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ISLINGTON

Resources Department
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 on **30 January 2020 at 7.30 pm.**
N.B. THERE WILL BE A PRE MEETING FOR MEMBERS OF THE COMMITTEE AT 7.15P.M. PRIOR TO THE MEETING IN COMMITTEE ROOM 3)

Enquiries to : Peter Moore
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Despatched : 22 January 2020

Membership

Councillors:
Councillor Osh Gantly (Chair)
Councillor Nurullah Turan (Vice-Chair)
Councillor Joe Caluori
Councillor Jilani Chowdhury
Councillor Tricia Clarke
Councillor Sara Hyde
Councillor Roulin Khondoker
Councillor Martin Klute

Co-opted Member:

Substitute Members

Substitutes:
Councillor Mouna Hamitouche MBE
Councillor Satnam Gill OBE
Councillor Anjna Khurana

Substitutes:

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.	Minutes of the previous meeting	1 - 10
6.	Chair's Report	

7. Public Questions

For members of the public to ask questions relating to any subject on the meeting agenda under Procedure Rule 70.5. Alternatively, the Chair may opt to accept questions from the public during the discussion on each agenda item.

8. Health and Wellbeing Board Update - Verbal

B. Items for Decision/Discussion **Page**

9. Scrutiny Review - Adult Paid Carers - Witness evidence - Verbal

10. Local Account 11 - 26

11. Executive Member Health and Social Care Annual Report 27 - 52

12. Performance update - Quarter 2 53 - 62

13. Work Programme 2019/20 63 - 64

C. Urgent non-exempt items (if any)

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

D. Exclusion of Press and Public

To consider whether, in view of the nature of the remaining items on the agenda, it is likely to involve the disclosure of exempt or confidential information within the terms of the Access to Information Procedure Rules in the Constitution and, if so, whether to exclude the press and public during discussion thereof.

E. Confidential / Exempt Items **Page**

F. Urgent Exempt Items (if any)

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

The next meeting of the Health and Care Scrutiny Committee will be on 10 March 2020

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

www.democracy.islington.gov.uk

London Borough of Islington

Health and Care Scrutiny Committee - Thursday, 21 November 2019

Minutes of the meeting of the Health and Care Scrutiny Committee held on Thursday, 21 November 2019 at 7.30 pm.

Present: **Councillors:** Gantly (Chair), Turan (Vice-Chair), Caluori, Chowdhury, Clarke, Hyde, Khondoker and Klute

Councillor Osh Gantly in the Chair

115 INTRODUCTIONS (ITEM NO. 1)

The Chair introduced Members and officers to the meeting

116 APOLOGIES FOR ABSENCE (ITEM NO. 2)

Councillor Janet Burgess, Executive Member Health and Social Care

117 DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. 3)

None

118 DECLARATIONS OF INTEREST (ITEM NO. 4)

None

119 MINUTES OF THE PREVIOUS MEETING (ITEM NO. 5)

RESOLVED:

That the minutes of the meeting of the Committee held on 10 October 2019 be confirmed, and the Chair be authorised to sign them

120 CHAIR'S REPORT (ITEM NO. 6)

The Chair stated that she had been due to meet the CCG, however this had been cancelled due to Purdah

121 PUBLIC QUESTIONS (ITEM NO. 7)

The Chair outlined the procedures for Public questions and the fire evacuation procedures

122 HEALTH AND WELLBEING BOARD UPDATE - VERBAL (ITEM NO. 8)

Councillor Burgess, Executive Member for Health and Social Care was not able to be present at the meeting so no verbal update was given

123 LONDON AMBULANCE SERVICE - PERFORMANCE UPDATE - PRESENTATION (ITEM NO. 9)

Graham Norton, and Sen Brinicombe, London Ambulance Service, were present for discussion of this item, and made a presentation to the Committee, copy interleaved.

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

- LAS operate out of over 70 sites, have 2 Emergency Operations Centres, a Motorcycle response unit, 2 HART teams, Hear and Treat, and a Cycle response unit
- There were 772,262 111 calls in the previous year
- The LAS attended 1.14 million incidents, handled approximately 5000 emergency calls every day, has 6000 staff, of which 65% are frontline staff. There is a growing aging population with complex health needs
- The LAS has introduced a new five-year strategy, designed to build a world-class service for a world-class city
- The LAS purpose is to provide outstanding care for patients, be a first class employer, provide the best value for the public, and partner with the wider NHS, and public sector, to optimise healthcare, and emergency service provision across London
- Patients – LAS playing a larger role in 111/Integrated urgent care provision across London. Integrating 999, and 111 call answering, and clinical support, in order to provide better, and faster care. Working with patient groups, and other providers, to introduce more specialised models of care for a greater proportion of patients. Reducing unnecessary conveyances to emergency departments
- People – LAS recruiting and retaining talent, improving engagement to make sure it is listening to staff, ensuring a healthy workplace, aspiring to excellence in leadership and management, championing inclusion and equality, and recognising and rewarding excellence
- Public value – integrating 111 and 999 call answering will provide a more cost effective service. Pioneer services will reduce unnecessary hospital conveyances, delivering savings for system partners. Detailed internal programme of work to implement the recommendations of Lord Carter's review into unwarranted variation within the NHS. There is also a new partnership with South Central Ambulance Service
- Partners – work closely with a range of partners across London, the Metropolitan Police, London Fire Brigade, and increasingly with other public sector bodies in London, including the Mayor, TfL, and other Local Authorities
- LAS is rated as good by CQC, and has exited special measures. A range of initiatives have been instituted, including reducing avoidable conveyances, upskilling the paramedic workforce to increase see and treat rates, increasing clinical effectiveness in clinical hubs, and increasing opportunities for patients to be conveyed to alternative care pathways
- Leadership – There are CEO roadshows, and LAS has created a Leadership Development Programme, Visible and Engaging Leadership programme, and launched 2 mentoring schemes
- Staff – in 2018/19 – recruited over 850 people across the front line – vacancy rate on 31 March 2019 was 4.6%, compared to 5.9% in previous year. 15% of workforce is from BME community. Launched second WRES action plan – senior trust leadership, workplace experience, and recruitment and development schemes. Freedom to speak up – staff survey indicator score has increased 18% between 2015-2019. Dignity at work – raising awareness and addressing bullying
- Engagement – LAS has had highest ever response to staff survey - 65%, and significant improvements have been made
- Quality and safety – increased Board oversight for clinical effectiveness, with the appointment of two non-executive clinical directors. Quality priorities 2018/19 were achieved, and priorities for 2019/20 agreed. Introduced senior clinical leads to address quality, clinical effectiveness, supervision and compliance against quality and standards. There have been improved risk management systems, and processes, introduced. LAS also completed an

independent review of training across the organisation, and agreed a quality improvement training programme

- Patient experience – Developed and piloted Pioneering Services, offering specialised responses for more patients. LAS is carrying out closer working with community services, in order to send an appropriate specialist, and refer without conveyance. Mental health calls have continued to increase, and initiatives have taken place in response to this
- Quality priorities 2018/19 Patient safety – Improve assurance processes, improve hospital handovers, roll out secure drug rooms, increase number of defibrillator downloads
- Quality priorities 2018/19 Patient Experience – to achieve a reduction in calls from frequent callers, patient quality improvement, improve knowledge, and training in maternity care
- Islington focus – Increased appropriate care pathways, and Direct access to urgent care centres. Whittington ambulatory care – LAS has had direct access to the Ambulatory Emergency Care Unit since 19 August. This is a significant step forward in managing ever increasing demand, also there has been an upload to i Pads, showing full acceptance criteria, the bypassing of Emergency Department, and enabling streaming of patients to where they need to be
- Since July, LAS have been working towards having access for crews to bring patients to urgent care centres, and to treatment centres directly, avoiding the Emergency Department. There is hospital agreement that, if direct access is not possible, crews will only do one handover in Emergency Department, and leave the hospital to move the patient, as appropriate. There is benefit to patients going to the right treatment locations first time
- LAS has had a direct access to the Ambulatory Emergency Care Unit since August, and this is a significant step forward in managing ever increasing demand. This enables the Emergency Department to be bypassed, and to stream patients to where they need to go
- Islington CCG areas – Conveyances – conveyances to Emergency Department have increased from the 2018/19 year to 2018/19 year, purely because of increased demand. The % figures of patients conveyed to Emergency Department from 2017/18 to 2018/19 has dropped dramatically, as work takes place on increased appropriate care pathways, to enable patients to be treated in their own home, and in the community
- Conveyances – there has been a considerable increase in figures for non-conveyance, dealing with patients in the community. There has been a considerable decrease in figures for See and Convey, bringing fewer patients to hospital. There has also been considerable, and sustained increase, in figures for See and Treat
- More locally for LAS North Central London region – there is senior representation, and engagement, with all external partners, bespoke education is being delivered continually in 2018/19, and a shadowing scheme is being repeated in 2019. There is also increasing, and enhanced appropriate care pathways across the sector, financial initiatives have been won to support Best Care, there are month on month debates with Emergency Departments, and partners, on Care flow, design, capacity and LAS concerns
- It was noted that performance in all categories is excellent
- In response to a question it was stated that most pathways had a clinician involvement, and paramedics provide a triage service
- In response to a question, it was stated that there had been significant improvements in staff training, morale, and support, and this was reflected in improved staff recruitment and retention rates
- Members were informed that staff were being trained in the handling of mental health, and that a pilot is taking place where a mental health nurse

accompanies a paramedic on calls. This has proved successful, and it is hoped will be more widely introduced in January/February
- Reference was made to the forthcoming winter pressures, and that more staff were now available than last year, and that training is taking place to clearly identify pathways, and keep patients out of hospital, where possible. The Control Room also carries out more hear and treat
- A Member of the Public enquired as to the problems with the algorithm around seriously injured children, and whether this would affect the LAS. The LAS stated that they would respond to him thereon

The Chair thanked Graham Norton and Sen Brinicombe for attending

124 SCRUTINY REVIEW - ADULT PAID CARERS - WITNESS EVIDENCE-VERBAL (ITEM NO. 10)

Jess McGregor, Service Director Strategy and Commissioning, and Ray Murphy, Joint Commissioning Manager, Older Adults, were present for discussion of this item.

Duncan Patterson, Care Quality Commission, was also present, and made a presentation to the Committee, copy interleaved.

During consideration of the presentation the following main points were made –
- The CQC is the independent regulator of health and social care in England. It ensures that health and social care services provide people with safe, effective, compassionate, high quality care, and encourage care services to improve
- State of Care 2018/19 – People's experience of care is determined by whether they can access good care when needed. There is a risk of being pushed into inappropriate care settings, and increased demand and challenges around access, and workforce risk, creating a 'perfect storm'
- Adult social care specific findings – 80% rated good, 4% outstanding, 15% requires improvement, 1% inadequate. There are concerns about capacity set amongst growing unmet need. Staffing is under pressure with high turnover, high vacancy rates, and a lack of people with the right skills. Continued uncertainty about long-term funding
- State of care recommendations 2018/19- action needed from Parliament, Government, commissioners, providers and communities for more and better services in the community, innovation in technology, workforce, and models of care, system-wide action on workforce planning, and long-term sustainable funding for adult social care
- Overview of local systems reviews – in 2017 CQC was commissioned by Government to carry out a programme of 20 local system reviews. CQC has now been asked to continue the programme - 3 new reviews, and 3 follow up reviews published Spring 2019
- The Beyond Barriers report highlights organisations that are focused on individual drivers for success, rather than thinking as a system - system incentives are needed. For people to receive a high-quality service in a real system, there is a need for strong vision, governance, culture and leadership of organisations. There is also a need to work together to focus on the same metrics for success
- Key themes for driving improvement – positive reaction to CQC report, leadership, cultural change, person centred care, staffing, working with partners, and building a community
- Need for consistent, passionate workforce – great consistency of staffing makes a massive difference, there should be limited or structured use of agency staff. Staff need to be empowered to speak out, and suggest changes,

and staff should be taken on an 'improvement journey'. There should be regular supervision and training, robust recruitment and induction, and management should provide bespoke training

