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 The Council Chamber, Town Hall, Upper Street, N1 2UD on, **15 April 2024 at 7.30 pm.**

Enquiries to : Samineh Richardson
E-mail : democracy@islington.gov.uk
Despatched : 5 April 2024

Membership

Councillors:
Councillor Jilani Chowdhury (Chair)
Councillor Joseph Croft (Vice-Chair)
Councillor Janet Burgess MBE
Councillor Tricia Clarke
Councillor Fin Craig
Councillor Mick Gilgunn
Councillor Caroline Russell
Councillor Claire Zammit

Substitute Members

Substitutes:
Councillor Benali Hamdache
Councillor Heather Staff
Councillor Flora Williamson

Quorum: is 4 Councillors

A.	**Formal Matters**	**Page**
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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.	Moorfields Eye Hospital Performance Report	19 - 46
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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 11 June 2024

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London Borough of Islington

Health and Care Scrutiny Committee - Monday, 4 March 2024

Minutes of the meeting of the Health and Care Scrutiny Committee held in the Council Chamber, Town Hall, Upper Street, N1 2UD on Monday, 4 March 2024 at 7.30 pm.

Present: **Councillors:** Chowdhury (Chair), Croft (Vice-Chair), Burgess, Clarke, Craig, Gilgunn and Russell

Councillor Jilani Chowdhury in the Chair

37 INTRODUCTIONS (ITEM NO. 1)

The Chair welcomed everyone to the meeting and members and officers introduced themselves. Fire safety, webcasting and microphone procedures were explained.

38 APOLOGIES FOR ABSENCE (ITEM NO. 2)

None. Apologies for lateness received from Councillor Gilgunn

39 DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. 3)

None.

40 DECLARATIONS OF INTEREST (ITEM NO. 4)

Councillor Finn Craig declared an interest in items on the agenda insofar as they related to Great Ormond Street Hospital and Whittington UCL.

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

RESOLVED:

That the minutes of the meeting held on 23 January 2024 be confirmed as an accurate record of proceedings and the Chair be authorised to sign them.

42 CHAIR'S REPORT (ITEM NO. 6)

The Chair thanked Councillors who attended the three evidence gathering sessions for the scrutiny review into access to GP services and Adult Social Care. Members had now heard from a number of residents and were very grateful to the residents who had taken the time to feedback on this topic. Particular themes were definitely emerging, around e-consult and digital access, staff retention and training, and access via phonelines and to familiar members of staff.

The Chair invited Councillors who had attended the sessions to report back to the Committee.

Councillor Burgess said that the sessions were interesting. Two of the attendees had children with special educational needs and a third was a user of the Shared Lives Service, which provided foster care for adults. This latter person had cared for two or three different people in her home, over a period of about forty years, and was content with all that the Council had provided by way of support. Her son, who had supported her, was also going into the same service, which was a positive for continuity. The Chair of the Family Carers' Group and another member of that group

who had a very disabled son, had raised the issue of what would happen when they were no longer able to look after their children. This was a major worry for many people in the same circumstances. Another worry was not being able to hire personal assistants. Recipients were happy with the direct payments from the Council, but there was a shortage of personal assistants. The lack of suitable staff willing to do this type of caring was a major concern at the present time in Social Services generally.

Councillor Clarke had attended an Age UK meeting, which was well attended, by approximately 60 people. The theme of the meeting was access to GP surgeries. There seemed to be a split in the Borough, with some people struggling with digital exclusion and experiencing difficulty with the e-consult forms and others able to walk in to, or telephone, their surgery, to make an appointment. Concern had been expressed about people with mental health or learning difficulties being able to make appointments with GPs, as many of them could not access or navigate the e-consult form. She suggested that this was an issue upon which the Committee needed to make a recommendation. The other matter considered was the question of people not being aware of, or not knowing how to access, the seemingly plentiful Adult Social Care resources in Islington. She anticipated that the establishment of hubs could help in this regard, advising people on getting the help they needed, given this apparent inequality of service. Some users had mentioned that staff had been rude to them on the telephone and of their difficulties in accessing the complaints system and in receiving responses. Attendees had also mentioned the amount of time they had wasted on the telephone, waiting for responses from GPs or Social Services. Some attendees had mentioned the helpfulness of pharmacies. Safeguarding had also been raised as an issue, with an example given of an issue being raised with the Safeguarding Team and no response having been given for four months, which could also be considered as an area for a recommendation.

Councillor Burgess concurred with the point about the digital divide faced by users and said that a carer of a person with severe needs simply would not have the time to engage with IT to access forms. Also a point had been made that it would make an enormous difference to someone with a learning disability to be looked after by the same GP at each visit.

The Chair stated that the minutes from the sessions would be circulated to members. The recommendations of the review had been moved to the April meeting to allow time for consideration of residents' feedback and the presentation from the Access Islington Hubs, which was due to be considered later at this meeting

The Chair asked Committee members and everyone presenting to keep presentations and questions short and to the point.

43 PUBLIC QUESTIONS (ITEM NO. 7)

None.

44 UNIVERSITY COLLEGE LONDON HOSPITALS (UCLH) PERFORMANCE UPDATE (ITEM NO. 8)

The Committee received a presentation from Simon Knight, Director of Planning and Performance, and Liz O'Hara, Director of Workforce, UCLH NHS Foundation Trust, on performance against key targets. The Committee had also requested an update on staff morale, which would also be covered in the presentation.

On the quality of care provided:

- Infections – all hospitals were required to monitor infections carefully. Numbers of MRSA cases had been kept low for the past few years. UCLH had more cases of clostridium difficile than other hospitals and it was thought that this was principally driven by the fact that UCLH looked after a number of cancer patients. However, these numbers remained below the target set for UCLH, which was somewhat reassuring.
- A good indicator of nursing care was the low number of patients with pressure ulcers, with numbers remaining no higher than seven or eight each month. As a result of following best practice, UCLH was proud of the low number of these cases.
- Another good indicator of the quality of care was demonstrated by the comments by patients about services. UCLH compared well to other London Trusts in this respect and appeared top in a table of comparison with peers.
- On the matter of the amount of time patients waited for care, there had been approximately 30,000 patients awaiting treatment in 2010, with the figure rising to 70,000 by 2023. This trend was similar across the country during that timeframe. However, numbers had increased significantly for UCLH in 2019 when a new electronic health system was taken on and which had proved a difficult time for the Hospital, attempting to keep on top of the figures and to work out what was happening in the system. This had also coincided with the Covid pandemic. One of the challenges now was for the Hospital to address the very long waits some patients were experiencing. UCLH was now focusing on patients waiting the longest for treatment
- UCLH was tracked around the longest waits. A couple of years ago, the aim was to ensure that no patient was waiting more than two years, but the focus was now on getting the numbers down to 78 weeks, or a year and a half and 65 weeks, which was 15 months. UCLH had attained the 78 week target by March of last year, although there had been particular spikes in dermatology services, affecting cancer care especially. However, this had now improved.
- On the number of patients waiting for over a year for treatment, current guidance was that no patient should be waiting longer than a year for treatment by the end of March 2025. It was anticipated that this would be a very hard target for UCLH to meet, so time was being spent predicting which specialties were likely to face the most challenge, through mathematical modelling and looking at referral rates and opportunities for maximising outpatient space.
- There had also been a significant reduction in the number of patients seen in time for diagnostic checks, which were meant to happen within six weeks of a referral. The numbers had been affected due to the issues associated with the introduction of the health records system and the Covid19 pandemic, The new standard was that 95% of patients should be seen within six weeks of a referral for a test and UCLH was currently at about 90%. Further improvements were being made to the MRI, which would hopefully assist the Hospital in moving closer to the 95% target in the next couple of months. UCLH performed well on endoscopy.
- Cancer care – UCLH performance had recovered faster, following the pandemic. The target for patients being given a diagnosis from time of referral was 28 days and UCLH had achieved this consistently for the last year and a half, together with the target of patients being treated within 31 days of a decision to treat them. The target of 96% was largely met, apart from a tail off in the past couple of months in the urology service.
- On the 62-day service target for cancer patients, from referral time to treatment for patients, performance had tailed off in the past year. Diagnosis and treatment were performed well at UCLH, but there were challenges with pathways from other Hospitals, where referrals were sometimes late. UCLH

managed to turn around treatment quite swiftly, but not enough to achieve the standard. This was a challenge to the sector as a whole, to try and make those pathways much clearer, along with the accountability for that pathway much clearer. There was room for improvement on this issue.

- A & E – where the main target was for patients to be seen and discharged within four hours, performance had tailed off in the past year or two, which could be attributed to lack of bed capacity. There were also numbers of people attending A&E who could perhaps be seen elsewhere, though UCLH worked well within the sector to ensure that patients went to alternative services.
- On safe care in A&E and the target of ensuring that patients did not wait longer than twelve hours, considered a clinical risk, UCLH had performed well against its London peers until the last quarter.
- Ambulance handover times – the target for which was to make sure that ambulances dropped off patients safely at the Hospital, and then moved on to look after the next patient, UCLH had performed well, close to the 95% target and ambulance handovers at the Hospital taking no longer than half an hour.
- Delayed transfers of care – the position had been improving over the past two or three quarters. UCLH enjoyed good relationships with Council colleagues and those providing services. Due to this, the position felt generally positive and because of the support from partners, UCLH had a relatively low number of patients waiting in Hospital who did not need to be there.
- UCLH's ability to meet all of its targets had been significantly affected by the number of strikes within the Hospital and across the NHS. Patients who needed to stay overnight in Hospital (elective care) were most affected. Fortunately, highest risk patients, including those with cancer, were being managed well, with any cancellations swiftly rebooked. However, the action had had an affect on those patients who had waited longest, as those patients were usually not in as serious a condition and could afford to wait longer for treatment.

- Health, Wellbeing and Morale
  First and foremost, UCLH recognised that good patient care required staff being looked after and health and wellbeing were consequently at the centre as key strategic priorities. The Hospital was fortunate in having a charity which helped to enable some of the issues which mattered most to staff.
- A number of issues had impacted the drive on health, wellbeing and morale within the organisation, including the Covid pandemic. It was recognised that staff needed ongoing support for this.
- Many lower paid staff were affected by the cost of living crisis and much had been done by UCHL as an employer eg providing advice and directing staff to services. Hardship funds had also been set up. On industrial action, UCLH was an open organisation and time and effort had been put into communication with staff. Formal and informal mechanisms of communication with staff had been established. Hospital management enjoyed good relationships with trade unions which had helped with continuing work which needed to take place, with staff feeling valued and respected through these difficult times.
- Health and Wellbeing indicators
  To enable UCLH to measure and have a grip on what was happening with regard to staff morale, one of the biggest indicators was the annual staff survey, which helped to measure staff morale against peers and nationally. UCLH tended to be above the national average in terms of how staff felt about working at UCLH. Particular attention was paid to staff sickness, managing vacancy rates and staff turnover. UCLH had noticed good signals with regard

to vacancy rates and staff turnover. There were also quarterly staff surveys, alongside a range of other informal ways of ensuring that the situation was being monitored. Regular fortnightly briefings with the Chief Executive were held, which staff could attend remotely and pose questions, whilst remaining anonymous, allowing staff to say exactly what they thought. UCLH tried to be aware of what was important to their staff and to ensure that subject experts were available to address any points raised by staff.

Some of the things which UCLH was proud of and had received good feedback directly from staff, all assisted by the Charity, were the launch of a long term programme which the Chief Executive started called “Be Well”. This was a range of ways to support staff, including basic hygiene factors, such as accessing hot food on an evening shift, discounted food and access to advice services, all based on what staff had asked for. There was also a spa, based on volunteer masseuses, all to make the working space better. All received good feedback from staff.

UCLH also recognised that staff needed to be able to let them know when things were not going well. Staff could raise issues through the “Freedom to speak up Guardian Service”, which was external to UCLH, with staff knowing that any concern raised through that Service would be acted upon. Mediation services were also available to help to address any conflict in the work place.

UCLH was particularly proud of its staff briefings and revamped staff network, which all helped to keep UCLH focused on diversity, equality and inclusion issues. In addition, there were a number of local champions who were passionate about Health and Wellbeing and could deliver messages about the services available. A staff psychological service and occupational health service were available to support day to day activity that people might need access to as part of their working lives at the Hospital. There were also reward and discount platforms for all staff, including bank staff, and salary sacrifice schemes. This year, UCLH was working to support working parents and carers at the Hospital, with a Strategy being launched this year. It was considered that one of the biggest things that could be done, and often the least expensive, was how staff in the NHS were thanked. How staff were rewarded was really important, and this was supported through the Charity, by long service awards and recognising the valuable work done by staff over a number of years. Recognition awards were held annually and staff enjoyed attending, with staff feeling valued and respected.

Questions/responses were supplied as follows:

Confirmation was given that the data supplied included children.

On the 31-day cancer wait to first treatment, did the wait include people waiting for radiotherapy and was that considered primary treatment? Was it considered that disproportionately affected the figures as there was often a slightly longer wait for radiotherapy than for chemo? It was not considered that the figures were disproportionately affected and figures has turned around in the past six months.

Regarding the12- hour trolley wait in A&E at UCLH and comparing the experience of a relative in another A&E department at another hospital, the relative was told that they had to be moved to a bed, as the wait approached 12 hours, and a bed was brought down to A&E so that person was no longer

on a trolley. It was confirmed that this was not the practice at UCLH, meaning the patient was actually in a hospital bed, or had gone home.

The work of UCLH with regard to its staff wellbeing was impressive and much of that work could be usefully shared with others. These were incredibly difficult times for the NHS and the days lost through industrial action were tragic. Agency staff had to be employed to cover staff on strike, which was an extra cost, and how could this be managed financially? UCLH were congratulated on their work for staff and, although staff morale was noted to be above average compared to other hospitals, it was still relatively low at 5.9%. A response was given that some central funding was provided for the impact of industrial action. Legislation had changed as to how the funding was used. It was UCLH's own staff who were used in different ways during the strike days, to support their colleagues to undertake their right to strike, while essential care services were still being provided.

One of the councillors commented that she had been offered a massage while in the staff canteen, proving that those services were being offered to staff!

The Chair thanked Simon Knight and Liz O'Hara for attending and for their presentation. The Committee was pleased to hear about all of the good work being carried out at UCLH.

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45 **UPDATE ON NCL START WELL PROGRAMME (ITEM NO. 9)**

Anna Stewart, Programme Director for Start Well, at North Central London Integrated Care Board, gave a presentation to the Committee on proposals that had been developed as part of the Start Well Programme proposals. This Programme of work had been initiated in 2021 to ensure maternity, neonatal, children and young people's services were set up to meet population needs and improve outcomes.

Anna Stewart said that she would take notes during the discussion of this item to feed back into the formal consultation. She also encouraged all present to submit their own feedback if they had not already done so.

She noted that Start Well had been operating in north central London for approximately two years. She described the programme as a "truly integrated piece of work", across the whole of the ICS, involving colleagues from all of the acute trusts across NCL, as well as GOSH as a key partner and local authority colleagues. A case for change had been initiated approximately 18 months previously and then time was spent with a wide range of clinicians developing best practice care pathways, with a view to developing idealised pathways of care needed for maternity, neonatal and children and young people's care. From there, three key areas were identified which would potentially need some organisational changes in order for them to be delivered

and could not be delivered through the normal systems of working together through the integrated care system.

The three main areas of the Programme which were the focus of public consultation were:

- The number of neonatal and maternity units in north central London and the proposal to move from five units to four. The reason for this was changing demographic patterns, the declining birth rate in north central London, the increasing complexity both of women and pregnant people giving birth and the babies they were having who needed additional care. This meant a mismatch between the existing pattern of care available in north central London and the need. There was a lot of pressure on services looking after women with more complex needs and complex babies, meaning pressure on the level three neonatal intensive care unit at UCLH. Conversely, there was a level one neonatal unit in NCL, which cared for the least unwell babies, which was generally half empty, because it was not able to meet the needs of the babies being born.

The proposals around maternity and neonatal services were not to save money, rather they were driven by a belief that having a smaller number of larger units would better deliver best practice care standards, improve the quality of care and improve the resilience of care in services that were historically pressured in terms of recruitment and retention.

Both options would require a considerable investment in the estate in north central London, in terms of the fabric of the buildings. Under both options, £40m capital had been earmarked to invest in those buildings.

Two options were being consulted on:

1. To close maternity and neonatal services on the Royal Free Hospital site and retaining services at UCLH, North Middlesex, Barnet and Whittington Hospitals
2. To close maternity and neonatal services at the Whittington Hospital, whilst retaining services at UCLH, North Middlesex, Barnet and Royal Free Hospitals.

In the interests of transparency, all of the reasons for the preference for option one, closing services at the Royal Free and retaining services at the Whittington Hospital, had been set out by the Board. However, both options were deliverable and affordable and were the subject of consultation.

- Also the subject of consultation was maternity care at the stand-alone midwifery-led unit at the Edgware community hospital site. Out of 20,000 births in north central London per year, only 34 had been born at this site in the last financial year. Only the birthing suite was the subject of closure, the remaining ante-natal and post-natal services would be retained.

- A further part of the consultation related to children's surgery. No changes were proposed to the paediatric emergency departments within north central London. This was about the onward care of very young children after they had been seen and assessed in the emergency department. The first proposal was to set up a paediatric surgical assessment unit at GOSH, to see predominantly under threes who needed a surgical opinion and some surgery. It was anticipated that approximately one thousand children would be assessed there and three hundred would have surgery. These were children who were predominantly seen at GOSH or outside NCL at the moment, so bringing their care into one place. A very small number of under threes would be seen for day surgery at UCLH, where there were a number of paediatric anaesthetists and skills to see children for predominately ENT and dental issues.

Much work had been carried out to involve people in the consultation and to seek their views. An independent partner would evaluate the outcome of the responses to the consultation. Based on that, decisions would have to be made on whether supplementary work was needed and therefore it was not anticipated that a final business case decision would be made until the end of the calendar year. It would then take time for any decisions to be implemented, pending the necessary capital works to buildings. Until that time, all current services remained open.

Questions/responses were as follows:

There was a fear that, with Whittington Hospital as the nearest in Islington, there was competition with the Royal Free. Islington Council did not want to see any closures in maternity wards. If maternity services were closed in the Whittington Hospital, would other services be affected in years to come? The response was that services had been reviewed, including paediatrics, and there were no plans to close emergency departments. There were inter-dependencies for some clinical specialties in both options which would need to be worked through and separated eg obstetrics and gynaecology with joint rotas. The Board had looked at all of the staff groups on all of the sites and the anticipated impact of any changes and this was just one of the reasons why retaining maternity services at the Whittington Hospital was the preferred option, as it would be less disruptive from a staffing point of view.

Islington councillors were in favour of maintaining services at the Whittington Hospital and had been campaigning to retain services there, as they had to retain A&E services at the Hospital some years ago. Noting that the final decision was to be made at the end of the year, it was suggested that this was a long time for people to be "in limbo".

On the proposals for surgery, it was noted that GOSH would provide services for children under five, although it was understood that this was something they were currently providing? If, for example, a four year old required an appendectomy, where would that be removed? Were UCLH carrying out much day care surgery at the current time? A response was given that some children who, for example, required an appendectomy, would be treated at GOSH and some were going outside north central London to the Royal London and Chelsea and Westminster Hospitals. Clinical colleagues who had been consulted on this, particularly those involved with paediatric emergency services, had said that there was no completely established pathway for very young children who, although not medically complex, were anaesthetically complex and would require a paediatric anaesthetist for opinion and intubation. It sometimes took hours for clinicians to ring around other hospitals to identify a suitable hospital to take a particular child. Setting up a four-bed paediatric unit at GOSH would assist in caring for those children at that Hospital. Much day care surgery was carried out at UCLH. However, UCLH had a growing service, particularly around radiotherapy, where a large number of children were anaesthetised, and had a large anaesthetic department and were well set up to manage that and to build it into their existing caseload. On dentistry and ENT, much work was carried out at Barnet Hospital and community dental services at the Whittington. GOSH dealt with young children requiring anaesthetics.

Although it would be difficult for staff to have to wait until the end of the year for a final decision on which services were to close/continue, much work had to be carried out between now and then, especially on all the observations to the consultation. It was thought that staff understood this and staff at the Whittington and Royal Free both wanted their points to be considered thoroughly. It was thought best to take time over this.

A comment was made about page 35, which referred to the Royal Free being underused and the Whittington not meeting standards, though no reference had been made to the Whittington being well used. The point was made that maternity services at the Whittington were well used. It was important that people responded to the consultation. However, digital exclusion had been referred to earlier in the meeting and that was an issue here. A person had to be digitally literate to respond to the consultation and it was not that easy. How was the ICB dealing with people who were not able to respond online? The response was made that many staff on multiple sites had been consulted. In terms of the reach of the consultation, the ICB was using a multiplicity of methods to gain feedback. There was an online questionnaire which was fairly intuitive, but it was acknowledged that one required a level of digital knowledge to be able to complete the form. Written questionnaires were also available and it had also been translated into community languages, with all the summary documents translated into eighteen languages, in an attempt to be as inclusive as possible. It was pointed out that the written questionnaire was only one way of responding to the consultation. Many targeted sessions had been arranged with voluntary and community sector groups, identified through the integrated impact assessment, and commissioned highly targeted

engagement through a specialist organisation to work with traditionally hard to reach groups, such as asylum seekers and traveller and gipsy roma communities. All of this feedback would be collated. There was an email address, postal address for a letter and a telephone number. It was pointed out that this was not a vote. Engagement and feedback in the round would help to guide the next steps.

It was good that the ICB was reaching out to community groups. How could Bangladeshi and Somali groups be reached? The response was that many engagement events had been held with the Somali community, working through VCS partners in Haringey. The Elfrida Society had assisted with some specialist work with particular groups too. If there were other groups that might not have been reached, members were asked to contact the ICB to let them know. There were between 3-4 hundred groups on the ICB's mailing list, who had been updated throughout the course of the consultation. It was pointed out that the Bangladeshi community was the largest ethnic community group in Islington and the second largest in Camden and that it would be good to have a system to reach out to them.

A question was asked about the impact of this on home births, noting that there were home birth services at all of the Hospitals and sites under consideration. What were the numbers for home births, which was a good option for some people? Had the impact of the home birth service being sited at Whittington or Royal Free been factored in to the proposals? In response, it was noted that there were not large numbers of home births. However, under both options, ICB wanted to enable the range of choice for birth, in an alongside unit, home birth, or an obstetrics led unit. One of the issues was that there were recruitment and retention challenges and, if there were pressures currently on the service, it was likely that home births and the alongside units were shut temporarily to support the obstetrics led units. The new proposition was that if there were a smaller number of resilient services, women and pregnant people would be better supported in their choices. There was no difference between the Whittington and the Royal Free options in this case. In the event that a decision was taken to move to a four site model, the boundaries of the home birth units would need to equalised, given the sizes of the units.

It was noted that approximately £40m of capital would need to be invested under both options. The funding would be used not only on the buildings, but also in upgrading services, dependent on the option chosen. The proposals were quality driven, rather than financially driven.

If Whittington Hospital lost its maternity unit, would it also lose its neonatal unit? It was confirmed that both would close. Clinicians were clear that there should be no level one neonatal units, as these were rare in London.

On behalf of the Committee, the Chair re-iterated the wish for maternity services to remain at Whittington Hospital. He thanked Anna Stewart for attending and for her presentation.

46 SCRUTINY REVIEW EVIDENCE - ACCESS ISLINGTON HUBS (ITEM NO. 10)

Manny Lewis, Assistant Director of Resident Experience, highlighted some aspects of the presentation from the Access Islington Hub initiative, which were based on the Covid response model "We are Islington", with a specific focus on early intervention and prevention, collaboration and wrap-around support for residents. Although the initiative had started off as a simple model of meeting residents' basic needs, it quickly expanded into a more sophisticated model including vaccine support, support for clinically extremely vulnerable residents and a test and trace service. All of the learning was remodelled into a face-to-face offer, meeting residents' needs at the initial point of contact, or assisting them through the journey to achieve their needs.

There were currently two hubs open: the central hub at 222 Upper Street and the south hub at Finsbury Library, both launched in September 2023. A hub was being developed in the north of the Borough, at the Manor Gardens site, which was due to open in June 2025. The aim of the hubs was to offer comprehensive wraparound support, including money, food, wellbeing, housing, family, community safety and work. Unsurprisingly, the majority of people attending the hubs needed support with money, food, housing and wellbeing, all of which were linked. Staff at the hubs had two roles. Firstly, triage advisers met with residents, talking with them to understand and identify what their needs were. This included assistance with digital technology. Secondly came the connector sessions, which involved more in-depth support to look beyond the preventative needs and attempted to identify the underlying needs. These sessions were not time limited and staff were clear that they had as much time as they needed to get to know the person in front of them, forging a connection to identify their needs and to meet those needs. Staff had undertaken specialised training for these roles, including trauma-informed practice, level three safeguarding and cultural competency. Training was ongoing as the needs of residents became clearer.

In terms of the priorities for the hubs, they were still in development. Continuous engagement, collaboration and partnership working was under way. The links with Bright Lives Coaching were very important as they provided short -term support for those needing it, assisting residents to develop their own resilience and skills to develop in the future, with support from the hub. Talks had taken place with the Single Homeless Project who were now providing sessions at the hubs. Close links with Citizens Advice Bureau, Islington Mind and Bet No More

existed, the latter of whom would be based in the hubs at certain times of the week. The service was already working well with the Council's Access services, adult social care, to see if it might be possible to meet needs at the first point of contact, rather than referring residents to other services, which often fed into dependency. More partnerships were in progress.

Another key element was engagement sessions and working groups. Islington's success was due to the development of good links with the voluntary and community sector, mutual aid groups and tenants associations and the Council was keen to proceed with this work. Discussions were currently being held with Help on Your Doorstep, Age UK and other voluntary and community sector groups about what needed to be done to develop the hub offer. A suggestion had been made to these organisations that Islington would take their lead, as they were often better placed in the community to understand what residents needed. An open day had been arranged with voluntary and community sector groups on 15th March 2024 to pursue further discussions. It was hoped that it might be possible to adapt one of their single assessment processes which seemed to work well. It would be helpful for all to be working in the same way, to be sharing resources and training.

Islington also had excellent links with other teams, such as mental health crisis teams, when housing and poverty and financial difficulties were often linked and being able to identify and report safeguarding issues which might emerge. In terms of next steps, Islington was already liaising with health and public health partners on what work might be done with GPs and other health professionals. The Council was also looking at ways in which they could help health initiatives, for instance by way of encouraging people to take vaccines and boosters.

Questions/responses were made as follows:

It was confirmed that the hubs team could be approached to help residents with assessments for social care.

Staff training was very important. Councillors knew from experience with constituency work that patience and caring were required in dealing with people whose cases could have been ongoing for a very long time. Given that the hubs were new, people may not be aware of their existence. Communication was important in this regard. The NHS staff were also under considerable pressure and needed support to maintain their wellbeing. The importance of staff training was acknowledged and hub staff had been specifically recruited who would be able to have the quality conversations with people to understand what their underlying needs were. Staff who had worked on the "We Are Islington" phoneline had been recruited as they were particularly able to develop the necessary relationships and obtain residents' trust, which often was not easy for people using the service. Managers in the hubs were also being

trained to support the staff who often had to deal with very difficult conversations.

The hubs seemed like a very good idea. Much councillor casework concerned people who had already approached the Council and councillors were merely acting as a conduit between the Council and officers. It was hoped that advice from the hubs would break down barriers and enable residents to obtain the help they needed directly. Were the hubs to be linked to community centres, which were often places where advice was sought anyway? One of the measures of the success of the hub project could be that casework received by councillors was not about issues which had already been raised at 222 Upper Street. The Assistant Director concurred with the idea of community centres and other organisations (working alongside the hubs). He was working on a separate project looking at how community centres and the voluntary and community sector groups could better offer advice and support to residents on their first contact and in one place. He was hopeful that councillors would see a positive impact on their caseloads in the future. On communications, the new website would shortly be launched and officers were looking at how they might advertise the offer of the hubs more widely.

It was good to see how the good work carried out during the pandemic by the Team had led to the new hubs service. However, councillors needed to be clear about how the hubs would work in connection with their casework. Should constituents be referred to the hubs? The response was that the hubs were looking for referrals from anywhere, be that councillors, neighbours or Council staff, as hub staff had the ability and experience to stand back and look at the system as a whole. It was hoped that, where there was a referral from a councillor, issues could be sorted out swiftly. However, where a matter was complicated, perhaps involving a range of directorates, as was often the case with members' enquiries, there was difficulty. The question then was who was to take the lead? It was probably easier if cases were referred directly to the hubs from councillors.

Under the new hub arrangements, it seemed that people could contact the hubs directly, rather than telephoning the access team to adult social care? The response was that the existing telephone number for access to social services was still operating. The hubs had been introduced to give people an opportunity for face to face contact with someone or who had struggled to gain help elsewhere.

Residents had reported long waits in contacting the access team to adult social care, especially to seek assistance with form filling. How could this be addressed? How would it be possible to monitor the outcomes of contacts with the hubs? The response given was that the hubs team worked very closely with adult social care and had good links. In fact, some of the hub staff had previously worked in the access care team. Those staff would advise and support hub staff and would even join in a

person-to-person conversation with a resident, as necessary. The case would be held until the outcome had been achieved, all as part of the connector session. Resident satisfaction would be sought by the community connector staff to ensure that residents were entirely satisfied with all the support they had received and that they had achieved all they needed to. Information on the number of telephone calls and face-to-face meetings could be supplied if required. However, the most important feedback was from residents, who really valued the service, and staff. Staff often reported that they were enjoying their work and spending time with residents and getting to know them. There were high numbers of enquiries via the Access Islington service and high volumes of numbers had to be dealt with, meaning that calls had to be dealt with as swiftly as possible. That, in turn, put pressure on staff on the amount of time they could spend with residents. There were no time limits on the new hub service which was important. However, it was thought that improved technology would help with monitoring outcomes of cases, perhaps a system similar to one operated pre-Covid, where individuals could be tracked across Council services.

It would be helpful for a cribsheet to be produced for councillors on how casework was to be referred to the hubs.

Manny Lewis was thanked for attending and for his presentation.

47 **EXECUTIVE MEMBER UPDATE (ITEM NO. 11)**

Councillor Nurullah Turan, Executive Member for Health and Social Care, referred to a recent email to councillors about the measles outbreak and MMR.

He was pleased to report that the Council had received about £4m funding for a new GP clinic on Andover Estate. The existing GP clinic on the Estate was due to close as it had been taken over by a private developer, unfortunately sold by its previous owner. The new developers were due to contribute to the new health centre and the Council was working with them. The new clinic

would be on the Newington Barrow Way site and would be a state of the art establishment. All the proposals had been approved in the previous week.

He was also pleased to report that the GP closure he had mentioned at a previous Committee, based in New North Road, would no longer close, as the GP had managed to find a partner, which was apparently unusual. This would mean 1800 patients would not have to move to another GP service or find another pharmacy service as there was one on site.

He also drew the Committee's attention to recent news about the development of two new Alzheimers drugs. These treatments significantly slowed symptom progression of Alzheimers disease and were most effective when given as early as possible. A decision was expected from drug regulators this year as to whether they could be approved for use in the UK. The treatment could mean the end of Alzheimers disease, offering hope that one day it might be considered a long-term condition, with people managing their symptoms and living full lives. However, only a relatively small number of people were likely to be able to access them as the majority of people were diagnosed quite late. However, because services were so well connected in Islington, the Borough was one of the leading places for dementia diagnosis. The Alzheimers Society had unofficially described Islington as a "Dementia Friendly" Borough.

One of the issues discussed at Healthwatch Islington was private care access, where Islington councillors raised the issue of the challenges faced by ethnic minority groups and the changes required. Healthwatch Islington had requested Healthwatch England to reserve a space on the Healthwatch London agenda to ask how others had used the Healthwatch England report to influence delivery and see how good practice might be implemented in Islington. Healthwatch Islington were also developing a strategy to get more men involved in their research.

A meeting had been held with the London Medical Council in the previous week, where he had been informed that fewer older patients were coming through for consultation. He had asked for figures and would take it up with next week's ICB meeting.

He had visited a surgery, the Miller Practice, and one of the issues raised was the estate. A visit had taken place to Pharmacy First in Newington Green, where things were working, although when discussed with LMC, concerns had been raised about the likely overprescription of antibiotics. He had heard a description of an older patient who had been prescribed antibiotics, after complaining of a pain in his throat, which could be a symptom of throat cancer, which was missed. There were obviously risks associated with Pharmacy First and he suggested that the situation be monitored.

He also asked to be kept aware of any pharmacies which were refusing to accept sharps bins for home use as they were meant to accept them. It could be due to lack of funds but, if made aware of it, the ICB would investigate.

Finally, ear wax removal services were no longer available on the NHS, although 2-3 million people per year used the service. However, NICE guidance was that the service should be provided by GPs through microsuction. However, national services provision were patchy or not available. GP contracts no longer paid for this service.

Councillor Turan undertook to look into an issue raised by Councillor Burgess, relating to the presence of a large van on the Whittington Hospital site advertising "affordable mobile digital imaging".

48 QUARTER 2 PERFORMANCE REPORT - PUBLIC HEALTH (ITEM NO. 12)

Jonathan O'Sullivan, Director of Public Health, invited questions on his written report on Public Health performance for quarter 2 in 2023/24.

