ISLINGTON

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

**Report of: Executive Member for Health and Social Care**

| Meeting of | Date | Agenda Item | Ward(s) |
|---|---|---|---|
| **Health and Social Care Scrutiny Committee** | **21 November 2019** | | **All** |

| Delete as appropriate | ~~Exempt~~ | Non-exempt |
|---|---|---|

# Report: Quarter 1, 2019/20 Performance Report

## 1. Synopsis

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

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

1.3. This report provides an overview of progress of Quarter 1 (Q1), in 2019/20 (1st April 2019 to 30th June 2019) against corporate performance indicators related to Health and Social Care.

## 2. Recommendations

2.1. To note progress at Q1 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 Q1 of 2019/20.

# 5. Public Health

| Objective | PI No | Indicator | Frequency | Actual Apr 19 – June 19 | Expected profile | 2018/19 annual target | On/Off target | Same period last year | Better than last year? |
|---|---|---|---|---|---|---|---|---|---|
| Support people to live Healthy Lives | HE1 | Percentage of smokers using stop smoking services who stop smoking (measured at four weeks after quit date) | Q | 49.6% | 50% | 50% | On | 52% | No |
| Effective detection of health risk | HE2 | Percentage of eligible population (40-74) who receive an NHS Health Check | Q | 3.1% | 3.3% | 13.2% | On (within 5% for target ) | 2.8% | Yes |
| 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 | 1344 | 1473 | 5892 | Off | 1316 | Yes |
| | | b) Percentage of those entering IAPT treatment who recover | Q | 54% | 50% | 50% | On | 54% | Same |
| 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 | 10.20% | 20% | 20% | Off | 16.4% | No |
| | HE5 | Percentage of alcohol users who successfully complete their treatment plan | Q | 31.4% | 42% | 42% | Off | 31.7% | Same |
| Improve sexual health | HE6 | Number of Long Acting Reversible Contraception (LARC) prescriptions in local integrated sexual health services | Q | 344 | 275 | 1100 | On | 304 | Y |

## 5.1 Reduce prevalence of smoking

5.1.1 In Q1 49.6% of smokers who set a quit date with our local stop smoking service quit successfully with the service's support, in line with the quarterly target of 50%.

5.1.2 187 residents quit smoking using local stop smoking services (as defined by the four week quit measure). Whilst there was a reduction in numbers of residents setting a quit date in community and pharmacy settings, there has been increased activity in General Practice settings.

## 5.2 Effective detection of health risk

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

5.2.2 In Q1, 1,600 eligible residents received an NHS Health Check, tailored lifestyle advice and referral into services to reduce their risk of cardiovascular disease. Although slightly below the quarterly target, this 2019/20 Q1 figure is above performance for the same period for Q1 last year, which stood at 2.8% Previous year's performance indicate a seasonal profile to NHS Health Check performance, with increased activity in Quarters 2-4.

## 5.3 Tackle mental health issues

5.3.1 In Q1 of 2019/20, over 1,344 people accessed support for common mental health problems through the Improving Access to Psychological Therapy (IAPT) programme. Performance is slightly below the new quarterly target for 2019/20 (1,344 vs 1,473), but shows an improvement from this time last year where 1,316 people accessed the service.

5.3.2 The percentage of Islington residents entering IAPT treatment who recover is above the nationally set target (50%), at 54%.

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

## 5.4 Effective treatment programmes to tackle substance misuse

5.4.1 The data for the percentage of drug users in drug treatment who successfully complete treatment and do not re-present within 6 months for Q1 was 10.2%.

5.4.2 The data for the percentage of alcohol users who successfully complete their treatment plan in Q1 was 31.4%.

5.4.3 The performance against both measures is disappointing. The provider, Camden and Islington NHS Foundation Trust (C&I), worked hard during the first year of the contract to bring

staff and service users from a number of providers together in to one cohesive service. The issues raised in this process where more challenging than anticipated but are now settling.

5.4.4 As the service enters year 2, officers are working with the provider to ensure that performance improves this year. To this end, substance misuse service performance has been escalated to Executive Director/Board level within Camden and Islington foundation Trust, in particular assurances are being sought from the provider that the service is receiving the corporate support and attention it needs in order to improve performance and to deliver the service model as specified and agreed in the contract.

## 5.5 Improve sexual health

5.5.1 The number of Islington women prescribed long acting reversible contraception in Q1 has substantially exceeded the quarterly target (344 vs 275). 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.

