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

AGENDA FOR THE HEALTH, WELLBEING AND ADULT SOCIAL CARE SCRUTINY COMMITTEE

Members of the Health, Wellbeing and Adult Social Care Scrutiny Committee are summoned to the meeting which will be held in Council Chamber, Town Hall, Upper Street, N1 2UD on, **15 October 2024 at 7.30 pm.**

Enquiries to	:	Bhavya Nair
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Despatched	:	7 October 2024

Membership

Councillors:
Councillor Jilani Chowdhury (Chair)
Councillor Joseph Croft (Vice-Chair)
Councillor Janet Burgess MBE
Councillor Tricia Clarke
Councillor Mick Gilgunn
Councillor Benali Hamdache
Councillor Praful Nargund
Councillor Heather Staff

Substitutes:
Councillor Caroline Russell
Councillor Claire Zammit
Councillor Sara Hyde

Quorum is 4 Councillors

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C. Exclusion of Press and Public

To consider whether, in view of the nature of the business in the remaining items on the agenda any of them are 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.

D. Exempt Items

The public may be excluded from meetings whenever it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that exempt information would be disclosed.

The next meeting of the Health, Wellbeing and Adult Social Care Scrutiny Committee will be on 11 November 2024

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London Borough of Islington

Health, Wellbeing and Adult Social Care Scrutiny Committee - 16 September 2024

Minutes of the meeting of the Health, Wellbeing and Adult Social Care Scrutiny Committee held at Committee Room 1, Town Hall, Upper Street, N1 2UD on 16 September 2024 at 7.30 pm.

Present:	**Councillors:**	Croft (Vice-Chair, in the Chair), Clarke, Gilgunn, Hamdache and Nargund
Also Present:	**Councillors:**	Williamson

Councillor Croft (Vice-Chair) in the Chair

12 APOLOGIES FOR ABSENCE (Item A1)

Apologies were received from Councillors Chowdhury, Burgess and Staff.

13 DECLARATION OF SUBSTITUTE MEMBERS (Item A2)

None.

14 DECLARATIONS OF INTEREST (Item A3)

None.

15 MINUTES OF THE PREVIOUS MEETING (Item A4)

RESOLVED:

That the minutes of the previous meeting held on 8 July 2024 be agreed as a correct record and the Chair be authorised to sign them.

16 CHAIR'S REPORT (Item A5)

The Chair advised that the order of business would be revised to consider item C3, the Adult Social Care performance report, as the first item of business.

Item C2, the HealthWatch Islington Annual Report, would be considered as the second item of business.

17 PUBLIC QUESTIONS (Item A6)

None.

18 QUARTER 4 PERFORMANCE REPORT - ADULT SOCIAL CARE (Item C3)

Victoria Nestor, Deputy Director Operations for Adult Social Care, introduced the report. The Deputy Director summarised the performance as detailed in the report. Councillor Williamson, the Executive Member for Health and Social Care, also commented on the performance data, noting that most indicators were in line with target, and Islington compared favourably to London and national comparators.

The following main points were noted in the discussion:

- The Committee noted those placed in care settings outside of the borough and queried how decisions were taken on placements outside of Islington. In response, it was advised that the majority of those receiving care were placed locally within London; some of those receiving care were placed elsewhere, and often this was a choice, to allow them to be closer to family. A review was undertaken last year, which sought to bring those placed elsewhere back into the borough, and a higher percentage than expected declined to move. In circumstances where care outside of the borough was considered, then the council did consult with the individual and their family to best meet their needs and wishes.
- It was noted that, when a resident was placed in care accommodation outside of the borough, Islington Council retained responsibility for that individual.
- In relation to the cost of care placements outside of borough, officers commented that care was often less expensive outside of London.
- Following a question on the financial status of Adult Social Care and the link to performance data, it was advised that keeping residents living healthy and independent lives in their own home for longer was more cost effective than residential care placements. However, the most important aspect was the health and wellbeing of those receiving care, and ensuring their needs were met.
- It was noted that the Chair of the Committee met regularly with the Executive Member and the Director of Adult Social Care to consider the financial challenges facing the service. It was queried if further information on the financial challenge could be appended to the quarterly performance report in future. The Executive Member indicated that this would be raised with the Chair and officers.
- A member queried the challenges associated with data collection and ensuring quality data. It was advised that a management dashboard had been developed which was now assisting with data collection; this was considered to be more reliable than saving data on spreadsheets.

RESOLVED:

That the quarterly performance report be noted.

19 HEALTHWATCH ANNUAL REPORT AND WORK PROGRAMME (Item C2)

Emma Whitby, Chief Executive of Healthwatch Islington, introduced the report. The following main points were noted in the discussion:

- The Committee noted Healthwatch's key achievements over the 2023-24 year. Over 800 people had shared their experiences of health and care services and 12,000 had approached the organisation for advice and information. In particular, the Committee noted the way in which Healthwatch supports those with long term conditions, helping them to receive quality advice from medical professionals on how best to manage their condition.
- Healthwatch Islington had been working with Somali and Turkish communities to encourage take up of cervical screening, and to understand the reasons why these communities had relatively lower rates of take up. This information then allowed services to better target information, providing accurate advice and addressing any concerns.
- Ms Whitby praised the volunteer team at Healthwatch for their work in providing support and advice to residents.
- It was noted that Healthwatch Islington was no longer able to provide the Digital Inclusion service due to a shortfall in funding; however the importance of digital inclusion and ensuring services are accessible was emphasised. While it has been

difficult to measure impact of the programme, those working on the scheme knew the significant impact of supporting residents to access online services.

- Following a question, it was advised that the digital inclusion work was funded through various organisations, and while digital inclusion was a significant priority during the pandemic, other issues had since taken priority for those funders.
- Following a question, it was commented that having a variety of contact options for health and care services was crucial as not everyone could access online services. Organisations also had to avoid stereotypes about the digital skills of older and younger generations; digital skills were varied among all age groups. It was also commented that having an easy-to-use online interface was crucial. It was reported that some health service websites were difficult to use, even for those with high levels of digital literacy.
- Healthwatch had worked with the council to seek feedback on the home care service, holding interviews with service users, next of kin and staff.
- It was noted that Islington was behind other London Boroughs on childhood immunisations and Healthwatch had attended various community events to speak to residents about the barriers to and benefits of immunisation.
- Ms Whitby commented on the positive working relationship with the council and welcomed the council's Evidence Islington programme, as well as Islington's focus on addressing the wider determinants of health and health inequalities.
- Healthwatch had worked with residents to understand the barriers to accessing mental health services; this identified the importance of building trust between services and service users, ensuring consistency in staffing, and the importance of diversity and inclusion in services.
- Healthwatch had used the Challenging Inequality toolkit to identify any areas for development in their own service; as a result, Healthwatch was seeking more board members aged over 45, as they currently had a very young board.
- The Committee asked how the council could best support Healthwatch, and what made the working relationship between the council and Healthwatch a success. In response, it was advised that having certainty over funding through a multi-year contract allowed the organisation to plan and carry out detailed work over multiple years. It was also commented that Islington Council invited Healthwatch to attend a variety of meetings, having an organisational culture that viewed Healthwatch as a trusted and respected partner in those meetings led to effective partnership working. It was also though that monitoring outcomes in the right way was an important factor in effective joint working.
- Following a question on equalities and engagement with men, it was commented that some men were not coming forward for prostate cancer screening, and it was also known that men tended to have lower rates of engagement with mental health services.
- The Committee commented on the importance of residents having positive experiences of health and care services; how patients feel about services will impact how they share their experiences with friends and family. Ensuring positive experiences of health and care services helps to build trust in communities.
- The Chair noted that Emma Whitby would soon be leaving her role at Healthwatch to take up a new opportunity elsewhere. The Committee thanked Emma for her contributions, praising her dedication to supporting the health and wellbeing of Islington residents.

RESOLVED:

That the Healthwatch Islington Annual Report for 2023-24 be noted.

20 SCRUTINY REVIEW - APPROVAL OF SCRUTINY INITIATION DOCUMENT & INITIAL PRESENTATION (Item C1)

(a) Approval of Scrutiny Initiation Document: Adult Social Care Accommodation

Jodi Pilling, Director of Strategic Commissioning and Investment, and Nikki Ralph, Assistant Director – Strategic Commissioning, introduced the scrutiny initiation document. Councillor Williamson, the Executive Member for Health and Social Care, also commented on the document and welcomed the scrutiny review, noting the importance of care services providing the right support, at the right time, in the right way.

The Committee approved the SID, with the caveat that the list of witnesses could develop over time. In particular, the committee was keen to hear from residents, and also community organisations working with those receiving care services. It was also suggested that receiving evidence from the council's workforce could provide an interesting perspective.

It was commented that evidence from an expert in digital inclusion and innovation in care may be helpful.

Officers also commented that the order of evidence received may need to be revised depending on the availability of witnesses.

RESOLVED:

(i) That the Scrutiny Initiation Document be approved;
(ii) It be noted that the list of witnesses was not exhaustive and further witnesses may be identified through the review.

(b) Scrutiny Review: Introductory Presentation

Jodi Pilling, Director of Strategic Commissioning and Investment, and Nikki Ralph, Assistant Director – Strategic Commissioning, presented to the committee. The presentation set out the principles and challenges of the council's approach to adult social care accommodation. The following main points were noted in the discussion:

- Islington's approach to adult social care accommodation had developed over time. The service always sought to engage with residents and co-production was crucial to ensuring that accommodation met the needs of service users.
- The service faced several challenges; while national challenges around funding for social care were significant, it was also recognised that Islington was a small and densely populated inner London borough with limited options for developing new care accommodation. Islington would have to take an innovative approach to ensure it had sufficient accommodation for service users in future.
- Demand for care services had increased over the past decade, and would continue to increase as life expectancy increased and the demography of the borough changed.
- It was also noted that Islington had the highest prevalence of severe mental illness in London. This presented challenges in terms of providing appropriate care support and accommodation.
- The Committee noted the range of accommodation types available. The service sought to support people's independence as far as possible, and also provided accommodation to those with very specific and complex support needs.
- The Committee commented on the importance of early intervention to support independence. Following a question on support for those with mental health issues,

officers summarised the local services available and joint working with Camden and Islington NHS Foundation Trust and the North Central London Integrated Care Board.

- A member asked if there was a specific part of the accommodation strategy that would benefit the most from member scrutiny. In response, it was commented that the ambitions around innovation would be useful to review, to better understand what could realistically be achieved. Due to the limited options for developing new care accommodation in the borough, the council needed to consider a range of innovative approaches to supporting those with care needs.
- It was commented that there was a range of new assistive technologies available to help those receiving care.
- The Committee considered the impact of loneliness and social isolation on wellbeing, and the need to ensure that those receiving care were able to remain part of a community. Social connectedness was a determinant of wider health.