Questions/responses were as follows:

Could the Committee have a picture of measles in the capital at the moment? The response given was that there had definitely been an increase in measles cases month on month, across London as a whole. There was also a similar pattern in the west Midlands. There was concern about the level of measles, mumps and rubella vaccination uptake, both for the first and second doses. Together with the NHS, the Council was working on a range of activities to improve measles, mumps and rubella vaccination uptake. As was apparent in the report, there was currently no data available through the local health system, so authorities had worked carefully on a triangulation of the other vaccinations given at the same time and the Director of Public Health had said that he was very confident that it was just a data coding issue which was not being picked up in the local system. He noted that in national data, an increase in MMR 2 vaccination was evident, again supporting the sense of a local coding issue. Key messages had been shared with councillors about the importance of the MMR vaccine, including sharing some of the information in community languages. NHS colleagues were doing more in terms of promotion and roll-out to the community to encourage more people to attend for their vaccinations.

The Chair reported that he had met the Bangladeshi Association last year and had met with Islington Public Health staff and offered to attend the mosques with information on vaccinations. He had suggested to the imam that it would be helpful if he could attend a Friday prayers session to talk about the issue. The Director of Public Health said that it would be helpful for councillors, who were trusted in the community, to do anything they could to spread the message about vaccinations.

On substance misuse, it was noted that services were delivered by the organisations "Inroads" and by "Via", the latter including outreach work for various people. Confirmation was requested on whether the carrying of Naloxone was carried by the outreach workers only? There was reference in the report to "services collaborate closely with criminal justice partners to ensure effective pathways into treatment from prison, probation and police, which includes co-locating of services and in reach support" and how exactly this was working in Islington? There was also a reference to "strong service focus for the coming quarter to help increase people with opiate addiction coming into treatment services." and whether there were problems with nitazenes and higher risks of overdose? The Director of Public Health replied that naloxone was carried by outreach workers to promote supplies for people using opiates as it was considered important. Harm reduction was most important. The kits previously were injectables but were now nasally administered. There was an

initiative with community pharmacies who were in contact with people using opiates in order to address that. Naloxone was a treatment which reversed the affect of an overdose and therefore dramatically reduced the risk of mortality. The concern for drug supply around opiates and other drugs in the UK was that it might follow the pattern of drug use in the US and other parts of the world, with synthetic opiates being far more potent and far more dangerous, with a risk of overdose. Part of the reason to proactively reach out to people, was about sharing harm reduction messages and there was a local plan for action if there were reports of overdoses. Over December to January, there had been some deaths due to opiates, which could have been linked to synthetic opiates or metazene, which made it even more important to share the messages about Naloxone and wider harm reduction. On collaboration, Public Health was working hard on relationships with the Criminal Justice System, with a good model in place in Probation and staff working in the custody suite (latter point to be confirmed). The very limiting factor was that the Police had much pressure in terms of vetting procedures as to who could work in those settings. Islington was not the only borough experiencing these difficulties and the matter had been escalated to London level to increase the pace of vetting. Positive work engagement had continued, including with the Prison Service. The Director of Public Health was pleased to note support to black African and black Caribbean men in the criminal justice system. The outreach service was receiving positive feedback from Police colleagues, particularly around the level of knowledge of outreach workers, helping to get people into treatment. Collaborative work was being carried out by the outreach workers, the Police and the Council's Community Safety Team on tackling these issues.

It was noted that there was no reference in the "Smoking" paragraph of the report to the detrimental affects of smoking on pregnant women. The Director of Public Health concurred with the concerns expressed about pregnancy and smoking. He reported that, in the most recent quarter, the quit rate for pregnant women was 84%. This compared to the London average of 56% and the England average of 50%. One of the reasons for maintaining the Start Well programme maternity and neonatal at the Whittington Hospital was because excellent public health services were inputted into that Hospital. Breast feeding initiatives were also high. It was suggested that these points be included in the current consultation on the future of maternity and neonatal services.

49 **WORK PROGRAMME 2023-24 (ITEM NO. 13)**

The Chair suggested that it would be helpful to receive a presentation from the Access Service at a future meeting, particularly to hear about how outcomes were monitored.

MEETING CLOSED AT 9.40 pm

Chair

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Moorfields Eye Hospital NHS Foundation Trust

NHS

Moorfields Eye Hospital update for Islington Health and Care Scrutiny Committee

Sheila Adam (CNO) and Jon Spencer (COO)
April 2024

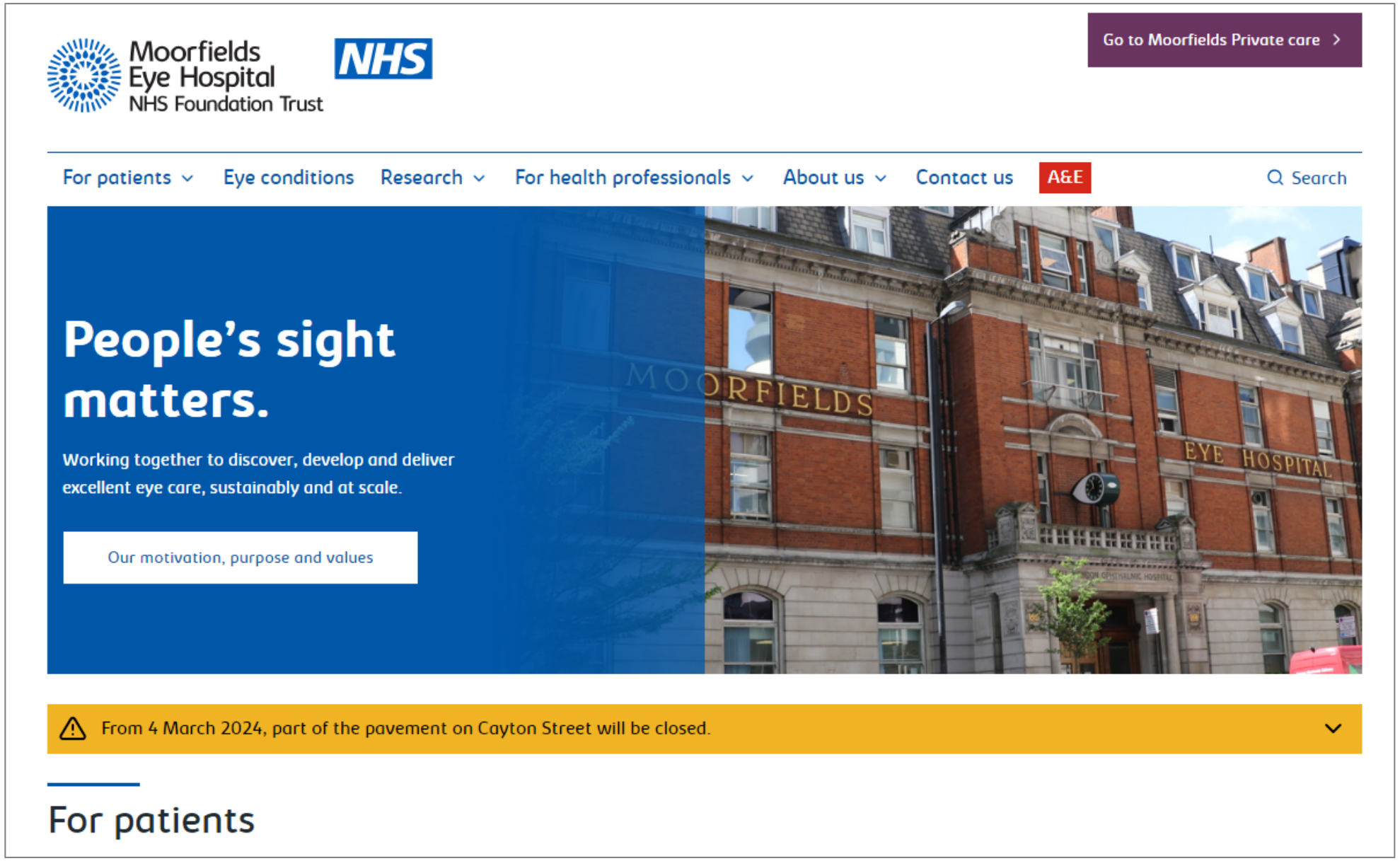
Agenda Item 8

Moorfields: a headline update

	Last year	This year
Performance	Moorfields was performing well locally and providing mutual aid to other providers.	• We are working regionally to more systematically reduce waits across the board using a dynamic single point of access • We have significantly reduced the length of time people wait to be seen and treated, eliminating the majority of waits over 52WW and we on track to meet the 18WW target next year.
Innovations for local benefit	We outlined our plans for a new digitally-enabled pathway	• We are beginning to see early benefits from the single point of access. • We have bid to be the lead provider for eye care in NCL. • We are evaluating diagnostic lanes which we believe provide a better patient experience for lower cost.
The patient at the heart of healthcare	We reported on our Eye Envoys programme and initiatives such as hand holding	• The Eye Envoy programme is being extended as part of our outreach work. • We are beginning to consider how we can reach more communities across Islington. • We are doing more digitally – but are working hard to ensure no-one is excluded and care is provided in ways accessible to all.
Serving all of our populations	With other local providers we were beginning our population health journey	The single point of access has begun to give us insights into the state of healthcare locally in ways that will enable us to target unmet need and make eye care much more accessible for everyone.
Supporting our staff and volunteers	We were working towards “a pathway to excellence”.	• We are pathway designated. • Our work on EDI is much more developed.
Our new hospital	Plans for a new hospital at St Pancras were well advanced.	Building is now underway and we recently held an Oriel Showcase attended by 700 staff.

A new more accessible website

- Clearer
- Cleaner
- Meets accessibility standards
- Easier to find the information you need



A snapshot of our overall performance (12/03/24)

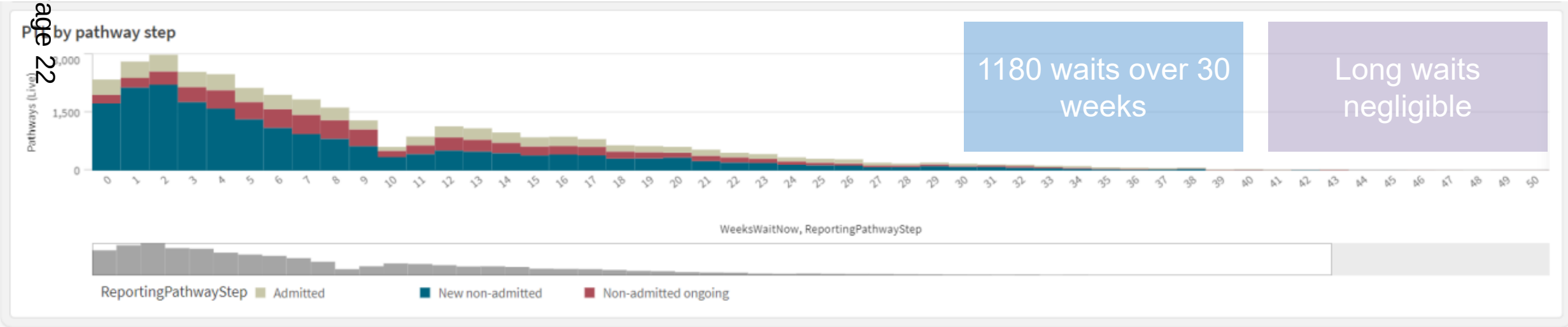
35,228 pathways

82.9% 18 week wait performance

100% A&E 4 hour wait target met

600,000 OP attendances in 2023-24

1,270 daily OP attendances (City Road)



Moorfields Eye Hospital NHS Foundation Trust

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Publication, Part of Patient-Led Assessments of the Care Environment (PLACE)

Patient-Led Assessments of the Care Environment (PLACE), 2023 - England

Publication Date: 22 Feb 2024

Category	Moorfields Score (%)	Regional average (%)	National average (%)
Cleanliness	97.84	98.4	98.1
Food-Ward	89.58	92.3	90.9
Privacy, Dignity & Well being	86.44	87.7	87.5
Condition and Appearance	98.09	96.5	95.9
Dementia	86.76	85.6	82.5
Disability	85.04	86.9	84.3

Three Moorfields sites were inspected: City Road, Stratford and St Georges.

Moorfields Eye Hospital NHS Foundation Trust

NHS

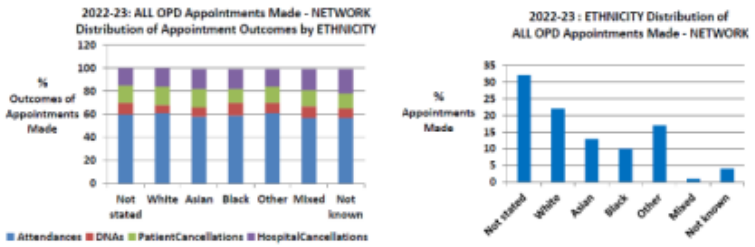
Population health

- Last year we reported on our nascent work on population health. Making progress here is the real opportunity for Integrated Care Systems and associated Partnerships – making the NHS work for all.

- The SPoA, AI and digital twin are helping us understand populations and target interventions in ways that have not been possible before – some examples are on the following slides.

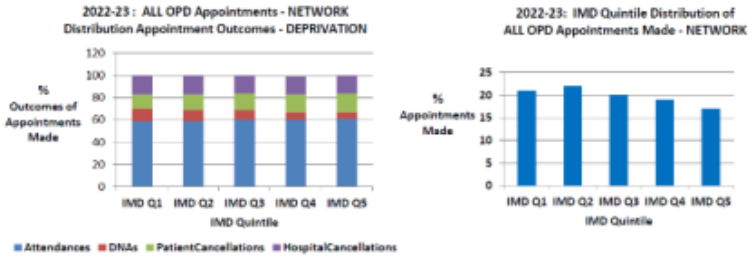
- We are also progressing work on health inequalities as part of developing our services to meet the needs of residents: one recent example being that the rate of DNAs (did not attend) was due more to age than e.g. ethnicity or deprivation.

Variations in ALL OPD Appointment Outcomes: ETHNICITY



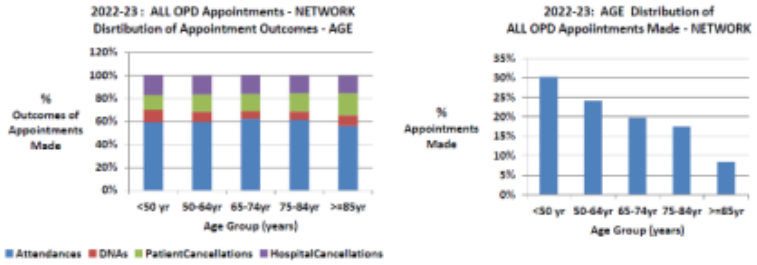
- **No variations apparent in types of attendance outcomes of ALL OPD appointments by ethnicity**
  - Patient Cancellations >> than DNAs for all groups
  - All Patient Non-Attendance (DNA + Patient Cancellation) – 23% for all groups
  - Hospital Cancellations – 16% for all groups
  - New and Follow-Up Appointments – similar appointment outcomes
- **Ethnicity Data: "Not Stated" largest ethnic group (32%) – greater for New Appointments (41%)**
  - Coding completion – 96%
  - Ascertainment issues –patient *and* process contributors involved

Variations in ALL OPD Appointment Outcomes: DEPRIVATION



- **Index Multiple Deprivation (IMD) ranks areas of deprivation in quintiles: IMD Q1 most deprived & IMD Q5 least deprived**
  - At Selected Sites - IMD distributions of appointments reflected their respective populations
- **No variations apparent in types of attendance outcomes of ALL OPD appointments by Deprivation**
  - Patient Cancellations >> DNAs for all groups
  - IMD Q1 more DNA than IMDQ5; but IMD Q5 more Patient Cancellations than IMD Q1
  - All Patient Non-Attendance (DNA + Patient Cancellation) – 23% for all groups
  - Hospital Cancellations – 16%
  - New and Follow-Up Appointments – similar appointment outcomes

Variations in ALL OPD Appointment Outcomes: AGE



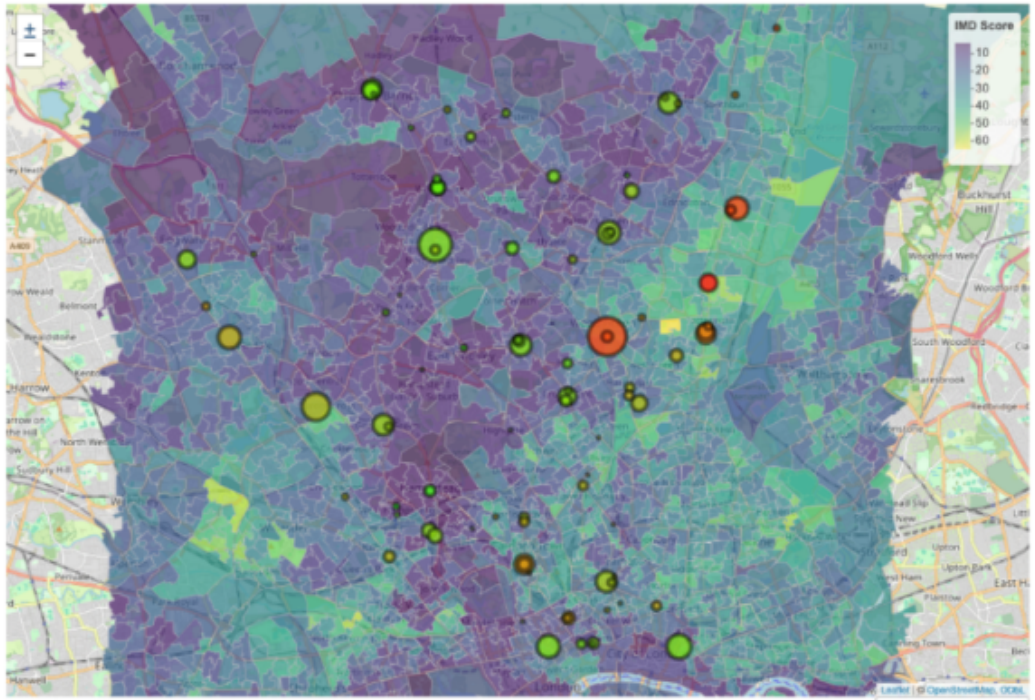
- **Variations apparent in types of attendance outcomes of ALL OPD appointments by AGE**
  - Oldest age group >=85yrs greater Patient Non-Attendance(DNA + Patient Cancellation) – 28%
  - All age groups –
    - Patient Cancellations > > DNAs
    - Hospital Cancellations – 16%
  - New and Follow-Up Appointments – similar appointment outcomes

Moorfields Eye Hospital NHS Foundation Trust

NHS

Improving inclusion

Tools like our single point of access (SPoA) are helping us understand the shape of demand, enabling us to better target interventions for population need, such as referrer or patient education.



Search:

	Optom Referrer	DeprivationIndex	No Emails
1	SPECSAVERS (WOOD GREEN)	46.325	493
2	SPECSAVERS (NORTH FINCHLEY)	14.405	365
3	VISION EXPRESS (HENDON)	23.325	247
4	SPECSAVERS (BISHOPSGATE)	13.584	191
5	SPECSAVERS (TOTTENHAM COURT RD)	14.252	169
6	SPECSAVERS (PALMERS GREEN)	17.405	160
7	BOOTS OPTICIANS (COLLINGDALE)	27.671	158
8	SPECSAVERS (EDMONTON GREEN)	46.391	158
9	SPECSAVERS (ENFIELD)	16.806	155

Deprivation map with referrers overlaid

(each circle is an optometry practice, red referrers are in deprived areas, larger circles mean more referrals).

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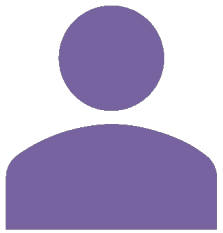
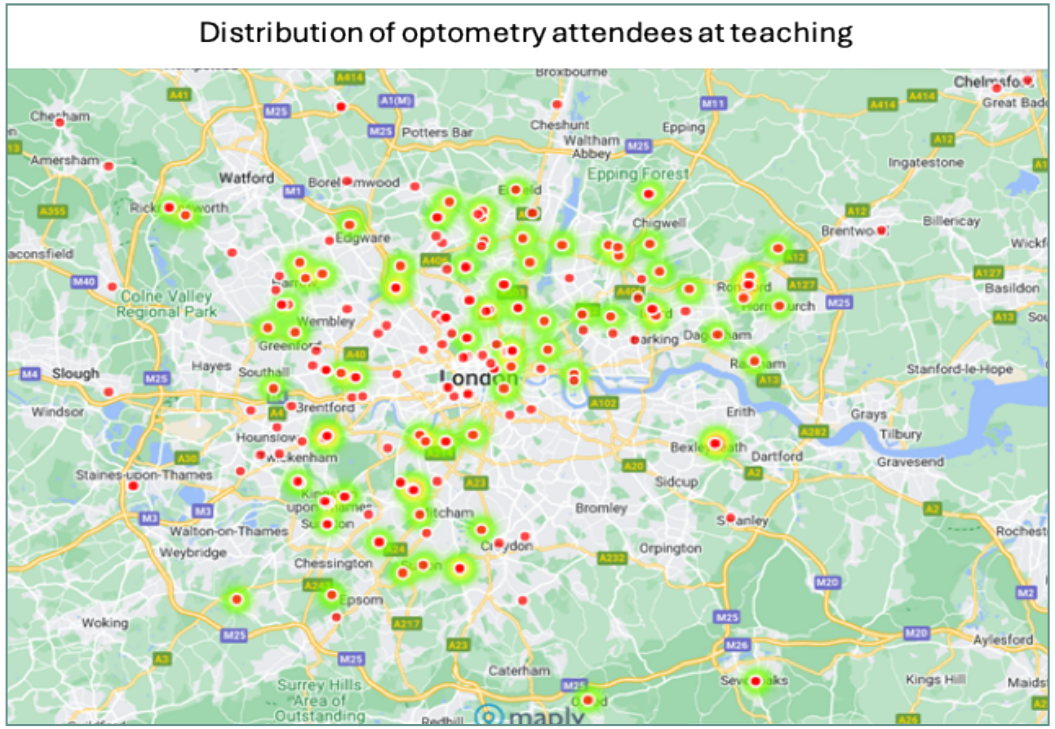
NHS

Monthly education sessions, targeted for referring optometrists

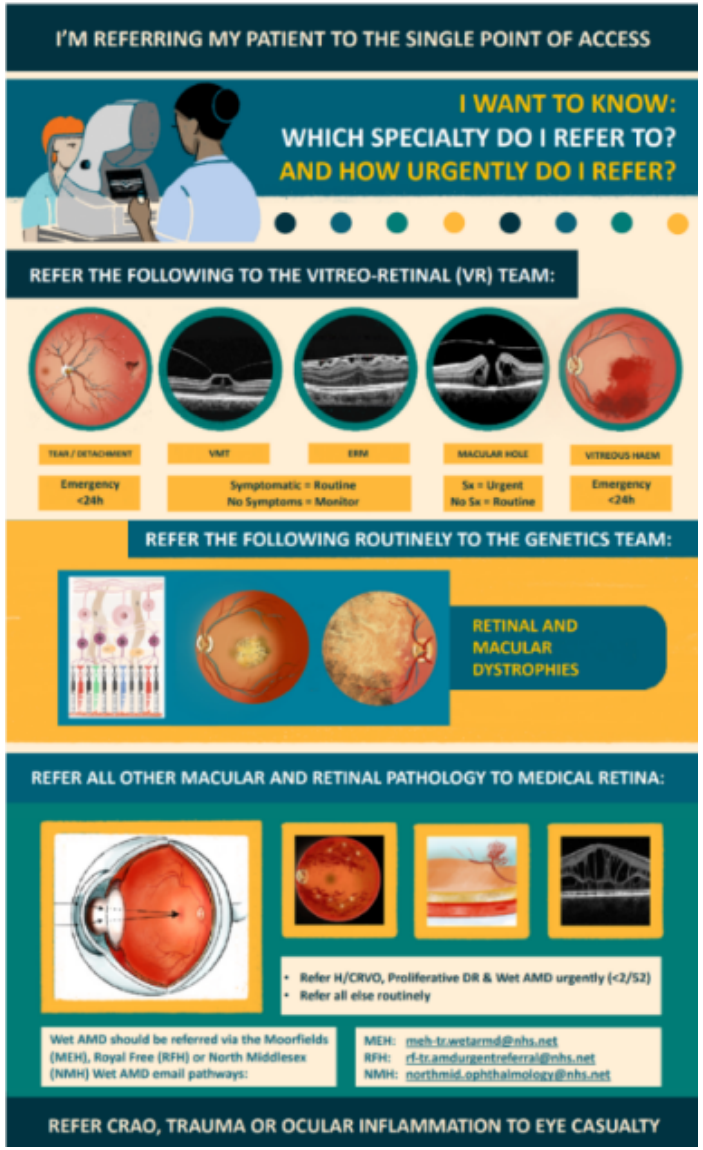
"I have learnt so much that I feel more confident on how to manage and where to refer patients presenting with symptoms discussed in the webinar."





Typical London attendance (high street optometrists) at a monthly teaching session (each dot can be multiple people, approx 150 at each)

99% of attendees registered for future events



Digital Twin

The digital twin is a constantly updating simulation tool of patient flow from referral to treatment.

Provides real-time optimal referral suggestions based on distance, waiting times and capacity.

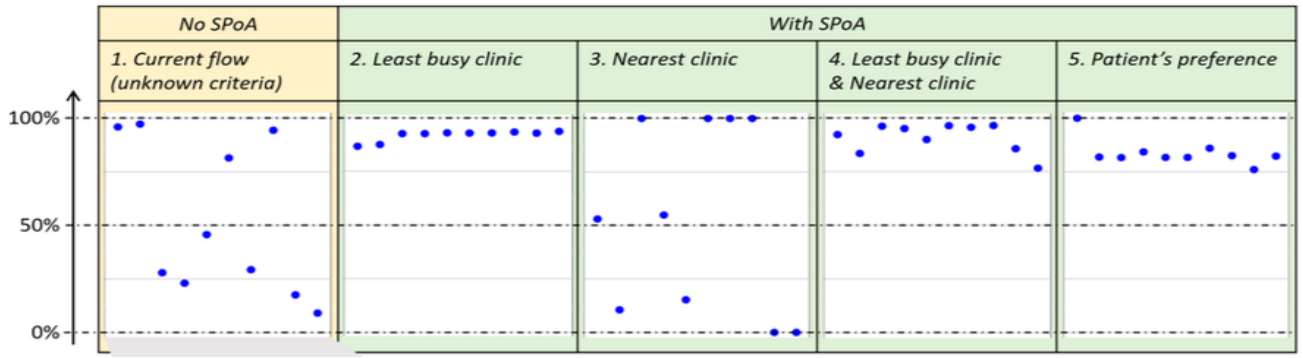
This will ensure all services across an ICB are used to the best of their capability - maximise whole-system patient flow.

The SPoA scenarios substantially outperform the “as is” scenario, **reducing time to first appointment by up to 35 days**.

Scenarios

Performance metrics	Routing criteria	No SPoA: 1. Current flow (unknown criteria)	With SPoA: 2. Least busy clinic	With SPoA: 3. Nearest clinic	With SPoA: 4. Least busy clinic & Nearest clinic	With SPoA: 5. Patient's preference
	Referral to triage (days)	39	3	3	3	3
	Triage to 1st appointment (days)	11	12	32	12	21
	Referral to 1st appointment (days)	50	15	35	15	24
	Distance travelled (km)	6	11	2	8	11
	Patient's satisfaction on assigned provider	9%	12%	15%	12%	100%
	Average resource utilisation (first appointments)	52%	92%	53%	91%	84%

Clinic’s resource utilisation for 1st appointments



- Lowest utilisation seen when only nearest clinic was considered (3)
- Maximal utilization if both least busy clinic and geographical location combined (4)
- Patient preference reduced clinic utilization but could be mitigated by combining with location and capacity (5)

Moorfields Eye Hospital NHS Foundation Trust

NHS

Using eRS to support patient choice

In a small scale sample, when 50 patients were given a choice of 5 options for cataract surgery in NCL 39 patients responded

The analysis from this cohort of patients shows that:

- Patients do not always choose the shortest waiting times nor the closest in distance
- This system demonstrates that **patients can, and do, choose care on the basis of the most important variable to them** – waiting time, outcomes, travel time etc.
- Once a patient has exercised a choice, this feeds directly into the shape of the PTL so that the next patient choosing has their options presented and optimised according to real time data.

78% of patients responded

36% of these patients remained with the default first choice

64% of these patients changed their decision from the Optom suggestion on the referral when 5 choices

5% of these patients choose out of NCL cataract service that was not specified

Moorfields Eye Hospital NHS Foundation Trust

NHS

Eye envoys

Last year we reported on our Eye Envoys programme and how it provides an outreach service. In October 2023 Moorfields' Eye Envoy programme won the Care of Older People award at the Nursing Times Awards 2023 ceremony.

- The Eye Envoy initiative was devised as a training programme by Moorfields nurses to upskill local community teams in care homes to improve service delivery, decision-making, risk management and supervisory capacity.

In the UK, 80% of people over age 60 already live with sight loss. Such conditions have knock-on effects beyond how it changes a patient's ability to see and carry out daily activities. For example, a fall can be the result of the patient not being able to see an obstacle instead of motor issues, while mental health issues may be accentuated by the degeneration of a patient's vision.

- The Eye Envoy programme looked to improve care and reduce hospital admissions for local, older patients with progressive eye conditions.

Moorfields Eye Hospital NHS Foundation Trust

Dr Roxanne Crosby-Nwaobi, lead nurse for research and Tendai Gwenhure, clinical tutor and programme lead for UCL Clinical Ophthalmic Practice Programmes.

NHS

Our Quality priorities for 2024-25

Safe

- Transition and embedding of the National Patient Safety Incident Response Framework (PSIRF)
- Development of a learning system to support knowledge transfer following events as described in the trust's patient safety incident response plan (PSIRP)

Effective

- **NEW** Continue to embed shared decision-making tools and guidance across the trust to support the way healthcare professionals work together with a patient to reach a decision about care. We must ensure we comply with NICE guidance.
- **NEW** Support staff engagement and empowerment in the development of shared decision-making councils

Patient Experience

- Improve the process for the allocation of Certificates of Visual Impairment to eligible patients.
- **NEW** To improve the experience of patients requiring transport to and from our sites by utilising data in collaboration with our third-party suppliers
- **NEW** To operationalise the approach developed for routine reporting, review and utilisation of data on service delivery for health inequalities, ensuring that it is readily accessible to teams to support their programmes of work; whilst also meeting the statutory requirements of NHS organisations.
- Implementation of patient experience principles
- Implementation of the patient experience framework
- **NEW** To review how we communicate with our patients. We will evaluate existing communication channels (digital and non-digital) and formulate a plan for the integration of patient-centred communication into clinical and operational practice, including the new EPR.
- Continue to embed the Accessible Information Standard (AIS) across Moorfields' network

Moorfields Eye Hospital NHS Foundation Trust

NHS

Staff survey results

- The NHS staff survey is one of the largest workforce surveys in the world and is carried out every year to improve staff experiences across the NHS.
- Alongside other trusts, NHS England published our 2023 NHS Staff Survey results on 7 March 2024
- 66% of us took the opportunity to have our say in the 2023 survey; 16% more than in 2022.

Our results show that against the seven NHS People Promise themes, plus the themes of Engagement and Morale, as a trust we have:

Improved against six themes. They are:

- we are recognised and rewarded
- we are safe and healthy
- we are always learning
- we work flexibly
- we are a team
- morale

Maintained against two themes. They are:

- we are compassionate and inclusive
- engagement

Deteriorated against one theme

- we each have a voice that counts

Moorfields Eye Hospital NHS Foundation Trust

NHS

Equality, diversity, inclusion

Our three equality, diversity, and inclusion (EDI) strategic priorities are based on evidence about where we need to improve as a trust. This includes the NHS Staff Survey, and our employee Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES), and Gender Pay Gap (GPG) data. We are working to improve each of these priorities:

1. Increase the diversity of our leadership and management teams

Leadership Academy Programme: for colleagues with disabilities or long-term health conditions in collaboration with Disability Rights UK.

Career Sponsorship Programme: to provide Black, Asian and minority ethnic colleagues with mentoring and sponsorship from a senior leader.

Debiasing recruitment: A revised recruitment and selection policy will be launched soon, alongside a good practice guide for managers to ensure consistent equitable recruitment. We are committed to being a Disability Confident employer.

Board recruitment: We have upcoming vacancies for executive and non-executive positions. We will ensure we interview diverse candidates so that our senior leadership teams better reflects our employee base and our communities.

2. Build a strong and positive culture of inclusion and belonging

- **Reasonable adjustments guidance**
- **Active bystander training**
- **Equality and Health Inequality assessments**
- **Developing approach to anti-racism**
- **NHS Rainbow badges assessment**
- **Embedding our values (Excellence, Equity, Kindness)**
- **Freedom to Speak Up**

3. Improve the collection, reporting and transparency of our EDI data

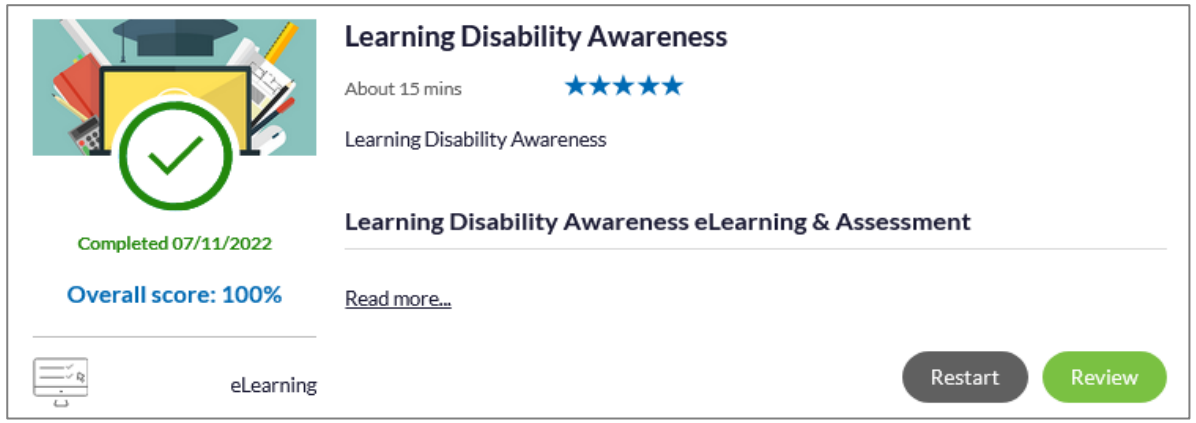
Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES): We report annually on our performance against the WDES and WRES indicators.
We share this data with our staff networks and seek their ideas for our action plans.

