to carrying out health related scrutiny reviews, the Committee invites local NHS trusts and health providers to the Committee to discuss their performance. This enables an ongoing dialogue to take place to enable the Committee to gain a better understanding of health service matters and to question the trusts on areas of concern throughout the year.

3.4. The following dates have been agreed for the remainder of this municipal year:

6 July 2017
14 September 2017
12 October 2017
14 December 2017
22 January 2018
1 March 2018
16 April 2018

Membership of the Committee 2017/18
Councillors:

Martin Klute – Chair
Nurullah Turan – Vice Chair
Gary Heather
Troy Gallagher
James Court
Jilani Chowdhury
Michelline Saffi-Ngogo

Bob Dowd – Islington Healthwatch

Subsitutes:
Alice Perry
Clare Jeapes
Angela Picknell
Satnam Gill

Olav Ernsten – Islington Healthwatch
Philip Watson – Islington Healthwatch

3.5. **Financial implications**
The Director of Finance and Resources confirms that costs associated with the Review Committees have been budgeted for in the 2017/18 budget.

3.6. **Legal Implications**
The Council appoints Scrutiny Committees to discharge functions conferred by section 21 of the Local Government Act 2000.

3.7. **Equalities Implications**
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.

3.8. **Environmental Implications**

Papers are circulated electronically where possible and consideration given to how many copies of the agenda might be required on a meeting by meeting basis with a view to minimising numbers. Any agendas not used at the meeting are recycled. These are the only environmental implications arising from this report.

4.5 **Resident Impact Assessment**

There are no direct equality or other resident impact implications arising from this report

4. Conclusion and reasons for recommendations

The Committee are asked to note their terms of reference and working arrangements.

Background papers:
The Council's constitution
Programme of Meetings

Final Report Clearance

Signed by …….

……
Director of Law and Governance Date

……. ….

Report author: Peter Moore
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APPENDIX A

HEALTH AND CARE SCRUTINY COMMITTEE

(This Scrutiny Committee is responsible in accordance with regulation 28 of the Local Authority (Public Health, Health and Wellbeing and Health Scrutiny) Regulations 2013) for the Council's health scrutiny functions other than the power under regulation 23(9) to make referrals to the secretary of state

Composition

Members of the Executive may not be members of the Scrutiny Committee.

Members of the Health and Wellbeing Board should not be appointed to this committee.

No member may be involved in scrutinising a decision which he/she has been directly involved.

The Scrutiny Committee shall be entitled to appoint a number of people as non-voting co-optees.

Quorum

The quorum for a meeting of the committee shall be four members.

Terms of Reference

1. To review the planning, provision and operation of health and care services in Islington area, invite reports from local health and care providers and request them to address the committee about their activities and performance

2. To respond to consultations by local health trusts and the Department of Health.

3. To consider whether changes proposed by local health trusts amount to a substantial variation or development.

4. To make reports and/or recommendations to a relevant NHS body or a relevant health service provider.

5. To recommend to the Council that a referral be made to the secretary of state under regulation 23(9) of the Local Authority (Public Health, Health and Wellbeing and Health Scrutiny) Regulations 2013.

6. To make reports and/or recommendations to the Council and/or the Executive on matters which affect the health and wellbeing of inhabitants of the area.

7. To carry out the functions of an overview and scrutiny committee in respect of matters relating to the Public Health Directorate or to Adult Social Services.

8. To undertake a scrutiny review, of its own choosing and any further reviews as directed by the Policy and Performance Scrutiny Committee and, consulting all relevant sections of the community, to make recommendations to the Executive thereon.

9. To carry out any review referred to it by the Policy and Performance Scrutiny Committee following consideration of a Councillor Call for Action referral.

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London Borough of Islington

Health and Care Scrutiny Committee - Monday, 6 March 2017

Minutes of the meeting of the Health and Care Scrutiny Committee held on Monday, 6 March 2017 at 7.30 pm.

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

Councillor Martin Klute in the Chair

1 INTRODUCTIONS (ITEM NO. 1)

The Chair introduced Members and officers to the meeting

2 APOLOGIES FOR ABSENCE (ITEM NO. 2)

Councillors Ismail and Ngogo

3 DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. 3)

None

4 DECLARATIONS OF INTEREST (ITEM NO. 4)

None

5 ORDER OF BUSINESS (ITEM NO. 5)

The Chair stated that the items would be dealt with as per the agenda item order

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

RESOLVED:
That the minutes of the meeting held on 12 January 2017 be confirmed and the Chair be authorised to sign them

7 CHAIR'S REPORT (ITEM NO. 7)

The Chair reported on the following matters -

8 PUBLIC QUESTIONS (ITEM NO. 8)

The Chair outlined the procedure for filming and recording and for Public questions to the meeting

A Member of the Public referred to recent guidelines concerning the numbers of learning disabled units at Windsor Street development and that these were not being applied despite a statement from the Director of Housing and Adult Social Services stating that the guidelines would be applied. The Chair stated that he would investigate this matter with the Director of Housing and Adult Social Services

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

Councillor Janet Burgess, Executive Member Health and Social Care, was present at the meeting and made the following main points –

- Noted that a Joint Health and Wellbeing Board had been established with L.B.Haringey to discuss matters of mutual interest
- Noted that Councillor Burgess had visited the Camden and Islington NHS Trust site to look at the redevelopment of the St.Pancras site
- The LUTS clinic at the Whittington had not yet reopened and it was noted that this would not reopen before April
- Noted that Whittington had improve their cancer response rates, however they were still not meeting their A&E targets in common with most London NHS Trusts

The Chair thanked Councillor Burgess for attending

10 NHS TRUST - MOORFIELDS QUALITY ACCOUNT/PERFORMANCE REPORT (ITEM NO. 10)

Ian Tombleson and Tracey Luckett from Moorfields Eye Hospital were present for discusson of this item and made a presentation to the Committee, copy interleaved.

During discussion the following main points were made –

- Moorfields have over 2000+ members of staa and 22000 foundation trust members, including staff
- Staff recommending Moorfields 95.3% as a place to receive treatment and staff recommending Moorfields as a place of work is 74.6%
- Moorfields sees 700000 + patients each year and there are 100000+ visits to A&E. There are 39000 inpatients per year and 560000 outpatients and the Trust has a turnover of £200m
- The CQC inspection took place on May 2016 across nine sites and there were also unannounced inspections at various sites. The outcomes were announced in six reports with an overall rating of good however it was noted that there were two areas where improvements needed to be made
- There were 78 recommendations grouped into 50 Trust actions and an action improvement plan is progressing well. A CQC summit was held on 14 March with stakeholders to agree actions and many actions completed by Quality Summit and vast majority by end of year
- There had been no national patient experience surveys however local surveys had been undertaken and Members noted compliance with national targets for 2016/17
- Patient led assessment of the care environment was positive and achieved high satisfaction rates above the national average

- To monitor the quality of patient experience there is a patient engagement group, accessible information standard, expanding the ECLO service and the use of 'floor walkers'
- Moorfield had a solid year financially and the January surplus forecast was £7.04m and there is satisfactory delivery against CIP's and good commercial performance and regulatory ratings are expected to be strong at year end
- Proposal is to relocate Moorfields Eye Hospital and the Institute of Opthalmology to construct a world class facility in a single building to integrate seamlessly Clinical Services, Research, Education and a positive working environment
- The site at Kings Cross will be in close proximity to London's research quarter and MedCity with good transport links and access. There will be a single phase of construction minimising disruption to patients, visitors and staff
- In response to concerns about access to any redeveloped site at Kings Cross Moorfileds stated that the new site would have buses available for patients
- It was stated that at the next Moorfields performance report to the Committee should have a representative from the Board of Governors present

The Chair thanked Ian Tombleson and Tracey Luckett for attending

11 SCRUTINY REVIEW - IAPT - WITNESS EVIDENCE (ITEM NO. 11)

Natalie Arthur, Islington CCG was present for discussion of this item and a presentation was made to the Committee, copy interleaved. She was accompanied by Farideh Dizadi, Clinical Services Manager, Nafsiyat and Tahera Aanchawan, Director Maya Centre.

During discussion the following main points were made –

- Non IATP talking therapies have a targeted service in response to local demand – 3 elements BMER communities, Child Sexual Abuse and Domestic Violence and Bereavement
- This is jointly funded by the Council and the CCG through third sector providers and is a time limited service of between 12 and 20 sessions
- This service complements existing IATP provision to support an increase in access to psychological therapy for identified under represented communities and to provide counselling for those who have suffered a bereavement
- The service differs from IAPT in that it has a higher threshold, equivalent to Step 3 on IATP stepped care model, has a women only element, access to therapists with a range of language skills, overcome cultural barriers by matching service users to therapists with the same background and is non NHS and helps to overcome barriers associated with the fear of Mental Health services
- 50% of those who complete treatment will be moving to recovery (aligned with IAPT) target and 60% of those who complete treatment maintain a clinically significant improvement at 3 months post therapy
- 40% of those who complete treatment maintain a clinically significant improvement at 6 months post therapy and 50% of those who complete treatment access ongoing support within the community including peer support
- 50% of those who complete treatment self-report an improved level of confidence in maintaining their own mental well-being
- A high number of referrals are received and the majority are accepted and the referral rate and number on the waiting list for BMER and Bereavement services indicates that the target for accessing treatment will be met however there were concerns around the recovery rates for CSA/DV and bereavement

services, however it is felt that the measurement is partly affected by data reporting tools

- Performance against key areas of focus an increase in people from BMER communities accessing talking therapies and increase in men accessing talking therapies and an increase in older people accessing talking therapies. LGTB representation is difficult to measure due to lack of self-reporting
- Challenges include – demand for services compared to service capacity, over 100 on waiting list, interim support for those on waiting list, availability of Turkish speaking therapists, encouraging access from other BMER groups, encouraging access from older people and men, and performance monitoring and measuring outcomes
- In response to a question it was stated that the therapies were complementary to IATP therapies and that it was encouraging to see new communities accessing services
- Future developments include investment in reporting system, in line with IATP service, improved performance reporting to support better understanding of gaps in provision and low recovery rate, performance figures to contribute to local IATP data from 2018/19 and supporting local Syrian refugees resettlement programme linking in with Camden and Islington Foundation Trust's Complex Depression and Trauma service
- It was noted that the Mayat Centre was a women's only project and therapists were community based and looked at the client in the whole and the Mayat and Nasfiyat Centres aimed to maximise their resources
- Discussion took place as to the over representation of the Turkish community accessing services and that whilst this needed to be assessed it indicated the success of the scheme given that the Turkish community had previously not accessed the service. It was noted that it was hoped to increase the number of Turkish therapists
- In response to a question it was stated that in terms of BMER there was a 4/5 waiting list but bereavement waiting lists were shorter but work did take place with people waiting for treatment
- Whilst it was difficult to get patients to provide feedback these were looking to be improved
- Reference was made to the fact that there was a need to establish the number of Kurdish users in relation to Turkish users of the service, and it was stated that Kurdish users were considered separately

The Chair thanked Natalie Arthur, ADD IN OTHERS for attending

12 WHITTINGTON ESTATES STRATEGY (ITEM NO. 12)

Siobhan Harrington and Joe Morrisroe Whittington NHS Trust, was present for discussion of this item and made a presentation to the Committee, copy interleaved.