The Committee thanked officers for their attendance.

21 **WORK PROGRAMME 2024/25 (Item C4)**

Noted.

The meeting ended at 9.05 pm

CHAIR

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Health, Wellbeing, and Adult Social Care Scrutiny Committee

Ian Swift Director of Housing Operations

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Introduction

- Homes and Neighbourhoods and Adult Social Care have excellent partnership working arrangements. The work between the Homes and Neighbourhood service and the ASC Operations service is national best practice.
- The majority of our vulnerable adults in Housing do not meet the care package criteria of ASC. However, we do have effective partnership arrangements with ASC Operations service to manage demand and need
- Meet with ASC Operations service daily.
- Good work around cuckooing of properties, complex needs of tenants with referrals conducted in partnership with fast information sharing.
- Good work around aids and adaptations and partnership work.

Current national and local trends

- The number of children who are homeless and living in temporary accommodation with their families in England has rocketed to 151,630- an increase of 15% in a year - and the highest figure since records began in 2004. The increase in Islington has seen a 35% increase over the last 12 months and we now have 1,586 homeless households living in TA .There are 1,340 children living in temporary accommodation in Islington within 865 families. There are 721 homeless single vulnerable adults living in temporary accommodation. However, vulnerable homeless households do not meet the threshold to access Adult Social Care services because they do not have needs identified within the Care Act

- The number of homeless families living in emergency accommodation such as B&Bs and hostels has reached 8,860 – a rise of 29% in a year. This type of emergency accommodation is notoriously overcrowded, expensive and unsuitable. Islington's figures are zero.

- There are 18 multiple complex needs people sleeping rough in Islington. However, none of these people receive care package support from Adult Social Care again, because they do not have Care Act eligible needs. Overall, there are now a record 117,450 homeless households living in temporary accommodation in England – the highest figure ever and up 12% in a year. The increase in Islington has seen a 35% increase over the last 12 months. No homeless household living in temporary accommodation has Adult Social Care support packages.

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- There are no Private Rented Sector properties available in Islington at the Local Housing Allowance rate. The average rent for a private rented property in Islington is £2,533 per month an increase of 14.2% in the last 12 months.
- The average property price is £687,000 in Islington
- Only 11% of people approaching Islington Council as homeless are in full time employment and therefore are unable to afford to live locally due to the high value of the private rented market. Poverty is the main reason for homelessness in Islington.
- There are no ASC support packages provided to any resident at Stacey Street scheme for single people sleeping rough or the homeless hostels provided by Homes and Neighbourhood's because they do not have care and support needs under the care act
- There are 15 properties provided to Adult Social Care each year by Homes and Neighbourhoods through a quota framework for people who have moved to independence, but there is limited if any take up of these properties and ASC wish to explore how to increase usage.
- Two new build schemes are being developed for Adult Social Care by the Homes and Neighbourhood service one for people with mental health support needs (Beaumont Rise) and one for people with learning disabilities (Rosehip formely known as Windsor Street).
- The commissioned service for Floating Support and Housing First will terminate in March 2026 and Homes and Neighbourhoods are exploring with ASC what elements may be brought in house as part of a restructure and which may be directly commissioned by ASC.

Context of local demand

- 103% increase in homeless presentations due to Domestic Abuse in the last 12 months
- 35% increase in homeless applications over the last 12 months
- 1,143 tenants of Islington Council receives support from Adult Social Care. This is one third of all care packages provided by Adult Social Care. The are 3,429 care packages in place from Adult Social Care. 16.80% General Fund budget spent on Adult Social Care in Islington. There are 25,357 Islington council tenants with 4% receiving Adult Social Care packages. 40% of Islington population live in social housing with 25% are living in Islington Council properties.
- 2% of the General Fund is spent on the homelessness service for 1,586 households living in temporary accommodation and 4,932 homeless applications over the last 12 months. 29% of homeless applications have complex multiple needs but not receive Adult Social Care services as they are not eligible for support under the care act.
- 18 people with multiple complex needs sleeping rough in Islington today. In London, there were 1,132 people estimated to be sleeping rough on a single night in Autumn 2023. This was an increase of 274 people or a 32% increase from 2022 and an increase of 717 people or 172% since 2010.There are 16,776 households on the housing register waiting to be rehoused. Only 7% of these households will be receive alternative accommodation over the next 12 months. 50% of homeless households living in temporary accommodation in Islington, 45% living in neighbouring boroughs and 5% living in other parts of London e.g. Greenwich or outside of London.

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Purpose into Action so what is Islington Council doing differently

- We have purchased 363 Ex Right to Buy properties in Islington to be used as Temporary Accommodation since 2021. This is the largest property purchase programme by any council in the country. These properties are being allocated to vulnerable and homeless households.
- We will purchase 94 more properties this financial year and a further 136 properties in 2025/2026
- We have provided 49 properties over two schemes for people sleeping rough. We have the lowest level of people sleeping rough in central London, Please note these people do not qualify for ASC.
- We will be Investing £200m in homelessness support and prevention over two years.
- We have the 7th highest number of homeless applications in London with 47% having multiple complex needs
- We have been awarded a City of Sanctuary accreditation, the Stonewall Housing accreditation and the Domestic Abuse Housing Alliance accreditation for our Housing Services
- We are restructuring the Housing Needs service to place prevention of homelessness at the heart of the service
- We have commissioned Shelter, Crisis, Homeless Link and PPL to conduct Mystery Shopping, Critical Friend, Customer Focus Groups, and a deep dive lean review to inform the restructure and service offer. ASC have been fully involved with the redesigns of our services.

Purpose into Action so what is Islington Council doing differently

- We have the Duty to Prevent not the Duty to Refer so any organisation can refer someone to the council who they believe are homeless or about to be made homeless and this assists with our vulnerable adult's work. ASC are one of these partners who refer into the service.
- We have an effective Homelessness Prevention and Rough Sleeping Forum chaired by an independent organisation which challenges the council's work again assisting with our vulnerable adult's work. ASC regularly attend these meetings
- We adopted quality standards for all TA two years ago designed in partnership with ASC.
- Anyone can access face to face services Monday to Friday. We have abolished the term Intentionally homeless, and we are committed to providing a single front door with ASC and health in the future and are currently exploring this with ASC colleagues.
- No one will ever leave hospital, prison, Home Office hotels, or any statutory institutions and sleep rough in Islington. We have an effective Housing First offer and excellent ASC partnerships in place.
- There will be an anticipated £2.25 million overspend for temporary accommodation in the current financial year compared to the average overspend in London being £7 million, but Islington has the 7th largest number of homeless applications. 60% of homeless applications are from vulnerable adults in Islington and most of these are not eligible for adult social care support.
- 635 adults have left the two local Home Office hotels with the right to remain in the country, with 829 current residents living in these hotels. The Director of Adult Social Service chairs the meeting, looking at needs of residents giving good strategic oversight as well as oversight on the gournd. Currently none of the residents have identified ASC needs.

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Local housing provision

- 25,357 Islington Council tenants and over 9,000 leaseholders.
- 16,521 Housing Association rented homes of which 2,197 are supported housing or housing for older people provided by 52 Housing Associations.
- Islington Council now embarking on an ambitious housing management restructure to ensure all residents receive the best service in the country.
- Resident empowerment framework, community drop-in sessions, RSIG, tenants and leaseholders appointed to the Housing and Communities Scrutiny Committee, Tenants and Residents Association work and TSM work.
- Fair, Inclusive and Accessible Housing Services Commitment, Anti-Social Behaviour Policy, Islington's Providers Partnership agreement and the Good Neighbourhood Management Policy will support our work with residents in Islington designed in partnership with ASC.
- Excellent partnership work with ASC Operations, and Assurance, Strategy, and Improvement service with seamless service provision. These two teams are the best I have experienced.
- Effective and professional communication with ASC Operations and Housing.
- LGA Peer Review identified excellent and effective partnership work between Housing and ASC

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Future Plans

- ✓ We are proud of the quality of our housing services, and we do believe we can positively change the world for our residents. However, we do need structural changes to be made by central Government to help us to make Islington a more equal place. Therefore, we hope the Government will work in partnership with councils across England in the following areas:
- ✓ Increase homelessness funding to councils through the Homelessness Prevention Grant and Rough Sleeping Initiative and for this increase in funding to be confirmed for every council during the lifetime of the Parliament
- ✓ The homeless prevention grant funding must address the highest numbers of homelessness since records began
- ✓ To provide additional Local Authority Housing Funding to enable councils to purchase Ex Right to Buy properties every year through the lifetime of the Parliament
- ✓ To provide grant funding which allows councils and housing association to build social rented housing to meet our growing community's needs.
- ✓ Update the framework around the Local Housing Allowance to allow councils to access private rented sector accommodation

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Challenges

- The overspends we are seeing across the country for homeless services will continue with some council's facing extreme financial challenges and having to issue section 114 notices because of overspends in the homelessness services.
- Some councils are spending 50% of the entire council expenditure on homelessness services. Islington spends 2% of its budget on homelessness services
- Homeless adults and families will be forced to live outside of Islington, and this will impact on the education attainment of children, and the well-being of families.
- The number of Islington Council and Housing Association lettings will continue to reduce due to the cost-of-living crisis, the reduction in the provision of new build accommodation and people being unbale to access other forms of accommodation.
- We need to address poverty if we are to address homelessness services. We are recruiting people to work in housing with lived homelessness and living in social housing experience and we are empowering our residents to help us to design our services.

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Camden and Islington NHS Foundation Trust

Report Prepared for:

Islington Council Health and Social Care Scrutiny Committee

15 October 2024

Reporting Officer: Prosper Mafu, Managing Director - Islington Division

1. SUMMARY

This report was prepared at the invitation of Islington Council's Health and Social Care Scrutiny Committee to provide an update about the Camden and Islington NHS Foundation Trust (C&I). We last provided an update to this committee in October 2023.

North London Mental Health Partnership (NLMHP) is the partnership between Camden and Islington NHS Foundation Trust (C&I) and Barnet, Enfield, and Haringey NHS Trust. We have been working with our borough partners in delivering place-based care in line with population health priorities.

