Haringey Council

NOTICE OF MEETING

Overview and Scrutiny Committee

WEDNESDAY, 29TH APRIL, 2009 at 18:00 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Councillors Bull (Chair), Adamou (Vice-Chair), Aitken, Alexander, Dodds, Winskill and Jones

Co-Optees: Ms. F. Kally plus 2 Vacancies (parent governors), L. Haward plus 1 Vacancy (church representatives)

AGENDA

1. WEBCASTING

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2. APOLOGIES FOR ABSENCE

3. DECLARATIONS OF INTEREST

A member with a personal interest in a matter who attends a meeting of the authority at which the matter is considered must disclose to that meeting the existence and nature of that interest at the commencement of that consideration, or when the interest becomes apparent.

A member with a personal interest in a matter also has a prejudicial interest in that matter if the interest is one which a member of the public with knowledge of the relevant facts would reasonably regard as so significant that it is likely to prejudice the member's judgment of the public interest **and** if this interest affects their financial position or the financial position of a person or body as described in paragraph 8 of the Code of Conduct **and**/**or** if it relates to the determining of any approval, consent, licence, permission or registration in relation to them or any person or body described in paragraph 8 of the Code of Conduct.

4. DEPUTATIONS/PETITIONS/PRESENTATIONS/QUESTIONS

To consider any requests received in accordance with Part 4, Section B, paragraph 29 of the Council's constitution.

5. NHS HARINGEY - BUDGET SETTING 2009/10

To receive a presentation by Tracey Baldwin and Richard Sumray from National Health Service (NHS) Haringey.

6. TRANSPORT - ADULT SOCIAL CARE (PAGES 1 - 76)

To receive a report presented by Cllr. Gideon Bull.

7. RECYCLING REVIEW: SOURCE SEPARATED AND CO-MINGLED COLLECTION METHODS IN HARINGEY (PAGES 77 - 98)

To present to the Overview and Scrutiny Committee the final report and recommendations of the Recycling Review of Source Separated and Co-Mingled Collection Methods in Haringey.

8. HEALTH: EVERYONE'S BUSINESS (PAGES 99 - 140)

To receive a report by Melanie Ponomarenko, Research Officer, on the Health and Inequalities Event.

9. ISLINGTON URGENT CARE CONSULTATION (PAGES 141 - 184)

To receive a presentation by Islington Primary Care Trust (PCT) and the Whittington Hospital.

10. MENTAL HEALTH TRUST (MHT) RESPONSE (PAGES 185 - 190)

To receive a presentation from the Barnet, Enfield & Haringey (BEH) Mental Health Trust.

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Agenda Item 6

Haringey Council

Overview and Scrutiny Committee
April 29th 2009

Report Title: **Scrutiny Review of Day Centre Transport (Adult Social Care)**	
Report authorised by: **Cllr Gideon Bull, Chair of the Overview and Scrutiny Committee**	
Contact Officer: Martin Bradford Scrutiny Research Officer: **Martin.bradford@haringey.gov.uk** 0208 489 6950	
Wards(s) affected: **ALL**	Report for: **Non Key**

1. Purpose of the report

1.1 That the Overview and Scrutiny Committee note and approve the recommendations laid out in the attached report.

2. Introduction by Cabinet Member N/A

3. State link(s) with Council Plan Priorities and actions and /or other Strategies:

3.1 This review links to the following objectives within the Sustainable Community Strategy:

- Healthier people with a better quality of life.
- People at the heart of change

3.2 This review links to the following priorities in the Council Plan:

- Encouraging lifetime well-being, at home, work, play and learning
- Promoting independent living while supporting adults and children when needed
- Delivering excellent, customer focused, cost-effective services

3.3 This review links to the following Local Area Agreement Targets:

- NI125 - Achieving independence for older people through rehabilitation /intermediate care
- NI141 - Number of vulnerable people achieving independent living
- NI175 (Local) Access to services and facilities by public transport

4. Recommendations

4.1 4.1 Review recommendations are laid out in the attached report.

5. Reason for recommendation(s)

5.1 Reasons for the recommendations laid out in the main report are covered within the main body of the attached report.

6. Other options considered

6.1 N/A

7. Summary

7.1 An executive summary is contained in the attached report.

8. Chief Financial Officer Comments

8.1 The cost of transport will be contained within existing budgets.

8.2 Systems must be in place to ensure performance data is captured and used to monitor unit costs of this service. Benchmarking of these unit costs must be used to assess the service for value for money and actions taken if this is not being achieved.

9. Head of Legal Services Comments

9.1 The Overview and Scrutiny Committee has conducted this review in accordance with its statutory functions. The report reviews and makes recommendations about community transport services in the area as well as local authority functions. The Overview and Scrutiny Committee is empowered to do this by section 21 of the Local Government Act 2000.

10. Head of Procurement Comments N/A

11. Equalities & Community Cohesion Comments

11.1 The review was assessed by the Research Governance Panel to ensure that all consultation processes adhered to equalities principles. The following was implemented within the review:

- Use of pictorial surveys to enable full participation from service users across day centres
- Interpreters made available at day centres should service users have needed them to participate in the consultation (complete the survey)
- A speech and language therapist was consulted to ensure that the format of the proposed consultation was appropriate and widely accessible
- Service users had staff assistance in helping them to complete consultation responses.

12. Consultation

12.1 In conducting this scrutiny review, three distinct consultations were undertaken with service users, carers and staff. The findings from these consultations are recorded within the attached report.

12.2 Consultation processes undertaken in this review were approved by the Research Governance Panel.

13. Service Financial Comments

12.1 see 8.

14. Use of appendices /Tables and photographs

13.1 All included within attached report.

15. Local Government (Access to Information) Act 1985

15.1 All included within attached report.

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Haringey Council

Scrutiny Review of Day Centre Transport (Adult Social Care)

www.haringey.gov.uk

A REVIEW BY THE OVERVIEW AND SCRUTINY COMMITTEE

April 2009

Foreword

Some of our most vulnerable residents that live in the community are not able to access public transport or cannot travel unaided. For these vulnerable people, the Council has a particular responsibility to ensure that they have access to safe and reliable transport so that they can obtain the support or services which they may need.

Without good quality and accessible community transport, there is a real danger that older people or people with a physical or learning disability becoming trapped in their own home, feeling isolated and unable to access the social opportunities which many of us take for granted. In this respect, safe and reliable community transport is a vital link to enable vulnerable people to participate in the communities in which they live.

This scrutiny review has assessed the way that transport services are provided at day centres providing services for older people and adults with a learning disability. As part of the review process Members have consulted widely with service users, carers and staff and have made a number of recommendations, which will help improve the way that day centre transport services are provided.

This review has highlighted how important not just day centre transport is to service users but how vital transport is to the community in general and it is hoped the Committee will be able to do further work in this area in the near future.

Gideon Bull

Chair Overview & Scrutiny Committee

Members of the review Panel:
Cllr Bull (Chair)
Cllr Butcher
Cllr Gorrie

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CONTENTS

1. Executive Summary

About the review

1.1 In April 2007, responsibility for the planning and provision of passenger transport services within adult social care in Haringey Council was devolved from a centralised service (Joint Transport Passenger Unit) to individual provider services (Learning Disabilities and Older Peoples Day Care). Through decentralisation, it was anticipated that provider services would have greater flexibility to plan and organise passenger transport to meet the evolving and often complex needs of their service users.

1.2 This scrutiny review sought to assess what impact this devolved model of passenger transport provision (service based transport) has had within Adult Social Care Day Centres. In particular, the review sought to assess whether this improved service users access to day opportunities (e.g. education, leisure and socialisation), improved the operational efficiency of the service (journey times, waiting times) and contributed to general improvements in the quality of passenger transport service provided to service users and carers. In addition, the review sought to assess the cost effectiveness of this development and the strategic impact on the remaining centralised transport service within the Council.

1.3 To assist these assessments, Members of the Scrutiny Review Panel received evidence from a range of sources including service users, their carers and day centre staff (e.g. drivers, escorts, service managers) via direct evidence to the panel and through evaluative surveys with each stakeholder group. Members also undertook a number of site visits to day centres and accompanied service users on planned transport routes to gain first hand experience of the new passenger transport service.

Key findings from the review:

1.4 The review has shown that passenger transport services to day centres on the whole work well and are appreciated by the majority of service users and their carers. Indeed, evidence received by the Panel indicates that the transport service is highly valued by service users and carers alike. During site visits, Members particularly noted the dedication and professionalism of front line staff (drivers, escorts and day centre staff) in ensuring the successful and smooth operation of this service and noted many instances of excellent care and support provided by them.

1.5 Findings from three individual consultations undertaken to support the review produced a wealth of evaluative information from service users, carers and staff about the development of service based transport. A full report of all evaluative data is contained in Appendix A, though three key findings from this have been summarised below:

- There are high levels of service satisfaction among both service users and carers for the passenger transport service

- There has been greater consistency in the use of individual drivers/ escorts which has improved the continuity and quality of care received by service users and their carers
- Service based transport has improved transport provision in terms of journey times, improved access to day opportunities and the flexibility of this service available to carers.

1.6 The Panel was hindered in assessing the operational effectiveness of service based transport as, prior to this review taking place, it was apparent that there were no systems in place to collect or record transport activity (nature and volume of passenger journeys) or other quality assurance data (i.e. journey times or punctuality) in Adult Social Care. The Panel is now satisfied that Adult Social Care has begun to collect such data which will help future assessments of the operational effectiveness and efficiency of this service.

1.7 The Panel noted that shortcomings in original project planning were integral to the failure of Adult Social Care to provide adequate monitoring and evaluation data to assist the review process. In particular, the Panel felt that there was insufficient data to support a business case for the planned development of service based transport. A tighter project initiation process and greater management oversight at this juncture would have ensured that appropriate systems were in place to record relevant transport monitoring data (i.e. activity, performance and other evaluative data). The Panel noted improvements to Project Management process in Adult Social Care and have made a number of additional recommendations in this area.

1.8 A key aspiration for the development of service based transport was that this would deliver a more cost effective transport service to day centres. Although service based transport has brought additional budgetary control to the service, the Panel noted that overall budgets for passenger transport have remained broadly neutral for the period 2005/6 to 2008/9. Whilst the service contended that cost effectiveness has been achieved through the provision of additional services within this budget, this remained unquantifiable due to the absence of service activity data to support this.

1.9 The Panel noted that a key benefit of the development of service based transport was its flexibility to meet the needs of individual service users and their carers. The Panel noted that this development has therefore placed the service in good stead to meet national policy requirements in developing the personalisation of social care through delivering greater choice and control for service users in their social care options.

1.10 The Panel was aware that service based model of passenger transport has been in operation for approximately 2 years, and whilst this has evidently been successful and welcomed by service users and carers, this model needs to constantly adapt to respond to individual needs and service demands. The Panel hopes that the findings and recommendations contained within this report, will assist Adult Social Care in this process and to guide and inform the ongoing development of this vital front line service.

2. Recommendations

2.1 That Overview & Scrutiny Committee conduct an initial scoping to assess the benefit of conducting a full scrutiny review of:

- capacity, appropriateness and integration of community transport services (door to door) in Haringey
- patient transport for health services in Haringey.

2.2 Haringey Council should consider developing a local community transport development plan to help:

- provide a consistent level of service quality for passengers
- ensure coordination of local services
- integrate local and pan London transport services
- maximise council resources.

2.3 Adult Social Care should ensure that all 2nd and 3rd tier managers are aware the Councils Project Management Framework to ensure that all future projects are compliant, particularly in respect of:

- full appraisal of relevant service options
- full assessment of potential project risks
- identification of clear business case to proceed
- clear milestones and change management plan

2.4 Adult Social Care should aim to develop appropriate monitoring data to support the operation passenger transport services. Data monitoring should relate to a small number of key performance indicators (e.g. council priorities, service objectives, access to day opportunities or passenger services standards) and should be accompanied by appropriate systems to ensure that such data is collated, analysed and informs the operation of the transport service.

2.5 Using activity and financial monitoring data, Adult Social Care should develop a process which supports the benchmarking of transport provision for day centres. This data should help to develop an assessment of the comparative performance of the transport service with other transport models/ services.

2.6 That Adult Social Care should establish service standards for journey times (i.e. max 1 hour) and service punctuality (i.e. within 30 minutes of specified time) for service users and their carers. These standards, and the service's performance against these standards, should be clearly communicated to service users and carers.

2.7 That Adult Social Care service should invest in occasional/ periodic specialist advice to support more effective planning, development and operation of day centre passenger transport services. Specialist advice should also be sought to identify how adult social care can minimise the environmental impact of vehicles under its operation and management.

2.8 That Day Centre Managers, or those that plan transport routes, attend passenger transport training (i.e. NVQ Passenger Safety) to ensure that passenger routes effectively and efficiently.

2.9 Adult Social Care should ensure that dual training of staff is fully implemented across the day centres to ensure that there is an adequate pool of drivers and escorts to support to operation of service based transport.

2.10 That Adult Social Care continues to utilise survey tools developed within the review to periodically to asses service user and carer satisfaction with transport services.

3. Introduction

3.1 In April 2007, responsibility for the planning and provision of passenger transport services within adult social care was devolved from a centralised service to individual provider services (Learning Disabilities and Older Peoples Day Care).[1] Through decentralisation, it was anticipated that provider services would have greater flexibility to plan and organise passenger transport to meet the multiple and often complex needs of their service users.

3.2 The introduction of service based transport at local day care centres would appear to conform to the national personalisation agenda which aims to improve the choice and control that service users have over the care that they receive. The following provides a brief overview of the legislative and policy context for the development of locally managed passenger transport systems.

National and local policy background

3.3 Recent legislative and policy changes have precipitated far reaching changes in the way that adult social care services are provided. In simple terms, these developments represent a departure from the traditional model of care where 'one size fits all' and services are 'building based'. Adult social care services are now more personalised, where services are tailored to meet the needs of individuals and where there is far greater choice in how and where services are received.

3.4 There are a number of significant policy developments which provide the national backdrop to this review and the development of locally managed passenger transport services in adult social care in Haringey.

3.5 *Valuing People (2001) and Valuing People Now (2007):* Valuing People is the government's plan for making the lives of people with learning disabilities, their families and carers better. The Council and Haringey Teaching Primary Care Trust agreed a local response (*Different Days)'* to enable people with learning disabilities to lead full and purposeful lives within the wider community and to develop a range of friendships, activities and relationships.

[1] Physical Disabilities and Residential Day Care had their own transport arrangements prior to this decision.

This planned to help people with learning disabilities to do more interesting things in their lives: to get a job, go to college, do voluntary work or take up new hobbies.

3.6 *National Service Framework for Older People (2001):* This stressed the need to promote the health and independence of older people and to ensure that services were shaped around their individual needs. The Councils response *'Experience Counts'* was a strategy for improving the quality of life for all older people and included a priority to develop transport provision to ensure older people can get out and about in the community.

3.7 *Our Health Our Care Our Say (2006):* This White Paper provided a strategy to help maintain individual independence through the development of individualised and person centred services. In response, the Council has worked with health and voluntary sector partners to develop the local Well-being Strategic Framework (2007-2010) which aimed to improved health and emotional well-being, improved quality of life, increased choice and control and maintain personal dignity and respect.

3.8 *Local Strategic Frameworks:* The Local Strategic Partnership has agreed a number of local strategies which have been key drivers in the development of locally managed transport. These include the Sustainable Community Strategy, the Wellbeing Strategic Framework and Greenest Borough Strategy. These strategies aim to ensure the development of individualised services which are sustainable and have a reduced environmental impact.

3.9 Central to the new vision of service provision is:

- That services should be person centred and outward looking.
- That the needs of the individual, as far as is possible, should be central to the planning of their service.
- That the needs of carers must also be taken into consideration.
- That a service should see people as citizens with the same rights and opportunities expected by other local residents.
- That provision of services should be designed to support service users in accessing leisure, social activities, life-long learning, public and commercial services, rather that to separate service users from the mainstream community
- That services should aim to be preventative, thus avoiding potential deterioration and enhancing wellbeing.
- That services should aim to maximise independence and choice.

4. Background - the development of service based transport in Haringey

4.1 Local Authorities have a duty to provide transport to service users that have mobility problems. This may include children and young people with Special Educational Needs (to the age of 19), adults with a physical disability or learning difficulty and older people with mobility problems. In this context, Local Authorities provide a range of transport services to enable vulnerable people to access education, welfare or other support services.

Joint Transport Planning Unit (JTPU)

4.2 Prior to April 2007, the Joint Transport Planning Unit (JTPU) provided for the majority of passenger transport services in Haringey. Transport services were provided through an in house vehicle fleet together with a range of externally commissioned routes/ services. All transport routes were planned and delivered through the JTPU. On internally provided routes, drivers and escorts were also directly employed and managed through the JTPU. These transport services supported over 400 young people and 150 adults to access schools, day centres and luncheon clubs each day.

4.3 Within the centralised service operated by the JTPU, service users were generally picked up from their home and dropped off at respective schools, day care centres or luncheon clubs in the morning with the reverse journey being undertaken in the evening. In addition to these established routes, the JTPU also provided transport for school swimming, school catering and council postal services. The make up of transport usage provided though the JTPU in 2005/6 was as follows: SEN 76%, Social Services 19%, School Swimming 2%, School Catering 2% and Council post 1%.

4.4 In 2005/6, the overall cost of transport services provided through the JTPU was £4.73m. Individual component services (i.e. SEN, Social Care) are recharged the cost of transport services based on their proportionate usage of the transport services. In 2005/6 the recharge cost of passenger transport for adult social services (the subject of this review) was £952k.

Development of Service Based Transport

4.5 The modernisation of day service provision for adult social care has precipitated the need for service users to access mainstream opportunities directly from their home and from day care centres throughout the day. This has required a more flexible and responsive passenger transport service to meet the varied needs of individual service users

4.6 Passenger transport configuration within JTPU was not felt to be sufficiently flexible to meet the evolving needs of service users at day centres in adult social care. It was therefore proposed that service based transport should be developed, where vehicles would be based at and managed through respective day centres instead of a centralised service. This would provide more localised control over passenger transport which could be more responsive to the needs of service users.

4.7 Within this new transport arrangement, social services transport in effect opted out of centralised passenger services provided through the JTPU. Transport is now directly procured, coordinated and managed through Social Services and respective day centre managers. Drivers and escorts are now also locally managed and have a new dual role in which they undertake support work within respective day centres in addition to their driver/escort role. A service level agreement remains with the JTPU for quality assurance purposes to ensure that vehicles comply with health and safety and other statutory regulations

4.8 Under new arrangements for service based transport, adult social care services currently has 31 vehicles in its "fleet". These are a mixture of tail-lift coaches and mini-buses and are based and managed in the various service centres. The fleet is distributed across Adult Services in the following configuration: 2 vehicles for Older People Residential Care, 2 vehicles for Physical Disability, 6 vehicles Older People Day Care and 21 vehicles Learning Disabilities Day Care.

4.9 The move from centralised to service based transport provision was anticipated to have a number of inherent advantages which would maximise day opportunities for service users, improve service delivery and enhance the level of care and support available to service users. These included:

- Increased access to transport during the day for clients to access mainstream and other community services
- More staff in service during the day to facilitate community access
- More flexibility for service users in pick up and drop off times
- Reduction in the time service users spend travelling (through use of smaller vehicles)
- Improved communication and liaison with parent/carers
- Greater continuity of care and improved understanding of service users needs by having dedicated and trained drivers/carers
- Establishment of a service which is adaptable to the evolving needs of service users
- More cost effective transport service.

4.10 In 2005/6, it was therefore decided that Learning Disabilities and Older Peoples Day Care would opt out of centralised transport service provision within the JTPU. This decision became effective in April 2007. Special Educational Needs transport provision continued to be provided through the JTPU.

5. Aims of the review

5.1 As service based transport had been in operation for over 1 year, it was felt that this had provided sufficient time for this model of passenger transport to establish itself within adult social care services and among service users. It was therefore felt that this was also an appropriate juncture at which to evaluate the impact of this new development.

5.2 Prior to this scrutiny review, no formal evaluation of the development of service based transport within adult social care had been undertaken. Thus the scrutiny review focused on assessing the operational effectiveness of devolved transport provision and whether the anticipated benefits (in 4.11) of the reconfiguration of passenger transport services had been realised.

5.3 The review also assessed the strategic impact that devolved transport provision has had upon remaining centralised passenger transport services provided through the JTPU, its implications for other passenger transport services and the broader policy and service aspirations of the council.

5.4 Specifically the review sought to:

- ascertain whether the development of service based transport in adult social care has met its intended aims (as set out in section 4.11)
- assess the strategic impact of the introduction of service based transport in relation to the remaining centralised transport service (through the JTPU) and how this relates to current transport and other borough wide strategies (i.e. Greenest Borough)
- identify and assess good practice from service based transport which may inform the development of passenger transport services elsewhere in the borough
- assess the overall operational effectiveness of service based transport and make recommendations to guide and inform the future development of passenger transport services throughout the borough.

6. Review methods

Panel Meetings

6.1 The review incorporated a range of investigative methods to ensure that Members had access to the necessary evidence to assist them in their assessment of service based transport and achieve the review objectives set out in 5. A series (n=5) of Panel meetings were held to approve the aims of the review, receive oral and written evidence, oversee project progression and formulate recommendations.

6.2 At these Panel meetings, Members heard evidence from a number of stakeholders in the development of service based transport which included;

- Assistant Director of Adult Social Care
- Manager of Older People Day Care Services
- Head of Day Opportunities
- Managers of respective day centres at which service based transport has been developed
- Head of Commissioning (JTPU)
- Service Users
- Carers
- Day Centre staff (including drivers and escorts).

6.3 A specially convened Panel meeting was held at the Winkfield Road Resource Centre (N22) to facilitate the participation of service users, their carers and staff who work across day centre sites in the review process. The meeting provided an opportunity for representatives to meet the Panel and to describe the impact that the development of service based transport has had upon services and the clients that use them. In total, 45 people attended this meeting.

Assessment of internal data

6.4 A range of written information was requested by the Panel to assist them in their assessment of service based transport. A number of reports were

submitted by Adult Social Care which provided a range of financial, operational and evaluative data to assist the deliberations of the Panel. The Panel also specifically requested a number of additional reports and briefings which included:

- Transport budgets for both learning disability and older peoples services
- Transport dairy detailing the utilisation of fleet vehicles over a 2 week period
- Additional briefings on the financial recharge process and the provision of Special Educational Needs transport

6.5 The review also assessed local policy and other borough wide documentation as was important to determine the strategic context of service based transport and demonstrate how this development supports both local and national service priorities and aspirations.

Consultation with Staff, Carers and Service Users

6.6 In addition to attending Panel meetings, service users, carers and staff were also able to contribute to the review through a planned consultation process. The administration of three separate consultation surveys enabled broader range service users, carers and staff to be involved in the review and an opportunity to describe their views on the development of service based transport at respective day centres.

6.7 Given the vulnerability of adult social care service users and the requirements of Research Governance procedures (**see 6.13**) considerable care was undertaken in developing an appropriate process through which to consult day care centre service users. The need to minimise any personal intrusion and to ensure that the planned consultation process was accessible were of paramount importance. Thus specialist advice and guidance was sought (from respective managers and a speech and language therapist) in the development and administration of the consultation survey with service users.

6.8 Given the prospective numbers of respondents and their relative accessibility a quantitative approach was felt to be the most appropriate method through which to consult carers. The survey was developed in consultation with service managers and sought to elicit a range of data concerning the impact of service based transport. The carers consultation was anonymous and distributed via post along with a reply paid envelope.

6.9 A survey was also felt to be the most appropriate mechanism to consult with staff about the impact that service based transport had at day centres. The survey was designed in consultation with service managers and sought to ascertain a range of data concerning the implementation of service based transport across the day centres. The final survey was anonymous and distributed to staff along with a reply paid envelope.

6.10 All returned consultation surveys were coded and analysed using SPSSX statistical software. A more detailed description of the consultation methods

together with a full analysis of the data from these surveys is contained in Appendix A.

Service Visits

6.11 A number of visits to day centres were organised for the Panel as part of the review process. The visits enabled the Panel to tour of the day centre, meet service users and staff and to experience first hand a transport run at each day centre site. The visits were intended to provide a practical insight in to the transport needs of service users, the operation of transport services and the effectiveness of the newly developed service based transport.

6.12 In total, the Panel undertook three visits to learning disability and older people day care centres during the course of the review:

- Ermine Road Day Centre (Learning Disability)
- Keston Road Day Centre (Learning Disability)
- The Grange (Older People)

Research Governance

6.13 As of April 2008, all research and consultation processes undertaken within Adult Social Care are requited to be approved by local Research Governance Panels. The service evaluation methods outlined above were risk assessed and ameliorating actions were identified and implemented. The consultation processes were approved by the Research Governance Panel on 26th September 2008. The full research governance application is contained in Appendix B.

Key findings from the review

Community Transport

7.1 Members were keen to understand how this review related to broader community transport issues such as the operation of Taxi-Card and Dial-a-Ride and the recent establishment of Haringey Community Transport. A number of service users who gave evidence to the Panel indicated that they had previously used Dial-a-Ride to access day centres but this service had proved too unreliable to be access the day centres.

7.2 The Panel heard evidence from both service users and service managers concerning the provision of Dial-a-Ride services in Haringey. The Panel was concerned that this service was not operating effectively, in particular the difficulties in booking this services, the lack of flexibility in making reservations (i.e. not more than 24 hours in advance) and the lack of capacity in the system. The Panel were strongly of the opinion that the operational difficulties of Dial-a-Ride represented a considerable problem for older and vulnerable people living in Haringey. This should warrant further investigation by the Overview & Scrutiny Service.

7.3 The Panel noted that the Greater London Assembly had recently initiated a London wide review of door to door transport services and had presented evidence to Transport for London (TfL) in anticipation of securing improvements to the London wide Dial-a-Ride service. Service developments

and modifications in the Dial-a-Ride service will need to be acknowledged in local community transport plans and services. Details of any service changes to Dial-a-Ride are not expected before June 2009.

7.4 In assessing evidence presented from service users and from service managers, the Panel noted that the additional flexibility in the new transport system had enabled vehicles to be used to support service users in wide range of activities; including visits to local health services. Whilst the Panel would not want to discourage this practice, it was felt that the degree to which transport is being used to support health service visits should be monitored (especially given the recent tightening of hospital transport eligibility criteria).

Recommendation 1:
That Overview & Scrutiny Committee conduct an initial scoping to assess the benefit of conducting a full scrutiny review of:
- Capacity, appropriateness and integration of community transport services (door to door) in Haringey
- Patient transport for health services in Haringey.

7.5 Evidence was received by the Panel which highlighted the range of activities that day centre service users were now able to enjoy subsequent to the development of service based transport across day centres in Haringey. Whilst the Panel heard evidence that from the Adult Social Care that vehicles were now being put to greater use, it remained unclear if full utilisation of vehicles was being obtained at all times during the day, in the evenings and at weekends. In particular, given the lack of relevant activity data, the Panel remained unconvinced of the extent to which day opportunities had been extended to service users. To this end, the Panel noted that the full potential of service based transport, particularly in relation to its integration with wider community transport services, has yet to be fully explored.

7.6 The Panel was of the view that accessible community transport is of critical importance to older and vulnerable people living in the community as it provides a vital link to support services that they may need. In this context, the Panel felt that it was important to maximise the use of council provided transport services and ensure that, where appropriate, this is linked with other community transport services available in the borough.

Recommendation 2
Haringey Council should consider developing a local community transport strategy to:
- maximise council resources
- provide a consistent level of service quality for passengers
- ensure coordination of local services
- help integrate local and pan London transport services

Project Management

7.7 Original documentation, outlining the case for the development of service based transport, was presented to the Panel during the review. The Panel was concerned at the lack of clarity and detail in this report, which by itself,

should not have been used to justify or support a service development of this magnitude and scale.

7.8 Specifically, the Panel noted that there were a number of significant shortcomings to original project documentation setting out the case for the development of service based transport. These shortcomings can be summarised as thus:

- Insufficient financial data
- Insufficient service activity data
- No baseline data to assess future service improvements
- Project description only related to the Learning Disability Service (no case made for older peoples services)
- No details as to how the service would assess the future success of service based transport.

7.9 Whilst the Council has an established Project Management process to support developments such as service based transport, it was apparent to the Panel that this standard guidance was not followed in this instance. The Panel highlighted the critical importance of adhering to Project Management procedures to ensure that in future, there is a clear business case for planned service developments.

7.10 It is noted that project management processes have been strengthened since the development of service based transport where projects are monitored by a Project Board, sponsored by an appropriate level manager and conform to established project management conventions (PRINCE).

7.11 Furthermore, the Panel wished to emphasise that there had been a significant lack of management oversight at the commencement of this project. The Panel noted that the paucity of senior management input in to this project at this juncture had precipitated a number of issues for ongoing project management (i.e. lack of activity and or monitoring data).

Recommendation 3

Adult Social Care should ensure that all 2nd and 3rd tier managers are aware the Councils Project Management Framework and ensure that future projects are compliant, particularly in respect of:

- full appraisal of relevant service options
- full assessment of potential project risks
- identification of clear business case to proceed
- clear milestones and change management plan

Monitoring data

7.12 The Panel noted that shortcomings in original project planning have contributed to the failure of the service to provide adequate monitoring and evaluation data throughout the review. The Panel felt that a tighter initial project initiation process would have helped the service to develop appropriate systems to record transport service activity, monitor service performance and assess how successful this development has been.

7.13 The Panel noted that the absence of monitoring data (e.g. transport activity, purpose of passenger journeys) represented a serious shortcoming for without it the Panel was unable to fully assess the nature of service based transport or the impact this had upon day care centre services. In particular, the service found it difficult to substantiate how the new model of passenger transport had improved day opportunities for service users, despite this being a key service objective.

7.14 To facilitate the process of data collection, the Panel suggested that the service maintain a transport diary over a two week period. It was anticipated that this process would help the service to identify which data would be most useful and practical to collect to support the operation (and further development) of the new transport system. The Panel noted that this process had been trialled in both Learning Disability and Older Peoples Services and both services were in the process of developing data monitoring procedures.

7.15 During the course of the review, the Panel was keen to emphasise that it did not want the service to collect data unnecessarily nor place any data requirement on the service that was over burdensome. The Panel therefore emphasised that it was important that the service fully assess what data is essential for the effective operation of the transport service and establish appropriate systems through which to collect this.

Recommendation 4
Adult Social Care should aim to develop appropriate monitoring data to support the operation passenger transport services. Data monitoring should relate to a small number of key performance indicators (e.g. council priorities, service objectives, access to day opportunities or passenger services standards) and should be accompanied by appropriate systems to ensure that such data is collated, analysed and informs the operation of the transport service.

Finance

7.16 A key aspiration for the development of service based transport was that this would deliver a more cost effective transport service to day centres. The Panel received evidence which indicated that the total budget for transport services for adult social care in 2005/6 prior to the development of service based transport was £952k. In 2008/9, the transport budget for adult social care was £1.1m. Although this represents an approximate 15% increase, the financial impact of developing service based transport can be broadly considered to be neutral once inflation is factored in.[2]

7.17 It was reported to the Panel that whilst the transport budget for adult social care had remained broadly neutral through the development of service based transport, additional value for money had been obtained through increased utilisation of vehicles (as these were now locally managed). Whilst the Panel received oral and survey evidence from service users, carers and managers to suggest that transport services had improved (more day opportunities,

[2] Assuming 3% inflation per annum.

more responsive service, shorter journey times), it was difficult for the Panel to assess whether service based transport had delivered value for money, as the service could not provide accompanying service activity data to demonstrate what had been achieved with respective budgets.

7.18 It was reported to the Panel that it was difficult to compare the costs of the new service based transport service with the previous centralised transport service as costs were calculated using the recharge system. In this system, services (such as adult social care) were simply recharged as a proportion of their usage of the overall transport costs for the whole borough wide passenger transport service. Consequently, this meant local adult social care managers had little control over transport budgets.

7.19 In addition to not being able to make comparative assessments of service based transport with the predecessor model of passenger transport service, the paucity of service activity data precluded the Panel from establishing whether the new model of passenger transport service was cost effective itself.

7.20 Data monitoring difficulties aside, the Panel noted that some financial benefits had been obtained through the development of service based transport. Most importantly, as a consequence of passenger transport services and budgets being devolved to Adult Social Care from the centralised service (JTPU), service managers were now able control budgets and manage component transport costs. The Panel noted that this was a significant first step and was welcomed.

7.21 Secondly, the Panel heard evidence from the service which suggested that cost efficiencies had been achieved through the development of service based transport. Within the new model of passenger transport service staff are now peripatetic which has minimised the need to use agency staff in day centres.

7.22 The Panel welcomed the improvement that had been brought to financial controlling since the inception of service based transport. It was also reported to the Panel that with additional control that local managers now had over transport budgets and collection of service activity data, it was now possible to develop financial benchmarks for the service (i.e. unit costs and cost per passenger journey). Approximate unit costs per passenger journey for Ermine Road and Keston Road LD day centres were calculated to be £28 and £21 respectively (see appendix 3). The Panel noted that this data would help to develop comparative assessments of the performance of service based transport with other passenger transport models.

Recommendation 5
Using activity and financial monitoring data, Adult Social Care should develop a process which supports the benchmarking of transport provision for day centres. This data should help to develop an assessment of the comparative performance of the transport service with other transport models/ services.

Impact on passenger transport services

7.23 The Panel noted evidence from the three consultations (with service users, carers and staff) which supported this review. From this data, the Panel were able to form a number of conclusions concerning the impact that service based transport had had upon passenger transport services in adult social care. The following paragraphs provide a summary of the key findings within the consultation though a full analysis of all the consultation data is contained in appendix A.

7.24 Firstly and most importantly, using data from the consultation the Panel were able to conclude that there is a high level of service satisfaction with the new locally managed transport service among both service users and their carers, where:

- 95% of service users indicated that the transport service was good
- 98% of carers were very satisfied/ satisfied with the transport service to and form day centres.

7.25 The Panel were also able to conclude from analysis of the consultation data that there was strong evidence to suggest that passenger transport services had improved as a result of developing a more locally managed system of transport:

- 75% of carers indicated that transport services have improved (45% indicating its improved a lot)
- 88% of staff indicated that transport services have improved (68% indicating its improved a lot)
- 89% of staff indicated that transport service have helped to improve services and support they were able to provide to service users.

Safety and reliability

7.26 Service users emphasised to the Panel the importance of the day centre in the provision of services, opportunities for socialisation and the respite it provided for their carers. In this context, safe and reliable transport to the day centre was perceived to be critical in them being able to enjoy these life enhancing benefits and that they were very thankful for the transport service.

7.27 Given the vulnerability of service users, the Panel received evidence to suggest that safety and reliability were also of paramount importance to carers in their assessments of the transportation services It is therefore important to record that both qualitatively and quantitatively in the consultation, carers indicated that they were reassured by nature and level of care provided to service users throughout their journeys using the transport service:

Punctuality

7.28 Consultation data indicated that the punctuality of the new transport service overall was recorded to be good across the services and by all stakeholders: 90% of carers and 82% of service users indicated that vehicles turn up at the right time. Analysis of qualitative data from the consultation significant minority of stakeholders who felt this aspect of the service could be improved further through providing clearer drop-off / pick-up times to service users.