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

- Whittington Care organisation (community and acute services) provide services to a population of 500000 – mainly to L.B.Islington and Haringey
- There is annual income of c£295m and a staff of c4,400
- The Whittington Estates and Facilities budget is c£24m and the in -house capacity to deliver major investment estate transformation is limited
- Hospital site – 33% built pre 1948 and 18% post 2005 and there are 9 community freehold sites and service delivery from over 40 community sites. There is a backlog of c£17m

- The Trust strategy was published in 2016 and stated aims are – a modern estate designed to deliver clinical services, and estate that enables care to be provided and when people need it and an estate that meets national guidelines regarding patient space, privacy and dignity
- Each transformation must support the delivery of new models of care and improve the efficiency of the Trust's estate and the Trust needs a long-term strategy to maintain and invest in the estate, to reduce the backlog and improve the environment for patients and staff
- Challenges include NHS capital funding availability being severely constrained, the Trust's capacity to move forward at pace and alone is limited but doing nothing is not an option. The Trust does not have the capital or capacity to develop and implement a long term transformational programme
- The Trust's approach is to procure a partner who will support the Trust with commercial and real estate experience
- A Strategic Estates Partnership is a 50:50 joint partnership between the Trust and its partner that seeks to maximise the potential of the Trust's estate to support and improve the delivery of clinical services
- As a non-Foundation Trust the Trust will enter into a contractual relationship with the partner to form the SEP. The SEP will bring a range of estates expertise, providing strategic advice to the Trust, helping to prepare an estates master plan, developing business cases, project managing new projects and identifying sources of capital. The relationship with the SEP is non-exclusive and each project is agreed on a case by case basis, but fits into a broader, strategic master plan and this approach is being increasingly used across the NHS
- The Trust's priorities for improvement include redevelopment of maternity and neo-natal services, staff residences, modernisation and rationalisation of the community estate, reprovision of facilities for specialist services for Community Children's services and reducing carbon emissions by developing a sustainable energy and infrastructure policy
- The SEP will enable the Trust to deliver its Estates strategy in a positive way, that focuses on redevelopment and can be a catalyst in development of integrated care and CHIN's in both Islington and Haringey
- Staff and community engagement will be essential in future detailed proposals and individual business cases will be essential
- Discussions were taking place with Camden and Islington NHS Trust about transfer of beds to the Whittington site
- Concern was expressed that the private developer would wish to sell off assets in order to generate a profit. It was stated that it was felt that a partner could provide fresh thinking on how assets were managed and given that the Trust operated across 32 sites and that this is not necessarily an efficient way to operate. The Whittington stated that they would report back to the Committee on proposals at the earliest possible opportunity
- Members expressed the view that effective communication of the proposals is vital and that Whittingt6n should reassure the community that they will maintain and improve services within the locations that they are accustomed to
- It was noted that the Whittington were committed to retaining its maternity unit
- It was noted that Whittington were working on a communications strategy to engage the community in the process which would involve the use of the internet, the Community Forum and local newspapers
- The Whittingtonn strategy since 2010 had been to build a stronger service and model

The Chair thanked Siobhan Harrington for attending

13 DURG AND ALCOHOL TREATMENT SERVICES (ITEM NO. 13)

Charlotte Ashton and Emma Stubbs, Islington Public Health were present for discussion of this matter and made a presentation to the Committee, a copy of which is interleaved. A service user was also present.

During discussion the following main points were made –

- Substance misuse services have been part of a programme of transformation and redesign since 2014 and savings of £2.3 million have been delivered since 2014/15
- Public Health commissioners are committed to finding a further £1.3 million savings. It is anticipated that by the start of the new contract 2018/19 the cost of services in the scope of this programme will be £4,900,000. This represents a 23% reduction on current 2016/17 contract values
- Services have historically been commissioned via a range of different funding streams and as a result the different parts of the drug and alcohol treatment service pathway have been designed and commissioned separately. Consequently different service types are provided through the same providers and some areas of provision are provided by several providers
- Pathways and referral routes into services can be complex and confusing and service users face multiple assessment, hand over and case working arrangements
- Due to the current challenges facing local authorities there is a need to ensure that services are operating as effectively and efficiently as possible
- The vision for the redesigned service is to continue to improve recovery outcomes, increase uptake of the most appropriate treatment for those who need it and ensure the treatment pathway meets the changing needs of the population of drug and alcohol users
- The specification for the new service model will be co-produced with a wide range of stakeholders, and most importantly, users. Key elements will be a single point of contact, focus on service users outcomes, think Family embedded within all aspects of the service, ensuring the right kind of specialist support is tailored to meet service user needs, expert advice to partners across the system in identifying needs, and a strong emphasis on recovery and social resilience
- It was noted that the new service would simplify the system and the service user stated that this would in his view be the case and lead to a more integrated service and would put service users at the forefront in order to facilitate services needed and the new proposals would involve service users to improve outcomes
- It was stated that the high level of NEET's needing services needed to be addressed and outcomes improved. It was stated that work is taking place with community safety and PREVENT to engage this group and the focus would be to direct users to community based services rather than specific hubs
- It was noted that VCS discussions had taken place with VCS organisations to discuss the model to be introduced and how they could tie in with community providers to access services and to promote what is available in the community to make them an offer they can utilise
- It was also noted that the Drug and Alcohol service also linked in with problem families and work is taking place with mental health services and that the service was optimistic that the new proposals would improve outcomes and access to services for service users

The Chair thanked Emma Stubbs and Charlotte Ashton for attending

MEETING CLOSED AT 10.15 p.m.

Chair

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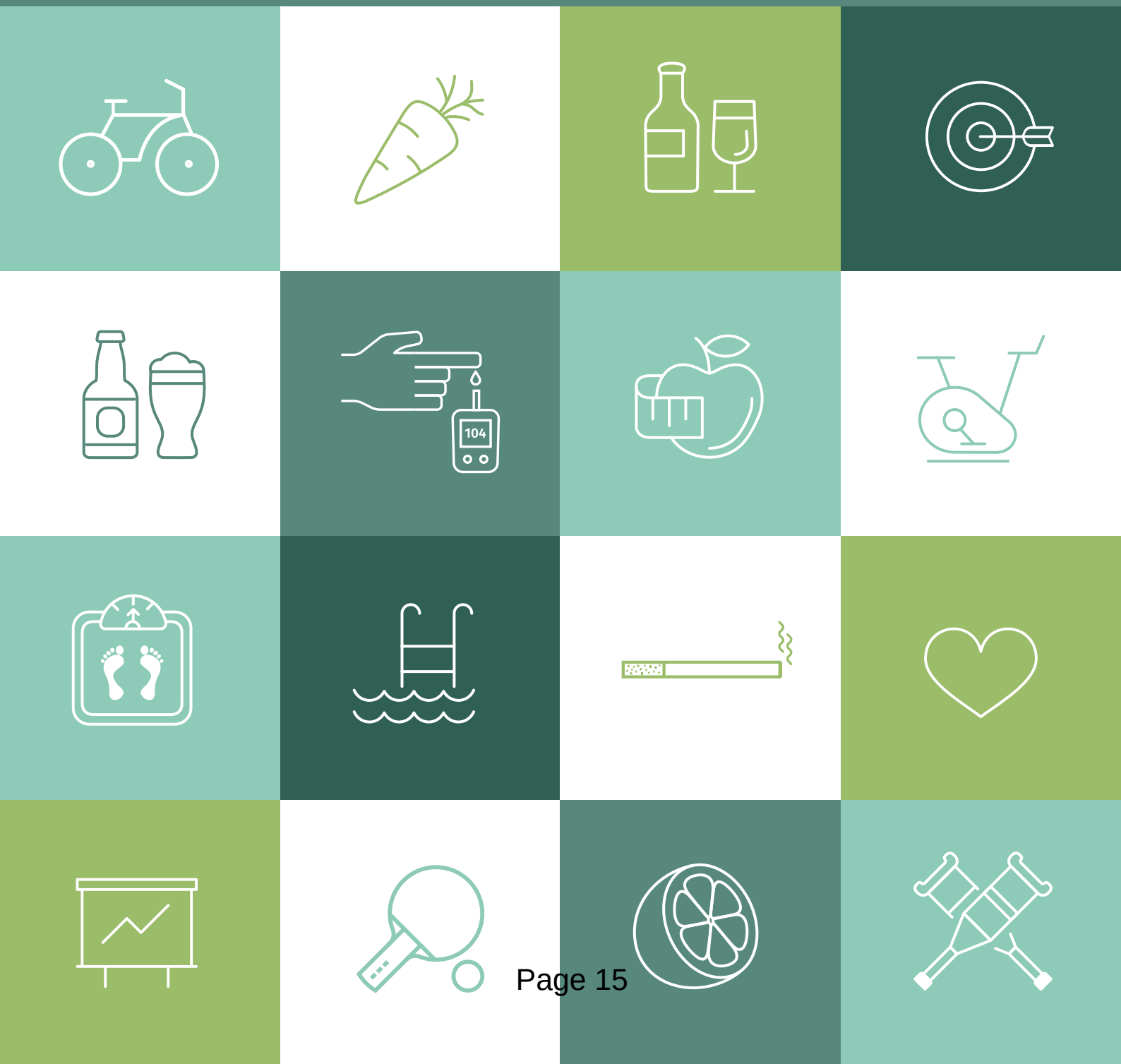
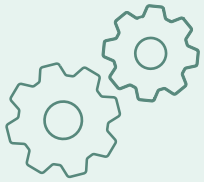
The economics of prevention and the role of the NHS

Annual Public Health Report 2016/17

ISLINGTON Camden



Contents



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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, mean 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 developped 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 which 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, businesses, 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

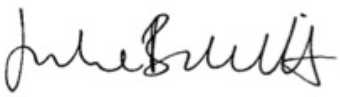
3 World Health Organisation. The Case for Investing in Public Health. 2014.
4 Imison, C et al. Shifting the balance of care: Great Expectations. Nuffield Trust: March 2017.
5 Camden and Islington Annual Public Health Report 2015. Healthy Minds Healthy Lives. Widening the focus on Mental Health. http://www.islingtonccg.nhs.uk/Downloads/CCG/BoardPapers/20150506/5.2.2%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 which 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,

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

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 the 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.

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.