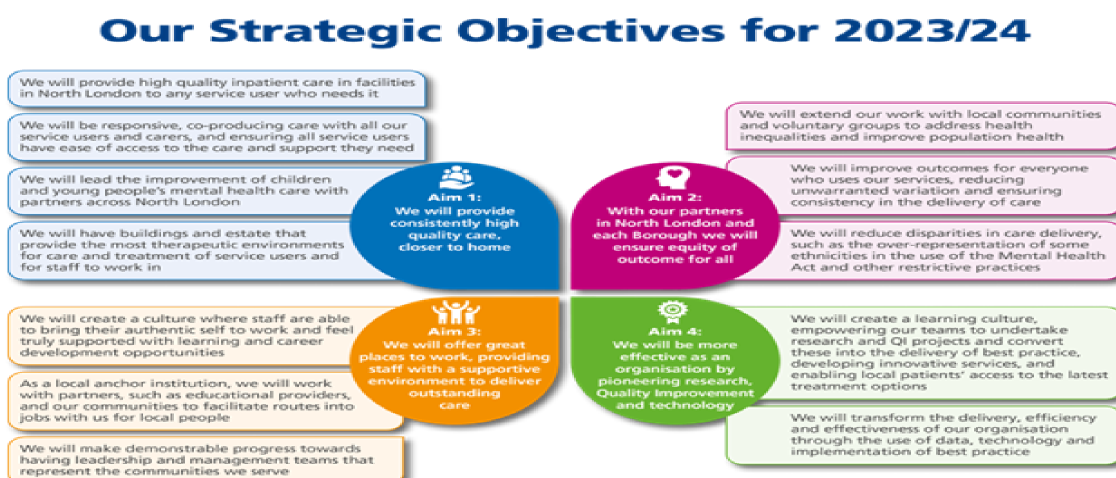
Whilst this paper will focus on the Camden and Islington part of NLMHP, there are some services which operates across the NCL footprint such as our inpatient services and perinatal mental health services.

This report gives an overview on performance over the last 12 months, the challenges we face and actions we are taking to address these challenges. We also update on the next step of our NLMHP, progress on the community mental health services transformation and estates transformation programme, all aimed at improving access, experience and outcomes for Islington residents seeking support from our mental health services.

The Islington Council's Health and Social Care Scrutiny Committee is asked to note the content of the report and provide comments.

2. INTRODUCTION

C&I is the largest provider of mental health and substance misuse services to people living in Camden and Islington. We have approximately 2,200 employees who work in multi-disciplinary teams providing a holistic approach to recovery. The Trust has delegated responsibility for the provision of social care in both Camden and Islington under the Section 75 agreements.



The sections of this paper will be presented under the following set of headings:

- Our services
- Our performance against Key Performance Indicators (KPIs)
- Service developments updates.
- Challenges
- Appendix 1: List of our services

3. OUR SERVICES

C&I provides high quality, safe and innovative care to our service users in the community, in their homes or in hospital. We provide services for adults of working age, adults with learning difficulties, and older people in the London area. We currently deliver the majority of our care to residents in the London Boroughs of Camden and Islington.

In addition, we have specialist programmes which provide help and treatment for: veterans living in London, young people caught in the cycle of gang culture and perinatal mental health conditions.

There are three divisions in Camden and Islington NHS; two are geographical – Camden and Islington, while the Hospital Division provides inpatient care across both Camden and Islington.

These are:

- Hospital

- Camden community
- Islington community

This structure is helping shape and support our transformation programmes and has put us in the best place to deliver our priorities, place-based care, and population health priorities.

For a list of our services see Appendix 1

In Islington, a number of our services are delivered in partnership with LBI Adult Social Care, VCS and the Whittington Hospital. We work closely with other agencies such as housing, police and probation services.

Partnership working between C&I and BEH (NLMHP) has continued to progress through 2023-24, with a single Partnership Executive Team in place across both Trusts.

Next steps for the North London Mental Health Partnership:

Our progress towards our new Trust, to be called the North London NHS Foundation Trust, continues. The final stage in the NHS England review process was a formal Challenge meeting with NHS England and representatives from the North Central London Integrated Care Board, which took place on 8 August. The feedback was very positive and was supportive of our application. Our formal application has now been submitted to the Secretary of State for Health and Social Care for final approval, which we expect very soon.

The new North London NHS Foundation Trust is due to come into being on 1 November 2024. We will keep all our external stakeholders updated once the merger process is completed and will keep you updated on our plans to continue to improve our services for local people and to make our new Trust a great place to work for all our staff.

4. OUR PERFORMANCE

OUR PERFORMANCE AGAINST KEY PERFORMANCE INDICATORS

The contents of the report are defined by the NLMHP's priorities which are informed by nationally defined objectives for providers - the NHS Constitution, the NHS Long Term Plan, the Oversight Framework for Mental Health, Adult Social Care Outcomes Framework, and Integrated Care Systems (ICS).

The report provides an update on the Partnership's operational and quality performance against national and local standards.

Below is a summary of performance against KPIs which relates to access and flow and the measures we are taking to improve and sustain our performance. This performance summary is based on the May 2024 board report and covers the following key performance indicators:

- 2+ Attended contacts - Community Mental Health Teams
- Talking Therapies – Recovery Rate
- Memory Service - % of patients diagnosed within 6 weeks of referral.
- Number of women accessing Perinatal services
- Psychiatric Liaison Service Response Rates
- CRT – 24-hour response rates
- Adult Acute Average Length of Stay
- Adult Acute - Over 60 days length of stay on discharge.

- NCL – Inappropriate Out of Area Placements
- 72-hour Follow-Up Post Hospital Discharge.

2+ Attended contacts - Community Mental Health Teams

The 2+ contact metric is a measure of how many people are accessing adult community mental health services and receiving help and support in new integrated model across the core and dedicated service provision including primary care, VCS, and MH services.

Current Performance

The C&I target for end of 24/25 is 8,005 2+ contacts. Performance in May 2024 was 7,570. Positive and sustained improvement has been delivered through 2023/24 and continues into 2024/25. The SPC charts indicate that we are failing to meet the target, with this due to the target line being the 2024/25 end of year out-turn figure – i.e. where we are working towards. We have an agreed monthly trajectory that we are tracking progress against. For April and May BEH did not meet the monthly trajectory, however they are continuing to increase towards it. C&I have exceeded the monthly trajectory in those periods and as a consequence the Partnership position is of meeting the agreed performance.

Actions to sustain and improve performance.

A continued focus on accurate activity recording alongside improvements in freeing up time to care to increase the number of contacts our workforce can deliver are contributing to the improvement. We have focussed programmes of work around seeking further ways to free up more time to care and the delivery of meaningful contact which this metric measures is an ongoing focus of our Community Transformation work. Where individual teams or Divisions are achieving positive results, the insights as to what has worked are shared across the Partnership, with an example being the Quality Improvement work carried out in Camden to reduce the numbers of unoutcomed appointments – a contact recording issue that has a direct impact on the number of reportable contacts. Additionally, pathways are being reviewed to ensure that we are better able to get people the help they need in a timely and meaningful manner which will have a positive impact as measured through this metric.

Talking Therapies – Recovery Rate

Talking therapy recovery rates refers to a measure used to evaluate the effectiveness of talking therapies (like cognitive behavioural therapy, counselling, etc.) in helping individuals with mental health issues who complete treatment (2 attended appointments) and who are moving to recovery. Specifically, it usually looks at the percentage of patients who report a significant improvement in their mental health after receiving treatment. High recovery rates can indicate that the therapies being offered are effective, while lower rates may prompt a review of treatment approaches or service delivery.

Current Performance

In May 2024, Camden's and Islington's Talking Therapies have met the 6 and 18-weeks wait time targets, however, the recovery rate target is not met. There was only a temporary deviation from this trend in April, October, and November and December 2023. Since C&I is currently falling short of their NCL access targets, recovery plans are being actively implemented to address this shortfall. An operations manager has been recruited to support the transformational change across the Partnership to improve performance.

The target for recovery rate is 50%, for May this was slightly below target at 48% - down from 50% for March and April. This remains within the normal range of variance.

Actions to sustain and improve performance.

Work is being undertaken to monitor this during supervision and with staff training to ensure accurate coding and prompt error correction. Regular data reviews will also help identify issues, especially in step 2 or step 3 variations. Referrals are assessed to accept only suitable cases. Priority is given to reducing waiting times for step 3, which directly influences overall recovery rates. Note that going forwards the recovery KPIs are changing to 'Reliable Improvement' (target 67%) and 'Reliable Recovery' (target 48%). This roughly equates to a Recovery Rate of 52% (so an increase in the current target of 50%). To achieve enhanced consistency of service delivery across the Partnership, all Talking Therapies services are now being overseen by a single Managing Director (Camden). An Operations Manager has also been recruited to support this approach and lead the transformational change required to deliver on the new access and outcomes requirements.

Memory Service - % of patients diagnosed within 6 weeks of referral.

This indicator measures the percentage of patients diagnosed with memory-related issues, such as dementia or other cognitive impairments, within six weeks of being referred to the service. It highlights the memory service's effectiveness in delivering prompt and efficient dementia diagnoses while reducing wait times.

Current Performance

Memory Services Recovery - Partnership wide performance across all boroughs in the Partnership has been challenged and as a result a Partnership wide recovery plan is being led by the C&I Older Adults Clinical Director and new Camden Division Managing Director. Collectively there is a renewed focus on performance improvement in this area including a full analysis of the wating time profile across all 5 boroughs. This work is ongoing and will be reported along with proposed mitigations.

Target performance is 85% Performance with C&I performance in May at 45%.

Actions to sustain and improve performance.

Performance across all boroughs has been challenged and is a cause for concern that has triggered a Partnership wide review, and Recovery Plan that is being led by the C&I Older Adults Clinical Director and Camden Division Managing Director, in collaboration with service and clinical leads from all boroughs. There has been continuous improvement within the Haringey division over the past three months, but this has been offset by a decline in performance in other boroughs. The learning from Haringey will be shared across the Partnership to help improve the overall position. However, there does remain concern about the availability of staff to deliver the model. Alternative initiatives to deliver change that is sustainable are being considered. The team are utilising Power BI to highlight those who have been seen and diagnosed as not having dementia to give a fuller understanding and narrative as this valuable activity (where other needs are identified) has an impact on this metric. It is anticipated that it will take some time for the performance to recover to the 85% standard, but there is an aim to improve performance by summer 2024. While improvements are yet to be reflected in the performance against this target, we are seeing improvements in 18-week performance which is an indication that patients are being seen earlier. The May '24 data unavailable (this was based on April 24 data) N.B: at the time performance was impacted by the industrial action by trainee doctors.

Number of women accessing Perinatal services

Up to 20% of women experience a mental illness during pregnancy or in the first year after delivering their baby. Specialist PMH services offer evidence-based psychiatric and psychological assessments and treatment for women with moderate to severe/complex mental health problems during the perinatal period. The number of women accessing specialist Perinatal Mental Health services represents the number of women utilising SPMH services during pregnancy, childbirth, and the first year postpartum. This metric sheds light on access to care, service demand, and the quality of maternal health, as higher numbers indicate greater awareness and availability of services, while lower numbers may highlight barriers to access.

Current Performance

Over the past ten months, there has been a steady uptick in the utilisation of NCL Perinatal services by women. With the supplementary funding secured for the service, the performance is progressing in the right direction, ultimately aligning with the target of 10% by March 2025. Managers are proactively promoting early planning for staff annual leave to minimize operational disruptions. The timely outcome of appointments is actively pushed through a divisional Quality Improvement (QI) project, with our dedicated analyst consistently monitoring progress and proactively engaging with the team to ensure prompt action.

