ISLINGTON

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

Report of: Executive Member for Health and Social Care

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

Delete as appropriate	~~Exempt~~	Non-exempt

Report: Q1 and Q2 2019/20 Performance Report

1. Synopsis

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

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

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

2. Recommendations

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

3. Background

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

4. Implications

4.1 **Financial implications**

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

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

4.2 **Legal implications**

There are no legal implications arising from this report.

4.3 **Environment implications**

There are no significant environmental implications resulting from this report.

4.4 **Resident impact assessment**

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

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

5. Adult Social Care

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

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

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

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

5.1 Delayed transfers of care (DTOC)

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

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

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

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

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

5.2 Discharge to home or community setting

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

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

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

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

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

5.3 Direct Payments

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

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

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

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

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

5.4 Admissions into residential or nursing care

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

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

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

5.5 Reducing social isolation

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

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

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

6. Public Health

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

Reduce prevalence of smoking

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

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

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

6.2 Effective detection of health risk

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

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

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

6.3 Tackling mental health issues

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

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

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

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

6.4 Effective treatment programmes to tackle substance misuse

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

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

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

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

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

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

6.5 Improve sexual health

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

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

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

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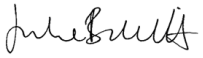
Signed by 

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