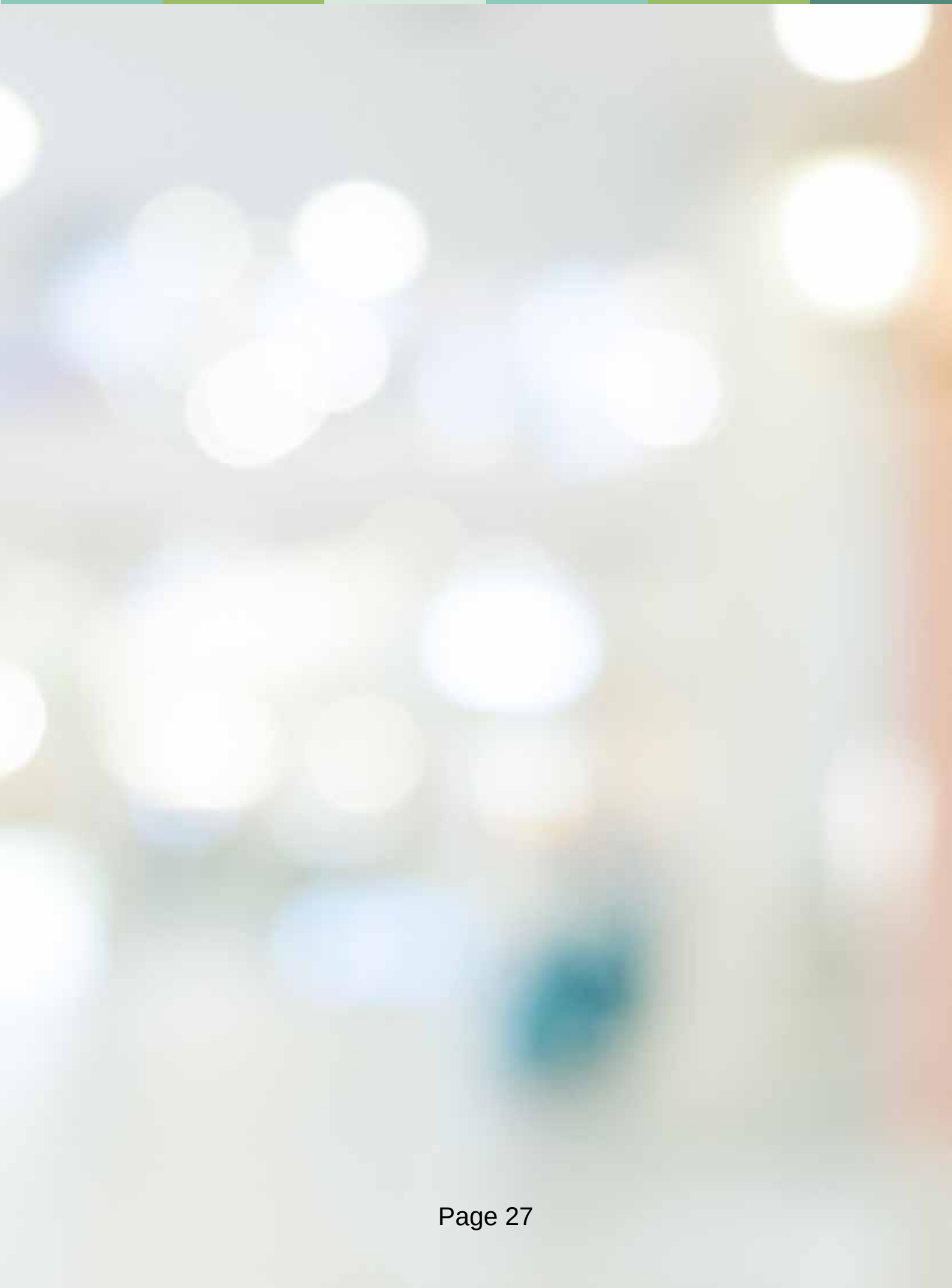
Chapter 3 describes the return on investment for a selection of key evidence-based preventative interventions. Investing in these interventions and supporting residents to live healthier, independent lives will prevent the development or progression of long-term conditions, improve quality of life and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



01
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 upon the poorest in society. The health and care system spends billions of pounds each year on treating illnesses and meeting care and support needs which 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 advice, 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, or providing a healthy food offer.

Impacts at a wider societal or population level:-

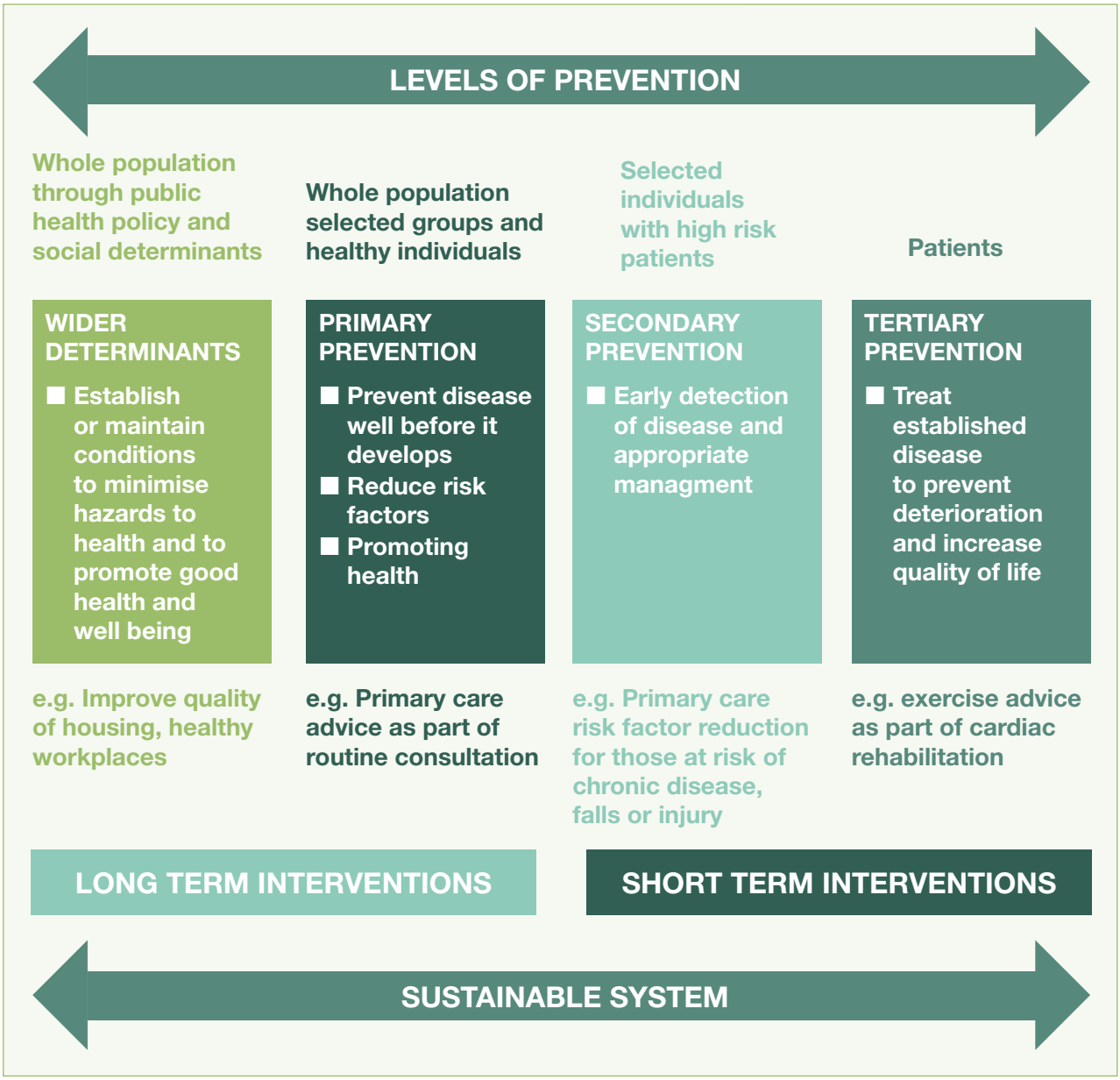
- As a major local employer, particularly of non-medical staff and through offering "good employment", for example, offering the London Living Wage, apprenticeships and job opportunities for people who face particular barriers to work.
- As a healthy employer, supporting the physical and mental health 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, businesses, the voluntary and community sectors, 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 support 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.

01
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	

01
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.

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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, as well as our Voluntary and Community Sector (VCS) partners, have thousands of daily interactions with patients and residents 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 in which 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 by up-skilling all resident facing public sector, VCS and emergency services staff to Make Every Contact Count (MECC). With competence in promoting self-care and prevention in their daily working lives, staff and volunteers 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, 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

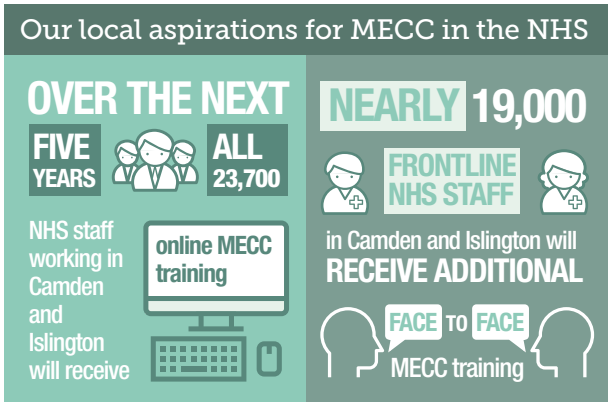
During 2016, Camden and Islington Councils launched MECC programmes across the two boroughs. The MECC programme consists of three elements: a short introductory e-learning course, which helps all staff recognise opportunities and the various needs of residents, understand the basics of brief advice and 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 resident facing staff in the NHS, public sector, VCS and emergency services 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, VCS 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 now opportunities 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
CHAPTER



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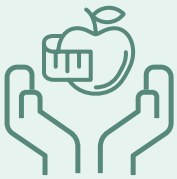
> Making Every Contact Count is key to really breaking down those barriers between health care, social care and other council services, most people just need advice and support on improving their health and quality of life, whoever provides it and all services across NCL should be doing that.
>
> **Royal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

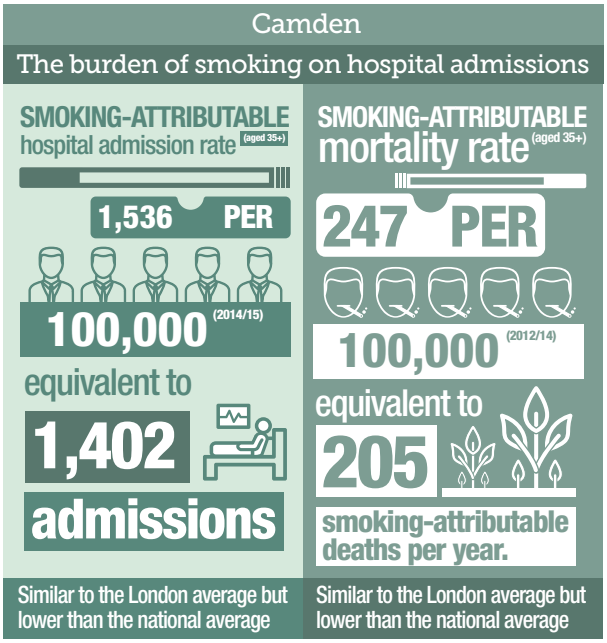
Supporting people to quit smoking

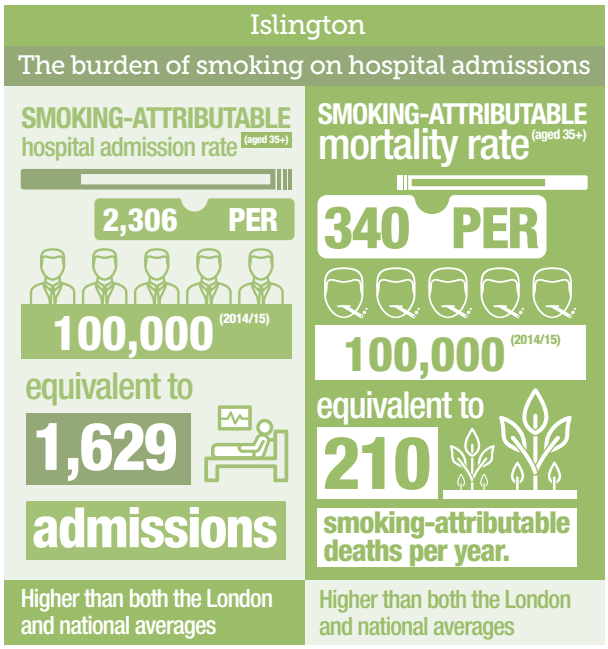
Smoking is the single greatest contributor to the health and wellbeing gap in Camden and Islington. People living in our most deprived communities are much more likely to smoke, and therefore die prematurely (before 75). Supporting people to quit smoking saves the NHS money by reducing smoking-related 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.