- Outstanding characteristics – People are at the centre, staff who want to offer improved life, not just a service. Good leadership extends beyond the manager, and there is a need to ensure those values are shared to inspire staff. 75% have a registered manager in post. There should be an open culture, and strong links to the local community, with a can-do attitude, dedicated staff, and be creative and innovative
- Common success factors – Committed leaders, putting principles into action, culture of staff equality, staff as improvement partners, people who use services being at the centre, utilisation of external help, and continuous learning
- Supporting providers – Beyond Barriers, quality matters, patch care model, skills for care, Outstanding society, Healthwatch, ADASS
- Effective staffing – new website resource, case studies where health and social care providers make effective use of their staff, different methods, not just numbers and ratios, how to make best use of skills and disciplines/work across the system, efficiency, teamwork, development. Taking flexible approaches to staffing can have a positive impact for people using services
- Medicines in health and adult social care – six common areas of risk – prescribing, monitoring and reviewing, staff competence and workforce capacity, supply, storage and disposal, reporting learning from incidents, administration, transfer of care
- CQC- encouraged improvement by talking about best practice through an independent voice, publish findings, through inspection reports, publications, blogs, learning from incidents, lots of speaking engagements, listening
- Innovation and technology at CQC – encourage improvement, innovation and sustainability – in next year's business plan CQC prioritising the development of a robust, and consistent approach, to regulating innovative, and tech-enabled care provision, and complex cross-sector providers
- Take home messages on tech – as technology and provision evolves, CQC will work alongside people who use, and deliver services, to encourage improvement, stay abreast of technological innovation, refine statutory approach, and welcome discussions with people who use services, providers in the private sector, and entrepreneurs, as to how technology can improve care, while safety and quality of care is ensured
- In response to an enquiry, as to the merging of the 5 CCG's in North Central London, and how this would affect service delivery, it was stated that it could be that improvements could be made from working together, however there is the need to consider how much funding will be made available to develop the service to meet its needs
- Reference was made to the initiatives to recruit and retain care workers, and that this is an important role, and carers needed to be properly rewarded. Carers do have induction and are trained, but there is not a standard qualification for carers. However, there are regulations that need to be adhered to, and there is a need to ensure providers respect protected characteristics, in terms of provision
- In response to a question, it was stated that the CQC carry out a survey of domiciliary services, and there is a guide for sampling of services. There is usually 10% of the service that is sampled, and specialist staff are often employed to assist in these
- A Member enquired if residents could complain to the CQC if they had a complaint, as a result of poor provision at a care establishment. It was stated that residents could contact the CQC if there were problems, and if the concerns were relevant they would be followed up

- It was stated that the CQC were not aware of any domiciliary services being carried out in house, apart from reablement services

The Chair thanked Duncan Patterson, Ray Murphy and Jess McGregor for attending

125 ANNUAL SAFEGUARDING REPORT (ITEM NO. 11)

Elaine Oxley Head of Safeguarding Adults, and James Reilly, Independent Chair Adult Safeguarding Board, were present and outlined the report to the Committee

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

- Key achievements – selected by the Office of the Public Guardian to pilot a scheme to raise awareness in the borough around Lasting Powers of Attorney. This is an important preventative protection against financial and other types of abuse, for people who lose the ability to make decisions about their finances, health and well-being. The Board continues to encourage partner organisations to focus on the link between homelessness, risk of abuse, and neglect
- A safeguarding adults review was commissioned into the care of Mr.Y, and the report published in August 2019. The Islington Safeguarding Adults Board is working on an action plan to implement recommendations, and its learning from the review. 157 organisations have signed up to the Hate Crime pledge, and the service user, and carer sub group, continues to run successfully, and is positively influencing decisions of the Safeguarding Adults Board. Over the past year, a new safeguarding structure has been introduced in the Police service, which means that Islington now has dedicated safeguarding police officer posts, and this has improved communication
- There has been a 15% increase in safeguarding adults concerns on the previous year, however safeguarding enquiries have decreased. This means that in roughly, 9 out of 10 cases of people where there were concerns, it had been decided not to proceed to a formal safeguarding enquiry
- Referral rates for concerns remain at a comfortable level, and regular case file audits are carried out to ensure that thresholds are being applied appropriately, and proportionately, by practitioners. The three most common types of abuse in Islington last year were neglect, financial and psychological abuse
- There were no cases to date, involving formal enquiries into any suspected cases of modern slavery, or sexual exploitation of adults with care and support needs, however work is taking place to raise awareness of these types of abuse
- The Annual report further details progress on delivering the first year of the Islington Safeguarding Board's 3-year strategy, and Annual Plan 2018/21. The strategy has been aligned with those of the Safeguarding Adult Boards in the North Central London cluster, and there has been collaboration, where it makes sense to do so, such as holding a joint Challenge event around Board assurance work
- In response to a question it was stated that the Safeguarding Board is functioning well and there have been improvements in training and development across the NCL region. It was stated the serious case review into Mr.Y had highlighted a number of issues that needed to be addressed across a number of Local Authorities and Members requested that the summary/action plan be forwarded to them once it is available

- In response to a question, it was stated that there is a need for more training on the mental health/mental capacity act, and there is a need to build up expertise on these issues
- It was stated that there is a need to review in the forthcoming year, the provision for the 16+ cohort of young people who are at the most risk, and work will take place between the Adult Safeguarding Board, the Children's Board, Community Safety and youth services in this regard
- Reference was made to Liberty Protection Safeguarding, and that this service will start at 16, to keep people safe. This will expand the number of places, where a care order can be made available, in order to keep people safe. In the event of an objection, it will come to the Local Authority for review. The Code of Practice would hopefully be published in December
- In response to a question as to HMP Pentonville, it was stated that the vast majority of prisoners did not reside in the borough, and that there is a challenge for prison officers in terms of training, due to the requirements of the job, and shortage of prison officers available, making it difficult for them to attend appropriate training. There is also a challenge to get home care into the prison, and at the moment in many instances, prisoners are providing care for other prisoners. Elaine Oxley informed Members that she is working closely with the Prison service
- Reference was made to the situation with Lasting Power of Attorney, and that where there is no family member, there is a team in the Council who can assist with financial services, or an alternative person or solicitor can be appointed

RESOLVED:
That the report be noted, and that a summary/action plan in respect of the report into Mr.Y, be circulated to Members when it is available

The Chair thanked Elaine Oxley and James Reilly for attending

126 ALCOHOL AND DRUG ABUSE - UPDATE (ITEM NO. 12)

Charlotte Ashton, Deputy Director, Public Health L.B. Islington/Camden, was present for discussion of this item and outlined the report. Georgia Brown, Chair of Islington Clients and Drug Abuse and Alcohol services, Lisa Luhman, Substance Misuse Commissioning Manager, Islington/Camden Public Health, Peter Kane, Divisional Director, Camden and Islington NHS Foundation Trust, and Liz McGrath, Clinical Director, Camden and Islington Substance Misuse service, Camden and Islington NHS Foundation Trust were also present

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

- Islington experiences some of the greatest levels of substance misuse related harm in London. Substance misuse has significant detrimental impacts on health services, crime and community safety, and is important contributor to adult and children's social care needs, as well as having wider economic, employment and societal impacts
- Better Lives, Islington's adult drug and alcohol recovery services, has been operational since April 2018, following a major redesign and transformation programme. The vision and operating model for the new service, aligns closely with the Council's Corporate Plan, and specifically the development of integrated, place-based working in localities focused on tackling the deeper

social challenges, which prevent residents from fulfilling their potential, and improving outcomes for themselves, and their families

- The new integrated contract and service model represents a very significant move away from previous ways of working, and service provision. As a consequence, public health commissioners acknowledged that, owing to significant mobilisation and change processes, that the provider needed to implement, in order to establish this new service, performance was likely to be impacted in the first year of the contract delivery
- Prevalence information – new estimates of the number of crack and/or opiate users were published in 2018, and give an indication of the number of people in a Local Authority area, who are in need of specialist treatment, as well as a measure of unmet need, (based on the proportion of those estimated to be in need), who are not currently in treatment. The Home Office estimated that in 2010/11 the cost of illicit drug use in the UK was £10.7 billion per year
- Research has shown that for every £1 invested in drug treatment, there is a £2.50 benefit to society. There were 203,808 people engaged in treatment in 2015/16, and if these people were not in treatment, they may have cost the NHS over £1billion. It is estimated that structured treatment prevented 4.9 million crimes in 2010/11
- Health risk factors for drug misuse include - family history of addiction, socio-economic deprivation, homelessness, unemployment. Men are more likely to use illegal drugs, and poor mental health is linked to drug misuse, and vice versa, and there are strong links between health inequalities, and drug use, however the picture is a complex one
- Feedback from service users – mystery shopping has found that users feel that the services that are available are helpful. The service user forums have developed some positive initiatives, however there is mixed engagement across the three main service sites – Grays Inn Road, Seven Sisters Road and King Henry's Walk
- Better Lives – the new adult Islington Drug and Alcohol service started on 1 April 2018. Camden and Islington Foundation Trust are the lead provider, working in partnership with Westminster Drugs Project, and Humankind (formerly Blenheim CDP). There were significant logistical challenges in the first 6 months of operation. There has been positive feedback from partners about the proactive, and flexible engagement, of staff from Better Lives, and a pilot project has been instituted, based in GP practices, to work with people who are being prescribed benzodiazepines, and opioids, who are showing signs of dependence. Since November 2018, Better Lives has offered a new structured day programme at King Henry's Walk, and more targeted group sessions are being offered across all sites. There has been a renewed focus on reducing drug related deaths, and there has been raised awareness of drug and alcohol harm, and how to support people that are using substances
- Better Lives has developed its partnership working, with housing/supported housing providers, and there is improved joint working to support service users. There has been a continuation, and support, of street outreach activity, in partnership with St.Mungo's outreach team. In addition, support is being provided for people in poor health, and the service is adapting to the changing needs of service users, and specifically those service users who have increasing health risks and needs
- Themed feedback – the Better Lives Family Service is a therapeutic service for children, young people and adults, whose lives are affected by someone else's drug or alcohol use. In year 1, the family service received 80 referrals, and in Q1 and 2 of 2019/20, there have been 49 referrals, and this is expected to continue to increase. There is a range of support available, including group sessions, and shortened interventions, in order to meet needs. More recently, the Family Service has made links with the Young Carers Group, to hear from

young carers as to what they feel would help them in understanding what their parents/guardians are experiencing

- Performance – Islington's new contract and service model Better Lives, represents a significant move away from previous ways of working. Owing to the significant service mobilisation effort, and change processes that the provider needed to implement, in order to establish the new service, the performance in the first year of the contract dropped. However, in Q1 2019/20 improvements in performance are evident, and the number of people in effective treatment has risen, together with treatment successful completions
- Further progress includes – abstinence rates for all four substance categories are within, or exceed, expected ranges. Better Lives has also been focusing on developing their partnerships with a number of key services, and providers
- Service user reported outcomes – Seven well-being related i statements were developed with Better Lives service users, and service users rate themselves at the start of treatment, and at each 3 monthly review. Service user reported outcomes are an important guide for joint care planning, and are a self-defined, and valid way, of measuring progress
- Key challenges and priorities for the year ahead – in the next 12 months, commissioners will support Better Lives, to increase the number of people accessing, and engaging, with the service, and continue to improve performance across all key performance indicators. In addition, work to continue to develop effective partnerships with key services, and providers, is taking place, to further develop and identify opportunities for co-production, continue to tackle drug related deaths by ensuring Naloxene is offered widely to those using drugs, and their friends/family, and also to support service users to access appropriate health care services
- Reference was made to the fact that at King Henry's Walk there is provision for a number of schemes that catered for specific needs. Footfall is increasing at the Seven Sisters Road site, however this is challenging, due to the drug problems in the Finsbury Park area
- Contact is being made with BAME groups, and specific training is being provided
- It was noted that Quarter 2 performance has shown a further improvement in the service
- Reference was made to the fact that the provider has undertaken a great deal of training, and that this is continuous
- There is still work to be done with young people who are involved in drug supply, and this is an area where partnership working needs to take place. There is also the need to also to work in conjunction with adult services. There are often a number of factors involved in dealing with substance misuse, such as housing, health, employment, and youth services, and there needs to be a co-ordinated approach. There is also a need for more work to be carried out with the criminal justice system
- It was noted that there is no wait time in order to access services at present
- Outreach staff are being trained to disseminate information in the community, and people often refer themselves to the service, as a result of contact with other service users
- It was noted that work is taking place with the Refugee Forum, and BAME groups, and there is a need to access services in the community at different locations, and this is additionally being looked at
- Members were informed that often users presented with multiple substance misuse issues, and the issues are often complex ones

RESOLVED:

(a) That the report be noted, together with the progress in developing the new service, and improving outcomes for Islington residents affected by substance misuse
(b) That when the update is presented to the Committee in 12 months, comparative performance figures be included for other similar Local Authorities
(c) That Members be informed of awareness training that Members can access, if they wish to do so

The Chair thanked Charlotte Ashton, Lisa Luhman, Peter Kane, Georgia Brown, and Liz McGrath for attending

127 PERFORMANCE STATISTICS - QUARTER 1 (ITEM NO. 13)

This item was deferred until the next meeting of the Committee

128 WORK PROGRAMME (ITEM NO. 14)

RESOLVED:

That the report be noted

MEETING CLOSED AT 10.40p.m.