Journey Times

7.29 The Panel heard that with the development of service based transport, adult social care had been able to procure smaller vehicles which had contributed to a reduction in passenger journey times. This assertion was supported within the consultation data, where both service users and carers appear to be satisfied with overall journey times: 89% of service users indicated that journey times were good and 73% of carers felt that the duration of the journey was 'about right'.

7.30 Whilst many service users and carers were evidently satisfied with the journey times of the new transport system, a small but significant minority of carers gave evidence to the Panel about what they felt were excessive journey times in excess of 1 hour 30 minutes. This position was verified by the Panel themselves during site visits, where one transport run was 1 hour 45 minutes in duration.

Recommendation 6 That Adult Social Care should establish service standards for journey times (i.e. max 1 hour) and service punctuality (i.e. within 30 minutes of specified time) for service users and their carers. These standards, and the service's performance against these standards, should be clearly communicated to service users and carers.

7.31 The service acknowledged to the Panel that for a minority of service users journey times were unacceptably long. The service reported to the Panel that the development of service based model of transport had helped to reduce journey times and excessively long journeys were now the exception. The panel also heard that further improvements could be expected when the new fleet of vehicles were delivered.

7.32 For the majority of service users, it would appear that journey times on the whole have improved. For a small number of service users, journey times remain about 90 minutes in duration, which in the view of the Panel was unacceptably long for carers and service users. The Panel were of the opinion that further advances in route planning and utilisation of other means of transport (i.e. taxis) may need to be considered to reduce journey times. In addition, specialist transport input may be required to improve efficiency of passenger routes, route serviceability and passenger journey times.

Route Planning

7.33 It was reported to the Panel that routes were planned in-house taking in to consideration a wide range of variables (e.g. location, service user mobility, day of visit). As well as the geographical location of service users, Day Centre staff also had to take in to account the physical needs of service users (whose needs preclude them from taking long journeys), the interactions between service users (behaviour of service users may challenging to others) and the needs of carers (who work or have other appointments themselves).

7.34 Given the range of issues and variables assessed, it was acknowledged that route planning was not an exact science; indeed, there was a degree of fluidity and flexibility to most routes. Although electronic and other technologies were used (i.e. multi-map) to inform planning, route determination was more often performed through physical resources (i.e. maps).

7.35 During the course of the visits, the Panel were not aware of any specialist input from the JTPU (at Ashley Road) or other transport consultants in to passenger route planning across day centres. The Panel was strongly of the opinion that day centres would benefit from such specialist input in helping them to plan and model routes and to make more efficient use of vehicles.

Recommendation 7 That Adult Social Care service should invest in occasional/ periodic specialist advice to support more effective planning, development and operation of day centre passenger transport services. Specialist advice should also be sought to identify how adult social care can minimise the environmental impact of vehicles under its operation and management.

7.36 During the course of the review a number of site visits were undertaken where Members accompanied service users on transport runs to and from the day centre. As a result of observations made my Members, day centres have installed telephone answering machines to ensure that out of hours calls / messages about potential route variations or timing (e.g. carers unwell, service user taken to hospital) can be incorporated in to route planning.

<u>Responsive and flexible service</u>

7.37 One of the key objectives of service based transport was that it would provide a more flexible day centre transport service to enable it to respond to the needs of service users and carers. The Panel heard evidence that localised control of vehicles, drivers and escorts had helped day centres provide a service that was more responsive to the needs of both service users and carers.

7.38 The Panel received evidence from a range of sources which demonstrated the additional flexibility of the new service based transport model. The Panel noted that more localised control over transport services had improved access to a small number of service users who live out of the borough (but who remain in the care of the Council) who did not have access to transport services within the previous centralised system. Additional transport flexibility was also recorded to be of benefit through:

- Improved access to transport for emergency situations
- Improved access to day care opportunities for service users
- More flexible in pick-up/ drop-off arrangements for service users and carers

7.39 The Panel noted that consultation data obtained from carers highlighted that most had not needed to vary the pick-up or drop-off time for service users, though it was acknowledged that carers may not actually be aware of the

flexibility of the service (i.e. that there may be the potential to vary times) and utilise this aspect of the service. Consultation data highlighted the need to engage with those carers who work to make sure they are aware and utilise the flexibility of the new passenger transport service.

Access to day care opportunities

7.40 As there was no monitoring data which records access to day opportunities for service users, the Panel found it difficult to make a definitive assessment as to whether the new transport service had increased day opportunities for service users. The Panel noted however, that there was substantive evidence from the consultations with service users, carers and staff to suggest that access to day opportunities has increased as a result of new transport system:

- 93% of staff indicated that access to day opportunities had increased
- 46% of carers indicated that access to day opportunities had increased

7.41 The Panel also heard evidence from service users at Panel meetings who indicated that the new transport system had increased and broadened opportunities for them during the day. Having access to transport services during the day had, for instance, enabled day centre users to go to the park, attend local and central London museums, access local recreational facilities and more informal events such as car boot sales.

7.42 Whilst there is evidence to suggest that weekday opportunities may have increased, the Panel noted that there was no evidence had been presented on the utilisation of transport services in the evening or at weekends. The Panel noted that it would like to see further recording of service user access to day opportunities and accompanying goals / standards for day opportunities.

Continuity of care

7.43 The Panel observed that a significant benefit of the service based model of passenger transport was that drivers and escorts were employed and managed from respective day centres instead of the centralised passenger transport service ((JTPU). Furthermore, drivers and escorts employed by the day centre would be dual trained to provide care and support to service users at the day centre whilst not undertaking transport duties. The Panel felt that this was very innovative and resourceful approach which would have benefits for service users, carers and the service itself.

7.44 The Panel noted that the development of services based transport had brought greater regularity and consistency in the drivers and escorts that are used to transport service users to and from day centres. From analysis of the consultation data, the Panel found that the consistency in drivers and escorts has been instrumental in achieving a range of improvements which helped to develop the continuity of care that was provided to service users:

- Drivers/ escorts able to develop stronger relationships with service users and carers
- Drivers/ escorts are more familiar with the needs of service users and how best to respond to these.
- Consistency in drivers/escorts helped improve communication between carers and day centre staff

- As drivers/escorts now part of the day centre team, this had helped to improve communication between staff groups

7.45 At this juncture, the Panel also wished to record the high levels of satisfaction recorded for both the drivers and escorts by service users and carers. From analysis of the consultation data, the Panel noted that drivers and escorts are widely perceived to be both friendly and helpful:

- 98% of service users agreed that drivers/ escorts were helpful and friendly
- 95% of carers indicated that drivers/ escorts were friendly

7.46 The Panel noted that there was strong evidence within the consultation data to suggest that personal satisfaction with drivers and escorts was integral to overall appreciation of the transport service:

> *'I want to thank the drivers and escorts for giving extra care for the elderly and doing a fabulous job – keep it up and thank you all for the work that you do for the support you provide to make them happy.' (Older People Day Care - Carer)*

Keston Road Day Centre

7.47 From analysis of the consultation data, the Panel noted an identifiable trend in both service user and carer satisfaction with transport services provided through Keston Road Day Centre (for Learning Disability). Analysis of service evaluation data demonstrated to the Panel that, comparatively, satisfaction with transport services at Keston Road Day Centre was consistently lower than that recorded at other day centres:

- 67% of service users indicated that bus turns up at right time - compared to day centre average of 82%
- 71% of service users indicated that journey time was ok – compared to a day centre average of 89%
- 39% of carers indicated that journey times were too long - compared to a day centre average 25%
- 59% of carers felt that service improved – compared to a day centre average of 75%

7.48 The Panel were made aware that learning disability services from Keston Road were in transition, as the service was in the process of being subdivided between two new day centres. The Panel heard that this move was expected to bring about a range of service improvements for service users. Given the additional flexibility of the new service based transport model, new transport arrangements could be developed for service users spanning both sites.

Staff Training

7.49 A number of staff training issues were raised during the course of the review from within Panel meetings, Panel visits to day centres and from the analysis of the consultation data. The Panel identified training issues revolving around those mangers or senior staff that plan and monitor transport routes and drivers and escorts at day centres.

7.50 The Panel heard evidence from day centre staff which suggested that the devolvement of the management and operation of transport services to local day centres represented significant new and additional responsibilities for local day centre managers (e.g. route planning, managing drivers/ escorts). The Panel heard that despite initial teething problems in accommodating these new responsibilities, centre staff were managing well. The Panel were of the view however, that centre managers or other staff to whom transport duties had been devolved, would benefit from dedicated passenger transport training (particularly in route planning/ fleet management).

Recommendation 8 That Day Centre Managers, or those that plan transport routes, attend passenger transport training (i.e. NVQ Passenger Safety) to ensure that passenger routes effectively and efficiently.

7.51 The Panel heard that in both Learning Disability and Older Peoples services, most driver/support workers had undertaken Minibus Driver Awareness Scheme (MiDAS) training. In respect of processes to support the Councils duty to support safeguarding adults, the Panel noted that all drivers and escorts had received appropriate training and all underwent Criminal Record Bureau check. The service was also training service users/ escorts and support staff to help increase the pool of dual trained workers. Here it was noted that a small number of drivers had passed NVQ 2 in Passenger Assisted Training and an NVQ in Care is being planned for some driver/support staff.

7.52 From analysis of the consultation data, the Panel concluded that there was a number of low level ongoing staff training issues which needed to be resolved to ensure the effective operation of service based transport. This model of passenger transport is reliant upon a pool of dual trained drivers/ support workers to ensure that there is capacity and flexibility to support transport needs of service users. Consultation feedback with staff highlighted that the implementation of the new transport system had not been unproblematic, particularly within the learning difficulties service, where a number of training issues remain:

- Dual training of drivers / escorts not fully implemented
- New service terms and conditions are not fully accepted by staff
- Need for a larger pool of drivers fore adequate service coverage (i.e. to allow annual leave and provide emergency cover)

Recommendation 9 Adult Social Care should ensure that dual training of staff is fully implemented across the day centres to ensure that there is an adequate pool of drivers and escorts to support to operation of service based transport.

Local Procurement

7.53 The Panel noted that through devolving the operation and management of transport services to adult social care, additional benefits have been obtained through more sensitive procurement of fleet vehicles. Although procurement is still undertaken centrally, Adult Social Care service is able to have direct input

in to vehicle specifications which was not necessary available when passenger transport was provided by JTPU. As the service also has greater control over procurement it can ensure that vehicles match the multiple and varied needs of local service users.

7.54 Since the establishment of service based transport, there has been a rolling programme of vehicle replacement which was completed in December 2008. This ensured that vehicles are of higher quality and meet the impending changes in emissions requirements (October 2010 onwards). The Panel noted that engines in the new vehicles are generally more fuel efficient due to cleaner burning and improved technology, thus giving increased mileage/litre and less CO2 emissions.

7.55 The Panel noted within the consultation that new vehicles have improved the convenience and comfort of transport to service users. Furthermore, there is some evidence to indicate that improved specifications of vehicles have improved the accessibility of day centre services for some service users (i.e. accessible tail lifts).

Impact on remaining JTPU

7.56 Given that the decentralisation of passenger transport services to adult social care would result in an approximate 20% loss of revenue for the JTPU, the Panel were keen to assess what impact this would have on the remaining centralised passenger transport services.

7.57 The Panel noted that the development of service based transport resulted in a significant drop in income for the JTPU. However, as a result of a subsequent rationalisation and changes to existing routes and a successful re-tendering exercise, external contractor costs were reduced significantly from £1,874k in 2006/07 to £1,397k in 2008/09. This covered the consequent budget pressures arising from the implementation of the service based transport model.

7.58 During the course of the review, the Panel noted that remaining transport services within the JTPU were subject to an internal review. Through a benchmarking process, remaining in-house routes were shown to be considerably more expensive than routes which were externally commissioned. Thus from November 2008, all remaining in house routes were commissioned externally, to achieve savings of approximately £700,000 per annum.

Ongoing service improvement

7.59 Throughout the course of the review a number of service developments and improvements were identified by the Panel to assist the ongoing development of service based transport. These have included the establishment of a transport diary to assist services in identifying and collecting appropriate monitoring data and the installation of answering machines at respective day centres to allow carers to leave messages for the transport service out of hours. The service is also beginning to develop benchmarks standards at the behest of the Panel.

7.60 The Panel acknowledged that given that service based transport had only recently been established (April 2007), the provision of passenger transport services were still evolving within adult social care services. As personnel knowledge and understanding of passenger transport services develops further, the Panel expected transport services to be refined and developed further.

7.61 The Panel were also keen to ensure that service improvements secured for both services user and carers through the development of service based transport were maintained. To this end, the Panel recommended that the survey tools developed during the consultation process, be periodically reapplied to gauge service user and carer satisfaction with the service and implement subsequent findings. In particular, the survey should be applied once Keston Road services have transferred to new sites to assess if there is any improvement in transport service performance.

Recommendation 10
That Adult Social Care continues to utilise survey tools developed within the review to periodically assess service user and carer satisfaction with transport services.

Sharing good practice

7.62 In the initial review objectives, the Panel were keen to assess what could be learnt from the development of service based transport in adult social care and transposed on to other passenger transport services in Haringey. The panel noted that the potential for sharing good practice among other Haringey transport services is limited given that the remaining passenger transport services provided by the Council (Special Educational Needs) has now been contracted out (on a 3 year contract). Whilst there are other community transport services available through the Council (Winkfield Road, Older Peoples Residential) the scale of provision is minor.

Appendix A – Consultation Report

Scrutiny Review
Service Based Transport

Report back from the service evaluation with service users, carers and staff

December 2008

Introduction

1.1 In April 2007, responsibility for the planning and provision of passenger transport service within adult social care was devolved from a centralised service to individual provider services (Learning Disabilities and Older Peoples Day & Residential Care).[3] Through decentralisation, it was anticipated that provider services would have greater flexibility to plan and organise passenger transport to meet the multiple and often complex needs of their service users.

1.2 In June 2008, Overview & Scrutiny Committee commissioned a review of these new transport arrangements in adult social care, primarily to assess whether the intended objectives of this reorganisation had been achieved. To facilitate this review process, it was agreed to consult with key stakeholders (service users, carers and staff) to ascertain what impact the transport changes have across Day Centres where new arrangements for transport service have been implemented.

1.3 This report provides an analysis of data from these service evaluations. It is anticipated that the analysis will inform assessments on the acceptability of the transport changes to key stakeholders and guide broader assessments on the overall effectiveness of this new model of transport service provision.

2. Service Evaluation Methods

The methods in which the three individual service evaluations were carried out with respective stakeholder groups are summarised below.

Service Users

2.1 Given the vulnerability of adult social care service users, considerable care was undertaken in developing an appropriate mechanism through which to consult with day care centre service users. The need to minimise the personal intrusion on service users, particularly from outside sources, was of paramount importance in this aspect of the service evaluation.

2.2 In this context, a pictorial survey was designed in consultation with service managers and staff at day centres. A speech and language therapist was also consulted to ensure that survey design was accessible to the widest possible range of service users attending day centre services. Whilst the pictorial survey formed the basis of the service evaluation, additional open ended questioning was included to allow more detailed and qualitative contributions where this was possible.

2.3 A pictorial information sheet and consent form accompanied the survey which explained to service users the purpose of the survey. Critically, the information highlighted that:

- Participation was voluntary
- Non participation will not affect future access or right to services
- Service users could withdraw at any time

[3] Physical disabilities had their own arrangements previous to this decision.

- The survey was anonymous and information given will not be used that will identify informants.

2.4 Where informed consent was obtained, service users were assisted in completing the survey by a member of the management team at respective day centres (where possible, someone with whom service users were familiar, but not involved in their day to day care). Completed surveys were coded and analysed using SPSS.

Carers

2.5 Given the prospective numbers of respondents and the relative accessibility of this group, a quantitative approach was used to service evaluation with carers. The survey was developed in consultation with service managers and sought to elicit a range of information including:

- The extent to which the new transport service meets the needs of service users
- Satisfaction with new localised transport service (timing, punctuality)
- Impact that new transport has had upon liaison between parents, staff and service users
- How the new localised transport has improved care for service users
- Possible improvements to transport services

2.6 The final survey was anonymous and distributed via post to carers along with a reply paid envelope. An explanatory letter accompanied the survey detailing why the review is being undertaken, why their response was important and reassuring respondents of their confidentiality. Completed surveys were returned direct to the researcher, and were coded and analysed using SPSS software.

Staff

2.7 Given the numbers involved (approximately 100) the staff service evaluation was predominantly quantitative in nature. The survey did however contain a number of open ended responses to allow staff to expand and develop their answers to set questioning. The survey was designed in consultation with service managers and sought to ascertain the following information:

- Confirmation of problems with old centralised service
- Benefits of new localised transport
- Impact on the roles of staff in day centres
- Extension of day care opportunities
- Identify possible improvements to transport services

2.8 The final survey was anonymous and distributed to staff along with a reply paid envelope. An explanatory letter accompanied the survey detailing why the review was being undertaken, why staff responses were important and reassurance that any material used would not identify informants. Completed surveys were returned direct to the researcher, where they were coded and analysed using SPSS software.

3. Research Governance

As of April 2008, all research and consultation processes undertaken within Adult Social Care have to be approved by the new Research Governance Panel. The service evaluation methods outlined above were risk assessed and ameliorating actions were identified. The service evaluation process was approved by the Research Governance Panel on 26th September 2008.

4. Responses to service user survey.

4.1 The survey was distributed at five day centre sites; three older people's services (The Grange, The Haven and Woodside) and two learning disabilities services (Ermine Road and Keston Road). From a total estimated distribution of 300 surveys, 101 completed surveys were returned from service users. This produced an approximate response rate of 33%. This can be considered a good response given the vulnerability of service users.

4.2 Responses were received from service users at each of the five day centres (Figure 1). The distribution of responses also reflects the nature of service users that attend each of the day centres, thus a higher response was received from The Haven and Woodside House which predominantly support older people with a physical disability than those day centres supporting people with a learning disability (Keston Road & Ermine Road) or dementia (The Grange). Thus whilst 35% of responses came from service users at The Haven (physical disability) just 5% of responses came from service users at Ermine Road (severe learning disability). The full distribution of responses is contained in Figure 1.

Service user views of the punctuality of transport service

4.3 There was general agreement among service users that the transport service was punctual where 98% of respondents agreed that the bus turned up on the right day and 82% agreed that it turned up at the right time (Figure 2). In respect of the bus turning up at the right time, there was a strong difference of opinion among service users; whilst almost all respondents from Ermine Road (100%), Woodside Day Centre (90%) and The Haven (89%) agreed the bus turned up at the right time, just 67% of respondents from Keston Road similarly agreed (Figure 3).

4.4 Qualitatively, service users were in agreement that the transport service was punctual in picking them up (from home) in the morning and dropping them off (at home) in the evening. In written comments provided by service users, it was acknowledged that problems with traffic or road-works were a big factor in these delays:

> *'It's sometimes late because of traffic.' (SU from Learning Disability)*
>
> *'There are sometimes delays but that's more to do with traffic and road-works.' (SU from Older People)*

Service user views of journey times

4.5 Within the service based model of transport provision, individual day centres plan and manage transport routes which convey service users to and from their home to respective day support centres. Given the home residence of service users and the bus routes to which service users are allocated, journey

times to and from the centre may vary. Whilst 89% of service users agreed that the journey time to and from the centre was acceptable (Figure 2), there were lower levels of satisfaction among service users attending learning disability services. Here, just 80% of service users attending Ermine Road and 71% of service users attending Keston Road thought the journey times were acceptable (Figure 4).

4.6 Analysis of written comments from service users in the survey would appear to verify quantitative data; most were satisfied with the journey time to and from the day centre though a small proportion felt that this was too long, particularly those attending learning disability services:

'It's too long.' (SU from Learning Disability)

'Too long.' (SU from Learning Disability)

'Rounds could be slightly shorter.' (SU from Older People)

Service users views about the comfort of the transport service

4.7 Analysis of survey data found that 95% of respondents indicated that the buses were comfortable, a finding which was consistent for service users across all day centres. This finding was again verified in the analysis of the qualitative data, where in addition to noting that the buses were comfortable also commented that the new buses were comparatively more comfortable than the older buses and that the staff made every effort to make them comfortable throughout the journey:

'[The buses] are really comfortable.' (SU from Learning Disability)

'New buses are better.' (SU from Learning Disability)

'I have a lot of difficulties but the staff try to make me comfortable with cushions.' (SU from Older People)

'Staff are very helpful and the bus is very spacious compared to the old buses.' (SU from Older People)

Service users' views of drivers and escorts

4.8 The buses which transport service users are staffed by one driver and an escort. Almost all (98%) respondents indicated that they found their drivers and escorts to be friendly and helpful (Figure 5). There were many comments to support the friendliness of drivers and escorts from service users at both older peoples services and learning disabilities services.

'Good drivers.' (SU from Learning Disability)

'Very helpful and polite.' (SU from Older People)

'Yes, they are very friendly and helpful.' (SU from Older People)

4.9 The survey sought to assess whether the bus drivers or escorts assisted service users in getting on and off the bus and in and out of their home. Survey respondents were in broad agreement that drivers or escorts were helpful; 90% agreed that they helped them on and off the bus and 77% agreed that they helped them in and out of the home (Figure 5). High levels

of service user satisfaction with the helpfulness of drivers and escorts were also verified through qualitative comments provided in survey:

'They help you on the bus.' (SU from Learning Disability)

'That's what I like, they are very helpful.' (SU from Older People)

4.10 It was also clear, that a significant number of service users remain physically independent and may not need the assistance of drivers or escorts in getting on or off the bus or getting in and out of the home:

'I can get on and off the bus myself.' (SU from Learning Disability)

'I don't need help to get on and off the bus.' (SU from Older People)

'I don't need much help.' (SU from Older People)

4.11 Prior to the development of service based transport, drivers and escorts were mostly provided through a centrally administered transport service and had little contact with day centres beyond transporting their service users. With the development of service based transport, drivers and escorts are employed by respective day centres to transport service users to and from the day centre but also to provide support activities both within and external to the day centre. A high proportion of service users (80%) confirmed that drivers and escorts now participate in the activities at the day centre (Figure 5).

Day trips and external activities

4.11 It was anticipated that through developing a locally managed system of transport this would develop service user's access to mainstream and community activities during the day (i.e. using sporting facilities, shopping and visiting relatives). Analysis of survey data found that 84% of service users agreed that they had trips out of the day centre as often as they would like (Figure 6). This finding was not replicated across all day centres however, as proportionally fewer respondents from Keston Road (67%) indicated that they went on day trips as often as they would like.

4.12 Qualitatively, many respondents indicated how much they enjoyed going on day trips out of the day centre which included trips to local parks, shopping centres, art galleries and day trips to the coast. Indeed, some respondents indicated that they now went on more trips under the new transport system:

'Enjoys trips out a lot.' (SU from Learning Disability)

'I enjoy the trips very much.' (SU from Older People)

'We get taken to places that we couldn't get to before.' (SU from Older People)

4.13 Further more, a number of respondents were keen that there should be more opportunities for service users to go on activities or day trips away from the day centre:

'I want to go on trips more often.' (SU from Older People)

'More trips would be nice.' (SU from Older People)

Overall perceptions of the transport service

4.14 Respondents were asked to indicate how they felt overall about the transport service which was provided from the day centre. 95% of respondents indicated that the transport service was good, 4% were unsure and 1% thought it was bad (Figure 7). This was finding was reproduced in the analysis of responses from other day centres.

4.15 Finally, service users were asked to comment on any aspect of the transport service, highlighting anything that was good about the service, or what needed to be improved. A summary of the main themes to merge from these findings are given below:

1) Drivers and escorts integral to perceptions of good service:

'Staff are friendly so it makes the journey good.' (SU from Learning Disability)

'The transport is good because the drivers and escorts make me feel good, they help me to get out of the house on time and make sure that I switch off my lights and they help me get my frame. I don't think there is anything to improve.' (SU from Older People)

'The transport makes for happy times at the centre for me. The staff care about us and make us laugh and make me a cup of tea.' (SU from Older People)

2) The service is reliable:

'We cannot rely on other transport.' (SU from Older People)

'Yes, the good thing about the transport is that they are reliable.' (SU from Older People)

'The fact that it exists is good.' (SU from Older People)

3) Some service users who attend older peoples day care centres would like to attend for longer:

'I attend the drop in centre and would like to attend for longer.' (SU from Older People)

'I would like a little longer here [at the Day Centre].' (SU from Older People)

'I would like more time at the Centre.' (SU from Older People)

4) There are some concerns about the steps on and off of buses:

'The steps are a little dangerous, the bars sometimes catch your fingers.' (SU from Learning Disability)

'Steps are a bit high.' (SU from Learning Disability)

5) There is room for some improvement in the punctuality of services:

‘The bad thing is that that it sometimes come and pick me up late.’ (SU from Older People)

6) Overall, there was broad satisfaction with the transport service:

‘I am very satisfied.’ (SU from Older People)

‘It can’t be any better it’s all very nice.’ (SU from Older People)

‘The service is very good, they are mostly on time and I get all the help I need.’ (SU from Older People)

‘The service is very good.’ (SU from Older People)

‘They are perfect.’ (SU from Older People)

Charts from survey of service users.

Figure 1

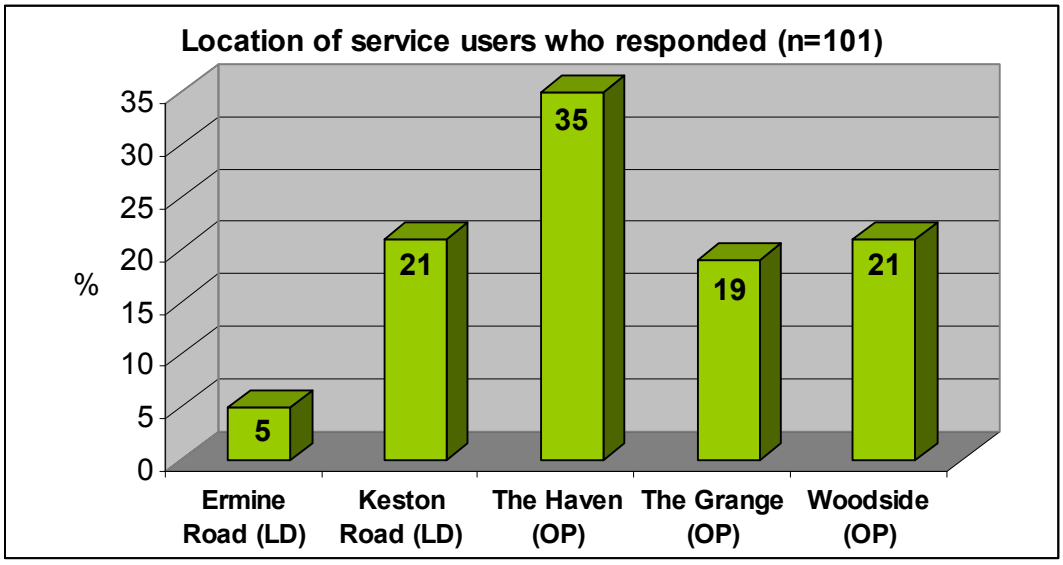


Figure 2

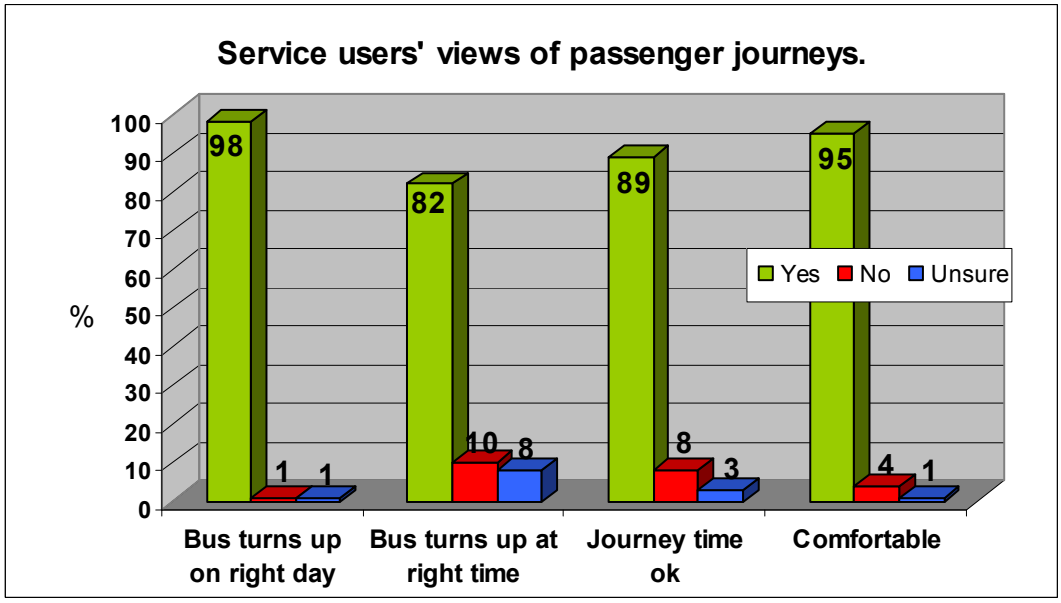


Figure 3

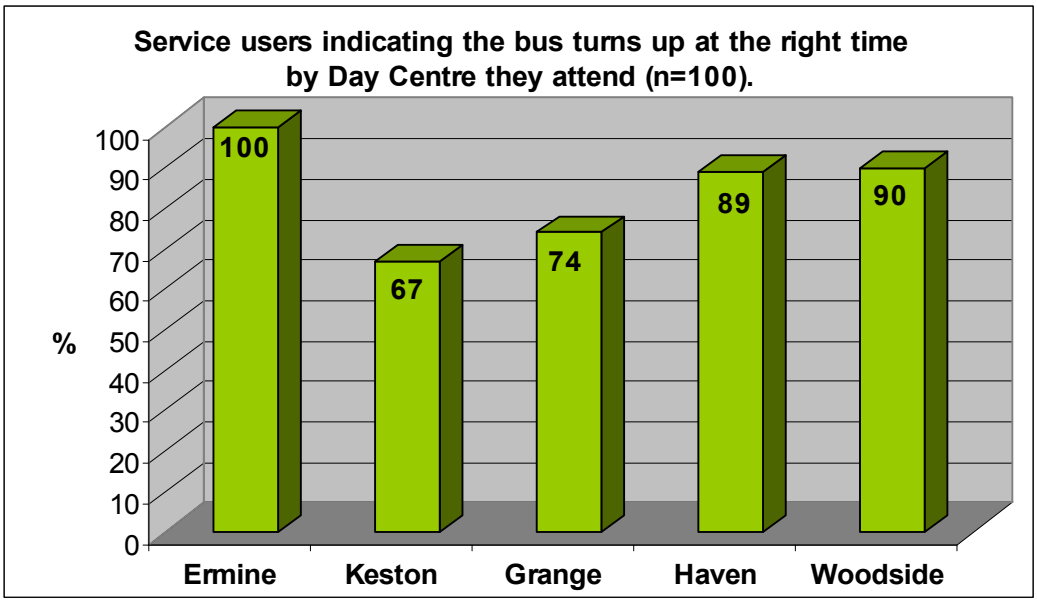


Figure 4

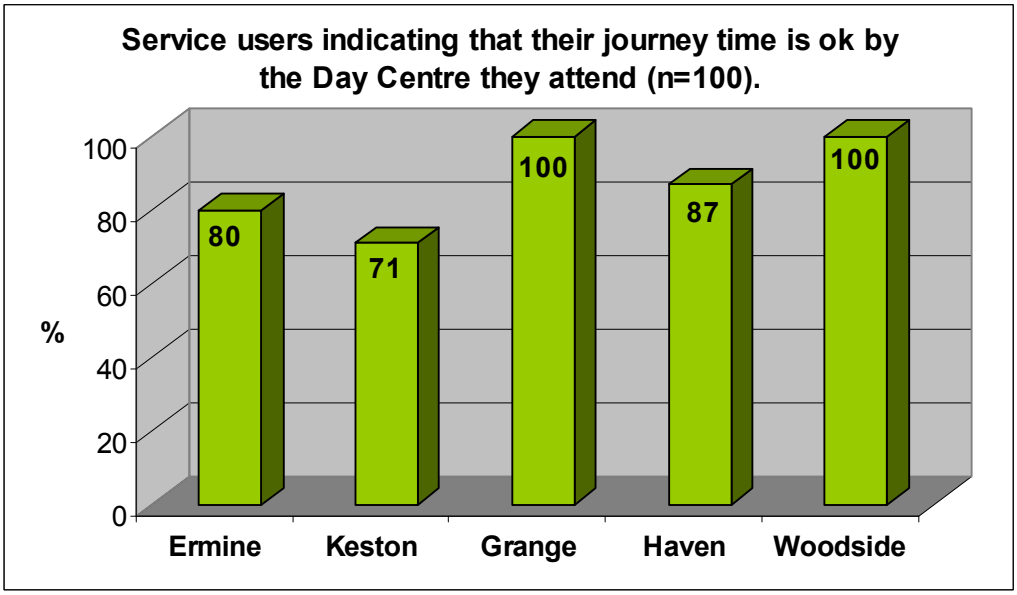


Figure 5

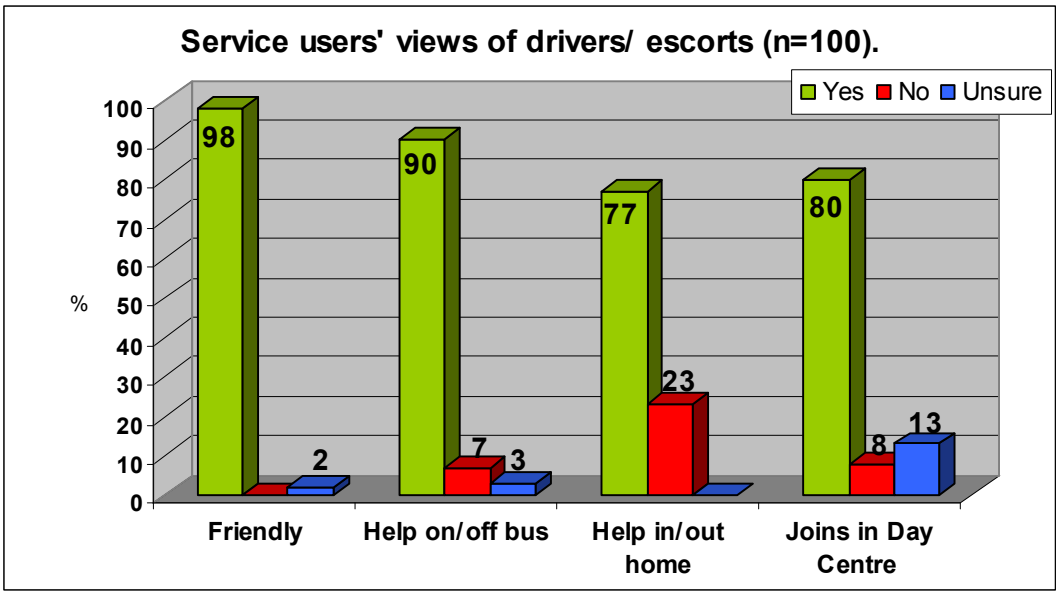


Figure 6

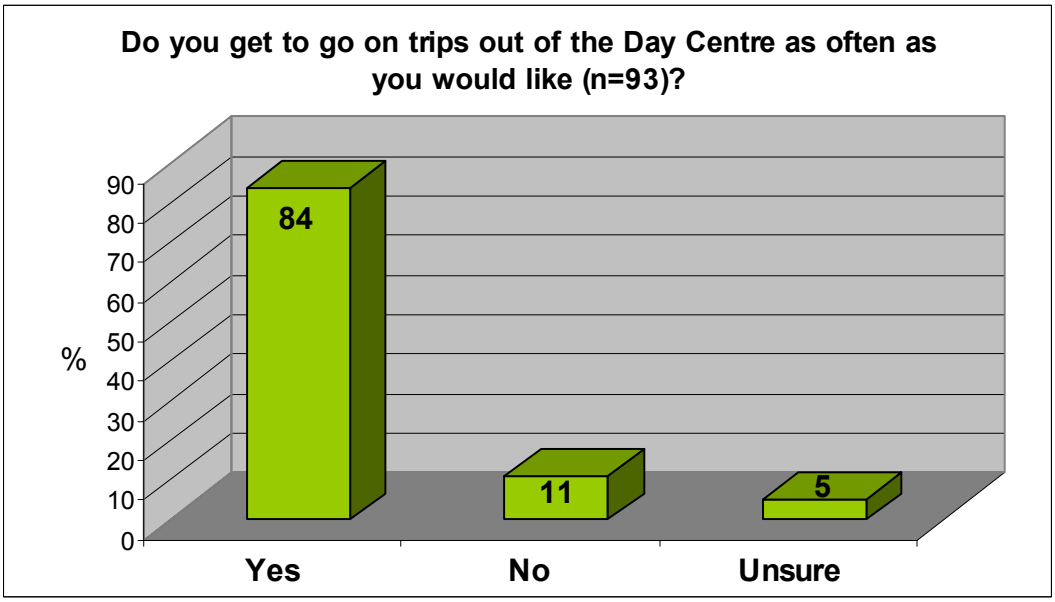
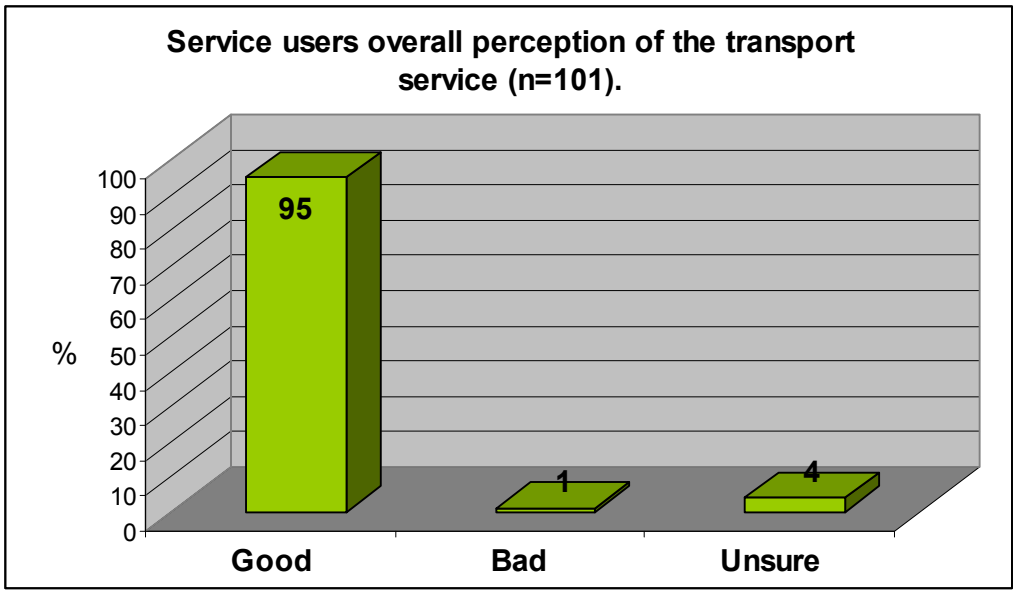


Figure 7


Service users overall perception of the transport service (n=101).
%
100
90
80
70
60
50
40
30
20
10
0
95
1
4
Good
Bad
Unsure

5.0 Responses to the carer's survey

5.1 The survey was distributed to carers of service users at five day centre sites; three older people's services (The Grange, The Haven and Woodside) and two learning disabilities services (Ermine Road and Keston Road). From a total estimated distribution of 225 surveys, 62 completed surveys were returned from carers. This produced an approximate response rate of 28%. This can be considered a good response given that the survey was administered via post.