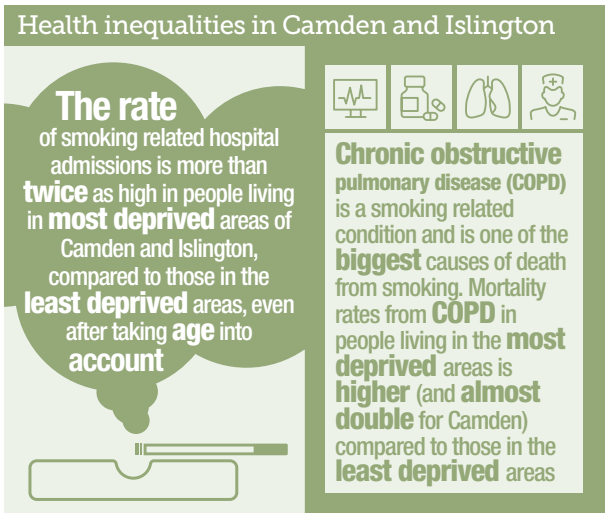
Collectively, the harmful effects of smoking on health place a significant burden on the NHS due to the costs associated with GP consultations, prescriptions for drugs and treatment of smoking-related illnesses within our hospitals. Disability associated with smoking–related conditions also places a 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

03 CHAPTER

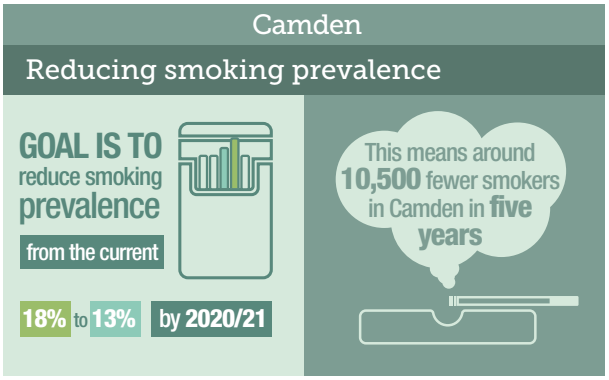




The number of people who smoke in Camden and particularly in Islington, has remained stubbornly stable since 2010, even though prevalence has been steadily decreasing nationally. Camden and Islington's Tobacco Control Strategy 2016-2021 lays out a bold ambition to significantly reduce the prevalence 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 up-skilling 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.



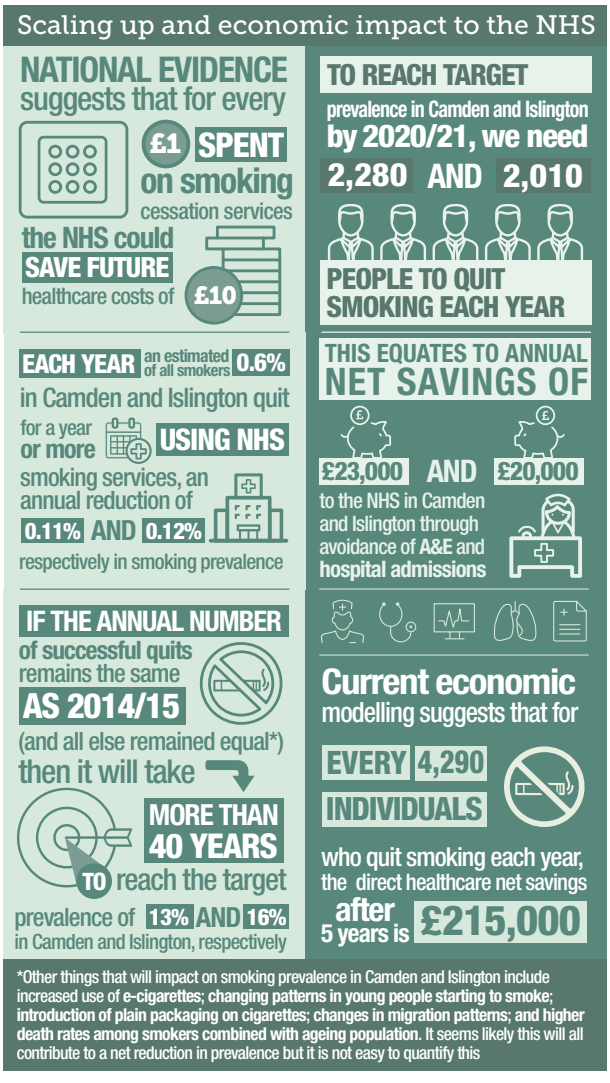
A reduction in smoking prevalence across both boroughs will deliver cashable savings to the NHS through a decrease in smoking-attributable hospital admissions over a five year period. In addition to these direct healthcare savings, health inequalities could be reduced through upscaling the targeting 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.



The role of the VCS in supporting healthier choices

VCS organisations are uniquely placed to support residents to quit smoking and make other positive behavioural changes. By building capacity within the VCS, a network of local stop smoking specialists is being developed in order to reach and provide stop smoking support to smokers from a range of population groups and communities. Trained VCS staff will use their day to day contact with residents to deliver opportunistic brief advice to smokers. They will also be able to support smokers who are motivated to quit by offering stop smoking brief support, including nicotine replacement therapy, from a range of well used and accessible community locations and venues.

03 CHAPTER



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 alcoholic 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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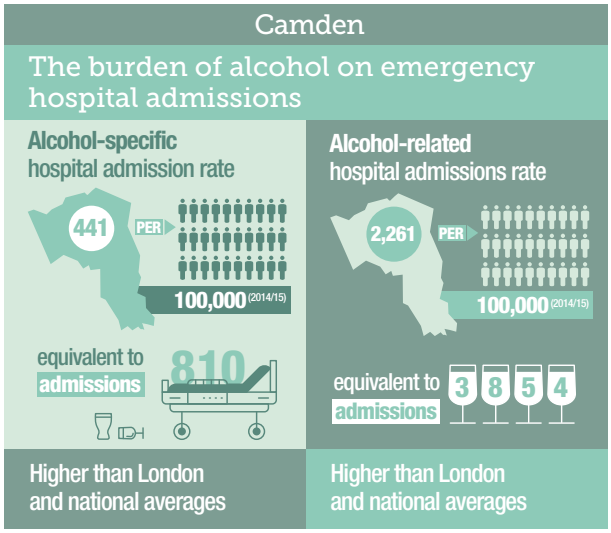
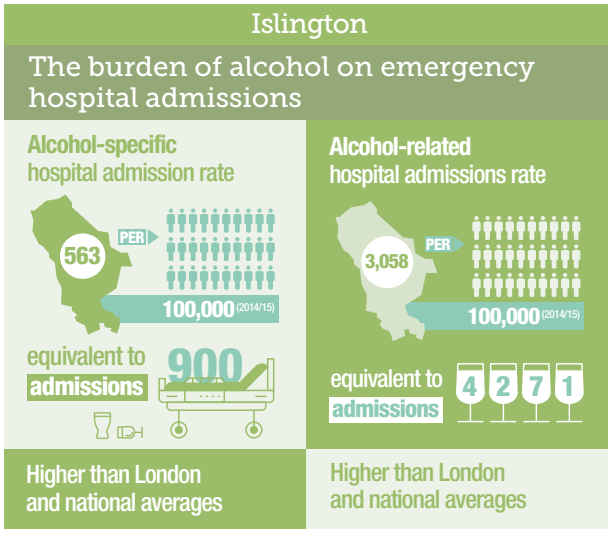




Across both Camden and Islington, reducing alcohol consumption and the associated harmful effects is a strategic priority for both of the Health and Wellbeing Boards, and a range of different interventions and levers are being used to achieve this, using a whole systems approach. In terms of the NHS, 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 degree in Camden and Islington, there is still potential to scale these up significantly given the high levels of alcohol-related harm within the boroughs.

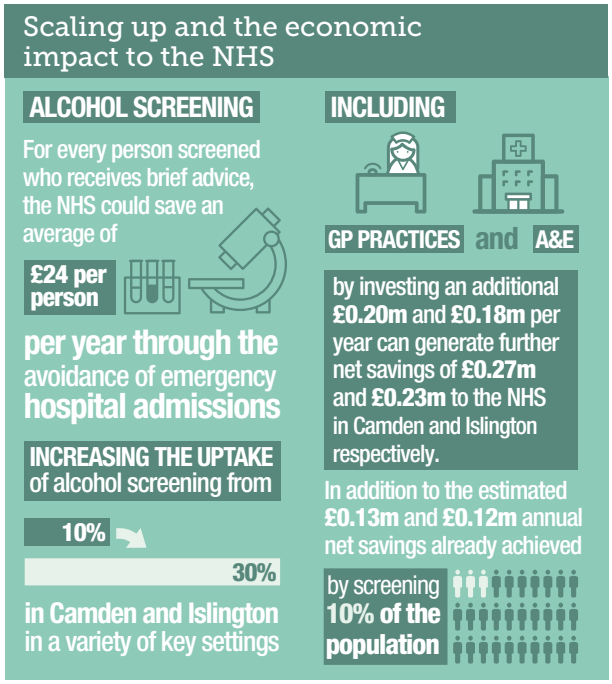
In addition to delivering cashable savings in terms of avoiding hospital admissions, and specifically repeat admissions, increasing the scale of delivery of these three interventions can also help to close the health and wellbeing gap locally by targeting high risk and dependent drinkers from those groups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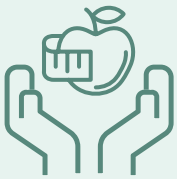
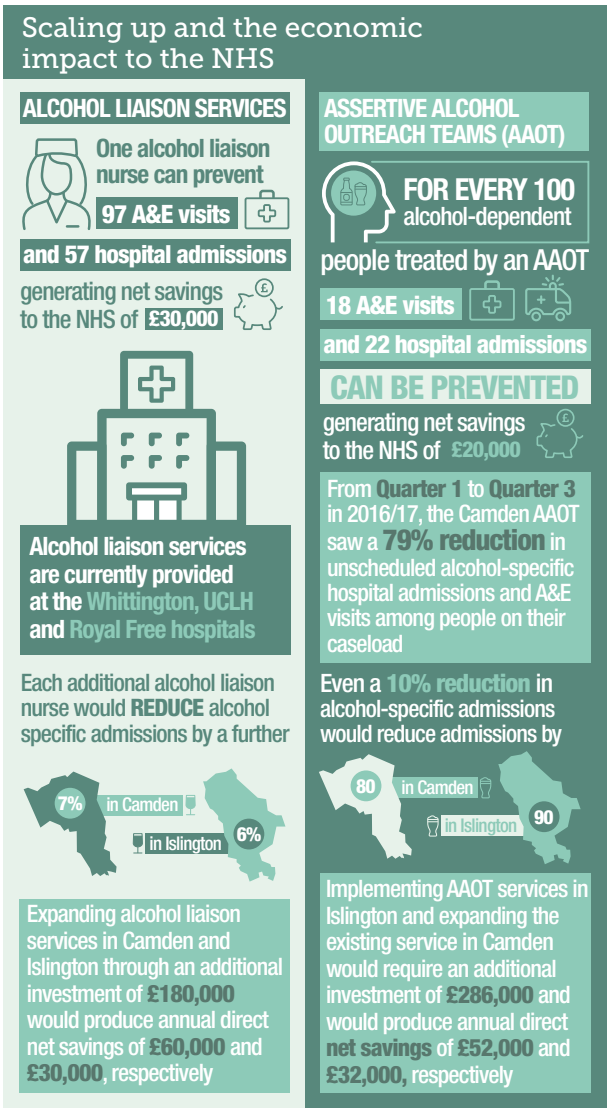




Finally, it is important to appreciate that the economic modelling of the benefits in reducing alcohol consumption captures only a small part of the possible impact on the system (by looking at hospital admissions). Given the wide-ranging impact of alcohol, there would also be other savings across the 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.