Chair

Joint Report of: Corporate Director of Housing & Adult Social Services and Corporate Director of Public Health

Meeting of:	Date	Ward(s)
Health and Care Scrutiny	January 2020	All
Delete as appropriate	~~Exempt~~	Non-exempt

SUBJECT: Islington Adult Social Care Report and Local Account

1. Synopsis

1.1. The Islington Adult Social Care Local Account and Health in Islington: Key Achievements give an overview of achievements for 2018/19 and areas of focus for the coming year.

1.2. The Local Account is an annual report for residents of Islington. The report provides information about how well we are serving the residents of Islington compared with similar London boroughs and also provides feedback from the surveys of service users and carers.

2. Recommendation

2.1. Health and Care Scrutiny Committee are asked:

- Note the contents of the Local Account.
- Note the contents of the Health in Islington: Key achievements report

3. Summary

3.1. Adult Social Services are facing increasing pressures with reductions in funding at a time when the numbers of frail older people are increasing and there is a high incidence of people with long-term mental health conditions, along with a population of people with physical and learning disabilities who require specialist services.

3.2. In 2019/20, to help meet these challenges we:

- Start with what people can do and build on their strengths, focusing on the things that can work to overcome barriers which are preventing them from reaching their potential and having the best possible lives they can.
- Have been providing support to carers of people receiving adult social care through the provision of direct payments, advice and information, respite care, support groups, special events and the Flexible Breaks fund service.
- Been working to reduce social isolation by broadening the number of social contacts through innovative schemes with the voluntary sector, so people are better connected to things that can engender a sense of wellbeing and greater quality of life.
- Support independent living through direct payments and self-directed support; and by supporting service users to make their own informed decisions and choices.

3.3. The rest of the Local Account report includes statistics and information relating to characteristics of people receiving services, details of adult social care finances and safeguarding.

3.4. The Health in Islington: Key achievements provides an update on life expectancy in Islington along with progress against the Health and Wellbeing Board priorities of:

- Ensuring every child has the best start in life
- Preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities
- Improving mental health and wellbeing

4. Implications

4.1. Financial implications

There are no financial implications arising as a direct result of this report.

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

4.2. Legal implications

The Care Act 2014 ("CA"), which came into force in April 2015 placed a duty upon local authorities under s.1 to promote the well-being of individuals within its area; this duty extends to physical, mental and emotional well-being and applies to adults with care and support, their carers, children and young carers.

Section 2 of the CA 2014 places an obligation upon the local authority to provide services, facilities or resources to prevent and/or reduce care and support needs for adults within its area.

4.3 Environment implications

There are no significant environmental implications resulting from these reports.

1.1. Resident Impact Assessment

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

A Resident Impact Assessment has not been completed because these are reports providing information about performance and services in 2018/19

ISLINGTON

Adult Social Care

Local Account 2019/20

1. Contents

2. Foreword

We are pleased to present the Local Account for Adult Social Services in Islington for 2018/19. This report provides information about how we are serving the residents of Islington and also provides feedback from the surveys of service users and carers.

Making sure that we can effectively respond to the changing needs of our population is one of Adult Social Care's key challenges. We continually review our services and develop our offer to keep pace with the changing needs of our population. We recognise that all our residents, including those with the most complex needs, have strengths and assets. Our role is to ensure services continue to support residents to achieve better outcomes and have a good quality of life.

To help meet these challenges we:

- Start with what people can do, what is important to them and what support they have within their own friends, family and wider community. Build relationships with people so that together we can consider different types of support and people can stay as independent as possible, be less socially isolated, and live the lives they want. Examples of this are supporting people to get involved with voluntary work, family members visiting regularly to avoid loneliness, or the provision of equipment and telecare so that people can continue to live in their own home.
- Have been providing support to carers of people receiving adult social care through the provision of direct payments, advice and information, respite care, support groups, special events and the Flexible Breaks fund service.
- Have been working to reduce social isolation by broadening the number of social contacts through innovative schemes with the voluntary sector, so that people are better connected to things that can bring about a sense of wellbeing and greater quality of life.
- Support independent living through direct payments and self-directed support; and by supporting service users to make their own informed decisions and choices.

Janet Burges

Councillor Janet Burgess
Cabinet Member for Health and Social Care

3. Islington's Population in 2018/19

People

Population: **241,600** with an expected increase of **10%** over the next 10 years.

The number of people aged **65+** is expected to increase by **28%** over the next 10 years.

Islington is this **5th** most deprived local authority in London as of 2019.

Health

Life expectancy

80 years 83 years

Healthy life expectancy

60 years 62 years

Life expectancy has increased, but healthy life expectancy has remained constant meaning that people are living longer in ill health and resulting in higher health and care costs.

Around 5% of the population has a dementia diagnosis. This is expected to rise with the population increase for 65+.

Care and support

Islington has a relatively large proportion of older people who live alone and are potentially isolated and is ranked **8th** nationally for estimated risk of loneliness in those aged 65+.

19% of service users had learning disabilities with **8%** being in paid employment.

Family carers and other informal or unpaid carers make an enormous contribution to supporting vulnerable people within our communities.

- **2,796** carers were registered with Islington Carers' Hub
- **23%** of unpaid carers provided more than 50 hours of care a week.

- Islington had a higher prevalence of serious mental illness than any other London borough
- In 2017/18, **1,237** people were admitted to hospital for alcohol-related conditions, significantly more than the London average.

4. About Islington Council Adult Social Care

Our vision
We want to ensure that people in Islington can live healthy and independent lives. Our approach starts with resident's strengths and abilities and seeks to intervene early to prevent or delay needs increasing.

Islington Council has a clear vision - to make Islington fairer and create a place where everyone, whatever their background, has the same opportunity to reach their potential and enjoy a good quality of life.

In our corporate plan we have made the commitment to ensuring our residents can lead healthy and independent lives by:

- Making Islington a fairer place for all which must include valuing all of our residents. We need to work with our partners to tackle health inequalities and help residents to stay fit and healthy, both physically and mentally, for as long as possible.
- Working with the NHS to deliver more joined up health and care services, arranged around people's lives, and focusing on early intervention before problems worsen.
- Ensuring that older and vulnerable residents are cared for and safeguarded, and that residents are supported to live independently where possible and well supported if not. We will work to ensure that residents are socially active and connected to their communities.

Our purpose
We provide and commission care and support for Islington residents who need it. Care and support includes help with essential daily activities like eating and washing, or help participating in work or socialising. We provide support in people's homes wherever possible to aid our residents' independence. If that is not possible, we support people to live in supported housing, residential or nursing homes.

Who we support
Our residents may need support for any number of reasons. Mainly, old age and dementia, physical, sensory and learning disabilities, mental health problems, and substance misuse. The demand for services is growing as our residents are living longer and there are more people living with long term conditions.

5. Adult Social Care 2018/19: By the numbers

13,626 contacts were received, **67%** of which were from people new to our services

2,348 safeguarding concerns were raised, **10%** more than in 2017/18

3,468 individuals received a long-term adult social care service

26% of service users received direct payments

Each day an average of **19** hospital beds were taken up by people who were well enough to go home.

587 referrals were made to Reablement Services

58% (1,859) of our long-term service users received care at home

599 individuals were in permanent residential placements

87% of those who received long-term support for the whole year received a review

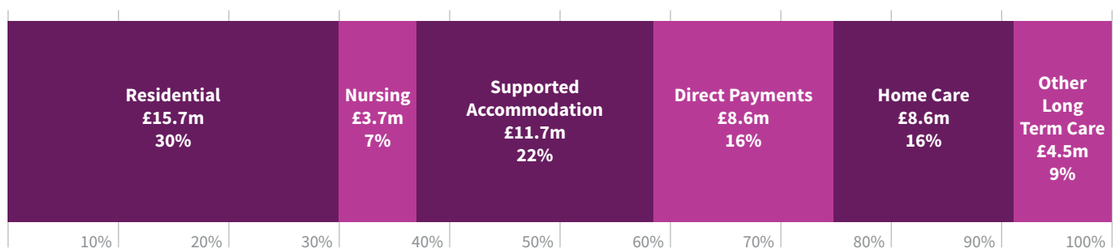
56% of service users and **27%** of carers are satisfied with the services we provide

64% of our service users said that they felt safe

75% of our service users said they had as much social contact as they would like

How we spent our budget

In the 2018/19 financial year, Islington Council's Adult Social Care net expenditure was **£80.5 million.**
Spend on long term care was divided in the following way:



6. Making social care better with your help

Your experiences of using care and support services, and your ideas about what could be better, help us to continually improve social care in Islington.

There are a number of ways in which we work or consult with residents to achieve this:

- Every year we ask social care service users to complete a survey about their experiences. We also ask carers to complete a similar survey every two years.
- We ask a number of service user and carer representative groups to gather feedback about how well our services are doing, and to work with us to make them better. Service user and carer representatives also join us on decision making panels to decide who we should commission to provide specific services on our behalf.
- Sometimes we undertake formal consultations about changes to a service or have informal discussions with people who use services to learn about what we could improve.

Below are some examples of where service users and their carers told us what couple be improved, and the work we have done or will do as a result. Some of these examples are featured in more detail throughout this report.

You said	We did/will do
People who use a direct payment for their care, or for someone they care for told us: ■ The experience of using direct payments could be improved. ■ There should be a mechanism for engaging and working with people using direct payments. ■ Together we should look first at previous co-production work in this area for suggestions to take forward.	■ Established a Direct Payments Forum and working group in partnership with people who use direct payments. ■ The group's work plan is based on the Making It Real Review and Spark a Solution Report. Both papers gathered feedback and explored how we could improve social care, particularly around direct payments.
Carers completing the statutory survey told us that they find the carers direct payments rules and processes difficult to follow.	We have made changes to the personal budget allocation for carers, removing the weekly cap. Additional work on this will continue in 2019/20.
The Better Days Engagement asked service users and their carers about how they wanted to spend their time. They told us: ■ They want better information about services and support on offer ■ They would like more social interaction and peer support in their day to day life. Transport can also present barriers to accessing specialist or universal day provision like leisure centres.	■ The Adult Social Care Plan includes work to improve information for the public. ■ Better Days will enable us to take a strategic approach to day provision in Islington – across universal and specialist provision. This will also inform the transformation of in-house services. ■ We have consulted with disabled and older residents for the Transport Strategy and will continue to work with them. This will also inform the upcoming Accessible Community Transport Strategy.
Through statutory surveys, service users told us that we need to reduce stigma in the community, particularly for people with mental health issues or learning disabilities. People with lived experience of mental health issues also identified intersections with other issues that experience additional stigma and discrimination: ■ Learning disabilities and mental health issues ■ LGBTQ+ and mental health issues ■ Substance misuse related to mental health issues.	Time to Change Islington launched this year – this is part of a national campaign to reduce stigma and discrimination about mental health issues. ■ The council is working with people with learning disabilities) to co-design learning disability accessible promotional materials and training. National Time to Change is also supporting this campaign. ■ All local Time to Change partners, including the council, are working with mental health service user representatives and an LGBTQ+ mental health peer support group to develop a campaign related to this. ■ Time to Change Hub partners are supporting a champion to deliver a campaign to reduce stigma and discrimination around mental health issues and associated substance misuse. National Time to Change is also supporting this campaign.
Service users told us that they would like more support to make and maintain friendships with their peers.	We are working to meet the needs of our service users around social isolation. The council is also supporting voluntary and community organisations in the south of the borough to develop a pilot project to address loneliness and social isolation.