Declaration campaign: We want colleagues to confidentially declare their disabilities and long-term health conditions within ESR to make sure we have an accurate picture of declaration rates, ensuring equity. We similarly want people to feel they can declare their sexuality. We will keep you updated on progress.

Learning disability and autism training

Moorfields has been at the forefront of providing staff training in working with people with learning disability and conditions such as autism – having done so since 2017. It is now a national requirement. The current compliance level for the training is 90% (Feb 2024)

- Interactive sessions delivered will ensure staff also are able to discuss how reasonable adjustments can be made.
- This is led by our Vulnerable Adults and Safeguarding Lead who is a registered learning disability nurse.
- Patient Hospital Passports are in use and use our digital systems to record flags to support consistent application of reasonable adjustments.



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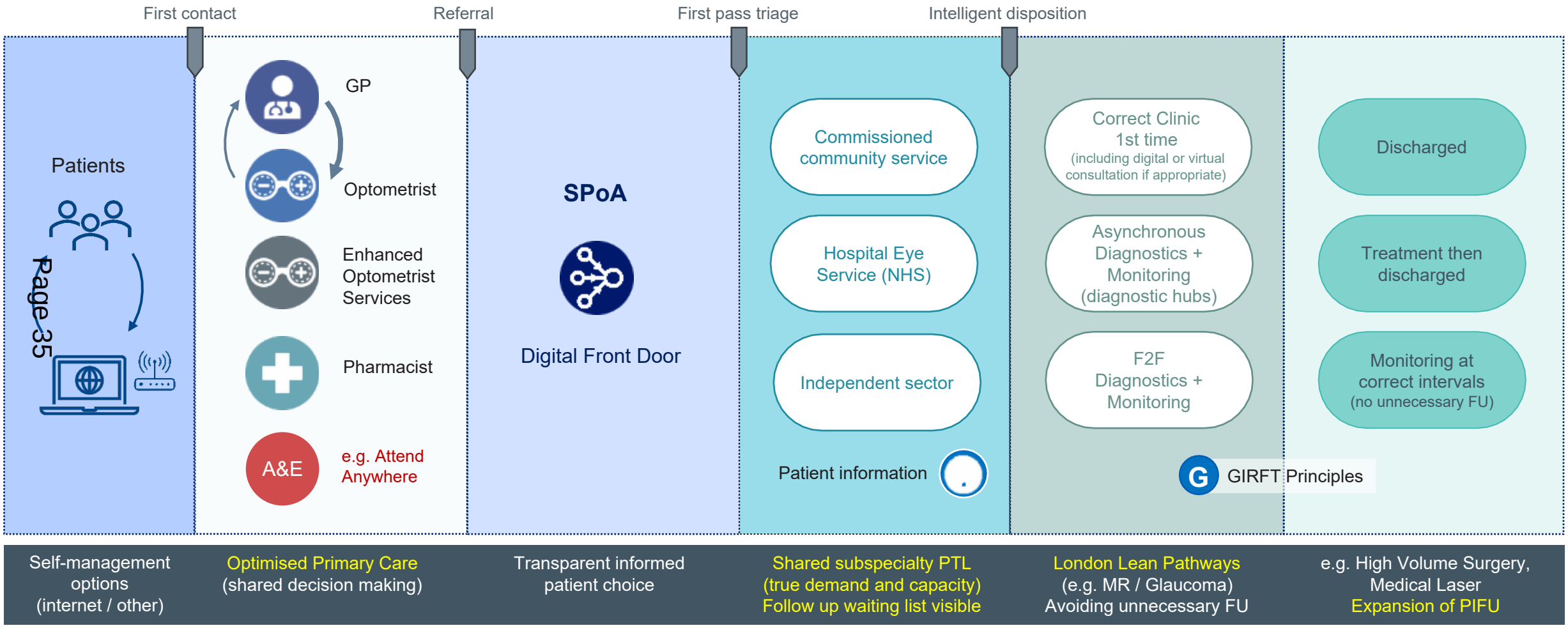
NHS

An improved eye care pathway

Moorfields Eye Hospital NHS Foundation Trust

NHS

A standard eye care pathway for London



- Population health based planning to address inequalities
- Use of AI and machine learning across pathway to improve outcomes

Yellow text = in development

Why are we doing this?: the case for change

The biggest outpatient speciality – 8.5% of all NHS attendances

People are suffering avoidable sight loss

People's sight matters – essential for a healthy, productive population

Increasing burden of disease - ageing population with more diabetes

Increased demand predicted 2017 – 2037:

- Cataracts up 50%
- Glaucoma up 44%
- Retinal conditions (AMD & diabetic retinopathy) up 60%

GIRFT report, RCOphth Way Forward

We need to transform

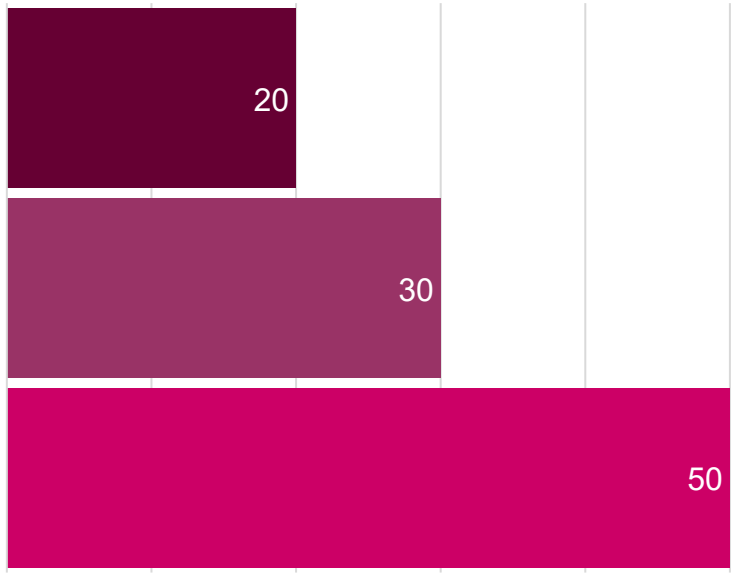
Moorfields Eye Hospital NHS Foundation Trust

NHS

Regional Urgent Eye Care

Video consultation using 'attend anywhere'

- By Dec 23, 47000+ patients had used our virtual A&E
- Earlier published data showed 95% gave a 5/5 rating
- Safety shown comparable to in-person triage
- Scalable



Recent disposition;

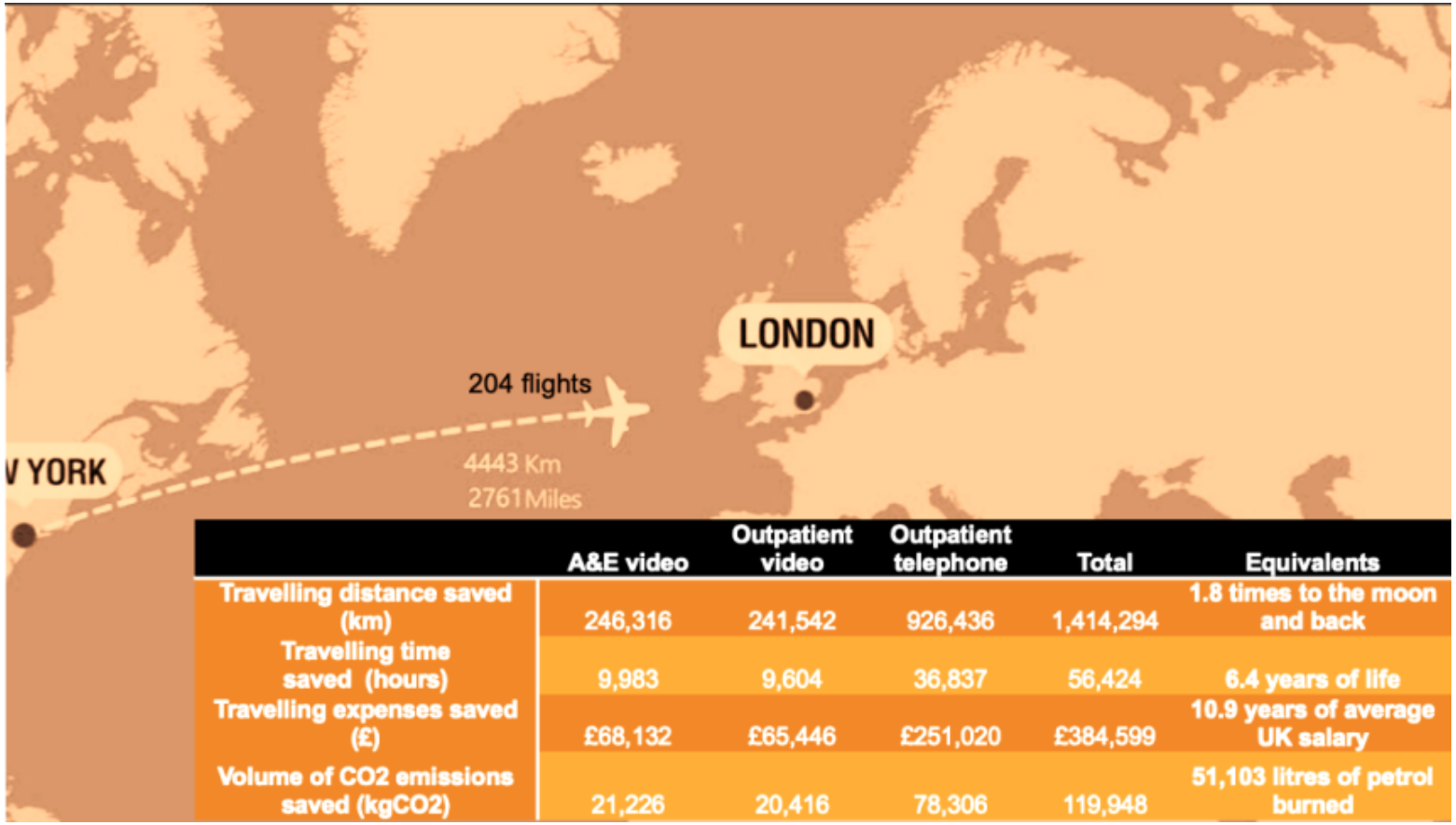
- 20% advised to attend in person that day
- 30% brought in for urgent outpatients in next 2 weeks
- 50% do not attend hospital – advised self care at home, or via local optometrist, pharmacist or family doctor

NB. ratios depend on capacity and knowledge base developed in primary care

Moorfields Eye Hospital NHS Foundation Trust

NHS

Environmental benefits: annual travel CO2 impact of our video services



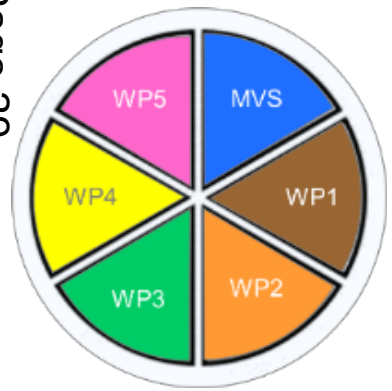
	A&E video	Outpatient video	Outpatient telephone	Total	Equivalents
Travelling distance saved (km)	246,316	241,542	926,436	1,414,294	1.8 times to the moon and back
Travelling time saved (hours)	9,983	9,604	36,837	56,424	6.4 years of life
Travelling expenses saved (£)	£68,132	£65,446	£251,020	£384,599	10.9 years of average UK salary
Volume of CO2 emissions saved (kgCO2)	21,226	20,416	78,306	119,948	51,103 litres of petrol burned

Moorfields Eye Hospital NHS Foundation Trust

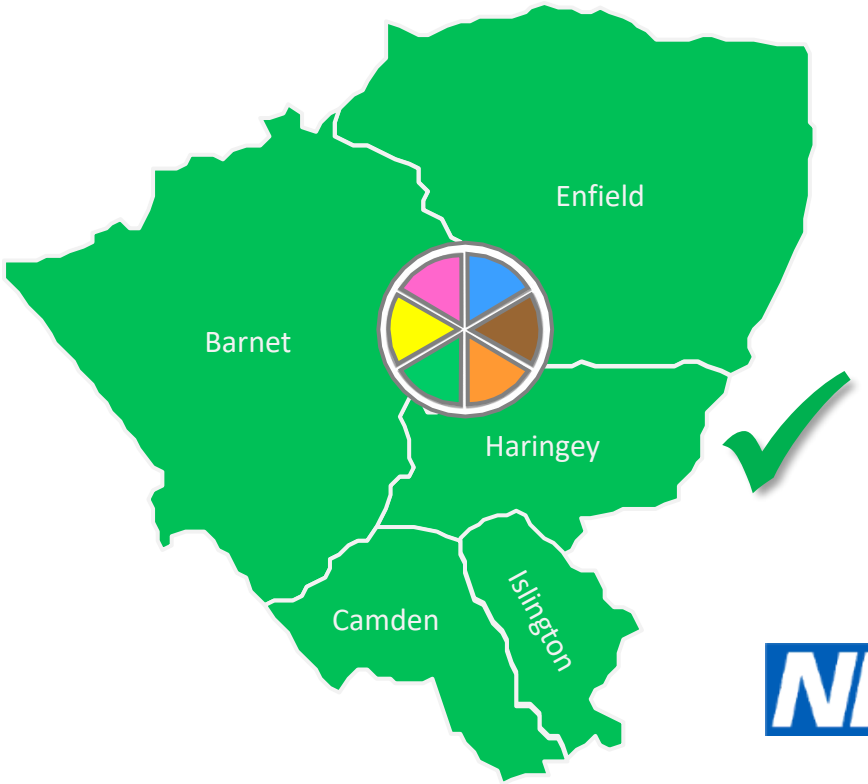
NHS

Single Point of Access (SPoA): Fully in place in Islington

- We have implemented a single point of access in North Central London since July 2023. It includes all referrals including direct from optometry.
- The SPoA shows demand and allows best use of system capacity; it also informs population health planning.
- The SPoA, or tools like it, are being implemented across the country. We hope an SPoA system will cover London in due course.
- In the meantime, Islington has the benefits of having our fully-developed model of SPoA which is driving improvements to system healthcare planning and patient experience.



MVS	Email referral, eRS and triage / booking
WP1	Digital twin to optimise use of resources
WP2	Centralised triage, advice & guidance
WP3	Educational interventions (for optoms)
WP4	Early patient information and support
WP5	Deployment of NHS Mail and eRS to optoms



Moorfields Eye Hospital NHS Foundation Trust

8777 NCL referrals

received since July 2023 (on 21.3.24)

NHS

Evidenced SPoA benefits to date (January '24)

Benefit	Baseline	Currently observed	Change/benefit	Scaled to 18k patients per year
Reduced time to triage (days)	11	1	↓ - 10 days	n/a
Reduce time taken for referral to go from optometrist to definitive provider	11 days (to re-baseline)	2 hours (median)	↓ 10+ days	
Appropriate clinic utilisation	38%	71%	↑ 33%	
Distance travelled by patient	49.3km	27.1km	↓ 22.2km	396,000Km
Clinical touchpoints for patients accessing care via A&E Medical Retina Wet AMD patients	2.3	2	↓ -0.3 touchpoints	Reduction in FU OP of c. 5400
Reduction in A&E attendance for Wet AMD cohort			↓ -25%	N/A
Carbon saving from travel	4.23kgCO2	2.33kgCO2	↓ 1.9kgCO2 per patient	34.2 TonnesCO2 (likely underestimate)
Reduce GP forwarding of referrals			↓ 43% reduction	6582 NCL referrals 1520 NEL referrals not processed by GPs
Reduction in referrals unneccessarily marked as "urgent"	21.6% of referals marked as urgent	12.6% urgent following first pass triage	↓ 58% rate of de-escalation from urgent to routine.	Annual reduction of 1620 urgent referrals
Increase proportion of referrals with imaging	17%	29%	↑ 12%	Additional transfer of 2160 images

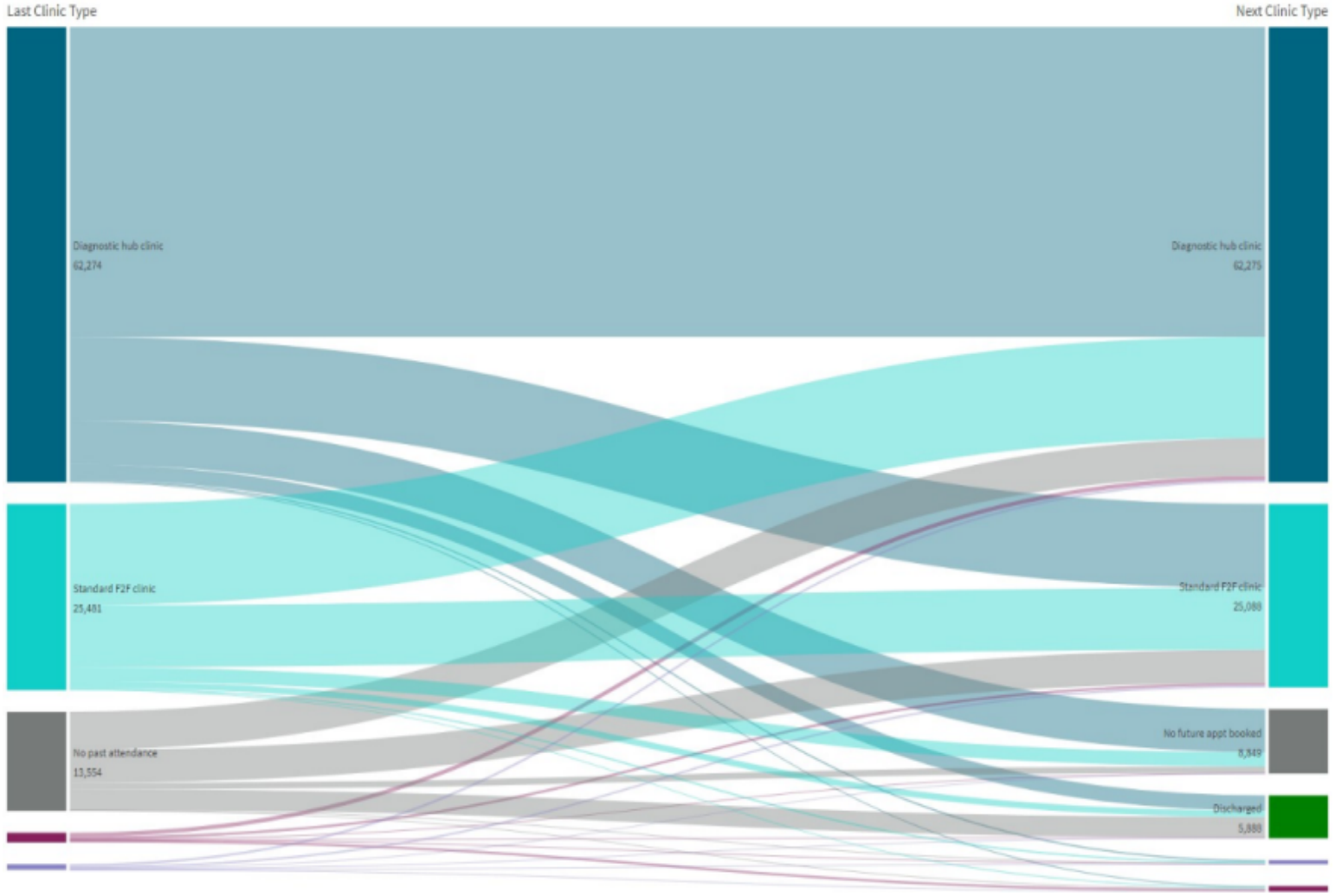
- The data here is mostly derived from NCL numbers, though NEL referrals have been included.
- SPoA promotes patient choice and potentially enables significant reductions in non-contracted activity and over-treatment. Coding is accurate and standardised.

Diagnostic hub flows Dec ‘22 – Nov ’23 (Moorfields)

60% attendances suitable for diagnostic hub care.
Asynchronous clinical review for all.
Patient journey time optimised (30-60 minutes)
Patient satisfaction 97%

Last Clinic Type	Total Attendances	Percentage
Diagnostic hub clinic	62,275	60.2%
Standard F2F clinic	25,483	24.6%
No past attendance	13,558	13.1%
Injection clinic	1,360	1.3%
Telemedicine clinic	793	0.8%

Next Clinic Type	Total Attendances	Percentage
Diagnostic hub clinic	63,013	60.9%
Standard F2F clinic	25,409	24.6%
No future appt booked	7,747	7.5%
Discharged	5,940	5.7%
Injection clinic	759	0.7%
Telemedicine clinic	601	0.6%



The diagnostic and monitoring service provides consistent and reliable clinical care with patients directed to alternate settings only as required. This releases hospital capacity.

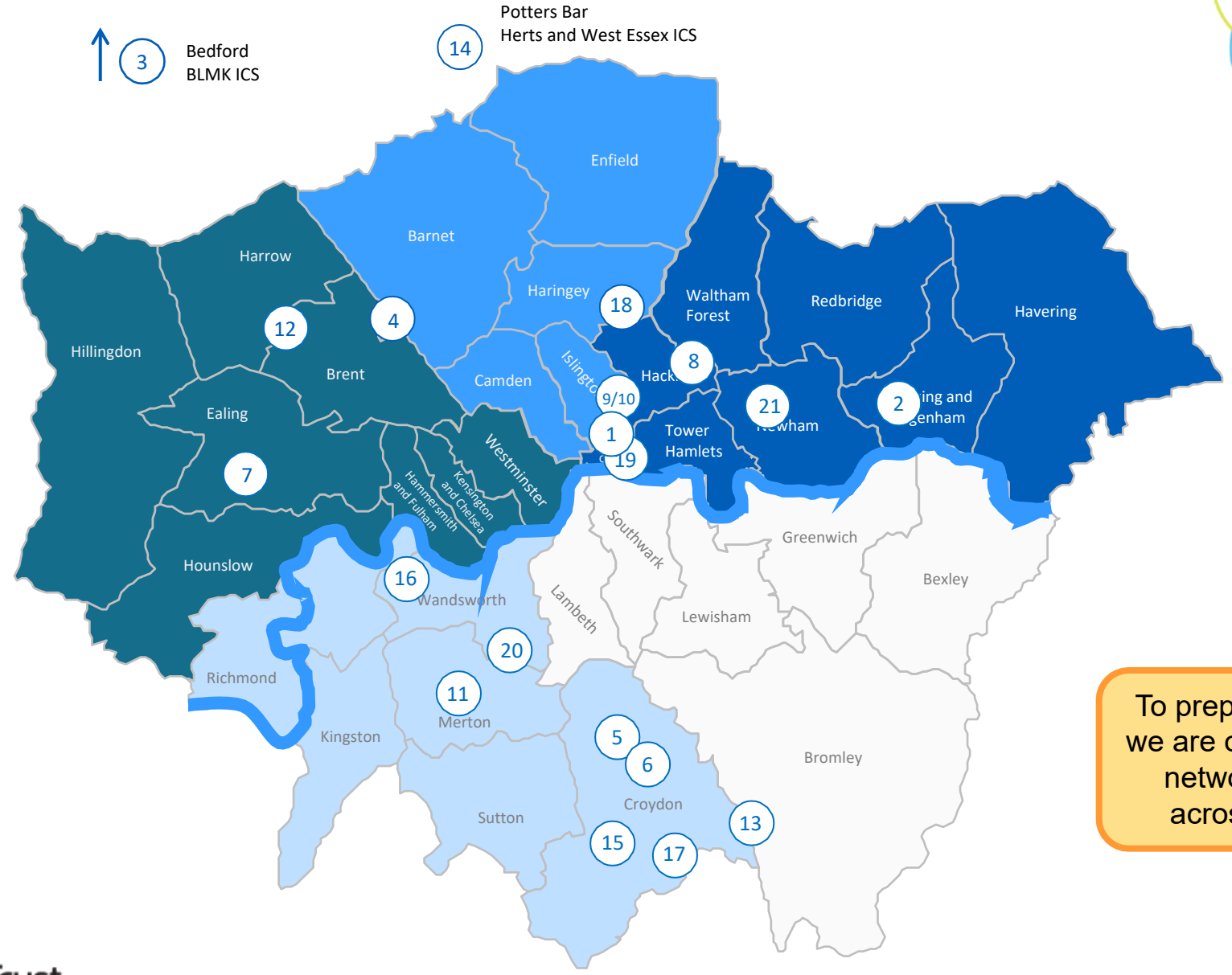
Oriel: our new hospital in St Pancras

Construction is well under way for Oriel with cranes onsite, foundations being laid and the building will start to appear from the ground up this year.

Moorfields Eye Hospital NHS Foundation Trust

NHS

1 MEH City Road (inc. RDEC)
2 Barking Hospital
3 Bedford Hospital
4 Brent Cross Diagnostic Hub
5 Croydon University Hospital
6 Croydon Vision LVA clinic
7 Ealing Hospital
8 Homerton Hospital
9 Hoxton Diagnostic Hub
10 Hoxton Maze (mobility assessments)
11 Nelson Health Centre
12 Northwick Park Hospital
13 Parkway Health Centre
14 Potters Bar Community Hospital
15 Purley War Memorial Hospital
16 Queen Mary's Hospital
17 Sanderstead Health Centre
18 St Ann's Hospital
19 St Bartholomew's Hospital
20 St George's Hospital
21 Stratford Broadway



To prepare for Oriel, we are optimising our network of sites across London

Moorfields Eye Hospital NHS Foundation Trust

NHS

February 2024: a new larger premises opens at Brent Cross

- As part of project Hercules, Brent Cross has paved the way in how we and our partners across NCL deliver diagnostic care more efficiently to patients.

- In its first year of opening, it provided care to more than **15,000** patients, helping to reduce patient waiting times in cataract, glaucoma, and medical retina services across north London.

- It now sees **25,000** patients, which would not be possible without the continued hard work of our dedicated teams.

- The hub has also provided new careers for those not traditionally employed in healthcare services. Many of our technicians across our sites were trained at Brent Cross.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Our new NEL Stratford hub: reducing waits in Islington

- In April 2023 we were pleased to open a new centre on Stratford Broadway; we opened our operating theatres there in October last year.
- This will create capacity for NCL and NEL, directly benefitting Islington residents (e.g. reducing wait times for surgery at St Anns).
- We did some analytical work which showed that if we put more of our sites near where people live and work (such as shopping centres) we can free up 20% of hospital capacity, improving our wait times even more.

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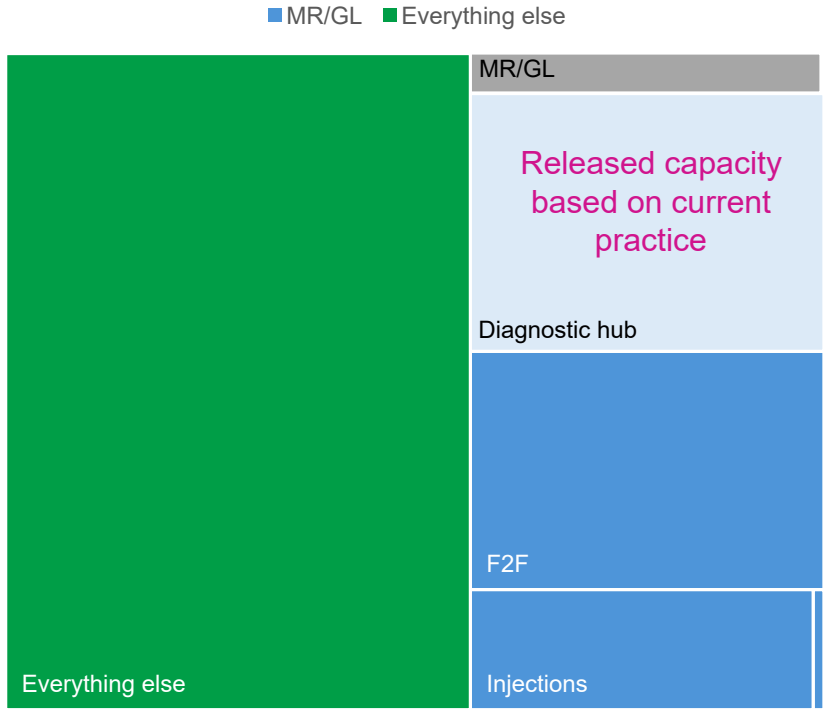

NHS

Hearing back from you.

Moorfields Eye Hospital NHS Foundation Trust

NHS

ISLINGTON
For a more equal future

Public Health

4th Floor, 222 Upper Street, N1 1XR

Report of: Director of Public Health

Meeting of: Health Scrutiny Committee

Date: 15 April 2024

Ward(s): all wards

Subject: Overview of services for people that use drugs or alcohol in Islington

1. Synopsis

1.1. Islington commissions a range of services to meet the needs of people that use drugs or alcohol. This paper summarises the population need, the national policy context, the services available, and recent and current delivery plans.

2. Recommendations

2.1. To note the contents of this report, including the treatment and support services available in Islington and recent and current service delivery plans, the current areas of national and local focus, and Islington's progress against the National Drug Strategy objectives.

2.2. To note the increases in people accessing treatment and improvements in the numbers of people accessing community treatment when leaving prison.

2.3. To note and support the recent and planned actions to reduce the risk of drug related deaths, to expand peer-led work and service-user involvement, and to work more effectively with communities to reduce inequalities in take up of services.

3. Background

3.1. Alcohol and drug use remain an important cause of preventable harm in Islington. As well as affecting health and wellbeing, it has social, housing, economic, crime and community safety impacts affecting individuals, families and communities, and is a cause and consequence of health inequalities. Understanding and reducing the health harms of drug and alcohol use is a longstanding area of focus for Public Health.

3.2. Responsibility for drug and alcohol misuse services transferred to local government as part of the NHS and public health changes under the Health and Social Care Act 2012. Services in Islington are provided through the NHS by Camden & Islington NHS Foundation Trust (in partnership with third sector organisation Humankind) – Better Lives, in primary care through general practice and community pharmacies, the community and voluntary sector, and Islington Council.

3.3. In December 2021 the Government published a 10- year, national drug strategy From Harm to Hope ("the strategy"). The strategy outlines the Government's ambition to break drug supply chains, develop a world class drug and alcohol treatment system, and to achieve a generational shift in demand for drugs.

3.4. The strategy, which responds to Professor Dame Carol Black's independent review of drugs, is regarded as the first national drugs strategy which is cross-government, setting out its vision and requirements for how public services need to work together to address shared goals. The strategy was followed by detailed guidance for implementation, including requirements for local partnership arrangements (establishment of "Combating Drugs Partnerships"), and development of local delivery and spending plans to meet national programme objectives.

4. Population health need

4.1. Risk factors for drug and alcohol use can include social, environmental and behavioural elements. How these factors interact is complex and not predictive of outcomes in any one individual. There is a strong correlation between addiction and trauma, and people with drug and alcohol needs are more likely to have experienced adversity in childhood or adolescence than those who do not use drugs or alcohol. Economic factors, such as economic downturns and rates of long-term unemployment or worklessness, have also been observed to increase population level needs. There are significant overlaps between drug and alcohol needs and several mental health conditions. Drug and alcohol use is associated with homelessness, including rough sleeping, contact with the criminal justice system, and with exploitation.

4.2. It is estimated that in 2019/20, Islington had the highest prevalence of opiate and/or crack cocaine use (OCU) in London (rate of 21.5 per 1,000 population), and the 5th highest prevalence out of all local authorities in England[1]. The next highest estimated rates of OCU prevalence in London in 2019/20 when estimates were last produced were in Haringey (20.4 per 1,000 population), Enfield (18.6 per 1,000 population), and Hackney (15.4 per 1,000 population). In England, the rate of opiate and/or crack cocaine use was 9.5 per 1,000 population in 2019/20. The breakdown of this was a rate of 4.6 per 1,000 population for

[1] Prevalence estimates are provided by the Office for Health Improvements and Disparities (OHID) and the UK Health Security Agency (UKHSA). The modelling incorporates 3 data sources – National Drug Treatment Monitoring System (NDTMS) information on people in community drug treatment, criminal justice system information on arrest records and drug treatment in prisons, and drug-related mortality information from the Office for National Statistics' (ONS) mortality register. The City of London was excluded from this analysis due to skewed rates secondary to a small number of residents.

opiates only, 3.6 per 1,000 population for both opiates and crack, and 1.3 per 1,000 population for crack only.

4.3. Modelled prevalence data suggests there were an estimated 3,960 opiate and/or crack cocaine users in Islington in 2019-2020, at a rate of 21.5 per 1,000 population. Use among males was four times higher than among females (34.3 per 1,000 population vs 8.4 per 1,000 population). Of the 3,960 estimated users of opiate and/or crack cocaine in Islington in 2019-2020: 1,911 used both opiates and crack cocaine (48%; rate of 10.4 per 1,000 population); 1,564 used opiates only (40%; rate of 8.5 per 1,000 population); 485 used crack only (12%; rate of 2.6 per 1,000 population).