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 these 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 exceeded 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'.

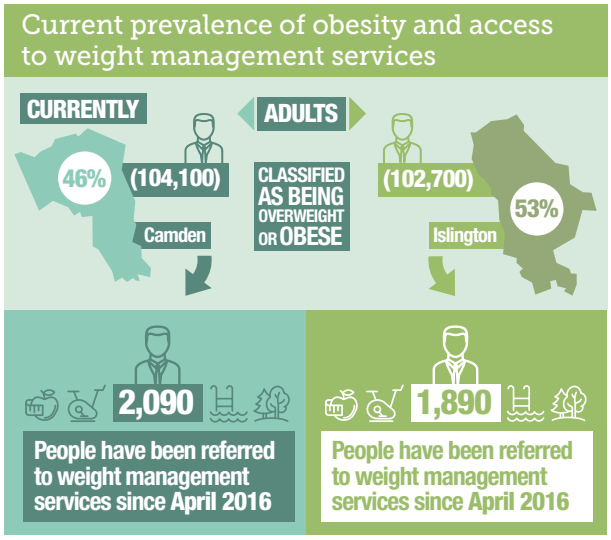
03
CHAPTER

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.

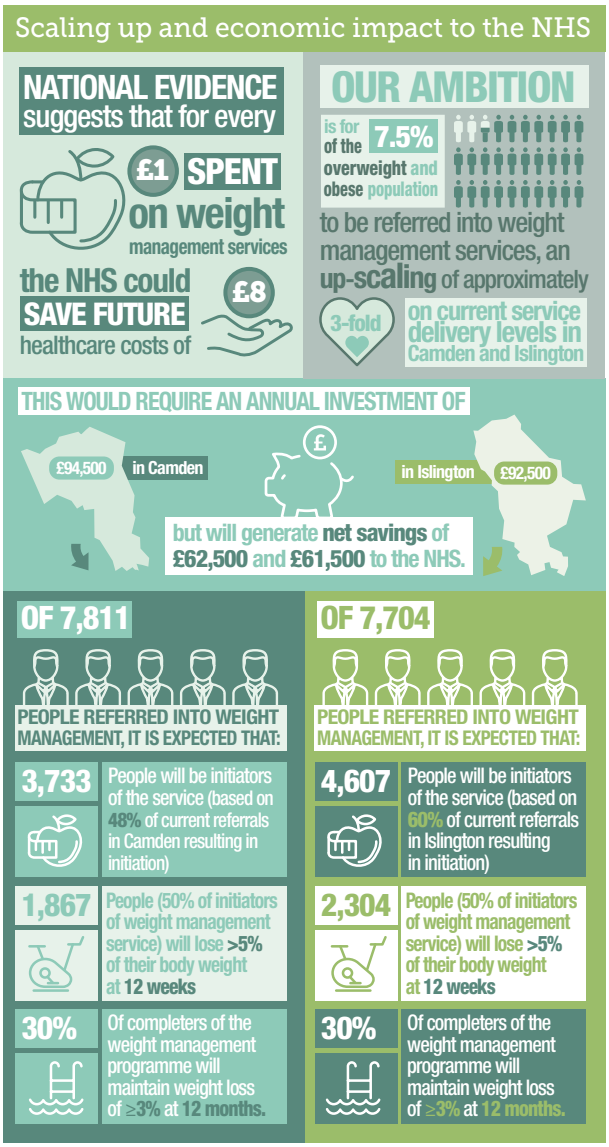
Compared to individuals with a healthy weight, people who are overweight or obese have an increased risk of many serious health conditions including high blood pressure, Type 2 diabetes, cardiovascular disease, mental illness, osteoarthritis and cancer. The treatment of obesity and related complications 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/or mental health problem.



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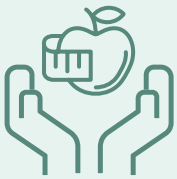


Prevention in action:

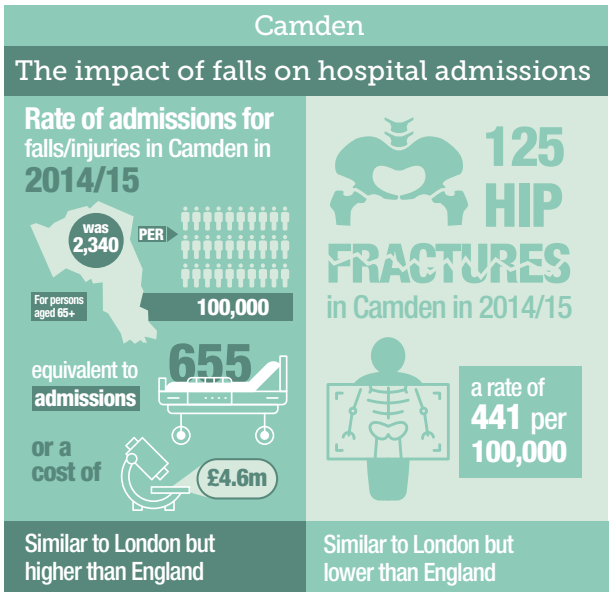
Testimonial from a resident enrolled in a local weight management programme

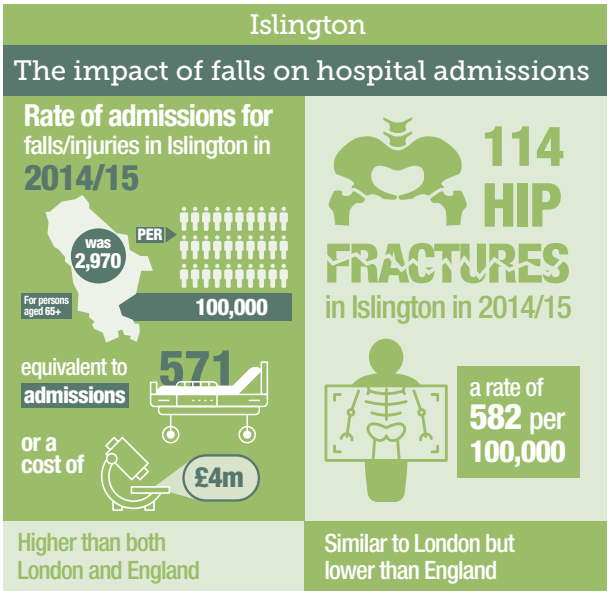
"I am incredibly grateful for my time in the programme. In the span of just 12 weeks I have lost 6 kilos. But even more importantly than the weight loss I have been supported on my journey of building better habits. I have absolute confidence that I can continue the great habits sparked by this programme. 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 in 2014/15. 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 the impact on health and wellbeing, as well as demands on and costs for the public sector, is 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 has been recently named as one of five pilot sites across London to roll out Safe and Well checks with the London Fire Brigade Service in both Camden and Islington 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. The Fire Service is looking to roll out successful aspects of the pilot into their core work across London, with Camden being well-placed to build on existing joint working in the Warmth, Income, Safety and Health referral scheme.

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

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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 both Camden CCG and the Haringey and Islington Wellbeing Partnership are 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 tahe 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)**

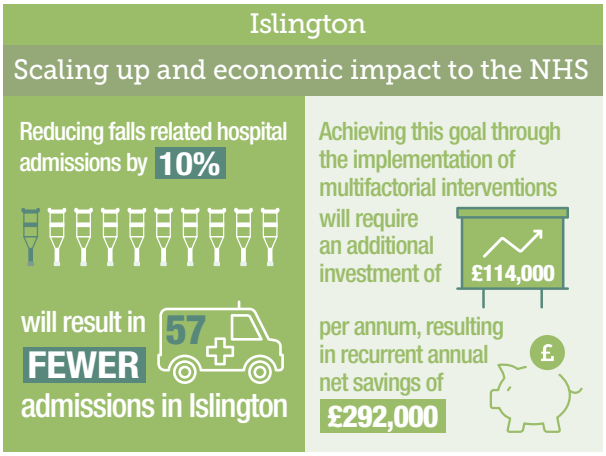
Camden

Scaling up and economic impact to the NHS

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

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

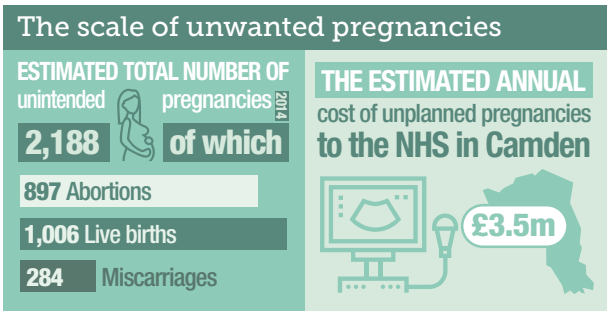
Achieving this goal through the implementation of multifactorial interventions will require an additional investment of **£124,000** per annum, resulting in recurrent annual net savings of **£341,000**

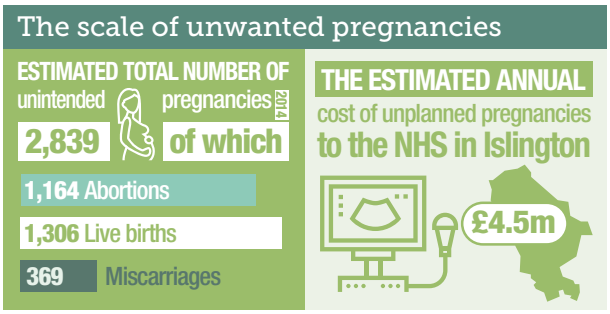


Reducing unintended pregnancies

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.

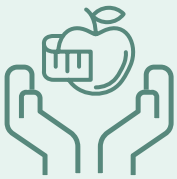
National evidence indicates that of all unintended pregnancies, 41% end in abortion, 13% in miscarriage and 46% in live birth.