7. Supporting people to live healthy, independent lives

Adult social care staff work alongside a variety of partners, such as Public Health, the NHS and voluntary and community sector organisations to ensure that adults have the support they need to live as healthily and independently as possible.

Creating accessible physical activity opportunities

In partnership with Islington Council, Greenwich Leisure Limited (GLL) run 17 gym and sports facilities across the borough and offer a low-cost inclusive membership to all disabled people. They work to make their centres as accessible as possible.

In 2018/19, we had an average of 846 disabled people signed up to our low-cost monthly membership. These members made an average of 2,360 visits per month to an Islington leisure centre to swim, use the gym and/or to do a fitness class. GLL run leisure facilities in 66 boroughs/areas across the UK, and Islington has the second highest number of Better Inclusive members. In partnership with Camden & Islington Foundation Trust, GLL arranges venues for weekly tennis, football and running sessions for adults with mental health difficulties and provides a variety of accessible activities such as disabled swimming and ice-skating sessions, and a weekly Disability Sports Coach session at the Sobell Centre.

Key fact
Across our targeted disability sports programme in 2018/19, we had an average of 695 attendances per month.

Bringing health care to people with learning disabilities

The Nursing Health Hub is a service for people with learning disabilities at the Islington Learning Disability Partnership (ILDP). The nursing team at ILDP improves the health of people with learning disabilities through advice, monitoring, and signposting. As part of the Nursing Health Hub, we offer other health initiatives, including a sexual health outreach service for people with learning disabilities, and a low vision clinic in collaboration with the Royal National Institute of Blind People. We offer longer appointments of an hour, and multiple appointments if necessary. The Care Quality Commission have commented on the outstanding work done in the Health Hub in tackling health inequalities.

Key fact
The Nursing Health Hub saw 74 patients in 2018/19.

Case Study:
A resident had ongoing issues with their sleep pattern and was prescribed medication for this to take when required. They visited their health hub where they were given support with creating a sleep hygiene plan. They returned for a follow up appointment where it was found that their sleep pattern had improved, and they no longer required the use of medication.

Helping people feel safe and secure in their homes

Our Telecare service keeps some of the borough's most vulnerable and elderly residents independent in their homes, offering equipment that can be installed in the home and that will alert Telecare when assistance is needed. Telecare had a very successful year in 2018/19, increasing the number of clients and responding to over 1,500 residents. Telecare also monitors various housing schemes that collectively house around 400 residents, and contribute to keeping these residents safe and secure in their homes. We are working to maintain their standard of service delivery and to identify opportunities to work with other teams and areas within Islington Adult Social Care.

> "Just a small thank you for Mum having this alarm, and a big thank you for being there, especially on that fateful day when she fell at home, forever grateful."

Supporting people to stay at home independently

Islington Council's Occupational Therapy (OT) team is a very busy team, receiving around 20 referrals every day in 2018/19. Our OT team works closely with partners in hospital, mental health, housing, prison and in both Adult Social Care and Children's Social Services. This work helps service users and their carers stay in their home environment as easily, safely and independently as possible. This keeps service users at home longer and can also reduce demand on social care and hospitals.

Case Study:
Islington Council Occupational Therapy liaised with an out-of-borough hospital to ensure timely discharge and ordering of appropriate equipment and aids for Jane, a 54-year-old wheelchair user who had undergone a recent amputation. Jane was discharged to her daughter's home as her own home was inaccessible. OT helped set Jane up a micro-environment in her daughter's living room and found that she had three young grandchildren also living in property. Islington OT submitted a re-housing report with recommendations for future housing and helped with property viewing. In the end, Jane and her daughter's family were rehoused to an accessible property together, and the OT made sure all necessary equipment and adaptations were available in the new property.

Funding and installing equipment in people's homes

The Disabled Facilities Grant (DFG) helps fund the installation of showers, ceiling track hoists, kitchen adaptations, ramps, and other equipment and adjustments recommended by occupational therapists. In 2018/19, a total of 458 adaptations were completed in Islington properties. In one case, an Islington Occupational Therapist identified a risk of falls for a husband assisting his wife on the stairs in their home, and the DFG helped provide a stair lift which enabled the wife to independently manage the stairs while reducing her husband's risk of falling. In 2019/20, the Disabled Facilities Grant is stopping the means testing qualification on applications for adaptations under £10,000.

Giving people choice and control over their services

In 2018/19, 26% of service users received a direct payment. People who receive direct payments generally feel that they have more choice and control over their services and are more satisfied with their service. We have re-formed the Direct Payment Forum, so people using direct payments and their carers can discuss issues and their experiences with council staff. We are working to set up a co-production working group to take forward actions from the forum and plan future events. We are also working with our colleagues in Children's Services to ensure that we offer a clear and supportive transition for young people moving into adulthood and with health partners to ensure a coordinated approach and sharing of expertise.

The studio space created for the Artist in Residence programme by the Mildmays Extra Care housing scheme.

8. Working with the NHS

Maximising our collaboration with health partners helps bring a greater focus on prevention and early intervention, ensuring Islington residents are as healthy and independent as possible and are leading fulfilling lives.

Working with health partners to help people leave hospital on time

Discharge to assess is a joint approach between Islington Council, the CCG and other NHS partners which aims to discharge qualified patients to have their social care needs assessed at home, or in a community setting, rather than on the ward. This approach eases demand on hospital beds and staff, makes better use of community services and delivers better overall outcomes for patients. The programme receives consistent feedback regarding its responsiveness, in line with a target of assessing 100% of patients at home within 24 hours of discharge.

Providing rehabilitation at home

Our Reablement Service provides up to 6 weeks of goal-orientated rehabilitation at home rather than on a hospital ward. As people leave hospital they are referred to Reablement following an assessment. In January 2019, our Reablement Service achieved an overall 'Good' Care Quality Commission rating which was recognised as a significant achievement following the previous years' inspections and challenges.

Case study:

BL had a fall resulting in a head injury and fractured knee. BL was referred to the Reablement Service from hospital. She initially needed support with personal care, meal preparation and medication administration (three times a day). BL received regular support from Pharmacy, Physiotherapy, Rehabilitation Assistant and Case Manager. She was supported for a total of 4 weeks and by the end she had achieved independence in all activities of daily living, with no ongoing support.

Avoiding hospital admissions

The Admission Avoidance pathway continues to provide an additional route into Adult Social Care from the Rapid Response Acute Community Service. This ensures service users receive timely access to relevant social care support following a period of ill health, whilst also remaining in their own homes. We are working with partners to establish a simpler route of access into Adult Social Care from all hospitals and community settings, as part of the Adult Social Care Plan 2019/21.

9. Help residents to feel socially active and connected in their community

Being part of the community can reduce social isolation and help to maintain an active lifestyle. By working closely with voluntary and community sector organisations, we ensure that our residents live independent and fulfilling lives while continuing to be an active part their community.

Creating social opportunities for people with learning disabilities

Islington Council provides several services to help people with learning difficulties develop new skills, lead lives as independently as possible, and access activities, groups and leisure opportunities in the community. Me Time, a social inclusion service run by the Royal Mencap Society, provides a programme of activities which is co-produced by service users and Mencap. Activities in 2018/19 included a football group, DJing, gardening and drama groups. At the Daylight Centre, a large in-house service in Islington, service users can access community and building based day opportunities and on-site activities such as art, drama, music, pottery, wheelchair dance, and gardening.

Key fact
An average of 80 service users participated in activities through Me Time every quarter of 2018/19.

> "I'm looking forward to the summer timetable already, even more so knowing that I've helped plan some of them."

Creating social opportunities for older people in care homes

Exciting partnerships between older people's care homes and Islington's Extra Care Housing Scheme benefitted both residents and the wider community. The Mildmays Extra Care Scheme worked with the local arts charity Cubitt to pioneer an Artist in Residence programme in which unused space within the Extra Care housing scheme was transformed into studio space and rented out at a reduced rate to socially conscious artists, who then worked with residents on a voluntary basis. Other exciting partnerships included co-developed intergenerational projects with local schools, a local music charity who have found a base in Bridgeside Lodge, and Pets as Therapy organisations, who have worked with care homes in Islington to encourage contact between residents and calming animals.

Musicians recording at the Daylight centre's on site studio space

Building a more responsive mental health recovery pathway

As part of Islington's strategy to embed our strengths based approach and to make our services more accessible, responsive and flexible, we have worked with service users to re-design and commission a new Mental Health Recovery Pathway, provided by Islington MIND. Following extensive transformation, this pathway has combined several services into one integrated service offer. We have also reconfigured the services delivered in day service buildings, enabling more residents to access spaces and resources.

Making Islington a Dementia Friendly Community

Islington's Services for Ageing and Mental Health (SAMH) offer has been highlighted by NHS England as a national best practice example for clinical care of people with Dementia. Over 2019/20, London Borough of Islington (LBI) will be working in partnership with the Alzheimer's Society to become a Dementia Friendly Community. Dementia Friendly Communities take active steps to encourage everyone to share responsibility for ensuring that people with dementia feel understood, valued and able to contribute to their community. Islington also aims to double the number of Dementia Friends Champions in-borough to 34. Dementia Friends Champions are volunteers who encourage others to make a positive difference to people living with dementia in their community by giving them information about the personal impact of dementia, and what they can do to help.

Supporting carers

In November 2018, Islington Carers Hub launched a suite of training designed for carers on both support areas related to the people they care for and also to support their general health and wellbeing. These courses ranged from training on mental health, dementia and carers first aid to workshops on mindfulness and meditation. In less than a year, there have been over 300 attendees who have benefited from accessing training and workshops held within the local community and Islington Council buildings.

> "I really enjoyed the first session and have asked a friend whose husband also had dementia to join me for the next sessions. There were a lot of women attending, just one man, but not all were there because their husbands had dementia like me. Some were there because of their mother or their nan. It was comforting to know that there were others out there in a similar situation as I am."
>
> **Dementia course attendee**

10. Safeguard and protect older and vulnerable residents

We take great care to make sure that our older and vulnerable residents feel safe and in control. We have a variety of safeguarding measures in place and work closely with providers to make sure our residents receive good quality and safe services.

Protecting vulnerable residents

Islington Council's Safeguarding Adults Board has membership from organisations across Islington including health, probation, emergency services and voluntary organisations. In 2018/19, our board focused on topics affecting adults with care and support needs that have also been of national interest, including homelessness, fire safety for disabled people, and gangs and knife crime. In 2019/20, making safeguarding personal is a priority for the board and much work is taking place around this.

Key fact
In 2018/19 we had 435 safeguarding enquiries (10% of the total concerns raised).

Helping our partners protect vulnerable residents

Training on safeguarding adults and the Mental Capacity Act that is available to partners in health and social care. In 2018/19, we delivered bespoke training on modern day slavery and human trafficking in partnership with Islington's Community Safety team. Around 300 people have been trained to date. We also created bespoke e-learning modules on a range of safeguarding adults' issues such as domestic abuse. In 2019/20, we are working on several trainings in partnership with other organisations, including a fire safety training to care home providers in partnership with the London Fire Brigade.

> "I have been to many human trafficking trainings before but this was the best I had ever had!"
>
> Modern Day Slavery training course participant

As part of our Safeguarding Awareness month week, service user drama group – Your Life, Your Say, performed a play on making safeguarding personal to social care staff and commissioners on 26 June 2019. The drama group performed at a conference for service users and carers which attracted over 50 people and was very successful.

Protecting the freedom of our residents

Islington's Deprivation of Liberty Safeguards (DoLS) service is one of the best performing services in the country, averaging 26 days from the completion of a referral to authorisation. Much shorter than the London (68 days) and England (138 days) averages. Our DoLS service processed over 1,000 referrals in 2018/19. Unlike many DoLS services across the country, we do not have any back logs so can give assurances that Islington residents within hospitals and care homes who lack the capacity to consent to their accommodation are cared for under the DoLS framework.