5.2 Almost 2/3 of responses came from those who cared for a service user who attended a learning disability service; 38% of responses came from carers looking after a service user at Keston Road and 23% of respondents who cared from a service user at Ermine Road (Figure 8). Lower response rates from carers of service users attending older people's services were to be expected, as many of these services may be living independently or without the support of a carer. Thus, it is unsurprising to record that just 7% of responses came from those carers looking after those service users that attended The Haven (a day centre predominantly supporting those with a physical disability).

5.3 Approximately one-half of all respondents (48%) indicated that the person they care for attended the day centre every day (Figure 8). A similar proportion also indicated that the person that they care for had attended the day centre for more than 5 years (Figure 8).

5.4 Analysis of demographic data provided by carers themselves revealed that a majority (72%) were aged 50 years and over, were predominantly female (81%) and had a familial (87%) relationship (partner, parent, son or daughter) with the person that they cared for (Figure 8).

<u>Carers views about the punctuality of the transport service</u>

5.5 Analysis of quantitative data would suggest a high level of satisfaction about the punctuality of the transport service among carers. Here, 90% of respondents indicated that the bus generally turned up at the right time to pick up or drop off the person that they cared for; 28% indicated that this was always on time and 62% indicated that it was 'mostly' on time (Figure 9).

5.6 Analysis of qualitative comments would seem to suggest that occasional problems with the lateness of transport remain a problem for a significant minority of carers. This seems to be particularly problematic for the morning route which picks up service users. It was apparent however, that not all carers were in a position to judge the punctuality of the transport service as drop-off/pick-up times were very broad or even unspecified at some day centres:

> *'Pick up time is not specified, so they turn up any time.' (LD)*
>
> *'Right time" is unknown, this seems to be moveable.' (LD)*
>
> *'The pick up time is fairly broad (8.30-10.00) so it's not hard to be on time.' (OP)*

5.7 In the survey, carers were asked to indicate if they were notified if the bus was going to be late in picking up or dropping off the person that they care for. In total, 73% of respondents indicated that they were generally notified if the bus was going to be late; 44% indicated that they were 'always' notified and 29% indicated that they were 'mostly' notified (Figure 9). Whilst it is noted that all buses carry a mobile phone, there does not appear to be a standard policy to notify carers if the transport is going to be late. What is evident from the analysis of qualitative comments is that carers would expect to be notified if the bus is going to be particularly late:

'Courtesy call when the bus is running really late would be appreciated.'(LD)

'No call at all and that's not nice.' (LD)

It was also evident that when this practice is instituted, it is appreciated by carers:

'Yes we are told and this is a commendable gesture from The Grange – a phone call informs me every time.' (OP)

5.8 Overall however, there was broad agreement among carers that the transport service on the whole was punctual where service users were generally picked up at their allotted time (where this is provided). Indeed, it was noted by some carers, that the punctuality and reliability of transport services had improved:

'Very reliable.' (LD)

'Buses are very reliable – no complaints.' (OP)

'I feel very good about the service, before the times were very unsettled – but almost everyday now the service is on time. I hope the service stays like this.' (LD)

<u>Carers views about the journey times</u>

5.9 The survey sought to ascertain carers views about the duration of the journey time that the person that they cared for took to and from the day centre. 70% of carers estimated the journey time of the person they care for to be less than 1 hour (Figure 10). Interestingly, 1 in 5 (20%) carers were unaware or unsure of journey times to the centre (Figure 10).

5.10 A majority (73%) of carers indicated that they felt the journey time was 'about right', though a significant minority (25%) felt the journey to be 'too long' (Figure 11). Further analysis of these responses revealed that there was less acceptance of the client journey time at Keston Road day centre, where almost 2 in 5 carers (39%) felt this was 'too long' (Figure 12).

5.11 Analysis of qualitative comments would appear to verify issues highlighted in the analysis of survey data; journey times on the whole were acceptable to carers although there were instances where the journey time was too long (due to traffic or other passengers). There would appear to be particular problems at Keston Road however, where it would appear that the journey

times for some service users continue to be unacceptably long, which may require an examination of the routes planned from this day centre:

'Far too long. (Keston)

There are too many pick ups for one bus, there should be separate pick ups for [more remote areas].(Keston)

Carers views about the flexibility of transport

5.12 It was anticipated that the development of service based transport would provide more flexibility within the transport service, which would better enable day centres to respond to carers needs (i.e. occasional variation of pick-up/ drop-off times). The survey sought to assess whether the new transport arrangements had provided additional flexibility in practice.

5.13 Although most respondents (71%) indicated that they had not needed to vary the pick-up/ drop-off time for the person they care for, when those that had occasioned to do so, most (90%) found this an easy process to arrange with the day centre (Figure 13). This was verified in the qualitative comments provided by respondents:

'I have occasionally made a special request for them to come on time or let me know if there is a problem, this has always been listened to and have been in good time.' (LD)

'This is never a problem.' (LD)

'If I need to change a pick up or drop off times it is always very flexible and the driver and escort will always work around this.' (LD)

Carers views about drivers and escorts

5.14 Within the new model of service based transport, drivers and escorts in adult social care services are now all located and managed through individual day centres. Drivers and escorts are now also dual trained to provide ongoing service user support outside transport runs. The survey sought to ascertain carers' perspectives on these changes.

5.15 Overwhelmingly (95%), respondents agreed that the drivers and escorts on the buses were friendly (Figure 14). This was substantiated in qualitative comments provided by respondents:

'They are helpful, cheerful and friendly. (OP)

'It makes a lot of difference when the drivers are friendly and talk to the clients.' (LD)

'Very friendly, polite and considerate.' (OP)

5.16 In addition to being friendly, respondents indicated that they found that drivers and escorts generally communicated well and in many cases had developed a good rapport with both service users and carers:

'They are very good with my son and communicates well.' (LD)

'They are very good and my mum is very happy with them as they make her laugh.' (OP)

'My son's driver is very good, he works well with my son.' (LD)

'My mother thinks they are very nice to her and I find their support of me helpful.' (OP)

5.17 Respondents were also in broad agreement that drivers and escorts provided appropriate support to service users; 92% indicated that drivers/escorts 'mostly' or 'always' helped service users on and off the bus (Figure 15). Written comments provided by respondents underlined their satisfaction with the support that was provided to service users in accessing the transport service:

'I find the escorts and drivers always helpful and kind when collecting and bringing back my husband – thank you very much.' (OP)

'It makes a lot of difference as I do not have the strength to get my son on and off the bus.' (LD)

'Very, very good.' (OP)

5.18 Proportionally fewer respondents (77%) indicated that drivers / escorts 'mostly' or 'always' helped service users in and out of their home (Figure 15). Analysis of qualitative comments found that in a number of cases, the provision of support in and out of the home was not necessary as service users were independent enough to do this themselves or preferred their carer to assist:

'There is no need to help my daughter as she is able to walk.' (LD)

'Quite often I take my wife to the front gate and the escort takes over and takes her on to the bus and sees that she is wearing a seat belt.' (OP)

'My daughter prefers it if I put her on the transport.'(LD)

5.19 Over 2/3 (67%) of respondents indicated that with greater frequency, the same drivers and escorts come to pick up services users and transport them to the day centre (Figure 15). Respondents felt that this was important as it helped to maintain the continuity of care for service users and helped build supportive relationships with service users in their care:

'Think staff continuity is important. It's important that the main drivers and escorts are regular.' (LD)

5.20 Further analysis of respondent's comments revealed that service users and carers were appreciative of the support that drivers and escorts provides to service users on passenger transport services. Indeed, some carers felt that service users enjoyed this aspect of their day:

'I have no problems with the escorts and drivers as my daughter has been using the service for many years.' (LD)

'[Drivers & escorts] seem to enjoy their job and my daughter looks forward to seeing them.' (LD)

'[Drivers & escorts] are wonderful and make a happy part of the day for my daughter. (LD)

Overall perceptions of the new transport service

5.21 Respondents were asked to give an overall assessment of the new transport service in respect of its perceived comfort to service users, improved access to day opportunities and the safety of transport services. All (100%) carers agreed that service users were transported safely and carefully to and form the day centre (Figure 16), though there were concerns about the steps on some buses being too high:

'Some buses in use the steps are too high. I don't think these are the regular buses.' (LD)

5.22 Approximately 2/3 (64%) of respondents indicated that the new transport service was more comfortable for service users (Figure 16). Proportionally fewer respondents (46%) indicated that the new transport service had provided more day opportunities (i.e. accessing community activities) for service users (Figure 16). Qualitative analysis would suggest whilst some respondents acknowledged that there were more day opportunities for service users within the new transport system, there was always a demand to increase provision further:

'They do seem to have more trips than with the previous system.' (OP)

My mother loves going on the outings. It's good for her as she can't go far on her own. (OP)

'They could always get out more.' (LD)

Overall satisfaction with transport service

5.23 Respondents were asked to indicate how satisfied they were with the transport service overall. There was a high level of satisfaction among respondents with the transport service where 98% were satisfied; 67% indicated that they were 'very satisfied' and 31% indicated that they were 'satisfied' (Figure 17). Satisfaction with transport services would also appear to be more resolute at older people's services (the Grange, the Haven and Woodside) than leaning disability services where proportionally more respondents felt that they were 'very satisfied' with the service (Figure 18).

5.24 Analysis of qualitative comments would appear to suggest that there is general satisfaction with the transport service among carers (with the exception of suggested improvements (highlighted in 5.29):

'There is nothing to add as the system seems to be working very well in our experience.' (OP)

'During the past 4 months my husband has been attending The Grange the transport has been and still is very good and the staff are always courteous and helpful.' (OP)

'The service has always been good.' (OP)

Perceived improvement in transport services

5.25 Overall, 75% of respondents indicated that the transport service had improved over the past 12 months; 45% indicated that there has been a lot of improvement and 30% indicated that there has been a little improvement (Figure 19). As one day centre has always managed its own transport service, it is not surprising to record that 25% of respondents noted that there was no discernible difference in transport provision.

5.26 Further analysis of this data revealed that a majority of carers across all the day centres felt that transport had improved (Figure 20). Of particular interest here, were carer's perceptions of the improvement in transport provision at Keston day centre; whilst this centre has undergone significant changes resulting from the development of service based transport, 41% of carers still felt that there had been no improvement in the service.

5.27 Analysis of qualitative comments in the surveys would seem to confirm that overall, transport services have improved at day centres over the past 12 months:

'The new service has been much better than it was before.' (LD)

'The service has always been good, so it's not improved that much.' (LD)

5.28 There is however a lingering perception within learning disability services, focussed within Keston Day Centre, that the new transport service has had a limited impact upon services:

'Made no difference.' (LD)

'No, nothing has changed.' (LD)

'No change.' (LD)

'It seems to be the same, nothing much has really changed.' (LD)

General qualitative comments

5.29 Finally, carers were asked to comment on any aspect of the transport service, highlighting anything that was good about the service, or what needed to be improved. A summary of the main themes to emerge from these findings is given below:

1) Carers were satisfied with a service that is safe and reliable:

'As a carer, my concerns are that my wife is taken to and from the centre safely – this has always been done…. if my wife is happier with the new transport then I am happy with the new buses and transport system.' (OP)

'Yes, [it's helped], it exists and facilitates a safe journey to and from the day centre.' (OP)

2) Those carers who work may have additional demands on transport service (flexibility / punctuality) which may need to be considered:

'I would appreciate it if they could pick up earlier as they are usually quite late.' (LD)

'As I work….I have to take my son in [to the day centre] in the morning, they then drop him off in the afternoon. When I request that he's picked up from home this isn't until 10.30am…. .'

3) The new system of transport has improved access to day centres for some service users:

'My mum will always get on the bus now because the lift at the back works all the time, but before there were times when she was not taken because this lift was not working. At the moment I have no complaints, the service is so much better because of the new transport, before I never knew if my mum was going or not.' (OP)

4) A number of unresolved transport problems remain which may be helped by improved route planning:

'We still need a Monday place on the bus as we have been waiting form over a year now - it would help me a lot as my job is wearing thin. My mother is collected by taxi on a Monday so I have to be at home am and pm which is a problem for my job.' (OP)

'Our mother attends the day centre twice a week, she is collected and returned on time. We have to take her and pick her up on Thursdays as the bus does not come to our area, but we manage.' (OP)

5) Carers are generally appreciative of the transport services:

'I want to thank the drivers and escorts for giving extra care for the elderly and doing a fabulous job – keep it up and thank you all for the work that you do for the support you provide to make them happy.' (OP)

'It is good to know that my mother is happy and really enjoys her trips to the day centre and looks forward to the visits.' (OP)

Figure 8

About the person you care for:		About you:	
Attends:		**Are:**	
Ermine Road	23%	**<30**	5%
Keston Road	38%	**31-40**	7%
The Grange	15%	**41-50**	16%
The Haven	7%	**51-60**	35%
Woodside	17%	**61 and over**	37%
5 days a week	48%	**Male**	19%
3-4 days a week	15%	**female**	81%
1-2 days	37%		
<1 year	15%	**Partner**	17%
1-2 years	20%	**Parent**	52%
3-4 years	7%	**Other relative**	18%
5 years and over	58%	**Other**	13%

Figure 9

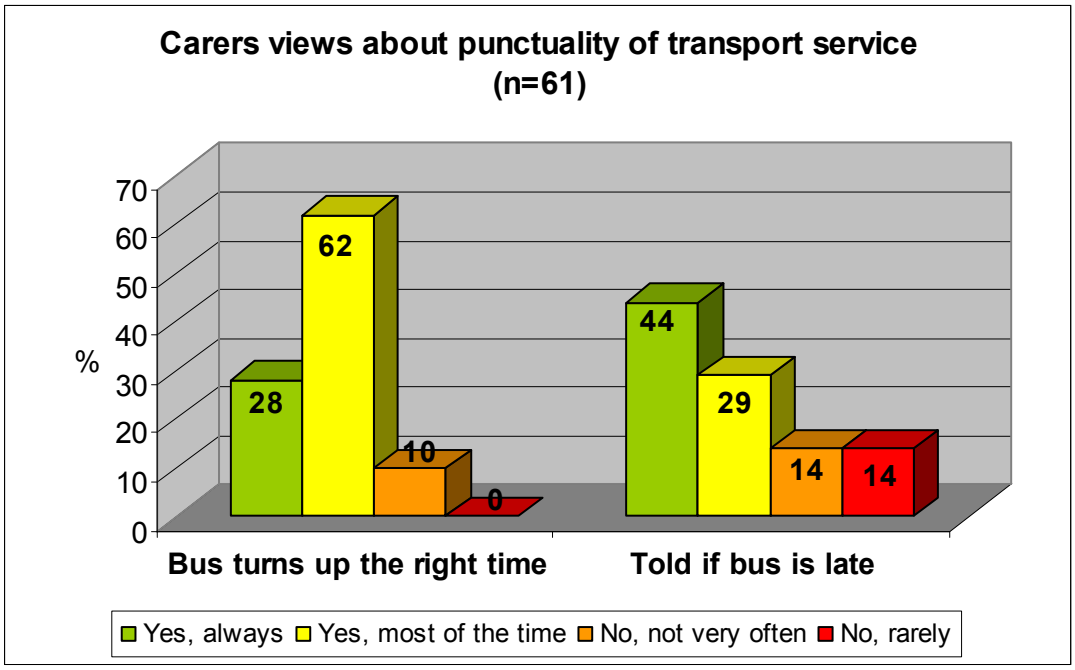


Figure 10

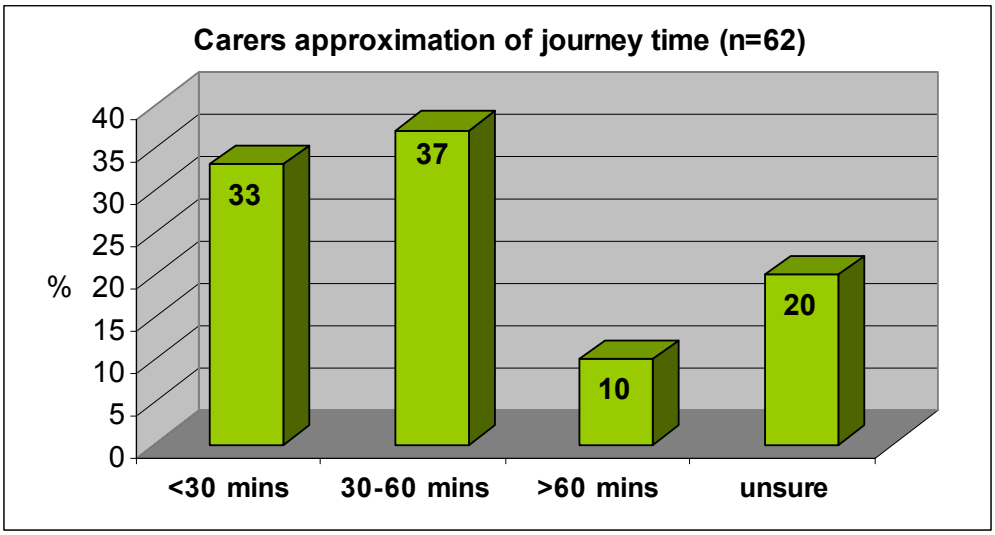


Figure 11

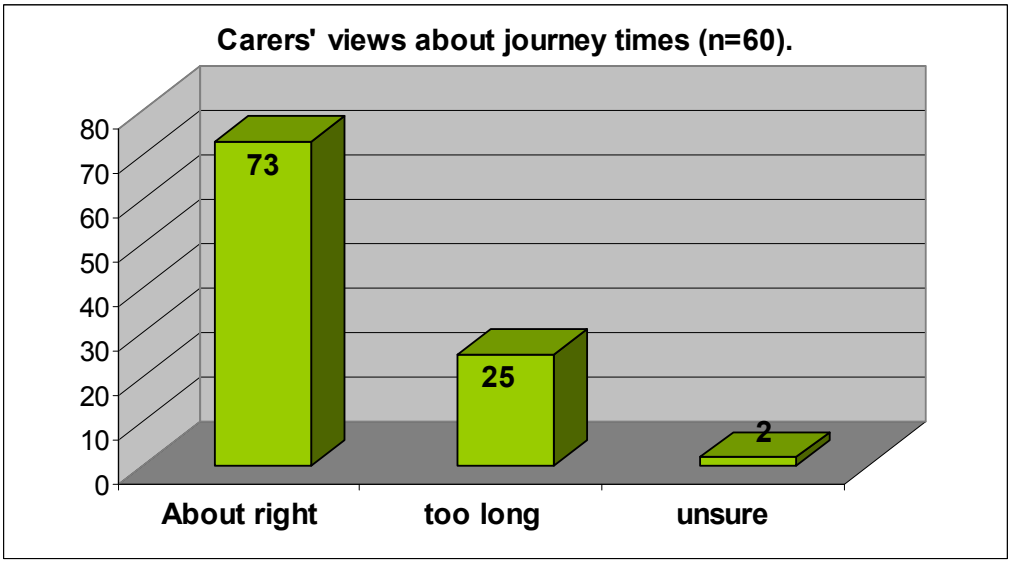


Figure 12

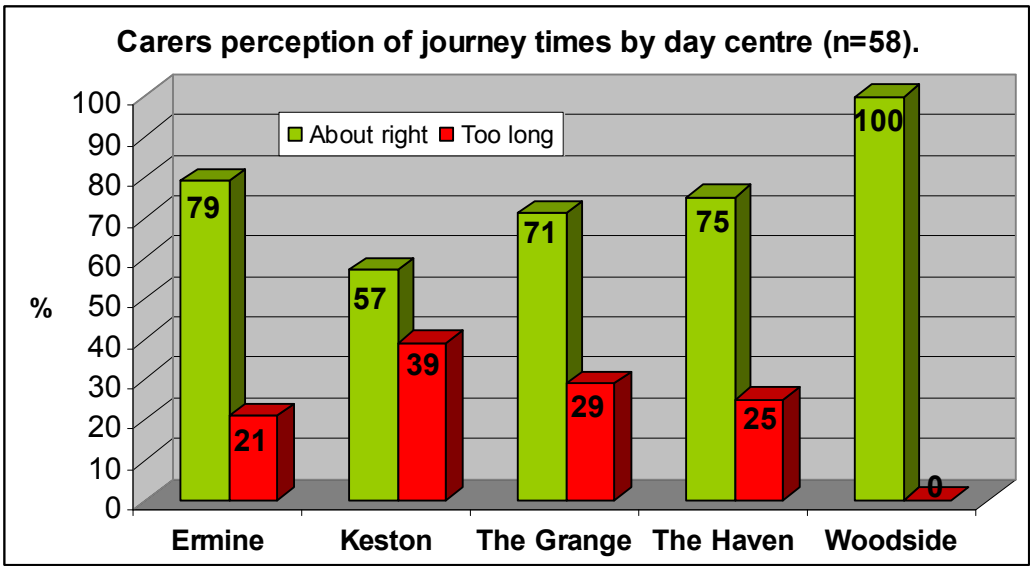

Carers perception of journey times by day centre (n=58).
About right
Too long
%
100
90
80
70
60
50
40
30
20
10
0
79
21
57
39
71
29
75
25
100
0
Ermine
Keston
The Grange
The Haven
Woodside