The partnership remains on track to reach 10% by March 2025. Performance in May was 8%.

Actions to sustain and improve performance.

New investments and role adjustments within the service have expanded the capacity. Furthermore, MMHS (Maternal Mental Health Services) service was launched in the south patch in October and there is already a noticeable rise in assessments and treatment activities.

Psychiatric Liaison Service Response Rates

Current Performance

Target performance is 95%. Performance in May 2024 was 92% against a benchmark of 66.7% – Q3 23/24 (NHS MH Dashboard). There is an improvement in the overall C&I response rate from 90% to 92% from April to May. The Whittington has seen an 34% increase in referrals in both April and May which has made it challenging to meet the target response time due to the volume of referrals. Despite this, there is a trajectory of improved response times in the latter weeks of May.

Actions to sustain and improve performance.

Engagement with agency staff has seen an improvement in effective documentation of response times and MHCAS staff continue to support the Whittington ED with high acuity to support with achieving the response target. The RFH ED response rate has improved due to increased staffing now in place, the 95% target has been met in 4 out of the 5 weeks in May, it is expected that the response rates will continue to improve, and the target routinely met. Senior leads are meeting with Team managers to review weekly response rates to identified trends and offer solutions to improve the response rates.

CRT – 24-hour response rates

The metric measures how often Crisis Resolution and Home Treatment (CRT) teams respond to mental health crisis referrals within 24 hours. These CRT teams offer urgent support to individuals in crisis, often aiming to prevent hospital admissions. A high response rate within this timeframe indicates the service's effectiveness in providing timely assistance during emergencies, which is crucial for stabilising individuals and supporting them in their homes.

Current Performance

The target is 90%. In May 2024 Performance was 86%. Response times within 24 hours has dropped below target and was 86% for the month.

Actions to sustain and improve performance.

The expansion of the pilot programme that includes a mobile assessment team, which will be operational across all Crisis Teams continues to roll out and it is anticipated that this will impact positively on response times. Additionally, we are in the process of creating a new role for Band 6 Practitioners who may not have traditional qualifications but can significantly contribute to our Crisis Teams, thereby addressing the persistent recruitment challenges for qualified personnel. These posts will be advertised imminently. N.B: performance continues to be impacted by the ongoing industrial action by trainee doctors.

Adult Acute Average Length of Stay

Length of stay (LoS) in our inpatient services is a key driver in reducing inpatient bed occupancy rates. There have been several factors that affect the LoS including the complexity of people's needs and acuity of presentation, highlighted by the numbers of people in our hospital beds who are detained under the Mental Health Act. This metric is calculated by dividing the total number of patient days by the number of admissions over a specific period. Another key factor contributing to the increased average length of stay is the number of individuals who are Clinically Ready and Fit for Discharge (CRFD) but are unable to leave the hospital. This often results from challenges related to finding suitable housing or support services.

Current Performance

Patient Flow - Partnership Wide While the North Central London's (NCL) goal of capping Out of Area Bed Days (OBDs) at 372 was not achieved in May, there has been a noticeable improvement in the utilisation of out-of-area beds overall since February 2023. The Patient Flow Improvement Programme was launched in April 2024 to focus further on making improvements.

The target is 32. Performance for C&I is 52 against a benchmark: 44 – 2022/23 (NHSBN)- C&I

The North Central London Integrated Care Board (NCL ICB) aims for an average length of stay (LoS) of 32 days. Presently, the current average LoS for C&I stands at 52 days for the reporting month along with a 12-month rolling average of 48 days. LoS has been impacted by the recovery and discharge of some service users who have had extended periods of inpatient care on C&I wards. LoS has continued to be impacted by the number of patients who are Clinically ready and Fit for Discharge (CRFD) which we remain heavily focussed on. Internal waits for the rehabilitation pathway, mainly due to delays in step down facilities continues to affect acute bed capacity and LOS particularly in C&I.

Actions to sustain and improve performance.

The Patient Flow Improvement Programme commenced in April 2024 has a specific focus on internal rehab waits alongside 7-day flow, reduction of OAPs and CRFD reduction. The FLOW tool is now being used across all acute inpatient settings and is coordinated by the single Patient Flow team to promote effective bed utilisation and support the work of the patient flow improvement program discussed in depth at QSC.

Adult Acute - Over 60 days length of stay on discharge.

This includes all patients discharged from an adult acute mental health bed who had a total hospital stay of over 60 days, remaining hospitalised longer than may be clinically necessary. A longer length of stay in the hospital can improve patient experience and contribute to better long-term outcomes, but in an acute care setting, a length of stay (LOS) exceeding 60 days is quite long, as these environments are typically designed for shorter stays. Such extended stays may indicate that the patient had complex medical needs, complications, or required prolonged treatment and observation.

Current Performance

Performance in May was 15 against a benchmark of 14 – Q3 23/24 (NHS MH Dashboard). The Partnership remains committed to measuring and monitoring the number of patients discharged with a length of stay of 60 days or more, including instances of leave during their stay. Both BEH and C&I hold weekly MADE event looking at every patient with a length of stay over 40 days. The data is showing that there is starting to show a reduction in on both sides of the partnership.

Actions to sustain and improve performance.

All Clinically Ready for Discharge (CRFD) numbers and escalations are now reported to the system and discussed on the daily bed management and Patient Flow calls. Access to accommodation, complex care packages and waits for rehab are the key blockers in CRFD for which divisions are in contact with system partners to help unblock systematically. A new CRFD dashboard has been designed and is being made widely accessible to colleagues to give accurate visibility of all CRFD patients and their LOS. Meetings are being arranged with the London Boroughs to help improve pathways and processes for discharge. Industrial Action both within the Partnership and elsewhere in the system over the last few months has further contributed to delays as well as impacted the flow.

NCL – Inappropriate Out of Area Placements

"Inappropriate Out-of-Area Placements" (OAPs) occur when mental health patients are admitted to hospitals outside their local area due to a lack of local capacity. These placements can disrupt patient care by separating them from their support networks and limiting access to personalised care. Reducing OAPs is a priority to ensure patients receive treatment closer to home and improve overall care outcomes.

Current Performance

Performance in May was 672 recorded number of OBDs for the month against a goal of 372. This measure excludes clinically appropriate Out of Area Placements (OOA), i.e., placements for safeguarding reasons. Throughout the present year, there has been a notable decrease in the utilisation of out-of-area beds; however, March saw a surge due to the closure of some beds in Enfield for two weeks and an annual peak in demand.

Actions to sustain and improve performance.

Data quality has remained a key focus especially around Estimated Discharge Date (EDD) and CRFD recording This is allowing teams to have a forward view of flow and escalate any blocks in a timely manner. The focus on CRFD discharges is also freeing up bed days which will further reduce the reliance on OOA placements. The Patient Flow improvement programme launched in April 2024 and has initiated a number of workstreams that are creating the conditions for positive flow and maximising bed availability across 7 days which will be the key enablers for sustainably reducing and then eliminating the use of out of area placements. Work is also being undertaken to maximise digital capabilities to create organisational preparedness for peak periods to help sustain a zero OAP ambition. QSC considered the impact of the work of the Patient Flow Improvement Program which is key to the improved performance in this area N.B: performance continues to be impacted by the ongoing industrial action by trainee doctors.

72-hour Follow-Up Post Hospital Discharge.

The 72-hour Follow-Up Post discharge involves contacting patients within 72 hours after they leave an adult acute mental health inpatient bed and return to their home, a care facility, residential housing, or a non-psychiatric care setting. This prompt follow-up by the responsible clinical team supports a safer transition, especially for those with mental health needs or complex conditions, by allowing any emerging issues to be addressed early and reducing the likelihood of readmissions.

Current Performance

The target performance is 80%. Performance in May was 63%. The decline in performance in our southern boroughs has been an area of particular focus and has been compounded by a lack of available monitoring systems to track progress. Additionally, there have been a number of issues that have impacted the correct recording of information which in turn leads to these errors being recorded as failure to meet the target despite the person having been seen within the timescale.

Actions to sustain and improve performance.

To provide additional assurance that people are being seen within the 72-hour period and that all people are followed up following discharge a temporary system has been established whilst a longer-term resolution is pursued. Additionally, community leads are meeting with Hospital site colleagues to improve communication to crisis in-reach teams for out of area discharges and making sure that the correct discharge destination is selected when a patient is being transferred to a secure hospital site.

5. UPDATE ON SERVICE DEVELOPMENTS

BOROUGH PARTNERSHIP KEY PROGRAMME UPDATE

a) Community Mental Health Care Transformation

Our mental health teams have adopted the new care planning approach called DIALOG+ making it much easier to co-produce a personalised care and support plan with our service users and/or their carers.

Our new working arrangements with our Voluntary and Community Sector (VCS) partners are established aligning with our vision of an expanded and transformed community mental health service in partnership with Primary Care Networks (PCNs), the Voluntary and Community Sector (VCS), local authorities, physical health providers, service users, families, carers, and

communities and in line with The Community Mental Health Framework for Adults and Older Adults.

We are looking to strengthen the interface of core mental health teams and intensive mental health services. This will enable a smooth pathway for people who use our services.

Our largescale programme of work is divided into seven key workstreams:

- Community Mental Health Core Teams
- Younger Adults 18-25
- Adult Eating Disorders
- Older Adults
- Personality Disorders
- Community Rehabilitation
- DIALOG+ Care plan.

The feedback from people who use our services is encouraging. The Trust continues to seek feedback through our Friends and Family Test (FFT) survey in line with the principle that people who use NHS services should have the opportunity to provide feedback on their experience, for us to continue to improve. In May 2024, the overall FFT score was 88%, slightly below the benchmark target of 90%. Comments of negative experiences are reviewed by teams and actions taken where possible and learning shared.

b) <u>Borough Partnerships Updates</u>

We work in partnership with Adult Social Care, Primary Care Networks and voluntary sector providers in delivering a number of services such as employment support, physical health checks for those with Serious Mental Illness (SMI) and Mental Health Social Work interventions.

<u>IPS / MH Employment Support</u>

The IPS provider Hillside Clubhouse have been working with C&I to provide employment support in our mental health teams through their specialist employment advisors. Through funding from the DWP, Hillside Clubhouse's Employment Advisors work within IAPT services to deliver employment support.

<u>Serious Mental Illness (SMI) Health checks</u>

The Islington SMI Health checks service, delivered in partnership between C&I and Islington GP Federation, has been a valued services by G.Ps. This highlights the team's proactive and flexible approach and how they have built strong partnerships with GP Practices. The SMI Health checks service has been able to encourage people with SMI to receive annual health checks and focus on population approaches to improve outcomes.