4.4. Across London, there was a substantial increase in the estimated number of people using opiates during the latter half of the last decade. The estimated use of opiates and/or crack cocaine in Islington is thought to have increased between 2016 and 2020 from 2,777 to 3,960 estimated users. This increase appears to be linked to an increase in opiate use. Indeed, there was an estimated 4% decrease in users of crack cocaine only in Islington between 2018-19 and 2019-20, from 505 to 485 estimated users. The trends in Islington are consistent with those modelled across London, but there are estimated to be substantially more opiate and/or crack cocaine users in Islington than across London as a whole (21.5 per 1,000 vs 10.9 per 1,000).

4.5. It is important to note that figures relating to opiate and crack use are estimates derived from modelled data. Nonetheless, the figures provide a clear indication that Islington's drug and alcohol support need is at the higher end of London boroughs and that there are opportunities to provide treatment and care to more residents.

4.6. Local data on the use of drugs *other than* crack cocaine and opiates is not available. Trends in drug use, and type/s of drugs used change over time. Nationally, the most commonly reported drugs in use by people aged 16-59 are cannabis (7.6% of respondents to the 2018-19 Crime Survey for England and Wales), powder cocaine (2.9%), nitrous oxide (2.3%), and ecstasy (1.6%). People aged 16-24 reported higher use overall and the most commonly reported substances were cannabis (17.3%), nitrous oxide (8.7%), powder cocaine (6.2%) and ecstasy (4.7%).

4.7. Islington had the 6th highest rate of drug misuse deaths in London in 2019-2021, with a rate of 8.4 per 100,000. The highest recorded rate in London (in Hammersmith and Fulham) was 11.3 per 100,000). Nationally, the mortality rate for deaths related to drug misuse have been increasing yearly over the past decade, reaching an all-time high in 2019-2021[2].

4.8. The rate of hospital admissions with a primary diagnosis of poisoning by drug misuse in Islington in 2019/20 was 15 per 100,000 in 2019/20, which is in line with the London average (12 per 100,000). This is substantially lower than the national average of 31 per 100,000. The rate of hospital admissions with a primary diagnosis of drug-related mental health and behavioural disorders has been lower in Islington than in London and England over the past

[2] Office for National Statistics, 2022

decade. In 2019/20, the rate in Islington was 6 per 100,000, compared to 11 and 13 per 100,000 in London and England, respectively[3].

4.9. The number of substance-related ambulance call outs in Islington decreased from 80 in 2017 to 39 in 2020. This number increased slightly in 2021 and 2022, to 44 and 46, respectively. The rate of substance-related call outs per 1,000 ambulance call outs in Islington was 1.1 in 2022. This is slightly higher than the rate of in London (0.9 per 1,000 ambulance call outs).[4].

4.10. In 2021, Islington had the second highest rate of deaths due to alcohol-related conditions in London. In 2021/22, Islington had the second highest rate of alcohol-related hospital admissions in London.

4.11. **Further information is available in the Drug and Alcohol Local Area Profile 2023 at Appendix 1.**

4. Community safety

4.1. In 2022, there were 8,288 reported antisocial behaviour incidents reported in Islington, of which 23.3% (1,933 incidents) were categorised as being drug-related. This is the second most frequently cited category, after 'Rowdy or inconsiderate behaviour' which makes up 57.0% of reported incidents (4,721 incidents).

4.2. The number of antisocial behaviour reports in 2022 categorised as related to drugs is similar to that received in 2018, 2019 and 2021. In 2020, there was a spike in most types of reported ASB, coinciding with the impacts of the early Covid-19 pandemic. In the same five-year period, reports related to street drinking have reduced. It is not currently possible to provide a further breakdown of the calls categorised as drug related.

4.3. Last year, the Community Safety team undertook a whole borough consultation named Safe Spaces, in which a range of localities in the borough were identified as locations where residents do not feel safe. Amongst the responses, there was a clear theme that the open dealing and usage of Class A drugs in particular, had a disproportionate effect on how unsafe residents feel in the borough.

4.4. Actions in response to reports in 2022 included police carrying out 30 warrants for a range of issues including drugs, which led to 12 police led premises closure orders, and LBI Housing led on five closure orders for drug related activity which were granted by the court.

4.5. In 2022, 250 Antisocial Behaviour Warnings were issued by police and Islington Parkguard in relation to drug related antisocial behaviour. ASB warnings are in the pre-criminal space and trigger support through referrals to young people and adults drug and alcohol services as

[3] SafeStats, 2023
[4] Ibid

well as through support from other specialist Outreach services. Community Safety also co-produce a 'Cuckooing Panel' with police to offer targeted help and support to people that may be vulnerable to having their property used for drug-related activity, or other exploitation.

4.6. Project Adder – the Met Police programme to improve drug treatment support for offenders – is increasing the number of people taking up 'test on arrest', with the aim of referring those testing positive to treatment services. In Q1 of 2023/24 year, around 50% of people accepting drug testing on arrest in Camden and Islington (for any offence) tested positive for at least one substance and were referred to drug treatment services[5].

5. Treatment services in Islington

5.1. Drug and alcohol treatment services support people to change their relationship with drugs and alcohol, stopping or reducing the risk and impact to themselves and those around them. There is a strong emphasis on social and economic recovery. There is a good societal 'return on investment' for funding invested into treatment services, contributing to a range of positive outcomes and reduced harm. At borough level, treatment services are an important and effective help to improve health and wellbeing, reduce crime, antisocial behaviour and acute healthcare demand, and to promote feelings of safety in the community.

5.2. Islington's current integrated drug and alcohol treatment service, **Better Lives** ("the service"), operates from three locations in the borough, supporting people that use drugs and/or alcohol, as well as their families and carers. Islington also commissions Via to deliver outreach support for people sleeping rough, or at risk of sleeping rough, and to deliver Islington's Individual Placement Support programme (supporting people into employment).

5.3. Drug and alcohol use is complex, and evidence shows individuals are more likely to benefit from a multi-faceted approach to their treatment and recovery. The treatment and recovery system reflects this diversity of need and multiple treatment options are made available, delivered by multi-disciplinary teams – including but not limited to, one to one key-working, counselling, psychological therapy, group work, day programme(s), self-help and mutual aid groups[6], pharmacological treatments[7], and residential rehabilitation.

5.4. The service also provides physical health support, including blood borne virus testing and treatment, and social support including housing and debt advice, skills coaching and Education, Training and Employment (ETE) support. Better Lives Family Service supports children and adults that are affected by drug or alcohol use by a parent or other family member(s).

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[5] Project Adder is in its early stages and data outputs are high-level at present. As the programme continues, we look forward to receiving more granular data around locality, substances detected and the outcomes of referrals to services. We will monitor its outputs through our Criminal Justice System strand of the Combating Drugs Partnership, as part of its work on reviewing and assessing the operation of referral pathways

[6] Narcotics Anonymous and Alcoholics Anonymous are examples of mutual aid groups.

[7] For example, opiate substitution therapy (OST) such as methadone.

5.5. The **Individual Placement and Support (IPS)** programme for people with drug and alcohol treatment needs has been operating in Islington since December 2022. IPS work with individuals for up to 12 months, providing support, advice and liaison to help people identify employment or voluntary opportunities suited to them. They then help with all stages of the applying for and starting a job. The service is provided by Via and is funded by the national IPS Grant, also administered by OHID.

5.6. The Rough Sleepers Drug and Alcohol Treatment Grant (RSDATG), also a national grant, has enabled Islington to commission the **In-Roads** service from Via. In operation since 2021, the service provides psychosocial support and prescribing outreach to people sleeping rough or at risk of sleeping rough in Islington. In-roads provide one-to-one key-working, connect people to health services, provide harm-reduction support, including Naloxone[8], and make referrals to a range of other support services.

5.7. Islington has commissioned an additional programme to provide culturally competent holistic support to men of Black African or Black Caribbean heritage who are in contact with the criminal justice system and who have non-opiate substance use needs. Now in its second year in Islington, **SWIM** (Support When It Matters) delivers a 10-week structured support programme for up following its Prepare, Adjust, Contribute, Thrive (PACT) model, supporting up to 60 people per year.

5.8. Young people are another important focus for prevention and early intervention. There is increased outreach in community centres, and a new dedicated worker in the youth (I-CAN) service and a specialist working with young people who are looked after and care leavers. There is also training to support how professionals can work with children and young people affected by parental alcohol and substance misuse.

6. Working in partnership

6.1. Islington's Combatting Drugs Partnership (CDP) brings together partners across the Council, criminal justice system, and the voluntary and community sector to provide strategic oversight of Islington's work to deliver the objectives of the 10-year National Drug Strategy. Operational sub-groups are looking at Criminal Justice System pathways, Healthcare pathways, and workforce, and Public Health recently led a cross-organisational self-assessment exercise to evaluate the continuity of care received by drug and alcohol users leaving custody, with actions improvement owned by the CJS sub-group - Public Health, Drug and Alcohol Treatment Provider, Police, Probation and Prison.

6.2. Public Health are working closely with colleagues in Community Safety to support the Combating Drugs element(s) of the Safer Islington Partnership Plan 2023-26, including supporting the facilitation of the SIP's August '23 workshop session on strategy development.

[8] Naloxone is a life-saving medication that reverses the effects of opiate overdose. Administered by injection or nasal spray, it works within minutes to reverse the effects of an opiate overdose, pending substantive medical treatment.

We recognise the many shared aims and common stakeholders of our work and the opportunities to align our efforts to deliver improvements for Islington residents.

6.3. In particular, partnership working between Public Health, Community Safety and Police colleagues will help to identify opportunities to progress the elements of the National Drugs Strategy that are less focused on treatment – breaking drug supply chains and achieving a generational shift in the demand for drugs. Hotspot identification and partnership, e.g. a current Andover Estate Working Group, provides an opportunity for different stakeholders and service areas to support improvements in areas showing high levels of need.

6.4. Public Health has recently established a Community of Practice: Drugs & Alcohol to bring together colleagues working with our most vulnerable and/or complex cohort, who tend to have multiple health and social needs. Improving access to drug treatment support for those in supported or temporary accommodation has been an early focus, which stands to benefit all residents in a setting and promote feelings of safety for staff and for those living in the community. To further this, Public Health is also working closely with Islington's commissioners of mental health accommodation – having recently joined its Provider Forum – to understand and help address the challenges co-occurring mental health and substance misuse needs can present for residents and for accommodation providers.

7. Service user and peer-led work

7.1. Service-user involvement in the design and delivery of drug and alcohol services is an essential part of quality assurance. Public Health are directly supporting the re-launch of its long-standing and highly valued service user group **Islington Clients of Drug and Alcohol Services (ICDAS)**. The relaunch will increase participant numbers, build resilience and improve diversity, so the group better represents the service user population and can be a more effective critical friend to commissioners and providers. This supports our ambition to achieve recognisable co-production in our commissioned services, improving their reach and outcomes. We have commissioned a Community Interest Company (Janus Solutions) to help us with this work.

7.2. Peer-to-peer support can promote holistic wellbeing and help to cultivate a supportive community that facilitates sustained recovery. While peer support interventions have long been available in Islington, we have identified a gap in regular peer support during weekends and in the availability of online peer support for people who find it easier or preferable to accessing services in that way. We are in the process of commissioning a peer-led service that will provide these aspects of support.

7.3. We are expanding our existing peer-to-peer harm reduction project to deliver harm-reduction coaching and training to peers working in a wider range of organisations, with the intention of reaching people who may not currently be in contact with treatment services. in 2024/25 we will continue to fund the senior peer naloxone coach within Better Lives, and plan to recruit an additional coach to drive further peer led initiatives within the services.

8. Reducing the risk of drug related deaths

8.1. In February 2024, the Metropolitan Police confirmed that Nitazenes (potent synthetic opioids) had been detected in multiple substances recently seized from drug users and dealers across London. Four fatal overdoses occurred in Haringey near the Finsbury Park area between December ‘23 and February ’24, and whilst toxicology reports are awaited, there is concern that synthetic opioids may have been involved in those deaths.

8.2. Reducing the risk of drug related deaths remains a priority, with particular consideration given to people using opiates and for people leaving prison. The potential availability of synthetic opioids adds to this concern. 2024/25 will see Public Health and partners undertake additional work to reduce the risk of drug related deaths in Islington.

8.3. Public Health is in the process of commissioning and implementing a new surveillance product which will enable more timely reporting of fatal and non-fatal overdose events. This will enable system partners to work together to assess and respond to incidents and risks more rapidly than current systems allow.

8.4. By connecting more people to timely, appropriate treatment and support in the community, the additional investment we are making in our criminal justice system treatment pathways aims to reduce the risk of drug-related harm and death for people leaving prison. This includes additional roles within Better Lives, including prison link workers, and the SWIM programme, which provides a structured programme for men of Black Caribbean and Black African heritage.

8.5. Commissioners and services are publicising the risks and harm reduction advice to users and issuing additional Naloxone (overdose reversal medication) to service users. Through our Community of Practice and other networks, Commissioners are raising awareness of the risk with providers of supported and temporary housing, street outreach, and other front-line teams. The Community of Practice has enabled supported accommodation settings and Better Lives to connect more effectively, improving access to Naloxone training for staff and to same-day assessment and prescribing for residents in need. We are expanding the availability of Naloxone through Islington pharmacies, and of long-acting Opiate Substitution Treatment, which can help people manage withdrawal more effectively.

8.6. To understand the impact of these interventions, we are currently scoping a piece of social research to understand how harm reduction advice and products, including Naloxone, are being received and taken up by residents who use drugs.

9. Addressing inequalities

9.1. Our 2023 local area profile identified inequalities in the need and take up of treatment services in Islington., and ways in which vulnerabilities can overlap. These include the over-representation of people in drug treatment that describe themselves as long-term sick or disabled (29% compared to 5% of the Islington’s population overall), the under-representation of residents of Black and Asian ethnicity and the under-representation of people of Muslim faith. Mental health needs are higher in

the drug treatment population than the general population, and accessing effective treatment is particularly challenging for people with co-occurring drug or alcohol and mental health conditions.

9.2. Women represent around 30% of Islington's treatment population. Women with drug and alcohol needs are more likely than men to report having experienced sexual trauma, abusive relationships and feeling a greater burden of stigma around their drug use. Better Lives currently offer specialist groups for women, as well as the Family Service for those affected by someone else's drug or alcohol use.

9.3. An area of focus for 2024/25 is to improve the visibility and accessibility of Islington's community treatment services among groups currently under-represented. Public Health is currently developing a communication strategy and plans to engage more proactively with Voluntary and Community Sector partners and faith settings to support better understanding and meeting of the needs of local communities, and the facilitators and barriers to accessing services.

10. 2024/25 grant income and delivery plans

10.1. To support local authorities with the delivery of the outcomes outlined in the national strategy, every local authority in England has been awarded the Supplementary Substance Misuse Treatment and Recovery Grant (SSMTRG) – this funding is focused on treatment and recovery. The grant is awarded by and manged by the Department of Health and Social Care/Office of Health Improvement and Disparities (OHID).

10.2. Local authority areas identified as having the highest levels of need have been prioritised for early investment, including Islington. Indicative funding allocations published by OHID state that Islington will receive just over £4.9 million in total over three years from 2021/22.

10.3. The SSMTR grant is received in addition to funding through the Public Health Grant. Alcohol and substance misuse is the single largest area of expenditure, within the local Public Health Grant, accounting for around £7.1 million (25%) of this budget. In addition to these funding streams, separate funding is also being disseminated for policing and related activities around the objective of action on drug supply chains and related harms ("Project Adder"). Other nationally funded drug and alcohol programmes being implemented in Islington include Individual Placement and Support (IPS), which provides tailored employment support to people in recovery, and activities under the Rough Sleeping Drug and Alcohol Treatment Grant programme.

10.4. This is the third year of SSMTRG funding and represents the largest grant payment, with Islington receiving an income of £2,700,656 in the financial year 2024/25. Officers were notified of the grant allocation in December 2023 and subsequently liaised with key delivery partners and grant leads at OHID to agree how the grant could be spent to support the council in achieving the outcomes outlined in the national Drug Strategy. There was a short timeline for production of an outline plan that was submitted to OHID at the end of December for review; and Islington received notification in January 2024 that the plan had been approved.

10.5. Officers were encouraged by OHID programme leads to fund activities from the SSMTRG that would optimise the attainment of the desired outcomes. For 2024/25, these outcomes are 1) increasing the numbers of people accessing alcohol and substance misuse structured

treatment, 2) improving the number of people engaging with alcohol and substance misuse treatment on release from prison and 3) increasing the number of people that enter residential rehabilitation. Additionally, a local milestone plan was required as part of the grant conditions, which sets out quarterly steps and progress towards the outcomes.

10.6. To that end, Islington's agreed grant spending plan includes additional staff posts within its existing integrated treatment service (Better Lives). This will provide additional out-reach capability to reach more people in contact with other services (particularly criminal justice system and acute or secondary]healthcare) who have drug and alcohol treatment needs and will increase capacity in the service to safely and effectively manage their care. Some of these additional roles will be co-located with key delivery partners including the local probation service, in-reach to prisons and police custody suites, co-location with mental health core community teams and increasing in-reach to supported accommodation sites.

10.7. Ahead of 2024/25, OHID has notified the Council that it is one of six boroughs in London that had been identified as an area with high levels of unmet need based on estimates of drug use in the borough and as such will be monitored closely throughout 2024/25 to ensure delivery of key outcomes of the strategy.

10.8. Local conditions in place for the 2024/25 SSMTRG include:

- Maintain (or build on) the Council investment in drug and alcohol treatment and recovery system through the Public Health Grant.
- The Council must keep to the agreed milestones in the plan and agreed ambitions for treatment. Should these not be achieved, OHID will withhold the following proportions of funding within the year during 2024/25:
    - Meeting the milestones in the local plan (3%)
    - Meeting the ambitions for numbers of people in treatment (7%)

10.9. Islington's 2024/25 milestone plan is summarised under the four domains of capability, capacity, quality and pathways. These include the following:

Capability

- Assessment of resource in Public Health and Commissioning, and in management of grant delivery within the service.
- Continuation of the operational sub-groups of the Combating Drugs Partnership, with a particular focus on Criminal Justice Pathways and Health Services.
- Growing our recently established Community of Practice, which is focusing initially on our highest need and most complex residents and settings.
- Developing and making best use of data, including purchasing a new surveillance tool to enable system-wide monitoring and response to drug-related deaths and non-fatal overdoses.

Capacity

- Analysis of staffing structure within treatment service to identify opportunities to increase delivery.
- Plans to fund a Programme Manager and Data Manager post within the Trust to enhance programme coordination and reporting capacity.
- Investment in service premises to deliver improvements to make the services more inviting to prospective clients.

Quality

- Enhancing our local data capture through a revised suite of KPIs, the introduction of a referral log to better understand reasons for unplanned exits from treatment and support, and improved data capture around deaths of people who are in treatment.
- Introduction of a caseload monitoring indicator, to complement the service's own recent work around caseload segmentation.
- Working with system partners and service users to identify additional service elements that may improve the local offer. This so far includes – remote / digital options; same-day prescribing; enhanced outreach in hotspot areas.

Pathways

- Development of a Drug and Alcohol Liaison Team in partnership with the Wittington Hospital and Camden & Islington NHS Foundation Trust.
- Criminal Justice System pathway development, including co-location or in-reach at Islington custody suites.
- Improve rates of referral from primary care, emergency care and mental health services into drug and alcohol treatment.
- Strengthen our joint working with the Voluntary and Community Sector and with faith organisations, to raise awareness of help that is available and for service promotion to currently underserved community groups.
- Growing our recently established Community of Practice, which is focusing initially on services and workers who work with our highest need and most complex residents and settings.
- Developing and making best use of data, including purchasing a new surveillance product to enable system-wide monitoring and response drug-related deaths and non-fatal overdoses.

4.12. **Islington's 2024/25 SSMTRG delivery plans** focus on increasing the numbers of people accessing drug and alcohol treatment in the borough, both in the community and via the criminal justice system. Key aspects of the local delivery plans for the 2024/25 financial year – including new **(new)** and continuing (cont.) areas of investment - are as follows:

Programme capacity

- Programme Lead and Data Manager within NHS C&I **(new)**
- Branding and content creation to promote the service and streamline access **(new)**
- Commissioning / Public Health capacity – Public Health Strategist role (cont.)
- Additional specialist roles in Young People's service (cont.)

Outreach and peer support

- Additional outreach & entry into treatment capacity for OCU (opiate and crack use) cohort **(new)**
- Hostel In-reach Worker to increase capacity to connect hostel residents to treatment services **(new)**
- Senior Mental Health Worker specialising in substance misuse **(new)**
- Enhancing peer-support offer to include weekend provision and Senior Peer Recovery coaching **(new)**
- Peer to Peer Harm Reduction project – coach and training (cont.)

Criminal Justice System pathways

- NCL-wide Criminal Justice Data role (contribution) **(new)**
- Criminal Justice System pathway roles to improve treatment pathways (cont.)
- Support When It Matters 10-week structured support for men of Black African and Black Caribbean heritage moving from prison to the community (cont.)

Healthcare pathways

- Establish Drug and Alcohol Liaison Team at Wittington Hospital **(new)**
- Increased allocation of funds for residential rehab places **(new)**
- Clinical Psychologist to increase structured intervention delivery (cont.)

Reducing the risk of drug related deaths

- Surveillance product to support fatal and non-fatal overdose reporting **(new)**
- Expansion of long-acting Opiate Substitution Treatment availability **(new)**
- Provision of Naloxone (overdose reversal drug) in pharmacies (cont.)

11. Progress against the National Drugs Strategy

11.1. The first meeting of Islington's Combatting Drugs Partnership was held in December 2023, with good attendance from partners across health and social care, criminal justice, community safety, VCS and a range of local authority teams. The Partnership considered the Islington Local Area Profile, which summarised the published estimates of drug and alcohol need in the borough, the current service provision, and opportunities for service development across the system as a whole. The next CDP meeting will take place in Summer 2024, with a workshop session in development for Spring 2024.

11.2. In Autumn 2024, Islington Public Health launched a Drugs and Alcohol Community of Practice to bring together colleagues working with our most vulnerable and/or complex cohort, who tend to have multiple health and social needs. Improving access to drug treatment support for those in supported or temporary accommodation has been an early focus, which stands to benefit all residents in a setting and promote feelings of safety for staff and for those living in the community. To further this, Public Health is also working closely with Islington's commissioners of mental health accommodation – having recently joined its Provider Forum – to understand and help address the challenges co-occurring mental health and substance misuse needs can present for residents and for accommodation providers.

11.3. We have invested in a number of outreach roles which will provide greater opportunity to connect people with drug and alcohol services when they present in other areas of the system, particularly police and prison custody, and in healthcare. We have added strategic capacity to the Public Health team by funding a Public Health Strategist post specifically focused on drug and alcohol needs in Islington and developing the Combating Drugs Partnership.

11.4. Service performance is showing encouraging improvements. We have seen a modest but steady increase in the numbers of people in treatment in the 3 months up to December '23 (latest available data) in all four recorded treatment categories (opiate, non-opiate only, non-opiate and alcohol, alcohol only). Numbers in treatment in these three months are higher across all categories compared to the same period of the previous year. We can observe corresponding increases in the number of **new presentation** to treatment in the 3 months up to December '23 and compared to

the same three months of the previous year. Overall, the number of people in treatment increased year on year by 12% comparing 2023 with 2022, from 1,540 to 1,732. The number of new people starting treatment increased by 59%, from 497 to 791. This suggests that the treatment population has grown as a result of new courses of treatment starting, rather than people staying in treatment for longer periods.

11.5. Commissioners continue to work closely with the provider to monitor existing contract performance and delivery of the additional grant-funded elements. We begin the 2024/25 grant period in a more favourable position than 2023/24 owing to earlier confirmation of grant allocation and approval of plans by OHID. This will enable us to make substantial progress with internal governance, recruitment to roles, implementation of new contracts, etc. before the new financial year.

11.6. We are developing our data and reporting frameworks, and have completed a comprehensive local area profile, which described local need and services. The national focus on combating drugs and improving treatment outcomes appears to have directed resources into improving national data sets and to certain data products being generated or updated to support local teams. For example, drug and alcohol needs prevalence data has recently been refreshed, which will enable us to better estimate needs in Islington and how we might configure services to respond.

12. Implications

12.1. **Financial Implications**

12.1.1. There are no financial implications arising from this report. The measures and recommendations proposed in this report are not currently quantifiable. If recommendations are subsequently made about the use of any money or grants, this will require a full set of Financial Implications.

12.2. **Legal Implications**

12.2.1. The council has a duty to improve public health under the Health and Social Care Act 2012, section 12.

12.2.2. The council must take such steps as it considers appropriate for improving the health of the people in its area including providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way) as well as providing services or facilities for the prevention, diagnosis or treatment of illness (National Health Service Act 2006, section 2B, as amended by Health and Social Care Act 2012, section 12 and Regulation 2013/351 made under the National Health Service Act 2006, section 6C).

12.2.3. The council may, therefore provide integrated drug and alcohol services as proposed in this report.

12.3. **Environmental Implications and contribution to achieving a net zero carbon Islington by 2030**

12.3.1. There are no environmental implications as a result of this report.

12.4. **Equalities Impact Assessment**

12.4.1. 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.

13. Conclusion and reasons for recommendation

13.1. There is a significant programme of local work underway to take forward the goals of the national strategy for drug and alcohol misuse and make best use of the Supplementary Substance Misuse Treatment and Recovery Grant to improve access and continuity of care in treatment.

13.2. There are early and encouraging signs of improvement in numbers of people in treatment, and a notable increase among all categories of need in numbers of people starting treatment. Pathways with criminal justice services have been an early priority focus, and this is expanding out more widely to health and social care and community and voluntary sector services. These pathways will support continued and increasing partnership opportunities to improve health and health inequalities, address community safety needs and reduce other impacts and harms caused by alcohol and drugs in Islington.

Appendices:

Local area profile

Background papers:

None

Final report clearance:

Signed by: J E O’Sullivan

Director of Public Health

Date: 5 April 2024

Drug and alcohol local area profile

London Borough of Islington, December 2023

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Aims

This area profile:

- Provides baseline **data** on drug use and its related harms through the following sections:
    1. Prevalence of drug use
    2. Drug-related harm
    3. Crime and community safety
    4. Drug treatments and services
- Identifies **gaps** in the existing evidence base and our knowledge of population need
- Facilitates translation of national strategic commitments to local objectives
- Highlights potential areas of focus for the year 2023/24 and beyond

Contents

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Key Findings

Prevalence data on drug use at borough level is limited. However, modelled estimates (best available source) suggest drug (**opiate and crack cocaine**) use in Islington is the highest in London, and has been increasing since 2016/17. It is also estimated that Islington has one of the highest alcohol dependency rates in London.

Whilst estimates may not be precisely accurate, there are **high treatment needs in Islington**, which are higher than at a regional or national level.

The most commonly used drugs in England and Wales in 2018/19 were **cannabis**, **powder cocaine**, and **nitrous oxide**. While local data is not available, we may anticipate similar patterns in London and Islington.

Certain groups are under-represented in drug and alcohol treatment in Islington – this includes people from **Black** and **Asian** ethnic backgrounds, **Muslim** people, and **women**.

Nearly one-quarter of people presenting to drug and alcohol treatment in Islington reported problems with their **housing**, with nearly 10% reporting an urgent housing need. This is higher than regional or national figures.

Just under one third of drug and alcohol service users described themselves as **long-term sick or disabled**, compared to 5% of Islington's population overall.

Continuity of care rates for people leaving prison are low in Islington, with most recent data showing that only 29% of people in Islington received structured drug and alcohol treatment within 21 days of their prison exit date.

Introduction

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National Context

In 2018, Dame Carol Black was commissioned by the Home Office and the Department of Health and Social Care (DHSC) to undertake an **independent review of drugs** to inform the government's approach to tackling the harm that drugs cause.

Part 1 – Findings

3 million people took drugs in England and Wales in 2019.

300,000 opiates and/or crack cocaine users in England.

Drug **deaths** in the UK reached an **all-time high** in 2018 (2,917).

Drugs within **prisons** are widely available, with ~15% of prisoners testing positive to random drug tests.

Considerable increase in **children and young people** using drugs.

Part 2 – Recommendations

By the end of year 5, the government should invest:

- An additional £552 million in the **treatment** system through Department of Health and Social Care (DHSC).
- An additional £15 million in **employment** support through Department for Work and Pensions (DWP).

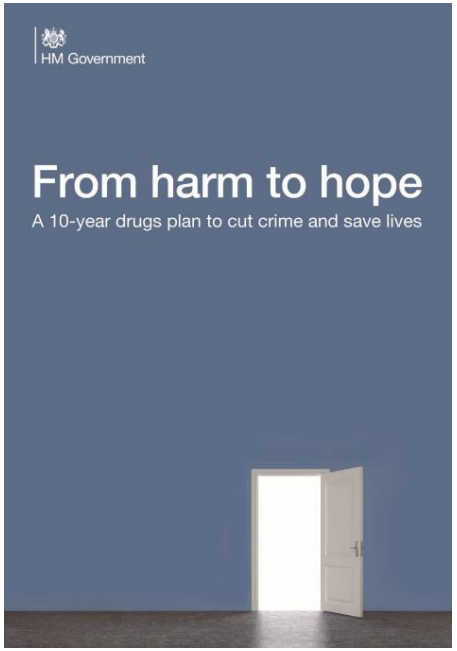
Funding for drug services should be guided by **needs assessment** and ring-fenced within local authority.

DHSC should commission HEE to devise a comprehensive **workforce** strategy.

DHSC should make increased funding available to specialist substance misuse services for **young people.**

'From Harm to Hope' - the National Strategy

Building on the conclusions of the Dame Carol Black report, a 10-year national drug strategy entitled ‘From Harm to Hope’ was published in December 2021, underpinned by a record investment of £3 billion over the next 3 years.



Three strategic priorities:

1. **Break drug supply chains**
   - Preventing drugs from reaching and entering the UK
   - Disrupting local drug gangs and street dealing, and seizing their cash
2. **Deliver a world-class treatment and recovery system**
   - Rebuild local authority commissioned substance misuse services
   - Develop and deliver a comprehensive substance misuse workforce strategy
   - Keeping prisoners engaged in treatment after release – better continuity of care into the community
3. **Achieve a generational shift in the demand for drugs**
   - Delivering school-based prevention and early intervention
   - Supporting young people and families most at risk of substance misuse – including Supporting Families Programme

Source: From harm to hope: A 10-year drugs plan to cut crime and save lives, HM Government, 2021

Islington Combating Drugs Partnership (CDP)

- The national strategy asked all local areas to establish Combating Drugs Partnerships (CDPs) as a **mechanism for delivering** the national strategy in local areas.
- The CDP will provide **strategic oversight** of the work covered under the national 10-year drug strategy.
  - Multi-agency forum that is accountable for delivering the outcomes outlined in the National Strategy
  - Subgroups created within the CDP will provide operational response
- The group will **advise**, **prioritise**, and **encourage** the mobilisation of **local action** as part of a whole system approach to combating drugs.
- CDP will:
  - Report into Health and Wellbeing Board
  - Work in partnership with Safer Islington Partnership

Islington CDP timeline

August 2023

Operational subgroups created:

Criminal Justice
- Focused on improving rates of continuity of care and diversion from police custody into treatment/support.

Workforce (NCL-wide)
- Focused on improving career pathways and addressing recruitment challenges across the NCL region

Healthcare Pathways/Alcohol
- Alcohol group focused on developing a Drug & Alcohol Liaison Team pilot at the Whittington Hospital

December 2023

Combating Drugs Partnership meeting

Grant income and delivery plans in Islington

- Every local authority in England has been awarded the **Supplementary Substance Misuse Treatment and Recovery Grant** (SSMTRG) – this funding is focused on treatment and recovery.
  - Indicative funding allocations published by OHID state that Islington will receive just over **£4.9 million over three years from 2021/22**.
  - Islington's SSMTR grant income for the financial year is £1.4 million
- Local authority areas identified as having the highest levels of need have been prioritised for early investment
  - Islington has been designated a "**priority partnership**" by OHID, i.e. the Council has been identified as an area where the greatest gains in achieving particular outcomes of the strategy have been identified
- Focus on:
  - **Increasing the numbers of people in treatment**
  - **Improving criminal justice pathways**

Progress against the National Strategy: 2022/23

- Investment in **outreach roles**
  - Will provide greater opportunity to connect people with drug and alcohol services when they present in other areas of the system, particularly police and prison custody, and in healthcare
- New **strategic capacity** added to the Public Health team
  - Public Health Strategist post specifically focused on drug and alcohol needs in Islington and developing the Combating Drugs Partnership.
- Recent self-assessment of **continuity of care** received by drug and alcohol users leaving custody
  - Highlighted opportunities to improve several aspects of the pathway and information-sharing between partners
  - Action plan – will be owned by Combating Drugs Partnership CJS sub-group.
- Identifying areas for **regional collaboration**
  - Combating Drugs Partnership sub-group for workforce was formed from cross-borough discussions in NCL – anticipate partnering with other North London boroughs around prison pathways

Islington: Population

Age structure and population density

- Islington has an overall **younger population** than London, with 40% of residents aged between 15-34, compared to 30% in London.
- Islington is the **2nd most densely populated borough in London** and England, with 14,575 persons per km^2 in 2021

Country of birth, ethnicity, language, and religion

- **40% of Islington residents identify as White British** and 16% as another White ethnic group.
- **13% identify as Black**, **7% identify as Asian**, and 15% as mixed, multiple or other ethnic groups.