Figure 13

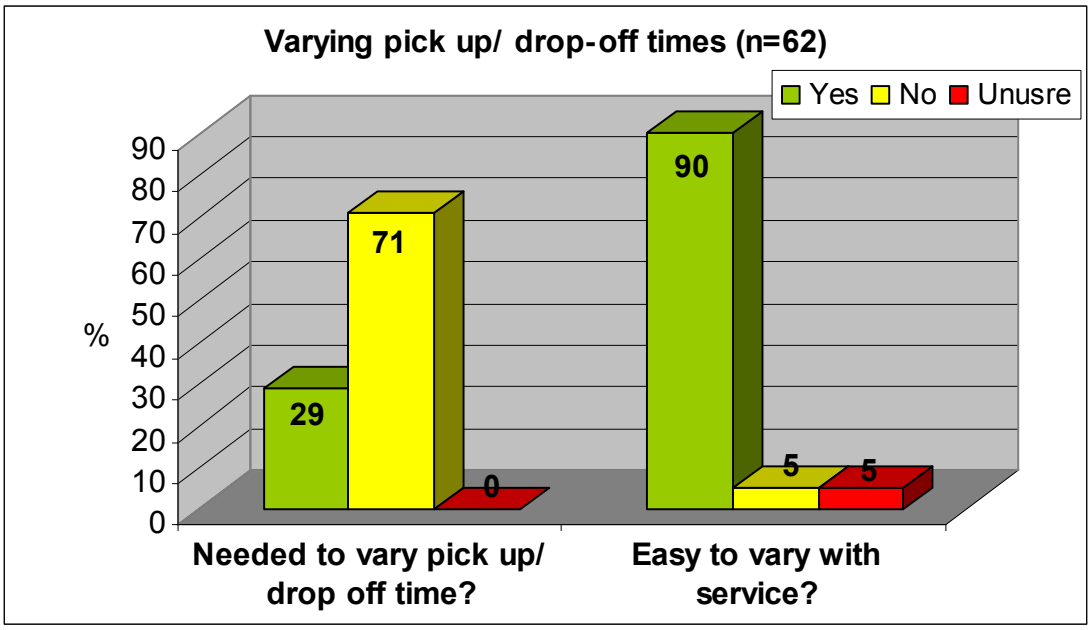


Figure 14

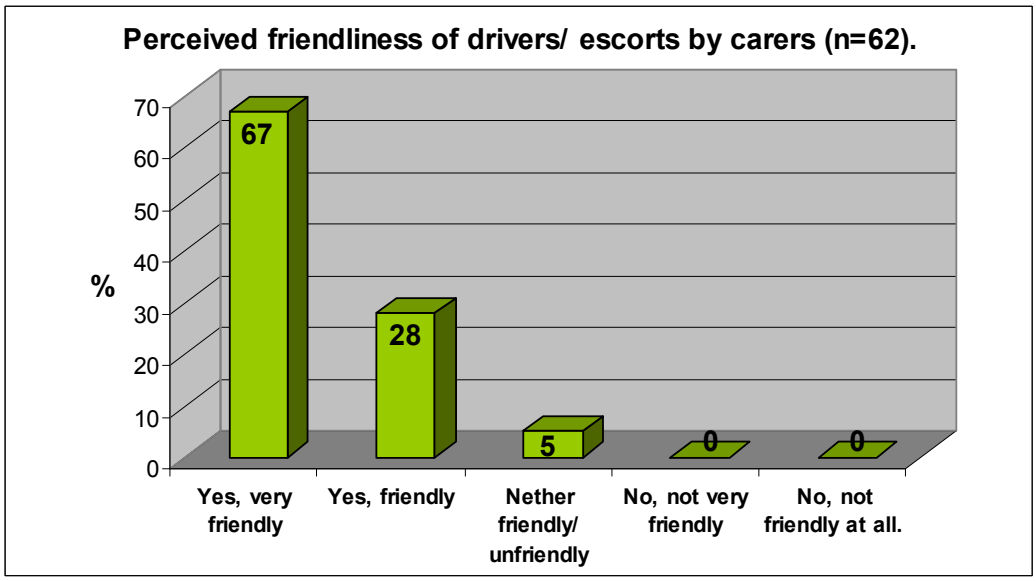


Figure 15

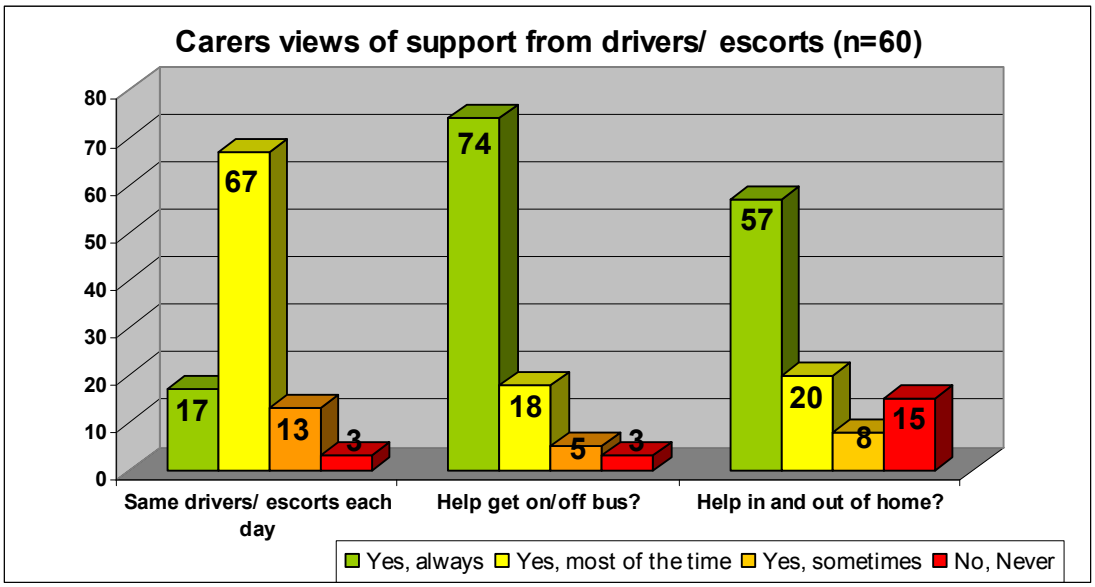


Figure 16

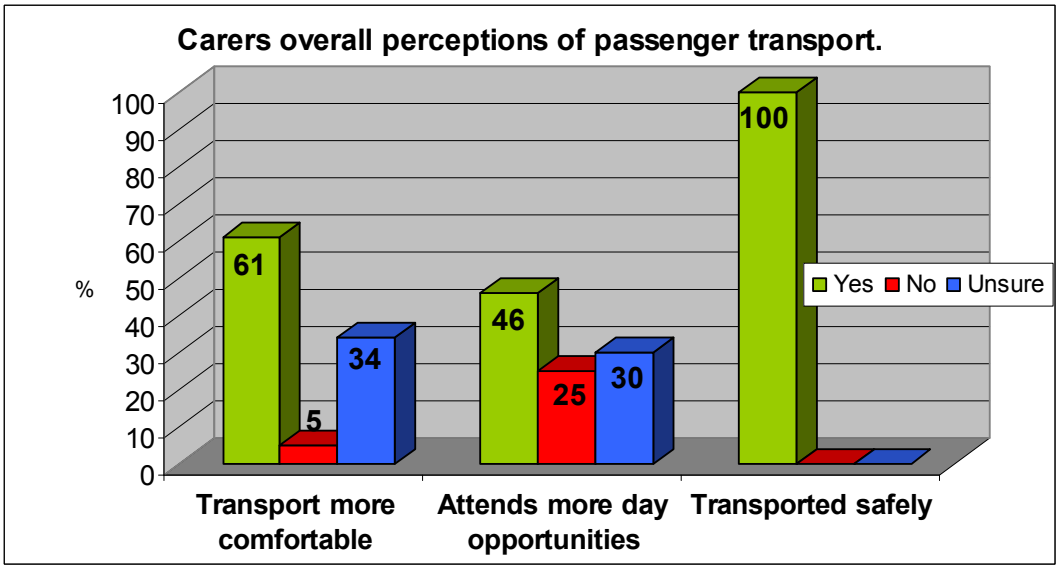


Figure 17

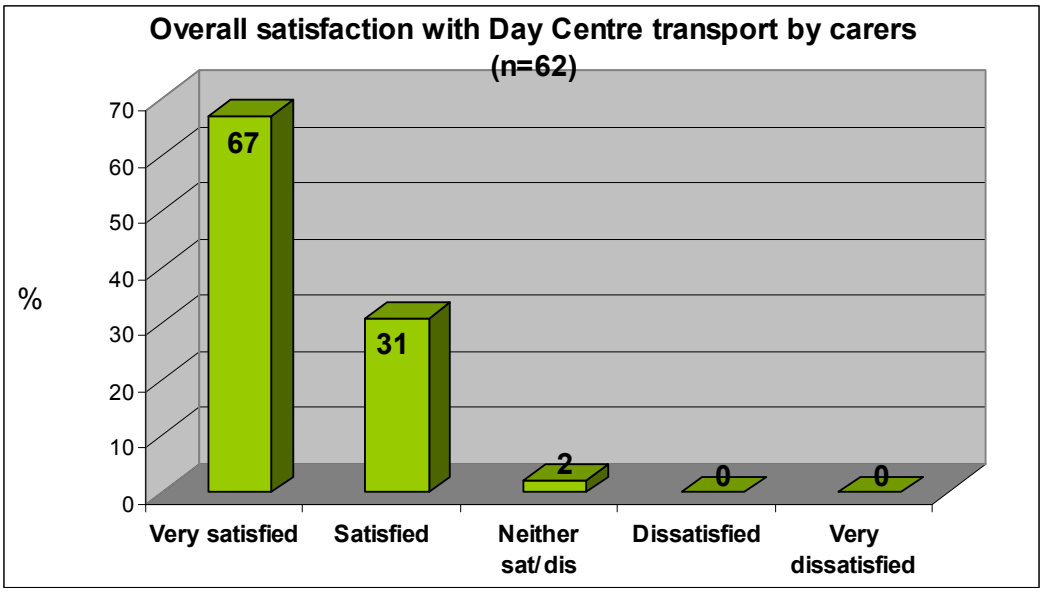


Figure 18

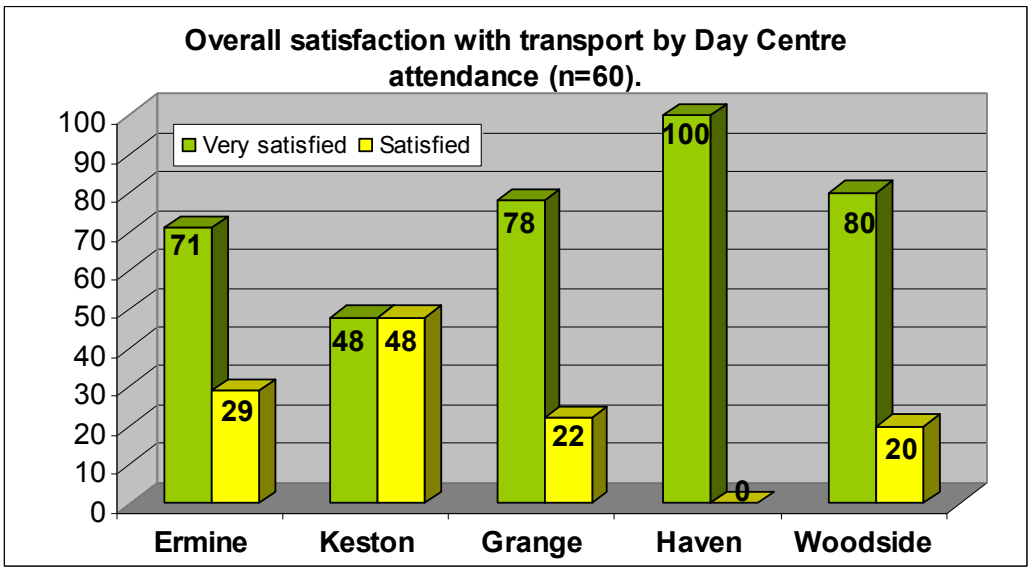


Figure 19

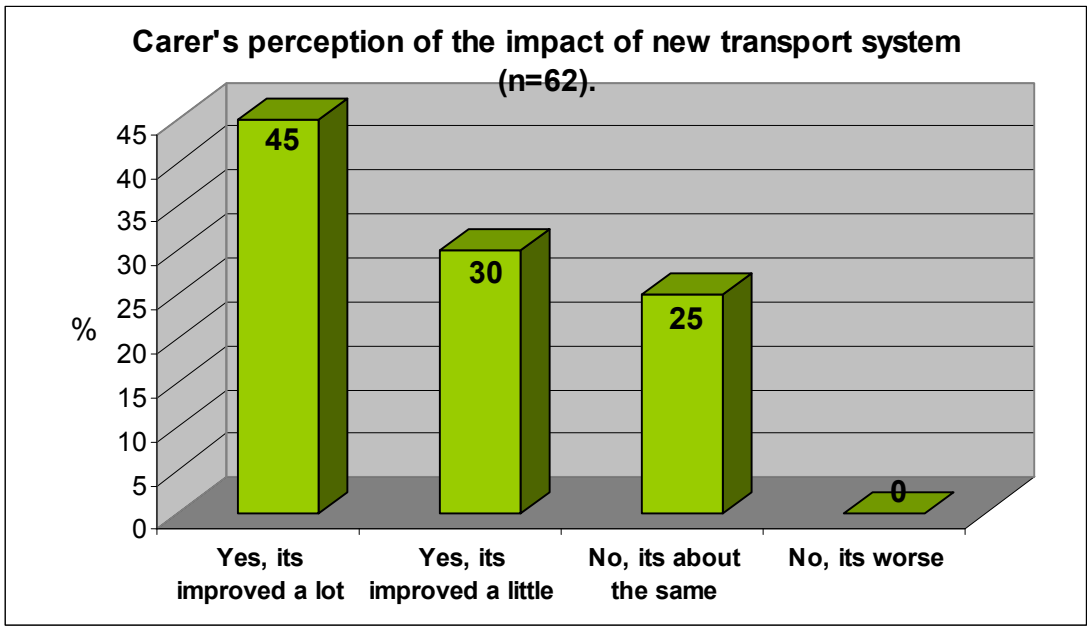
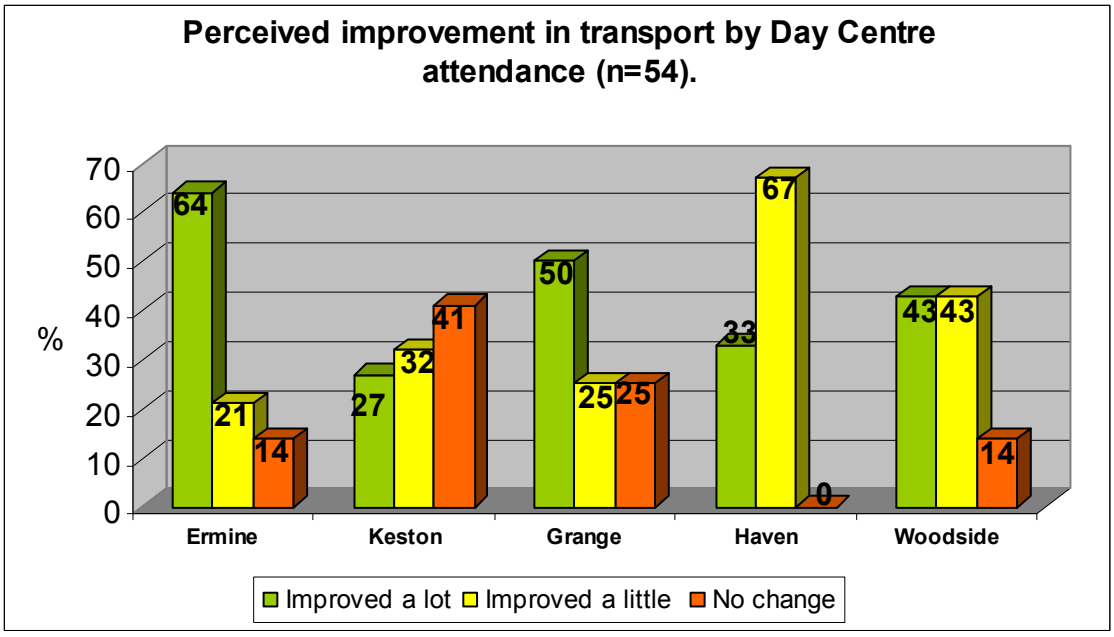


Figure 20



6. Responses to the staff survey

6.1 In total, 54 completed survey responses were received from staff working in the five day centres. 33 (61%) of staff responding to the survey were located in learning disabilities services and 21 (39%) located in older peoples services (Figure 21). Singularly, staff from Ermine Road (learning disability service) were the largest contributor to the survey, making up 37% of all respondents.

6.2 A broad range of staff groups were represented including driver/ support workers (making up 26% of all respondents), escort/support workers (24%), day centre support workers (20%) and managerial staff (14%) (Figure 21). Other support centre staff (i.e. key workers) made up the remainder of contributors to the survey (Figure 21).

6.3 Analysis of survey responses found that 91% of staff had been in post for one year or longer; indeed, almost one-half (48%) had worked at the day centre for over 6 years. In terms of eliciting staff perspectives of the new transport service, this was encouraging as almost all respondents were in a position to provide a comparative assessment with the centralised model of transport provision which service based transport replaced.

Views of new vehicles and the needs of service users

6.4 Analysis of survey responses found that 70% of staff agreed that vehicles provided within the new transport system were better equipped to deal with the needs of service users (Figure 22). Furthermore, 77% of staff indicated that the new transport system was more comfortable for service users. These issues were verified in the written comments provided by respondents, where on the whole staff felt that the vehicles were more spacious and comfortable for service users:

> *'[Its] better for wheelchair users with added safety and space. Some of our clients have big wheelchairs which can make it difficult to manoeuvre them, so there is a need for space on the bus.' (Ermine)*
>
> *'Better seating and more space in the new buses compared to the old ones.' (Woodside)*
>
> *'The buses have air conditioning and much more comfortable seats.' (Keston)*

6.5 Respondents did however note that a number of further improvements could be made to ensure that vehicles were better equipped to deal with the needs of service users. It was noted by staff working in older peoples services that there was limited room in the new vehicles for service users walking frames or other walking aids, though this was being rectified by providing additional equipment at the Centre:

> *'Need more storage space for client's frames.' (Haven)*
>
> *'Buses are new but still have storage problems.' (Haven)*

'The buses are comfortable and new but they have storage difficulties – arrangements are being made to have 2nd mobility aids at the centre to stop the Centre from having to store these on the transport.' (Haven)

6.6 In the service user survey, it was recorded that service users had anxieties about accessing some of the vehicles because of the height of the steps. This concern was also highlighted in the staff survey:

'The step could be lower for the clients. I think the transport service could be improved for service users by making the step ladder closer to the bus so that it is easier for service users to climb on and off.' (Grange)

'The step is too steep and the door entrance too wide.' (Grange)

6.7 A number of additional health and safety issues were also highlighted by staff in the survey which merit a mention within the report and which may guide services to make further assessments:

'The van door when opened lets the rain in on the nearest client to the door. Also when the door opens and closes it can trap a client's hand.' (Grange)

'Some buses do not have first aid equipment.' (Keston)

Staff views new driver/escort arrangements

6.8 Drivers and escorts are now universally employed by the day centre and not by the centralised transport service and provide additional support activities to service users throughout the day (such as additional driving or support within the day centre itself). As such, the driver/escort role is more integrated within the operation of the day centre. The staff survey sought to assess the impact of this change particularly in relation to the continuity of care of service users and improved communication with carers.

6.9 It would appear that the new transport system has facilitated the integration of drivers/ escorts in to the day to day operations of the day centre, where 86% of respondents agreed that the driver/escorts now felt part of the day centre team (Figure 23). Respondents from both learning disabilities and older peoples services concurred with the improvement that dual training had brought to the day centre:

'It improves on teamwork.' (Haven)

'Helps to build better relationships between all staff groups.' (Keston)

6.10 Furthermore, being embedded within the operations of the day centre, it was also apparent drivers/ escorts were more aware of individual health and social care needs of service users they were transporting and how best to respond to these when the need arose. Qualitatively, staff felt that this had helped to improve the level of care provided to service users whilst using transport services:

'In addition, members of staff providing escort services are very informed and aware of each individuals care and support needs, their health

conditions and well trained on decision making in case of an emergency. (Woodside)

'Drivers/ escorts now know clients better as they work with them during the day as well.' (Ermine)

6.11 Analysis of responses found that 77% of staff agreed that new transport arrangements had improved the continuity of care for service users (Figure 23). This was also verified in the qualitative responses to the survey:

'They bring continuity for service users, better knowledge of their needs, likes, dislikes and wishes. ' (Haven)

'The staff are consistent and the service users get used to the staff too.' (Woodside)

'We love the close working relationship with the driver it's an integral part of our continuity with clients.' (Grange)

6.12 Over ¾ of respondents (78%) indicated that, given the continuity of drivers/ escorts in the new passenger transport service, improved communication between carers and the staff at the day centre had resulted (Figure 23). Again, this was verified within the qualitative responses provided by staff at all day centres:

'As the drivers/ escorts get to know service users family and teams and home staff makes for better communication.' (Ermine)

'Since members of staff who are allocated key workers provide escort services, it has improved communication between carers, families or scheme managers and others involved in the care of clients.' (Woodside)

'Messages get passed on regularly between parents and carers and those working on the transport service.' (Keston)

'We are more aware of service users needs and have better communication with parents and carers.' (Haven)

6.13 Whilst staff were in broad agreement that the new transport arrangements may have benefited service users and carers, it was apparent that the implementation of service based transport was not universally perceived to be beneficial among other stakeholders, namely staff themselves. Analysis of qualitative comments provided by staff reveal that a number of workforce issues remain in developing the service based model of transport across learning disability day centres. Firstly, there appears to be some concern around the availability and nature of training providers to all drivers/ escorts:

'Training for the escorts, like MIDAS is good, but there is a need for more training for some of the drivers, not all of them are professional (employing someone just because they have driving license is not good enough).' (LD)

'I've never had any training!!!' (LD)

'I have not seen the dual training happen for escorts.' (LD)

6.14 Secondly, analysis of qualitative comments from staff would suggest that changes to the roles of escorts /drivers working from learning disabilities day centres have not been universally accepted, where outstanding concerns remain around the terms and conditions of the new role:

> *'....I know that they should be paid substantially more as what they're actually doing is two jobs. The drivers who are not support workers and drivers should be paid for the extra hours they are working.' (LD)*
>
> *'Driving more and more without pay and not in our job description, being expected to pay fines without earning extra to pay for them and also driving as a favour now without any limit to it.' (LD)*
>
> *'Required to start work early and work on transport as well as support. I enjoy it but the changes and increased workload should be reflected in the pay – it is not fair on the drivers as they take on the responsibility of the driver but get paid the same as a support worker.' (LD)*
>
> *'The buses are better equipped to deal with the needs of the service users but the drivers and escorts have been added extra workload of being drivers and escorts and not paid any extra – hence the low morale.' (LD)*

Staff views on the flexibility of new transport service

6.15 One of the key anticipated benefits of the service based model of transport provision at day centres was that locally managed vehicles would have more flexibility to respond to service users' needs. Analysis of quantitative data would appear to support the view, where 74% of respondents agreed that the new transport system is more flexible to meet the needs of service use (Figure 24).

6.16 Analysis of qualitative comments would suggest that the day centres have benefited form the additional flexibility of the transport service in two ways. Firstly, the new transport system would appear to be more flexible in picking up and dropping off service users from home:

> *'The Centre is in a position to be more flexible and we can return to collect [a service user] if for one reason or another they are not ready.' (Haven)*
>
> *'There is no problem calling back for service users if they are not ready or have an appointment and needs to be picked up at different time or carers need to be somewhere.' (Keston)*

6.17 Secondly, as vehicles are located and managed from respective day centres, there is greater flexibility in accessing transport during the day; this means that that service users have access to a wider range of community facilities. Similarly, as the management of vehicles is local, there are fewer restrictions on the times they are available for service users which extend the time and opportunities for which they can be used:

'With trips outings and other community events yes. There is more variety in the events that service users can attend as they can return to the centre at any time.' (Ermine)

'There is more chance for service users to experience the community. Service users can relax having more time on their hands.' (Ermine)

'The transport now being managed by the day centre has undoubtedly increased flexibility of the service i.e. in arranging outings for service users in a more relaxed manner and more time to enjoy their trips.'(Woodside)

'As the bus is based at the Chestnuts throughout the day it enables us to give the service users good support in case of emergencies or people choosing to go home. (Keston)

Staff perceptions on passenger journey time

6.18 Quantitative data would seem to suggest that staff were ambivalent about the impact that the new transport system had had upon passenger journey times (the duration of service user journeys to and from the day centre). Here only 52% of respondents agreed that journey times had improved for service users, the remainder being unsure (30%) or actually disagreeing (18%) (Figure 24).

6.19 Under previous transport arrangements, large buses were used in some services to ferry service users to and from the day centre which inevitably meant that journey times could be of considerable duration. Therefore the procurement of more numerous but smaller buses (under new transport arrangements) has had an impact in reducing passenger journey times in some services. For vulnerable service users, a shorter passenger journey was perceived to be very beneficial:

'It is shorter journeys as the buses are smaller, we used to have one big bus now we have two smaller ones.' (Keston)

'Shorter and more flexible routes with less clients on the bus.' (Ermine)

'Less number of service users on the bus means there are shorter routes and less time that service users have to spend on the bus in the mornings and evenings which is less stressful for them.' (Ermine)

6.20 As was revealed from the survey data, not all staff were of the opinion that the new transport system had had a positive impact upon journey times. From the comments provided by staff, it was evident that journey times were beset with delays relating to other local factors over which they little control, such as traffic congestion or the readiness of passengers:

'Due to traffic I am not so sure.' (Ermine)

'...it depends on the weather, road conditions and the other service users. (Grange)

'I believe the length of journeys are affected by many different factors such as road works, road closures and the weather.(Woodside)

6.21 Staff acknowledged that for some service users, their journey time to and from the centre remained unacceptably long and day centres were attempting to reduce this. From the written comments provided by staff, it may be that additional support in route planning may bring about a decrease in passenger journey time and more effective use of vehicles:

> 'No, no [improvement] really... some service users live in the same place but yet go on different buses – it doesn't make sense to me.' (LD)
>
> *'I don't understand how the routes are worked out as clients who live in the same area are driven home in separate buses.' (OP)*

Staff views on improved access to community activities

6.22 Proportionally more staff were in agreement that the new system of localised transport had improved service users access to community activities outside the day centre. Here, 93% of staff were in agreement that service based transport had improved day opportunities for service users at day centres (Figure 24). This was verified in the analysis of qualitative comments provided by staff responding to the survey:

> *'It is wonderful to have this minibus as its gives service users more choice to use other facilities during the day like for day trips, museums or for sport.' (Ermine)*
>
> *'In a way it is flexible as the bus is there whenever we need it. Buses are at our disposal during the day and small groups can go out more frequently.' (Ermine)*
>
> *'Having centre based transport allows us to a lot more trips out which clients have really enjoyed. By having [our] own driver allows us to stay out longer and we are not tied down by time.' (Woodside)*
>
> *'There is more flexibility throughout the day for service users and are able to visit more community based activities.' (Keston)*

6.23 Qualitative comments provided by staff would suggest that the new locally managed transport system has been instrumental in developing new opportunities and extending the range of experiences for service users. This has evidently been well received by service users, which is reaffirming for those staff working to support them:

> *'We had a summer programme for the first time and it was successful. There were trips every day for small groups.' (Ermine)*
>
> *'Not having to return at a set time* [means that] *service users have a different range of experiences.' (Ermine)*
>
> *'The new transport system has created better opportunities for service users for outings and staff* [are] *encouraged and feel positive about the feedback that they get from the service users.' (Woodside)*

6.24 It should be noted however, that opportunities for service users to access community and mainstream activities are still restricted by the availability of staff at day centres:

'The staffing levels in the service frequently restrict outings in the minibus to the community.' (Ermine)

Staff overall perceptions of transport provision

6.25 The survey sought to assess whether staff felt that the new locally managed system of transport had brought about an improvement in transport provision and whether this had improved the support and service provided to service users. 88% of staff felt that service based transport had brought an improvement in transport provision; 68% indicated that it had brought a lot of improvement and 20% indicated that it had improved a little (Figure 25).

6.26 The perceived improvement that service based transport has brought to day centres would appear to be fairly consistent, with between 79%-100% of respondents indicating that the new transport system has precipitated some improvement in transport provision in each day centre (Figure 26). Qualitatively, there was evidence to suggest that staff throughout the day centres felt that service based transport has brought improvements to the transport service:

'I believe transport services have improved significantly since we have had new buses.' (Woodside)

'Overall I have seen lots of improvement in the transport service.' (Keston)

6.27 The survey also found that the majority of staff felt that the development of service based transport had helped to improve the support that they were able to provide to service users. Here, 89% of respondents indicated that the nature and level of support that they were able to provide to service users had improved through the development of the transport service; where 64% indicated that the level of support provided to service users had improved a lot (Figure 25).

Suggested improvements in transport provision

6.28 Analysis of qualitative responses identified a number of possible developments which could further improve the transport service for day centre service users. Firstly, staff across the day centres suggested that there needed to be a larger pool of qualified drivers/escorts so that adequate cover could be provided for annual leave, or indeed for emergency situations:

'I feel that the present service is quite effective the only drawback is that we need more drivers and escorts to deal with emergencies.' (Ermine)

'More drivers and more escorts to cover sick and AL sometimes service users are waiting at home in the morning until 10am.' (Ermine)

'[Need] to get more support workers / drivers in the service.' (Keston)

6.29 Qualitative analysis would also appear to suggest that the development of service based transport has neither been universally accepted among staff or has been an unmitigated success. With service based transport, staff have evidently had to take on new roles and responsibilities, though some staff evidently feel that this work is not recognised or not compensated for. In

addition, some staff feel that new transport duties detracted from the support that they provided for service users:

> *'Support workers miss the both the start and the end of the day at the day centre, often involving team/ staff meetings and strategic work which is bad. (LD)*

> *'....we spend the majority of the day doing transportation... since it's been [service based] transport it's been a waste as a lot of time is now wasted on transport rather than the client. (LD)*

6.30 With transport now being managed and coordinated locally, it was evident that the development of service based transport has had a considerable impact on the nature of work undertaken by many staff at the day centres. In particularly large day centres, there may be many vehicles in operation throughout the day, transporting service users to and from their home or to community activities during the day. This inevitably takes considerable coordination at each day centre, which in the views of some staff, would benefit from additional support

> *'They should appoint a person to oversee day to day transport issues – it can get very confusing trying to find out who you need to see regarding any matter arising.' (LD)*

Figure 21

Location of work:	
Ermine Road	37%
Keston Road	24%
The Grange	11%
The Haven	17%
Woodside Day Centre	11%
Duration of work:	
< 1 year	9%
1-3 years	26%
4-6 years	17%
> 6 years	48%
Nature of work:	
Driver/ support worker	26%
Escort/ support worker	24%
Day Centre Support Worker	20%
Managerial	14%
Other	18%

Figure 22

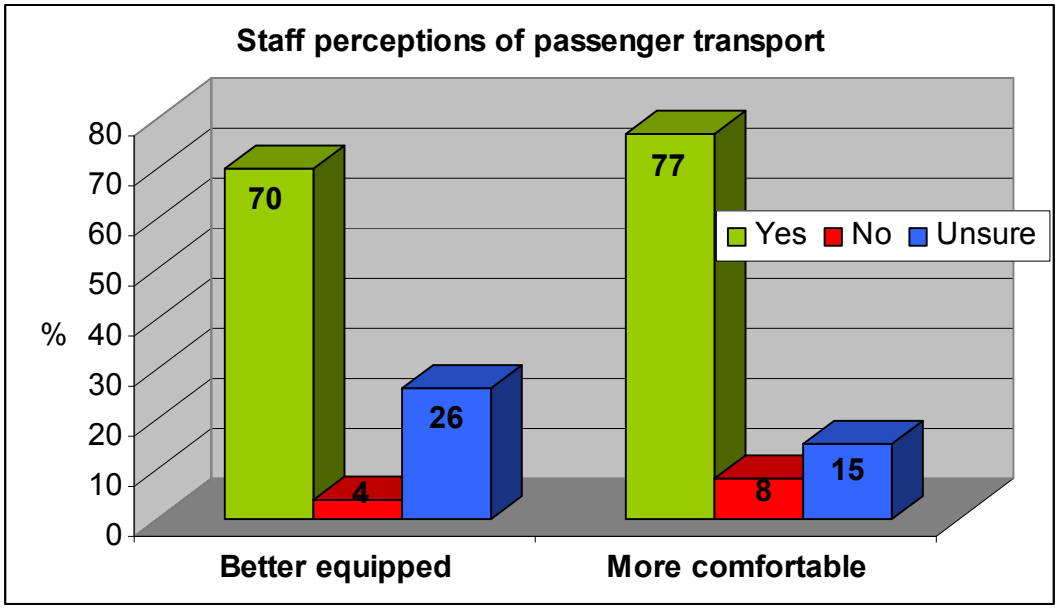


Figure 23

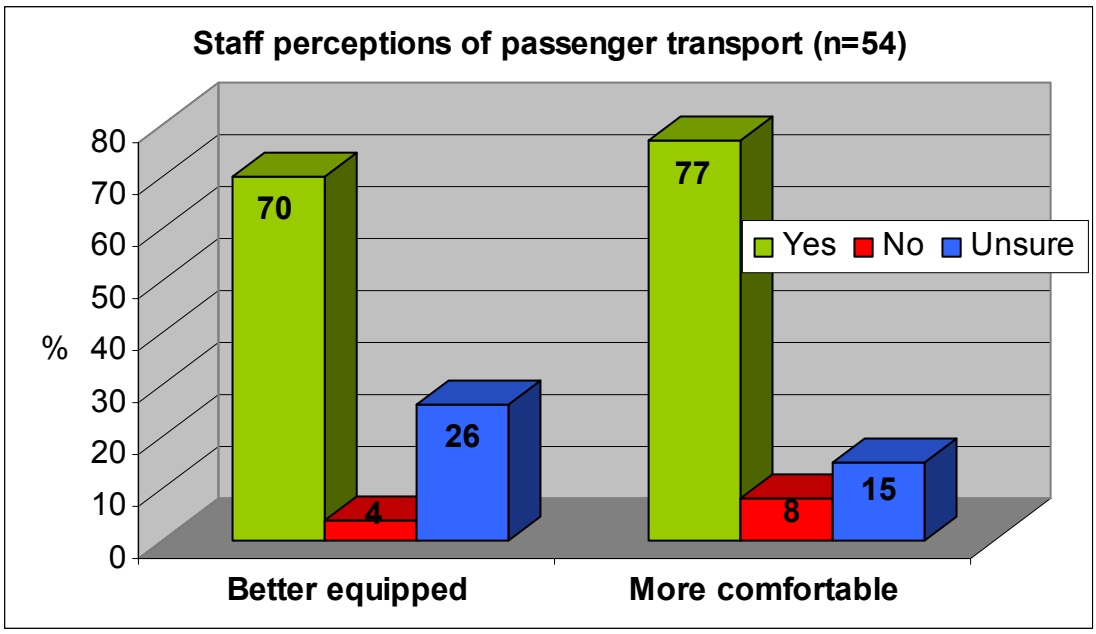


Figure 24

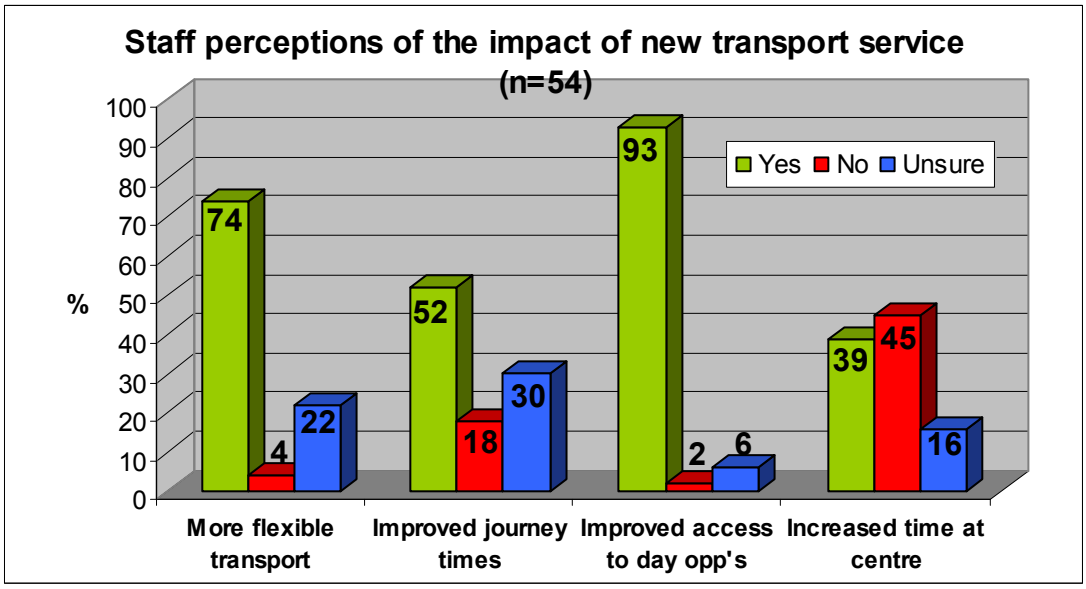


Figure 25

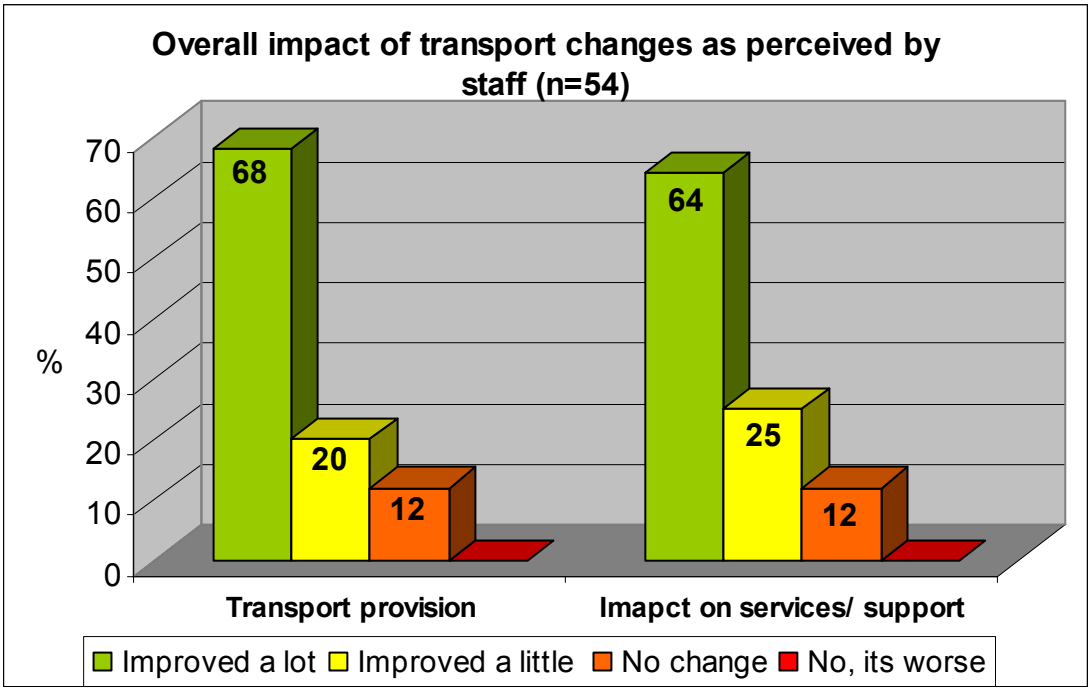
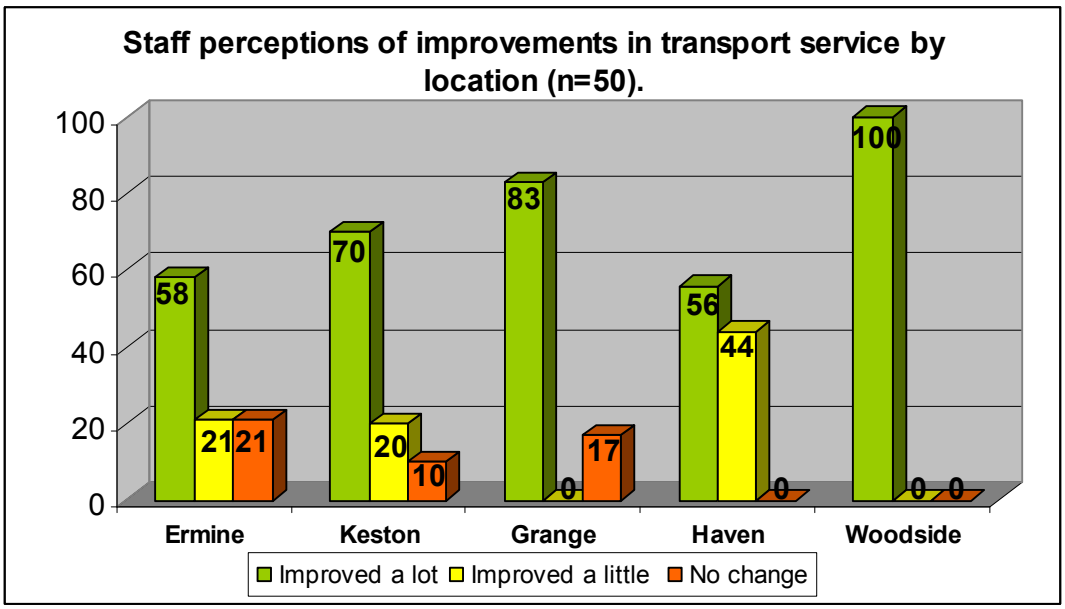


Figure 26



7. Summary of consultation responses

7.1 This final section aims to bring together data analysis from the three individual surveys with key stakeholders. Clearly there is a wealth of information in the previous sections from this report, so this section is an attempt to bring out the key messages form the service evaluation.

7.2 Firstly and most importantly, it is clear that there is a high level of service satisfaction with the new locally managed transport service among both service users and their carers:

- 95% of service users indicated that the transport service was good
- 98% of carers were very satisfied/ satisfied with the transport service to and form day centres.

7.3 In the context of the scrutiny review, it is important to record that there is evidence to suggest that transport services have improved as a result of developing a more locally managed system of transport:

- 75% of cares indicated that transport services have improved (45% indicating its improved a lot)
- 88% of staff indicated that transport services have improved (68% indicating its improved a lot)
- 89% of staff indicated that transport service have helped to improve services and support to service users.

7.4 Safety and reliability are paramount importance to carers in assessing the transportation services. It is therefore important to record that both qualitatively and quantitatively, carers indicated that they were reassured by nature and level of care provided through the transport service:

- 100% of carers indicated that the person they care for is transported safely to and from the day centre.

7.5 The punctuality of the transport service overall was recorded to be good across the services and by all stakeholders: 90% of carers and 82% of service users indicated that the bus turns up at the right time. There was however a small but significant minority of stakeholders who felt this aspect of the service could be improved further:

- Ensure that services provide a clear drop-off pick up times to carers

7.6 Similarly, journey times overall were felt to be good: 89% of service users indicated that these were good and 73% of carers felt that the duration of the journey was about right. It was acknowledged for a small minority of service users however, that journey times were unacceptably long. Traffic and congestion clearly influence journey times of service users to and from the day centre as too does the planning of individual routes that vehicles take each day. There is some evidence to indicate that journey times could be improved through better route planning.

7.7 Drivers and escorts are broadly perceived to be both friendly and helpful, indeed, there is evidence to suggest that this is integral to overall satisfaction

with the service. Overall, 98% of service users and 95% of carers indicated that drivers/ escorts were friendly. Critically, it would appear that the new system of locally managed transport has delivered consistency in the drivers and escorts, which has been instrumental in achieving a range of service improvements:

- To develop stronger relationships with service users and carers
- To improve communication between carers and day centre
- Drivers/ escorts to become familiar with the needs of service users and how bets to respond to these.

7.8 One of the key objectives of the new transport service was that it provides a transport service which is more flexible to respond to the needs of service users. Within the staff survey, 74% confirmed that the new transport was more flexible which was instrumental in increasing service user's access to further day opportunities: 93% of staff indicated that access to day opportunities had increased as a result of new transport system. Other advantages of flexible transport system:

- Improved access to transport for emergency situations
- Able to be more flexible in pick-up/ drop-off arrangements

7.9 The carer's survey highlighted that most had not needed to vary the pick-up or drop-off time for service users, though almost all felt that the system was flexible and responsive to their needs if these were required to change. Qualitatively a small number of carers indicated that improved access and flexibility of transport services would:

- Help those carers that work
- Improve access to the transport service itself

7.10 The staff survey has clearly highlighted that the implementation of the new transport system has not been unproblematic, particularly within the learning difficulties service where a number of staffing issues remain:

- Dual training of drivers / escorts not fully implemented
- Service terms and conditions are not fully accepted by staff
- There are elements of staff disaffection / low morale
- Need for a larger pool of drivers for emergency cover
- Preoccupation with transport issues over service user issues

7.11 Analysis of service evaluation data demonstrates that, comparatively, satisfaction with transport services at Keston Road Learning Disability Centre is consistently lower than that recorded at other day centres.

