ISLINGTON

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

Report of: Executive Member for Health and Social Care

Meeting of	Date	Agenda Item	Ward(s)
Health and Social Care Scrutiny Committee	**September 2019**		**All**

Delete as appropriate	~~Exempt~~	Non-exempt

Report: 2018/19 Performance Report

1. Synopsis

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

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

1.3. This report provides an overview of progress in 2018/19 (1 April 2018 to 31st March 2019) against corporate performance indicators related to Health and Social Care and Public Health.

2. Recommendations

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

3. Background

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

4. Implications

4.1 **Financial implications**

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

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

4.2 **Legal implications**

There are no legal implications arising from this report.

4.3 **Environment implications**

There are no significant environmental implications resulting from this report.

4.4 **Resident impact assessment**

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

A Resident Impact Assessment has not been completed because this is a report providing information about performance at the end of year for 2018/19.

1. Adult Social Care

Delayed transfers of care (DTOC)

1.1 Social Care delayed transfers of care have trended upward throughout 2018/19, with a year-end total average social care delayed beds per day of 6.5, missing the target of 5.0 beds per day.

1.3 To improve the rate of delayed transfers of care, processes have been reviewed and supports strengthened within the local system, with daily DTOC teleconferencing calls for UCLH, and continued management attendance at the Multi-Agency Discharge Event (MADE), held twice-weekly with partners at Whittington Health and Haringey at the main acute trust.

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

Discharge to home or community setting

1.5 At the end of 2018/19 95% of people discharged from hospital into enablement services were at home or in a community setting 91 days after their discharge meeting the target of 95%. The Discharge to Assess service continues to operate as one of the main pathways for people discharged from acute hospitals into the community. Pathway 1 is dedicated to those who have rehabilitation needs and goals that can be met at home via the Reablement service. The person is supported with up to 6 weeks of care, therapy and reviews, and then set up with an ongoing care package via a care agency should it be required following Reablement.

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

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

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

1.9 Work has commenced in establishing a true single point and route of access into Adult social care from all hospitals and community settings, as part of the Adult social care plan 2019-21. This work involves integrating the existing entry points into social care including the Hospital Social Work, Single Point of Access / Discharge to Assess, Access and Advice,

and Reablement teams. This is also part of the Intermediate Care work with CCG and Whittington Health. The main objectives of this work is the creation of one referral process, quicker access to social care support for the service user, reduced DToCs, and consistency in strength-based and person-centred practice.

Direct Payments

1.10 Currently 23% of all Islington community care and support is provided through Direct Payments. The total number of service users receiving services in the community through direct payments has increased to 675 compared to 591 at the beginning of the year. In percentage terms the figure reported last year for the uptake of direct payment was 37%. This figure was calculated using a different methodology to this year. If this year's methodology is applied to last year's numbers the percentage of service users receiving services in the community through direct payments was 21% last year, resulting in a small improvement in uptake of direct payments this year.

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

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

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

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

Admissions into residential or nursing care

1.15 The Council provides residential and nursing care for those who are no longer able to live independently in their own homes. The aim is to keep the number of permanent placements as low as possible, supporting more people to remain in the community. We have exceeded the target of 130 new placements for 2018/19, with a total of 137 new placements. To address this rise in placements, adult social care has implemented a new assurance process at the start of Q1 19/20. This assurance process includes senior management review and implementation of a strengths based approach to consideration of care options. This is already beginning to reduce the number of placements where other care options were appropriate.

1.16 There were around 800 placements in nursing or residential care homes in total in 2018/19. New admissions accounted for 20% of these placements. By primary support reason, the largest *number* of new placements in 2018/19 were for personal care support (93 new admission, equating to 29% of placements being new for this reason). However the highest *proportion* of new placements by primary support reason, was for substance misuse (5 out of the 6 placements were new, equating to 83%) and access & mobility support (22 out of 48 placements were new, equating to 46%) in 2018/19.

1.17 We have supported 1,857 people with long term homescare services during the year, which includes extra care and supported accommodation.

Reducing social isolation

1.18 Social isolation refers to a lack of contact with family or friends, community involvement or access to services. Results from the 2018/19 Social Care User Survey show an increased percentage of working age adults known to Adult Social Care feeling that they have adequate or better social contact (78%, compared to 70% in 2017/18).

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

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

Table 1: Adult Social Care Key Performance Indicators

ADULT SOCIAL SERVICES								
Objective	**PI No.**	**Indicator**	**Frequency**	End of Year 2018/19	Target 2018-19	On/Off target	Same period last year	Better than last year?
Support older and disabled adults to live independently	ASC1	Average number of patients delayed per day	Q	6.5	5.0	Off	N/A	N/A
	ASC2	Percentage of people who have been discharged from hospital into enablement services that are at home or in a community setting 91 days after their discharge to these services	Q	95%	95%	On	95%	No change
	ASC3	Percentage of service users receiving services in the community through Direct Payments	M	23%	37%	Off	32%**	N
Support those who are no longer able to live independently	ASC4	Number of new permanent admissions to residential and nursing care (aged 65 and over)	M	137	130	Off	127	N
*Reduce social isolation faced by vulnerable adults **(E)***	ASC5	The percentage of working age adults known to Adult Social Care feeling that they have adequate or better social contact. **(E)**	A	78%	75%	On	70%	Y

Frequency (of data reporting): M = monthly; Q = quarterly; T = termly; A = annual B=Biennial

(E) = equalities target

** NB: The figure reported last year for direct payments was calculated using a different methodology to this year. If this years methodology is applied to last years numbers the percentage of service users receiving services in the community through direct payments was 21%.