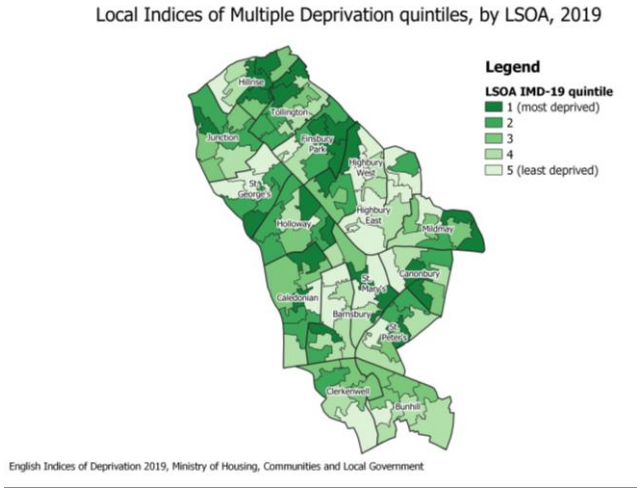
General health, disability, and economic activity

- 32% of Islington residents are economically inactive. Of these, **5.3% of these long-term sick or disabled**.
- 55% of Islington residents report themselves as being in 'very good health', while just over 5% report 'bad' or 'very bad' health.
- **16%** of Islington residents are classified as **disabled** under the Equality Act.

Source: 2021 Census; ONS, 2023

Deprivation, household composition, and housing

Figure 1: Islington IMD map by national deprivation deciles.



Islington is the 6th most deprived borough in London, and 53rd most deprived in England (out of 317 local authorities).

Six lower layer super output areas (LSOAs) in Islington are in the 10% most deprived nationally. These are located in **Caledonian, Finsbury Park, Hillrise, Junction,** and **Tufnell Park** wards.

Islington is ranked the 4th most income deprived local authority in London, and 35th in England.

Income deprivation in Islington affects children and older people more than income deprivation overall. Islington has the 10th highest level of income deprivation affecting children, and 4th highest in England for income deprivation affecting older people.

Prevalence of Drug Use in Islington

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Drug and alcohol prevalence: overview

It is estimated that in 2019/20, Islington had the **highest prevalence of opiate and/or crack cocaine use in London**.[1]

Modelled prevalence data suggests there were an estimated **3,960** opiate and/or crack cocaine users in Islington in 2019/20, at a rate of **21.5 per 1,000 population**.[1]

In London, the rate of opiate and/or crack cocaine use was **10.9 per 1,000 population** in 2019/20. In England, the rate of opiate and/or crack cocaine use was **9.5 per 1,000 population** in 2019/20.[1]

Nationally, the most commonly used drugs are **cannabis** (2.5 million users), **powder cocaine** (976,000 users), **nitrous oxide** (763,000 users), and **ecstasy** (524,000 users).[2] While local data is not available, we may anticipate similar patterns in London and Islington.

In 2021, **7%** of Year 8-10 pupils in Islington reported that they had taken drugs, while **12%** reported that they had been offered drugs.[3]

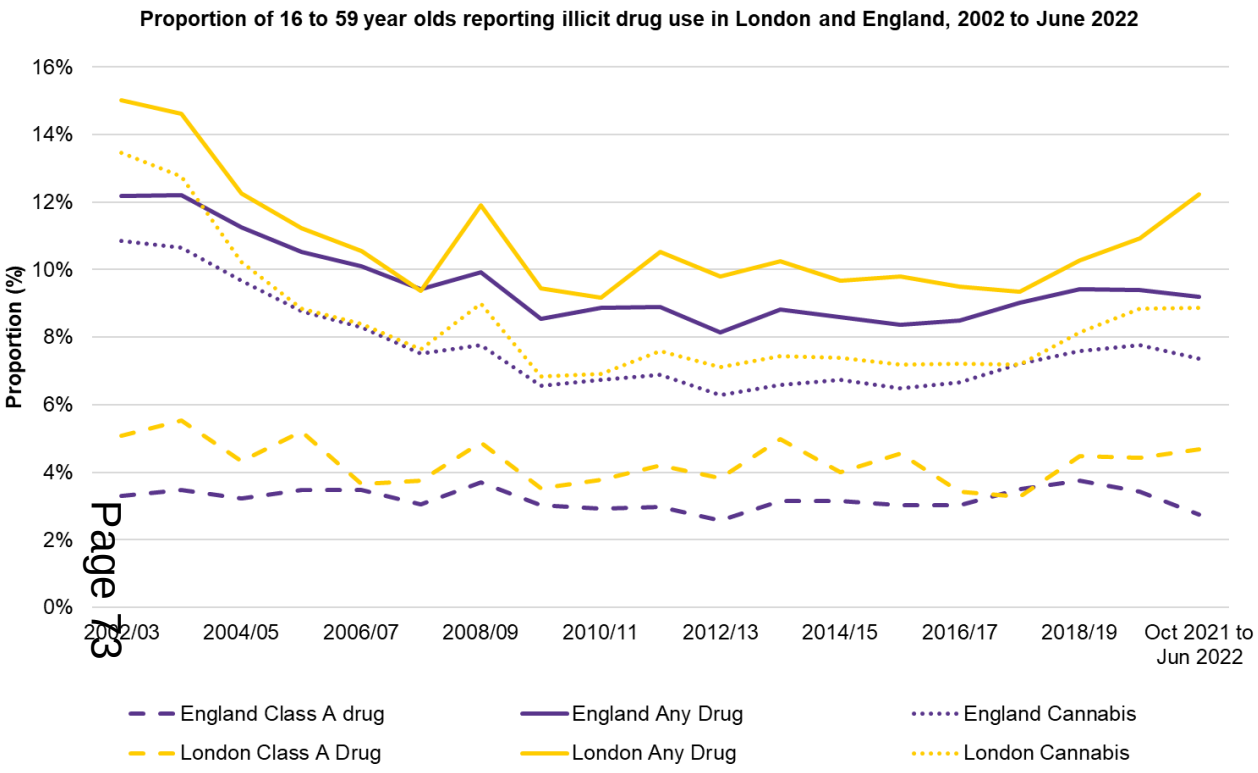
As with adults, **cannabis** is the most popular drug among school aged children, with 7% of secondary school pupils in England reporting cannabis use in 2019. **Nitrous oxide** and **cocaine** are also in the top four most reportedly used substances in children, as seen in adults. However, the use of **glue, gas, aerosols or solvents** is relatively higher among children, cited as the second most used drug among secondary school pupils in England in 2021, at 2.4%.[3]

It is estimated that in 2018/19 (latest available data), Islington had the **second highest prevalence of alcohol dependency** in London, with a rate of 17.9 per 1,000 population. Based on an 18+ population estimate of 197,044, this suggests that in 2018/19, there were approximately **3,535** people with an alcohol dependency in Islington. **Hackney** was estimated to have the highest prevalence of alcohol dependency in London, with a rate of 18.3 per 1,000 population.[1]

[1] NDTMS, 2023
[2] Dame Carol Black Report Evidence Pack, 2020
[3] Islington Children and Young People Joint Strategic Needs Assessment, 2023

Prevalence of drug use in London and England

Figure 2



Source: Office for National Statistics - Crime Survey for England and Wales, 2022

The Crime Survey for England and Wales provides 20 years' worth of data regarding self-reported illicit drug use, from 2001 to June 2022.

In London, the proportion of 16 to 59 year olds reporting illicit drug use in the past year **decreased** overall between from 15% in 2002/03 to 12% in June 2022.

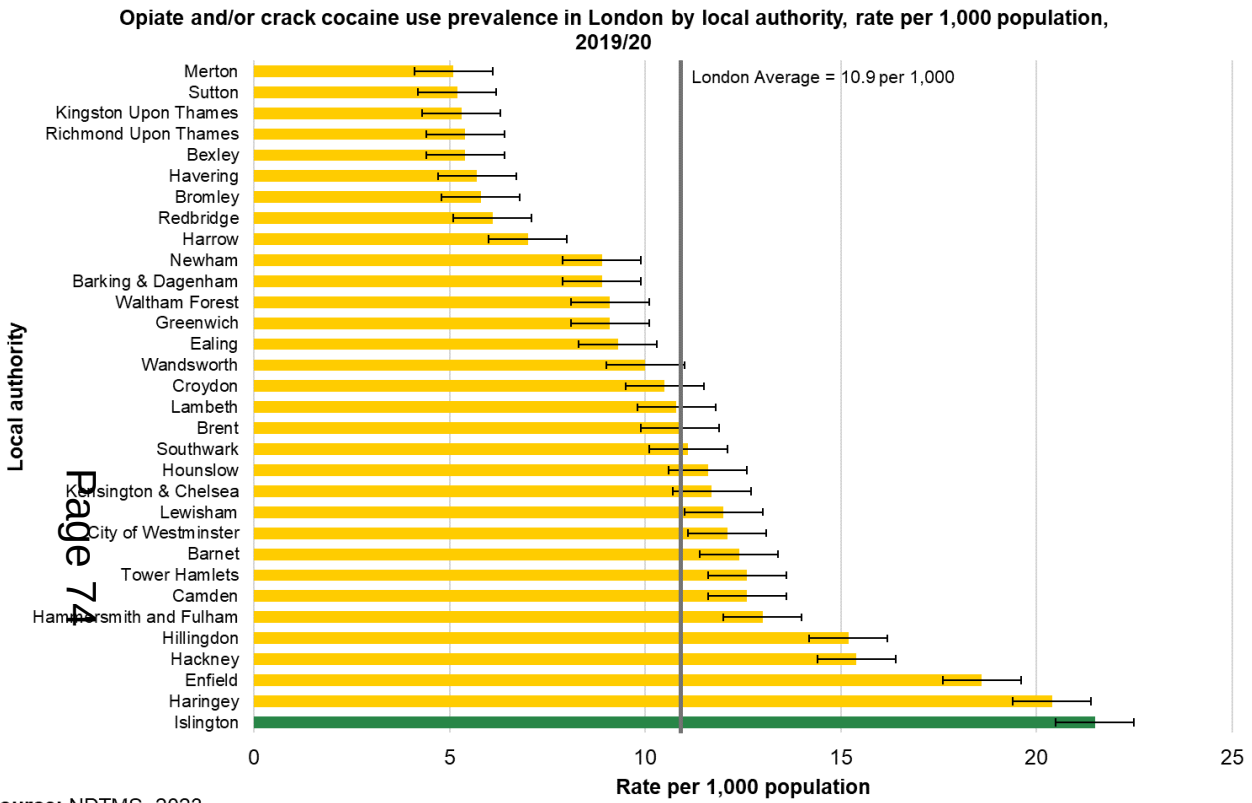
However, **since 2016/17 illicit drug use has started to increase in London**, rising from 10% to 12%.

The overall trend of self-reported illicit drug use in London appears to mirror national trends, though is **higher than the England average (9% in June 2022)**. Furthermore, in contrast to London, there has been a relative plateau noted on a national level in illicit drug use between 2017/18 to June 2022.

About this data: Prevalence estimates are provided by the Crime Survey for England and Wales, a face-to-face survey in which people resident in households in England and Wales are asked about their experiences of a range of crimes in the 12 months prior to the interview. It does not cover certain key groups, such as those experiencing homelessness and those livings in institutions such as prisons.

Prevalence of opiate and crack cocaine use in London by local authority

Figure 3



Source: NDTMS, 2023

It is estimated that in 2019/20, Islington had the **highest prevalence of opiate and/or crack cocaine use in London** (rate of 21.5 per 1,000 population), and the **5th highest** prevalence out of all local authorities in England.

The City of London was excluded from this analysis due to skewed rates secondary to a small number of residents.

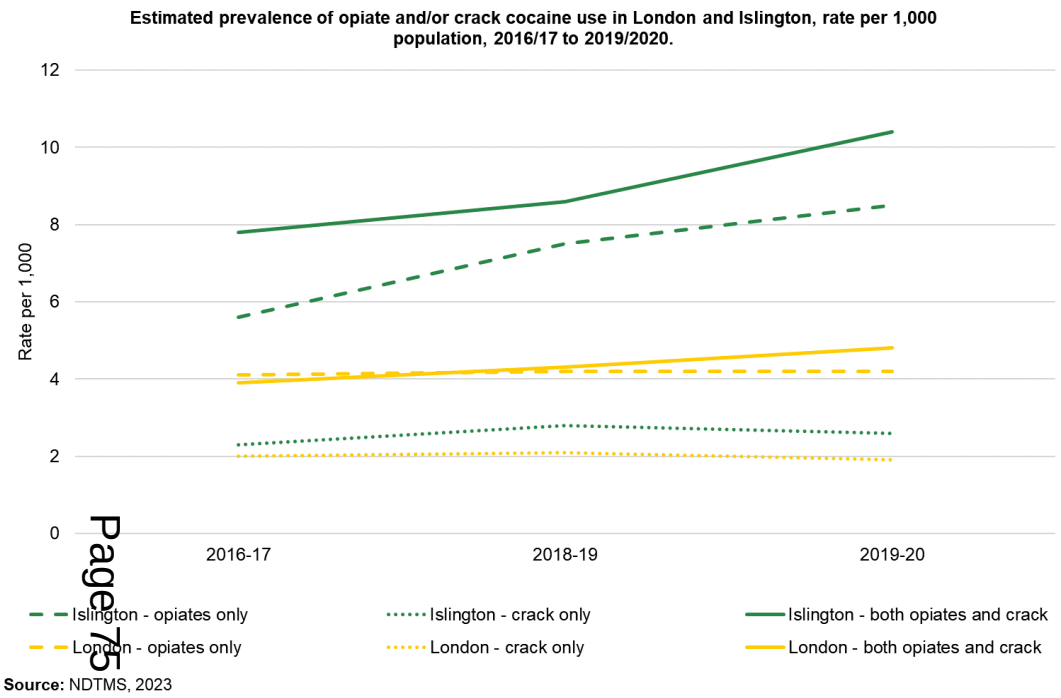
The next highest estimated rates of OCU prevalence in London in 2019/20 were in **Haringey** (20.4), **Enfield** (18.6), and **Hackney** (15.4).

In **England**, the rate of opiate and/or crack cocaine use was **9.5 per 1,000 population in 2019/20**. The breakdown of this was a rate of 4.6 for opiates only, 3.6 for both opiates and crack, and 1.3 for crack only.

About this data: Prevalence estimates are provided by the Office for Health Improvements and Disparities (OHID) and the UK Health Security Agency (UKHSA). The modelling incorporates 3 data sources – National Drug Treatment Monitoring System (NDTMS) information on people in community drug treatment, criminal justice system information on arrest records and drug treatment in prisons, and drug-related mortality information from the Office for National Statistics' (ONS) mortality register.

Prevalence of opiate and crack cocaine use over time

Figure 4



Source: NDTMS, 2023

About this data: Prevalence estimates for 2016/17-2019/20 are provided by the Office for Health Improvements and Disparities (OHID) and the UK Health Security Agency (UKHSA). The modelling incorporates 3 data sources – National Drug Treatment Monitoring System (NDTMS) information on people in community drug treatment, criminal justice system information on arrest records and drug treatment in prisons, and drug-related mortality information from the Office for National Statistics' (ONS) mortality register.

Modelled prevalence data suggests there were an estimated **3,960** opiate and/or crack cocaine users in Islington in 2019-2020, at a rate of **21.5 per 1,000 population. Use among males was four times higher than among females** (34.3 per 1,000 population vs 8.4 per 1,000 population).

Of the 3,960 estimated users of opiate and/or crack cocaine in Islington in 2019-2020:

- **1,911** used both opiates and crack cocaine (48%; rate of 10.4 per 1,000 population);
- **1,564** used opiates only (40%; rate of 8.5 per 1,000 population);
- **485** used crack only (12%; rate of 2.6 per 1,000 population).

The use of opiates and/or crack cocaine in Islington is thought to have increased between 2016 and 2020 from 2,777 to 3,960 estimated users. This increase appears to be driven more by an increase in opiate use than crack cocaine use. Indeed, there was a **4% decrease in users of crack cocaine only** in Islington between 2018-19 and 2019-20, from 505 to 485 estimated users.

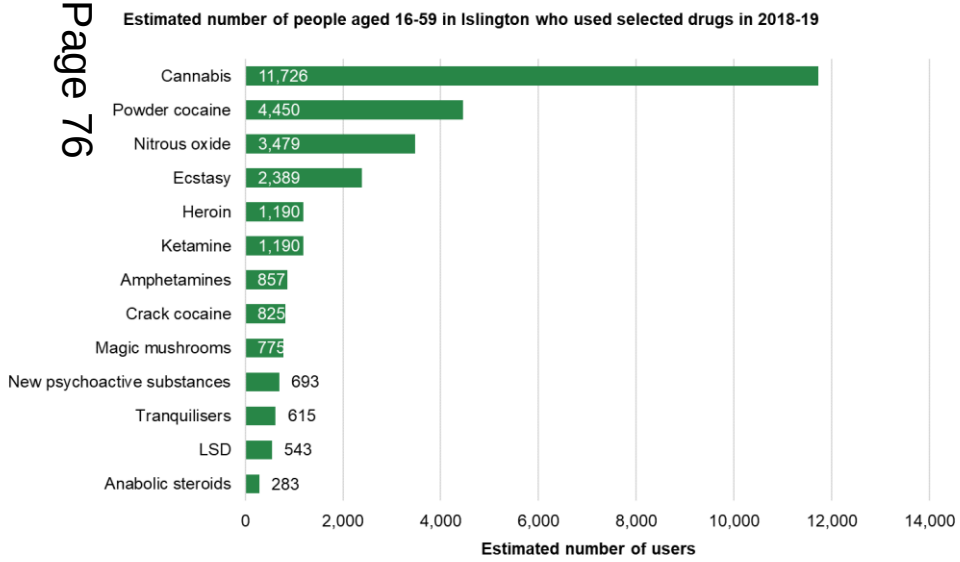
While trends in Islington mirror those seen across London, there are estimated to be twice as many opiate and/or crack cocaine users in Islington than across London (**21.5 per 1,000 vs 10.9 per 1,000**).

Recreational drug use by substance

Table 1: Proportion of total population aged 16-59 and 16-24 reporting drug use by substance in England and Wales in 2018/19.

Drug	Proportion of population **aged 16-59** reporting use	Proportion of population **aged 16-24** reporting use
Cannabis	7.6%	17.3%
Powder cocaine	2.9%	6.2%
Nitrous oxide	2.3%	8.7%
Ecstasy	1.6%	4.7%

Figure 5



Note: Estimates based on England and Wales prevalence adjusted to Islington population.

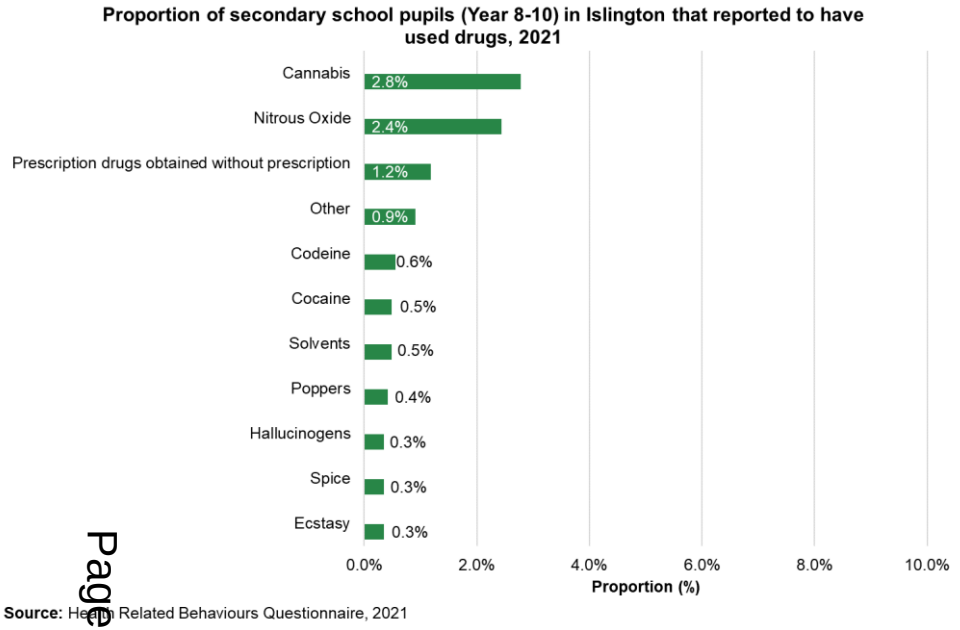
Source: Crime Survey for England and Wales, 2018-19.

- **Cannabis** was the most commonly used drug in England in Wales in 2018/19 (most up-to-date data available), with **7.6%** of people aged 16 to 59 years old and **17.3%** of people aged 16 to 24 years old reporting cannabis use.
- There is no **local data** on the prevalence of drug use by substance in Islington. Applying national estimates to the Islington population show an estimated 11,700 cannabis users.
- These estimates do not take into account Islington's demographics, particularly its relatively young population. Prevalence of drug use locally may therefore be higher than estimated.
- Several data sources can be analysed to give a broader picture of local drug use. These include drug treatment service data (i.e., numbers accessing services), acute hospital presentations related to substance use, and substance-related ambulance and police call-outs. However, this data is likely to under-represent recreational drug use, which is less likely to result in healthcare or criminal justice system encounters.

About this data: Prevalence estimates are provided by the Crime Survey for England and Wales, a face-to-face survey in which people resident in households in England and Wales are asked about their experiences of a range of crimes in the 12 months prior to the interview. It does not cover certain key groups, such as those experiencing homelessness and those livings in institutions such as prisons.

Drug use among children and young people

Figure 6



Source: Health Related Behaviours Questionnaire, 2021

- In 2021, **7%** of Year 8-10 pupils in Islington reported that they had taken drugs. **12%** reported that they had been offered drugs.
- Among Year 10 pupils, the most used drug was **cannabis**, followed by **nitrous oxide** (7% and 4% respectively). The reported usage of cannabis among Year 10 pupils has halved since 2017 (see Table 2).
- This mirrors the national picture, with 6% of secondary pupils in England reporting cannabis use in 2021 (Figure 6).
- Across England, there was a decrease in the proportion of pupils who reported taking drugs in the past year in England between 2016 and 2021, falling from 18% to 12%. **In 2021, 18% of pupils reported ever taking drugs, down from 24% in 2016**.

Table 2: Proportion of Year 10 students in Islington offered and used individual drugs, 2017 and 2021.

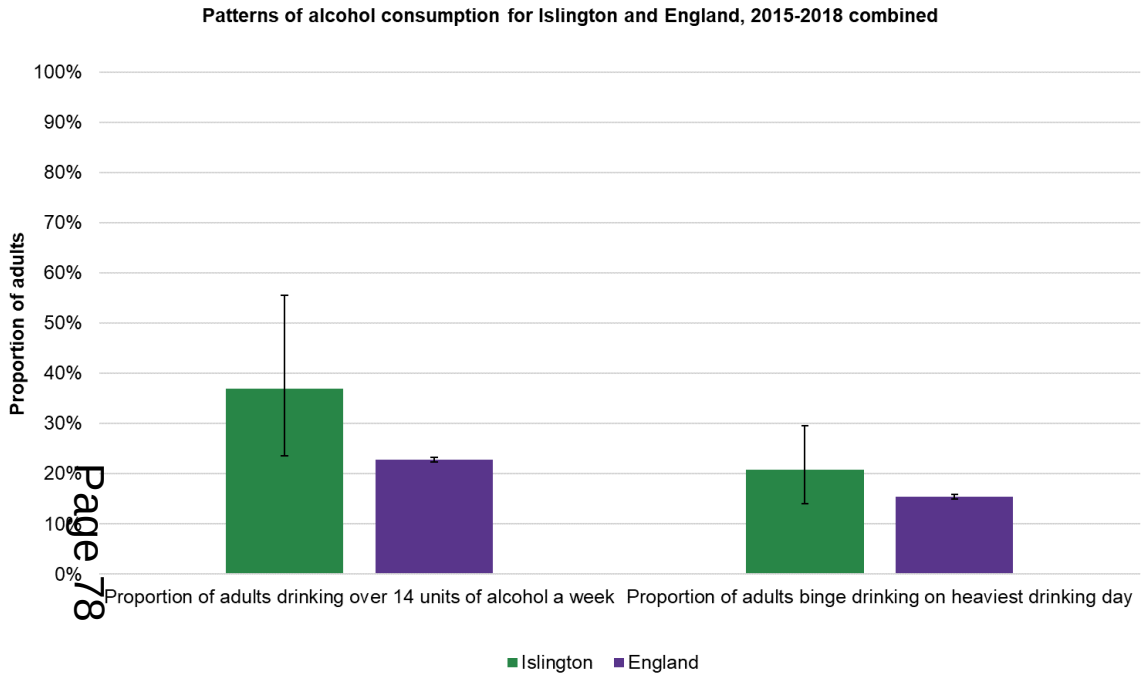
Drug	2017		2021	
	% Offered	% Used	% Offered	% Used
Cannabis	23	14	20	7
Nitrous oxide (not asked in 2017)	-	-	10	4
Solvents used as drugs	8	5	4	0
Poppers	4	1	3	0
Cocaine	6	2	3	0
Ecstasy	6	2	3	0

Source: Islington Children and Young People Joint Strategic Needs Assessment, 2023

About this data (Figure 6):
The Survey on Smoking, Drinking and drug use in young people in England takes place in secondary schools, with pupils in years 7 to 11, mostly aged 11 to 15. It covers a range of topics including prevalence, habits, attitudes, and wellbeing. Since 2016, the survey has run every 2 years, however, the 2020 survey was postponed to 2021 due to COVID-19. Novel psychoactive substances (NPS) and nitrous oxide were added to the list of drugs included for overall drug prevalence measures in 2016. For this reason, it is not recommended that direct comparisons are made with drug prevalence data prior to 2016.

Prevalence of alcohol dependency

Figure 7



Source: NDTMS, 2023

About this data:
The data presented here gives an indication of potential local need for some form of alcohol intervention and is a weighted estimate from the Health Survey for England (2015-2018 combined).

- Data from the Health Survey for England estimates that, between 2015-2018, Islington had a **higher proportion of adults drinking over the recommended unit limit per week** and a higher proportion of adults **binge drinking** than in England.
- It is estimated that in 2018-19 (latest available data), Islington had the **second highest prevalence of alcohol dependency in London**, with a rate of 17.9 per 1,000 population.
- Based on an 18+ population estimate of 197,044, this suggests that in 2018/19, there were approximately **3,535 people with an alcohol dependency in Islington**.
- **Hackney** was estimated to have the highest prevalence of alcohol dependency in London, with a rate of 18.3 per 1,000 population.
- Whilst the rate of alcohol dependency in Islington **decreased** between 2016-17 and 2018-19 from 19.4 to 17.9 per 1,000 population, it **remained higher than average estimated rates in London** (13.5) and **England** (13.7).[1]

[1] Public Health England, 2021

Drug Related Harm

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Drug-related harm: overview

Islington had the **6th highest rate of drug misuse deaths in London in 2019-2021, with a rate of 8.4 per 100,000.** The London boroughs with the highest rate of drug misuse deaths in this time frame were Hammersmith and Fulham (11.3 per 100,000), Kensington and Chelsea (6 per 100,000), and Camden (5.9 per 100,000). [1]

Nationally, the mortality rate for deaths related to drug misuse have been **increasing yearly** over the past decade, reaching an **all-time high** in 2019-2021.[1]

The rate of hospital admissions with a primary diagnosis of poisoning by drug misuse in Islington in 2019/20 was **15 per 100,000** in 2019/20, which is in line with the London average (12 per 100,000). This is lower than the national average of 31 per 100,000.[2]

The rate of hospital admissions with a primary diagnosis of drug-related mental health and behavioural disorders has been **lower in Islington than in London and England** over the past decade. In 2019/20, the rate in Islington was 6 per 100,000, compared to 11 and 13 per 100,000 in London and England, respectively.

The number of **substance-related ambulance call outs** in Islington **decreased** from 80 in **2017** to 39 in **2020**. This number **increased slightly in 2021 and 2022**, to 44 and 46, respectively. The rate of substance-related call outs per 1,000 ambulance call outs in Islington was 1.1 in 2022. This is **slightly higher than the rate of in London** (0.9 per 1,000 ambulance call outs).[3]

By ward, **Barnsbury** had the highest number of substance-related ambulance call outs between 2017-2022 with 51, followed by Finsbury Park (29).[3]

In 2021, Islington had the **second highest rate of deaths due to alcohol-related conditions** in London. In 2021/22, Islington had the second highest rate of alcohol-related hospital admissions in London.

[1] Office for National Statistics, 2022
[2] NHS Digital, 2021
[3] SafeStats, 2023

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Alcohol-related hospital admissions

In 2021/22 in Islington there were **543** per 100,000 hospital admissions where the primary diagnosis was an alcohol-related condition. This was the **second highest rate in London** (after Ealing, at 593 per 100,000) and significantly higher than both the London and England averages.

The rate of admission was significantly higher among males than females.

Table 3: Rate of alcohol-related hospital admissions in Islington in 2021/22 by age group

Age group	Number of admissions	Rate (per 100,000)	Significant difference to London	Significant difference to England
Under 40	175	116	No Difference	Lower
40-64	495	848	Higher	Higher
65+	219	1,046	Higher	Higher

The rate of admission increases with age, with the 65+ population having a rate of 1,046 per 100,000. However, the largest number of admissions were seen in the 40-64 age group (n=495).

Source: OHID, 2023.

Alcohol-related mortality

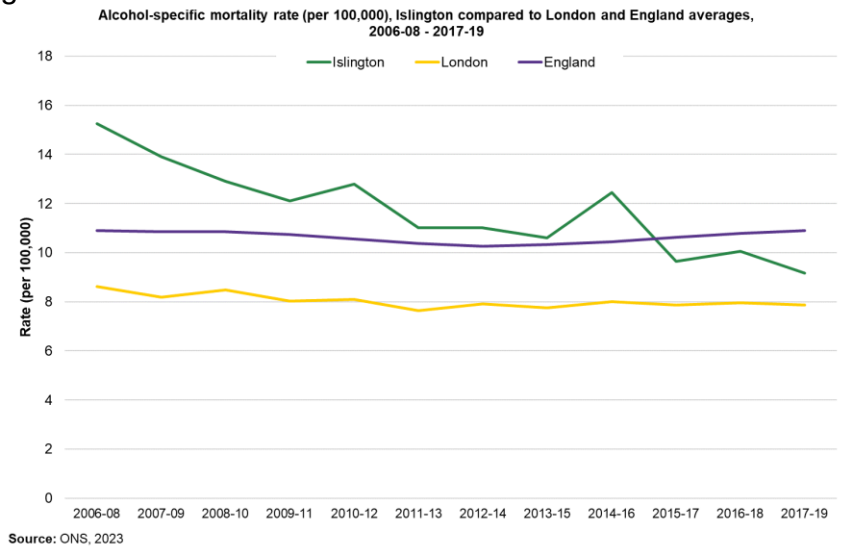
In 2021, **46** per 100,000 deaths were due to alcohol-related conditions. This was the **second highest rate in London** (after Hammersmith and Fulham, at 48 per 100,000) and significantly higher than the London average. Males were three times more likely to die from alcohol-related conditions than females (49 per 100,000 vs 18 per 100,000).

Alcohol-specific mortality

In 2021, **17** per 100,000 deaths were due to alcohol-specific conditions. The **third highest rate** in London and significantly higher than the London average.

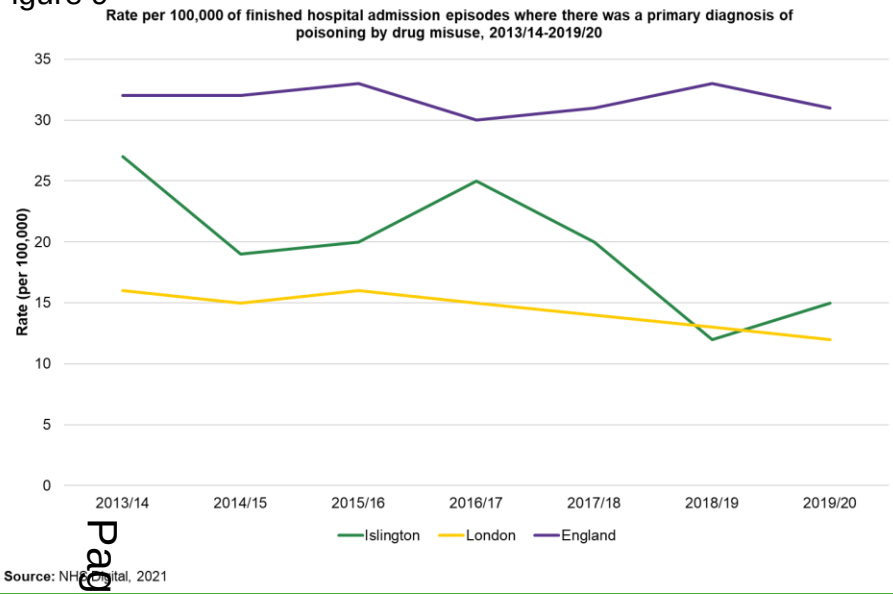
3-year trends shows that there has been a general decline in alcohol-specific deaths in Islington since 2006-2008.