Key fact
There are currently 485 Islington residents in care homes and hospitals who have a DoL in place.

Case study:

Robert is a 50-year-old man with a learning disability and a history of alcohol abuse. Robert's first Deprivation of Liberty was six months ago, and as a result of serious concerns regarding the suitability of his placement, two further short term DoL authorisations were put in place together with a number of conditions, and a paid Relevant Persons Representative (RPR) to support him. Following the work of the DoLS assessors, paid RPRs and care management, Robert is now far more settled and his placement is secured.

"I had a great visit with Robert yesterday and spent some time with various members of staff. In the last 3 months Robert has been allocated a social worker; his personal allowance is now well managed by client affairs; he has been reviewed twice by a Consultant Psychiatrist and he is presenting with very few challenges. The placement is no longer in jeopardy; there have been no incidents in the last 3 months and he is now agreeing to drink in his room instead of on the street. Robert continues to go out on his own and always returns without issue. In my opinion the DoLS is now fairly straightforward and I would recommend a 12-month authorisation.''

From a recent assessment

11. Supporting people into employment

Having a fulfilling job contributes to wellbeing. It can give us a purpose, an income, promotes independence, and allows us to develop social contacts. We want to support residents to gain the skills they need to get a good job.

Helping unemployed Islington residents to get jobs they want

Our iWork employment service offers one to one tailored coaching and mentoring support to get unemployed Islington residents into jobs that they want to do. It has a holistic approach, looking at the person's strengths and interests. Clients can engage with the service for as long as required.

Clients regularly feedback how much the iWork service has improved their quality of life, with many reporting that before engaging with the service they had very little or no support and the daily challenges of being unemployed were having a detrimental impact on their health and wellbeing. In 2018/19, iWork created a "Hub" at 222 Upper Street, which is a collaboration of 11 services offering specialist employment support to residents.

Bringing unemployment services together

Islington Working brings together 61 organisations that are currently offering employment support in Islington to coordinate a coherent, well understood and accessible employment support offer for the borough. Among many other activities in 2018/19, Islington Working produced an online directory of employment support in Islington and launched a refreshed and re-branded ebulletin. We also tested an Outreach Navigator model of resident engagement with Help on Your Doorstep. We are building on this work in 2019/20, with plans to launch an online jobs board that is shared and used by all employment support partners.

Supporting people with learning disabilities to find work opportunities

The Community Access Project (CAP) is a short-term support service for adults with learning disabilities, many of whom can be socially isolated. CAP provides an initial assessment and co-produces a plan of action with a service user who is looking for work or wanting to try something new in their community. A successful referral results in a long-term positive outcome that can be sustained independently by the service user. This work has demonstrated that employment for candidates with learning disabilities can be achieved, and we have fostered good links with local employers and other supported employment teams over the years. One goal for 2019/20 is to build closer relationships with local schools for students with special educational needs.

Case study:
In 2018, Islington Council CAP was part of a project to develop opportunities for people with Learning Disabilities in the NHS. A great deal of planning and consideration was put into the creation of posts, specifically creating roles for candidates with Learning Disabilities in mind and attempting to pre-emptively resolve or avoid any issues. As a result of this project, CAP helped support two people to work as Health Care Assistants for the NHS and they have sustained employment for over a year. Both candidates work over 12 hours a week to support residents with dementia.

12. Workforce

Embedding strengths based practice in our workforce

Building Strengths for Better Lives is Islington Adult Social Care's approach to supporting and caring for people. It is a strengths based approach, which encourages people to use their own strengths and resources and to lead the independent and fulfilling lives they want. Independence, social relationships and being connected to the local community, are all promoted by this approach, and people are involved in all discussions and decision making about their own lives. In 2018/19, we put in place a programme of support and training for frontline practitioners and reviewed and rewritten policies with a strengths based approach to ensure these ideas continue to be put into practice.

Case study:

A young mother with Sickle Cell was visited because she was asking for support from carers visiting. The practitioner had an open and strengths based conversation with her about how often her Sickle Cell flared up, what were the warning signs and trigger factors, how could she plan ahead to manage things differently at these times such as do shopping online. This contingency planning was also explored in partnership with community health staff and the plan will be to provide a direct payment so that she can arrange support for herself when her illness flares up.

13. Future priorities 2019/20

Our overall vision for Adult Social Care is clear. We want to ensure that people in Islington can live healthy and independent lives, by taking an approach that starts with people's strengths and abilities and seeks to intervene early to prevent or delay needs increasing. We want to build the capabilities of our communities and services to help people to help themselves, and to ensure people get the right support at the right time.

In order to achieve this, we have an Adult Social Care Plan which prioritises the areas we need to focus on to make improvements to Adult Social Care in the context of rising demand and reducing budgets. Some of our key priorities for 2019/20 are:

- Supporting our whole workforce to practice a strengths based approach, making sure that we are building on strengths and assets rather than just assessing needs.
- Driving forward the personalisation of Adult Social Care to make sure people can be in control of their lives through self-directed support and direct payments.
- Developing our local services, whether provided by the council or by our partners, to prioritise our resources to have the most positive impact on health and independence.
- Improve our partnerships and joint working to deliver better outcomes. This includes closer working with Health, Public Health, Housing, the Community & Voluntary Sector and the prison services to join up our priorities and work together on improvements in care and support.

In addition to these areas of focus, we are developing further plans for improvements in the coming years, these include:

- Developing an easily accessible information offer for Adult Social Care
- Improving our use of assistive technology to support health and independence
- Transforming our own in-house Adult Social Care services to offer high quality, good value specialist support
- Reviewing our offer to family carers to make sure we are giving the support they need to continue their vital and valued role
- Reviewing how people access Adult Social Care to ensure people get the best possible service experience however they come into contact with our services
- Supporting and developing our workforce to ensure they are equipped to deliver the services our local residents need and want.

Do you need this information in another language or reading format such as Braille, large print, audio or Easy Read?
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ISLINGTON

HEALTH IN ISLINGTON: Key achievements

Cllr Janet Burgess

Presentation to Health Scrutiny
January 2020

Life expectancy

ISLINGTON

- Since 2006-08, life expectancy has increased in Islington for both men and women.
- Life expectancy at birth for men in Islington is now 79.6 years, an increase of 4.4 years since 2006. However life expectancy for men in Islington remains lower than the London average (80.7) and is **the 8th lowest amongst all London boroughs**.
- For women in Islington life expectancy is 83.3 years, which is statistically significantly lower than the London average (84.5), and is **the 4th lowest amongst all London boroughs.**

Life expectancy at birth

Men	2006-08	2016-18	Percentage increase
Islington	75.3	79.6	5.5%
London	78.0	80.7	3.4%
England	77.8	79.6	2.3%

Women	2006-08	2016-18	Percentage increase
Islington	81.1	83.3	2.6%
London	82.4	84.5	2.5%
England	81.9	83.2	1.6%

Source: ONS, 2019

Healthy life expectancy

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- In Islington, men and women spend on average the last 17.0 and 20.7 years of life in poor health respectively.
- Healthy life expectancy (HLE) for men and women in Islington is statistically similar to London and England.
- For both men and women, the change in average healthy life expectancy since 2009 is not statistically significant, but both men and women in Islington have seen a greater increase in HLE compared to London and England.

Healthy life expectancy at birth

Men	2011-13	2016-18	Percentage increase
Islington	57.6	62.6	8.6%
London	63.4	64.2	1.3%
England	63.2	63.4	0.3%

Women	2011-13	2016-18	Percentage increase
Islington	57.6	62.6	8.6%
London	63.4	64.2	1.3%
England	63.2	63.4	0.3%

Source: ONS, 2019

Islington's Health and Wellbeing Board priorities (2017-2020)

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Ensuring every child has the best start in life	Preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities	Improving mental health and wellbeing
Improving outcomes for children and families.	Addressing wider causes of poor health: particularly housing, employment and isolation.	Increasing focus on mental health and wellbeing for children and families.
Driving integration across early childhood services.	Promoting and enabling healthier lifestyles.	Increase employment opportunities and workplace health.
Remaining focused on prevention and early intervention.	Providing a collaborative, coordinated, and integrated care offer to residents.	Focusing on reducing violence and the harm it causes.
		Improving the physical health of people with mental health conditions.
		Working better as a system to provide a better holistic service to people with multiple needs which include mental health.
		Focusing on dementia.
		Improving service access.

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Ensuring every child has the best start in life

Key achievements – Best Start in Life

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Early Years Integration

- The major **structural transformations** for fully integrated early years services through Islington Bright Start are now complete, and many health staff are now co-located in children's centres.
- **Health visiting services** maintain good coverage of the mandated universal development checks. In 18-19, new birth visits were made to over 94% of families within 14 days of birth, and at age 2 to 79% of families. These rates compare favourably with London and England.
- In July, integrated Bright Start Islington services gained full **UNICEF Baby Friendly accreditation**. Breast feeding rates in Islington are considerably higher than national rates.
- A review of information provided to parents on **childhood illness** has been completed. A new suite of resources is currently in development, as well as discussions with voluntary sector partners about ensuring information and materials reach all sections of our communities.
- Our face-face **parenting programmes** have been enhanced through the launch in October of an online version of the Solihull courses for parents to increase the reach of our evidenced-based parenting skills programme.
- A 3rd cohort of Bright start early years **parent champions** have completed their training.
- Islington led the development of the **Healthy Early Years London** award and 60 local early years settings have transitioned to be accredited through this regional award. 11 childminders have registered for First Steps and 1 childminder has achieved the bronze award in Islington.
- Leadership of the integrated early years service has been formalised through formation of an **Early Years Partnership Board.**

Key achievements – Best Start in Life

ISLINGTON

Mental health

- **A perinatal mental health needs assessment** was recently completed, and a specialist post created within health, with a plan to implement a new pathway for mild-moderate perinatal mental health problems. This post will also lead on taking forward the other recommendations from the review, working through the working group of perinatal mental health champions led by health visiting.

- **A self-harm needs assessment** was completed in August 2019 and recommendations are currently being discussed. A number of these have already been addressed through the recent transformation of the Children and Young People Social and Emotional Mental Health Service. Outstanding recommendations in relation to improved data and transition to adult services will be taken forward with joint commissioners.

- **Embedding approaches to support better mental health in schools:**
  - **Islington Mental Health and Resilience in Schools Programme** (IMHARS): a whole-school approach provides a framework for Islington schools to support pupils' mental health and resilience
  - **Islington Trauma Informed Practice** (iTIPs): works to develop and embed whole-school trauma approaches providing a stable, safe space to regulate and increase learning potential
  - Good mental health and emotional wellbeing are key components of the **Healthy Schools** award. 33 out of 65 schools have been successful in achieving the Healthy Schools award at bronze level or above. Other components include healthy weight, physical activity and sexual health.

Key challenges – Best Start in Life

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Immunisations

In line with London and England, **childhood vaccinations** rates in Islington have fallen for the past four years. Only 72% of children are fully protected against measles, mumps and rubella at 5.

We are:

- Working with health visiting, school nurses, schools and nurseries to ensure vaccination status is checked and encouraged at routine contacts
- Undertaking a centralised recall and catch up programme of MMR vaccination for 5 year olds using Islington's extended hours GP hub.
- Ensuring that all staff in early years settings are confident to answer questions about childhood vaccinations
- Ensuring that catch-up vaccinations are now available through the school age vaccination programme

Key challenges – Best Start in Life

ISLINGTON

Healthy weight

- **Childhood excess weight** continues to be a challenge in Islington. In 2018-19 21% of children aged 4-5 years old were overweight. The rate has not changed significantly over the past 3 years and is currently similar to England and London. Amongst children aged 10-11 years old, 38% were overweight in Islington, similar to London but higher than England.

- In 2018-19 204 families attended **Families for Life Early Years and Primary cooking programmes**. 60% were from BME groups and an average of 69% of attendees completed the programmes.

- The 0-18yrs **weight management pathway** has been updated in order to integrate and build stronger links between available services for children/families.