<u>Section 75 Agreement</u>

We continue to work in partnership with the London Borough of Islington with LBI social workers co-located with and part of the mental health multi-disciplinary teams. We report on progress at the Islington's Mental Health Social Care Board.

<u>UPDATES ON ST PANCARS TRANSFORMATION PROGRAMME</u>

Highgate East

The Highgate East is a brand-new NHS mental health inpatient building on the Camden, Haringey and Islington border, next to the Whittington Hospital, opened in March 2024.

The building's cutting-edge design provides 78 all single en-suite rooms, replacing ageing inpatient facilities at St Pancras Hospital and providing a purpose-built environment which will support the recovery of service users and significantly improve the working lives of staff.

The new building has outdoor space from each ward, therapy spaces and a sports' hall. Highgate East will also be a valuable community asset with a café open to the public helping to destigmatise mental health.

Lowther Road Community centre

The state-of-the-art integrated community mental health centre at 1 Lowther Road opened its doors in March 2024. The centre provides a modern, welcoming space in the heart of the community offering integrated mental and physical health services and an enhanced working environment for staff.

Lowther Road is home to the majority of NLMHP's Islington Community Services including Complex Depression Anxiety and Trauma, Personality Disorder Service, Community Rehabilitation and the Islington Clozapine and Depot Clinic. A community café on the ground floor will make Lowther Road a place which everyone can use and enjoy.

On 18 April 2024, Arsenal Academy Manager, Per Mertesacker, joined staff and service users to officially open Lowther Road. Our Islington team has close links with the Arsenal in the Community project which delivers sport, social and education programmes to over 5,000 individuals each week including many with mental health diagnoses. The opening of the new community centre – less than a mile from the Emirates Stadium – will further strengthen those bonds and enable even more effective community working.

New Mental Health Crisis Assessment Service:

The Mental Health Crisis Assessment Service (MHCAS) opened in new location at Highgate West. This 24/7 emergency mental health care across North London offers much better alternative to A&E for those in a mental health crisis, really transforming service users' experience. At least 5 to 10 patients a week no longer needing mental health admission than was the case before MHCAS. This was an innovative national pilot, so successful it is now being replicated elsewhere.

Launched Section 136 pilot with the Metropolitan Police.

This is one of two pilots pioneering new approach providing specialist advice to Police about people detained with a mental health need. This has had a major impact in reducing inappropriate detentions, particularly reducing detentions of BAME service users, helping reduce inequalities, reduction in people attending A&E and reduction in Police time spent attending mental health emergencies.

Launched new 24/7 111 Think Mental Health service.

This is for anyone in North Central London in mental health crisis. It adds dedicated mental health option to NHS 111, improving ease and speed of access. The volume of 150 – 200

calls per week, with an average waiting time to get through to specialist help of only one minute, 11 seconds.

6. CHALLENGES:

Prevalence of Serious Mental Illness

As reported last year, we continue to have a high prevalence of serious mental illness and prevalence of common mental disorders in Islington. This includes high demand for Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactive Disorder (ADHD) assessments leading to longer waiting times for assessments.

Our ambition is that the community mental health transformation work, with a place-based focus and harnessing on opportunities to work across NCL as one mental health trust will help reduce inequality and improve access, experience and outcomes for people who use our services.

NCL have put some additional investments over the past couple of years to increase assessment capacity in our specialist Neurodevelopmental Disorder Services.

Camden and Islington remain two of the highest boroughs for Dementia prevalence across London. While improvements are yet to be reflected in the performance against the target of patients diagnosed within 6 weeks of referral, we are seeing improvements in 18-week performance which is an indication that patients are being seen earlier and there is an opportunity to learn from other services across our mental health partnership.

Recruitment

Overall vacancies are within expected targets. However, we have struggled to fill some vacant qualified nursing roles within our crisis services and often relying on bank shifts.

We are continue to look at creative ways of to reach a wider audience to improve our recruitment and advertising roles through various media platforms. One of our priority areas is to increase the number of staff employed from a postcode within the five NCL boroughs. We have seen some success in Islington IAPT services through working with the Islington health and social care academy where they successfully recruited Psychological Wellbeing Practitioners from NCL. There is an opportunity for other services to learn from the IAPT service in recruiting into these entry level roles. We are aiming to increase the number of apprenticeships, targeting local people to undertake an apprenticeship. We have offered success placement for apprentices in roles such as Clinical Associate Psychologists in our Core Teams, Graduate Management Programme trainee, and Psychological wellbeing practitioners in IAPT services and now in Better Lives SMS services.

CONCLUSION

We continue to build on the strength of our Islington borough partnership and the NLMHP. This is enabling us to take system wide approach in responding to the mental health needs of Islington residents and addressing inequalities.

This work is supported by our clinical strategy, embedding of community transformation and our recent estates developments will enable us to sustain and improve on our performance.

Key areas of focus for us remain on improving of memory assessments and perinatal mental health services.

APPENDIX 1: SERVICES BASED IN CAMDEN AND ISLINGTON NHS TRUST

Community Services
Assertive Outreach teams
Crisis Response Team and Crisis Single Point of Access
Clozapine wellbeing Clinic
Community Rehabilitation services
Substance Misuse Services
Women's crisis unit
Out of Area and Assessment Team
Réhabilitation and Recovery Teams
Serious Mental Illness (SMI) Nursing Team
Core Teams in Primary Care
Trauma Stress Clinic
Neuro developmental Disorder service
Psychotherapy Service
Complex Depression, Anxiety and Trauma (CDAT)
Personality Disorder Service
Veterans Services
Young people's services over 18-25
Early Interventions in Psychosis Teams
Services for Ageing and Mental Health
Community Learning Disability Team
Whittington Psychology Services
Perinatal Mental Health
Mental Health Crisis Assessment Service (MHCAS) and our acute hospital liaison services
Health Based Place of Safety
Inpatient Services
Acute Mental Health for working age adults
Older Adults wards
Rehabilitation wards

Psychiatric Intensive Care Units

ISLINGTON
For a more equal future

Public Health
222 Upper Street

Report of: Director of Public Health

Meeting of: Health and Care Scrutiny Committee

Date: October 2024

Ward(s): All

Public Health Performance Q4 (Quarter 4), 2023/24

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 is 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 the quarter 4, 2023-2024 (reported one quarter in arrears due to data lags) progress against targets for those performance indicators that fall within the Health and Social Care outcome area, and for which the Health and Social Care Scrutiny Committee has responsibility.

2. Recommendations

2.1 To note performance against targets in quarter 4, 2023/24 for measures relating to Health and Independence.

3. Background

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

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

3.3 Scrutiny committees can suggest a deep dive against one objective under the related corporate outcome. This can enable a comprehensive oversight of the suggested objective, using triangulation of data such as complaints, risk reports, resident surveys, and financial data and where able to, hearing from partners, staff, and residents, getting out into the community and visiting services, to better understand the challenges in order to provide more solid recommendations.

Public Health Performance Q4 2023/24

4. Key Performance Indicators Relating to Public Health – Table 1.

Public Health Priority	PI Ref	Key Performance Indicator	Annual Target 2023/24	Actual 2022/ 23	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24	On target?	2023/24 End of year position for comparison to last year.
Immunisation	**PHI1**	**Immunisation - Population Coverage**								
	PHI1a)	DTaP/IPV/Hib3 at age 12 months.	- Improvement on 89%	89%	87%	86%	87%	86%	Similar	87% (average)
	PHI1b)	MMR2 - 1st and 2nd dose (Age 5)	- Improvement on 70%	70%	68%	68%	68%	68%	Similar	68% (average)
Children & Young People	**PHI2**	**% Uptake of the NHS Healthy Start Scheme**	Now measured by actual uptake Annual uptake of 1692	N/A New Corporate KPI	1705	1757	1808	1781	Yes	N/A New Corporate KPI
Smoking	**PHI3**	**% of people quitting successfully who use the stop smoking service**	55%	62%	56%	59%	65%	63%	Yes	61% (average)
Health Checks	**PHI4**	**% of eligible population (40-74) who have received an NHS Health Check.**	10%	12.10%	3.70%	4.50%	4.10%	3%	Yes	15.3% (cumulative)
Substance Misuse	**PHI5**	**Number of adults accessing treatment in a 12-month rolling period – by Q4 2023/24**							Yes	N/A New Corporate KPI
	5a	Alcohol	389	N/A New Corporate KPI	370	407	413	428		
	5b	Alcohol and non-opiate	222		203	226	211	272		
	5c	Non-opiate	128		116	126	190	169		
	5d	Opiate	1033		866	899	926	944		
		Total	**1772**		**1555**	**1658**	**1740**	**1813**		
Substance Misuse	**PHI6**	**No. of people successfully completing drug and/or alcohol treatment of all those in treatment (12 months rolling) – by Q4 2023/24**							No	N/A New Corporate KPI
	6a	Alcohol	150	N/A New Corporate KPI	140	146	145	125		
	6b	Alcohol and non-opiate	81		61	47	56	52		
	6c	Non-opiate	54		40	35	43	46		
	6d	Opiate	55		43	49	41	40		
		Total	**340**		**284**	**277**	**285**	**263**		
Sexual Health	**PHI7**	No of Long-Acting Reversible Contraception (LARC) prescriptions.	1200 based on 22/23 baseline.		296	339	358	340	Yes	1333 (cumulative)

5. Quarter 4/End of Year Performance Update – Public Health

5.1 Immunisation population coverage

5.1.1 This measure considers population coverage of two key routine childhood vaccinations:

- PHI1a - The 6-in-1 vaccine (DTaP/IPV/Hib3, vaccinating against diphtheria, hepatitis B, Haemophilus influenzae type b (Hib), polio, tetanus and whooping cough) is given in three doses at ages two, three and four months. This indicator is measured by the percentage of children aged 12 months who have had the complete set of three vaccinations.

- PHI1b - The MMR vaccine (measles, mumps and rubella) is given in two doses, at age twelve months and at age three years and four months. This indicator is measured by the percentage of children aged five who have had both doses of MMR.

5.1.2 The data provided is from the local HealtheIntent childhood immunisation dashboard. This may differ from nationally reported data due to data quality and upload requirements of the national system but is considered the more accurate and most timely measure.

5.1.3 Primary care practices are required to upload vaccination information to inform the national programme of COVER data (Cover Of Vaccination Evaluated Rapidly), which provides open-access, population-level coverage of childhood vaccinations across the country.

5.1.4 While HealtheIntent is considered as the more accurate local data source, COVER data allows benchmarking against other geographical areas.

5.2 PHI1a - DTaP/IPV/Hib3 at age 12 months

5.2.1 In quarter 4 (Q4), 86% of children aged 1 year had received a complete course of the 6-in-1 DTaP/IPV/Hib/HepB vaccine. Coverage in this period is therefore slightly lower to the previous quarter when it was at 87%.