Figure 8



Hospital admissions due to drug poisoning

Figure 9



Source: NHS Digital, 2021

Rates of hospital admissions with a primary diagnosis of poisoning by drug misuse in Islington has fluctuated year-on-year (Figure 8). There was a general decline from 2016/17 to 2018/19 from 25 to 13 per 100,000, however there with a slight increase from 13 per 100,000 in 2018/19 to **15 per 100,000** in 2019/20.

This is slightly higher with the London average (12 per 100,000), but **lower than the national average of 31 per 100,000**.

About this data:
This data from NHS Digital presents information on inpatient settings only. Hospital admissions with a primary diagnosis of 'poisoning by drug misuse' are defined as poisoning by illicit drugs, i.e., those that are listed as controlled under the Misuse of Drugs Act 1971. Rates are age-standardised

Drug-related mental health and behavioural disorders

Rates of hospital admissions with a primary diagnosis of drug-related **mental health and behavioural disorders** have been lower in Islington than in London and England over the past decade. In 2019/20, the rate in Islington was **6 per 100,000**, compared to **11** and **13** per 100,000 in London and England, respectively.

Men were more likely to be admitted for drug-related mental health and behavioural disorders than women.

A&E Admissions

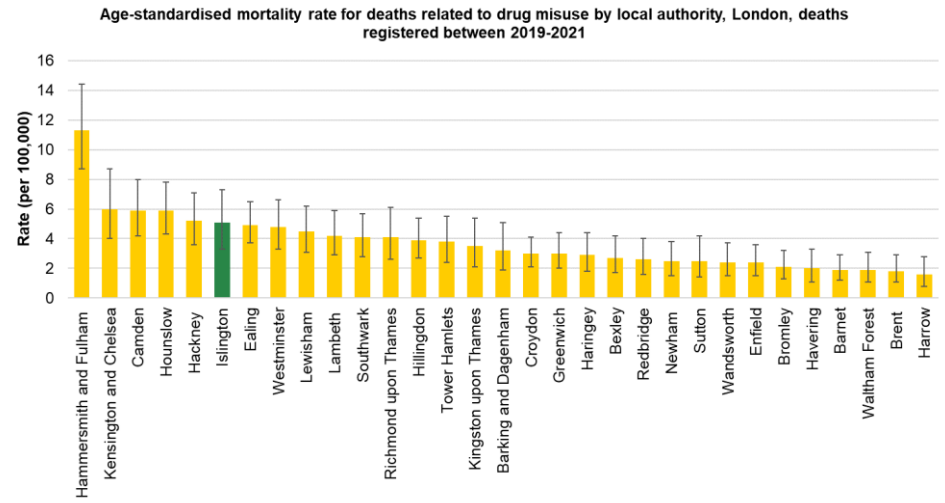
In 2021/22, at the **Whittington Hospital** (the only A&E department in Islington) there were **105 A&E attendances where 'illicit drug use'** was the First or Second Diagnosis Code.[1]

However, illicit drug-related health issues may be coded under a number of diagnosis codes, including 'overdose of opiate' (65 attendances), 'sedative overdose' (50 attendances), 'drug-induced seizure' (15 attendances), and other physical health conditions that may have been caused by illicit drug use.

[1] NHS Digital, 2022

Drug-related deaths

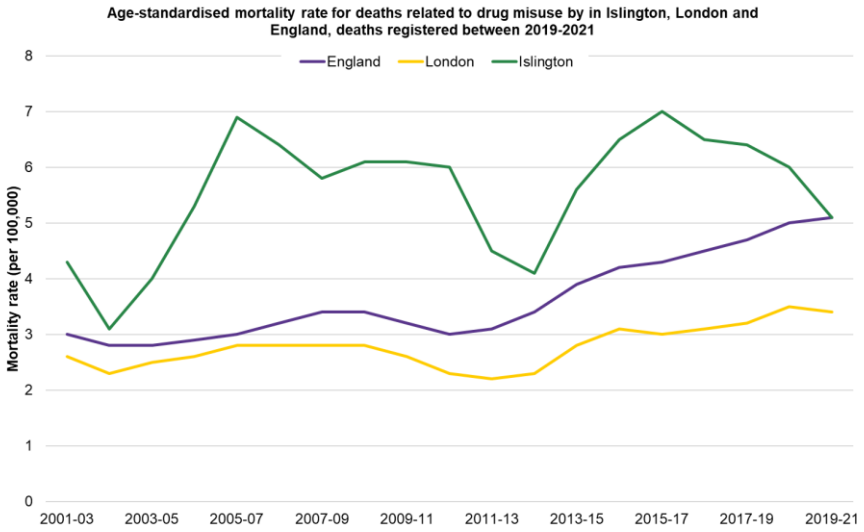
Figure 10



Note: City of London and Merton have been excluded due to small numbers.

Source: Office for National Statistics

Figure 11



Source: Office for National Statistics

In 2019-2021, there were **30 deaths** due to drug misuse in Islington, a rate of **5.1 per 100,000**. This was the **sixth highest rate in London**. 70% of deaths in Islington in 2019-2021 were males.

Generally, the rate of death due to drug misuse in Islington has **declined from 2015-17**, which contrasts the picture seen at a regional and national level which has seen an increase in the death rate. However, the mortality rate in Islington fluctuates year-on-year, due to the small number of deaths. This is similar in other London boroughs. Rates of drug misuse death in England continue to be elevated among those born in the 1970s, with the highest rate in those aged **45 to 49 years**.

Approximately half of all drug poisoning deaths registered in 2021 in England involved an **opiate** (46%). Of note, there was an 88% increase in deaths involving **new psychoactive substances (NPS)** and a 29% increase in deaths involving **methadone** between 2020 and 2021.

About this data:
Statistics on mortality are derived from the information provided when deaths are certified and registered. A death classified as drug misuse must be a drug poisoning and meet at least one of the following conditions. The first condition is that the underlying cause is drug abuse or drug dependence, defined by ICD-10 as mental and behavioural disorders as a result of use of: opioids, cannabinoids, sedatives or hypnotics, cocaine, other stimulants, including caffeine, hallucinogens, or multiple drug use and use of other psychoactive substances. The second condition is if any of the substances controlled under the Misuse of Drugs Act 1971 are involved – this includes class A, B and C drugs.

Drug-related deaths in Camden and Islington

A review of drug-related deaths in Camden and Islington was undertaken in January 2021, when Public Health was a joint service between the two councils. This review looked at deaths which occurred in treatment, meaning the person either died whilst in contact with community treatment, or they had not been discharged from community treatment.

The review looked at 46 drug-related deaths which occurred between March 2020 and January 2021. Of these, 28 were male, 16 female, and 2 unknown. The mean age at time of death was 52.7 years, with a range from 22 to 73 years.

Most people were using two substances, with the most commonly used substances being **heroin**, **crack cocaine**, and **alcohol**.

Key issues identified were: no recent **urine drug screen** (UDS), no regular **face-to-face** contact (review took place during COVID-19 restrictions), inaccurate and/or out of date **case notes**, no provision of **naloxone**, missed **pharmacy pick-ups** with no alerts and change or absence of a **caseworker**.

Recommendations of the review included:

- Ensure sufficient in-person appointments, not just phone appointments
- Make adequate and appropriate use of UDS
- Ensure system of prompt notification by pharmacy and follow-up action by service if a methadone collection is missed
- Ensure adequate casework capacity and quality.

The findings and recommendations of the review were shared with the treatment provider upon completion.

New psychoactive substances (NPS)

New Psychoactive Substances (NPS) – “designer drugs” – refers to **laboratory-generated substances** that mimic the effects of existing drugs, and which are not in use as medicines. Safety concerns about their use typically stem from their being novel substances, meaning users are not able to foresee a drugs’ strength or effects, including its interaction with alcohol or other substances.[1]

In 2021, there were **258 deaths involving new psychoactive substances** in England and Wales, compared to 137 the year before. This was driven by an increase in the number of deaths involving benzodiazepine analogues, particularly flubromazolam and etizolam.[2]

[1] OHID, 2023
[2] ONS, 2021

Preventing drug-related deaths

Actions to prevent drug-related deaths must be taken not only by local authority commissioners and providers of drug services, but also for other local health, social care, criminal justice, employment and housing services where appropriate.

(1) Drug treatment service commissioners and providers

- Ensure treatment is easily accessible and attractive, improving access through, for example, outreach, needle and syringe programmes, and accessible opening times
- Provide adequate doses of opioid substitute medications to protect against continued use of illicit drugs
- Consider the value of broader harm reduction interventions in reducing drug-related deaths, including the consistent provision of naloxone
- Focus on intervening in non-fatal overdoses, a major risk factor in predicting future drug-related death

(2) Criminal justice

- Promote the provision of standard information on drug users being released from prison to their local drug treatment services
- Support a smooth and safe prison release for drug users, including meeting them at the gate on prison release and not releasing prisoners on Fridays
- Improving the continuity of care for people leaving prison with a substance misuse treatment need, so they are referred to and engage in community treatment after release

(3) Health services

- Support improved access for people who use drugs to physical and mental health care services

Source: Public Health England, 2017; Public Health England, 2016; OHID, 2023.

Synthetic opioids

Illicit **fentanyls** and **isotonitazene** caused spikes in drug-related deaths in England in 2017, 2021 and 2023.

There are signs that synthetic opioids are being seen more often in local drug markets and there are concerns that they may become much more prevalent.

They are many times stronger than heroin – increase the risk of **overdose** and other **harms** significantly

There is a risk that fentanyl or other synthetic opioids (which can be more easily imported) may start to **contaminate** or replace heroin.

Naloxone

Naloxone is a non-invasive, fast-acting medicine given as a **nasal spray** which acts **to reduce or reverse the effects of opioids** and the risk of **overdose**. Administering it carries almost zero risk to the recipient and to the person administering. It can be lifesaving.

In Islington, naloxone is distributed to hostels and supported housing settings by treatment services and by 3 pharmacies, who also offer needle exchange and methadone.

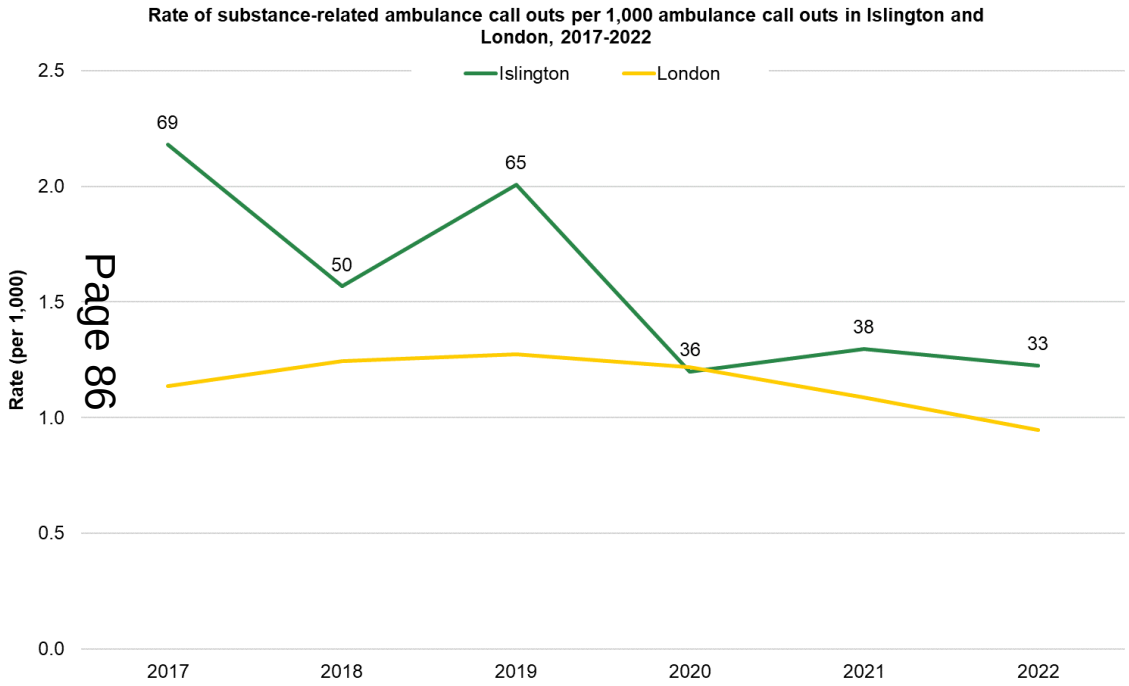
Source: NHS England, 2023; OHID, 2023.

Drug-related ambulance call-outs

In 2022, **1.2 per 1,000** ambulance call outs in Islington were substance-related. This represents a slight increase from 2020, but a significant decrease from 2.2 per 1,000 in 2017. Generally, between 2017 and 2022, Islington has had a higher rate of substance-related ambulance call outs than the London average.

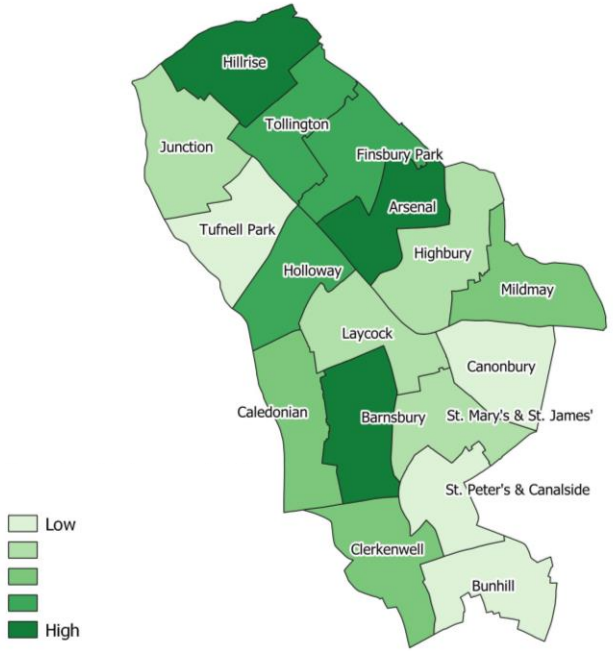
By ward, **Barnsbury** had the highest number of substance-related ambulance call-outs (n=51) between 2017 and 2022, twice as many call-outs as the second highest ward (Finsbury Park: n=23).

Figure 12



Source: SafeStats, 2023

Figure 13: Heat map of number of substance-related ambulance call outs in Islington by ward, 2017-2022



About this data:
The dataset provided by the London Ambulance Service consists of details of every vehicle dispatched to incidents responded to by the LAS across the Greater London area.

Crime and Community Safety

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Crime and community safety: overview

Volume of drug offences in London have shown an overall decline in the past decade, with an overall **15% decrease between 2012 and 2022** from 53,708 to 45,184 drug offences.[1]

The volume of drug offences in **Islington** largely mirrors regional trends, with **a 29% decrease between 2012 and 2022** from 1,764 to 1,249 drug offences.[1]

85% (n=13,566) of drug offences in Islington between 2012 and 2022 were for **drug trafficking**, while 15% (n=2,355) were for drug possession.[1]

Breakdown of drug offences in Islington by ward reveals that between 2018 and 2022, **Finsbury Park** had the highest number of drug offences at 12% (n=817) of all drug offences in Islington. This was followed by **Caledonian** (9%; n=599) and **Barnsbury** (8%; n=537) wards.[1]

In 2022, there were **1,172 drug-related police call outs** in Islington, representing 4.2% (n=27,784) of all police call-outs that year. The highest proportion of these were in **Finsbury Park** (17%; n=195), followed by **Barnsbury** (9%, n=109) and **Highbury West** (9%, n=108) wards.[1]

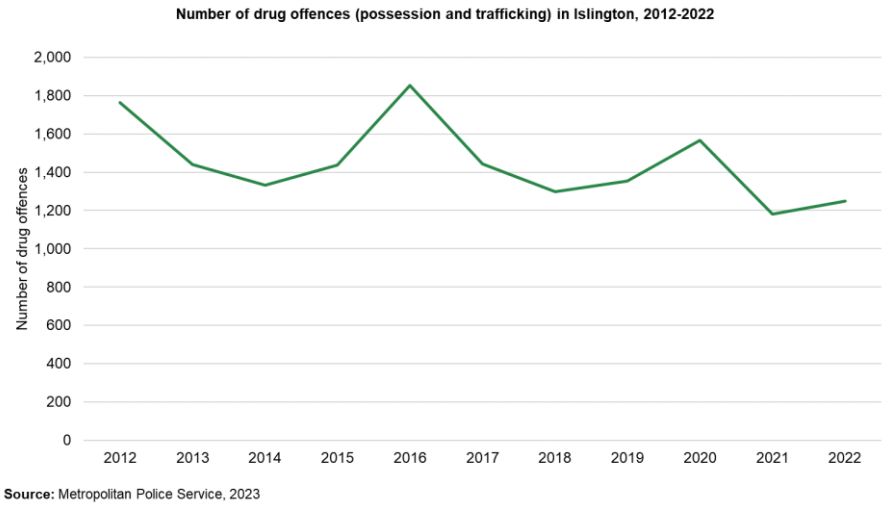
Drug-related issues are a key concern for Islington's residents. Between January 2021 and July 2023, **drugs were the second most reported antisocial behaviour** (25%; n=3097), after rowdy or inconsiderate behaviour (58%; n=7182). By ward, the largest number of reports were in **Finsbury Park** (22%; n=680), followed by Junction (8%; n=256) and Holloway (8%; n=232).[2]

Of the 1,993 drug-related street based antisocial behaviour reports in 2022, the three largest hot spots were concentrated around Andover Estate (128), Elthorne Estate (78) , and Tremlett Grove Estate (54).[2]

[1] Metropolitan Police Service, 2023
[2] Islington Community Safety Team

Drug offences

Figure 14

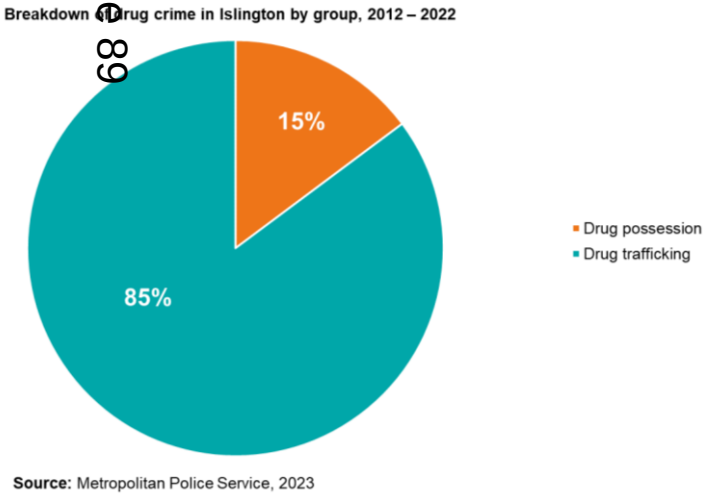


Source: Metropolitan Police Service, 2023

In 2022, there were **1,249 drug offences** in Islington, which represents a **general decline since 2012**. Drug offences include possession or trafficking (crimes such as supply, possession with intent to supply, and production). This mirrors the trend seen across London. A peak in drug offences in Islington was noted in **2016** (1,854 offences), the reasons **for** which are unclear. An increase in drug offences was also noted in 2020, with 1,567 offences. This may be attributed in part to an increased stop and search activity for drugs, which peaked in London in May 2020. The Covid-19 pandemic may have also played a role.[1]

In 2018, Mayor of London's Office for Policing and Crime launched a strategy against county lines, which included the creation of a **Rescue and Response (R&R) team** that intervenes directly with young people suspected of involvement in drug distribution. In 2020/2021, Islington ranked **17th** of all local authorities in London with respect to the number of individuals linked to county line exploitation (n=14 referrals, compared to 21 in 2019/2020).[2]

Figure 15



Source: Metropolitan Police Service, 2023

85% (n=13,566) of drug offences in Islington between 2012 and 2022 were for **drug trafficking**, while 15% (n=2,355) were for drug possession (Figure 14).

Cuckooing

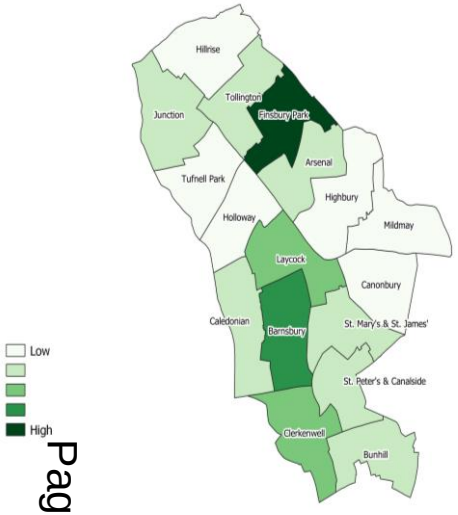
Cuckooing is a practice where people target the homes of vulnerable adults and take over their property.

In March 2022, the Metropolitan Police, alongside the Islington Community Safety Team, relaunched Operation Pantera. This was part of an MPS-wide focus on identifying and managing suspected cuckooed addresses. Islington identified **Finsbury Park**, **Holloway**, and **Junction** wards as the areas with most addresses of concern identified. In July 2022, **87 addresses of concern** were identified.

The Cuckooing Panel heard and investigated cases, with actions ranging from closure orders and police raids to referrals to inpatient rehabilitation and community drug and alcohol services. The number of addresses of concern in Islington was **reduced to 32** by January 2023.

Drug offences by ward

Figure 16: Heat map of number of drug-related offences (drug trafficking and drug possession) in Islington by ward, August 2022 to July 2023.



- Breakdown of drug offences in Islington by ward reveals that between August 2022 and July 2023, **Finsbury Park** had the highest number of drug offences at 17% (n=203) of all drug offences in Islington. This was followed by **Barnsbury** (9%; n=108) and **Caledonian** (7%; n=81) wards.
- This was also the case for all drug offences in Islington between 2018 and 2022, with Finsbury Park at 12% (n=817), followed by Caledonian (9%; n=599) and Barnsbury (8%; n=537) wards.
- Drug offences by ward do not show a consistent trend in Islington between 2018 and 2022, i.e., there is no overall trend of increase or decrease in drug offences by ward over this period.
- While some wards have shown an overall increase, such as **Finsbury Park** (153 offences in 2018 to 203 offences in 2022) and **St Mary's & St James'** (55 to 78 offences) have shown an overall increase, other wards have shown an overall decrease, such as Caledonian (185 offences in 2018 to 81 offences in 2022) and St Peter's & Canalside (102 to 48 offences).

This data is provided by the Metropolitan Police Service Monthly Crime Dashboard.

*The police call out data was collected before the Islington ward boundary changes of 2022, therefore the ward names are reflective of previous ward boundaries. A map of the new ward boundaries can be found on the Islington Council website.

Police call outs

Table 4: Proportion of drug-related police call outs to total police call outs in Islington, 2020-2022.

Year	Number of drug-related police call outs	Proportion of drug-related police call outs to total police call outs
2020	1,560	6.1%
2021	1,156	4.6%
2022	1,172	4.2%

Between 2020 and 2022, there were 3,888 drug-related police call outs in Islington, with just over 40% of these occurring in 2020 (n=1,560).

In 2022, there were **1,172 drug-related police call outs** in Islington, representing 4.2% of all police call-outs that year. This is similar to 2021, but lower than 2020 (see Table 3). The Covid-19 pandemic may have affected the total number of police call outs.

17% of these call outs were in **Finsbury Park**, followed by **Barnsbury** (9%) and **Highbury West** (9%). The lowest proportion of call outs were seen in Holloway, Hillrise, and St. George's wards (3% each). *

Antisocial behaviour (ASB)

Figure 17

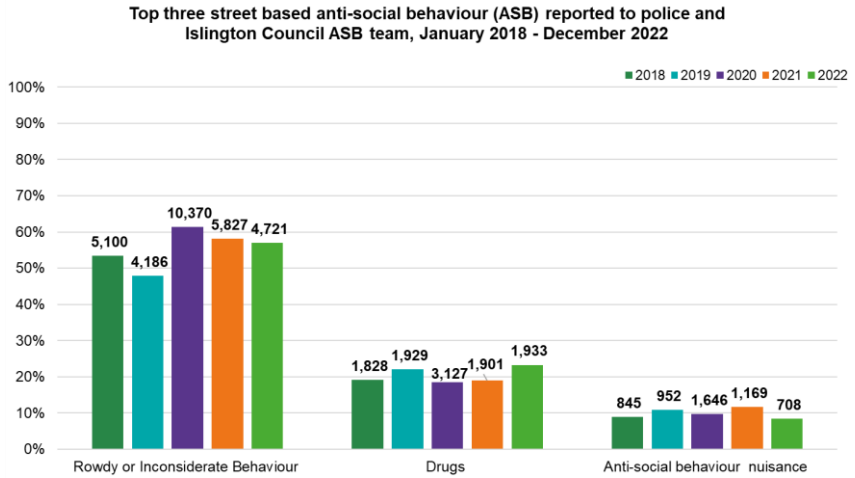
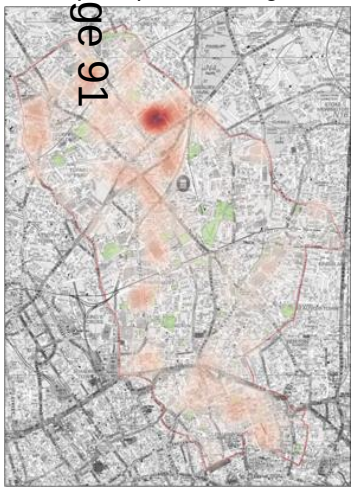


Figure 18 Drug-related street-based antisocial behaviour reports in Islington, 2022



Of the 1,993 drug-related street based antisocial behaviour reports in 2022, the three largest hot spots were concentrated around: Andover Estate (n=128), Elthorne Estate (n=78), and Tremlett Grove Estate (n=54).

† Local antisocial behaviour data does not have a further breakdown past the initial category. Therefore, 'drugs' reports could range, for example, from young people smoking cannabis near a residential property, to drug dealing of Class A illicit substances.

Source: Metropolitan Police Service, London Borough of Islington data, 2022

Drug-related issues are a key concern for Islington's residents. Between January 2021 and July 2023, **drugs were the second most reported antisocial behaviour** (25%; n=3,097). By ward, the largest number of reports were in **Finsbury Park** (22%; n=680), followed by Junction (8%; n=256) and Holloway (8%; n=232).†

While ASB reports have seen a decrease over the past five years, the proportion of drug-related ASB reports has increased by 6%. The number of drug-related ASB reports peaked in 2020 (n=3,127) which may be attributed to the unprecedented challenges brought about by the COVID-19 pandemic, influencing community dynamics, law enforcement capabilities, and social services.

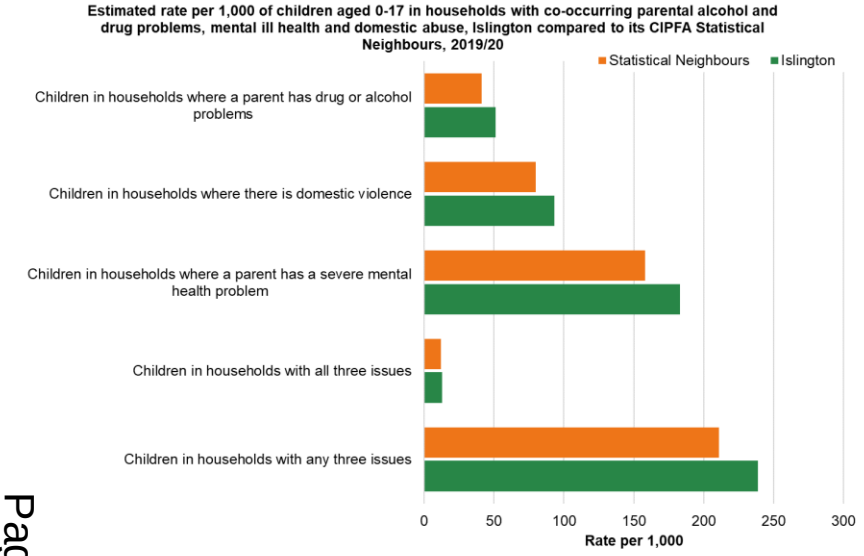
Existing partnership work in action

- **Weekly intelligence product** focussing on street based Anti-Social Behaviour, feeds into weekly tasking multi agency meeting with services that focuses on support and enforcement .
- **Joint outreach shifts** with Via (drug & alcohol service) with Councils street pop team and St. Mungo's – currently tasking Finsbury Park and Tollington, which are identified hotspots.
- **Targeted Youth Support** detached work to engage with young people who may be involved in Anti-Social Behaviour and link them into relevant services such as young persons' drug and alcohol service .
- Regular meetings with **substance misuse commissioners**, **Housing** and **Community Safety** to enhance joint working and collaboration.

Recommendations for further work include building upon outreach services and capacity, and building upon strong existing partnerships working on this subject.

Child safeguarding

Figure 19



Source: NDTMS, 2023

About this data:
The Childhood Local Data on Risks and Needs (CHLDRN) produced by the Children's Commissioner for England provides data on the number of children at risk using data from the 2014 Adult Psychiatric Morbidity survey (AMPS). These are modelled prevalence estimates, as no local data is available.

Table 5: Estimated number of adults with substance dependence living with children in Islington, rate per 1,000 and estimated unmet need, 2018/19

Substance	Estimated number of adults living with children	Rate per 1,000 population	Number in treatment (2019/20)	Estimated level of unmet need
Alcohol	561	3	81	86%
Opiate	441	2	104	76%

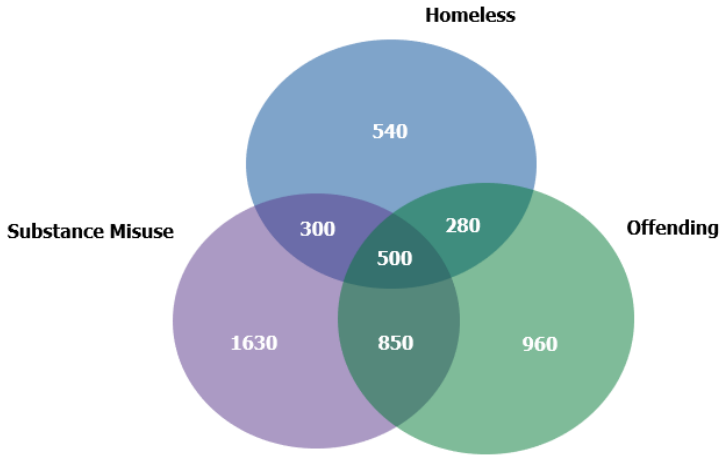
Source: NDTMS, 2023

- Exposure to drug and alcohol use by a **parent** or **carer** presents a safeguarding risk to children and adolescents, and can manifest as neglect, abuse, exploitation and trauma for the child or young person. Experiencing trauma or adversity in childhood can increase the risk of adverse outcomes in adulthood. Adverse experiences in childhood have been found to be more common in adults with drug and alcohol use issues than they are in the general population.
- In Islington, 51 per 1,000 children aged 0-17 years live in **households where a parent has drug or alcohol problems.** This is higher than across its statistical neighbours.
- The estimated number of adults with substance dependence issues living with children in Islington in 2018/19 is in line with national rates (Table 4). There is a high estimated level of unmet need for this population.
- In 2018/19, there were an estimated **873-987 children in Islington living with at least one adult with alcohol dependence**, at a rate of **21-23 per 1,000 children** aged 0-17 years. This data is not available for children living with adults with opiate dependence.
- The Islington Children and Young People's Health and Wellbeing Survey 2021-22 found that **24%** of primary school children and **14%** of secondary school children in Islington were **worried about the alcohol or drug use of someone at home**.[1]
- In Islington, the **Better Lives Family Service**[2] offers a service to families living in Islington who have a child or children under 18 years of age where the parent is using drugs or alcohol and adults who are affected by the drug or alcohol problems of someone close to them.

[1] Islington Safeguarding Children Partnership Annual Report, 2021-22
[2] Better Lives, 2023

Multiple disadvantage and safeguarding

Figure 20: Venn diagram of multiple disadvantages with estimated number of individuals in each category in Islington.



	Islington estimates	Islington: Region-adjusted estimates*
Substance Misuse	880	1,630
Substance Misuse + Homeless	160	300
Substance Misuse + Offending	460	850
Homeless + Offending + Substance Misuse	270	500
Substance Misuse total	1,770	3,280

*Region-adjusted estimates were based on data in the "Hard Edges" report from the Lankelly Chase Foundation. The report states London urban areas have elevated rates of multiple deprivation compared to the national average and reports increased rates of 1.85 times for Islington.

Multiple disadvantage is a term that can be used to describe the problems faced by adults involved in the **homelessness, substance use and criminal justice systems** in England, with **poverty** almost a universal factor, and **mental ill-health** a common complicating factor.[1]

Severe and multiple disadvantage (SMD) is defined as experiencing one or more of the relevant disadvantage domains – **homelessness**, **offending**, and **substance** use.[2]

National estimates of multiple deprivation were published in the 2015 'Hard Edges' report.[2] These estimates have been applied to the Islington population in Figure 19.

People with co-occurring mental health and drug/alcohol use conditions (or 'co-occurring conditions') including dependence, often have multiple needs with poor physical health alongside social issues such as debt, unemployment or housing problems. They are also more likely to be admitted to hospital, to self-harm and to die by suicide.[1]

Conversely, drug and alcohol use, and particularly dependence, can make individuals **vulnerable to exploitation**, which is compounded in people sleeping rough or in unstable accommodation.

The drug and alcohol service in Islington is supported by a consultant psychiatrist and a team of psychologists that can support with complex needs and referral pathways into mental health and other services including adult safeguarding team within adult social care. The service also has a weekly MDT meeting where complex cases, including safeguarding, are discussed.