- 67% of service users indicated that bus turns up at right time (average 82%)
- 71% of service users indicated that journey time was ok (average 89%)
- 39% of carers indicated that journey times were too long (average (25%)
- 59% of carers felt that service improved (average 75%)

7.12 New vehicles have improved the convenience and comfort of transport to service users. Furthermore, there is some evidence to indicate that improved specifications of vehicles have improved the accessibility of day centre services for some service users. Future procurement however may wish to consider additional health and safety issues highlighted in the evaluations:

- Sliding doors
- Step accessibility

Appendix B – Research Governance Application

Haringey Council

Adult, Culture & Community Services
Internal Research/Consultation Study Plan

Details of lead researcher
Name: Martin Bradford
Job title: Research Officer
Team: Overview & Scrutiny
Location: 7th Floor River Park House, 221 High Road, London. N22 4HQ
Telephone number: 0208 489 6950
Details of research
Title of research: Scrutiny Review – Service Based Transport in Adult Social Care
Start date: 31st July 2008
Estimated end date: December 2008

What do you want to identify/achieve with the research?
The Review Panel have agreed the following objectives for the review:

- To ascertain whether the development of service based transport in adult social care has met intended aims;
  - Increased access to transport during the day for clients to access mainstream and other community services
  - More staff in service during the day to facilitate community access
  - More flexibility for service users in pick up and drop off times
  - Reduction in the time service users spend travelling
  - Improved communication / liaison between service and parent/carers
  - Greater continuity of care and improved understanding of service users needs by having dedicated and trained drivers/carers
  - Establishment of a service which is adaptable to the evolving needs of service users
  - More cost effective transport service
- To assess the strategic impact of the introduction of service based transport in relation to the remaining centralised transport service (through the JTPU) and how this relates to current transport and other borough wide strategies (i.e. Greenest Borough).
- To identify and assess good practice from service based transport which may inform the development of provision of passenger transport services elsewhere in the borough.

- To assess the overall operational effectiveness of service based transport and make recommendations to guide and inform the future development of passenger transport services throughout the borough.

How are you going to do the research?
A full description of the proposed research methods to be used within this consultation is contained in **Appendix A**.

Will your methods be qualitative, quantitative or mixed?
The evaluation will primarily utilise quantitative methods though other qualitative methods will be used at various stages the consultation process (i.e. to identify and verify survey questioning and open ended responses within surveys). A full description of the proposed research methods is contained within **Appendix A.**

Throughout its work, Haringey Council is committed to reflecting the full diversity of the community it serves and to promoting equality of opportunity for everyone. How will you ensure that equalities and diversity principles are promoted throughout the research process?

- All service users at day centers will be consulted.
- Use of pictorial surveys will be used to enable full participation from service users across day centres
- Interpreters will be available at day centres to help service users participate in the consultation (complete the survey)
- A speech and language therapist will be consulted to ensure that the format of proposed survey is appropriate and widely accessible.
- Service users will be involved in identifying and verifying questioning within the consultation and survey
- Service users will have staff assistance in helping them to complete consultation responses.

Will there be user involvement in the study (e.g. with its design, management, conduct or analysis)? Yes ☒ No ☐

If yes, please give brief details:

Please see **Appendix A.**

What are you going to do with the findings?

- Overview & scrutiny Panel meetings are public meetings thus all publications and reports that support the review process will be made public.
- Findings from the consultation will be written and presented to scrutiny review Panel meetings.
- Panel Members will consider the findings and make subsequent service recommendations within a final report. Once approved by Overview & Scrutiny Committee, this report is sent to Cabinet for response.
- Findings from the consultation will be fed back to staff, carers and service users at appropriate forums and in appropriate formats.

- Final review report will be published on the internet.

Risk assessment - Please tick the score you have given each potential risk category using the risk assessment tool (a separate document). 1 = low, 3 = high. Where the grade is higher than 1, please outline how risks will be minimised in the research if possible.

Characteristics of research participants 1 ☐ 2 ☒ 3 ☒

***Mitigation if risk graded higher than 1**:*
Consultation will be undertaken with three groups of informants: service users, their carers and staff. Whilst the latter two groups pose no significant risks, there are clear risks in consulting day care centre users given their physical and mental vulnerability and their ability to provide informed consent to participate.

- Consultation stages are undertaken in order of relative risk, minimising duplication or unnecessary questioning of subjects as the consultation progresses to more vulnerable groups.
- Consultation will incorporate predominantly quantitative methodologies so as to minimise intrusion from external personnel.
- Consent will be sought from service users through an adapted consent form (pictorial) which will clearly state:
  - that participation is voluntary
  - service users will have the right to withdraw at anytime
  - non participation will not affect service users rights to future services
  - information is given confidentially
- The consent of carers may also be sought as 'the personal consultee' of service users.
- Planned surveys are to be administered with the support of day care centre staff, as these are familiar with respondents and pose less disruption or disturbance than an external researcher.

Researcher competence 1 ☒ 2 ☐ 3 ☐

***Mitigation if risk graded higher than 1**:*
See Appendix C.

Nature of information being sought 1 ☒ 2 ☐ 3 ☐

***Mitigation if risk graded higher than 1**:*

Appropriateness of methodology 1 ☒ 2 ☐ 3 ☐

Mitigation if risk graded higher than 1:

Methods/nature of data collection 1 ☒ 2 ☐ 3 ☐

Mitigation if risk graded higher than 1:

Level of privacy for participants 1 ☒ 2 ☐ 3 ☐

Mitigation if risk graded higher than 1:

Relationship between researcher and subject/participants 1 ☒ 2 ☐ 3 ☐

Mitigation if risk graded higher than 1:
External considerations 1 ☒ 2 ☐ 3 ☐ ***Mitigation if risk graded higher than 1:***
To be completed by line manager
By returning this form electronically, I confirm that I have read the project plan form and the associated risk assessment tool and I believe that with the measures proposed the project is a level 1 risk project. **(If the risk assessment contains a number of scores of 2 or 3 it is recommended that the project is reviewed by the panel).** **Name:** **Job title: Scrutiny Manager** **Date: September 12th 2008** **By returning this form I also confirm that the conditions below have been satisfied for this project:** • **Agreement is given that these details may be uploaded to the National Research Register for Social Care** (www.researchregister.org.uk). • **Agreement is given that the findings may be published on Harinet.** • **If this is public consultation, the requirements of Haringey Council's Corporate Consultation Team will be met (see the Consultation ToolKIT in the 'Tools and Processes' section of Harinet).**

Appendix C - Transport Audit data for Learning Disabilities

Transport Audit Information 20.10.08 - 15.11.08

Ermine Road LD Day Centre	Average per week
Number of passenger journeys weekly	13.2
Number of non passenger journeys	1.6
Average mileage per bus each week	181.4
Average journey time for passenger pick up from home	74.8 minutes
Average downtime for buses	665.4 minutes
Number of community trips each week	10.6
Average distance travelled for community trips	7.4 miles
Approximate unit cost per passenger journey	28.2

Keston Road LD Day Centre	Average per week
Number of passenger journeys weekly	16.75
Number of non passenger journeys	0.75
Average mileage per bus each week	249.75
Average journey time for passenger pick up from home	80 minutes
Average downtime for buses	700 minutes
Number of community trips each week	6.75
Average distance travelled for community trips	9.5 miles
Approximate unit cost per passenger journey	20.89

Agenda Item 7

Haringey Council

OVERVIEW AND SCRUTINY COMMITTEE MEETING – 29TH APRIL 2009

Report Title. RECYCLING – SOURCE SEPERATED & CO-MINGLED COLLECTION METHODS IN HARINGEY	
Report of Councillor Gina Adamou – Chair of the Scrutiny Review Panel.	
Contact Officer : Sharon Miller – Principal Scrutiny Support Officer 0208 489-2928	
Wards(s) affected: All	Report for: Non Key Decision

1. Purpose of the report (That is, the decision required)

To present to the Overview and Scrutiny Committee the final report and recommendations of the Recycling Review of Source Separated and Co-Mingled Collection Methods in Haringey

2. Introduction by Cabinet Member (if necessary)

2.1. N/A

3. State link(s) with Council Plan Priorities and actions and /or other Strategies:

The Greenest Borough Strategy

The work of this Scrutiny Review links closely to the Council's priorities for a The Greenest Borough Strategy aimed at highlight the key environmental issues that the council needs to tackle.

4. Recommendations

That the Overview and Scrutiny Committee agrees the recommendations of the report.

5. Summary

5.4 The report sets out the findings of the Panel.

6. Chief Financial Officer Comments

6.1 Recommendations agreed by the Overview and Scrutiny Committee will be considered by the Cabinet. Some of the recommendations will have financial implications for the Council, possibly involving significant additional resources. These will need to be costed so that additional funding requirements are clearly identified either from existing approved budgets or from external bidding opportunities where appropriate, or through the Council's business and budget planning framework.

6.2 Recommendations will also have implications for the development of a new waste management contract. The Urban Environment Directorate will need to ensure it obtains best value for the Council from any new arrangements eventually agreed for delivering waste management services.

7. Head of Legal Services Comments

8. Equalities &Community Cohesion Comments

8.1 These are considered throughout the report

9. Use of appendices /Tables and photographs

9.1 Please see the report.

10. Local Government (Access to Information) Act 1985

Cleaner Environment Act 2005
Overview & Scrutiny Work programme 2009/2010

11. Background

11.1 A Scrutiny review into Waste, Recycling, Collection and Disposal was completed in April 2008. The review made a number of recommendations on a range of issues aimed at improving performance across various waste management activities within the Service. The Cabinet responded to the recommendations on 15th July 2008 and commented that the Council's own comparison of source-separated and mixed material collection methodologies demonstrated that the latter [mixed, co-mingled] was more cost effective for Haringey when this issue was examined in detail in 2006.Over 65,000 properties receive a regular collection of food and green garden waste on a weekly basis as part of the mixed recycling service, which will be extended to remaining 'kerbside' households during 2009.

11.2 Recycling Collections In Haringey

11.3 The recycling bank network in Haringey has been converted to co-mingled facilities. Panel Members suggested that Haringey should consider retaining separate paper and glass banks in some parts of the borough to preserve the quality of the recycling and achieve a better market value. The Panel also suggested that the council should consider options other than co-mingled.

11.4 The recycling banks are now part of an expanded network of recycling facilities for estates, blocks of flats and schools. It is not cost-effective to operate these separately, so the recycling banks have been converted to co-mingled so that the same vehicles can serve all sites. This has also allowed plastic bottles and cardboard to be collected, improving the service for residents living in flats above shops.

11.5 Haringey would continue to operate its existing recycling fleet for the next few years. However, a four-stream collection system could be looked at when the new waste contract is in place, as the refuse fleet could be replaced with split-bodied vehicles.

11.6 Conclusions

11.6 The debate about which of the two methods is better is ongoing. Haringey provide co-mingled services where the materials are collected from households and then taken to a Materials Recovery Facility [MRF] for sorting into constituent materials and from there are sent to the reprocessors. Some authorities operate the two systems side by side. Hackney has been running co-mingled collections systems on housing estates where there are communal collection containers and then source-separated collections for individual low rise properties.

11.6 The aim is to make recycling easier for the average householder. The view is that co-mingled collections [where all dry recyclables are placed by householders into just one bag ready for collection] are the way forward, as oppose to source separated collections [where householders are expected to separate their recycling at home for refuse workers, working “kerbside” to then put these sorted materials by hand into separate containers on their vehicles, which some believe are less efficient, both environmentally and economically. The traditional argument against co-mingled is that it gets more contaminated than kerbside. Due to advances in technology the situation has improved. Nine of the ten best performing local authorities, when it comes to recycling rates, use co-mingled collection methods and reporting up to 20% increase in recycling rates.

11.7 One of the main issues regarding the co-mingled verses source separated collections debate is the level of contamination in co-mingled collections and the reject rates from the MRFs as well as the quality of the recyclate from the MRFs and the markets for the material resulting. Some UK reprocessors are reluctant to take material that has been collected from a co-mingled service. Levels of contamination are higher for co-mingled collections compared to source separated services. However there is a need to future proof design of MRFs to take account of advancement in technology.

HARINGEY COUNCIL

Scrutiny Services

RECYCLING REVIEW
COMPARISION OF SOURCE SEPERATED AND CO-MINGLED COLLECTION METHODS IN HARINGEY

SCRUTINY REVIEW – RECYCLING – COMPARISON O F SOURCE SEPERTED & CO-MINGLED COLLECTION METHODS IN HARINGEY

RECYCLING REVIEW – COMPARISION OF SOURCE SEPERATED AND CO-MINGLED COLLECTION METHODS IN HARINGEY

1.0 Background and Terms of Reference

1.1 A Scrutiny review into Waste, Recycling, Collection and Disposal was completed in April 2008. The review made a number of recommendations on a range of issues aimed at improving performance across various waste management activities within the Service. The Cabinet responded to the recommendations on 15th July 2008 and commented that the Council's own comparison of source-separated and mixed material collection methodologies demonstrated that the latter [mixed, co-mingled] was more cost effective for Haringey when this issue was examined in detail in 2006.

1.2 One of the recommendations of the 2008 review related to the different types of collection methodologies as follows:

> "The Council should look at the conclusions of the Welsh Review into co-mingled and source-separated collections, in terms of value for money, overall environmental impact, employment considerations and the quality of the recycling. If the conclusions were to lead the Council to consider the possibility of developing the recycling service to become source-separated in the future, this should be taken into account when purchasing new collection trucks"

1.3 The Welsh Review entitled "Survey of Funding of Municipal Waste Management Kerbside Collection" considered the performance of Welsh Local authorities in the context of expenditure, income and future targets. The overall aim was to assess the current funding and future need for waste management operations in Wales, in order to meet recycling, composting and landfill diversion targets.

1.4 At the first meeting Panel Members discussed the recommendation and the merits of extending this review to cover wider issues such as the environmental impact of the various collection methods, they suggested that the terms of reference should be expanded to incorporate such issues as CO2 emission; the environment; resources; quality and destination of materials. These concerns were acknowledged together with the fact that a major recycling scrutiny has already been undertaken and Urban Environment Directorate is yet to report on implementing the recommendations contained therein. The Chair of Overview and Scrutiny Committee and the Chair of the Review Panel concurred that this review should remain a short focussed research exercise. Panel Members were also of the view that the Welsh Review had little relevance to Haringey and that a more appropriate comparison should be considered focussing on the merits of the two collection methods. The following terms of reference were agreed:

1.5 Terms of reference

"To consider the overall impact of recycling by co-mingled and source separate collection methods to include resources issues, quality of recycling and value for money"

2.0 THE REVIEW

2.1 The Panel learned that the Recycling Strategy for Haringey was approved by the Cabinet in January 2007. The Strategy outlined the objectives and key actions for improving Haringey's performance on recycling and waste reduction. In addition an appraisal of the future of the service was also carried out and the following three options were considered:

	Options	**Financial implications**
1	A 'do nothing approach where existing services would remain unchanged	£1,252,000 revenue and £0 capital expenditure
2	Wider range of materials collected through the co-mingled system	£1,277,000 revenue and £1,485,000 capital
3	Wider range of materials collected through source separated system	£,255,000 revenue and £3,030,000 capital

2.2 The [1]Cabinet elected to pursue Option 2, namely to employ a borough-wide co-mingled collection system for recycling. This would apply to kerbside services as well as facilities for flats and estates.

2.3 Urban Environment Directorate outlined the advantages of co-mingled collection to all kerbside properties as follows:

- The service would offer the best value for money overall
- The service received by all residents would be equitable
- A wider range of materials would be captured.
- The Council would be in a better position to meet locally set recycling targets and the targets set out by the North London Joint Waste Strategy.
- The service could be easily specified within the new Integrated Waste Management and Transport contract.
- Communications with residents would be much easier due to the consistent service levels across the borough and
- The Service can be adapted to use wheelie bins.

2.4 It was anticipated that this option would provide the potential for achieving a recycling rate of between 28% and 30%.

2.5 Urban Environment Directorate made a comparison between the three options in terms of the environmental impact CO2 emissions for each of the collection services. The table below shows the estimated level of CO2 emissions created by all three options.

[1] Recycling Strategy Report 23 Jan 2007

	Option 1	Option 2	Option 3
Estimated CO2 emissions	526 tonnes per annum	796 tonnes per annum	995 tonnes per annum

2.6 The two options capable of delivering higher rates of recycling, CO2 emissions under option 2 are 25% lower than that for option 3. This is due to the higher number of vehicles deployed to provide the hand sorted service. The number of vehicles that would be used under option 3 would also increase the level of congestion in Haringey.

The number and types of collection vehicles used would have an impact on CO2 emissions.

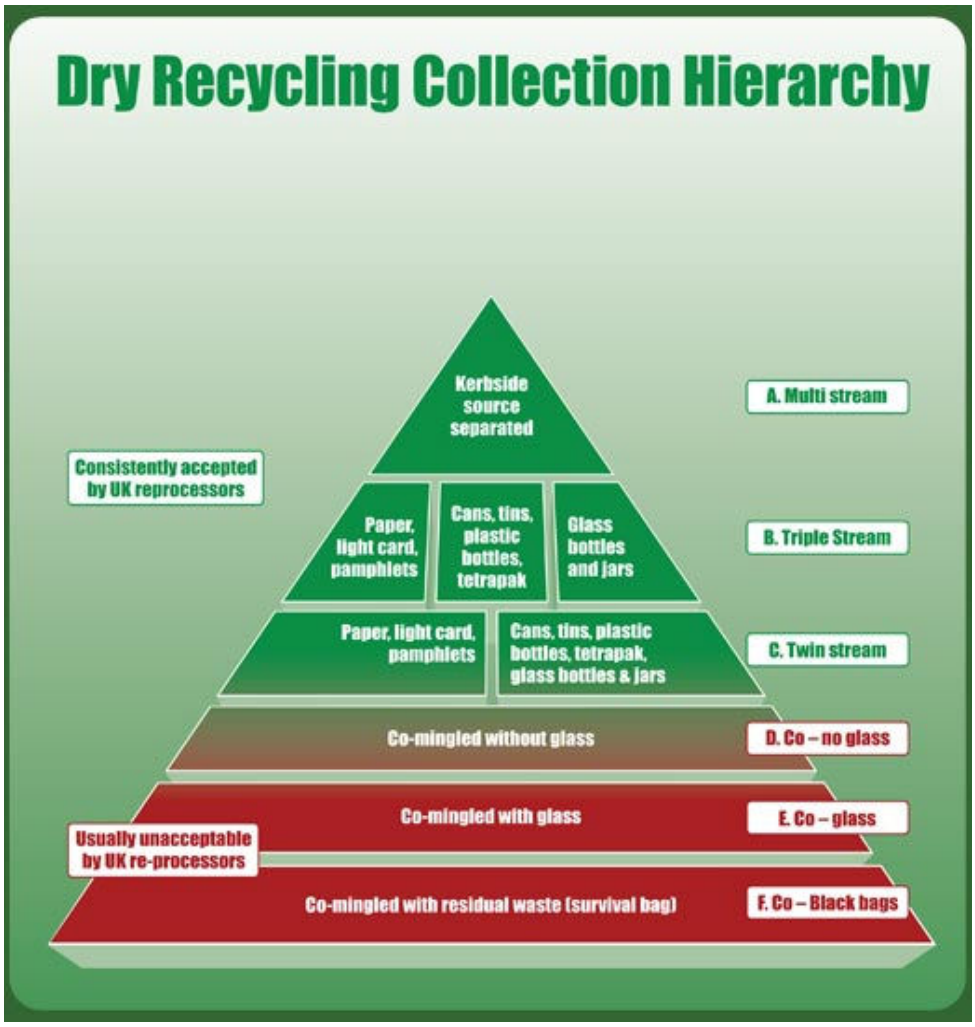
2.7 Panel Members queried the wisdom of undertaking a review at this time when the Cabinet had already made the decision to implement a co-mingled collection system in Haringey. They therefore raised the following issues:

- The timescale for the current review.
- The timescale for awarding the new Waste Management contract [originally scheduled for Dec 09].
- Proposals to incorporate the recommendations from the Recycling review into the Recycling Strategy
- How does the review relate to the Recycling Strategy?

3.0 SOURCE SEPERATED COLLECTION METHOD

3.1 A representative from The Campaign for Real Recycling was invited to address the Panel. Members heard that Real Recycling wants central government and local authorities to act urgently to improve the quality of materials collected for recycling in the UK. Their main concern is that collection systems that gather a range of different materials in one bag or bin could permanently undermine the environmental and financial benefits of recycling. Their primary aim is to influence local authority policy and practice, and build consensus within the UK of the economic and environmental importance of high quality separated collections.

3.2 According to Real Recycling, the recyclate collection [2]hierarchy [demonstrated below] focuses on the most commonly used collection systems currently practiced in the UK. The Hierarchy provides guidance on what the materials re-processing industries consider the best [and worse] collection systems currently being used. It also focuses on doorstep collection services. Bring sites have consistently provided very good quality materials but from a local authority perspective can only provide part of the recycling solution.



Dry recyclate collection hierarchy

[2] Produced by The Campaign for Real Recycling

3.3 This means that residents have one or more separate boxes for different 'dry' recyclable materials and another for 'wet' materials such as kitchen waste. These materials are collected in a way that maintains this separation, usually by placing the materials into different containers on the collection vehicle. UK reprocessors of paper and glass, clothes and aluminium prefer [and often pay higher price for] source separated materials. The improved price for materials collected can be used to offset collection costs.

3.4 According to Real Recycling during 2006-2007 local authorities reported a total of 89,000 tonnes collected for recycling from household sources as rejected for disposal at a Materials Recycling Facility [MRF] and a further 32,000 tonnes that were rejected at the gate of a recycling processor. These statistics are based on data reported by local authorities to Waste Dataflow. Expressed as a percentage, of the 1.3 million tonnes of municipal waste sent to sorting facilities, this means that over 9% of materials set out for recycling doesn't actually get recycled – however, it is does not specify how much of these materials are recyclable but which are collected anyway.

3.5 Advantages of source separation

- Increased revenue from the sale of materials from higher quality materials.
- Reduced carbon footprint – recycling into like for like materials within the UK or Europe reduces greenhouse gas emissions.
- More flexible additional markets such as batteries, textiles, etc can easily be added to the range collected.
- Better public relations - people have greater confidence that source separated waste will be recycled efficiently.

4.0 CO-MINGLED COLLECTION METHOD

4.1 Critics of co-mingled collections claim that co-mingled materials tend to be more contaminated, and that inefficient Materials Recycling Facility [MRF] processing leads to lower output quality and therefore higher rejection rates by reprocessors.

4.2 In order to make a comparison between co-mingled and source separated collection methods, the Panel invited the London Representative [who is employed by Westminster City Council] of Local Authority Recycling Advisory Committee, [LARAC] for a discussion and learned that as an officer-led organization within local government, LARAC's main purpose is to provide information and networking service and develop and disseminate good practice among its members. They are also advocates - making the voice of waste practitioners heard and ensuring that its views are taken into account when decisions are taken, regulations made and laws passed by the Government.

4.3 This role has become more important as the rate of environmental policy making has increased and Europe has become more prominent. It has become increasingly obvious that, even though trust is placed in the professional judgment and good common sense of leading Executive Committee Members, common and understood positions on matters of waste policy are needed to ensure that LARAC's message continues to be consistent, environmentally sound and representative of its membership

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Types of materials likely to be seen in a co-mingled collection bag

4.4 It was stressed that as far as recycling is concerned, the most important issues are quality and fitness of purpose. Although LARAC does not seek to prescribe what systems or processes should be used to achieve quality, LARAC will work with its members, contractors, recyclers and Waste & Resources Action Programme [WRAP] to develop appropriate specifications and promote good practice. It is LARAC's view that there are no prescribed methods of collection and a local solution was necessary to suit local needs - Whatever fits locally.

4.5 It was also stated that co-mingled collection method was likely to be the most convenient for areas with a high percentage of flats in addition to also providing bring banks sites. For example. Westminster has 87% high rise plus 200 bring bank systems this is a flexible method created to meet resident's needs.

4.6 It was acknowledged that the mix of collection and sorting methods across all authorities will always be necessary to some extent due to the rural/suburban split across authorities. Co-mingling was better suited to the complexity of people living in built-up cities whereas kerbside collection would best suit those living in more leafy suburbs with enough space for separating and sorting recyclables.

4.7 Co-mingled collections are simpler for recyclers to use, encourage higher participation, are easier and safer to operate, produce greater recyclable recovery rates, and are as cost-effective as alternative methods. Used in the right place and in the right way, at home or in the workplace, co-mingling could dramatically improve the country's recycling record.

4.8 Co-mingled collections can be single stream collection (all in one wheeled bin) or dual stream, where paper is usually collected separately from containers. If recycling is simple and takes up no more space than traditional waste disposal containers, then it's well received.

4.9 Whatever the collection method, all recyclables ultimately go to a materials recycling facility (MRF), where they are separated and cleaned for sale for reprocessing and remanufacture by the paper, plastics, metal and glass industries.

4.10 **Co-Mingled Collection Benefits Identified**

- Single container.
- High recovery rate
- Flexibility of materials that can be recovered
- Standard collection vehicle
- Lower collection costs and faster pick up times.

4.11 North London Waste Authority

4.12 Within the North London Waste Authority there are a range of dry recycling collection systems operating in North London. For example Barnet, Hackney and Waltham Forest provide a source separated collection service, whereby a range of dry recyclables are collected from householders and then the individual materials are sorted into different compartments on the collection vehicle at the kerbside. Materials are then bulked up or directly transferred to the reprocessors. It should be noted that Hackney offers a co-mingled collection service for estates and Waltham Forest are in the process of trailing co-mingled collection service in parts of the borough.

4.13 The other four boroughs Camden, Enfield, Haringey and Islington provide a co-mingled service whereby the materials collected from householders are mixed together and then taken to a materials recovery for sorting into the constituent materials and from there are sent to reprocessors.

4.14 The third variant is for a three stream recycling collection whereby all the co-mingled materials, except for paper, are collected together as and then taken to a MRF for sorting. The paper is separated and then taken direct via bulking facilities to the reprocessors, with biodegradable waste being the third stream.

5.0 RECYCLING COLLECTIONS IN HARINGEY

5.1 Officers informed the Panel that Haringey currently provides a complete waste collection service and a comprehensive weekly recycling service for residents. The council faces challenging recycling targets – including 45% by 2015 – which it is working towards through introduction of more recycling services, extra communications and waste reduction projects.

5.2 Haringey's mixed recycling collection boxes and containers can be used recycle paper, cardboard, plastic bottles, tins and cans, and glass bottles and jars. All are put together in the same container.

5.3 Over 65,000 properties receive a regular collection of food and green garden waste on a weekly basis as part of the mixed recycling service, which will be extended to remaining 'kerbside' households during 2009.

5.4 The recycling bank network in Haringey has been converted to co-mingled facilities. Panel Members suggested that Haringey should consider retaining separate paper and glass banks in some parts of the borough to preserve the quality of the recycling and achieve a better market value. The Panel also suggested that the council should consider options other than co-mingled.

5.5 Officers stated that the recycling banks are now part of an expanded network of recycling facilities for estates, blocks of flats and schools. It is not cost-effective to operate these separately, so the recycling banks have been converted to co-mingled so that the same vehicles can serve all sites. This has also allowed plastic bottles and cardboard to be collected, improving the service for residents living in flats above shops.

5.6 The Panel also learned that Haringey would continue to operate its existing recycling fleet for the next few years. However, a four-stream collection system could be looked at when the new waste contract is in place, as the refuse fleet could be replaced with split-bodied vehicles.

5.7 Transport And Waste Management Contract

5.8 Haringey's procurement work programme aims to optimise the way in which waste disposal authority and waste collection authority services are structured, so that the best overall solution in terms of collection and disposal and what is best for council tax payers, is selected. This is in relation to net costs as well as net environmental impact. Common modelling work is currently underway to assist this assessment. The Panel felt that there was a need to consider recycling in the wider context for the future, including ensuring that reprocessors are designed to fit collection systems

6.0 THE CAMDEN REPORT - CARBON FOOTPRINT.

6.1 Carbon footprint depends on the number of vehicles needed, the fuel used, and the location of bulking facilities and end processors. Recycling into like for like materials within the UK or Europe reduces the greenhouse gas emissions.

6.2 The Panel learned that the London Borough of Camden commissioned an energy audit of their current [2006/7] co-mingled weekly collection service for dry recyclables that are transported for sorting to a materials recycling facility, with their previous [2005/6] system of kerbside sorting on the collection vehicles.

6.3 The energy audit compared the overall energy, CO2 footprint and the efficiency of collection as measured by distance covered, against the functional unit of tonne of dry recyclable collected.

6.4 The [3]audit also compared commingled and separated kerbside collections - and recommended that rather than collecting co-mingled materials paper and card should be collected separately from glass, tins and cans and plastic bottles.

6.5 The audit gave Camden a detailed picture of how the Council could improve service. Camden's residents are recycling more of their waste and the Council is committed to providing the service that residents deserve such as improving the quality of recyclables by separating out paper from cardboard.

6.6 The WRAP report 'The Energy Audit of Kerbside Recycling Services' which concluded that the carbon footprint of the collection service within the borough [Camden] was 32% smaller for the co-mingled service; however the advantage is reduced to 19% when the transport to the MRF is added. The carbon footprint of the co-mingled collection system, transfer and MRF is 77% greater than for the kerbside sorted waste collection.

6.7 It was further noted that Camden have now taken the decision to introduce a 'four stream' system whereby residents will get a collection of:

- Residual waste/refuse
- Commingled [tins/cans, glass, plastic bottles]
- Separate paper/cardboard collections
- Organic waste [food and garden waste]

6.8 Camden residents will have an improved recycling service with anew separate paper and cardboard pick-up and a borough wide food and green waste collection.

6.9 The new waste collection agreement - to be rolled out from April 2010 - was approved by Camden Council's Executive on 25 February.

[3] Camden – go ahead for improved recycling service March 09

6.10 The improved service includes:

- Twice weekly domestic refuse collection.
- Weekly mixed paper/cardboard and mixed recycling doorstep collection.
- Weekly borough-wide doorstep food/green waste collection.
- Individual colour glass collections from recycling bring sites.
- Weekly borough-wide communal food waste/green waste collections from housing estates and mansion blocks.
- More schools recycling.

6.11 The changes are a result of when Camden became one of the first councils nationally to release a comprehensive report on the environmental effects of the way it collects materials for recycling at the kerbside.

"We are absolutely committed to tackling climate change and improving the environment for future generations. Getting the right solution for our recycling service means we can target our resources where they will have the most impact in meeting this important aim." –

Camden's Executive Member for Environment

7.0 VISIT TO BYWATERS WASTE MANAGEMENT AND RECYCLING SERVICES

7.1 Members of the Panel visited the recycling facilities at Bywaters in East London and saw first hand the operation of the new Materials Recycling Facility [MRF]. The MRF has been designed to process a wide range of co-mingled office and commercial dry recyables. Bywater has developed recycling and waste management solutions for a wide range of business sectors. They own and operate two sites, a 9.2 acre Recycling and Recovery Centre in Bow where they have invested £7 million installing a cutting-edge MRF, the largest undercover dry recyclable MRF in London with a capacity of 250,000 tonnes per annum.

7.2 The MRF is mainly automated to maximize efficiency and recovery rates and uses state of the art technology to recover a different material at every point of the process, generating fifteen different material streams for recycling. It is Bywater's aim to become the leading supplier of recycling and waste management services to London and the South East by making recycling easy. Bywaters state of the art MRF sort co-mingled material to the highest specifications and therefore had continuous markets for the high grade material produced.

7.3 John Glover, Bywaters Managing Director says: "In the current difficult market conditions Bywaters continues to produce high quality recovered recycled products, products that remain in continuous demand in the UK, Europe and Asia. More than 95% of all material delivered to Bywaters at Bow is recycled and therefore diverted away from landfill".

Recycling at Bywaters

8.0 OTHER ISSUES CONSIDERED

Plastics

8.1 The report "Local Authority Plastics Collection Survey 2008' was produced by Valpak Consulting in conjunction with Recoup (Recycling of Used Plastics) following a commissioned from WRAP, and is the fourteenth such survey to be produced. Approximately 182,000 tonnes of plastic bottles were collected in the UK in 2007, which is equivalent to 4,525 million plastic bottles, according to WRAP. This means that around 35% of bottles in the household waste stream are now being collected for recycling compared to only 3% in 2001.

8.2 The 2007[4] tonnage was also a hefty 68% up on the 2006 total of approximately 108,000 tonnes. Bring systems still play an important role with 19% of tonnages coming from that source in 2007. Tonnages for bring sites were up by just over 9,000 tonnes when compared to the previous survey covering 2006.

Underground recycling systems and other Innovations.

8.3 The panel discussed underground recycling systems, used in some authorities. Some systems were installed at high-rise/high density multi-occupancy council flats to encourage local residents to separate at source, certain items from their general household refuse, into the recycling stream and away from Landfill.

8.4 For example in Stockton the systems will be used for the safe and secure storage of paper, glass, tins, cans and plastics leading to increased recycling statistics on behalf of the local Borough. By storing the containers underground, Service Stockton aim to reduce local noise when glass items are deposited, and provide a more discreet and aesthetically pleasing recycling storage solution to the local community at the same time, remove the containers and their contents from potential vandalism to a more secure location. Waist high surface level receptors are shaped for the appropriate recycling materials being discarded and which will prevent general refuse from being deposited, making the systems more user friendly to the elderly and disabled persons.

8.5 The Panel felt that new major building developments in Haringey give the Council the perfect opportunity to incorporate Section 106 planning agreement to build-in underground facilities or other innovations.

[4] WRAP survey on collection of plastics by local authorities

9.0 FINANCIAL COMMENTS

9.1 Recommendations agreed by the Overview and Scrutiny Committee will be considered by the Cabinet. Some of the recommendations will have financial implications for the Council, possibly involving significant additional resources. These will need to be costed so that additional funding requirements are clearly identified either from existing approved budgets or from external bidding opportunities where appropriate, or through the Council's business and budget planning framework.

9.2 Recommendations will also have implications for the development of a new waste management contract. The Urban Environment Directorate will need to ensure it obtains best value for the Council from any new arrangements eventually agreed for delivering waste management services.

10.0 CONCLUSIONS

10.1 The debate about which of the two methods is better is ongoing. Haringey provide co-mingled services where the materials are collected from households and then taken to a Materials Recovery Facility [MRF] for sorting into constituent materials and from there are sent to the reprocessors. Some authorities operate the two systems side by side. Hackney has been running co-mingled collections systems on housing estates where there are communal collection containers and then source-separated collections for individual low rise properties.

10.2 The aim is to make recycling easier for the average householder. The view is that co-mingled collections [where all dry recyclables are placed by householders into just one bag ready for collection] are the way forward, as oppose to source separated collections [where householders are expected to separate their recycling at home for refuse workers, working “kerbside” to then put these sorted materials by hand into separate containers on their vehicles, which some believe are less efficient, both environmentally and economically. The traditional argument against co-mingled is that it gets more contaminated than kerbside. Due to advances in technology the situation has improved. Nine of the ten best performing local authorities, when it comes to recycling rates, use co-mingled collection methods and reporting up to 20% increase in recycling rates.