5.2.2 The data for Q4 is for children aged one year (i.e. any age between 12 and 24 months) in March 2024 (i.e. born between April 2022 and March 2023). This cohort of children were due their first vaccinations between June 2022 and May 2023 and may still have been affected by missed or delayed vaccinations due to fear of accessing healthcare following the pandemic. Children who miss scheduled vaccinations can catch up at any age.

5.2.3 In Q4, the rates of coverage reported through COVER for all 3 doses of 6-in-1 DTaP/IPV/Hib/HepB vaccination at age 12 months were 87% in Islington, 86% in London and 91% in England. This highlights local vaccination rates are in line with the averages for London.

5.2.4 The overall performance at the end of this year (2023/2024 – 87%) is slightly lower when compared to the position at the end of 2022/2023 (89%).

5.3 PHI1b - MMR2 - 1st and 2nd dose (Age 5)

5.3.1 The MMR vaccine (measles, mumps and rubella) is given in 2 doses, at age 12 months and at age 3 years and 4 months. The indicator reported, known as MMR2, is the percentage of children aged 5 who have had both doses of MMR vaccine.

5.3.2 The cohort of children were aged 5 in March 2024. These children were due their first dose vaccination (at age 2) between April 2020 and March 2021, and their second dose (at age 3 yrs 4 months), between August 2022 and July 2023.

5.3.3 In Q4, 68% of children aged 5 had received both doses of the MMR vaccination. Coverage for this quarter is the same as all previous periods of the year for 2023/24.

5.3.4 In Q4, the rates of coverage reported through COVER for both doses of the MMR vaccination at age 5 years were at 66% in Islington,74% in London and 85% in England, highlighting lower coverage than the regional and national averages for this period. The programmes COVER report may have also been affected by COVID -19 pandemic restrictions for 2023/24 and the fear of accessing health services as described for DTaP.

5.4 Population vaccination coverage (PHI1a and PHI1b) - key successes and challenges

5.4.1 Primary vaccinations are important in providing long-term protection to children against several diseases, which can cause serious illness. Individual unvaccinated children are at risk from these diseases. When population levels of vaccination are low, the risk of outbreaks of these infections are higher since they can spread more easily through the unvaccinated population.

5.4.2 Measles is a particularly infectious disease and can be a serious infection leading to serious complications, especially in young children and those with weakened immune systems. Measles spreads very easily between unvaccinated people, but two doses of the MMR vaccine confers very high level and lifelong protection.

5.4.3 The data issues which had been previously preventing reporting of the HealtheIntent MMR2 data were resolved and have been backdated to fill in data gaps in the previous two quarters.

5.4.4 During Q4 2023/24, the national catch-up programme continued. Messages went out to families of under 5's via the Bright Start, Bright Ideas newsletter and health visitors reinforced these messages and checked vaccination status at every routine health review.

5.4.5 MMR information leaflets were provided to community events, and there was close co-ordination with the Childhood Immunisation Project Outreach Worker who started working with HealthWatch in Q3. This has enabled greater outreach to community events and to under-served communities.

5.4.6 The Integrated Care Board (ICB) continued to collaborate with the General Practitioners (GP) Federation to provide targeted telephone recall to children identified as unvaccinated.

5.4.7 Key challenges faced this quarter and year 2023/24 include:

- During Q4, the outbreak of measles in North-West London began to spread to other areas of London, with 217 confirmed cases across the capital, although there were no confirmed cases in Islington. As a single dose of the MMR vaccine provides a high level of protection, the focus has shifted to ensuring as many children as possible receive their first dose of MMR (at age 1) to provide protection from the current outbreak of measles. Rates of MMR1 at age 2 have been rising steadily since a low of 76% in early 2022. The rate in Q4 2023-24 at age 2 was 81%.

5.4.8 The focus for 2024/25:

- Over the summer, there was continued emphasis on building awareness of the current outbreak of measles and starting to prepare for summer holiday travel and new school starters in September. Summer travelling to and from abroad brings particular risks of infection in countries where vaccination rates are low. Parents of children starting school in September have been targeted for information to ensure that children have had all their childhood vaccinations before starting school.

- Other opportunities with parents are being used to check vaccination status and to remind parents of the importance of vaccines, sources of trusted information, and the availability of catch-up at any age. This includes health visitor contacts, newsletters to parents and childcare settings.

6. Children and Young People's Health

6.1 PHI2 - Uptake of the NHS Healthy Start Scheme

6.1.1 The NHS Healthy Start programme is a national scheme which financially supports families on a low income to buy fruit, vegetables, pulses, milk, and infant formula. To qualify for the scheme, beneficiaries must be at least ten weeks pregnant or have at least one child under the age of four years. They also must be receiving income support.

6.1.2 Eligible families receive a prepaid Healthy Start card that can be used in shops to buy milk, fruit, and vegetables only. Once registered, the card is topped up monthly with:

- £4.25 each week of pregnancy from the tenth week.
- £8.50 each week for children from birth to one year old.
- £4.25 each week for children between one and four years old.

6.1.3 This is a highly targeted programme that benefits those with the lowest incomes. Most of the eligible population live in highly deprived areas. The data reported is usually % uptake by eligible beneficiaries.

6.1.4 This indicator is normally measured by % uptake by eligible beneficiaries. However, due to data quality inconsistencies regarding the number of eligible beneficiaries, this report will only report the average number of actual beneficiaries for the quarter.

6.1.5 In Q4, there were 1781 Islington residents who benefitted from the programme. Performance over the year has been on an upward trajectory to Q3, with increasing number of families signing up. Despite a slight decrease in the fourth quarter, the overall growth reflects the effectiveness of outreach and the various health promotion and support initiatives in promoting the programme.

6.1.6 Promotional resources are available at all children's centres in Islington, whilst resources are also being shared more widely. The Healthy Start Co-ordinator has been delivering ongoing awareness training for all new receptionist staff at children's centres. In addition to the system-based approach, the local team have shared a briefing about the scheme with local councillors in Islington.

6.1.7 The Healthy Start scheme can be a significant source of income for low-income families. A family with 3 children under age 5 could receive £17 per week. It ensures that the additional income is used to buy fruit and vegetables (and milk), with all the immediate health benefits and longer-term eating habits it brings to adults and children.

6.1.8 Key challenges faced this quarter:

- Missing data feeds between DWP & HMRC have led to underestimating the numbers of eligible beneficiaries from centrally produced sources since July '23. This is an ongoing issue, which means a denominator against which to calculate the percentage uptake is not available. Islington continues to promote the scheme, aiming to increase the number of eligible residents receiving financial support through strategic coordination, targeted efforts, and universal outreach.

6.1.9 The focus for the next quarter:

- This year, the primary focus is on increasing the programme's uptake. A breakdown of uptake by ward has been obtained to help guide targeted interventions through the Early Years/Bright Start Network. To support this goal, communication and health promotion resources will be reviewed and improved. Additionally, there will be more frequent training and resources provided to health professionals in the Bright Start network and via the Voluntary, Community Sector (VCS) to better promote the scheme.

7. Healthy Behaviours

7.1 PHI3 - Percentage of smokers using stop smoking services who stop smoking (measured at four weeks after quit date).

7.1.1 The community stop smoking service 'Breathe' provides an evidence-based offer of behavioural support and stop smoking aids to people who live, work or study in Islington or Camden and those who are registered with a GP in the borough.

7.1.2 The three-tiered service model ensures that smokers receive the support that is appropriate for their needs and suited to their lifestyle and circumstances. Breathe also supports, trains and monitors a network of community pharmacies and GP practices to deliver stop smoking support under the Locally Commissioned Service (LCS).

7.1.3 The indicator for service delivery is the proportion of service users successfully quitting at the four-week outcome point, with a target of 55% (referred to as four-week quit rate or success rate).

7.1.4 The new Breathe provider, Central and North West London NHS Foundation Trust, began delivery on 1st April 2023.

7.1.5 In Q4, 311 smokers set a quit date. The success rate is above target across the service in Q4 (63%) and it is slightly lower than Q3 (65%). Overall, in 2023/24, 1,262 smokers set a quit date and 764 successfully quit. This represents a success rate of 61%, above the target of 55%.

7.1.6 The service has supported more people to quit in 2023/24 compared with the previous year (1,131 smokers set a quit date in 2022/23 and 691 quit). The quit rate was similar between the two years: 61% in 2023/24 compared with 62% in 2022/23.

7.1.7 The community service, Breathe, continued to perform at a high standard, delivering a flexible, tailored, evidence-based service. In 2023/24, 74% of people successfully quitting using stop smoking support in Islington accessed Breathe directly, with an excellent success rate of 68%. Half (48%) of service users received intensive personalised tier 3 support.

7.1.8 The community service, Breathe, is well placed to reach smokers from target populations and has worked closely with secondary care trusts to support the implementation of the NHS Long Term Plan offer to start people on tobacco dependency treatment in hospital and in some outpatient services. Half of all service users seen by the community service in Q4 (47.5%) and in 2023/24 (53%) were referred by secondary care. 72% successfully quit smoking in Q4 and 70% in 2023/24.

7.1.9 Established partnership meetings with secondary care trusts were instrumental in ensuring that all referrals are effectively contacted and that no one is missed. A Breathe advisor attends clinical ward rounds twice weekly at the Whittington Hospital and offers bedside support to clients as part of the partnership.

7.2 Key successes and impact on inequalities /health inequalities:

7.2.1 NHS Digital reports on cumulative stop smoking data for 2023/24 in London and England by local authority. In the same period, the Islington service performed better (61%) than the average quit rate in London (53%) and nationally for England (54%).

7.2.2 In 2023/24 Islington achieved the 3rd highest rate of persons setting a quit date (8,567) and quitting (5,186) per 100,000 smokers in London. This was significantly higher than the London averages (3,160 and 1,670 respectively).

7.2.3 In 2023/24 Islington achieved the highest rate (83%) of pregnant women successfully quitting (closely followed by Newham and Tower Hamlets at 82%).The service's quit rate is significantly higher than London (58%) and England (50%) rates for this group. Over half of pregnant women successfully quit (61%) were verified with a carbon monoxide (CO) monitoring test.

7.2.4 In Islington, the estimated smoking rate amongst routine and manual occupations (24.7%) is double the rate of its adult population (13.2%) [Annual Population Survey estimates, average for 2020 to 2022]. Adults with long-term mental health conditions and residents on low incomes have smoking rates that are higher than the borough average. These are contributing to higher rates of long-term conditions, thus widening health inequalities.

7.2.5 In 2023/24, the service successfully reached groups that experience health inequalities due to higher smoking rates.10% of all successful quit attempts during the year were for people who disclosed a mental health condition either current or past (a quit rate of 57%), and 11% were for people with Chronic Obstructive Pulmonary Disease (a quit rate of 54%). In aggregate, 48% of people from ethnic minority communities setting a quit date successfully quit.