[1] Dame Carol Black report, evidence pack, 2020.
[2] Lankelly Chase Foundation, 2015.
[3] Research into Severe Multiple Disadvantage in Islington, 2018.

Drug treatment and services

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Drug treatment and services: overview

Structured drug and alcohol treatment and support is available to any Islington resident and is commissioned by Public Health at Islington Council. Pharmacies provide needle exchange, opiate substitute therapy, and naloxone.

There has been a decrease in the number of adults and young people in drug and alcohol treatment in England, London and Islington over the past decade. There has been a larger decrease in Islington than on a regional or national level.[1]

The substance use profile for people in drug and alcohol treatment differs between adults and young people. In adults, people seeking treatment for **opiate use** are the largest treatment group, followed by alcohol and crack cocaine. By contrast, **cannabis** was the most cited substance used by young people in drug and alcohol treatment in Islington in 2021/22, followed by **alcohol** and **ecstasy**.[1]

Local rates of successful completions of drug and alcohol treatment (50% in 2021/22) are **in line with regional and national trends**.[1]

Levels of unmet need in Islington are estimated to be **higher** than levels in both London and England.[1]

Certain groups are under-represented in drug and alcohol treatment in Islington – this includes people from **Black** and **Asian** ethnic backgrounds, **Muslim** people, and **women**.[1]

Nearly one-quarter (23%) **of people presenting to drug and alcohol services in Islington reported problems with their housing**.[1]

Just under one-third (29%) of drug and alcohol service users described themselves as long-term sick or disabled, compared to 5% of Islington's population overall.[1]

Continuity of care rates are low in Islington, with just under one-third (**29%**) of people referred from the criminal justice system beginning treatment within 3 weeks in the most recent quarter.[1]

[1] NDTMS, 2023

Drug and alcohol services in Islington (1)

Structured drug and alcohol treatment and support is available to any Islington resident and is commissioned by Public Health at Islington Council.

Islington's main service is provided by **Better Lives**, an integrated drug and alcohol service delivered by **Camden & Islington NHS Foundation Trust** in partnership with two third sector organisations – **Humankind** and **Via** (formerly known as Westminster Drug Project).[1]

Multiple treatment options are made available, delivered by multi-disciplinary teams – including but not limited to:

- One to one key-working
- Counselling
- Psychological therapy
- Group work
- Day programme(s)
- Self-help and mutual aid groups
- Pharmacological treatments
- Residential rehabilitation
- Physical health support, including blood borne virus testing and treatment
- Social support including housing and debt advice, skills coaching and Education, Training and Employment (ETE) support.
- Better Lives Family Service

The **Individual Placement and Support (IPS)** programme for people with drug and alcohol treatment needs has been operating in Islington since December 2022. IPS work with individuals for up to 12 months, providing support, advice and liaison to help people identify employment or voluntary opportunities suited to them. They then help with all stages of the applying for and starting a job. The service is provided by Via and is funded by the national IPS Grant, also administered by OHID.

The Rough Sleepers Drug and Alcohol Treatment Grant (RSDATG), also a national grant, has enabled Islington to commission the **In-Roads** service from Via. In operation since 2021, the service provides psychosocial support and prescribing outreach to people sleeping rough or at risk of sleeping rough in Islington. In-Roads provide one-to-one key-working, connect people to health services, provide harm-reduction support, including Naloxone, and make referrals to a range of other support services.

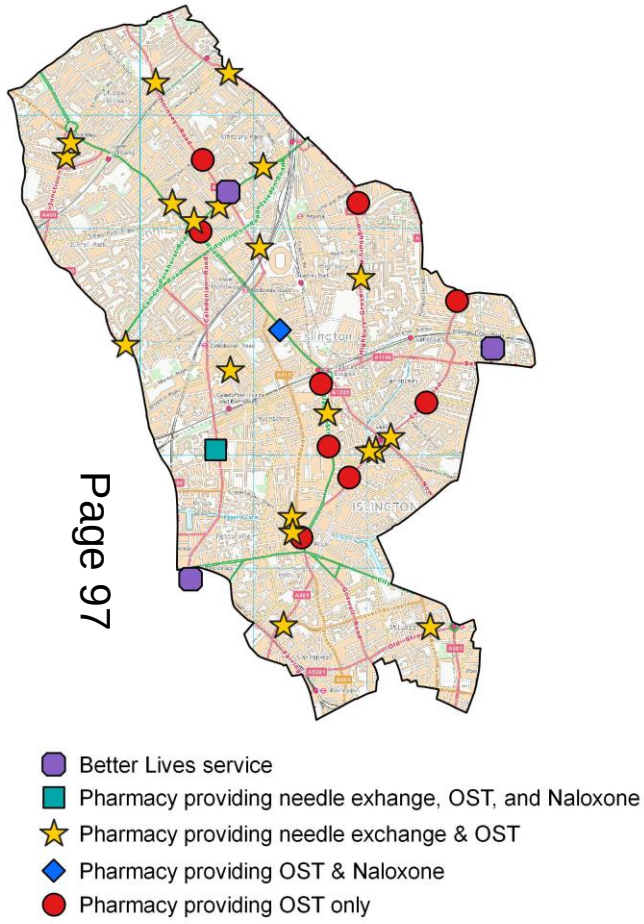
Islington has commissioned an additional programme to provide culturally competent holistic support to men of Black African or Black Caribbean background who are in contact with the criminal justice system and who have non-opiate substance use needs. **SWIM (Support When It Matters)** will deliver its 10-week structured support programme for up to 60 Islington residents, following its Prepare, Adjust, Contribute, Thrive (PACT) model.

Service-user involvement in the design and delivery of drug and alcohol services is an essential part of quality assurance. Public Health are directly supporting the re-launch of its long-standing and highly valued service user group **Islington Clients of Drug and Alcohol Services (ICDAS)**. The relaunch will increase participant numbers, build resilience and improve diversity, so the group better represents the service user population and can be a more effective critical friend to commissioners and providers. This supports our ambition to achieve recognisable co-production in our commissioned services, improving their reach and outcomes.

[1] Better Lives - Islington's Drug and Alcohol Service, 2023.

Drug and alcohol services in Islington (2)

Figure 21: Map of drug and alcohol services in Islington



Better Lives operates from three locations in the borough (see Figure 20). These are located at **Seven Sisters Road** (Finsbury Park ward), **Gray's Inn Road** (Caledonian ward), and **King Henry's Walk** (Mildmay ward).

Providing equitable access to drug services is important in reducing discrepancies in outcomes. There are services in Finsbury Park and Caledonian wards, which other data suggests have a high level of need.

Some local drug and alcohol services are provided through **general practice**, **community pharmacies**, the **community and voluntary sector**, and **Islington Council**. Below are three services provided by pharmacies in Islington:[2]

Needle exchange pharmacies (NEX)

- Community-based NEX will provide **access to sterile needles and syringes**, and sharps containers for return of used equipment. This prevents the spread of **blood-borne diseases (mostly HIV and hepatitis)** and other drug-related harm, including drug-related death
- In Islington, **21 pharmacies** (47%) provide NEX service.

Opiate Substitute Treatment (OST)

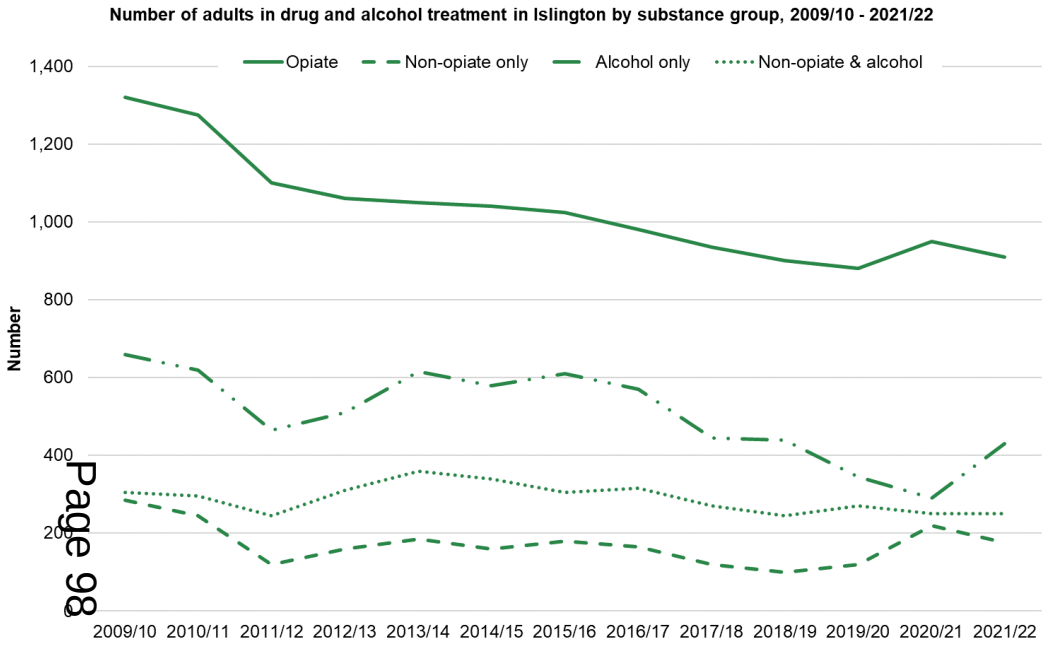
- OST medications broadly work by reducing or stopping withdrawal and cravings without producing the extreme highs that heroin and other illicit opioids cause. The two medications used for OST in the UK are **methadone** and **buprenorphine**.[3] The aim of the **supervised self-administration** service is to ensure individual client compliance with the agreed treatment plan for opiate dependence by dispensing of OST in specified instalments.
- In Islington, **31 pharmacies** (69%) provide supervised self-administration service.

Nasal naloxone distribution (pilot)

- **Naloxone** is a life-saving medication that reverses the effects **of opiate overdose**. Administered by injection or nasal spray, it works within minutes to reverse the effects of an opiate overdose, pending substantive medical treatment.
- This service is provided from **three pharmacies in Islington**. Pharmacies issue nasal naloxone alongside the NEX and will provide access to and information on nasal naloxone, including how and when to administer.

Number of adults in structured drug and alcohol treatment

Figure 22



Source: NDTMS, 2023

About this data:

The National Drug and Alcohol Treatment Monitoring System (NDTMS) collects person level, patient identifiable data from drug and alcohol treatment providers at a national level. The NDTMS collects data from about 600 sites providing structured substance misuse interventions, covering every local authority in England. Treatment centres returning data include community-based drug and alcohol services, specialist outpatient services, GP surgeries, residential rehabilitation centres, and inpatient units.

'Non-opiate only' refers to people receiving drug treatment for substances other than opiates, such as cannabis, cocaine, and benzodiazepines.

In Islington, there has been an **overall 31% decrease in the total number of adults in drug and alcohol treatment in the past decade**, from 2,570 in 2009/10 to 1,765 in 2021/22. This mirrors regional and national trends.

In 2021/22, 52% (n=910) of adults in treatment were seeking help for opiate use (includes opiate use with and without crack cocaine). This was followed by those seeking help with 'alcohol only' (28%; n=430), 'non opiate and alcohol' (14%; n=250), and then 'non-opiate only' (12%; n=175).

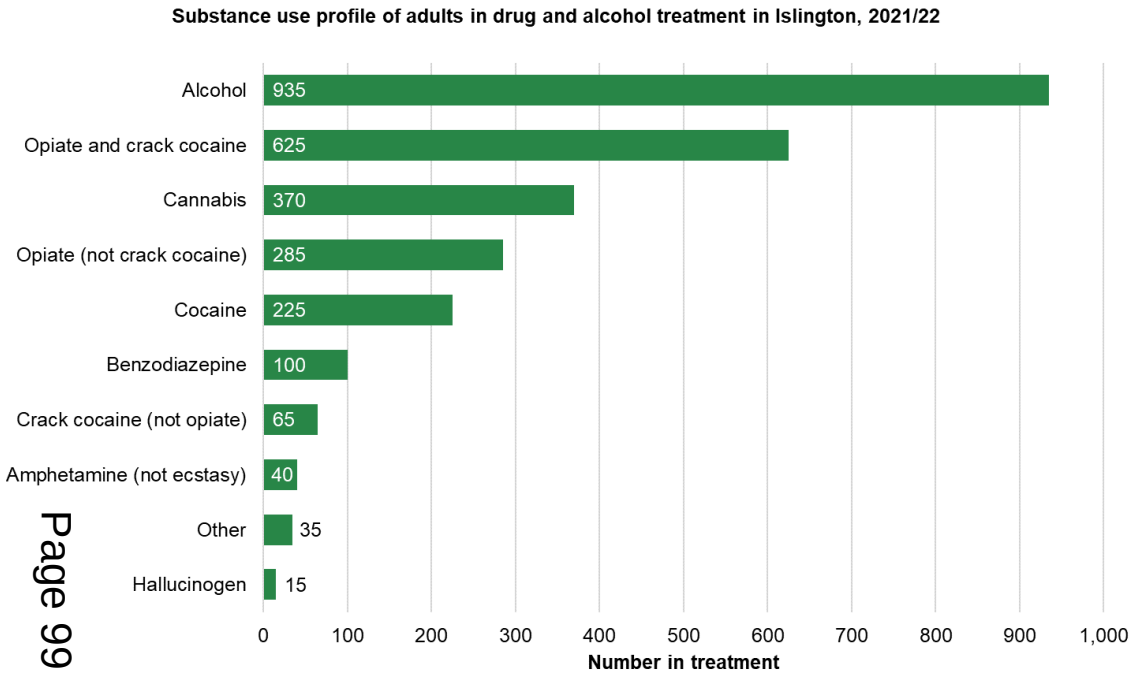
There has been a **31% decrease in the number of opiate users in treatment** in Islington the past decade, from 1,320 in 2009/10 to 910 in 2021/22. This trend can be seen across London and England. However, this does not appear to be in line with opiate use prevalence, which has been increasing both locally and nationally.

There has been a **38% decrease in non-opiate users** in treatment in Islington, from 285 in 2009/10 to 175 in 2021/2022. There has been a smaller decline in London, with a 13% decrease.

There has been a **34% decrease in the number of 'alcohol only' users in treatment in Islington** over the past decade, however between 2020/21 and 2021/22, an increase of 32% was observed (290 to 430 users). On a regional and national level, numbers have remained relatively stable over this period.

Proportion of adults in drug and alcohol treatment by substance group

Figure 23



Note: NPS, Mephedrone, and Ecstasy have been removed due to small numbers
Source: NDTMS, 2023

About this data:
This data represents the proportion of adults in structured drug and alcohol treatment in each substance group – 'opiate', 'non-opiate only', 'alcohol only', and 'non-opiate and alcohol'.

'Non-opiate' refers to people receiving drug treatment for substances other than opiates, such as cannabis, cocaine, and benzodiazepines.

In 2021/22, 53% (n=935) of adults in drug and alcohol treatment cited **alcohol** use, followed by **opiate and crack cocaine** use (35%; n=635) and **cannabis** use (21%; n=370).

The proportion of adults in drug and alcohol treatment in Islington by substance group has been mostly **in line with the national and London averages** over the past decade.

Of adults in drug and alcohol treatment, there is a larger proportion citing opiates as their main substance in Islington compared to London and England averages (52% vs 44% and 49% respectively). This is consistent with prevalence data, with Islington having double the rate of 'opiate only' use compared to London and England.

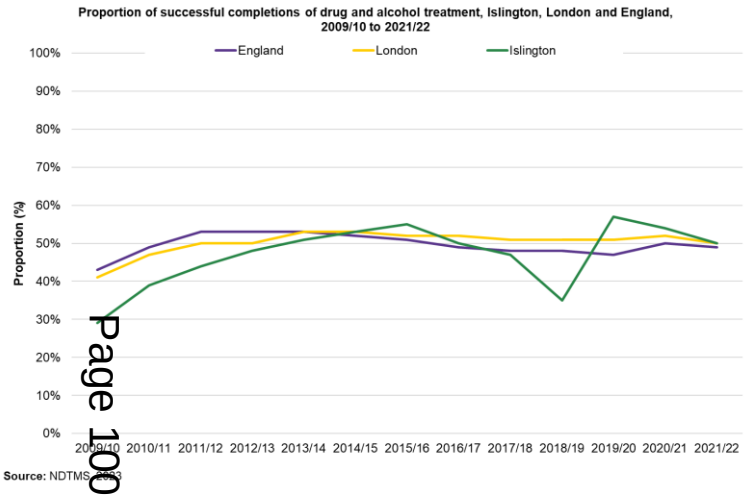
The largest substance group in the 'non-opiate only' treatment group in Islington in 2021/22 was **cannabis**, with 90 users in 2021/22, followed by **powder cocaine** (45 users), **crack cocaine** without opiate use (35 users), and **benzodiazepines** (15 users). This is consistent with national data.

[1] OHID, 2023.

Drug and alcohol treatment outcomes

In 2021/22, 50% of adults successfully completed drug and alcohol treatment. This was in line with the London and England averages.

Figure 24



Since 2009/10 successful completion rates have increased and peaked in 2019/20 during the COVID-19 pandemic. This is in part due to **changes in the treatment model**; service users were retained in treatment for longer, and at a lower threshold of need to safeguard them amid reductions in the availability of other sources of support in the community. 2018/19 data for Islington was affected by an organisational-wide data outage within the NHS Trust.

In Islington, just under **half** (47%; n=835) of people in drug and alcohol treatment had been in treatment for **less than 1 year**. 18% were in treatment for 1-2 years, 15% for 2-4 years, and the remaining 20% for 4 years or longer. This is broadly in line with regional and national data.

Re-presentation to drug and alcohol treatment within 6 months of successful completion of treatment was **4%** in Islington in 2022/23. This was roughly consistent across the four substance groups (opiate, non-opiate, alcohol, alcohol and non-opiate), though was slightly higher in the opiate group (6%).

Treatment exit reasons, 2021/22

In 2021/22, **32%** (n=235) of people **dropped out of/left** treatment in Islington without successful completion. This is in line with regional and national data.

Exit reason	Number	Proportion
Successful completion	365	50%
Dropped out/left	235	32%
Transferred - not in custody	60	8%
Transferred - in custody	35	5%
Died	25	3%
Treatment declined	5	1%

Unplanned exits, 2021/22

Unplanned exits from drug and alcohol treatment are higher nationally than in Islington, particularly in the non-opiate and alcohol substance groups.

Substance group	Islington	England
Opiate	13.2%	16.5%
Non-opiate	5.6%	19.0%
Alcohol	5.7%	13.2%
Alcohol and non-opiate	3.4%	17.1%

Level of unmet need for drug and alcohol treatment

Table 8: Level of unmet need for drug and alcohol treatment in Islington, London, and England, Jul 2022 – Jun 2023.

	Islington: Numbers in treatment	Islington: Prevalence estimate (most recent*)	Islington: Unmet treatment need	London: Unmet treatment need	England: Unmet treatment need
OCU†	869	3,960	78%	73%	58%
Opiates only	227	1,564	86%	78%	60%
Crack only	50	485	90%	88%	83%
Both opiates and crack	592	1,911	69%	63%	47%
Alcohol	573	3,535	83%	82%	80%

Level of unmet need is calculated as the number of people in structured drug and alcohol treatment over the prevalence estimates for that substance group, i.e., opiates only or crack only. This data helps to identify the amount of people with drug and alcohol problems who **could benefit from treatment, but who are not currently in treatmen**t.

Levels of unmet need in Islington are estimated to be high, with **90%** of estimated crack cocaine users not in treatment. Estimated levels of unmet need in Islington are higher than both London and England across all substance groups.

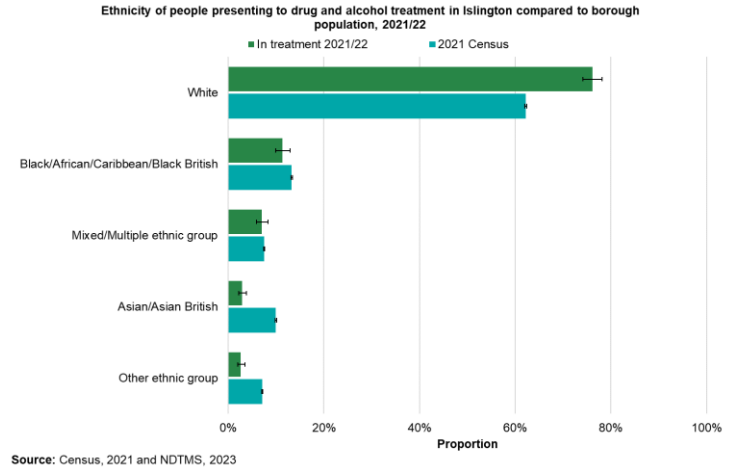
Based on the data, we can estimate that there are the following number of people in Islington who could benefit from treatment but are not currently in treatment:

- **3,091** opiate and/or crack cocaine users
- **1,338** users of opiates only
- **435** users of crack only
- **1,319** users of both opiates and crack
- **2,962** alcohol users

Increasing numbers of people accessing structured treatment is a key outcome metric for additional investment in local drug and alcohol services. Islington commissioners and providers have commenced work to improve pathways, assessments and other opportunities to improve access.

Ethnicity and religion of people in drug and alcohol treatment

Figure 25

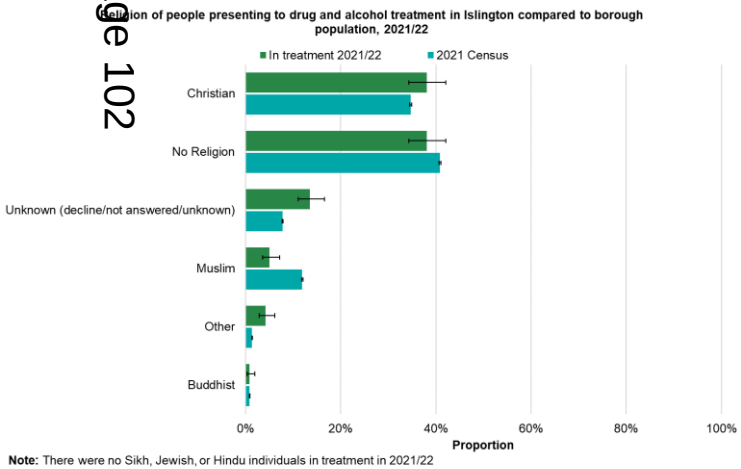


Source: Census, 2021 and NDTMS, 2023

In 2021/22, there were significantly more White people in drug and alcohol treatment than expected based on Islington's population – 76% of people in drug and alcohol treatment in Islington in 2021/22 identified as White (n=1310), compared to only 62% of Islington's population.

Asian/Asian British people were under-represented in treatment, making up only 3% (n=48) of the treatment population in Islington in 2021/22, compared to 10% of Islington's population.

Figure 26



Note: There were no Sikh, Jewish, or Hindu individuals in treatment in 2021/22
Source: Census, 2021 and NDTMS, 2023

Christianity and **atheism** ('none') were the most reported religious beliefs of people presenting to drug and alcohol treatment in Islington in 2021/22, both at 38% (n=226 and n=225, respectively).

Muslim people were under-represented in drug and alcohol treatment, comprising of only 5% (n=30) of those in treatment in Islington in 2021/22, compared to 12% of Islington's population.

There may be **cultural reasons** (for example, stigma around seeking help for substance use) or **access issues** (for example, language barriers) for the under-representation of certain ethnic and religious groups in drug and alcohol treatment in Islington.

Women's experiences in drug and alcohol treatment

Women who seek treatment for drugs and alcohol face different needs from their male counterparts, including high incidence of **trauma and abusive relationships**, a greater burden of **stigma** around substance use and more common **childcare responsibilities**. However, research shows that women's needs are not being met within the treatment system. Some women describe being forced to attend mixed-gender treatment groups, which made it difficult for some to discuss about traumatic experiences that may be linked to their substance use, such as sexual violence. Some also described how the way services were set up meant that it was difficult to manage alongside childcare responsibilities – particularly for women of South Asian or Eastern European backgrounds.

In Islington, just over **one-third** (34%; n=605) of people presenting to drug and alcohol treatment in 2021/22 were women.

Access to **gender-specific support** and treatment in safe, appropriate spaces suitable for those with children, and providing gender-specific care (which can help explore drivers of addiction such as trauma and abuse), will enable the best chance of recovery for women.

Source: Exploring women's experience of drug and alcohol treatment in the West Midlands, Centre for Justice Innovation, 2023.

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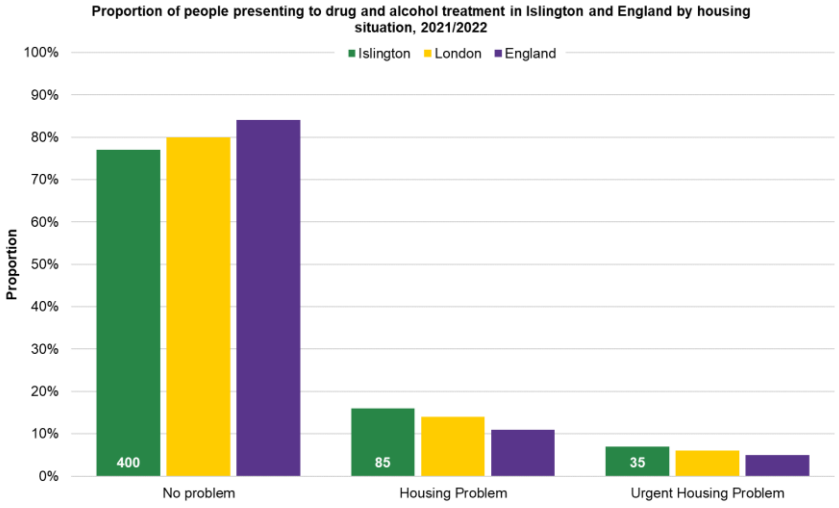
Housing situation of people in drug and alcohol treatment in Islington

Figure 27



Source: ONS, 2021 and NDTMS, 2023

About this data:

This data shows the self-reported housing status of people when starting treatment. People are grouped into the following categories: No problem, Housing problem, Urgent housing problem and Other.

Housing problem and urgent housing problem are made up of the following sub-categories:

- *Housing problem*: Staying with friends/family as a short-term guest, Night winter shelter, Direct Access short stay hostel, Short term B and B or other hotel, Placed in temporary accommodation by Local Authority, Squatting.
- *Urgent housing problem*: Lives on streets/rough sleeper, Uses night shelter (night-by-night basis)/emergency hostels, Sofa surfing/sleeps on different friend's floor each night.

Rough sleeping figures

337 people were seen rough sleeping in Islington in 2022/23. This represents a **42% increase** from the previous year. An estimated **43%** of rough sleepers in Islington during this period had a support need relating to drug use.[1]

There were an estimated **741 deaths of homeless people in England and Wales** registered in 2021. Almost **two in five deaths** of homeless people in 2021 were related to **drug poisoning (35%**; n=259), consistent with previous years.[2] This is higher than the proportion of deaths caused by drugs in the general population.

Housing situation in drug and alcohol treatment

In 2021/22, **23% (n=120) of people presenting to drug and alcohol services in Islington reported problems with their housing**. 16% (n=85) reported a housing problem, and **7% (n=35) reported an urgent housing need**, indicating that they were rough sleepers, or using night shelters, emergency hostels, or friend's homes every night.

This is higher than regional or national figures. In England, this figure was 16% in 2021/22, with 5% reporting an urgent housing need. In London, this figure was 20%, with 6% reporting an urgent housing need.

Addressing housing problems in drug and alcohol treatment

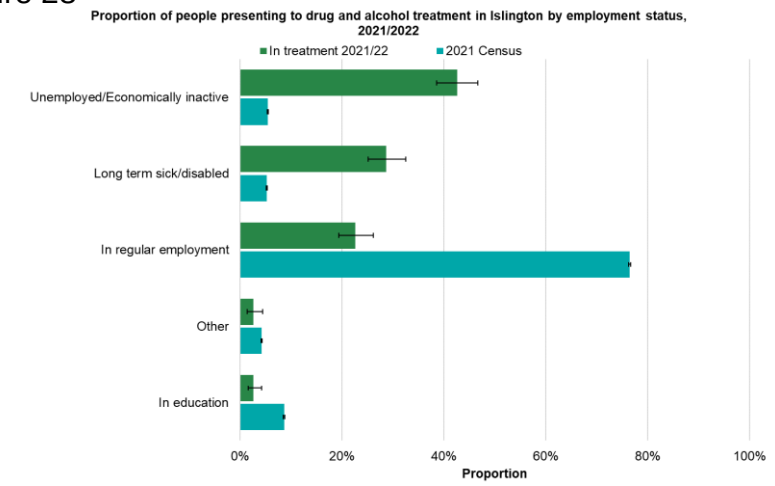
People in treatment for drug and alcohol dependence are often easier to support if their housing needs are addressed at the same time, as there is a strong link between having a stable home and improved treatment outcomes.[3]

In Islington, the **In-Roads service delivers outreach support for residents that are sleeping rough** or at risk of sleeping rough. In operation since 2021, the service provides psychosocial support and prescribing outreach, including one-to-one key-working, connecting people to health services, providing harm-reduction support (including Naloxone), and making referrals to a range of other support services.

[1] GLA, 2023.
[2] ONS, 2022.
[3] DHSC and DLUHC, 2023.

Employment status of people in drug and alcohol treatment in Islington

Figure 28



Source: Census, 2021 and NDTMS, 2023

In Islington, 43% (n=245) of people in drug and alcohol treatment were unemployed/economically inactive, which was significantly higher than the general population (5%). They were also more likely to describe themselves as being **long-term sick or disabled** – **29%** (n=165) compared to 5% in the general population. A similar picture can be seen across London and England.

About this data:
The data shows the self-reported employment status of people at the start of treatment. Unemployed/Economically inactive is made up of the following sub-categories: Unemployed and seeking work, Homemaker, Not receiving benefits, Retired from paid work and Unemployed and not seeking work.

Individual Placement and Support (IPS)

In Islington, The **Individual Placement and Support (IPS)** programme for people with drug and alcohol treatment needs has been operating since December 2022. IPS work with individuals for up to 12 months, providing support, advice and liaison to help people identify employment or voluntary opportunities suited to them. They then help with all stages of the applying for and starting a job. The service is provided by Via and is funded by the national IPS Grant, also administered by OHID.

Islington's integrated drug and alcohol service – Better Lives – also provides employment advice and signposting, as does the SWIM programme (see Slide 32).

Addressing inequalities in treatment services

Just under one third (29%) of drug and alcohol service users described themselves as long-term sick or disabled, compared to 5% of Islington's population overall. Commissioners and providers may wish to investigate this further to better understand the needs to this client group and the role that treatment services may have in **ensuring people are accessing support and treatment for their physical and mental health needs**.

This could include a focus on ensuring people's physical health needs are being met and that they are able to access all their appointments, ensuring advocacy for them, or even commissioning an additional navigator service to work specifically with physically disabled clients.

Criminal justice system – context and prisons

Context

Dame Carol Black's report highlighted that **more than a third** of all prisoners nationally are incarcerated due to crime relating to drug use – these prisoners tend to serve very short sentences, have limited time in prison with **poor continuity of care** when returning to the community, and are very likely to **re-offend**. The report also found that drug use within prisons was an issue, particularly in male local and category C prisons, with around 15% of prisoners testing positive to random drug test. **New psychoactive substances** have become particularly problematic in prisons (see Box 8).[1]

Reducing drug use in prisons – including drug treatment services in prisons – is the remit of the Ministry of Justice and HM Prison and Probation Service. In 2019, they published the National Prison Drugs Strategy, which outlines their approach to reducing drug use in prisons – restrict supply, reduce demand, and build recovery.[2]

NHS England commissions specialist treatment services in secure settings which are equivalent to community-based treatment and informed by evidence-based clinical guidance. Treatment includes interventions to reduce harm and to help people recover from alcohol and drug dependence.[3]

Prisons

There were 79,092 prisoners in England in December 2021.

Islington has one prison, **HMP Pentonville**, which holds roughly 1100 prisoners.[4] This holds male prisoners only.

There is no female prison in Islington; female prisoners go to HMP Bronzefield in Ashford.

[1] Dame Carol Black review of drugs: phase one report, 2020.
[2] Ministry of Justice and HM Prison and Probation Service, 2019.
[3] OHID, 2023.
[4] HM Chief Inspector of Prisons, 2022.

Project ADDER

Project ADDER (Addiction, Diversion, Disruption, Enforcement and Recovery) is a programme being piloted across 13 areas in England and Wales to test new approaches to tackling drug misuse.

The programme focuses on **co-ordinated law enforcement activity**, alongside expanded diversionary programmes (such as Out of Court Disposal orders), using the criminal justice system to divert people away from offending.

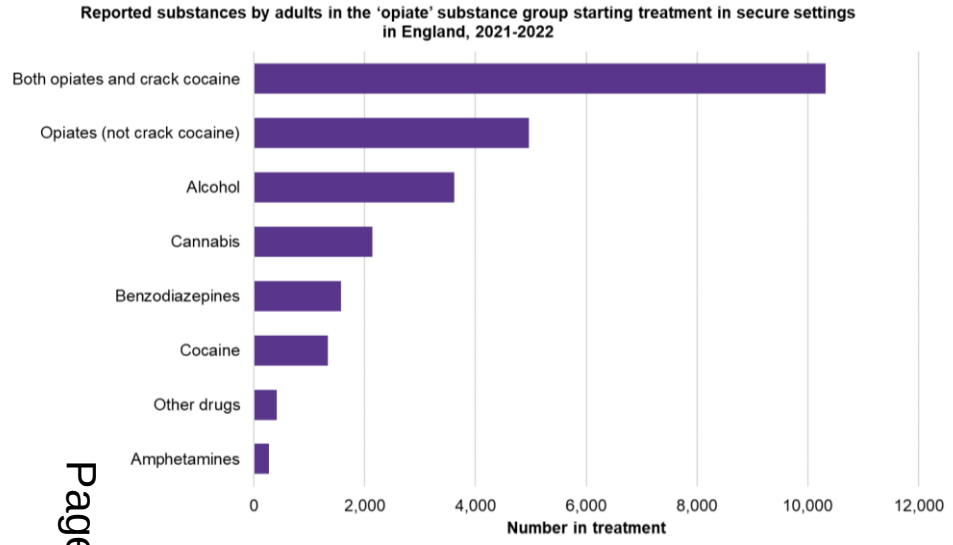
The programme seeks to ensure that more people get effective treatment, with enhanced treatment and recovery provision, including housing and employment support, and improved communication between treatment providers and courts, prisons, and hospitals.