Forward look – Best Start in Life

ISLINGTON

- To improve links with voluntary sector partners to **improve reach of universal early integrated services** to refugees, migrants and non-English speakers and to develop an **integrated dashboard for early years outcomes**, to inform joint annual priorities within Bright Start.

- **Tiny TIPS** (Trauma informed practice in Early Years settings) has started in two children's centre nurseries and a nursery school with funding provided from Public Health with a plan to review and monitor progress. Staff have attended schools training.

- Planning to formalise the process of **recording vaccination status** on entry to nursery, children's centres and school and respond to barriers to vaccination uncovered through the iHub project. Aiming to ensure that all staff in early years settings are confident to answer simple questions about childhood vaccinations.

- Monitoring engagement in and outcomes achieved through engagement of children and families with the **0-18yrs weight management pathway** in Camden.

Key challenges – Best Start in Life

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Maternity & early years

Maternity

- Reduce smoking
- Support healthy maternal weight
- Reduce teenage pregnancy

Breast feeding

- Support UNICEF baby friendly standards in all settings
- Ensure peer support

Early years

- Ensure universal delivery of the Healthy Child Programme through integrated early years services
- Provide parenting programmes
- Support delivery of healthy start vitamins and vouchers

Screening & immunisations

- Ensure antenatal and new-born screening
- Ensure childhood vaccinations

School age and beyond

School Health and Wellbeing

- Support whole school approaches to health and wellbeing
- Support early identification of health problems and early intervention
- Deliver vision and hearing screening

Healthy Weight

- Deliver a whole system approach to healthy weight
- Support families to make healthy lifestyle choices
- Deliver and follow-up national child measurement programme (NCMP)

Oral Health

- Continue delivery of fluoride varnish
- Support universal oral health promotion

Transition to Adulthood

- Build health independence and behaviours for life
- Support student health and wellbeing

Vulnerable children

Safeguarding

- Implement learnings from local child deaths
- Ensure working to new national CDOP arrangements

Mental health

- Reduce smoking
- Support healthy maternal weight
- Reduce teenage pregnancy

Youth safety

- Implement a public health approach to reduce youth violence

Poverty and Inequality

- Support system recognition of the wider determinants of health
- Ensure targeted provision reaches those with greatest vulnerability

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Preventing and managing Long-term conditions (LTCs)

to enhance both length and quality of life and reduce health inequalities

Key achievements – Long Term Conditions

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- We are working with North Central London (NCL) STP partners to implement projects funded by the **National Diabetes Transformation funding** (including increasing the number of patients reaching 'treatment control' targets in primary care, expanding the number of diabetes inpatient nurses in NCL and establishing a multidisciplinary diabetic foot team at Royal Free).

- We have supported the development of a NCL wide programme of work to improve **Atrial Fibrillation (AF) management** including training practice based pharmacists and supporting the delivery of the NHS virtual clinic demonstrator programme, which provides primary care with access to specialist secondary care pharmacists to increase the number of people receiving treatment for AF to **reduce their risk of stroke**.

- Cancer Transformation Funds have been used to successfully deliver a local social marketing campaign in partnership with Claremont using local health champions to increase uptake of **cervical screening within BAME communities**. In addition, Islington GP federation have been commissioned to deliver a telephone recall programme to follow-up with women who have missed their cervical screening.

- **Proactive Islington** has developed and agreed a new physical activity action plan with partners (2019-2024). The plan supports our least active residents by promoting local activity assets & opportunities more effectively, bringing activity onto our estates, ensuring we have an expert and diverse workforce, and through joint work with the NHS.

Key achievements – Long Term Conditions

ISLINGTON

Islington has developed the Islington Food Poverty Action Plan (2019-2022). Islington has been recognised as the best performing borough in London's 2019 food poverty profile. The local plan will ensure continued focus on this key issue.

Islington & Camden's Parks for Health initiative was awarded £667k by the National Trust and the National Lottery Heritage Fund. This ground breaking programme focuses on supporting more residents with the greatest health and wellbeing needs to regularly access our parks and open spaces, and to transform the local parks and green spaces offer, including enabling parks staff to more effectively support health & wellbeing outcomes.

Our behaviour change services continue to deliver a high quality support offer to Islington residents. During 2018-19:

- **14,958** people were offered an NHS Health Check at their general practice, and 6,417 people took up the offer.
- **637** pre-diabetics residents have been referred onto the NHS Diabetes Prevention Programme.
- **1007** residents who attempted to stop smoking using the Breathe service did so successfully, representing a 53% stop smoking rate. A third of these service users (665 people) had a long-term condition (52.5% stopped smoking). 205 service users disclosed a history of mental health problems (50% stopped smoking).
- **3,986** Islington residents were referred to adult weight management and exercise on referral services. More than one in four (1,102) reported they had musculoskeletal conditions, one in five (850) had diagnosed high blood pressure, and one in seven (616) had type 2 diabetes. Of those who completed the programme, 56% lost at least 3% of their body weight.

Key achievements – Long Term Conditions

ISLINGTON

- The top 3 contributors to **premature mortality in Islington are cardiovascular disease, cancer and respiratory illness**.

- Long term conditions account for an estimated **70% of health and social care expenditure**. Older adults are one of the fastest growing population groups and the **number of people living with long term conditions is expected to increase**, with more people living with multiple long term conditions.

- **Inequalities** in long term conditions relating to ethnicity, deprivation and people living with mental health conditions or disabilities is a key challenge.

- An estimated 5,350 people are living with **undiagnosed diabetes** in Islington. The prevalence of diabetes is expected to increase to 8.9% by 2035, in line with increasing prevalence of excess weight.

- Islington is significantly below the **detection and treatment targets for atrial fibrillation and hypertension**; detecting and treating both these diseases is key to reduce the incidence of and mortality from stroke.

- Increasingly cancer is seen as a long term condition. **Uptake of cancer screening** in Islington (breast, bowel and cervical programmes) is below national targets, and only 55% of all cancers were diagnosed at an early stage in Islington (52% nationally).

Forward look – Long Term Conditions

ISLINGTON

- The coming year will see increased work with partners across the NCL STP to support improvements across long term conditions:
  - We will support the **NCL wide delivery plan on CVD prevention** to target improvements in AF detection and hypertension management over the next two years.
  - We will seek to significantly **increase the number of pre-diabetics referred to NHS DPP** in Islington over the next 3 years, with a focus on increasing the equity of access for BAME communities. We will continue supporting programmes of work supported by the National Diabetes Transformation funding and improve the uptake of structured education programmes for people living with diabetes.
  - To improve early diagnosis of cancer, develop the local evidence base and reduce health inequalities, we will continue to support local delivery of new projects funded via the **Cancer Transformation Fund**.

- Closer meaningful collaboration with partners on supporting residents to change unhealthy behaviours will also be a key theme. Across the council, NHS and third sector we will:
  - Further develop Islington's **whole systems approach to obesity**.
  - Drive improvements to **physical activity services** and opportunities through Proactive Islington.
  - Test how we can make our **parks and open spaces** public health assets that attract more residents with greater health and wellbeing needs.

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Improving mental wellbeing

Key achievements - Mental wellbeing

ISLINGTON

- 5,148 people entered **Improving Access to Psychological Therapies** (IAPT) treatment in 2018/19 in Islington; this is approximately 17.4% of those estimated to have a common mental health problem. The national access target has risen from 15% to 20% for 2019/20. Just over 51% of those who enter treatment recover after treatment, above the national target of 50%.

- Public Health funded **mental health promotion services** include mental health awareness training. In 2018/19 the service in Islington trained **642** people.

- There has been an overall **downward trend in suicide rates** in Islington over the last 10 years. A multi-agency suicide prevention strategy and steering group has been developed with good engagement from all relevant partners. We have informed Thrive LDN's work to develop a pan-London reporting hub for suicides, which is now live. This will increase swift identification of deaths by suicide, inform our response and provide a better understanding of trends.

- Islington is leading the commissioning of an NCL **Support after Suicide Service** to provide support for those affected by suicide, who themselves are at increased risk of suicide.

- **Training in suicide awareness** for non-clinical frontline staff in the borough has proved very popular.

Key achievements - Mental wellbeing

ISLINGTON

Workplace mental health and wellbeing continues to be a focus for Public Health, working with employers to raise awareness of their role towards ensuring that employees have access to the right policies, support and environments to positively impact their mental health and wellbeing. CMB have recently agreed a Council-wide Workforce Strategy, which includes actions to improve the mental health of staff.

- **Dementia** is not an inevitable part of ageing. However, 5% of Islington's older population have a diagnosis of dementia. Islington has previously been recognised as having the **7th highest recorded dementia prevalence** in people aged 65+ in England, this means that the number of people living with dementia who have not been diagnosed is very low (estimated to be less than 20 undiagnosed cases). Islington is one of three areas nationally identified by NHS England as having an **exemplar clinical model**. Key strengths include:
  - Diagnosis: In 2019, Islington's estimated dementia diagnosis rate in older adults was 86.9% (significantly higher than the London and England rates).
  - Proportionality: people are triaged by complexity of needs to the appropriate professional.
  - Continuity of care: from diagnosis to death.
  - Support for carers: a well-regarded offer.

Key challenges - Mental wellbeing

ISLINGTON

- The relationship between **poor mental health outcomes and deprivation/social disadvantage** works in both directions; factors such as poor housing, poverty, unemployment and other causes of deprivation increase the risk of mental illness, but these issues/factors are also caused or exacerbated themselves by mental health conditions.

- The **Community Mental Health and Wellbeing service** in Islington aims to promote awareness of mental health and mental wellbeing, challenge the stigma associated with mental illness, and increase access to mental health services across all Islington communities, and particularly within identified excluded communities for example black and ethnic minority groups, older people and men. During 2018 /19 the project had 75 residents working as Mental Health Champions.

- Physical health and mental health are inextricably linked. **Life expectancy is lower among people with some mental health conditions,** and this is **largely attributed to long term physical conditions**. Younger people (aged 15 to 34 years) with SMI experience the greatest level of health inequalities. They are 5 times more likely to have 3 or more physical health conditions than the general population.

- Older adults are one of the fastest growing population groups and the number of **people living with dementia is expected to increase**. In December 2017, Islington members approved a motion to become a Dementia Friendly Community, making dementia a priority area for Islington.

Forward look - Mental wellbeing

ISLINGTON

- **Embedding a Public Mental Health approach** will be a key element of the work that we do around mental health in the coming year. The approach includes:
  - promoting good mental health and wellbeing,
  - preventing the development and escalation of mental distress, and, mental health problems,
  - improving the lives of people living with, struggling with and recovering from mental health problems.
- We are already achieving a lot in the Public Mental Health space e.g. our Making Every Contact Count and mental health training and work with BAME groups. UCL are conducting research into best practice around what else should be done on a local basis, and, to **devise outcome measures to enable areas to ascertain achievements**. We are a pilot site, which will help us to understand any gaps in the work we are doing and to be able to ascertain how well we are performing.
- We already know that there is more we can do to ensure our existing Public Mental Health work is embedded across the system and to do this we are working with CCG Joint Commissioner colleagues, and through the **Mental Health Partnership Board**, which has Experts-by-Experience and a wide-range of NHS and community and voluntary sector stakeholders in attendance.
- The **Community Mental Health Framework**, which is part of the NHS Long Term Plan, is an excellent opportunity that puts wellbeing and mental ill-health prevention at the heart of mental health services, it joins up support for issues that impact on our mental health and wellbeing. We will be working closely with our NHS colleagues to implement this.
- Supporting primary care to promote the importance of a healthy lifestyle to reduce the risk of developing dementia during the NHS Health Check for 40-64 year olds. Public health have commissioned Alzheimer's Society to support Islington to become a **Dementia Friendly Community**.