7.2.6 More than half (59%) of successful quits were also amongst residents with higher smoking rates, including those who are sick, disabled, or unable to work, long-term unemployed, unpaid carers and routine and manual workers. Ethnic minority groups with higher-than-average smoking prevalence successfully reached by the service included Bangladeshi men, Black Caribbean, and Black African residents:

- 18 Bangladeshi men quit with a success rate of 69%.
- 39 people of Black African ethnicity quit with a success rate of 78%.
- 32 people of Black Caribbean ethnicity quit with a success rate of 60%.
- 41 residents of Irish ethnicity quit smoking, a quit rate of 55%.
- 177 residents in 'White other' ethnic groups (which is a broad group and includes communities with higher rates of smoking, such as Turkish and Polish speakers) with a quit rate of 64%.

7.2.7 Key Challenges in 2023/24:

- Despite the increased offer of face-to-face support in accessible community locations, most service users continue to prefer the model of telephone and other remote support instigated during the pandemic. However, this does not allow the service to verify the quit outcome with carbon monoxide (CO) testing. This is an ongoing issue for stop smoking services and reflective of national trends. 16% of all successful quits were verified with a CO test in 2023/24, which was slightly lower than London and England (20%).

- Activity levels across GPs and pharmacies remained relatively low compared with the pre-Covid period. Quit rates were lower within GP practices (42%) than in community pharmacies (61%) over the whole of 2023/24. Lower activity levels can be attributed to ongoing challenges in recruitment and retaining of staff to deliver stop smoking work, competing work pressures which add to the difficulties in engaging smokers in the service in these settings, amongst other factors.

- Public Health officers have completed a comprehensive review of how stop smoking support is delivered within GPs and community pharmacies and are considering options to increase access to stop smoking support through these settings.

7.2.8 The focus for the next quarter:

- Breathe are expanding their work with voluntary and community sector (VCS) partnerships, drug and alcohol services, services working with homeless people, community mental health services, family hubs, Access Islington, and others from local VCS (Voluntary Community Sector) venues, to improve their reach into communities.

- The new government Local Stop Smoking Services and Support Grant for 2024-25, aims to support the delivery of outcomes of the government's smokefree generation plans and offers additional ring-fenced funding for local authorities to increase stop smoking support. This enables us to look at a range of options to increase access to stop smoking support through our stop smoking community provider, the Breathe service, and GPs and community pharmacies.

- The new government grant will enable us to focus on significantly scaling up service capacity and increasing service demand from 2024/25 onwards. Working with the Breathe provider (CNWL), commissioners are finalising the grant allocation to Breathe for 2024/25, to create new staff roles, increase the budget for the provision of stop smoking aids and scale up the targeted promotion of the service.

7.3 PHI4 Percentage of eligible population (aged 40-74) who have received an NHS Health Check.

7.3.1 NHS Health Checks is a national prevention programme, which assesses the top seven risk factors associated with non-communicable disease and where appropriate, provides individuals with support and treatment.

7.3.2 The programme aims to improve the health and wellbeing of adults aged 40-74 who do not have a diagnosed long-term condition, and who may benefit from advice and the promotion of early awareness, assessment, and where needed, treatment and management of risk factors for cardiovascular disease (CVD). It is a rolling programme, and over a five-year period all eligible patients should be invited for a check.

7.3.3 In Islington, NHS Health Checks are provided through the GP Locally Commissioned Service (LCS).

7.3.4 In 2023/24, 15.3% (7,986 individuals) of the eligible population received an NHS Health Check compared with a locally set target of 10%. In Q4 this was 3% (1,554 individuals) of the eligible population. The performance this quarter is lower than in Q3 (4.1%), but the overall performance in 2023/24 (15.3%) is higher than in 2022/23 (12.1%). This indicates a strong overall performance for the programme.

7.3.5 In Q4 2023/24, the percentage of the eligible population completing an NHS Health Check (3.0%) was slightly below the London average (3.2%) but above the England average (2.4%). When looking at 2023/24 as a whole, the percentage of the eligible population completing an NHS Health Check (15.3%) surpasses both the London average (12.0%) and the England average (8.8%).

7.3.6 The Department of Health and Social Care and NHS continue to recognise the importance of CVD prevention and the opportunity that the NHS Health Check offers to support this. For example, the NHS Long Term Plan (2019) describes CVD as 'the single biggest area where the NHS can save lives over the next 10 years. Health Checks play an important role in achieving England's 10-year CVD ambitions, through prevention and early diagnosis.

7.3.7 CVD causes just over a quarter (26 per cent) of all deaths in England. In Islington, approximately 14,000 people are living with CVD and CVD kills more than 1 in 5 people. Premature (under 75 years) deaths from CVD in Islington are higher than the London and England average. In Islington, across London and nationally, long-term downward trends in early preventable deaths from CVD slowed in the 2010's and have begun to increase slowly since the start of the 2020's.

7.3.8 The majority of CVD is preventable, so there is a significant opportunity to improve outcomes; risk factors, such as obesity, physical inactivity, smoking and drinking at unsafe levels, can all be modified to help reduce a person's risk of developing CVD. The NHS Health Check can help reduce inequalities by prioritising those at the greatest risk of CVD.

7.3.9 Impact on health inequalities:

- To address inequalities, Public Health Officers ensured that the offer of health checks to residents on the mental health and the learning disability registers is prioritised, along with residents with a predicted very high risk of developing cardiovascular diseases (CVD). As a result, 12.5% (214 residents) of the eligible population on the learning disability and

mental health registers and 35.9% (267 residents) of the eligible population with a very high risk of CVD have received a health check during 2023/24.

- Residents who complete a health check are made aware of the risk factors for cardiovascular disease, given appropriate advice and support, and signposted or referred to clinical interventions, or other services appropriate to their needs. For example, weight management services, diabetes services, advice on physical activity, smoking cessation services, alcohol advice or support services.

7.4 The focus for the next quarter:

- During Q4, Public Health started a review of all of Islington's Locally Commissioned Services, including for NHS Health Checks. Opportunities to improve the quality of delivery and equity of access to health checks have been identified, and Public Health will use these findings to inform the future development of the service.

- Public Health also plan to do a more in-depth audit of the quality of health checks delivered (e.g. having conversations around alcohol intake or healthy weight), to understand what aspects of the check are being undertaken well, and where there may be scope for improvement. Based on the findings, Public Health will then develop a package of training or support to help improve quality.

7.5 Substance Misuse

7.5.1 Islington's integrated drug and alcohol treatment service, Better Lives operates from three locations in the borough, supporting people that use drugs or have problem alcohol use, as well as their families and carers.

7.5.2 The service offers multiple support interventions including: one to one key-working, group work and day programmes, self-help, and mutual aid groups; pharmacological treatments including opioid substitution therapy (OST) and alcohol relapse prevention medication; access to residential rehabilitation and inpatient detoxification; physical health support, including bloodborne virus testing and treatment.

7.5.3 As well as the above, services delivered by Via (in operation since 2021) provide psycho-social support and prescribing outreach to people sleeping rough, or at risk of sleeping rough in Islington. Services by INROADS provide one-to-one key-working, connecting people to health services, pharm-reduction support including Naloxone; which can save lives by reversing the effects of an overdose, as well as referring into a range of other support services.

7.5.4 Islington Public Health also commission a service called SWIM (Support When It Matters), which provides 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. This is a group who are over-represented in the criminal justice system but under-represented in treatment, and this offer is important to help address this inequality. As well as offering a tailored group programme, SWIM ensures that those that require structured treatment are actively supported to access the Better Lives service. The service which mobilised through the summer and autumn was making good progress on building links and recruiting into their programme during the quarter.

7.5.5 All 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.

7.6 PHI5 Number of adults accessing treatment in a 12-month rolling period.

7.6.1 There has been a quarter-on-quarter increase in individuals accessing treatment in 2023/24, surpassing the annual target. Notably, 310 more structured treatment journeys have commenced compared to 2022/23. Additionally, there has been an increase in individuals seeking help across all substance categories, ensuring that the service is accessible to those with diverse drug and alcohol support needs.

7.6.2 There has been a significant increase in the workforce within the drug and alcohol service offer using grant funding, with supportive monitoring and oversight by Public Health commissioners. This is translating into more people being reached and coming into treatment and support.

7.6.3 Islington has a broad and dynamic service offer delivered by a range of providers. The service offer includes options for people who are still actively using substances (and seeking support to manage and reduce this use), and those in abstinence-based recovery. On top of universal drug and alcohol services (open to anyone) there are also specific services focused on individual cohorts where there is higher need, such as individuals who are rough sleeping.

7.6.4 Additional investment in services for men from Black heritage communities, through outreach with people who are street homeless and in hostels, and increased focus on prevention and early intervention with young people is addressing health inequalities within these groups.

7.6.5 Partnership working has improved over the last 12 months, through dedicated efforts to build relationships and work together around our most vulnerable cohorts, with notable progress in work with the criminal justice system, Police and Community Safety and through outreach activities. This has helped to improve our continuity of care rate, i.e. the proportion of people leaving prison who continue drug or alcohol treatment in the community post release, and further increased the number of people accessing treatment from 25% in Q4 22/23 to 45% in Q4 23/24.

7.6.6 A new online and weekend Peer Support programme has been commissioned and commenced in June 2024, with a new provider mobilising the service. This will extend the opportunities for people using substances or in recovery to access a 7-day peer support, holistic offer.

7.6.7 There is a national and regional emphasis from the Office for Health Improvement and Disparities (OHID) on increasing the number of individuals in treatment, supported by the Supplementary Substance Misuse Treatment and Recovery Grant (SSMTRG) funding as part of the ten-year national drug strategy. Islington's local performance is ahead of regional and national trends, with many areas experiencing increased treatment numbers due to the additional national funding. Notably, Islington has seen a steeper increase in 'new presentations' compared to the London regional average, demonstrating success in the local focus on reaching and getting new individuals into structured treatment.

7.7 PHI6 Number of people successfully completing drug and/or alcohol treatment of all those in treatment (12 month rolling).

7.7.1 PH16 numbers are lower than projected for 2023/24, and the number of individuals successfully completing treatment is similar to that of the same period last year. While this initially

appears to reflect static performance, reviewing service performance overall (indicator PH15) shows that there has been an increase in the number of individuals in treatment (both new and existing) who were retained in the service compared with the previous year.

7.7.2 Further lengthy periods of treatment can reflect the complexity of cases entering structured treatment; with extended time needed for pharmacological, psychosocial, or recovery support. Many individuals with alcohol and opiate dependencies require long-term interventions due to established dependencies and co-morbidities.

7.7.3 Recognising that there are limitations of only measuring 'successful exits' due to the complexity of the treatment population and that a proportion of service users, particularly with opiate dependency, remain in treatment for long periods of time, the National Drug Treatment Monitoring System (NDTMS) has introduced a new performance measure called 'treatment progress.' This metric allows us to assess individuals' progress during treatment, rather than focusing only on their exit status and will be used to closely review the proportion that are not showing substantial progress going forward.