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 individual 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:

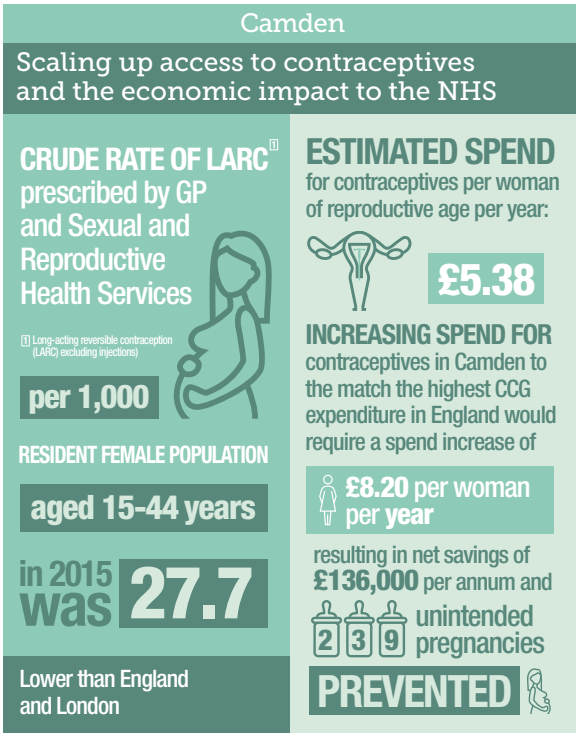
Local services to prevent unwanted pregnancies

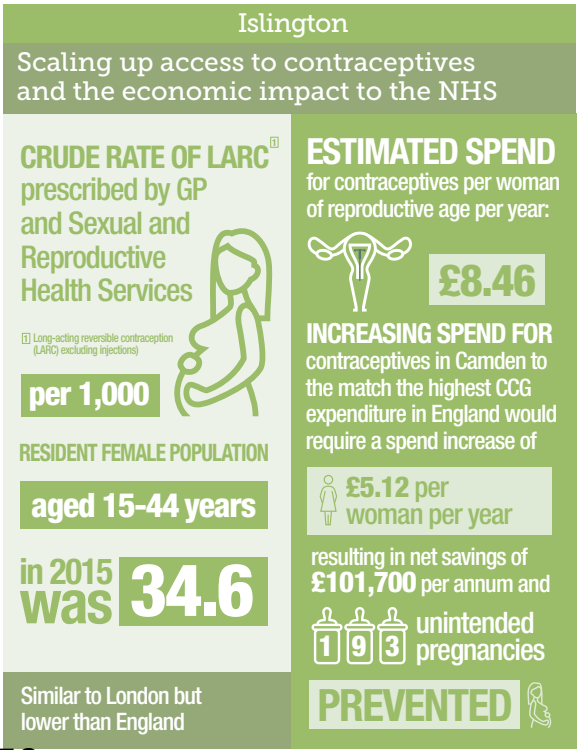
The PAUSE programme is an innovative programme offered in Islington designed to address the needs of women who have had or are at risk of having multiple children removed into care. PAUSE aims to intervene at a point when women have no children under their own care, creating a space to support women 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.

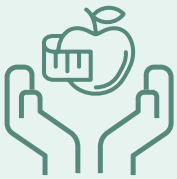
Case study

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.

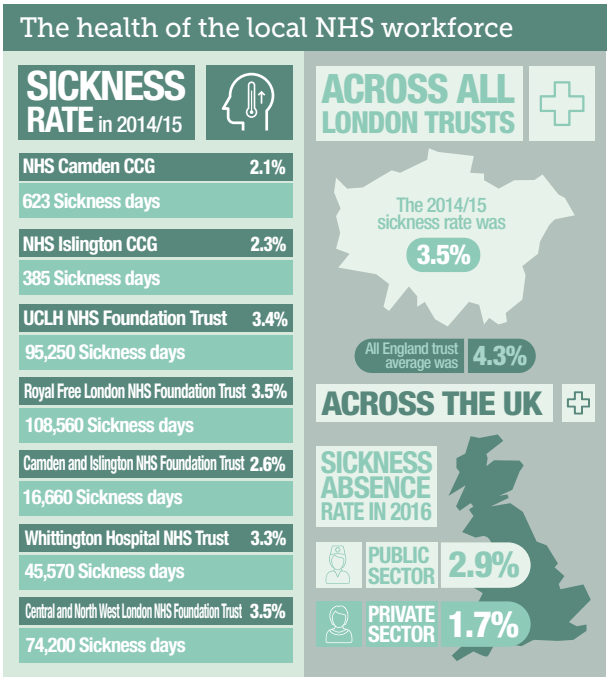
We know we will be successful when…

…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.

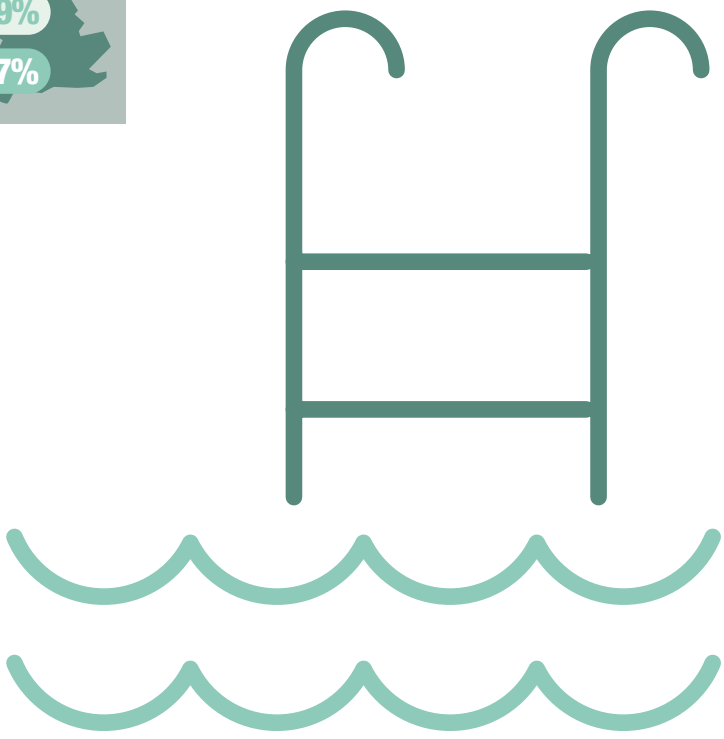
In 2015, Public Health England estimated the annual cost of sickness absence to the NHS was £2.4bn. The benefits of a healthier workforce to the NHS of investing in staff health and wellbeing go beyond productivity and cost savings. They include:

- 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 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 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

The Whittington has introduced a variety of health and wellbeing initiatives for staff targeting physical activity, mental health improved access to physiotherapy, and healthy eating. They have promoted a range of physical activity schemes including promoting active travel, introducing lunch time walks, and negotiating discounts at local gyms. They held a healthy eating event with their dieticians promoting healthy breakfast and distributed over 2000 pots of porridge to staff. The Whittington has also improved access to physiotherapy services for staff, especially staff suffering from musculoskeletal issues, and provided a range of mental health initiatives including stress management courses. Other works in progress include creating a relaxation area for staff. Activities are promoted through the staff newsletter, on screen savers and posters throughout The Whittington.

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 North West 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; not only to improve the health and wellbeing of their staff, but also to 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 is embedded into our corporate cultures and values. Investment in this area has been shown to demonstrate a clear return on investment, and 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 businesses.

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REPORT OF THE HEALTH AND CARE SCRUTINY COMMITTEE

EFFECTIVENESS OF IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT) AND SIMILAR SERVICES

London Borough of Islington
July 2017

CHAIR'S FOREWORD

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COUNCILLOR MARTIN KLUTE
CHAIR HEALTH AND CARE SCRUTINY COMMITTEE

Effectiveness of IAPT Scrutiny Review

Evidence

The review ran from September 2016 until July 2017 and evidence was received from a variety of sources:

1 Presentations from witnesses – Dr. Judy Leibowitz and James Gray – Camden and Islington Foundation Trust, Maya Centre – Tahera Aanchawan (Accept Consortium) Nafsyiat – Farideh Dizadi (Accept Consortium)

2. Presentations from council officers – Jill Britten, Islington CCG, Natalie Arthur, Islington CCG

Aim of the Review
To understand local arrangements in accessing IAPT and similar services, and the effectiveness of these services in helping people recover from mental health conditions

Objectives of the Review

- **To understand current arrangements and mechanisms for accessing IAPT services**
- **To review waiting times for IAPT services**
- **To assess the effectiveness of IAPT services**
- **To feedback the findings of the scrutiny to providers**
- **Publicity and awareness of the service**

The detailed Scrutiny Initiation Document (SID) is set out at Appendix A to the report

RECOMMENDATIONS:

That the Executive be recommended –

1. Funding Given the target for access to treatment is set to increase to 25% from the current target of 15%, as part of the 5 year plan for Mental Health, commissioners, the Council and the CCG should look to build on any opportunities to access additional funding from NHSE as it becomes available, and to press for funding to be increased pro-rata across the service to support future delivery of the service in line with the Five Year Forward View
2. Long Term Conditions: Work should continue to increase the focus on supporting people with long term conditions or medically unexplained systems, as well as supporting people into employment
3. Waiting Times: Whilst the performance of IAPT services in Islington has met its targets for 2015/16 in relation to access and 18 week waiting times, the performance of other CCG's in the North Central London area, particularly in Haringey, exceed that of Islington in a number of areas. The Committee suggests Haringey's performance be used as a driver for improvement with sharing of best practice pursued to achieve this target
4. Recovery rates: The recovery rate for ICOPE has risen each year, but is still below the target of 50%. Whilst an action plan is in place to address the poor performance against recovery levels, this is an area that needs improvement.. The Committee recommends that the action plan is reviewed, and that best practice be shared with other boroughs to try to improve recovery rates
5. Feedback: All service users using the ICOPE service be encouraged to complete Family and Friends patient experience questionnaires, and provide comments in relation to their experience of the service
6. Hard to Reach Groups: Given the under representation of Hard to Reach and BMER groups in accessing mental health services, alternative methods of advertising and accessing the service be pursued
7. Interim Support: Given that many service users experience long waiting times, the service needs to develop some form of interim support for those on waiting lists
8. Turkish Speaking Therapists: It has been suggested that there is a particular shortage of Turkish speaking therapists. The service provider should attempt to improve recruitment for this community group
9. More after-work session: In order to enable equality of access to the services more after-work appointments should be made available, and that efforts should be made to locate these appointments in non-NHS (i.e.community) premises, as there is an element of stigma attaching to attending an NHS building for mental health treatment
10. Reporting: Action to be taken to identify and address the reporting inaccuracies identified in the locally and nationally published data for 2015/16 and ensure that this is more accurate in future. Efforts should be made to address the need for more comprehensive information in relation to ethnicity data when accessing the service

MAIN FINDINGS

1.1 Improving Access to Psychological Therapies (IAPT) is a national programme, which aims to deliver NICE compliant treatments for adults, suffering from depression and anxiety disorders, which are also described as 'common mental health problems.'

1.2 The initial programme was developed in 2006, with pilot sites in Newham and Doncaster, focussing on adults of working age. In 2007 there were further 'Pathfinder' sites developed with outcome measures, in order to explore how vulnerable groups within the local population might benefit from this service, and identify barriers to access.

1.3 In 2010 the programme was rolled out nationally to adults of all ages. Services are commissioned by local Clinical Commissioning Groups (CCG's).

1.4 IAPT services are characterised by three things: evidence based psychological therapies delivered by fully trained and accredited practitioners, with type and level of treatment matched appropriately to the mental health problem. There is routine outcome monitoring, to enable both patients and clinicians to have up to date information on progress made. Data is anonymised and published by NHS England, in order to promote transparency and to support service improvement.

1.5 Regular, outcome focussed supervision also supports clinicians to continuously improve and deliver high quality care.

1.6 Locally, IAPT services are commissioned by Islington CCG and delivered by Camden and Islington Foundation Trust and the service locally is called i COPE. This service is delivered from a range of locations to support ease of access, e.g.GP surgeries and community sites, such as Manor Gardens.

1.7 Performance is monitored quarterly by Islington CCG, as part of the larger contract monitoring framework for NHS community mental health services.

1.8 The IAPT model is a 'stepped care' model, which seeks to deliver the minimum amount of treatment required, in order to deliver a positive outcome, whilst ensuring that the intensity of treatment can be increased or decreased, in line with the people's needs and progress – i.e. 'stepped up' or 'stepped down'.

1.9 Examples of treatment available include –

- Cognitive Behavioural Therapy (CBT)
- Interpersonal Psychotherapy (IPT)
- Brief Dynamic Interpersonal Therapy (DIT)
- Couple therapy for Depression
- Counselling for Depression

1.10 IAPT services sit within primary care, and can be accessed through referral by a professional, or by self- referral, including online and Islington aims to support the majority of people suffering from step 2 or step 3.