2. Public Health

Reduce prevalence of smoking

2.1 In Q4 performance was once again above target. 506 people set a quit date and 280 successfully stopped smoking, using the support of our local smoking cessation service. This makes the four week quit rate for the quarter 55%.

2.2 The annual quit rate was 53% and a total of 1,007 Islington residents quit smoking, using local stop smoking services. The proportion of smokers who set a quit date, and who successfully stop smoking with the support of our local service (as defined by the four week quit measure) has improved in 2018/19 compared to the previous year, and is significantly higher than the Department of Health recommended minimum quit rate of 35%.

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

Effective detection of health risk

2.4 NHS health checks is a national programme, delivered locally, designed to detect residents aged between 40 and 74 who are at increased risk of cardiovascular disease (including stroke, kidney disease, heart disease and diabetes) and to support them to reduce this risk through a range of behaviour change and clinical interventions. In 2018/19, over 6,000 (13%) eligible residents in Islington received an NHS Health Check, tailored lifestyle advice and referral into services to reduce their risk of cardiovascular disease. Although this is slightly below the annual performance achieved last year (13% vs 15.3%), performance was on target for 2018/19.

Tackle mental health issues

2.5 In 2018/19, over 5,000 people accessed support for common mental health problems through the Improving Access to Psychological Therapy (IAPT) programme. Performance is slightly below the annual target (5,148 vs 5,379), but shows an improvement from last year (5,132).

2.6 The percentage of Islington residents entering IAPT treatment who recover is above the nationally set target (50%), at 52%.

2.7 There is an ongoing Service Development Improvement Plan in place with the service provider to ensure the access target is met in 2019/20 and that the improved recovery rates are maintained.

2.8 Public Health commission services to raise awareness and understanding of mental health and mental illness, to reduce stigma and to support early access to mental health services and early signposting to support. This is through the provision of mental health awareness training (including Mental Health First Aid training), the community wellbeing service, aimed specifically at reducing stigma and raising awareness in communities with low access to

services, and work with children and young people through schools, and in community youth settings.

Effective treatment programmes to tackle substance misuse

2.9 In 2018/19, 10.4% of drug users in treatment during the year successfully completed treatment and did not re-present within 6 months of treatment exit. This is significantly below the target of 20% and a reduction in performance from last year.

2.10 Similarly, in 2018/19, the proportion of alcohol users who successfully completed their treatment plan was significantly below target (27.2% vs 40%).

2.11 A new integrated substance misuse treatment and recovery service, Better Lives, was procured and mobilised at the start of 2018/19 which has impacted on performance figures. The deterioration in performance compared to the previous year is related to: -

- The complexities of bringing together staff from across 6 different services in order to deliver to shared goals through a single integrated service
- Staff performance issues which have now been addressed
- Changes in performance monitoring as part of the new integrated service model.

2.12 Performance of the service in 2019/20 is now being managed at Board level by the provider (Camden and Islington Foundation Trust, in partnership with Blenheim and WDP) to ensure a concerted corporate focus on improving performance across all aspects of service delivery.

Improved sexual health

2.13 Full year data show that performance for the number of Islington women prescribed long acting reversible contraception in 2018/19 has substantially exceeded the annual target (1397 vs 520). Long-acting reversible contraception, such as the contraceptive implant, is more effective than user dependent methods (such as the pill or condoms) in reducing unplanned pregnancies.

Table 2: Public Health Key Performance Indicators

Objective	PI No	Indicator	Frequency	Actual Apr 18 – March 19	Expected profile	2018/19 annual target	On/Off target	Same period last year	Better than last year?
Support people to live Healthy Lives	HE1	a) Percentage of smokers using stop smoking services who stop smoking (measured at four weeks after quit date)	Q	53%	50%	50%	On	48%	Y
Effective detection of health risk	HE2	Percentage of eligible population (40-74) who receive an NHS Health Check	Q	12.6%	13%	13.%	On	15%	N
Tackle mental health issues	HE3	a) Number of people entering treatment with the IAPT service (Improving Access to Psychological Therapies) for depression or anxiety	Q	5,148	5,379	5379	Off	5132	Y
		b) Percentage of those entering IAPT treatment who recover	Q	52%	50%	50%	On	48%	Y
Effective treatment programmes to tackle substance misuse	HE4	Percentage of drug users in drug treatment during the year, who successfully complete treatment and do not re-present within 6 months of treatment exit	Q	10.4%	20%	20%	Off	18%	N
	HE5	Percentage of alcohol users who successfully complete their treatment plan	Q	27.2%	42%	42%	Off	34%	N
Improve sexual health	HE6	Number of Long Acting Reversible Contraception (LARC) prescriptions in local integrated sexual health services	Q	1397	520	996	On	942	**Y**

Report author(s)
Name: Mahnaz Shaukat
Tel: 020 7527 3860
E-mail: Mahnaz.Shaukat@islington.gov.uk
Final Report Clearance
Katharine Willmette – Director of Adult Social Care
Julie Billett – Director of Public Health

Signed by

Received by …… ……