10.3 One of the main issues regarding the co-mingled verses source separated collections debate is the level of contamination in co-mingled collections and the reject rates from the MRFs as well as the quality of the recyclate from the MRFs and the markets for the material resulting. Some UK reprocessors are reluctant to take material that has been collected from a co-mingled service. Levels of contamination are higher for co-mingled collections compared to source separated services. However there is a need to future proof design of MRFs to take account of advancement in technology.

10.4 The review was considered in line with the Council's Community Strategy - Environmentally Sustainable Future and the Council's aim to tackle climate change and manage its environmental resources more effectively, increase levels of recycling, improve and promote sustainable transport and create sustainable and energy efficient homes and buildings and to reduce the borough's environmental footprint.

11.0 RECOMMENDATIONS

1. The Panel recommends that the council explores the option of collecting paper and glass separately from one another on its recycling services.

2. The Panel recommends that the council should consider retaining the paper and glass banks in Haringey.

3. The Panel recommends that the council commission a report on co-mingled and source separation collection methods as part of the procurement process for the new Waste Services Contract. The report should consider the costs and benefits, environmental impacts and carbon dioxide emissions of both collection systems.

4. The Panel recommends that a report is produced on the impact of the North London Waste Authority's procurement process on Haringey, with regard to co-mingled and source separated collection methods. The report should include analysis of the impact of a crash in the recyclate markets owing to the global economic crisis.

APPENDIX A

Membership of the Review Panel

Councillor Gina Adamou - Chair
Councillor Ray Dodds
Councillor Lyn Weber
Councillor Laura Edge

The Panel wish to thank all individuals who participated in the review.

Participants in the Review	
Cllr Haley	Cabinet Member – Urban Environment
Michael McNicholas	Head of Waste Management
David Rumble	Bywaters Waste Management and Recycling Services
Zoe Robertson	Environmental Resources Manager
Jon Hastings	Communications & Engagement Manager Environmental Resources Team
Phillip Robson,	London Representative of Local Authority Recycling Advisory Committee , [LARAC]
Andy Moore	Campaign Co-ordinator, Real Recycling
Cllr Sheik Thompson	Haringey Council
Sarah Mitchell	Green Party

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Agenda Item 8

Haringey Council

Overview and Scrutiny Committee **On 29th April 2009**

Report Title: **Health: Everyone's Business event**
Report of: **Councillor Bull, Chair of Overview and Scrutiny Committee**
Contact Officer : Melanie Ponomarenko Email: Melanie.Ponomarenko@haringey.gov.uk Tel: 0208 489 2933

Wards(s) affected: **All**	Report for: **[Key / Non-Key Decision]**

1. Purpose of the report (That is, the decision required)

1.1. That the Overview and Scrutiny Committee approve the recommendations laid out in the attached report.

2. Introduction by Cabinet Member (if necessary)

2.1. N/A

3. State link(s) with Council Plan Priorities and actions and /or other Strategies:

3.1. Sustainable Community Strategy outcomes:

- People at the heart of change
- An environmentally sustainable future
- Economic vitality and prosperity shared by all
- Safer for all
- Healthier people with a better quality of life
- People and Customer focused

4. Recommendations

4.1. Recommendations are laid out in the attached report.

5. Reason for recommendation(s)

5.1. Reasons for the recommendations laid out in the main report are covered within the main body of the attached report.

6. Other options considered

6.1. N/A

7. Summary

7.1. Reducing health inequalities is a key priority for the Haringey Strategic Partnership, which is working to meet challenging national targets to reduce the gaps in life expectancy and infant mortality between deprived areas and the population as a whole. This is a large, complex agenda.

7.2. Overview and scrutiny has a specific role in relation health inequalities as part of its health scrutiny powers. These powers have been used regularly in looking an inequality in terms of access to healthcare. However, healthcare is only one factor in health inequalities and is limited in its wider influence.

7.3. Scrutiny held a health inequalities scrutiny event in November to provide training for Members and Non-Executive Directors of NHS Haringey on health inequalities based on the recommendations of the Health Inequalities Audit conducted by Grant Thornton in June 2008.

7.4. The event focused on the theme “Health – Everyone’s business” to highlight the importance of the cross-cutting nature of health inequalities and the wider determinants of health, for example lifestyle factors, living and working conditions, community networks, cultural conditions etc.

7.5. For the purpose of the event the focus was health - not in the provision of health care services but the broader determinants and solutions needed to address the inequalities

8. Financial Comments

8.1. There are no financial implications arising from this report.

9. Head of Legal Services Comments

9.1. The Overview and Scrutiny Committee is empowered to do this by Section 21 of the Local Government Act 2000 as amended by Section 7 of the Health and Social Care Act 2001 and in accordance with The Local Authority (Overview and Scrutiny Committees Health and Scrutiny Functions) Regulations 2002.

9.2. The Council also has the power to implement a broad range of measures by virtue of the well being powers of Section 2 of the Local Government Act 2000.

10. Head of Procurement Comments – [Required for Procurement Committee]

10.1. N/A

11. Equalities & Community Cohesion Comments

11.1. **Education**

- Education is one of the critical factors that can determine the opportunities available to us. As such the level and quality of education can have both long and short term implications for health.
- The percentage of school children achieving 5 or more GCSE's (A*-C) is higher in the west of the borough than the East.
- Poor educational attainment has been shown to be a risk factor for teenage pregnancy, social exclusion, motivation, depression and civic participation.
- The level of qualifications held by Haringey's working age population varies significantly across the borough.
    - In Hornsey and Wood Green, only 6.8% of residents have no qualifications compared with 21.8% in Tottenham.
    - Some 54% of Hornsey and Wood Green residents have a level 4 or above qualification compared with only 24.7% in Tottenham.
    - The proportion of highly skilled Hornsey and Wood Green residents is nearly double that of England.

11.2. **Alcohol**

- Haringey has the highest rate of male alcohol-related mortality in London, and as is the case elsewhere, rising rates of alcohol-related hospital admissions.
    - Mortality rates from chronic liver disease are significantly higher for Haringey than both the regional and English average.

11.3. **Exercise**

- Physical inactivity is a significant risk factor for many diseases including ischaemic heart disease, type 2 diabetes and stroke.
    - 56.3% of respondents in the 2006 Haringey Resident's Survey reported undertaking at least 30 minutes of moderate intensity physical activity on

three or more days each week.

11.4. **Obesity**

- The estimates for obesity vary considerably across the borough, ranging from less than 10% in a middle super output areas in Highgate to greater than 25% in middle SOAs in Tottenham Hale, West Green, White Hart Lane, Bruce Grove and Northumberland Park.

11.5. **Income deprivation**

- Income deprivation in families with children is much more common in the east of the borough, particularly Northumberland Park and White Hart Lane.
- The highest concentrations of IB/SDA claimants are mainly in the east of the borough, specifically in areas in Bruce Grove, Harringay, Hornsey, Noel Park, Northumberland Park, West Green, White Hart Lane and Woodside wards. In these areas, IB/SDA claim rates range from 11.8 per cent and 15.3 per cent.

11.6. **Housing and homelessness**

- The Haringey Housing Needs Survey 2005 identified 8.9% of households are living in overcrowded conditions. Households in Seven Sisters and White Hart Lane wards are the most overcrowded (nearly 20% of households in these wards).
- In Haringey 5,400 households are in temporary accommodation (nearly 6% of all households in Haringey) - or 16,000 residents overall, including 8,000 under 18.
- In Haringey, people from some black and minority ethnic (BME) communities and young people are over-represented in the homeless population. In the borough, ethnic minority groups made up 34.8% of the local population in 2005, but accounted for 62% of those accepted as homeless in 2006/07.
- Children and young people aged 0-16 make up around 21% of Haringey's population, but accounted for 45% of those in temporary accommodation in March 2008, demonstrating the high number of families living in temporary accommodation.
- Children living in sub-standard accommodation are more prone to developmental delay, poorer educational attainment and injuries in the home. For example, when children are developing their reading skills, they need quiet.

11.7. **Domestic Violence**

- There were reports in all of Haringey's wards of domestic violence. Noel Park and Northumberland Park wards had the highest number, accounting for 10% and 9% respectively of the borough's reports (380 and 360 reports). Stroud Green, Muswell Hill, Alexandra and Highgate wards each accounted for fewer than 2% of offences.

Please see the appendices of the main report for further information.

11 Consultation

11.2 The attached gap analysis and report were written based on information provided by elected Members and Non Executive Directors and NHS Haringey.

11.2.1 Also in consultation with Haringey's Policy network, NHS Haringey's Public Health team and the Joint Director of Public Health.

12 Use of appendices /Tables and photographs

12.2 Please see Contents page in main report for appendices

13 Local Government (Access to Information) Act 1985

- Sustainable Community Strategy 2007-2016, Haringey Strategic Partnership
- Well-being Strategic Framework 2007-2010, Haringey Strategic Partnership
- Local Area Agreement 2008-2011, Haringey Strategic Partnership
- Grant Thornton Health Inequalities Audit, 2008
- Children and Young People's Strategic Plan 2006-2009, Haringey Council
- Experience Counts 2005-2010, Haringey Strategic Partnership
- Comprehensive Area Assessment Framework, Audit Commission, 2009

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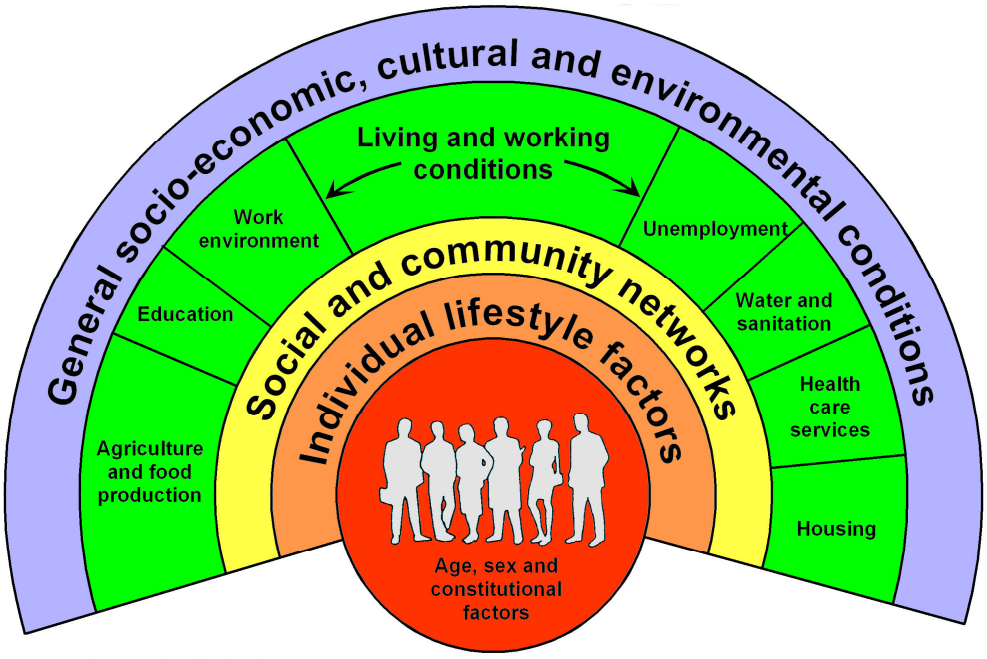
Haringey Council

Health: Everyone's Business



Source: Dahlgren and Whitehead, 1991

OVERVIEW AND SCRUTINY COMMITTEE

April 2009

www.haringey.gov.uk

Contents:

1. Executive Summary:

1.1. Reducing health inequalities is a key priority for the Haringey Strategic Partnership, which is working to meet challenging national targets to reduce the gaps in life expectancy and infant mortality between deprived areas and the population as a whole. This is a large, complex agenda.

1.2. Overview and scrutiny has a specific role in relation health inequalities as part of its health scrutiny powers. These powers have been used regularly in looking an inequality in terms of access to healthcare. However, healthcare is only one factor in health inequalities and is limited in its wider influence.

1.3. Scrutiny held a health inequalities scrutiny event in November to provide training for Members and Non-Executive Directors of NHS Haringey on health inequalities based on the recommendations of the Health Inequalities Audit conducted by Grant Thornton in June 2008.

1.4. The event focused on the theme "Health – Everyone's business" to highlight the importance of the cross-cutting nature of health inequalities and the wider determinants of health, for example lifestyle factors, living and working conditions, community networks, cultural conditions etc.

1.5. For the purpose of the event the focus was health - not in the provision of health care services but the broader determinants and solutions needed to address the inequalities.

2. Recommendations:

2.1. That the Overview and Scrutiny Committee add the following areas to the list of topics which will be considered as part of the work plan for 2009/2010.

1. Housing, particularly in relation to temporary accommodation and the impact of the recession on private sector contributions.

2. Sexual health, particularly in relation to teenage pregnancy and Chlamydia rates.

3. Physical activity, particularly in relation to behaviour change.

4. Use of green spaces.

2.2. That the Overview and Scrutiny Committee consider the attached gap analysis for other areas to be considered in the 2009/2010 work plan.

3. Background:

3.1. Health Inequalities Audit

3.1.1. Haringey's external auditors, Grant Thornton, carried out an audit to assess "the extent to which public sector organisations in Haringey understand their local health inequalities… [and] …have arrangements in place to challenge and review their actions"1. The report noted that Haringey is ahead of other organisations in South East England that it has audited, that outcomes for local people are generally moving in the right direction and also noted that it is important that this momentum continued.

3.1.2. The report also highlighted the need for joint training in public health to be enhanced at "all levels" with particular benefit seen in joint Member and Non-Executive Director training to embed partnership working further.

3.1.3. Overview and scrutiny has a specific role in relation health inequalities as part of its health scrutiny powers. These powers have been used regularly in looking at inequality in terms of access to healthcare. As an extension of this work and due to the Health Inequalities Audit recommendation Overview and Scrutiny presented an event to highlight the wider determinants of health and to link the health inequalities agenda with wider scrutiny work, e.g. housing, recreation etc.

4. Main report

4.1. **Haringey Strategic Partnership**

4.1.1. Partners on the Haringey Strategic Partnership are working together to reduce health inequalities, tackle preventable ill health and improve quality of life for Haringey's residents. The Partnership aims to help target specific resources where there is most risk of ill health developing, and so ensure that everyone has greater opportunities to lead healthier, rewarding lives as independently as possible.

4.1.2. There are six thematic partnership boards which sit under the HSP. These thematic boards have responsibility to deliver the HSP's outcomes, as laid out in the Sustainable Community Strategy, and also the Local Area Agreement (LAA) targets within their remit.

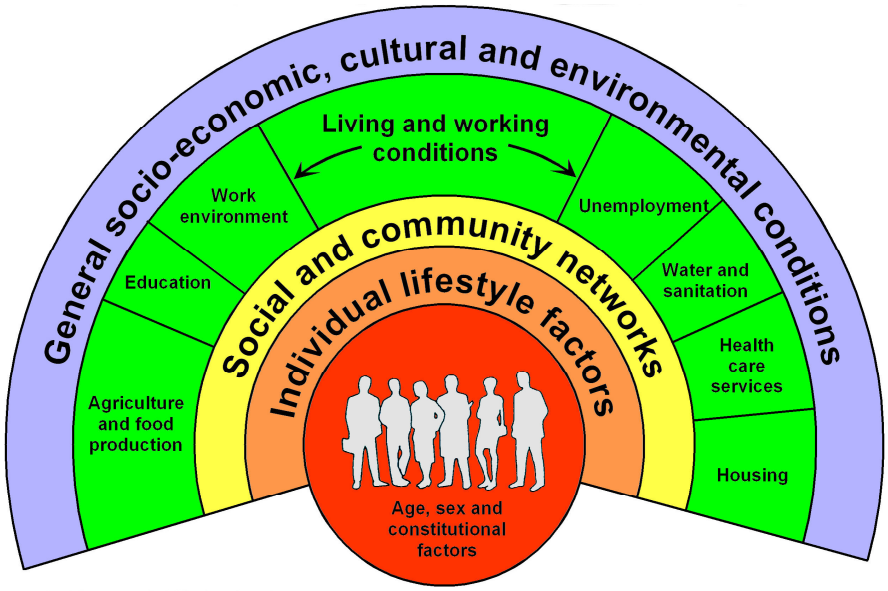
4.1.3. One of these boards is the Well-being Partnership Board. The Well-being Partnership board's vision for Haringey is that 'Everyone in every part of the borough has the best possible chance of an enjoyable, long and healthy life[2]'.

4.1.4. However, many factors combine to affect the health and well-being of individuals and communities. Although commonly considered factors such as access to and use of health care services have an impact on health and well-being, they are also determined by individual circumstances and the local environment. Factors such as where people live, inherited characteristics,

[1] Tackling Health Inequalities in Haringey, Grant Thornton, June 2008
[2] www.haringey.gov.uk

income, education, life experiences, behaviours and choices and relationships with friends and family all have considerable impact as shown in the diagram below.

Dahlgren and Whitehead. Determinants of Health



Source: Dahlgren and Whitehead, 1991

4.1.5. For this reason, it is important to remember the wider determinants of health and that reducing health inequality in Haringey is covered by the work of the all of the thematic boards under the Haringey Strategic Partnership. Each board has responsibility for tasks which fall under their remit and impact on the health of our community.

4.1.6. Examples of work carried out by other partnership boards that are essential ingredients to creating a healthier borough:

- Better Places Partnership Board is responsible for better and safer local transport and traffic management and environmental quality including reducing air pollution by encouraging less reliance on motor vehicles for transport.
- Children's and Young People's Strategic Partnership is responsible for the welfare of children and young people. It links with the Well-being Partnership Board around the transition to adulthood for all aspects of life through universal and targeted services to achieve key targets, such as reducing teenage pregnancy. Transition to adulthood presents all young people and their families with many challenges and it is important to ensure that we work together to ensure that this is a smooth process.
- Enterprise Partnership Board is responsible for achieving economic wellbeing by increasing training and employment. This includes working to increase the number of young people leaving school and entering employment or training.
- Safer Communities Partnership Board is responsible for drugs and alcohol misuse related crime, as well as protecting vulnerable adults. This includes looking at the whole drug treatment pathway from initial engagement to getting people back into their communities, for example finding work.
- Integrated Housing Partnership Board is responsible for meeting current and future housing needs. For example, developing new housing options

including long-term private sector tenancies as well as ensuring an appropriate number of Homes for Haringey and housing association lettings go to households prevented from becoming homeless.

4.1.7. Haringey's high level priority outcomes for improving the quality of life for our residents are set out in the overarching documents in Table 1.

Table 1: Overarching documents

Strategy	Aimed at	Priority outcomes
Sustainable Community Strategy	All residents	Healthier people with a better quality of life
Children and Young People's Strategic Plan	Children and Young People	5 Every Child Matters outcomes
Well-being Strategic Framework	Adults aged 18 years & over	7 Our Health, Our Care, Our Say outcomes
Experience Counts: Haringey's Strategy for improving the quality of live for older people	People aged 50 years & over	10 goals agreed by local older people

4.2. Comprehensive Area Assessment

4.2.1. As of April 2009 the Comprehensive Area Assessment (CAA) has replaced the Comprehensive Performance Assessment (CPA). The main change is a move away from a focus on service provided by local authorities (as under the CPA) and a move towards a look at the services which are provided across the partnership in a given area and the outcomes that are being achieved for the local community. The CAA will pay particular attention to those who are most at risk of disadvantage or inequality:

"*Effective local public services target effort where improvement is most needed to tackle inequalities within and between communities. This may include focusing on the particular needs of people who are disadvantaged or discriminated ….. It may also include efforts to reduce child poverty or other inequalities within communities. We will consider how well local partners know and understand the nature and extent of inequality and disadvantage within their communities and how effectively they are working to reduce or eliminate discrimination*.[3]"

4.3. "Health: Everyone's Business" event

4.3.1. The event was attended by a range of representatives from both NHS Haringey and Haringey Council, particularly Non Executive Directors of NHS Haringey and elected Members.

4.3.2. The event stressed the need for everyone to consider health inequalities in the work that they do and reminded people that health is much more than access to health care services, and that all aspects of people's work links to

[3] Comprehensive Area Assessment Framework document, Audit Commission

the health inequality agenda. For example, the impact of a planning application on the green space in an area and subsequently physical activity and mental health.

4.3.2.1. All attendees were provided with a wallet sized, with the Dahlgren and Whitehead rainbow on one side, and three top tips to remember on the other side:

1. Health is created in communities
2. Health is not evenly distributed
3. Consider the health impact

4.3.2.2. After receiving a number of presentations and taking part in an interactive quiz to draw out some issues, attendees were split into themed groups. Each group was given a briefing on some key health inequalities in Haringey. The themes were:

- Housing
- Education, Training and Skills
- Healthy Lifestyles
- Wealth and Deprivation
- Safer and Cohesive Communities
- Healthy Places

4.3.2.3. Groups were then given three questions around which to centre their discussion.

1. Are there any major inequalities that have been missed?
2. What do you consider the top three issues in the area that you are looking at?
3. What else could we be doing?

4.4. **Gap Analysis**

4.4.1. Attached to this document is a health inequalities gap analysis. Issues which were highlighted at the event have been drawn out and explored to identify some key areas in which Overview and Scrutiny could add value. Please note that the gap analysis is a snap shot of what is happening and is not an in-depth comprehensive analysis. The aim to highlight areas and provide a snap shot of what is being done/planned.

4.4.2. The criterion that has been used to draw up the table was as follows:

- Where does the issue fit under the Sustainable Community Strategy outcomes and priorities?
- Which Local Area Agreement targets are related to this issue?
- How is the partnership currently performing on this?
- What key existing and forthcoming plans are there associated?
- What key initiatives are there currently?

4.4.3. It is important to note that the gap analysis does not include everything that is taking place or is planned in an area. Nor is the gap analysis an analysis of all aspects of health inequalities in the borough, only those areas which Members and Non Executive Directors focused on at the event.

4.4.4. Further to the 'Health: Everyone's Business' event, the gap analysis was discussed at an Officer level Policy Network to fill in any gaps and the Public Health team at NHS Haringey have also contributed to the piece of work.

4.4.5. It is also important to note that the current performance associated with each Local Area Agreement and issue is as of Quarter 3 of the reporting cycle. The full year performance data will be available in May 2009.

4.4.5.1. When looking at the analysis Members should remember that even where a Local Area Agreement target is green, scrutiny may be able to add value. At the same time, where the Local Area Agreement target is red and there is currently an in-depth piece of work being done, scrutiny may not, at this time, be able to add value.

4.4.5.2. This is particularly the case when considering the Comprehensive Area Assessment's focus on outcomes for a particular area. A LAA target may be reporting as green, yet the community may still feel that there is significant work to be done in a particular area.

4.4.6. The main areas to have come out of the event, where scrutiny could add value and where they may wish to investigate in depth or receive further reports are:

- **Sexual health**
  - Particularly in relation to Chlamydia and teenage pregnancy.
- **Housing**
  - Particularly in relation to temporary accommodation and the impact of the recession on being able to meet the target. For example, with the reduced financial contribution of the private sector.
- **Physical Activity**
  - In relation to behaviour change and ensuring there is sufficient access for vulnerable and disadvantaged groups.
  - Also in relation to the impact on life expectancy and high cardio-vascular rates within in the borough.
- **Green Spaces**
  - The importance of green spaces and their impact to the wider determinants of health and subsequently health inequalities was also stressed at the event. For example allotments contribute to healthy eating, community cohesions, mental health etc.

4.4.7. However, Members may wish to focus on, or ask for further information on any of the areas which have been included in the attached Gap Analysis with a view to reducing health inequalities in Haringey.

4.4.8. It is recommended that any reports received or further work commissioned ensure that all wider determinants of health are considered, with reference to the Dahlgren and Whitehead diagram.

Appendices

APPENDIX 1

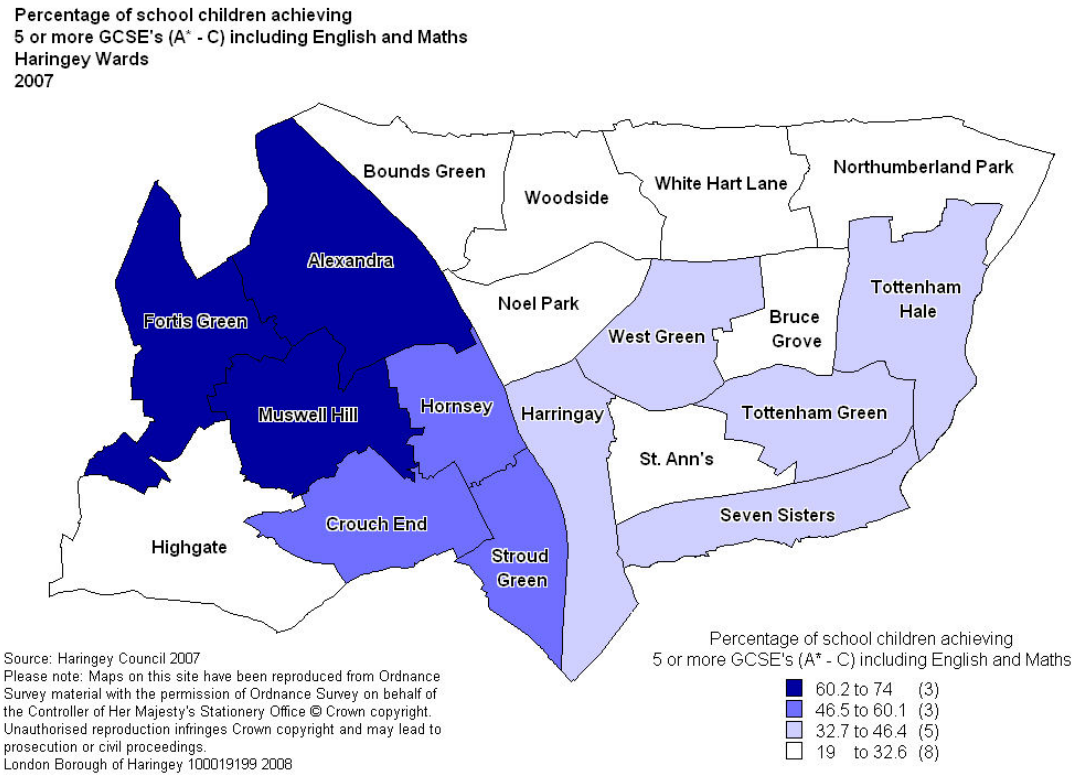
Education, Training and Skills

1.0 Introduction

Educational success has a dramatic impact on a person's quality of life and wellbeing. A strong positive relationship exists between education and health outcomes whether measured by death rates (mortality), illness (morbidity), health behaviours or health knowledge[4]. Poor education can also keep families excluded, as it has a pivotal role in the intergenerational transmission of social exclusion.

2.0 Where are the Health Inequalities in Haringey?

- Education is one of the critical factors that can determine the opportunities available to us. As such the level and quality of education can have both long and short term implications for health.
- The map below shows the percentage of school children achieving 5 or more GCSE's (A*-C) is higher in the west of the borough than the East. (*N.b A number of children and young people living in Highgate attend school outside the borough explaining the low figure for this ward*).
- Poor educational attainment has been shown to be a risk factor for teenage pregnancy, social exclusion, motivation, depression and civic participation.



2.0 Adults' skills and qualifications

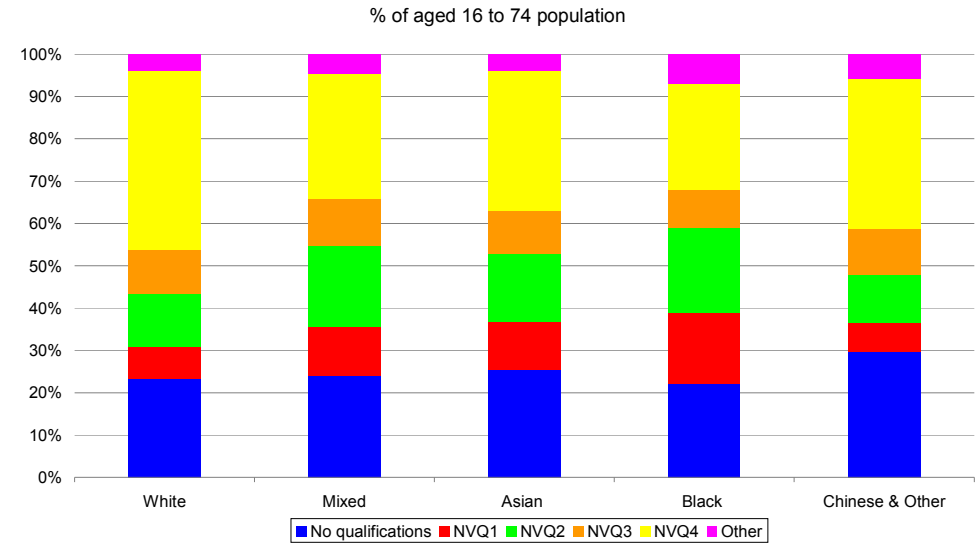
- The level of qualifications held by Haringey's working age population varies significantly across the borough.
    - In Hornsey and Wood Green, only 6.8% of residents have no qualifications compared with 21.8% in Tottenham.

[4] Institute of Public Health, Ireland

- Some 54% of Hornsey and Wood Green residents have a level 4 or above qualification compared with only 24.7% in Tottenham.
- The proportion of highly skilled Hornsey and Wood Green residents is nearly double that of England.

- There are more white people in the borough that are highly skilled than any other ethnic group; 42.3% have level 4 or above qualifications compared with 24.9% of black people, 29.3% of people of mixed ethnic origin and 32.9% of Asian people.

Figure xx: Qualifications by ethnicity, Haringey, 2001



Source: 2001 Census Standard Table

Learning opportunities for adults and older people have been shown to lead to improvements in health and wellbeing including emotional resilience, more active social lives, and greater community involvement.

3.0 Initiatives to address Health Inequalities

- Haringey mentoring project for children in care supports our young people's educational aspirations, increases their self esteem, confidence and sense of well-being and encourages their participation in social networks and group activities.

- Course aimed at teenage parents and another at pregnant teenagers, (run through CoNEL, Keeping It Simple, 14-19 & Teenage Pregnancy coordinator) which is a portfolio based course from basic skills to eventually NVQ which accredits study to prevent NEET (Not in Education, Employment or Training) but is linked to SWIM sessions and sports centre membership / reduced fees. Childcare / child-friendly study environment.

- NVQ level 2 & 3 courses for parents/carers & community members including governors in Speakeasy programme – to enable adults to talk comfortably about 'growing up'. Now in 4th year of programme.

APPENDIX 2

Healthy Lifestyles

1.0 Introduction

Lifestyle behaviours have a significant impact on people's health and wellbeing, but healthy lifestyles are more common and more attainable among wealthier and better educated communities.

2.0 Where are the Health Inequalities in Haringey

2.1 Alcohol

- Haringey has the highest rate of male alcohol-related mortality in London, and as is the case elsewhere, rising rates of alcohol-related hospital admissions.
    - Mortality rates from chronic liver disease are significantly higher for Haringey than both the regional and English average.

- Alcohol is also linked to violent crime in the borough (10% of all violent crime in the borough is recorded as alcohol related).

2.2 Exercise

- Physical inactivity is a significant risk factor for many diseases including ischaemic heart disease, type 2 diabetes and stroke.
    - 56.3% of respondents in the 2006 Haringey Resident's Survey reported undertaking at least 30 minutes of moderate intensity physical activity on three or more days each week.

- In June 2008, interim (half yearly results) from the latest Active People survey was published which though not statistically valid because of the small sample size, reported a drop in the headline participation indicator of 3.9% from 2006. This appears to be part of a London wide trend with participation across London reducing by an average 2.7%.

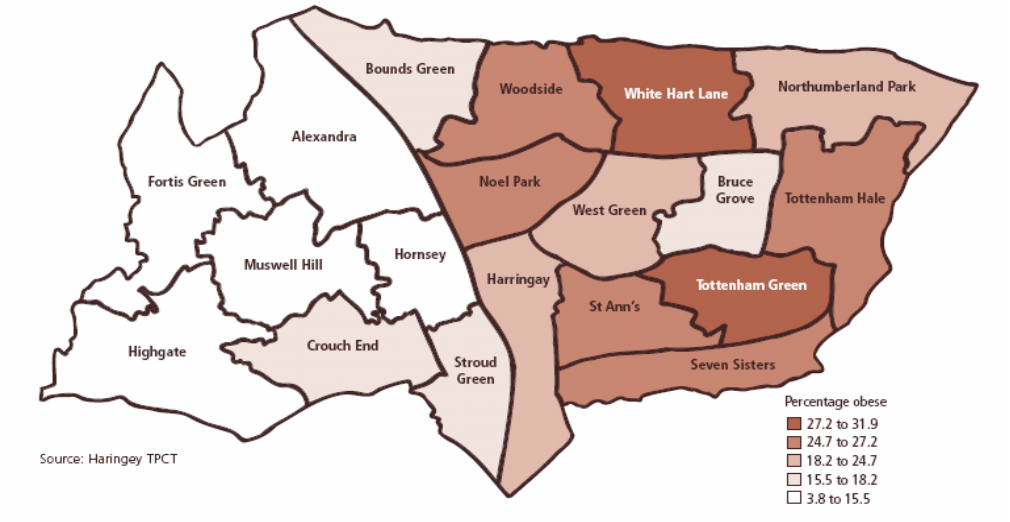
2.3 Obesity

- The estimates for obesity vary considerably across the borough, ranging from less than 10% in a middle super output areas in Highgate to greater than 25% in middle SOAs in Tottenham Hale, West Green, White Hart Lane, Bruce Grove and Northumberland Park.

- 8% of residents registered with a GP in Haringey were recorded as obese in March 2008.
    - Obesity rates were highest in the north and central general practice collaboratives (8.9% and 9.7%) respectively, followed by 8.4% in the east collaborative.
    - The lowest obesity rate was recorded in the west collaborative (5.5%).

- In 2007, 18% of Haringey School children weighed were considered to be obese, and a further 14% were overweight.
    - This varied by age, 24% of year 6 children were obese compared to 13% in reception year. These figures are currently above the national predicted levels for 2010.
    - There is also a variation between males and females with a higher proportion of boys considered overweight or obese.

Figure 52 Percentage of obese year 6 children by ward (June 2006)



2.4 Smoking

- Smoking is currently the principal avoidable cause of premature death and ill health in England and a major cause of health inequalities.
    - Reducing prevalence is therefore a key priority in improving the health of the population in Haringey, particularly in the more deprived boroughs, where smoking rates tend to be higher.

- Highest smoking prevalence of between 29 and 33% is predicted for MSOAs in Noel Park, Tottenham Green, Northumberland Park, Tottenham Hale and White Hart Lane.

- Prevalence of smoking tends to be lower in Black African, Indian, Pakistani, Bangladeshi and Chinese minority ethnic groups than England as a whole, whereas Irish respondents were more likely to be current smokers.

3.0 Initiatives to address Health Inequalities

- There are many healthy lifestyle initiatives underway in the PCT, including the smoking cessation service, Active for Life GP referral scheme, and the development of social marketing campaigns.