1.11 Online self-referral consists of a simple form and requires minimal information, i.e. name of GP surgery, if registered with a GP, name, a date of birth, address and information on the type of support required. Individuals can also self-refer by telephone if they prefer.

1.12 Following referral to the service, initial assessment is carried out by a Psychological well-being practitioner, in order to determine whether the service is suitable for the individual. Where possible, assessments will take place on the telephone, however face-to-face assessments are also possible.

1.13 Step 2 includes low intensity interventions, which include self -help, computerised cognitive behaviour therapy, advice and support in taking anti -depressants, or other psychotropic medication prescribed by GP's,, psycho-educational groups, support with accessing local community resources, including employment support, and exercise on prescription and pure self-help (Books on Prescription).

1.14 Step 3 high level interventions can include, cognitive behaviour therapy, individual and group therapy, interpersonal psychotherapy, behaviour couples therapy, and for PTSD eye movement desensitisation and reprocessing therapy.

1.15 In addition, Islington CCG commissions Camden and Islington Foundation Trust to deliver a step 4a service, known locally as IATP plus. This service supports patients who present with longstanding complex problems of depression or anxiety, often associated with major adverse historical and/or current life difficulties, and co-morbidities, such as personality or relationship difficulties, or long tem physical health conditions and medically unexplained conditions

1.16 The aim of the intervention is to support the management of individuals within primary care and help people manage their conditions better, and achieve personally defined goals, rather than anticipating significant clinical improvement on existing IAPT measures i.e. many will not be expected to report that they have recovered as part of the clinical definition. Patients in these groups are offered a range of interventions appropriate for Step 4a clients, to help support their management within primary care, with additional psychological support. Interventions are offered in a variety of settings, including in a patients home.

1.17 In respect of the national picture there are national targets in place – 15% of adults with relevant disorders should have timely access to IAPT services, and in Islington this equates to 31,031 people.

1.18 50% of people accessing IAPT services will recover and 75% of people referred to the IAPT programme begin treatment within 6 weeks of referral, and 95% begin treatment within 18 weeks of referral.

1.19 The rate of referral to the service increased by 13%, year-on-year, between 2013/14 and 2014/15. The service employed a number of methods to promote the service, amongst both professionals and the general public, and the increase in referrals is likely to be as a result of this work. Similarly, projected figures for 2016/17 suggest referrals are expected to reach approximately 9,202 people.

1.20 Access to treatment is measured nationally, with a target of 15% of the prevalent population to access treatment each year. The access rate in Islington has gradually increased year-on-year, exceeding the target from 2014/15 onwards.

1.21 Performance shows that the waiting times, against the 18 week target period, were exceeded in 2015/16, and have continued this trend into 2016/17. However, the proportion of people accessing treatment within 6 weeks of referral has fallen short of the target in 2015/16, with results for Quarter 1 showing similar results.

1.22 Recovery rate targets are set nationally, with the expectation that 50% of people entering treatment will report to be 'in recovery' at the end of the treatment period. Recovery rates are defined by the number of service users moving to below case level on clinical outcome scores, as a proportion of the number of people ending contact with services, and receiving at least two sessions of treatment. On average the number of sessions of treatment required is 6/9 sessions

1.23 The recovery rate for the service continues to be below target. Although local data for 2015/16 showed a recovery rate of 48%, once ratified at national level this fell to 43%, The service provider has in place an action plan, which seeks to address this challenge, and continues to work to identify areas, which may affect final performance in this area.

1.24 IAPT services use a number of well validated patient completed questionnaires to measure change in a person's condition. Most of the questionnaires are administered at each appointment, making it possible to track improvement comparing scores over time.

1.25 A number of factors can affect whether an individual meets the criteria of having recovered including -

- Severity of need at the start of treatment
- Delayed discharge from treatment
- Clinical decisions
- Whether an individual has met the 'threshold' for recovery, prior to being discharged

1.26 The widening of the acceptance criteria for the iCOPE service, (referred to in more detail below) to include patients whose needs fall within Step 4a, means that the service is more inclusive, and supports a much broader range of patients within primary care. However, due to the way in which recovery is measured nationally, it is acknowledged by commissioners that the issue has an impact on recovery rate.

1.27 There are local reporting challenges and the IAPT service is subject to quarterly monitoring by Islington CCG, as part of the wider NHS contract for mental health services in Islington.

1.28 As mentioned earlier, in 2016/17 it was identified that there were significant discrepancies between the locally reported data and the nationally published data for 2015/16. Following investigation, it has been identified that errors within the performance monitoring programme, used by IAPT service, had led to these discrepancies. It should be recognised therefore that the published performance data for 2015/16 does not reflect the work that was delivered. The service has taken action to address the errors identified in the 2015/16 reporting process, and it is expected that the reporting for 2016/17 will be much more accurate.

1.29 The majority of the adults accessing the service are between the ages of 18 and 64 years of age. Adults over 64 are currently under-represented, and the service is working to identify ways to increase levels of engagement from this group.

1.30 Ethnicity data shows that 30% of all referrals were from adults who identified as White British, whilst 19% identified as being from non-white backgrounds. Both figures are below the Islington population, as determined by the 2011 census, which recorded 48% of the population as White British and 32% from non-white backgrounds. However, the ethnicity data must be treated with caution, due to a number of reasons, including the census population data relating to all ages not just adults and the younger population in Islington being more ethnically diverse than the older population. In addition, almost 40% of all adults referred to the service either chose not to state their ethnicity or their ethnicity was not recorded, and therefore it is possible that the

ethnicity breakdown would look very different if the ethnicity of all referees was reported. Ethnicity reporting has improved in 2016/17, with 95% of ethnicity information recorded

1.31 There are additional l outcome measures and the IAPT employs a variety of methods to measure outcomes and progress of individuals accessing the service. These include work and social adjustment measures, and an enablement instrument to suit the client group involved

1.32 These measurement tools allow the service to capture outcomes relating to a number of aspects of an individual's life, and progress made in these areas before, during and at the end of treatment. Examples of this measurement include the ability to understand and cope with problems, work, social activities, and family and relationships.

1.33 In terms of long-term physical health conditions, it is widely accepted that physical and mental health are closely linked with having a long term condition, which can increase the likelihood of developing a physical health need, whilst people with long term physical health conditions can develop mental health problems. IAPT services will be expected to increase their focus on supporting people with long term physical health conditions.

The 5 year forward plan for mental health sets out the following priorities for service development by 2021-

- To expand IAPT services, with access to increase to 25%
- Focus on people with long term conditions
- Supporting people to find or remain in work
- Improving the quality and people's experience of the service

1.34 With regard to local performance in 2014/15, the access rate exceeded 15%, however recovery rates fell well short of 50%. Waiting times were also below target and identified as an area for improvement in 2015/16. In 2015/16 the 15% target for access was exceeded. The recovery rate is 48%, waiting times improved and the 18 week target was met. In 2014/15 an action plan was put in place to address the poor performance against recovery levels, which delivered a small increase by the end of the year. However, it is recognised that this needs to be a key area for improvement.

1.35 In 2016/17 access is expected to again exceed the target of 15%, possibly to 17%. This is likely to have an impact on waiting times, due to finite resources. Islington IAPT service takes referrals with higher levels of depression and anxiety, which is positive, but is likely to affect the recovery rate.

1.36 There are challenges facing the service and also in terms of delivering the 5 year forward view for mental health, however it is the intention to increase access to 25% by 2021/22. There has been to date, no further detail from NHS England as to how this will be supported and the Committee feel that this is an area that needs to be addressed.

1.37 As highlighted by the performance data, the current target for access to treatment is 15% of the prevalent population, and the service is on course to achieve 16/17% access. This was also achieved in 2015/16. As stated above, as part of the 5 year plan, this is set to increase by 25% by 2020. This will pose a significant challenge within current resources, and commissioners will be working with service providers in order to identify how to address this.

1.38 In addition to increased access rates, as part of the 5 year forward plan for Mental Health, there will be an expectation that IAPT services will increase the focus on supporting people with long term conditions, or medically unexplained symptoms, as well as supporting more people into employment. This Islington service already works well with the local Mental Health Working

(Employment Support) programme, and local reporting of long-term conditions is already underway.

1.39 The performance of IAPT service in 2015/16 shows that, whilst Islington has met the targets for access and 18 week waiting times, the performance of other CCG's in the North Central London region, particularly Haringey, exceed that of Islington in a number of areas. The recovery rate for iCOPE has risen each year, but this is still below the target of 50%. In 2014/15 an action plan was put in place to address the poor performance against recovery levels, which delivered a small increase by the end of the year. However, it is recognised that this needs to be a key area for improvement in 2016/17.

1.40 The Committee received evidence from Camden and Islington NHS Foundation Trust, who delivered services on behalf of the Council, through the iCOPE service, which is referred to earlier in the report.

1.41 The iCOPE service has an established service user advisory group, which includes both current and former service users. The service consults the user group and seeks feedback, in order to identify areas of the service that can be improved, and to support developing new ideas to promote and deliver the service. In addition to the group, all service users are encouraged to complete patient experience questionnaires, friends and family feedback and there are suggestion boxes for anonymous feedback at team bases.

The service is in the process of recruiting to 'peer mental' health worker posts, to facilitate treatment workshops, and for other opportunities of supporting delivery.

The Islington iCOPE service promotes the service in a number of ways -

- Leaflets
- Posters
- Co-location in GP surgeries and other community settings to encourage ease of access
- Partnership working with local organisations and giving talks to members of those organisations

1.42 The level of mental health need in Islington is high, both in comparison with other London Boroughs, and nationally. The recent 'Healthy Lives, Healthy Minds' report by Camden and Islington Public Health team identified that local data shows that approximately 29,900 adults in Islington have diagnosed unresolved depression or anxiety (16% of residents aged 18 or over), whilst an additional 15,897 adults are estimated to have a common mental health disorder, which has not been diagnosed.

1.43 The high level of need, and the severity of those needs, presents a challenge for the IAPT service, not just in terms of capacity, but also with regards to being able to provide interventions that support people to move into a state of sustainable recovery. Where an individual's needs require more intensive support, the IAPT plus service is available to provide a variety of interventions, however, it is recognised that many people accessing the IAPT plus service will not meet the criteria for recovery.

1.44 There are a number of examples of local innovation and good practice. Examples of these include 'iCOPE talks', which in 2014/15 was delivered to parents (working in partnership with schools). This promoted the service and raised awareness of good mental health and well-being. Partnership work is also taking place with other local community organisations, in order to promote good mental health wellbeing.

1.45 The ‘Leaps Project’, in conjunction with Training Job Centre Plus, also enables staff to identify and refer individuals to’ iCOPE’. There is also ‘Mental Health Working’, which regularly submit the highest number of referrals to the commissioned mental health working (employment

1.46 The Committee also received evidence from Dr. Lucy Williams-Shaw, the user involvement lead and service users of the iCOPE service.

1.47 Members were informed that there is good user satisfaction with the service and a variety of methods are used to ask users about their experience of the service with therapists asking for feedback, feedback user forms being made available in waiting areas and the ability to provide e mail feedback. This feedback is reviewed and discussed and any necessary changes made.

1.48 It was noted that 98.1% of users would recommend I COPE to family and friends as indicated by the Family and Friends test. 48% of discharged patients completed the Patient Experience Questionnaire however there are a number of reasons preventing this from being a greater return at present, although work is taking place on this.

1.49 The Committee noted that the service users who gave evidence had stated that it had been easy for them to access the service and their experiences had been positive. One of the residents had attended the group session and the other one an individual session and that they had both benefitted from these.