The two pilot areas in London are Tower Hamlets and Hackney.

At present, there is limited data on substance needs for those in **police custody**. For Quarter 2 of 2022/23, 194 detainees in custody in Camden and Islington were tested for drugs, and 105 of them tested positive. All 105 were referred onto the local substance use service provider, Better Lives or Change Grow Live (CGL).

Criminal justice system – drug and alcohol treatment in prisons

Figure 29



Source: OHID, 2023

About this data:
The statistics in this publication come from analysis of the NDTMS, which collects data from services providing structured substance misuse interventions to adults and young people in about 140 prisons and secure settings across England. This includes adult settings (prisons and immigration removal centres) and the children and young people's secure estate.

Drug and alcohol treatment in prisons in England

- There were 45,096 adults in alcohol and drug treatment in prisons and secure settings in England between 1 April 2021 and 31 March 2022. Numbers in treatment had been decreasing year on year until this year, which saw a 3% increase from the 43,607 reported in 2020 to 2021.[1]
- **Opiates were the most reported drug by adults in treatment (46%),** with 30% reporting both opiate and crack problems, and 16% reporting problems with opiates but not crack (see Figure 28).[1]
- Of the adults in the 'non-opiate only' substance group starting treatment in secure settings in England, cannabis was the most reported drug (45%), followed by cocaine (28%), and crack cocaine (15%).
- **New psychoactive substances** (NPS) were a problem for 7% of people in treatment in secure settings in 2021-22. However, this may not reflect overall NPS use in prisons, because data is collected when people enter treatment, so does not include people who started using NPS while they were in prison.

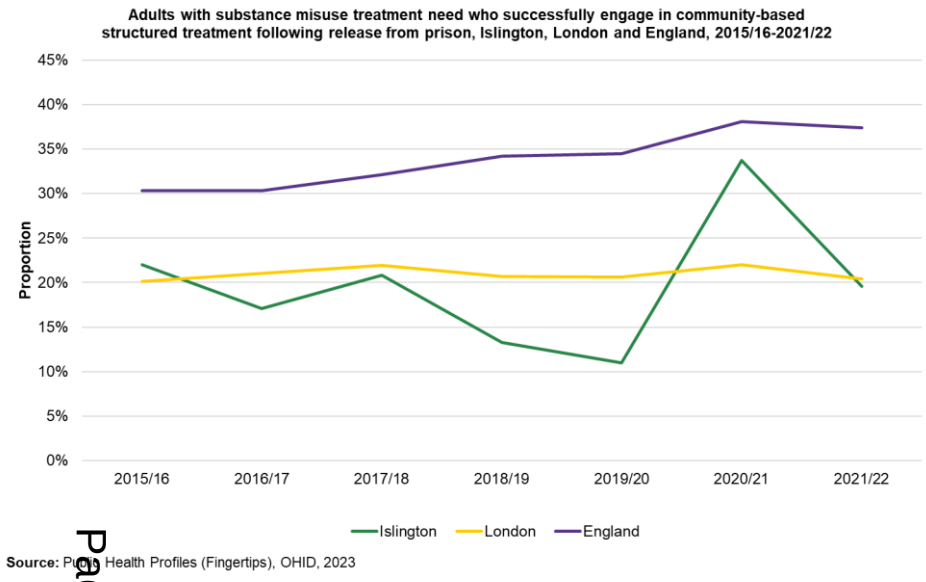
Probation and engagement with drug and alcohol treatment

- Some people may be sentenced to a community order or suspended sentence order in England with an alcohol treatment requirement (**ATR**) or a drug rehabilitation requirement (**DRR**), as defined by the Criminal Justice Act 2003.[2]
- Overall, **just over a third (38.9%)** of people on probation with ATRs or DRRs in England between August 2018 and March 2022 were **engaged with treatment services** on the dates they were sentenced or after being sentenced.[2]
- Of the 15,121 people who engaged in treatment: **37% dropped out of treatment**, 35% successfully completed their treatment journey, 27% were still on the same treatment journey, and 1.4% died.[2]

[1] OHID, 2023.
[2] Ministry of Justice and OHID, 2023.

Criminal justice system – continuity of care

Figure 30



Source: Public Health Profiles (Fingertips), OHID, 2023

About this data: NDTMS data is analysed by OHID to determine the number of these individuals that successfully engaged in community based structured treatment following release within 21 days as a proportion of individuals who, at the point of departure from prison, were transferred to a community provider in the local authority for structured treatment interventions post-release. Engagement is defined as having started a treatment intervention.

In 2022, 542 prisoners were released from HMP Pentonville.[1]

These are not necessarily Islington residents; there have been challenges around attributing people leaving prison to the correct borough of residence, leading to some prisoners being incorrectly categorised as Islington residents. This creates a challenge for Islington's continuity of care data. There is work underway on prison release data by the Criminal Justice sub-group of the CDP.

In Islington, **20% (n=21) of adults released from person in 2021/22 successfully started community treatment within 3 weeks of release** (see Figure 29). This is a decrease from 34% (n=33) the previous year. This is compared to 21% across London and 37% across England.

Continuity of care in Islington

For people leaving prison, the period immediately after release can be difficult because they are at high risk of **overdose** and **reoffending**. People leaving prison should get a priority appointment with a community treatment service to help them stay engaged. This appointment should be **within 3 weeks** of leaving prison for the person's care to be classed as continuity of care.[2] Treatment engagement and continuity of care is vital to reducing their risk of death and in supporting them from reoffending.[3] There are several barriers to continuity of care, including: lack of two-way **communication** between prisons and community treatment providers and limited **follow-up** for individuals who did not attend their appointment in the community.[4]

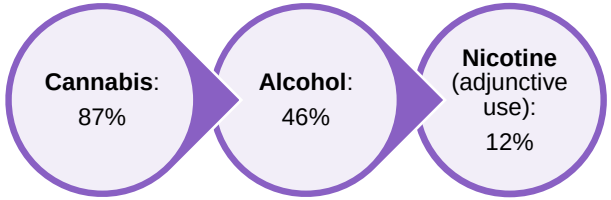
A recent continuity of care audit in Islington found that in the most recent quarter (Q2 2023-24), **29.1%** of people referred from the criminal justice system began treatment within 3 weeks (n=84/336). The continuity of care target is 45% for 2023/24, and 60% for 2024/25. Partners working on continuity of care in Islington include: Better Lives, Phoenix Futures at HMP Pentonville, SWIM, and the Probation Service.

[1] HM Chief Inspector of Prisons, 2022.
[2] OHID, 2023.
[3] OHID and HM Prison & Probation Service, 2023.
[4] Public Health England, 2018.

Young people in drug and alcohol treatment

Figure 31: Top 3 substances cited by young people in drug and alcohol treatment in Islington, 2021/22

Figure 32: Top 3 substances cited by young people in drug and alcohol treatment in England, 2021/22



Substance use profile of adults compared to young people in drug and alcohol treatment

There is a very different substance use profile of adults in drug and alcohol treatment compared to that of young people. While **alcohol** and **cannabis** were in the top three cited substances for both groups in Islington in 2021/22, adults cited **opiate** and **crack cocaine** use at a much higher proportion than young people. 24% of adults in drug and alcohol treatment in England in 2021/22 cited opiate and crack cocaine use, and 24% cited opiate without crack cocaine use. Only 2% of young people cited opiate or crack use. By contrast, while 8% of young people cited **ecstasy** use in treatment in England in 2021/22, 0% of adults did so in this year (people can report up to 3 substances at the start of each treatment).

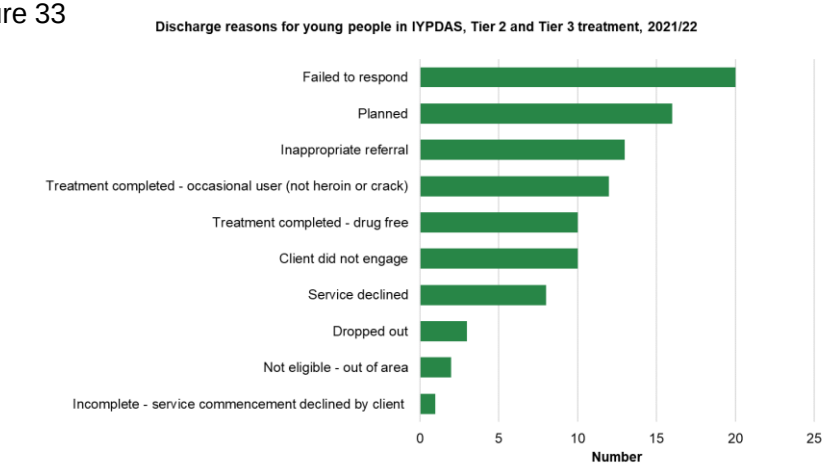
Source: NDTMS, 2023

- Drug and alcohol services are provided through a tiered approach:
  - Tier 1 – Non-substance misuse-specific services providing minimal interventions.
  - Tier 2 – Non-structured treatment. Includes drug advice information, brief interventions, and harm reduction advice.
  - Tier 3 – Structured treatment. Consists of a care plan that covers a range of options.
- There has been a **general decline** in the number of young people (under 18s) in Tier 3 drug treatment and alcohol in Islington in the past decade. There has been an **80% decrease** in numbers from 2009/10 to 2021/22, from 100 to 20.
- There has been also been a **decline noted both regionally and nationally**, though to a lesser extent. In England, the number of young people in treatment decreased 48% between 2009/10 and 2021/22, and in England, 53%.
- The top three substances cited by young people in drug and alcohol treatment in Islington and England can be seen in Figures 30 and 31.
- Compared with prevalence data, while cannabis was the substance with the highest prevalence among secondary school pupils in England and Islington in 2021, the second and third most cited substances were **nitrous oxide** and **solvents**. These are under-represented in treatment.

About this data:
Data on the number of young people in drug and alcohol treatment is available from the National Drug Treatment Monitoring System (NDTMS) and Islington Young People's Drug and Alcohol Service (IYPDAS), the local drug and alcohol service provider for young people. It is important to note that NDTMS only captures data on Tier 3 structured treatment clients, whereas IYPDAS data includes both Tier 2 and Tier 3 clients. The figures provided can therefore not be compared between the two sources.

Young people's drug and alcohol services in Islington

Figure 33



Note: 'Planned exit' refers to where an agreement was made between the worker and the young person to discontinue the intervention for varied reasons.

Source: YCSMAS Annual Report, 2021/22

Islington Young People's Drug and Alcohol Service (IYPDAS)

- Provides advice and information to young people aged 12 to 21 years using substances and/or alcohol in the borough and supports partners working with young people with such needs
- They also provide **structured treatment support** for young people whose drug and/or alcohol use requires longer term intervention
- In addition to this, the **Substance Misuse practitioners** offer group work sessions in the community and hold specialist lead roles – Lead for Whittington A&E, Lead for Schools and Alternative provision and Lead for Young Women & Girls
- IYPDAS also has a newly developed role – **Youth Counsellor & Substance Misuse Worker**, lead for the YJS

- **Islington's Youth Counselling and Substance Misuse and Alcohol Service (YCSMAS)** is a newly integrated health team and holistic health service that incorporates the Targeted Youth Support Youth Counselling Service and the Islington Young People's Drug and Alcohol Service (IYPDAS).
  - **Islington Targeted Youth Support (TYS) Counselling Service**: This offers counselling sessions to any young person aged 12 to 21 years, who lives or studies in Islington and have moderate to complex mental health needs.
  - **Islington Young People's Drug and Alcohol Service**: See Box.
- A total of 92 people were referred to IYPDAS in 2021/22, of which 62 were seen (this includes Tier 2 and Tier 3 treatments). Of those seen by IYPDAS, the largest referral source into IYPDAS in 2021/22 was **Targeted Youth Support** (34%; n=21), followed by '**children looked after**' (10%; n=6), and **children's mental health services** (10%; n=6).
- 60% (n=50) of referrals to IYPDAS in 2021/22 were male, and 40% (n=34) were female. The modal age group was 16-18 years.
- There were 95 young people discharged from IYPDAS in 2021/22, however less than half of these appear to have received treatment (see Figure 32; several failed to respond, were inappropriate referrals, declined service, etc.). **10 young people completed treatment drug-free in Islington in 2021/22**, with a further 12 remaining occasional users.
- The service is exploring how to improve levels of engagement and planned exits from treatment. They are also exploring how best to reduce 'failed to respond' to ensure that referrals are appropriate and have been consented to, which is an ongoing piece of work.

Recommendations

1) Take action to reduce the risk of drug-related deaths

Islington had the sixth highest rate of drug misuse deaths in London in 2019-2021. In 2021, approximately half of all drug-related deaths in England involved an opiate; modelled estimates suggest a high prevalence of opiate use locally. Furthermore, synthetic opiates are an emerging risk both locally and nationally.

Recommendations include:

- Develop an action plan to increase naloxone presence and awareness across the borough. This includes not only by people who use drugs, but also people close to them and people who may encounter drug use in their work, such as people working in hostels and supported accommodation, caretakers, park guards, and police. Part of the work to do so should include steps to reduce the stigma associated with drug use and overdose.
- Ensure people with complex needs, those who are rough sleeping, and those leaving prison, are included in naloxone distribution and harm reduction support.

2) Expand data-led, partnership approaches to understand and address hotspots for drug-related crime, antisocial behaviour, and vulnerability

Police data and local community safety data reveals that drug-related crime (particularly trafficking), antisocial behaviour, and ambulance call outs are higher in some wards, particularly Finsbury Park and Barnsbury. There is also a noted concentration of antisocial behaviour on particular estates. One of the key objectives of the National Strategy is to break drug supply chains. The membership of the Combatting Drugs Partnership, including police, community safety, and service providers, creates an opportunity for collaborative action in addressing and tackling hotspots of drug-related harm and crime in Islington.

Recommendations include:

- Explore opportunities to access more granular data around drug-related antisocial behaviour reports to potentially identify areas of drug use vs. drug dealing, and how to best direct enforcement activity and treatment outreach resources.
- Islington exemplifies strong partnership working in hotspot areas (for example, the joint outreach service run by the service provider, the Council, and St Mungo's). It is recommended that commissioners take steps to understand and ensure that the current outreach offer is sufficiently flexible and responsive to meet local needs.

Recommendations

3) Ensure safeguarding needs are recognised

Drug and alcohol use, and particularly dependence, can make individuals vulnerable to exploitation. Exposure to drug and alcohol use by a parent or carer presents a safeguarding risk to children and adolescents, and can manifest as trauma in the child or young person.

Recommendations include:

- Public Health should ensure that drug and alcohol services are able to identify when service users, or their children and families are at risk of harm, and operate robust and effective safeguarding practices.
- Public Health should ensure that its outreach services are meeting the needs of the most vulnerable street-active drug and alcohol users, who are at particular risk of harm and exploitation, and that drug and alcohol services are able to support people with complex needs who may require a range of service interventions.
- Drug and alcohol services – and particularly the Better Lives Family Service – must be regularly promoted to agencies working with children and families.
- The Combatting Drugs Partnership should take steps to ensure that drug and alcohol commissioners are linked to appropriate safeguarding boards and reviews.
- Recognising that both reporting of and responses to safeguarding concerns can vary between communities.

4) Ensure people with multiple or complex needs can access drug and alcohol treatment

Data on severe and multiple disadvantage (SMD) reveals that Islington has one of the highest prevalence of co-occurring substance use, mental health, housing, and criminal justice needs in London. There has been a noted increase in homelessness in Islington in recent years, with increasing pressure on local authority housing.

Recommendations include:

- Commissioners and the CDP should ensure services can adapt to meet the needs of this complex client group, and that the various services are streamlined for ease of access.
- Understand and improve pathways for people with co-occurring mental health and substance use needs. Establishing mental health pathways is a recommended area of focus for the Healthcare sub-group of the CDP and local commissioners.
- Islington may wish to establish a complex needs working group with an outreach focus, to ensure people experiencing multiple domains of disadvantage are able to access services. This could include a focus on ensuring people's physical health needs are being met and that they are able to access all their appointments, ensuring advocacy for them, or even commissioning an additional navigator service to work specifically with clients with a physical disability.

Recommendations

5) Increase numbers of people in drug and alcohol treatment

Prevalence estimates suggest there is a high level of unmet need for drug and alcohol treatment in Islington. Over the past decade, there has been almost a one-third decrease in the total number of adults in drug and alcohol treatment in Islington. One of the key objectives in the National Strategy is to increase the number of people accessing structured treatment.

Recommendations include:

- Assess and improve pathways into service – this includes self-referrals as well as referrals from other healthcare settings and the criminal justice system. We recommend that work is undertaken to ensure these are streamlined and person-centred.
- Improve data on all substance use – at present, reporting data focuses on opiate and crack use, as these are associated with the highest harms. However, from national survey and local service data, we know that use of cannabis, cocaine, and nitrous oxide is likely to be high. We recommend that commissioners work with local service providers to understand data around a range of substance needs, and that the services offered are able to meet those needs. It is also important that people using these substances are aware that treatment is available.
- Promote the local drug and alcohol service – this would involve reviewing the ways that we currently promote the service to stakeholders, and ensuring a communications plan is in place.

6) Explore opportunities to improve treatment outcomes

While there is a strategic focus on increasing the numbers of people accessing structured treatment, given the high levels of need in Islington, this should be coupled with efforts to understand and improve the rates of people that are able to complete treatment successfully, and to reduce the number of unplanned exits. Islington's service performance generally mirrors that of London and England, at around 50% successful completions. Increasing this proportion alongside increasing the numbers of people accessing treatment will deliver the greatest overall benefit.

Recommendations include:

- Work to further understand and improve treatment outcomes – Commissioners should work with treatment providers to understand reasons for unplanned exits, and if certain groups are less likely to complete, and whether there are:
  - (i) improvements indicated within the service, and/or
  - (ii) opportunities to invest in supplementary support for particular service user groups.

Recommendations

7) Develop our understanding of our local population's needs to promote uptake and equity of access to services

Data on the characteristics of people in drug and alcohol treatment in Islington reveals that there is some variation in access by ethnicity and religion. While this may speak to variations in prevalence of need, it may also be an indicator of barriers to accessing such services. Furthermore, qualitative research on a national level has revealed that women may experience a number of barriers to accessing and benefitting from drug and alcohol services.

Recommendations include:

- Ensure the re-launch of Islington Clients of Drug and Alcohol Services (ICDAS), Islington's substance use service user forum, and emphasise service-user involvement in the design and delivery of drug and alcohol services locally. Further work will also need to be undertaken in order to ensure this group is representative of the service user population in Islington.
- Undertake bespoke insight work with specific sub-populations, particularly those that are under-represented in treatment. This may include forming focus groups.
- We also recommend exploring opportunities to partner with VCS organisations in Islington to scope and/or deliver this work.

8) Understand and improve criminal justice system (CJS) pathways

National data reveals that rates of drug use in prison are very high, and we can anticipate similar levels locally in HMP Pentonville. People are at high risk of overdose and reoffending in the period immediately after prison release, and engagement with community treatment is vital. Local data reveals that continuity of care rates in Islington are low (29%), although there are challenges around this data due to incorrect attribution of borough of residence. One of the key objectives of the Supplementary Substance Misuse Treatment and Recovery Grant (SSMTRG) is to improve this rate. Operation Adder and an increased focus on identifying drug treatment needs in police custody presents an opportunity for more people to access treatment.

Recommendations include:

- Understand and improve CJS data-sharing and pathways – the Criminal Justice System sub-group of the CDP has commenced work on this, and recently completed a self-assessment in continuity of care. It is recommended that the findings from this self-assessment are applied, and that the members of the CDP are used to support effective delivery from partners, including cross-borough partners such as the police, the probation service, and HMP Pentonville.
- Public Health commissioners and Police should improve partnership and data-sharing opportunities to understand treatment pathways, and may wish to consider opportunities for additional support services around leaving police custody, as it has invested in additional support for people leaving prison (i.e., the SWIM programme).

Further Information

About Public Health Knowledge, Intelligence and Performance team

Public Health KIP team is a specialist area of public health. Trained analysts use a variety of statistical and epidemiological methods to collate, analyse and interpret data to provide an evidence-base and inform decision-making at all levels. Islington's Public Health KIP team undertake epidemiological analysis on a wide range of data sources.

All of our profiles, as well as other data and outputs can be accessed on the Evidence Hub at: https://www.islington.gov.uk/about-the-council/islington-evidence-and-statistics

About Drug and Alcohol Use Local Area Profile

This data pack/profile was produced by Lauren McGivern and Emilia Bernecka, reviewed and approved for publication by Miriam Bullock.

We would also very much welcome your comments on these profiles and how they could better suit your individual or practice requirements, so please contact us with your ideas.

ISLINGTON

Chief Executive Department
Town Hall, London N1 2UD

Report of: Director of Adult Social Care

Meeting of: **Health and Care Scrutiny Committee**	**Date:**	**Ward(s):**
	15 April 2024	

Delete as appropriate	~~Exempt~~	Non-exempt

SUBJECT: Quarter 3 (October - December 2023) Performance Report

1. Synopsis

1.1 The council has in place a suite of corporate performance indicators to help monitor progress in delivering the outcomes set out in the council's Corporate Plan. Progress on key performance measures are reported through the council's Scrutiny Committees on a quarterly basis to ensure accountability to residents and to enable challenge where necessary.

1.2 This report sets out Quarter 3 2023/24 progress against targets for those performance indicators that fall within the Adult Social Care outcome area, for which the Health and Care Scrutiny Committee has responsibility.

2. Recommendations

2.1 To note performance against targets in Quarter 3 2023/24 for measures relating to Health and Independence

3. Background

3.1 A suite of corporate performance indicators has been agreed for 2023/24, which help track progress in delivering the seven priorities set out in the Council's Islington Together 2030 Plan. Targets are set on an annual basis and performance is monitored internally, through Departmental Management Teams, Corporate Management Board and Joint Board, and externally through the Scrutiny Committees.

3.2 The Health and Care Committee is responsible for monitoring and challenging performance for the following key outcome area: Adult Social Care.

4. Quarter 3 performance update – Adult Social Care

4.1 Key performance indicators relating to Adult Social Care.

#	Indicator	2021/22 Actual	2022/23 Actual	Q3 Target 2023/24	Q3 2023/24	On target ?	Q3 last year	Better than Q3 last year?
ASC 1	NEW: The percentage of people with an outcome of no support needed after a reablement	*Not Available*	81%	*Monitoring only*	**72%**	*New*	*New*	*New*
ASC 2	New admissions to nursing or residential care homes (all ages)	225	194	150 (200 end of year target)	**112**	Yes	127	Yes
ASC 3	Percentage of ASC service users receiving long term support who have received at least one review	48%	48%	39% (52% end of year target)	**37%**	Within 5%	34%	Yes
ASC 4	Percentage of service users receiving services in the community through Direct Payments	29%	29%	31%	**29%**	Within 5%	*29%*	*Similar*
Safeguarding								

ASC 5	Percentage of service users who have been supported with safeguarding and who are able to comment, report that their desired outcomes were fully or partially achieved	**95%**	95%	95%	**92%**	No	**Not Available*	**Not Available*
ASC 6	The proportion of section 42 safeguarding enquiries where a risk was identified and the reported outcome was that this risk was reduced or removed	91%	93%	96%	**86%**	No	**Not Available*	**Not Available*

**Comparisons to last year are not available due to a change in reporting systems at the Mental Health Trust.*

ASC 1 **NEW: The percentage of people with an outcome of no support needed after a reablement**

This new indicator is one of the statutory reablement indicators that monitors outcomes after a period of reablement. The service aims to reable people and promote their independence. A high percentage for this measure provides evidence of a good outcome in delaying dependency and supporting recovery. Of the residents who received reablement in quarter 3, 72% were reabled and did not require long term support from adult social care. No target has been set for this indicator as this is newly reported. Performance is below end of year performance last year, however the data this year is more robust as more people are receiving reablement compared to quarter 3 last year. Reablement has also increased the cohort of people seen to include community and mental health referrals, and residents with increased needs. This will have an initial impact on the outcomes achieved. Q3 performance is similar to the London 2022/23 performance (London 74%, England 78%).

New admissions to nursing or residential care homes (all ages)

ASC 2 The Council provides residential and nursing care support for those who are no longer able to live independently in their own homes. The aim is to support more people to remain independent and within the community for longer, therefore keeping admissions to a minimum. In Q3, there were 112 new admissions to care homes. Performance is better than Q3 last year (127 new admissions) and met the target of having no more than 50 new admissions each quarter.

Recent benchmarking analysis from 2022/23 shows that as a rate, Islington has a similar or lower rate of new admissions to a care home per 100,000 of the population compared to London and England.

- For those aged 65+, in 2022/23 435 per 100,000 people were admitted to a care home in Islington. This is similar to London (433 per 100,000) and better than England (561 per 100,000).
- For those aged 18-64, in 2022/23 8 per 100,000 people were admitted to a care home in Islington. This is a lower rate than London (12 per 100,000) and better than England (15 per 100,000).

What action has been taken:

- Daily Integrated Quality Assurance Meeting (IQAM) and daily hospital meeting to sign off any packages of care or requests for placements. Chaired by member of the Senior Leadership Team at Assistant Director level or above. The purpose of the meeting is to be assured that a strength-based approach is being taken when assessing or reviewing residents and that the least restrictive options are explored with innovative solutions being used to meet need and to achieve the best outcomes for residents.
- Management actions are in place to provide assurance that all support packages are recorded in a timely manner on the electronic care records system (LAS) to enable accurate performance recording in this area.

ASC 3 **Percentage of ASC service users receiving long term support who have received at least one review**

As of Q3 2023/24, 37% of the service users who have been receiving services since the beginning of the year have received a support plan review. This is a cumulative measure with targets set for each quarter with the aim of reviewing 52% of the eligible population by the year end. Performance is better than this point last year (34%) and is withing 5% of the target this quarter (39%). It is important to note that this only reflects the 1,000 reviews on long-term service users with us for 12 months+. The team also completes reviews on service users who have received care for less than 12 months. When we look at all review activity, teams have completed 1,700 care act reviews including both annual and 6-week reviews.

What action has been taken:

- Daily Integrated Quality Assurance Meeting (IQAM) and daily hospital meeting to sign off any packages of care or requests for placements. Chaired by member of the Senior Leadership Team at Assistant Director level or above. The purpose of the meeting is to be assured that a strength-based approach is being taken when assessing or reviewing residents and that the least restrictive options are explored with innovative solutions being used to meet need and to achieve the best outcomes for residents.
- Management actions are in place to provide assurance that all support packages are recorded in a timely manner on the electronic care records system (LAS) to enable accurate performance recording in this area.

ASC 4 **Percentage of service users receiving services in the community through Direct Payments**

Providing support by direct payment aims to give the individual in need of support greater choice and control over their life. In 2022/23 it was decided to increase the target for this indicator from 30% to 31%. This decision was made to drive improvements in performance and align with performance in the upper London quartile for this indicator. In Q3 2023/24 29% of Islington service users receiving services in the community were supported via a Direct Payment. Performance for this indicator is similar to last year (29%) and within 5% of the new target ambition of 31%. Benchmarking from the Adult Social Care Outcomes Framework (ASCOF) 2022/23 shows Islington is performing better than, London (25%) and England (26%).

What action has been taken

- Direct payments support people to have greater choice, independence and control over their lives. This quarter teams have worked with a number of people who have a support reason of learning disability to enable them to start receiving support via a direct payment.

What action are you taking to keep it on track?

- There are a number of Direct Payments User and carers forums and working groups that have been commenced that are focussing on improvements to processes that will simplify the Direct Payment process.
- Other work within the department includes the review and refresh of Direct Payments (DPs) policies and procedures
- Direct Payments are being discussed in the daily quality assurance meetings with the aim to identify residents who would benefit from having a direct payments to more flexibly manage their support.

ASC 5 **Making Safeguarding Personal (An individualised approach to safeguarding that focusses particularly on what the resident would like the outcome of the safeguarding to be)**

This indicator measures the percentage of service users who have been supported with safeguarding, and who are able to comment, report that their desired outcomes were fully achieved.

The safeguarding adult's duties are enshrined in the Care Act 2014. The Care Act formally introduced the requirement for local authorities to safeguard people using a personalised approach. This approach is Making Safeguarding Personal (MSP). MSP places the service user at the centre of safeguarding conversations, decisions and actions. One of the assurance mechanisms to track that the Making Safeguarding Personal principles are being followed is by asking service users if their desired outcomes were fully met at the end of the safeguarding investigation.

In Q3 2023/24, 92% of service users reported that their desired outcomes were fully or partially achieved. Quarter 3 performance is below the target (95%) and end of year performance last year (95%). It should be noted that the data source for this indicator comes from both Adult Social Care and the Mental Health Trust. We are aware which teams need to improve their data recording and practice in order to drive performance.

What action has been taken

- The Trust, the safeguarding hub and Islington Council are working closely together to ensure that safeguarding practice is accurately recorded on the new Electronic Patient Record system, RIO.
- A safeguarding handbook has been developed alongside internal training and forums ongoing to discuss expectations. Moving forward, data collection will be automatic but still requires managers to check constantly the quality and recording thereof.
- Ongoing forums for Safeguarding Adult Managers (SAM's) and drop in for frontline workers are continuing to discuss complex cases, obtain advice and ask about the safeguarding processes.

What action are you taking to keep it on track?

- In quarter 3 progress has been made with the electronic case record system improvement. Teams are working with Islington Digital Services to review the safeguarding module of our electronic case records system to ensure that this, and other key questions, are mandatory to answer for staff completing
- Safeguarding audits and reviews led by the Safeguarding Team leads, will focus on improving this indicator, along with training.
- A weekly safeguarding closure panel is now in place to oversee the outcomes of safeguarding enquiries and to support the embedding of best practice in this area.
- There has been an issue of different recording processes in Mental Health as a result of the use of a different management information system in that service. Considerable work has been undertaken in that area and continues to provide assurance.

ASC 6 ***NEW* - The proportion of section 42 safeguarding enquiries where a risk was identified and the reported outcome was that this risk was reduced or removed**

This measure is included in the internal safeguarding performance monitoring and forms part of the annual Safeguarding Adults Collection statutory submission (SAC). From 2023/24, this indicator will be included in the national Adult Social Care Outcomes Framework (ASCOF). Based on this, it was decided to include the measure in the scrutiny report.

In Q3 2023/24, 86% of service users had a reported outcome of risk removed or reduced. Quarter 3 performance is below the target (96%) and end of year performance last year (93%). It should be noted that the data source for this indicator comes from both Adult Social Care and the Mental Health Trust. This was the first quarter that the Mental Health Trust used a new reporting form and system after a national cyber attack last year, so as this embeds the expectation is to see an improvement.

What action has been taken

- The Trust, the safeguarding hub and Islington Council are working closely together to ensure that safeguarding practice is accurately recorded on the new Electronic Patient Record system, RIO. These forms were newly introduced in quarter 1.
- Support has been provided to the Mental Health Trust to review any potential data quality challenges with reporting this figure

What action are you taking to keep it on track?

- As in ASC, the Trust continues to hold forums for officers and SAM's to explore safeguarding matters, seek advice and support when overseeing difficult cases.
- In partnership with ASC and the Trust, a system has been developed to collect and quality assure data within the Trust before passing over to Public Health to double check and combine with ASC.
- Since RIO went live in August 2022, new safeguarding S42.1+2 forms have been designed and built onto the system to ensure the necessary data is being captured.
- A new dashboard has been developed and is currently in its final stages with plans to go live at the end of the financial year. This dashboard will give better assurancesof the data

being collected as it will be established from RIO directly and reported via PowerBi which then managers can use to support their teams.

- Presently data is collected on a spreadsheet and cross checked by a business manager within Camden and Islington however we are aware this is open to human error due to the large data set. The spreadsheet is also difficult to read and miniplate by managers. A checking system has been put in place where the business manager and a senior officer within C+I meet weekly to validate the data and that all returns must be approved/signed off by the senior before submitting to Public Health.

5. Implications

Financial implications:

5.1 The cost of providing resources to monitor performance is met within each service's core budget.

Legal Implications:

5.2 There are no legal duties upon local authorities to set targets or monitor performance. However, these enable us to strive for continuous improvement.

Environmental Implications and contribution to achieving a net zero carbon Islington by 2030:

5.3 There are no environmental impact arising from monitoring performance.

Resident Impact Assessment:

5.4 The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010).

5.5 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.

6. Conclusion

6.1 The Council's Corporate Plan sets out a clear set of priorities, underpinned by a set of firm commitments and actions that we will take over the next four years to work towards our vison of a Fairer Islington. The corporate performance indicators are one of a number of tools

that enable us to ensure that we are making progress in delivering key priorities whilst maintaining good quality services.

Signed by:

Director of Adult Social Care Date:

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