- In order to achieve the 26.9% target, the Council, with our partners, are proposing to launch the HARIACTIVE campaign from April 2009. This campaign is an innovative approach towards achieving a challenging target which will require the Council and partners to be focused and sophisticated in using high quality marketing information to influence and change local people's behaviour in respect of physical activity participation

- School Travel Plans - actively encouraging as many children, parents and staff to walk or cycle to school to boost their health and well-being.

- Libraries for Health programme attracted over 10,000 participants in 2007/2008 and is attracting greater numbers this year. The programme focuses on key health issues identified in "Choosing Health" and addresses:

    - Diet and nutrition (A weight management programme is offered in all libraries)
    - Increasing exercise participation (The Library Walkers walk from major libraries, accompanied by a trainer)
    - Improving mental health (Libraries are the most popular venue for stress counselling which is provided by the TPCT and also hold "Stretch your mind and stretch your body" classes funded by the BBC's Headroom programme)
    - Sensible use of drugs and alcohol (We work in partnership with BUBIC and DASH)
    - Smoking cessation (Monthly information and support sessions are held which provide health checks and practical support.)
    - Improved sexual health. (Support is provided in partnership with 4YP, PASCH and Gyachanda and Hunt)

- Learning relating to Health is also provided through the HALS programme: courses are held relating to a range of exercise activities, including yoga for all levels, Pilates, Tai Chi for stroke survivors, free salsa for the over 50's etc.

- Work with Spurs on healthy eating, parenting and healthy lifestyles for 20 schools with higher levels of; Children in Care, Free School Meals, Mobility, as part of a family programme and focus work in schools with children. For example cooking classes run on Saturdays at the Sixth Form Centre.

- Haringey been selected to run national research evaluation of Teens and Toddlers intervention programme (preventing teenage pregnancy) funding provided from a national source. We have been running this programme for 3 years and Department of Children, Schools and Families/NHS wants to do a larger scale project evaluation targeting over 100 young people at risk.

APPENDIX 3

Wealth and deprivation

1.0 Introduction

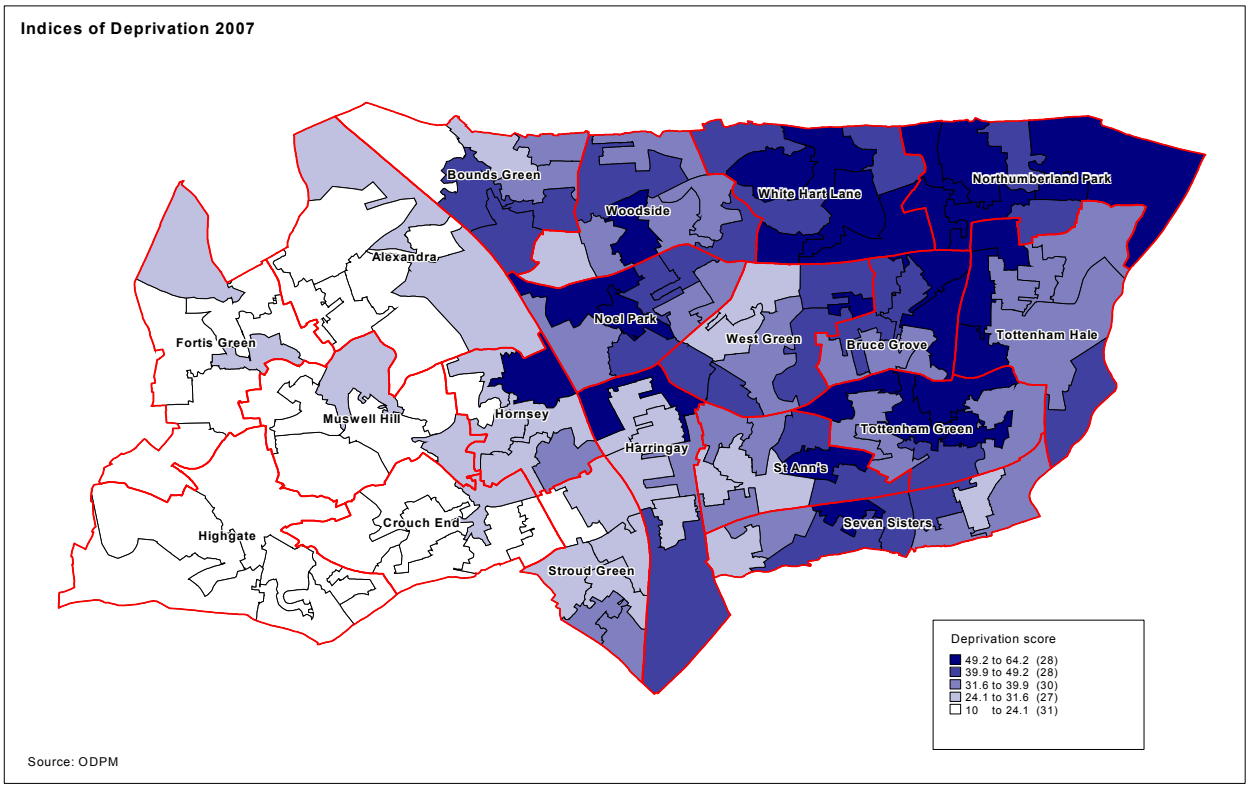
Employment is one of the most important determinants of health. Having a job or an occupation is an important determinant of self-esteem. It provides a vital link between the individual and society and enables people to contribute to society and achieve personal fulfilment. The World Health Organisation identifies a number of ways in which employment benefits mental health. These include the provision of structured time, social contact and satisfaction arising from involvement in a collective effort.

Levels of disposable income affect the way we live, the quality of the home and work environment, and the ability of parents to provide the kind of care for their children they want to. The relationship between poor health and low income exists across almost all health indicators.

Where are the Health Inequalities in Haringey?

- Fig X shows the distribution of deprivation in the Borough by SOA. It shows that areas in Haringey that have the highest deprivation scores are in the East of the Borough, particularly the north east, in White Hart Lane and Northumberland Park.

Fig X- IMD 2007- SOA level



- The level of poverty in London, particularly child poverty, is a major long-term cause of health inequalities across the city. Levels of poverty and deprivation correlate closely with levels of poor health. Action to reduce income inequality is therefore a high priority.

- Some of the most obvious effects of health inequality are seen in:

o Premature mortality and morbidity
  - Infant mortality rates tend to be higher in the more deprived communities.

    - Low birth weight: Inappropriate nourishment or smoking can reduce infant and pre-natal development.
- Mental health problems: Stress and depression reduce parents' stimulation of the child and disrupt emotional attachment.
- Health related behaviours: Smoking, poor diet and lack of exercise (for example) are more common in lower income social groups.

- Income deprivation in families with children is much more common in the east of the borough, particularly Northumberland Park and White Hart Lane.

2.1 Employment

- Unemployment is a significant risk factor for a number of health indicators. Unemployed people are found to have:
    - Lower levels of psychological well-being which may range from symptoms of depression and anxiety through to self harm and suicide.
    - Higher rates of morbidity - such as limiting long term illness.
    - Higher rates of premature mortality, in particular for coronary heart disease and injuries and poisoning including suicide.

- People with poorer health are more likely to be unemployed - this is particularly true for people with long term disabilities.
    - Across Haringey, there remain persistent pockets of unemployment deprived areas. This is particularly true in Northumberland Park where, in certain parts, JSA claim rates reach as high as 16.7 per cent – nearly four times the borough average and nearly eight times the national average.
    - Estimates from the GLA show Northumberland Park to have the highest JSA claim rate out of all wards in London[5].

- The highest concentrations of IB/SDA claimants are mainly in the east of the borough, specifically in areas in Bruce Grove, Harringay, Hornsey, Noel Park, Northumberland Park, West Green, White Hart Lane and Woodside wards. In these areas, IB/SDA claim rates range from 11.8 per cent and 15.3 per cent.

3.0 Initiatives to address Health Inequalities

- Haringey Guarantee - a public/private partnership programme where priority groups are targeted for training and guaranteed job interviews with local employers.
    - Families into Work will be a key project of the Haringey Guarantee – a special family focused dimension to the Guarantee.

- In addition to the Claim It campaign run for all residents, special focus on reducing Child Poverty through a similar campaign for parents/carers through schools, focused in areas where deprivation is high but benefit take up is low. Ten schools signed up.

- The Council is working in partnership with the Citizen's Advice Bureau in running 'Reaping the Benefits', a project aimed at driving up benefit and tax credit take-up, and delivering debt counselling in eight different venues in Northumberland Park, Bruce Grove and Noel Park.

    - As of the beginning of 2008 the project has dealt with more than 950 enquiries and generated over £200,000 in extra benefits for residents that would

[5] GLA (2007) *Claimant count data by age, gender and duration for London boroughs and wards, October 2007*: GLA Data Management and Analysis Group.

otherwise have gone unclaimed in some of the most deprived areas of the borough.

APPENDIX 4

Housing

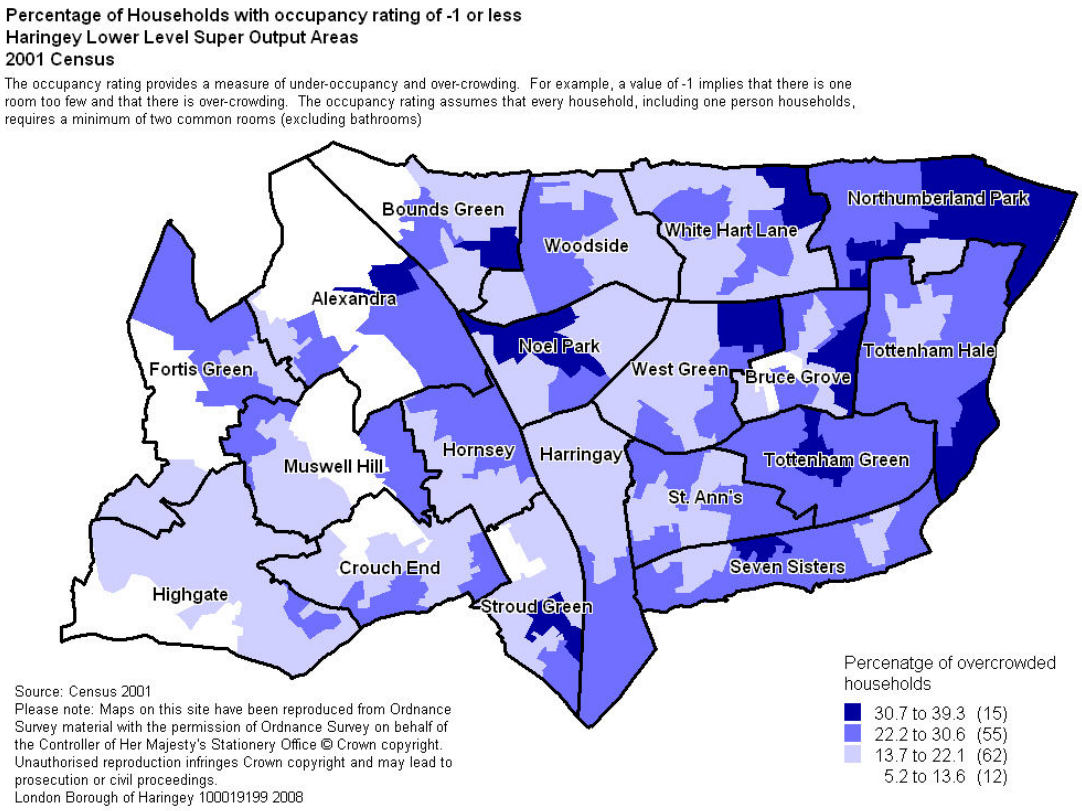
1.0 Introduction

The physical environments in which people live - their homes and Neighbourhoods - have a significant bearing on their health. Good quality housing is conducive to good physical and mental health. Improving the availability and quality of housing in an area can help to tackle poverty, particularly fuel poverty, cut crime, strengthen communities and, through these changes, lead to improvements in health. Decent housing is a prime requisite for health, as is reducing overcrowding and homelessness. Provision of a reasonable standard of accommodation for all will have health benefits for the most disadvantaged in society; in the long term it may even lower health care costs. The improvement of poor housing was a key driver for earlier public health reform initiatives.

2.0 Where are the Health Inequalities in Haringey?

2.1 Overcrowding

- The Haringey Housing Needs Survey 2005 identified 8.9% of households are living in overcrowded conditions. Households in Seven Sisters and White Hart Lane wards are the most overcrowded (nearly 20% of households in these wards). Households in the more affluent Fortis Green and Muswell Hill areas were the least overcrowded (around 1% of households in the wards).



2.2 Homelessness and Temporary Accommodation

- In Haringey 5,400 households are in temporary accommodation (nearly 6% of all households in Haringey) - or 16,000 residents overall, including 8,000 under 18.
- In Haringey, people from some black and minority ethnic (BME) communities and young people are over-represented in the homeless population. In the borough, ethnic minority groups made up 34.8% of the local population in 2005, but accounted for 62% of those accepted as homeless in 2006/07.

- Children and young people aged 0-16 make up around 21% of Haringey's population, but accounted for 45% of those in temporary accommodation in March 2008, demonstrating the high number of families living in temporary accommodation.
- Children living in sub-standard accommodation are more prone to developmental delay, poorer educational attainment and injuries in the home. For example, when children are developing their reading skills, they need quiet.

2.3 Unsuitable Housing

- Haringey has a high number of homes that do not meet the 'decency' standard. In June 2006, 44.5% of social housing in Haringey was non-decent. Tottenham and Wood Green have higher levels of non-decent properties than the borough average.
- "Support needs[6]" households are almost twice as likely to be living in unsuitable housing as non-support needs households. 32.2% of all support needs households are living in unsuitable housing, which compares with 20.9% of all households and 18.1% of all non-support needs households.
- The usual definition of fuel poverty is of a household which spends more than 10% of their income on keeping themselves warm. The fuel poverty indicators from the Centre for Sustainable Energy rank Haringey as 230th out of 304 local authorities, with 5.7% of households deemed to be in fuel poverty. (Ranking of 1 = lowest level of fuel poverty in the country, and 304 highest).
- Impacts of poor housing on health include cold (negative impact on respiratory and heart disease, as well as chronic obstructive pulmonary disease (COPD), damp and mould (75% of asthma sufferers are sensitised to mould spores, increased levels of tuberculosis in properties that are poorly ventilated, poorly heated and overcrowded), increased accidents and falls (causing physical injury), social isolation (causing mental health problems/depression)

3.0 Initiatives to address Health Inequalities

3.1 Overcrowding

Current initiatives include:

- Hostel deconversion programme delivering much needed large sized accommodation (1 x 7 bed and x 5)
- Working with RSL partners to increase the proportion of larger size units on new build schemes.
- Increase in priority awarded to under occupying households to encourage the freeing up of family homes. Further work to be done on reviewing incentives offered.

3.2 Reducing the use of temporary accommodation

There is now a steady fall in the number of households living in temporary accommodation. As at 7 November there were 4,808 households living in TA. The Council target is to reduce the number to 2,600 by 2010. A number of initiatives are helping us to achieve the reduction, including:

[6] Households with a member requiring support by support needs: frail elderly, physical disability. Learning disability, mental health problem .

- Supporting households to access private rented accommodation through the provision of comprehensive advice and the payment of rent in advance and deposits.
- Helping survivors of domestic violence to remain in their own homes, where they choose to do, through support to achieve injunctions and the installation of Sanctuary schemes.
- Providing benefit and money advice to households who are facing eviction.

3.3 Delivering decent homes

- £198.5million, phased over a six year period, to support the delivery of the decent homes programme.
- Haringey's decent homes programme, will involve the refurbishment of more than 11,000 council homes
- Works undertaken under the decent homes programme include: the installation of replacement double glazed windows, kitchen and bathroom refurbishment, multi lock 'secure by design' front entrance doors, renewed fascias, soffits and rainwater goods, and roof works where required.

3.4 Tackling fuel poverty

- Through the North London sub region approximately £500,000 is available each year to provide new heating system and energy efficiency measures for households in receipt of the main means tested benefits.
- Thermal image of borough completed, which is being used to target activity and outreach sessions to reach those most likely to be in fuel poverty. Fuel poverty Officer actively sign posts households to assistance available to them e.g. Warm Front scheme.

APPENDIX 5

Safer and Cohesive Communities

1.0 Introduction

Social capital[7] has been linked to health, and there is increasing recognition that the context of people's lives, their social networks and the neighbourhoods in which they live are related to their quality of life and health. Those with high stocks of social capital are more likely to remain healthy and are quicker to recover from illness. Social inequalities directly undermine community cohesion.[8]

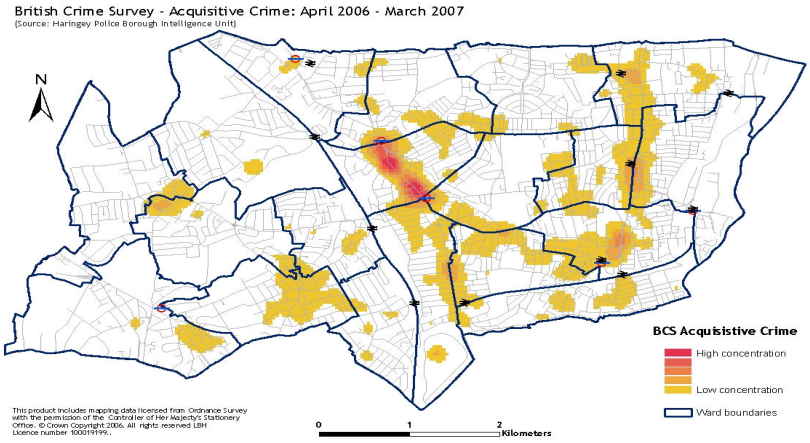
Although Haringey is a very diverse, multi-cultural borough, its many communities generally get on well together. In 2007, 80% of residents agreed that 'the local area is a place where people from different backgrounds get on well together' – the same as in 2006, and roughly comparable to most other similar boroughs.

Crime and fear of crime are both strong negative predictors of community cohesion.[9] Sustainable health is achieved when people and communities can take control of their lives and are able to live their lives to the full. A safe environment free from crime or fear of crime contributes significantly to an individual's sense of well-being.

2.0 Where are the Health Inequalities in Haringey?

2.1 Crime

The following map show hotspots for BCS acquisitive for 2006/07 across Haringey. They illustrate the split between the east and west of the borough, with the majority of crimes occurring in the east. However, these crimes do occur in the west, in particular the shopping areas around Crouch End and Muswell Hill.



Map showing hotspot locations across the borough of BCS acquisitive crimes

2.2 Youth crime

- There were 275 more victims of crime aged from 10-17yrs from January to June 2008 than throughout July to December 2007 (this represents a 26% increase)

2.3 Anti-social behaviour

[7] The definition used by ONS is "networks together with shared norms, values and understandings that facilitate co-operation within or among groups"
[8] Community Cohesion – an action guide LGA, 27 October 2004
[9] Crime reduction and community safety: The crucial role of the new local performance framework DCLG February 2008

- There were 761 calls to the Anti-Social Behaviour Action Team (ASBAT) regarding ASB in 2006/07. This was 2% lower than in 2005/06.

2.4 Domestic Violence

- There were reports in all of Haringey's wards of domestic violence. Noel Park and Northumberland Park wards had the highest number, accounting for 10% and 9% respectively of the borough's reports (380 and 360 reports). Stroud Green, Muswell Hill, Alexandra and Highgate wards each accounted for fewer than 2% of offences.

2.5 Accident & Injuries

- Road traffic accidents are the leading cause of accidental fatalities in children and young people- Between January and December 2006, 15 children between the ages of 0-15 were killed or injured in road traffic accidents in the borough.

3.0 Initiatives to address health and inequalities

- We have widely advertised Haringey's Domestic Violence Advice and support centre, Hearthstone, in the Maternity and A&E departments at North Middlesex and the Whittington. We have carried out targeted outreach with hospital staff to distribute Hearthstone phone number for Domestic Violence information stalls and organised seminars.

- The London Boxing Academy provides full-time education for young people who would otherwise be excluded from school. A GCSE timetable is structured around sporting activity, not exclusively boxing. There are currently 32 students from Haringey. Existing monitoring suggests that none of the young people are involved in offending behaviour during their time with the Academy.

- In Haringey, the Drug Intervention Programmes and Prolific and Other Priority Offenders (PPO's) programmes have been effective. There is evidence to show that convictions are reduced for PPOs while on the schemes and immediately after leaving.

- *The Mayor's Road Safety Plan* has set a target to reduce child casualties by 60% by the year 2010. Haringey has made road safety a specific priority in the Children and Young People's Plan. Haringey currently has 62 School Travel Plans (STP) and a further 18 submitted to DfES. This equates to 95% of maintained schools within the borough having STPs approved or to be approved.

APPENDIX 6

Healthy Places

Almost every planning decision or policy has a potential effect on health. Improving the design of the environment in which people live and work and providing high quality, well-maintained open space has been shown to have positive effects on both physical and mental health. Providing safe and convenient parks to allow physical activity, mental and physical well being is promoted and obesity prevented.[10]

Availability of healthy food is an important aspect of where we live. 'Food deserts' are those places where people do not have adequate opportunity to purchase healthy fruit and vegetables at a reasonable cost.

Well-designed areas are also more conducive to the use of healthy forms of transport such as walking or cycling, and the use of public transport. The availability of accessible and low cost transport has indirect health benefits as it enables participation in training, employment, and social and cultural activities. It is particularly important for certain groups such as households on low incomes, older people, disabled people, and children.

1.0 Where are the Health Inequalities in Haringey?

1.1 Pollution

- Local environmental quality has significant impacts on health. Studies have shown that higher mortality is seen on days with high pollutant concentrations and in areas with high pollutant levels. Hospital admissions particularly for respiratory and cardiovascular diseases are also linked to pollutant levels, in particular affecting children and young people.

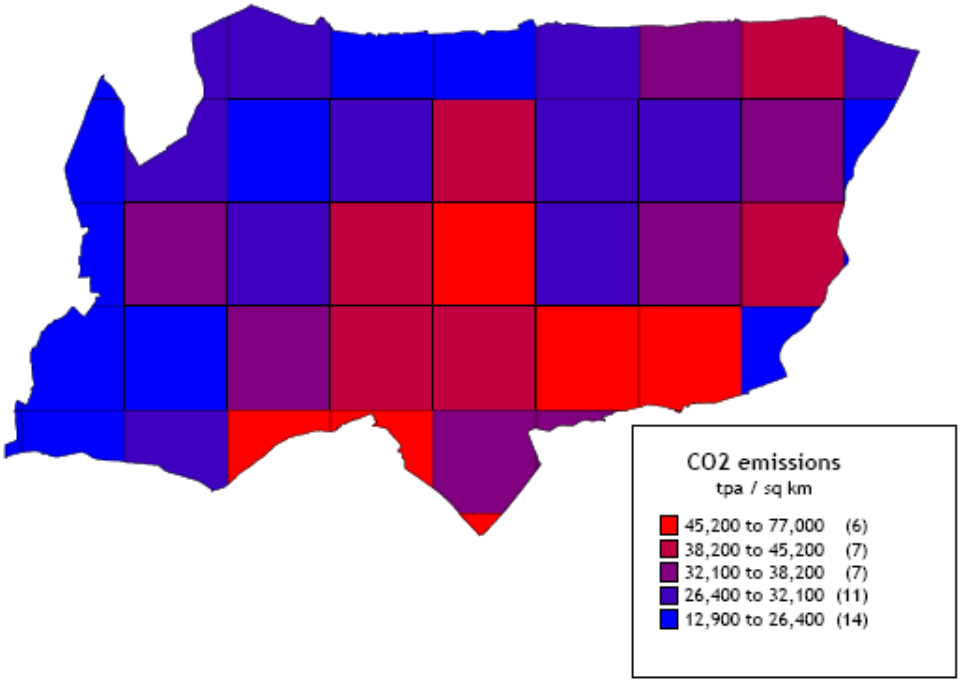
- Traffic congestion and associated air pollution can affect health. In Haringey, as expected, NO2 pollution is concentrated around the borough's major roads.

- There are strong links between environmental quality and deprivation. Many areas with poor air quality, high levels of noise and deficiencies in quality green space tend to also have high levels of deprivation.

- Map 1, shows CO2 emission levels across the borough, for domestic and non-domestic settings, reveals that emissions tend to be lower around the more residential and more affluent western edge of the borough and higher in the south, Centre (Wood Green) and east of the borough.

Map 1: CO2 Emissions density Map for Haringey (2003)

[10] www.healthyurbandevelopment.nhs.uk



1.2 Litter and Detritus

- Litter can be dangerous, unhealthy, and it can persist in the environment for a very long time. If an area is heavily littered, it can lead to the 'broken window' effect – more litter, dumping of rubbish, flyposting, graffiti and vandalism. It effects local communities and the people who live there and can also have a detrimental effect on the local economy and on tourism.

- The proportion of streets with unacceptable levels of litter has reduced from 21% in 2007/08 to below 9%. The target for this year is 12% (NI 195a and LAA target). The score for unacceptable levels of detritus has also improved from 34% in 2007/08 to 21%, against a target of 24%. Higher levels of litter and detritus have been found in some wards in the east of the borough.

1.3 Access to goods, services, people and jobs

- The main purpose of transport is to travel from one location to another to obtain access to services (eg education, health or social care), goods (eg shops), or people (particularly friends and family). Facilities that are planned assuming universal car use are often difficult to access for those without a car. Opportunities for employment are restricted by an inability to travel between home and work venues.

- Haringey's location means that much of the borough, including some of its deprived neighbourhoods, has relatively good public transport. Areas of particularly low accessibility in Haringey are Alexandra and Hornsey in the west and White Hart Lane in the east.

2.0 Initiatives to address health inequalities

- Nine parks managed by Haringey Council have been declared as being among the best in the country. Chestnuts Park is the newest edition to the borough's collection of nine Green Flag Parks, winning its Green Flag in 2008.

- Development of the City Farm and related activities in Lordship Lane Park which will give local adults work experience, is running healthy eating café (already open), give opportunity for outdoor environmental activity for schools and for families – will also potentially provide alternative placements for young people at risk of exclusion.

- The Government has set a target for all schools to be engaged in the Healthy Schools Programme by 2009, with 75% of schools to have achieved healthy schools status by 2009. Haringey has stated its commitment to improving the health and wellbeing of its young people by including Healthy Schools as one of its Local Area Agreement stretch targets. This brings forward the 2009 national target by one year-with the intention that 75% of Haringey schools to be Healthy Schools by the end of 2008. Currently 68% of Haringey schools have achieved Healthy School status with 98% of Haringey schools already participating in the programme. We are on track to meet the 2008 stretch target.

- Council investment in improving cleanliness has resulted in a borough-wide increase from once per week cleansing to twice or three times per week cleansing from April 2008 where previously only a few roads had more than once per week cleansing. In addition, the Council has agreed an LAA stretch target for 2009/10 which is designed to ensure that good standards of cleanliness are achieved in the borough overall.


INVESTOR IN PEOPLE


Beacon
Council
2005-2006
Getting Closer to Communities

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Appendix 7

Health Inequalities gap analysis

Area identified at event: **Social Marketing (understanding the local population e.g. demographics and the levers which would encourage behaviour change)**

Sustainable Community Strategy Outcome: Healthier people with a better quality of life
Sustainable Community Strategy Priorities:
Tackle health inequalities
Improve life expectancy
Give greater opportunities to live a healthier lifestyle
Give babies, children and young people the best possible start in life

Local Area Agreement	2008/09	2009/10	2010/11	Current HSP scorecard RAG (Qtr 3)	Key Existing and forthcoming plans and strategies	Key current initiatives	Possible areas for scrutiny focus	General/Cross cutting
NI8 Adult participation in sport (2007-2010 stretch target)	22.9% (24.9% Local target)	26.9%	27.9%	R	Change4Life Sports and Physical activity action plan	HARIACTIVE Active for Life Making a Difference funded projects e.g. community walks	Uptake of physical activity	Getting the message to the right people using the right levers to get people to change their behaviour and take responsibility for themselves Sexual health
NI56 Obesity among primary school age children in year six	24%	24%	24%	G	Obesity Strategy 2007-2010	Healthy eating initiatives funded by Area Based Grant and other grants- Healthy Schools, Breakfast Clubs, Well-London (Noel Park) Making a Difference funded projects e.g. Healthy eating Children's Networks Work with Spurs on healthy eating, parenting and healthy lifestyles for 20 schools with higher levels of; Children in Care, Free School Meals, Mobility, as part of a family programme and focus work in schools with children. For example cooking classes run on Saturdays at the Sixth Form Centre.		Recession - impact on healthy eating

Local NI119 self reported measure of peoples overall heath and well being	n/a	80%	80%	Awaiting data		Libraries for health programmes HALS programmes		
NI123 Stopping smoking	1,008	1,008	1,008			Stop Smoking - commissioned services		
Local - Number of smoking quitters in the N17 area (2007-2010 stretch target)	300	300	Stretch target to end in 09/10		Smoking Action Plan Tobacco control strategy	Stop It- PCT programmes		
NI121 Mortality rate from all circulatory diseases at ages under 75	95.00	94.00	93.00	**Annual**	Life Expectancy action plan (under review)	GP referal scheme Vascular Checks		
Local - % of HIV-infected patients with CD4 count <200 cells per mm3 at diagnosis	42.1	40.1	27.95	Awaiting data	Sexual health needs assessment			
NI 112 Under 18 conception rate	5.3% (59)	18.1% (51)	55% (28)	R	Teenage pregnancy action plan	Teens and Toddlers intervention programme (preventing teenage pregnancy) funding provided from a national source.	Sexual health - teenage pregnancy	
NI113 Prevalence of Chlamydia in under 25 year olds	15%	16%	17%	R	Sexual health needs assessment Sexual health strategy		Sexual health - chlamydia	
NI126 Early access for women to maternity services	50%	60%	80%	G				
Local NI 53 Prevalence of breastfeeding at 6-8 weeks from birth	1)50% 2)85%	1)50.1% 2)90%	1)52.9% 2)95%	G	Infant mortality action plan			
NI 39 Rate of hospital admissions per 100,000 for alcohol related harm	1579 (1% reduction)	1654	1750	Awaiting data	Adult Drug Treatment Action Plan 2008/09			
Local - Increase the % of children immunised by the second birthday	80%	85%	90%	Awaiting data	Infant mortality action plan	MMR Campaign		
Local - Number of schools achieving healthy schools status (2007-2010 stretch target)	67 75%	75 85%	Stretch target to end in 09/10	G		Healthy schools School Travel Plans	Cooking in schools	

Area identified at event: **Healthy Eating**

Sustainable Community Strategy Outcome: Healthier people with a better quality of life
Sustainable Community Strategy priorities:
Tackle health inequalities
Improve life expectancy
Give greater opportunities to live a healthier lifestyle
Give babies, children and young people the best possible start in life

Local Area Agreement	2008/09	2009/10	2010/11	Current HSP scorecard RAG (Qtr 3)	Key Existing and forthcoming plans and strategies	Key current initiatives	Possible areas for scrutiny focus	General/Cross cutting
NI56 Obesity among primary school age children in year six	24%	24%	24%	G	Obesity Strategy	Healthy eating initiatives funded by Area Based Grant and other grants- Healthy Schools, Breakfast Clubs, Well-London (Noel Park)		Getting the message to the right people using the right levers to get people to change their behaviour and take responsibility for themselves. Link with ethnic groups North-East of Haringey
Local NI119 self reported measure of peoples overall heath and well being	n/a	80%	80%	Awaiting data	Breast feeding initiative	Libraries for Health programmes		
NI121 Mortality rate from all circulatory diseases at ages under 75	95.00	94.00	93.00	Annual		Green Lanes Festival Chang4Life HALS programmes		
Local - Number of schools achieving healthy schools status (2007-2010 stretch target)	67 75%	75 85%	Stretch target to end in 09/10	G		Cooking in schools School Travel Plans Work with Spurs on healthy eating, parenting and healthy lifestyles for 20 schools with higher levels of; Children in Care, Free School Meals, Mobility, as part of a family programme and focus work in schools with children. For example cooking classes run on Saturdays at the Sixth Form Centre.		
Local NI 53 Prevalence of breastfeeding at 6-8 weeks from birth	1)50% 2)85%	1)50.1% 2)90%	1)52.9% 2)95%	G				

Area identified at event: **Social networks and cohesion**

Sustainable Community Strategy Outcome: People at the heart of change
Sustainable Community Strategy priorities:
Community cohesion

Local Area Agreement	2008/09	2009/10	2010/11	Current HSP scorecard RAG (Qtr 3)	Key Existing and forthcoming plans and strategies	Key current initiatives	Possible areas for scrutiny focus	General/Cross cutting
Local NI1- % of people who believe people from different backgrounds get on well together in their local area		78%	81%	**Annual**	Haringey Compact Community Engagement Framework Greenest Borough Strategy Core Strategy	My City Too Preventing violent extremism Reducing drug abuse Community Walks including Better Haringey, Active for Life, surgery walks	Creating places to stop and chat, public art, shared spaces	Housing regeneration
NI6 Participation in regular volunteering		22.7	24.7	**Annual**	Volunteer development plan (HAVCO) Third Sector mapping (HAVCO)	Community Cohesion forum Intergenerational projects- Age Concern Making the Difference - Youth Service Allotment Project Timebank-Northumberland Park Social networking- Haringey Online Lobby groups- Friends of the Earth and Parks User Forum Area Based Grant funded projects e.g. Age Concern Befriending	The scope of volunteering ie CRB checks for vulnerbale adults; safeguarding	
NI4 % of people who feel that they can influence decisions in their locality		42.9	45.1	**Annual**	Community Engagement Pledge Experience Still Counts			
NI16 Serious acquisitive crime	37.8 per 1000 residents	37 per 1000	35.4 per 1000	A				

NI21 Dealing with local concerns about ASB and crime by the local council and police		32%	34%	**Annual**		The London Boxing Academy provides full-time education for young people who would otherwise be excluded from school.		
NI35 Building resilience to violent extremism	2	3	3	A				
NI15 Serious violent crime		4% (reduction)	5% (reduction)	Awaiting data		Reducing murder rates and violence		
NI7 Environment for a thriving third sector		21.9	24.9	**Annual**				
Local Repeat victimisation of domestic violence	176	156	156	R	Domestic and gender based Violence Strategy 2008-2012	Hearthstone and associated targetted outreach in local hospitals		

Area identified at event: **Access to cultural opportunities**

Sustainable Community Strategy Outcome: People at the heart of change
Sustainable Community Strategy priorities:
Provide even better shopping, cultural and leisure opportunities

Local Area Agreement	2008/09	2009/10	2010/11	Current HSP scorecard RAG (Qtr 3)	Key Existing and forthcoming plans and strategies	Key current initiatives	Possible areas for scrutiny focus	General/Cross cutting
Local Number of Green Flag parks	N/A	12	12	G	Greenest borough strategy	Better Haringey	Accessing hard to reach groups and individuals, in particular relation to parks, leisure etc.	
Local Number of parks achieving Green pennant status	N/A	7	7	G	Open Spaces Strategy 2006-2016			
Local The % of people who report they are satisfied or fairly satisfied with local parkd and green spaces	N/A	77%	Stretch target to end 09/10	Annual				
					Cultural Strategy			N.b there are no LAA targets specifically relating to culture. However as it was flagged at the event, it was felt that it should be included in this analysis.