7.7.4 At the end of 2023/24, the successful completion rate is currently lower than the regional and national averages: Islington – 15%, London Regional- 20%, National- 21%. This is reflective of the previous year, when the completion rate for Islington was at 18%, London at 22% and national averages at 20% for 2022/23.

7.7.5 As detailed in the PH15 narrative, significant effort has been put into accessibility of those entering treatment, with the expectation that this will lead to more successful treatment completions in the coming year. There are several service improvements being implemented to enhance the quality of interventions, which will likely increase successful treatment completions. These improvements include:

- Lower caseloads (through grant-funded investment in additional staff roles within the service).
- Caseload segmentation – service improvement delivered by the provider.
- Increased availability of long-acting Buprenorphine for individuals with problematic opiate use, which can improve adherence with opiate substitute therapy treatment compared to more frequent regimens.
- Expanded access to residential rehabilitation for individuals where community treatment has not been effective.
- Improved pathways supporting people with co-occurring mental health and substance use issues.
- Introduction of a structured day programme and enhanced psychological services.
- Launch of a new online and weekend peer support service providing 7-day access to peer-led recovery support in Islington.
- Enhanced local data capture through a revised suite of KPIs, a referral log to better understand reasons for unplanned exits, and improved data tracking of deaths among individuals in treatment, which will enable Public Health commissioners more effective oversight and monitoring of service delivery.
- Collaboration with system partners and service users to identify additional service elements that may improve the local offering. This includes remote/digital options, same-day prescribing, and enhanced outreach in hotspot areas.

- Dedicated resource to support 'in reach' to supported accommodation settings; and other community settings where the presence of drug and alcohol services would support engagement in treatment e.g. Access Islington.

7.8 Summary for 2023/24 for PH15 and PH16:

7.8.1 Working collaboratively with the service providers, Public Health have developed an ambitious programme of work (funded by the aforementioned grants) to increase the breadth of the offer and increase the number of people accessing drug and alcohol treatment and recovery support in Islington. There include several initiatives being delivered within the Borough that specifically aim to address inequalities and health inequalities. These include:

- A LGBTQ+/Novel Psychoactive Substances pathway has been developed, aiming to address the specific needs of the LGBTQ+ community in relation to drug use and associated risks.
- Dedicated women's groups and enhanced collaboration with Bronzefield prison to provide support for women following their release.
- Physical Health Pathways improvements recognising that individuals using drugs and alcohol face physical health inequalities, encounter barriers to accessing primary and preventative care, and often have multiple co-morbidities.
- Introduction of the new 'Swap to Stop' scheme which is a pioneering initiative designed to encourage people with drug misuse needs to switch from cigarettes to vapes, recognising that rates of smoking are much higher in this cohort than in the general population.
- Support When it Matters (SWIM) has delivered bespoke tailored interventions to 36 Black and African Caribbean men in the borough, assisting them with drug use and navigating the criminal justice system.

7.8.2 The enhancement of our service offerings aims to improve the user experience of drug and alcohol services, thereby increasing the likelihood that individuals will make and sustain positive changes in their drug and alcohol use. This will benefit not only the individuals themselves but also their close networks and the wider community.

7.8.3 Key challenges /issues this year:

- Many new roles have been introduced to the drug and alcohol workforce; however, these are fixed term contracts funded by the Supplementary Grant. There is uncertainty surrounding the future of this supplementary funding beyond March 2025.
- Capacity challenges in certain parts of the system limit the contribution these partners can make to borough-based Combating Drugs Partnerships and local delivery plans. For example, the Probation Service is a key partner in our work to improve criminal justice system pathways into treatment and the London service continues to experience significant capacity and resourcing challenges. This brings practical issues for partnership working.

7.8.4 Focus for the new year 2024/2025 and the next quarter:

- Public Health is working with services in developing a Communication and Engagement Strategy, which aims to increase visibility and knowledge of drug and alcohol services and improve access to harm reduction advice and information for all residents. Deliverables include a double page spread in the Islington Life winter edition (December) and associated digital content; a wider workforce training offer, and closer partnership working with VCS organisations work-

ing with people currently underserved by treatment and recovery services. We are also reviewing the information and process to make available online referral as an option. Critically in addition to communicating out, we will create more opportunities for service users, residents, and those working in services to feed into service development so we can better understand and address barriers to access.

8. Sexual Health Services

8.1 PHI7 Number of Long-Acting Reversible Contraception (LARC) prescriptions in local Integrated Sexual Health Services.

8.1.1 Long-Acting Reversible Contraception (LARC) is safe and highly effective in preventing unintended pregnancies. Unlike other forms of birth control, it is a non-user dependent method of contraception. Increasing the uptake and on-going use of LARC as part of contraceptive choice is very effective in reducing the risk of unintended pregnancies.

8.1.2 LARC is delivered through the Integrated Sexual Health (ISH) service provided by CNWL (Central North West London NHS Foundation Trust) and is a mandated open access service providing advice, prevention, promotion, contraception and testing and treatment for issues related to sexually transmitted infections, sexual and reproductive health care.

8.1.3 Additional access to LARC is also offered through primary care and abortion service providers.

8.1.4 In Q4, 340 women had a LARC device fitted in Integrated Sexual Health services. The annual target for the financial year 2023/24 was 1200 LARC fittings. The provider has delivered 1333 LARC fittings, exceeding their target by 133 and continued to provide good access to LARC for local women through the service.

8.1.5 The most recent national data shows that Islington has the third highest rate in London of LARC fitted within Integrated Sexual Health Services (31 per 1000 women aged 15-44) which is higher than the rate in London (23 per 1,000) and England (18 per 1,000).

8.1.6 In January 2024, CNWL launched a new online booking platform integrated into their website which allows service users to book appointments for LARC fittings and removals and other services online, making the service more accessible across all sites within North Central London (NCL). Appointments can also be made by contacting the service directly.

8.1.7 North Central London (NCL) have commissioned CNWL to deliver its PrEP programme to engage with communities at highest risk of acquiring HIV. (The programme aims to increase uptake of PrEP (Pre-exposure Prophylaxis) within these communities). In December, CNWL launched a service which enables people already accessing PrEP the option to order repeat prescriptions online. They have also launched two new awareness videos which include a Q&A about PrEP and how to access medication and a video to promote and demystify its use. In September, CNWL's PrEP programme was awarded the HSJ Patient Survey Award.

8.1.8 CNWL subcontracts various community groups working directly with communities to increase access and uptake of HIV testing. This includes Umoja Health Forum, a partnership of various African organisations concerned about health, housing and social welfare challenges experienced by Black African Communities, and Amaya, a social enterprise that aims to reduce inequalities

within minority communities and provides community HIV testing through a partnership with HIV Prevention England.

8.1.9 The service continues their health promotion outreach and in-reach services to people at risk of sexual ill health. These groups include sex workers, gay, bisexual and other men who have sex with men (GBMSM), racially minoritised groups, people who are experiencing homelessness or rough sleeping. In Q4, the service supported: 222 GBMSM, 104 sex workers, 60 people from Black African/Black Caribbean/Black other ethnic groups, and 61 people experiencing homelessness.

8.2 Key challenges faced in 2023/24:

- The challenge for the service this year has been recovery and increasing activity following the impacts of Covid -19 followed by Mpox. The service has been instrumental in the London and local response to the Mpox outbreak which predominantly affected GBMSM groups, including substantial vaccination delivery.

8.3 The focus for the next quarter and 2024/25:

- Public Health Officers are working with the Integrated Care Board on the development of a Women's Health Hubs initiative, which will offer opportunities for collaboration between women's health services, including co-location arrangements of the Haringey and Islington Gynae-Collab within the Archway Sexual Health Service.
- Public Health Commissioners for Barnet, Camden, Haringey and Islington are working on developing plans for the new sexual health contract and feeding into the developments of the City of London, pan-London sexual health e-service re-commissioning.
- For the new financial year, the PrEP programme has used data on local and national HIV transmissions and PrEP patients to identify three target groups for further outreach work. These are: young Gay, Bisexual and Men who have sex with men (GBMSM), GBMSM of colour and Black African heterosexuals. Public Health Commissioners are also working to identify other target groups for PrEP support.

9. Implications

9.1 Financial implications:

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

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

9.2 Legal Implications:

There are no legal implications arising from this report.

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

There is no environmental impact arising from monitoring performance.

9.4 Resident Impact Assessment:

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

The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

10. Conclusion

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 vision of a more equal 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:	Jonathan O' Sullivan Director of Public Health	September 2024
	Cllr Flora Williamson Executive Member	Date: September 2024
Report Author:	Jasmin Suraya - Islington Public Health	
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Health, Wellbeing and Adult Social Care Scrutiny Committee

WORK PROGRAMME 2024/25 – WORKING DRAFT

Meeting date: 8 July 2024

1. Membership, Terms of Reference and Dates of Meetings
2. Quarter 3 Performance Report – Public Health
3. Health and Care Scrutiny Committee Review 2023-24: Access to Health and Care Services – Final Report and Recommendations
4. Scrutiny Review – selection of topic
5. Work Programme 2024/25

Meeting date: 16 September 2024

1. Scrutiny Review – Approval of Scrutiny Initiation Document & Initial Presentation
2. Healthwatch Annual Report and Work Programme
3. Quarter 4 Performance Report - Adult Social Care
4. Work Programme 2024/25

Meeting date: 15 October 2024

1. Scrutiny Review – Witness Evidence
2. Camden and Islington Mental Health Trust Annual Performance Update
3. Quarter 4 Performance Report – Public Health
4. Work Programme 2024/25

Meeting date: 11 November 2024

1. Scrutiny Review – Witness Evidence
2. London Ambulance Service Annual Performance Update
3. Quarter 1 Performance Report – Adult Social Care
4. Work Programme 2024/25

Meeting date: 17 December 2023

1. Scrutiny Review – Witness Evidence
2. Islington Safeguarding Adults Board - Annual Report
3. Quarter 1 Performance Report – Public Health
4. Work Programme 2024/25

Meeting date: 04 February 2024

1. Scrutiny Review - witness evidence
2. Whittington Hospital Performance update
3. Quarter 2 Performance Report – Adult Social Care
4. Executive Member for Health and Care - Annual Report
5. Work Programme 2024/25

Meeting date: 20 March 2025

1. Quarter 2 Performance Report – Public Health
2. Scrutiny Review – Draft Recommendations
3. UCLH Annual Performance Update
4. Work Programme 2024/25

Meeting date: 29 April 2025

1. Quarter 3 Performance Report – Adult Social Care
2. Moorfields Eye Hospital Annual Performance Update
3. Scrutiny Review – Approval of Final Report
4. Work Programme 2024/25