# 6. Adult Social Care – Quarter 1 2019/20

## 6.1 Delayed transfers of care (DTOC)

6.1.1 Social Care delayed transfers of care are at 5.3 beds per day at the end of Quarter 1 2019/20, in line with the target of 5.0 beds per day, but at a slightly higher rate than at the end of Quarter 1 2018/19.

6.1.2The national Better Care Fund (BCF) target for Islington has changed this year to reflect just the total average beds delayed per day rather than distinguishing by responsible organisation. In Quarter 1, we have averaged 17.1 total delayed beds per day, slightly higher than the target rate of 16.0.

6.1.3To 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.

6.1.4 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.

## 6.2 Discharge to home or community setting

6.2.1 At the end of 2018/19, 95% of people discharged from hospital into enablement services were at home or in a community setting 91 days after their discharge, meeting the target of 95%. *There is no update to this figure for Quarter 1 2019/20 as this target is presented for Quarter 3 cases only, in line with Short And Long Term support reporting and ASCOF indicator 2B*. 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.

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

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

6.2.4 Reablement's scheduling system has been updated to ensure service outcomes for those discharged via Discharge to Assess and/or following a period of Reablement are recorded. This is on top of the already collated information from Discharge to Assess regarding bed days saved,

hospital re-admissions, referral cancellations and delays. Evaluation of this information is received via monthly or quarterly reports and shared with our Health/CCG partners.

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

**6.3 Direct Payments**

6.3.1 In Q1 of 2019/20 25% of all Islington community care and support is provided through Direct Payments, compared to 24% at this point last year. The total number of service users receiving services in the community through direct payments has also increased slightly, to 614 compared to 608 at this point last year.

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

6.3.3 Personalisation is a key work stream of the Adult Social Care Plan 2019-2022. Building on the Spark a Solution mapping project, and the Personal Assistants (PA) Pathway Proposal, we are partnering with an organisation called ‘In-Control’ who work with Councils to support them in increasing uptake of Direct Payments to make it the default choice, and looking at how to ensure the market is meeting the needs of those who choose Direct Payments. This will involve a review of all of our processes and policies, with a view to updating and improving our offer to people receiving Direct Payments. In Control will also be working with us to embed the POET tool 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.

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

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

***6.4 Admissions into residential or nursing care***

*6.4.1* The Council provides residential and nursing care for those who are no longer able to live independently in their own homes. The aim is to keep the number of permanent placements as low as possible, supporting more people to remain in the community. To maintain the same target rate per 100,000 residents aged 65 and older as 2018/19, the target for 2019/20 is 134 new placements. At the end of Quarter 1 2019/20, we have had a total of 23 new placements of people aged 65 and older. This places us on target for 2019/20 and is an improvement against the same point in 2018/19 (42 placements). To address last year's rise in placements, adult social care has implemented a new assurance process at the start of Q1 19/20. This assurance process includes senior management review and implementation of a strengths based approach to consideration of care options. This is already beginning to reduce the number of placements where other care options were appropriate.

6.4.2 In Q1 there are 470 placements in nursing or residential care homes for service users aged 65 and over. New admissions have accounted for 5% of these placements. We have supported an additional 969 service users aged 65 and over with long term homecare services in the year to date.

***6.5 Reducing social isolation***

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

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

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

# Table 2: Adult Social Care Key Performance Indicators

| ADULT SOCIAL SERVICES | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Objective** | **PI No.** | **Indicator** | **Frequency** | Q1 2019/20 | Target 2019-20 | On/Off target | Same period last year | Better than last year? |
| *Support older and disabled adults to live independently* | ASC1 | Average number of social care beds delayed per day* | Q | 5.3 | 5.0 | On | 4.2 | No |
| | ASC2 | Percentage of people who have been discharged from hospital into enablement services that are at home or in a community setting 91 days after their discharge to these services | A | 95%** | 95% | NA | NA | NA |
| | ASC3 | Percentage of service users receiving services in the community through Direct Payments | M | 25% | 30% | Off | 24% | Yes |
| *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 | 23 | 134 | On | 42 | Yes |
| *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%*** | 80% | NA | NA | NA |

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

**(E)** = equalities target

*The total average beds delayed per day in Q1 was 17.1, against a target of 16.0.

**Reablement indicator is reported annually for Q3 in line with ASCOF indicator 2A, updated expected for Q4 report.

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

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