Transformation programmes

ISLINGTON

Sexual health:

- The **Young People's Sexual Health Network** (Camish) continues to see high numbers of young people across its three clinics, as well as delivering clinical and educational outreach into young people settings across Camden and Islington.
- While also delivering a programme of **Relationship and Sex Education (RSE)** in secondary schools, Camish have started working to support the preparation and planning of statutory RSE, which is being rolled out in September 2020.
- In terms of adult sexual health services, work continues with partner boroughs (Camden, Haringey and Barnet) to embed the **complex and significant service transformation** with the commissioned provider, Central North West London NHS Foundation Trust (CNWL). Whilst CNWL have been implementing the new service model, service performance has remained stable throughout the year.
- The **sexual health e-service (online testing)**, a key part of transforming sexual health services, has seen increases in the numbers of people accessing testing through this route and this service has also been integrated into the young people's sexual health clinics to increase access and self management for the 'older' users of young peoples services. As a result, **online testing is increasing** as a proportion of overall testing for local residents.
- The London Programme for Sexual Health is leading negotiations around the possible further **expansion of the PrEP trial**. Currently NHSE fund the drugs but other costs are borne by the local sexual health system (LA commissioners and NHS providers). As of September 2018, we estimated there were around 350-400 residents on PrEP in Islington.
- A key priority moving forward is to ensure that **young people have quick access to clinical and educational sexual health services**, and prioritising access for those most at risk. This means creating capacity for more targeted work, through improving access to self-care options and through targeted training of community services that are used and trusted by young people, to deliver sexual health interventions and support.

Transformation programmes

ISLINGTON

Drug and alcohol services:

- **Better Lives**, the **new Islington drug and alcohol service** started on the 1st April 2018. The lead provider for the service is Camden and Islington NHS Foundation Trust. The first 18 months of the contract have been challenging logistically, Camden and Islington NHS Foundation Trust have invested significant amounts of money into refurbishments in order to give **service users, their families and staff comfortable and welcoming environments in which to transform their lives**, and this work has taken longer to complete than originally planned.

- Whilst building and site work has been ongoing the service has been focussing on developing newer elements of the service and **partnerships with a number of key stakeholders**.

- This new contract and service model represents a very significant move away from the previous model and ways of working. It was therefore acknowledged that, owing to the significant mobilisation and change processes that the provider needed to implement to establish this new service model, performance during the first year of the contract (18/19) was likely to be impacted. However, Q1 of 2019/20 has already seen **improvements in performance**:
  - 4% increase in numbers in effective treatment (to 95.2%)
  - Increases in treatment successful completions for opiate, non-opiate, alcohol and alcohol and non-opiate

Islington's Joint Health and Wellbeing Strategy

ISLINGTON

- Over the coming months planning will start for the **development of Islington's new Joint Health and Wellbeing Strategy**
- The new strategy provides an opportunity to:
  - lay out a **clear shared vision** for improving health and wellbeing of residents and reducing health inequalities to make Islington a fairer place
  - further cement a **population health approach** for Islington, with an increased focus on prevention and early intervention
  - help maintain a focus on **the key issues that impact on the health and wellbeing** of Islington residents
  - build on the work taking place to deliver the **integration of health and care** across the borough, supporting a system shift away from high cost services to more community-based models of health, care and support, and making more efficient use of system resources
- The strategy will be coproduced with partners and residents
- We welcome Health Scrutiny committee engagement and input into the new strategy as it develops, during the course of 2020

Appendix 1:Measuring progress against
Islington's HWBB priorities

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		Islington			London average
		Time period	Value	3 year trend (where possible)	
Ensuring every child has the best start in life	Percentage of new births that received a visit within 14 days	2018/19	93%	No change since 2016/17	93%
	Percentage of two year olds receiving a development check	2018/19	79%	No change since 2016/17	68%
	Percentage of 5 year olds achieving a good level of development	2019	71%	Up from 66% in 2016	74%
	Percentage of 3-4 year olds accessing funded early education programmes	2019	86%	No change since 2016	82%
	Percentage of Reception children who are overweight or obese	2018/19	21%	No change since 2015/16	22%
Preventing and managing long term health conditions	Rate of 4 week smoking quits	2018/19	2,400 per 100,000		1,432 per 100,000
	Rate of hospital admissions for alcohol related conditions	2017/18	736 per 100,000	No change since 2014/15	533 per 100,000
	Gap in employment rate between those with a long term health condition and overall employment rate	2017/18	9%	Down from 20% in 2014/15	12%
	Under 75 mortality rate from cardiovascular disease considered preventable	2016-18	52 per 100,000	No change from 2013-15	43 per 100,000
	Under 75 mortality rate from cancer considered preventable	2016-18	92 per 100,000	No change from 2013-15	69 per 100,000
	Under 75 mortality rate from respiratory disease considered preventable	2016 -18	21 per 100,000	No change from 2013-15	17 per 100,000
Improving mental health	The number of people entering IAPT services as a proportion of those estimated to have anxiety and/or depression	2018	17%	No change since 2015	17%
	Age standardised mortality rate from suicide and injury of undetermined intent	2016-18	10 per 100,000	No change since 2013-14	8 per 100,000
	Gap in employment rate for those in contact with secondary mental health services and overall employment rate	2017/18	74%	Up from 65% in 2014-15	68%

London Comparison:

- Significantly better than London average
- Similar to London average
- Significantly worse than London average

Trend:

- Significantly better
- No change
- Significantly worse

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ISLINGTON

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

Report of: Executive Member for Health and Social Care

Meeting of	Date	Agenda Item	Ward(s)
Health and Social Care Scrutiny Committee	**21 January 2020**		**All**

Delete as appropriate	~~Exempt~~	Non-exempt

Report: Q1 and Q2 2019/20 Performance Report

1. Synopsis

1.1. Each year the Council agrees a set of performance indicators and targets which, enables the monitoring of progress in delivering corporate priorities and working towards the goal of making Islington a fairer place to live and work.

1.2. Progress is reported on a quarterly basis through the Council's Scrutiny function to challenge performance where necessary and to ensure accountability to residents.

1.3. This report provides an overview of progress in the first two quarters of 2019/20 (1 April 2019 to 30 September 2019) against corporate performance indicators related to Health and Social Care.

2. Recommendations

2.1. To note progress at the end of quarter two against key performance indicators falling within the remit of the Health and Social Care Scrutiny Committee.

3. Background

3.1. The Council routinely monitors a wide range of performance measures to ensure that the services it delivers are effective, respond to the needs of residents and offer good quality and value for money. As part of this process, the Council reports regularly on a suite of key performance indicators which collectively provide an indication of progress against the priorities which contribute towards making Islington a fairer place.

4. Implications

4.1 **Financial implications**

There are no financial implications arising as a direct result of this report.

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

4.2 **Legal implications**

There are no legal implications arising from this report.

4.3 **Environment implications**

There are no significant environmental implications resulting from this report.

4.4 **Resident impact assessment**

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

A Resident Impact Assessment has not been completed because this is a report providing information about performance at the end of quarter two 2019/20.

5. Adult Social Care

ADULT SOCIAL SERVICES								
Objective	**PI No.**	**Indicator**	**Frequency**	Q2 2019-20	Target 2019-20	On/Off target	Same period last year	Better than last year?
Support older and disabled adults to live independently	ASC1	Average number of social care beds delayed per day	M	5.6	5.0	On	5.8	Yes
	ASC2	Percentage of people who have been discharged from hospital into enablement services that are at home or in a community setting 91 days after their discharge to these services	A	95%**	95%	NA	NA	NA
	ASC3	Percentage of service users receiving services in the community through Direct Payments	M	24%	30%	Off	24%	Same
Support those who are no longer able to live independently	ASC4	Number of new permanent admissions to residential and nursing care (aged 65 and over)	M	51	134	On	78	Yes
Reduce social isolation faced by vulnerable adults	ASC5	The percentage of working age adults known to Adult Social Care feeling that they have adequate or better social contact.	A	78%***	80%	NA	NA	NA

**Reablement indicator is reported annually for Q3 in line with ASCOF indicator 2A, updated expected for Q4 report. The 2018/19 figure was calculated with the assumption that anyone who was neither dead nor in nursing or residential care was assumed to still be at home 91 days after reablement.

***Social isolation indicator is reported annually, update expected for Q4 report

Data Quality Note: Data is to the end of September 2019, as at 8 October 2019. Figures are subject to change due to delays in loading information onto adult social care data systems and continuing data quality improvements.

5.1 Delayed transfers of care (DTOC)

5.1.1 Social Care delayed transfers of care are at 5.6 beds per day at quarter 2 over the target of 5.0 beds per day, but at a lower rate than at the end of Quarter 2 2018/19.

5.1.2The national Better Care Fund (BCF) target for Islington has changed this year to reflect just the total average beds delayed per day rather than distinguishing by responsible organisation. At the end of August 2019, we have averaged 19.4 total delayed beds per day, slightly higher than the target rate of 16.0. This higher rate of beds per day is due to a very high NHS Delays figure in August 2019, which we are investigating with Islington CCG.

5.1.3 To improve the rate of delayed transfers of care, processes have been reviewed and supports strengthened within the local system, with daily DTOC teleconferencing calls for UCLH,

and continued management attendance at the Multi-Agency Discharge Event (MADE), held twice-weekly with partners at Whittington Health and Haringey at the main acute trust.

5.1.4 In addition there are weekly heads of service/AD escalation meetings chaired by the local authority and CCG with the Whittington, UCLH and St Pancras to ensure that complex DTOC cases are resolved and there is a strategic approach in identifying themes and recurrent issues to be addressed and resolved. These strategies will be under constant review, collaboratively led by the CCG and local authority.

5.2 Discharge to home or community setting

5.2.1 At the end of 2018/19, 95% of people discharged from hospital into enablement services were at home or in a community setting 91 days after their discharge, meeting the target of 95%. *There is no update to this figure for Quarter 2 2019/20 as this target is presented for Quarter 3 cases only, in line with Short And Long Term support reporting and ASCOF indicator 2B. An update is expected for Quarter 4*. The Discharge to Assess service continues to operate as one of the main pathways for people discharged from acute hospitals into the community. Pathway 1 is dedicated to those who have rehabilitation needs and goals that can be met at home via the Reablement service. The person is supported with up to 6 weeks of care, therapy and reviews, and then set up with an ongoing care package via a care agency should it be required following Reablement.

5.2.2 We are continuing to work flexibly with our acute partners in co-ordinating hospital discharges and ensuring they have full utilisation of our pathways. We have successfully expanded our daily offer and capacity to hospitals without the requirement of additional resources.

5.2.3 The Admission Avoidance pathway continues to operate as an additional route into Adult social care from the Rapid Response acute community service. This ensures service users receive timely access to the relevant social care support following a period of ill health, whilst also remaining in their own homes.

5.2.4 Reablement's scheduling system has been updated to ensure service outcomes for those discharged via Discharge to Assess and/or following a period of Reablement are recorded. This is on top of the already collated information from Discharge to Assess regarding bed days saved, hospital re-admissions, referral cancellations and delays. Evaluation of this information is received via monthly or quarterly reports and shared with our Health/CCG partners.

5.2.5 Work has commenced in establishing a true single point and route of access into Adult social care from all hospitals and community settings, as part of the Adult social care plan 2019-21. This work involves integrating the existing entry points into social care from hospital or the community virtal ward including Hospital Social Work, Single Point of Access / Discharge to Assess, and Reablement teams. This is also part of the Intermediate Care work with CCG and Whittington Health. The main objectives of this work is the creation of one referral process, quicker access to social care support for the service user, reduced DToCs, and consistency in strength-based and person-centred practice.

5.3 Direct Payments

5.3.1 In Q2 of 2019/20 24% of all Islington community care and support is provided through Direct Payments, compared to 24% at this point last year. The total number of service users receiving services in the community through direct payments has also remained steady compared to last year, 633 compared to 634 at this point last year.

5.3.2 Feedback from the 2018 service user survey continues to showed that direct payment recipients felt that they had the most "choice and control over their care and support services" and had the highest percentage of those "extremely" or "very" satisfied with their service, which ties into our corporate value of Empowering service users.

5.3.3 Personalisation is a key work stream of the Adult Social Care Plan 2019-2022. Building on the Spark a Solution mapping project, and the Personal Assistants (PA) Pathway Proposal, we are partnering with an organisation called 'In-Control' who work with Councils to support them in increasing uptake of Direct Payments to make it the default choice, and looking at how to ensure the market is meeting the needs of those who choose Direct Payments. This will involve a review of all of our processes and policies, with a view to updating and improving our offer to people receiving Direct Payments. In Control will also be working with us to embed the POET tool (Personal Outcome Evaluation Tool) into our review process, to accurately capture whether people's outcomes in relation to personalisation are being met. We aim to develop a new training offer for social work staff regarding our approach to personalisation, and updated policies and procedures.