1.50 The Committee noted that the maximum number of sessions permitted is 20 sessions and usually ranged from 6 to 20 sessions. It was added that some evening sessions are provided, however this is constrained by availability of premises. The Committee were of the view that this is an area that should be looked at to provide more evening sessions.

1.51 A monthly poster is displayed in waiting areas regarding the feedback that has been received and how it is being acted upon.

1.52 Service users contribute by attending the iCOPE advisory group where service developments are discussed and they can join the list of advisers and contribute to focus groups, answer surveys and get involved with specific projects. In addition, they can apply to work in a paid capacity as a peer-well- being worker. Service users can also provide feedback and help recruit new staff by training to be interview Panel members.

1.53 The Committee were also informed that ‘Silvercloud’ is a 2016/17 pilot of online Cognitive Behavioural Therapy, for those people with a low level of need. This may also help to attract those people currently under-represented in IAPT services e.g. men.

1.54 In addition to the statutory IAPT service, Islington also commissions third sector organisations, to provide ‘Talking Therapies’ to meet specific needs, and the new contract commenced in September 2016.

1.55 These services are – Talking Therapies for people with Black, Minority Ethnic and Refugee (BMER) communities – Talking Therapy for people who have suffered child sexual abuse and/or domestic violence and Talking Therapy for people who have suffered bereavement. This service is commissioned through a lead provider model and includes the following organisations –

- Nafsiyat Intercultural Therapy Centre – Lead Provider
- Women’s Therapy Centre – sub contractor
- The Maya Centre – sub contractor

- Camden, City and Islington Bereavement Service – sub contractor

1.56 The support needs of those who may need longer treatment or have more complex needs, will need to be addressed e.g. refugees. Currently, additional talking therapies from the third sector support this need, however demand is high

1.57 There are also a number of challenges facing the Islington IAPT service, alongside areas where commissioners expect performance to improve.

1.58 National campaigns to remove the stigma of mental health were continuing to take place, and the IAPT service worked closely with Job Centre Plus and employment services to support people suffering from mental health problems. The benefit cap has had an effect on the mental wellbeing of some of the people who have been affected by this, and this is creating additional problems.

1.59 As stated earlier, elderly people are underrepresented in accessing mental health services, but when they did, the recovery rate is good.

1.60 Alternative ways of enabling people to access the service more conveniently and to increase access are being implemented including the use of skype or by e mail, however where people needed face to face contact, the Committee noted that this would continue to be provided.

1.61 There are a number of people with complex needs, and the IAPT plus service can assist in this. The IAPT service is well integrated with primary care and this helps increase access to the service.

1.62 The Committee noted that some BME communities had difficulty in filling in forms, and that there is a continuing need to investigate alternative methods of advertising and accessing the service. However, the most under represented group accessing services at present were in fact the white/other group. It is recognised that there are gaps in the service and the Committee noted that the Manor Gardens centre is employed to try to reach those communities currently not accessing the service.

1.63 The Committee also received evidence from service providers delivering non IATP therapies – the Mayat and Nasfiyat centres. These organisations provide a targeted response in response to local demand and had 3 elements, BMER communities, Child Sexual Abuse and Domestic violence and Bereavement service. The Mayat Centre is a women's only project and therapists were community based and looked at the client in the whole and both the Mayat and Nasfyiat Centres aimed to maximise their resources.

1.64 This is jointly funded by the Council and CCG through third sector providers, such as the Mayat and Nasyfiat centres and is a time limited service of between12 and 20 sessions. This complements existing IATP provision to support an increase in access to psychological therapies for identified under represented communities, and to provide counselling for those users would not normally access services.

1.65 The service differs from IAPT, in that it has a higher threshold, equivalent to stage 3 on the IAPT stepped care model, has a women only element, access to therapists with a range of language skills and overcomes barriers by matching therapists with the same background. As it is non NHS and helps overcome barriers associated with the fear of Mental Health services.

1.66 50% of those who complete treatment move to recovery, this is aligned with the IAPT target and 60% of those who completed treatment maintain a clinically significant improvement at 3 months post therapy. 40% of those who complete treatment maintain a clinically significant improvement at 6 months post therapy, and 50% of those who complete treatment access ongoing support within the community, including peer support. 50% of those who complete treatment self-report an improved level of confidence in maintaining their own mental well-being.

1.67 A high number of referrals are received and the majority are accepted. The numbers on the waiting list and referrals for BMER and Bereavement services indicate that the target for accessing treatment will be met. However, there are concerns about the recovery rates for Child Sexual Abuse, Domestic Violence and Bereavement services, however it is felt that the measurement is partly affected by the data reporting tools used.

1.68 Performance against key areas of focus are - to increase people from BMER communities accessing talking therapies, and an increase in men and older people accessing talking therapies. LGTB representation is difficult to measure due to lack of self-reporting.

1.69 The challenges include demand for services compared to service capacity, there are over 100 on the waiting list, interim support for those on the waiting list, availability of Turkish speaking therapists, encouraging access from other BMER groups, encouraging access from older people and men, and performance monitoring and measuring outcomes.

1.70 It was noted that it was encouraging to see new communities accessing services.

1.71 It was also noted that future developments included investment in reporting systems, in line with the IATP service, improved performance reporting to support better understanding of gaps in provision and the low recovery rate, and to collect performance figures to contribute to local IATP data from 2018/19. In addition, to support the local Syrian refugee resettlement programme, there will be linking in with the Camden and Islington Foundation Trust's complex depression and trauma service.

1.72 The Committee considered the over representation of the Turkish community in non IATP services and whilst this is of concern, it is an indication of the success of the scheme given that the Turkish community had previously not accessed the service. It was noted that it is hoped to increase the number of Turkish therapists in the future.

1.73 The Committee were informed that in terms of BMER there was a 4/5 month waiting list but bereavement waiting lists were shorter, however work did take place with those people waiting for treatment.

1.74 The Committee were also informed that it was proving difficult getting patients to provide feedback and this is currently being looked at to introduce measures that will increase response rat

CONCLUSION

The Committee have made a number of recommendations that it is hoped will improve access to IAPT and similar services in the future. However, the Committee are of the view that the underfunding of mental health services by the Government in recent years has made it more difficult to provide adequate service provision and that, in view of the proposals in the Government's 5 year plan for mental health there needed to be much more clarity around funding for mental health provision in order to meet the targets set.

The Committee would finally like to thank all the witnesses who gave evidence to the Committee and to the service providers for the excellent work that they undertake.

MEMBERSHIP OF THE HEALTH AND CARE SCRUTINY COMMITTEE – 2016/17

MEMBERSHIP 2016/17	MEMBERSHIP 2017/18
Martin Klute – Chair	**Martin Klute - Chair**
Rakhia Ismail – Vice Chair	**Nurullah Turan – Vice Chair**
Nurullah Turan	**Michelline Safi-Ngogo**
Michelline Safi-Ngogo	**Jilani Chowdhury**
Una O'Halloran	**Gary Heather**
Jilani Chowdhury	**Troy Gallagher**
Gary Heather	**James Court**
Tim Nicholls	**1 Vacancy**
Co-opted Member:	**Co-opted Member:**
Bob Dowd – Islington Healthwatch	**Bob Dowd – Islington Healthwatch**
Substitutes:	**Substitutes:**
Alice Perry	**Alice Perry**
Dave Poyser	**Satnam Gill OBE**
Clare Jeapes	**Angela Picknell**
Satnam Gill	**Clare Jeapes**
Angela Picknell	
Marian Spall	

Olav Ernsten/Philip Watson – Islington Healthwatch

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Officer Support:
Peter Moore – Democratic Services
Lead officer/s- Simon Galzynski, - Directorr Adult Social Care Jill Britten – Islington CCG

APPENDIX A

SCRUTINY REVIEW INTITATION DOCUMENT
Review: Improved Access to Psychological Therapies (IAPT)

Scrutiny Committee: Health Scrutiny Committee

Lead Officer: Simon Galczynski, Service Director Adult Social Care

Overall aim: To understand local arrangements for accessing IAPT services and similar services, and the effectiveness of these services in helping people recover from mental health conditions.

Objectives of the review:-

- To understand current arrangements and mechanisms for accessing IAPT service.
- To review waiting times for IAPT services.
- To assess the effectiveness of IAPT services
- To feedback the findings of the scrutiny to providers
- Publicity and awareness of the service

Duration: Approx. 6 months

How the review will be conducted

Scope: The services in scope of this time limited scrutiny review are NHS IAPT services commissioned from Camden and Islington Mental Health Trust (iCOPE).

Types of evidence to be assessed:

- Documentary evidence on demographics of those using the service and accessibility or reason adjustments made to ensure accessibility to the service

- Documentary evidence on national standards for access, waiting times and recovery rates; including any additional outcome measures collected.

- Witness evidence from a range of relevant individuals and organisations

    a. Patients and their representatives and consumer organisations
        i. Patients by experience
        ii. Patient representatives and groups e.g. Islington Borough User Group (IBUG)
    b. Commissioners
        i. Islington Joint Commissioning Team
    c. Providers
        i. Camden and Islington Foundation Trust

Additional information:

In addition to the statutory IAPT service Islington has recently commissioned 3rd sector organisations to provide Talking Therapies to meet specific needs as below (contract commences September 2016).

- Talking Therapy for people within Black, Minority Ethnics and Refugee (BMER) communities
- Talking Therapy for people who have suffered child sexual abuse and/or domestic violence
- Talking Therapy for people who have suffered bereavement

This is commissioned under a lead provider model, the following organisations are involved.

- Nafsiyat Intercultural Therapy Centre

- Women's Therapy Centre
- The Maya Centre
- Camden, City and Islington and Westminster Bereavement Service

HEALTH SCRUTINY COMMITTEE
HEALTH AND CARE SCRUTINY COMMITTEE – WORK PROGRAMME 2017/18

06 JULY 2017

1. Camden and Islington Mental Health Trust Performance update
2. Scrutiny Review – IAPT Scrutiny Review – Final report
3. New Scrutiny Topic
4. Annual Public Health report
5. Health and Wellbeing Board update
6. Work Programme 2017/18
7. Membership, Terms of Reference

14 SEPTEMBER 2017

1. NHS Whittington Trust – Performance update/Estates strategy
2. Scrutiny Review – New topic – Approval of SID/witness evidence
3. Healthwatch Annual report
4. Healthwatch work programme
5. Health and Wellbeing update
6. Quarter 4 performance report
7. Work Programme 2017/18

12 OCTOBER 2017

1. London Ambulance Service – Performance update
2. Scrutiny Review – New topic – witness evidence
3. Annual Adults Safeguarding report
4. Health and Wellbeing update
5. Work Programme 201/18
6. Performance statistics - update
7. Work Programme 2017/18

14 DECEMBER 2017

1. Presentation – Executive Member Health and Social Care
2. Health and Wellbeing Strategy – Progress report
3. Scrutiny Review – 12 month report back – Health Implications of Damp Properties
4. Health and Wellbeing update
5. Alcohol and Drug Abuse - update
6. Work Programme 2017.18
7. Scrutiny topic – witness evidence

22 JANUARY 2018

1. UCLH Performance update
2. Scrutiny topic – witness evidence
3. Health and Wellbeing Update
4. Work Programme 2017/18

01 MARCH 2018

1.Scrutiny topic – Draft recommendations
2.Moorfields Performance update
3. Health and Wellbeing update
4. Performance update
5. Work Programme 2017/18

16 APRIL 2018

1. Scrutiny topic – Final report
2. Health and Wellbeing update