5.3.4 We are working with our colleagues in Children's services to ensure that our personalisation offer is consistent and allows a clear and supportive transition for young people moving into adulthood. We are also working with our partners in health to ensure a coordinated approach to personalisation, and the sharing of knowledge and expertise. This is being taken forward in conjunction with the wider work around moving towards more locality-based ways of working, making the offer more relevant to where people live.

5.3.5 We have recently re-formed the Direct Payments Forum, so that people using Direct Payments and their carers can discuss issues arising with Direct Payments processes and their experiences with council staff, and make suggestions for improvements. We have invited interest from people using Direct Payments and their carers to set up a co-production working group to take forward actions from the forum and plan future events. These include setting up a peer support group for people using Direct Payments, and improving the training and support offer to people using Direct Payments and their PAs, and making it easier for people to find PAs. We anticipate this co-production approach will enable us to respond more quickly and appropriately to issues arising with our Direct Payments infrastructure, and improve Direct Payment uptake.

5.4 Admissions into residential or nursing care

5.4.1 The Council provides residential and nursing care for those who are no longer able to live independently in their own homes. The aim is to keep the number of permanent placements as low as possible, supporting more people to remain in the community. To maintain the same target rate per 100,000 residents aged 65 and older as 2018/19, the target for 2019/20 is 134 new placements. At the end of Quarter 2 2019/20, we have had a total of 51 new placements of people aged 65 and older. This places us on target for 2019/20 and is an improvement against the same point in 2018/19 (78 placements). To address last year's rise in placements, adult social care has implemented a new assurance process at the start of Q1 19/20. This assurance process includes senior management review and implementation of a strengths based approach to consideration

of care options. This is already beginning to reduce the number of placements where other care options were appropriate.

5.4.2 In the year to date up to the end of Quarter 2, there have been 510 placements in nursing or residential care homes for service users aged 65 and over. New admissions have accounted for 15% of these placements. We have had an additional 1,062 placements with long term homecare services for service users aged 65 and over in the year to date.

5.5 Reducing social isolation

5.5.1 Social isolation refers to a lack of contact with family or friends, community involvement or access to services. Results from the 2018/19 Social Care User Survey show an increased percentage of working age adults known to Adult Social Care feeling that they have adequate or better social contact (78%, compared to 70% in 2017/18). *This indicator is updated annually so was not updated for this report.*

5.5.2 There is a Strengths Based Approach and Framework for practice in place within Adult Social Care; Building Strengths for Better Lives. This focuses on enabling people to be as independent as possible, contributing and being connected to their local community as well as being supported by it. It is an optimistic, person-centred approach, believing that people can live the lives they want by making best use of informal support networks such as family, friends and community without having to be reliant upon funded support. This approach encourages social connection and contribution, thereby reducing loneliness and isolation.

5.5.3 All staff in Adult Social Care are expected to work in a Strengths Based way and this will be continually monitored and further embedded. Information for people who need support, carers and staff is vital to support this approach. Work has already been done to improve the ASC Information offer by improving the ASC Web pages and also developing an Independent Living Guide which is a booklet recently published, accompanied by an e-version for the website. Further work on enhancing the information about what support is available in the community is underway by commissioning and operational teams and this again will help to reduce social isolation.

6. Public Health

Objective	PI No	Indicator	Frequency	Actual June - Sept 19	Expected profile	2018/19 annual target	On/Off target	Same period last year	Better than last year?
Support people to live Healthy Lives	HE1	Percentage of smokers using stop smoking services who stop smoking (measured at four weeks after quit date)	Q	59.2%	50%	50%	On	54%	Yes
Effective detection of health risk	HE2	Percentage of eligible population (40-74) who receive an NHS Health Check	Q	3.3%	3.3%	13.2%	On	3.3	Same
Tackle mental health issues	HE3	a) Number of people entering treatment with the IAPT service (Improving Access to Psychological Therapies) for depression or anxiety	Q	1492	1473	5892	On	1217	Yes
		b) Percentage of those entering IAPT treatment who recover	Q	50.8%	50%	50%	On	50%	Yes
Effective treatment programmes to tackle substance misuse	HE4	Percentage of drug users in drug treatment during the year, who successfully complete treatment and do not re-present within 6 months of treatment exit	Q	12.7%	20%	20%	Off	15.6%	No
	HE5	Percentage of alcohol users who successfully complete their treatment plan	Q	37.7%	42%	42%	On	28%	Yes
Improve sexual health	HE6	Number of Long Acting Reversible Contraception (LARC) prescriptions in local integrated sexual health services	Q	355	275	1100	On	298	Yes

Reduce prevalence of smoking

6.1.1 The Q2 quarterly figure of 225 four week smoking quits against a target of 200 showed clear improvement on the previous quarter when the service missed its target by 12 quits. The quit rate in Q2 was 59.2%, over the 50% target.

6.1.2 Over half of all people who quit with the service were from key target populations with high rates of smoking. The service's outreach work continues to build good links with these key groups and communities, through work in and with community centres, markets, faith organisations and businesses. Partnership work with Octopus Communities is helping to build a team of trained smoking cessation volunteers. The service continues to focus on trying to improve engagement and quit outcomes amongst housebound smokers with respiratory conditions, and pregnant

women and working with secondary care to increase the referral of smokers into community stop smoking support services.

6.2 Effective detection of health risk

6.2.1 NHS Health Checks is a national programme, delivered locally, and designed for residents aged between 40 and 74 who are at increased risk of cardiovascular disease (including stroke, kidney disease, heart disease and diabetes). At the check, residents' risk of cardiovascular disease is calculated from a range of measurements (e.g. cholesterol, blood pressure), and conversations take place to support the individual to reduce their risk through behaviour change, referral to lifestyle services and clinical interventions.

6.2.2 In Q2, 3.3% of eligible residents (1199 people) received an NHS Health Check, tailored lifestyle advice and where appropriate referral into services to reduce their risk of cardiovascular disease, meeting the quarterly target and an improvement on the previous quarter. The 2019/20 cumulative year to date figure is above that achieved for the period last year (i.e. 6.4% vs 6.1%).

6.2.3 The government's Prevention Green Paper signalled a national review of the NHS Health Check programme, including consideration of how the programme can become more targeted to reach those at greatest risk of cardiovascular disease, as well as how digital technologies and approaches might enable more effective delivery of the programme.

6.3 Tackling mental health issues

6.3.3 Public Health commission services to raise awareness and understanding of mental health and mental illness, to reduce stigma and to support early access to mental health services and early signposting to support. This is through the wide provision of mental health awareness training (including Mental Health First Aid training) and MECC (make every contact count); the community wellbeing service, aimed specifically at reducing stigma and raising awareness in communities with low access to services; and work with children and young people through schools, and in community youth settings.

6.3.1 In Q2, 1492 people accessed support for common mental health problems through the Improving Access to Psychological Therapy (IAPT) programme. Performance exceeds the quarterly target (1473), and shows an improvement from this time last year when 1217 people accessed the service. This represents good progress towards the overall aim of the service to see 19% of the eligible population (i.e. 19% of adults estimated to be suffering from a common mental health problem) by the end of the year, but is slightly below the cumulative target for this point in the year (2836 vs 2946).

6.3.2 The percentage of Islington residents entering IAPT treatment who recover is in line with the national target (50%), at 50.8%

Alongside IAPT service provision, a range of mental health awareness, training and promotion programmes are in place to build awareness, signpost residents into local services and tackle stigma, encouraging residents to seek help and support for their mental health.

6.4 Effective treatment programmes to tackle substance misuse

6.4.1 Q2 data demonstrates an improvement in performance across both indicators. Successful completions for both drug and alcohol users have increased, although both are still below target. Commissioners are continuing to work with and support Better Lives (service provider) to improve

performance further, which includes closely monitoring the service improvement plan produced by the provider.

6.4.2 Better Lives has been able to demonstrate further success in other areas of service delivery. The new BOWS (Benzodiazepine and Opiate Withdrawal Service) established in October 2018 works with GP practices to reduce the number of benzodiazepine and opiate prescriptions at their practice, and supporting primary care patients to reduce or stop their prescribed benzodiazepine or opiate use. Since October 2018, the service has completed 119 assessments and 41 detoxes.

6.4.3 Better Lives has also been focussing on developing their partnerships with a number of key services and providers. This has included:

- Islington Young Carers group - exploring how Better Lives Family Service can identify and support young carers who have parents in treatment
- Islington Safer Neighbourhoods team - working together to enhance outreach provision in the borough
- Future Parks Project – identifying how Better Lives service users can access these parks and green spaces to enhance and sustain their recovery
- Adult Learning Islington – to discuss how Better Lives service users can access adult learning opportunities

VCS Organisations – to offer drug and alcohol awareness training to community organisations.

6.5 Improve sexual health

6.5.1 Data for Q2 shows Islington to be on target for Long Acting Reversible Contraception (LARC) and to be in excess of the quarterly target.

6.5.2 Islington's sexual health service provider, CNWL, continues to upskill their nurses to increase capacity for LARC prescribing throughout the service. Commissioners are also working with CNWL to oversee the implementation of an action plan for increasing appropriate use of London's online e-service, Sexual Health London. This "channel shift" to the online service is important, in order to free up adequate capacity within sexual health clinics to meet the needs of residents requiring face-to-face access and services e.g. LARC prescribing, management and review of participants on the national PrEP trial.

6.5.3 CNWL have also started redesigning the web site to ensure a more streamline approach to booking appointments on line. The second element to this work will be to be for CNWL to able to link their internal booking system to their updated website (rather than an external system they currently use), this second piece of work will follow in early 2020

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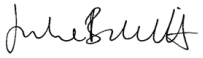
Signed by 

Julie Billett – Director of Public Health

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Received by …… ……
Date

HEALTH AND CARE SCRUTINY COMMITTEE – WORK PROGRAMME 2019/20

15 JULY 2019

1. Camden and Islington Mental Health Trust - Performance update
2. Scrutiny Review – Adult Paid Carers – witness evidence
3. Health and Wellbeing Board update
4. Work Programme 2019/20
5. Walk in Centres update

10 SEPTEMBER 2019

1. NHS Whittington Trust – Performance update
2. Scrutiny Review – Adult Paid Carers – witness evidence
3. Health and Wellbeing update
4. Performance update – Quarters 3 and 4
5. Work Programme 2019/20

10 OCTOBER 2019

1. Health and Wellbeing update
2. Work Programme 2019/20
3. Scrutiny topic – Adult Paid Carers – witness evidence
4. Healthwatch Annual Report/Work Programme

21 NOVEMBER 2019

1. Scrutiny Review – Adult Paid Carers – witness evidence
2. Health and Wellbeing Update
3. Work Programme 2019/20
4. Alcohol and Drug Abuse update
5. Annual Safeguarding report
6. London Ambulance Service – Performance update
7. Performance indicators – Quarter 1

30 JANUARY 2020

1.Scrutiny Review – Adult Paid Carers - witness evidence
2 Health and Wellbeing update
3. Work Programme 2019/20
4. Local Account
5. Executive Member Health and Social Care - Annual Report
6. Performance update – Quarter 2

10 MARCH 2020

1. Scrutiny Review – Adult Paid Carers– witness evidence
2. Health and Wellbeing update
3. Work Programme 2019/20
4. Annual Health Public Report
5. UCLH Performance update

02 APRIL 2020

1. Health and Wellbeing update
2. Work Programme 2019/20
3. Scrutiny Review –Adult Paid carers– Draft recommendations
4. Moorfields NHS Trust – Performance update

11 JUNE 2020

1. Scrutiny Review – Adult Paid Carers – Final Report
2. Health and Wellbeing update
3. Work Programme 2020/21
4. New Scrutiny topics – to be decided
5. Quarter 3 - Performance update
6. Membership/Terms of Reference etc.

JULY 2020
Quarter 4 Performance update/Council Targets 2020/21
Scrutiny Review – GP Surgeries 12 month report back