Area identified at event: **Housing**

Sustainable Community Strategy Outcome: People at the heart of change
Healthier people with a better quality of life
Sustainable Community Strategy priorities: Meet housing demand
Create more decent and energy efficient homes, focusing on the most vulnerable
Meet population growth and change

Local Area Agreement	2008/09	2009/10	2010/11	Current HSP scorecard RAG (Qtr 3)	Key Existing and forthcoming plans and strategies	Key current initiatives	Possible areas for scrutiny focus	General/Cross cutting
NI 154 Net additional homes provided	1657	1602	1195	Annual	Homelessness Strategy 2008-2011 Housing Strategy Older People Housing Needs Plan	Warm Front Scheme		Homelessness Recession impact on ability to reach TA target (lack of private sector funding)
NI 155 Number of affordable homes delivered (gross)	340	340	340	Annual	Homes for Haringey Plan JSNA - needs analysis into population growth	Hostel deconversion programme delivering much needed large sized accommodation Handyperson scheme	Providing enough available properties to meet population growth Affordable Homes target and the impact of the recession (e.g. lack of private sector funding)	
NI156 Number of households living in temporary accommodation	4,000	2,600	2,600	R	JSNA core data set Move on Strategy	Working with RSL partners to increase the proportion of larger size units on new build schemes	Meeting the TA reduction target by 2010 - including the impact of the recession	
Local Carbon emissions from vulnerable private households	n/a	376	376	Awaiting data	JSNA core data set Affordable Warmth Strategy	Increase in priority awarded to under occupying households to encourage the freeing up of family homes.		
Local NI158 % of decent homes	42.0%	36.0%	30.0%	G		Home safety - fire alarms, Metropolitan Care and Repair	Overcrowding	
					Regeneration Strategy 2008-2016			

Area identified at event: **Mental Health**

Sustainable Community Strategy Outcome: People at the heart of change
Healthier people with a better quality of life
Sustainable Community Strategy priorities:
Meet population growth and change
Promote independence and provide high quality support and care for those in greatest need
Give babies, childrens and young people the best possible start in life

Local Area Agreement	2008/09	2009/10	2010/11	Current HSP scorecard RAG (Qtr 3)	Key Existing and forthcoming plans and strategies	Key current initiatives	Possible areas for scrutiny focus	General/Cross cutting
NI149 Adults in secondary mental health services in settled accommodation	Agreed a statistically significant increase once baseline is available			Delayed to 09/10	Mental Health Strategy JSNA - Mental health needs assessment Older People Mental Health Strategy	Big Lottery- Noel Park		Prevention - particularly in relation to the recession and impact on Mental Health in the borough
NI151 Effective of Child and Adolescent Mental Health Services (CAMHS) services	13	15	16	G	CAMHS Needs assessment 1yr - Mental Health Strategy		Scrutiny feasibility report due in next municipal year	
					Supporting People Strategy			
					Day Opportunity Services Strategy	New Day Care Service at Hornsey Hospital		
					Carers Strategy			
					Personalisation agenda			

Area identified at event: **Benefits maximisations**

Sustainable Community Strategy Outcome: Economic prosperity and vitality shared by all
Sustainable Community Strategy priorities:
Maximise income
Address child poverty

Local Area Agreement	2008/09	2009/10	2010/11	Current HSP scorecard RAG (Qtr 3)	Key Existing and forthcoming plans and strategies	Key current initiatives	Possible areas for scrutiny focus	General/Cross cutting
NI153 Working age people claiming out of work benefits in the worst performing neighbourhoods	-1.5%	-3.1%	-4.7%	Awaiting data	The Haringey Guarantee Credit Crunch Action Plan (HSP)	Claim It campaign		Impact of the recession
NI 187 Tackling fuel poverty - % of people receiving income based benefits living in homes with a low and high energy efficiency rating a) SAP rating <35 b) SAP rating >65		a) 13% b) 14%	a) 12% b) 15%	Awaiting data	Experience Still Counts	Reaping the Benefits Warm Front Scheme		
NI116 Proportion of children in poverty	34.5%	32.5%	30.5%	**Annual**	Child poverty strategy and Action plan Children and Young People's Strategic Plan 2006-2009			

Area identified at event: **Skills and training for employment**

Sustainable Community Strategy Outcome: Economic prosperity and vitality shared by all
Sustainable Community Strategy priorities:
Reduce worklessness
Increase skills and educational achievement

Local Area Agreement	2008/09	2009/10	2010/11	Current HSP scorecard RAG (Qtr 3)	Key Existing and forthcoming plans and strategies	Key current initiatives	Possible areas for scrutiny focus	General/Cross cutting
NI 151 Overall employment rate (working age)	69.3%	69.6%	70.0%	Awaiting data	Changing Lives - The Haringey Children and Young Peoples plan 2006-2009	Haringey Guarantee 2006		Getting Carers back into work or supported to stay at home
NI 152 Working age people on out of work benefits	17.4%	16.7%	16.1%	Awaiting data	Welfare to Work Strategy	Claim It campaign		
NI 153 Working age people claiming out of work benefits in the worst performing neighbourhoods.	-1.5%	-3.1%	-4.7%	Awaiting data		Haringey mentoring project for children in care		
Local Number of people from the worst twelve wards helped into sustained work (2007-2010 stretch target)	40	41	Stretch target to end in 09/10	G		Course aimed at teenage parents and another at pregnant teenagers, (run through CoNEL, Keeping It Simple, 14-19 & Teenage Pregnancy coordinator)		
Local Number of people on incapacity benefit for more than six months helped into sustained work (2007-2010 stretch target)	85	180	Stretch target to end in 09/10	R		NVQ level 2 & 3 courses for parents/carers & community members including governors in Speakeasy programme Haringey Guarantee working with NHS Haringey Working for Health linked to GPs and Health Centres condition management programme working with long term sick and Incapacity Benefit		
Local Number of registered Haringey Guarantee participants with a completed better off calculation	**400**	**400**	**400**	**A**		Families into work- Northumberland Park		

NI 79 Achievement of level two qualifications by aged 19 (2007-2010 stretch target)	68.0%	68.5%	74.3%	**Annual**		The London Boxing Academy provides full-time education for young people who would otherwise be excluded from school. A GCSE timetable is structured around sporting activity, not exclusively boxing.		
NI117 16 to 18 year olds who are not in education, training or employment (NEET) (2007-2010 stretch	11.0%	10.4%	8.9%	G				
Local Adults achieving a Skills for Life qualification and entered employment and those gaining a qualification in the workplace.	Awaiting information			Awaiting data	HALS Plan	ESOL language aquisiton Skills refresh (IT)		
Local Adults achieving a full level two qualification and entered employment and those gaining a qualification in the workplace	Awaiting information			Awaiting data				

Haringey Council

Overview and Scrutiny Committee on 29 April 2009

Report Title: Consultation on Urgent Care in Islington	
Forward Plan reference number (if applicable): N/A	
Report of: Chair of Overview and Scrutiny Committee	
Wards(s) affected: **All**	Report for: **N/A**

1. Purpose

1.1 To receive a presentation from representatives from NHS Islington on their consultation concerning Urgent Care in Islington. A copy of the consultation document is attached.

2. Introduction by Cabinet Member (if necessary)

2.1 N/A

3. Recommendations

3.1 That the Committee receives the presentation by NHS Islington.

3.2 That the Committee comments, as appropriate, on the proposals in the consultation document and, in particular, its implications for Haringey residents.

Contact Officer: **Rob Mack, Principal Scrutiny Support Officer, 020 8489 2921**
rob.mack@haringey.gov.uk

4. Local Government (Access to Information) Act 1985

4.1 Background Papers:

None

5. Report

5.1 NHS Islington has recently undertaken a formal consultation on the provision of urgent care within the Borough. A copy of the full consultation document is attached.

5.2 A key part of this is the establishment of an urgent care centre at the Whittington Hospital, which provides services for a large percentage of Haringey residents, especially those living in the west of the Borough. One proposal involves tendering for an urgent care centre on the Whittington site. The purpose of this will be to meet the needs of people presenting at A&E whose treatment can be more effectively dealt with by primary care practitioners, such as GPs and nurses. This is hoped to reduce the pressure on A&E and assist it in dealing effectively with genuine medical emergencies.

5.3 Once the urgent care centre is established, patients will not be able to directly access A&E. Access will be only by:

- Ambulance
- GP referral
- Fast tracking from the urgent care centre.

5.4 Whilst the Whittington Hospital are favourable to the principle of the setting up of the urgent care centre, they are not comfortable with competitive tendering taking place for a service on their site. They have been invited to attend the meeting to put their case.

5.5 The formal consultation on the strategy took place between 5 January and 30 March. There is a requirement for NHS bodies to consult relevant overview and scrutiny committees on proposals for change that could be considered significant. Although the proposal was reviewed by Islington Overview and Scrutiny Committee, no formal approach was made to Haringey's Committee for a view. However, Islington PCT have accepted that the Committee should be given the opportunity to submit its comments.

NHS Islington

Strategy for consultation

Urgent Care Strategy

2009 - 2014

Contents:

1. Introduction

1.1 This strategy focuses on the support local people require when they are in need of urgent care. Urgent care is a broad term and may include a range of conditions from suspected serious illness, to more minor conditions although still perceived by patients as urgent.

1.2 In this document we describe the current range of services available locally to provide support and care when needed. We also comment on how the system has performed over the past few years and identify priorities for improvement.

1.3 Set out in this document are proposals for the development of local services with a vision of a new mix of community and hospital based services – led from a community perspective – working with other parts of the health and social care system to provide the right treatment in the right place for people who live and work locally. The main proposals are:

- Tendering for an Urgent Care Centre located on the Whittington NHS Trust site to deal with all primary care related urgent attendances;
- Exploring the feasibility of establishing a 'hospital at home' and rapid response community service, and subject to a costed business cases go out to tender
- Establishing a new range of primary care led urgent care services including an improved response and coordination in-hours within general practice and extending the range of scope of community pharmacists to deal with urgent care;
- Implementing new models of highly specialised care as set out in the *Healthcare for London* work around stroke and major trauma, provided at a smaller number of sites; and
- Undertaking research and social marketing to understand patterns of attendance, to shape care around them and influence patterns of use.

1.4 This document is closely linked with the NHS Islington's draft Primary Care and Community Services Strategy, which will be going out to consultation early in 2009. Many of the proposals identified within the Urgent Care Strategy will be underpinned by the aims and initiatives resulting from the Primary Care and Community Services Strategy, which has amongst its aims to improve access to primary care.

1.5 This focus of this strategy is a model of urgent care for adults, although reference is made to some of the thinking that is going on around children's services within the *Healthcare for London* model. We recognise that there is much complexity more about how to deliver services for children and we are therefore proposing a phased approach with a roll out for adults services initially, allowing time for further discussion about how to implement the children's model. For this reason there is limited discussion about the children's model in this document.

2. What do we mean by Urgent Care?

2.1 The need for the public and patients to access medical care with a rapid response can arise in a variety of situations.

2.2 Situations requiring an urgent response can be vary, some of the range is set out below:

- When something is serious, not necessarily life threatening, but known by the individual or others to need immediate support (bad falls, initial chest pains)
- When something seems serious but you just don't know what to do (a child with worsening fever, a badly disorientated older person who has fallen, an individual who seems very depressed, an individual with tummy pains)
- When there is a minor injury which needs immediate attention (cuts, bruises)
- When you suspect a common illness or condition, but are not sure what to do about it (bad coughs, colds, flu, tummy upsets, toothache).

2.3 For members of the public the need for an urgent response is often driven by the need to understand their problem and then move quickly to specific diagnosis, treatment and care. The NHS often looks at requirements for urgent care in a different way, and organises' different responses depending on the level of need.

2.4 The response will need robust signposting to a range of service responses within primary, community and hospital care, and it is these responses which are the focus of this strategy.

2.5 For the purposes of this strategy we define urgent care as

> "Care, excluding planned care, which the patient seeks access to on the same day that the patient perceives it is needed."

2.6 There are times when an emergency rather than urgent response is needed when something critical or life threatening happens for example a major accident, a deep wound, heavy blood loss or a suspected heart attack. In these cases an immediate response is needed either an ambulance or attendance at Accident and Emergency. These kinds of cases are not included within the main focus of this strategy.

3. What Services Exist Locally?

3.1 Our definition of urgent care is broad and includes services provided by:

- GP Services and out of hours
- Pharmacists – Minor Ailments Scheme
- Dentistry – Urgent
- NHS Direct
- London Ambulance Service
- Local A&E
- Minor Injuries Unit
- Other urgent care services

GP Practices and Out of Hours

3.2 There are 39 GP practices in Islington, with more than 50% of practices providing extended hours. Local doctors' surgeries offer a wide range of services, including advice on health problems, physical examinations, diagnosis of symptoms and prescribing medication and other treatments. The doctor will usually be supported by a team of nurses, health visitors and midwives, as well as other specialists, including physiotherapists and occupational therapists. Local GPs also generally provide access to home visits for those unable to attend the practice.

3.3 All practices in Islington are covered by the GP Out of Hours (OOH) service commissioned by NHS Islington. The service operates every day, from 18.30 to 08.00 and all hours during weekends and bank holidays, which is available people including residents, workers, and visitors who happen to be in Islington at the time. Initial contact can be made by telephone and this may be followed by advice over the phone, a face-to-face consultation in local centres, or a home visit.

Pharmacists – general

3.4 Pharmacists are able to offer advice and treatment for many conditions, including ear infections, coughs, colds, diarrhoea and headaches. As health professionals on the high street, the public do not need an appointment to see them, nor is registration with an Islington GP required.

Pharmacists – minor ailments scheme

3.5 Since 2005/06, Islington residents have also been able to access through their GP practice the Minor Ailments Scheme provided by their chosen pharmacist. The scheme enables the community pharmacy to provide advice and support to people who have been given a voucher from the GP practice on the management of minor ailments, including where necessary, the supply of medicines for the treatment of the minor ailment, for those people who would have otherwise gone to their GP for a prescription.

Dentistry - Urgent

3.6 In-hours open access sessions are commissioned from a dental practice (based in Camden) for those patients who are directed for urgent treatment in-hours following a call to the OOH service via Camidoc. An out-of-hours telephone dental triage service is provided by Camidoc, as an add-on to the main GP OOH contract.

NHS Direct

3.7 NHS Direct is a phone service staffed by nurses and professional advisors, giving confidential healthcare advice and information 24 hours a day. The service covers what to do if an individual or a family member feels ill and needs information on particular health conditions

and local health services (such as GPs, dentists and out-of-hours pharmacies or self-help and support organisations). Over two million people access NHS Direct every month, which includes an average of 1,750 calls made by Islington residents (59 per day). Islington's peak calling period is during the hours of 9am-10am weekdays and weekends.

The London Ambulance Service

3.8 The London Ambulance Service (LAS) provides an accident and emergency service 24 hours a day across the capital. Ambulance staff attend emergencies and are trained to provide care at the scene of an incident and/or transport the patient to the most suitable service, such as Accident and Emergency Services. Category A calls are outside the scope of this strategy as they require an emergency response; the focus of this strategy is around categories B and C.

3.9 In 2006/07 the LAS responded to an average 72 calls a day in Islington, which included the following categories:

- Category A (immediate threat to life) = 9491 (26 average per day) in 2006/07
- Category B (serious but not life threatening) = 12,490 (34 average per day) in 2006/07
- Category C (neither serious nor life threatening) = 3,421 (9 average per day) in 2006/07
- Urgent (GP calls) = 1,082 (3 average per day) in 2006/07

Local A&E services

3.10 The local hospitals, Whittington NHS Trust in North Islington and UCLH NHS Foundation NHS Trust in Camden, provide the main points of access to Accident and Emergency services to Islington residents and those working locally.

3.11 The Whittington A&E department is open 24 hours a day; seven days a week providing treatment for anyone seeking attention for an urgent problem caused by an accident or illness. In 2007/08 80,000 people attended A&E, most of them from Islington or Haringey, along with those out of borough working in the vicinity. The Whittington Hospital has a separate paediatric A&E, around 25% of the total attendances at the Whittington A&E are children. Given the complexity of children's services, they are excluded from the scope of this initial strategy

3.12 At UCLH Accident & Emergency services comprise both the A&E Department and the Acute Admissions Unit (AAU). The A&E Department sees approximately 90,000 patients a year serving patients from Islington, Camden, Westminster and non-resident people from out of borough working nearby or visiting London. The A&E Department is subdivided into four areas: resuscitation; majors; minors; paediatrics. The Acute Admissions Unit (AAU) comprises a 56-bed unit and patients who are admitted remain on the Unit for up to 48 hours, during which time treatment will be supervised by the AAU clinical team.

Minor Injuries Unit

3.13 The Minor Injuries Unit located at St Bartholomew's Hospital in the City of London, is staffed by nurse practitioners. The service can treat injuries such as cuts and grazes, broken bones, minor burns and scalds, bites and stings, strains and sprains, minor head injuries, and minor eye or ear problems. It is a walk-in service, so no appointment is needed. Patients are seen in order of urgency. The Minor Injuries Unit is open Monday to Friday, 8am-8pm. It is closed at weekends and on bank holidays.

Other urgent care services

3.14 The Islington Social Services' Emergency Duty Team provides an 'out of hours' service for emergencies. An emergency is considered to be something that cannot wait until the next

working day when the full range of services will be available. The duty social worker will give advice and guidance over the phone on how to deal with the problem. You may be advised about other services which can help, or that it would be best to wait until the normal day services are available.

3.15 Adult Mental Health Crisis support is provided by Camden and Islington NHS Foundation Trust to provide a service to adults with serious mental illness who are being considered for hospital admission.

3.16 Young people with mental health needs who present as an emergency are offered a tailored service depending on whether they are already known to the CAMHS (Child and Adolescent Mental Health) team. If not currently known to the service they would be seen via their local A&E and if necessary would be admitted to the paediatric ward and a risk assessment is jointly carried out by paediatric and social work staff. If the child is already known to the service the clinician involved can seek advice from the psychiatrists within the Islington community team whho would assess the urgency of the case and ensure that they are seen by the service. If it is an emergency the young person may be advised to attend the Emergency Department as above.

3.17 A rapid response service is also available to patients requiring the establishment of social services care packages, which can be implemented within 2 hours.

4. How are local Services Used?

Access to Urgent Care Services

4.1 The Healthcare Commission published in September 2008 its review of urgent care services across the country, which rated Islington as a local health community as Fair Performing with an overall score of 2.88 on a scale of 1 to 5, placing it mid range amongst PCTs nationally.

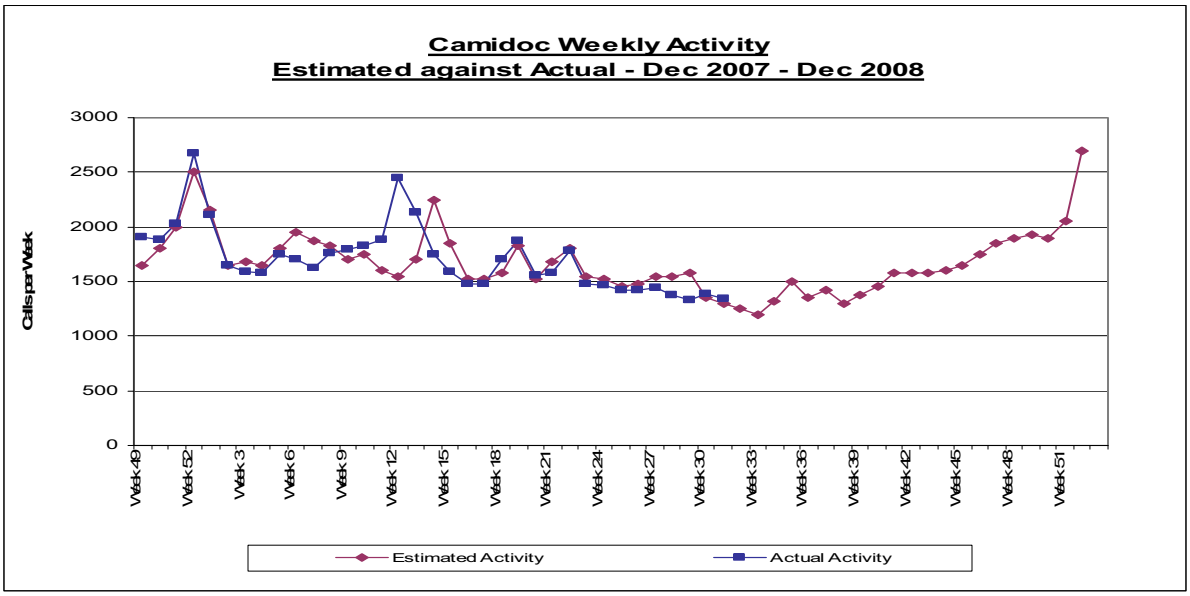
4.2 The main areas from the review where Islington scored a mark of two or less were:
- the level of A&E attendances for conditions which could be avoided or treated in other settings;
- the public satisfaction with the opening hours of GP services;
- the percentage of patients who see a clinician within an hour of arrival at A&E/urgent care centre; and
- the score for facilities for people with disabilities.

4.3 In addition to the Healthcare Commission report, research conducted within six London boroughs: Kingston, Hammersmith & Fulham, Camden, Barnet, Waltham Forest and Newham, provides a useful insight to the drivers for urgent care activity where a number of influences impacting on patient behaviour were identified. This research found that:
- Patients select their place of care on the basis of proximity and speed of access.
- People often attend A&E because they are confused about the number and range of ways to access urgent care services
- Patients' assessment of the urgency of their need appears to influence their choice of access point; patients attending A&E departments and WiCs (Walk in Centres) assessed their need as more urgent than those attending GP and pharmacy services for care/advice.
- Patients visit multiple access points for the same condition; more than 25% of A&E attendees with a minor illness/injury had visited either a GP or A&E department in the previous 3 days;
- One third of people attending A&E felt that their condition could have been treated by their GP and did try or consider accessing their GP as a first choice
- Whilst standards of care are important to patients, patients did not report a significant quality gap between care provided by GPs and care provided by A&E clinicians; only 12% of the patients interviewed at A&E stated quality of care influenced their decision to attend
- People understand and accept the process and rationale of triage
- People generally lack awareness of the skills of pharmacists
- Parents/carers of young children tend to use A&E more and are also more likely to use telephone access (GP out of hours and NHS Direct)
- There is a greater tendency for BME communities to access unscheduled care (need to define) than White British
- White British are more likely to use telephone services, BME communities are much less likely to use these services
- Older people appear to access GP services and A&E for their unscheduled care needs, with a lower propensity to use telephone access

4.4 The usage of services associated with urgent care can be depicted by the following information:

GP Out of Hours usage

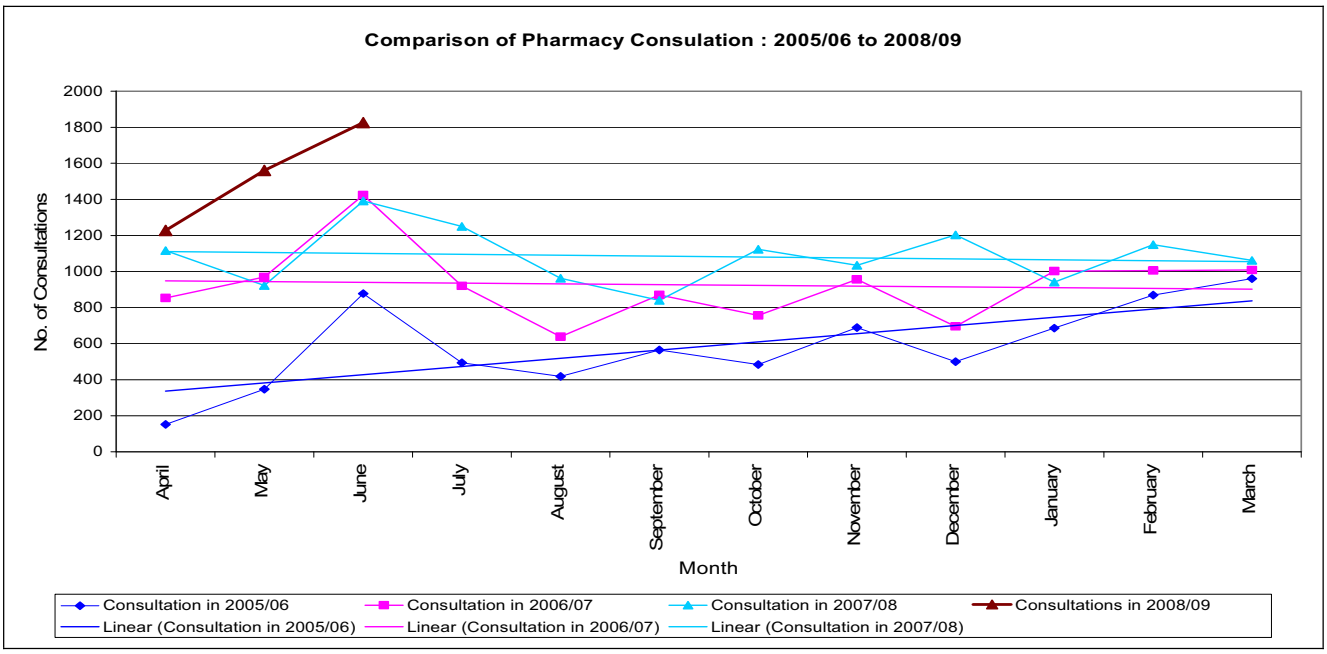
4.5 Between December 2007 and August 2008 there were an average 1,700 calls per month to the GP out of hours services.



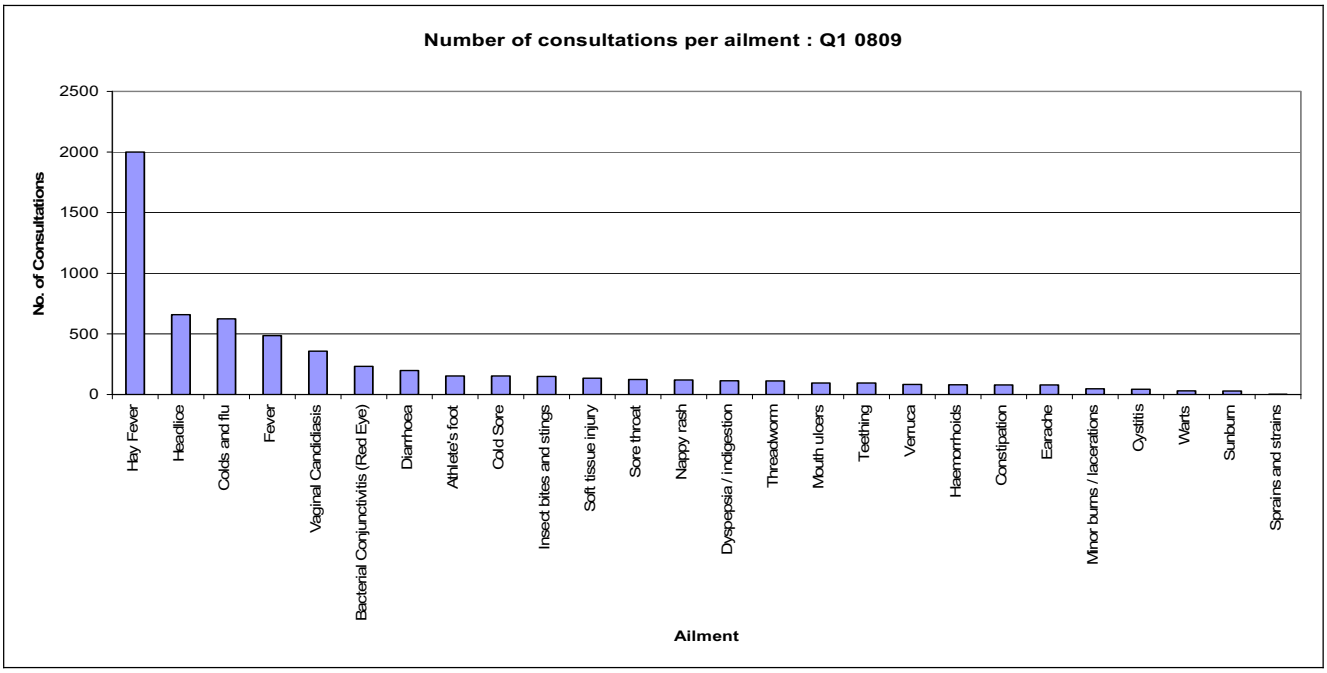
4.6 In terms of the response provided by the out of hours service the Healthcare Commission review identified that 84% of phone calls to the service were answered within 60 seconds of an introductory message. This placed Islington in the bottom 30% of PCTs nationally. Of calls received 47% of cases were provided with advice over the phone, 38% received a face-to-face consultation and 15% received a home visit.

Minor Ailments Scheme usage

4.7 Since its inception the minor ailments scheme's usage has gradually increased. The average number of consultation per month increased from 1143 in Quarter 1 2007/08 to 1538 in Quarter 1 2008/09. At present patients can be referred to the scheme from local GPs, everyone eligible who is referred to the scheme is seen.

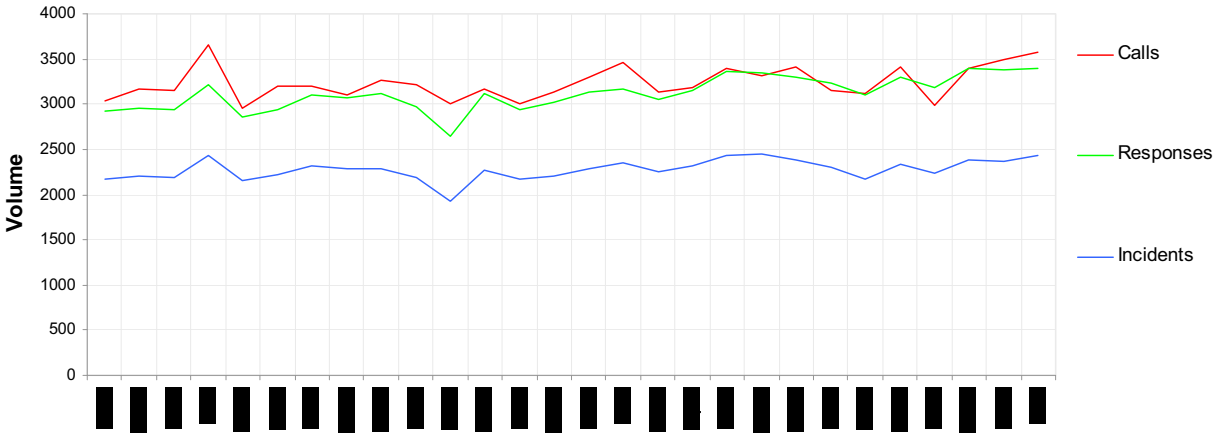


4.8 From April 2008 to June 2008 a total of 6,272 people were seen as part of the scheme. The graph below shows that the highest numbers of consultations are for cold and flu, hay fever and head lice, which is a similar pattern of conditions to previous years.



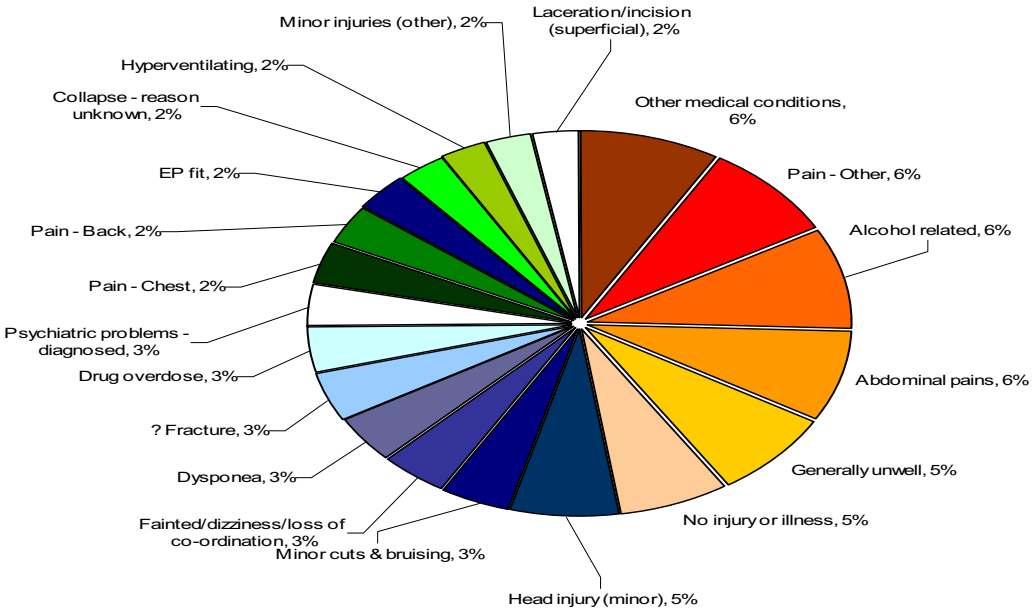
London Ambulance Service

4.9 Islington's activity in relation to the London Ambulance Service has broadly remained consistent over time; with between 3,000 to 3,500 calls received and responses made monthly.



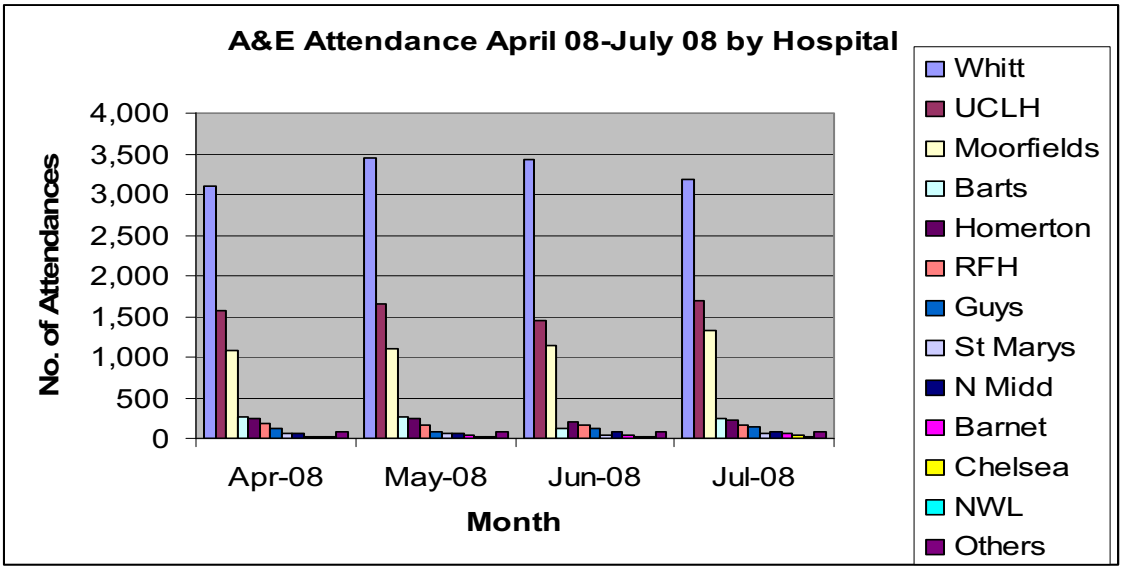
The number of incidents is lower than the number of calls and responses because incidents excludes calls abandoned for any reason, duplicate calls about the same incident or hoax calls. Calls are defined as the total number of emergency calls.

4.10 Of the calls made to the London Ambulance Service the top 20 illnesses reported are displayed below. Abdominal pain, alcohol related, and pain other each make up 6 percent of the activity reported.

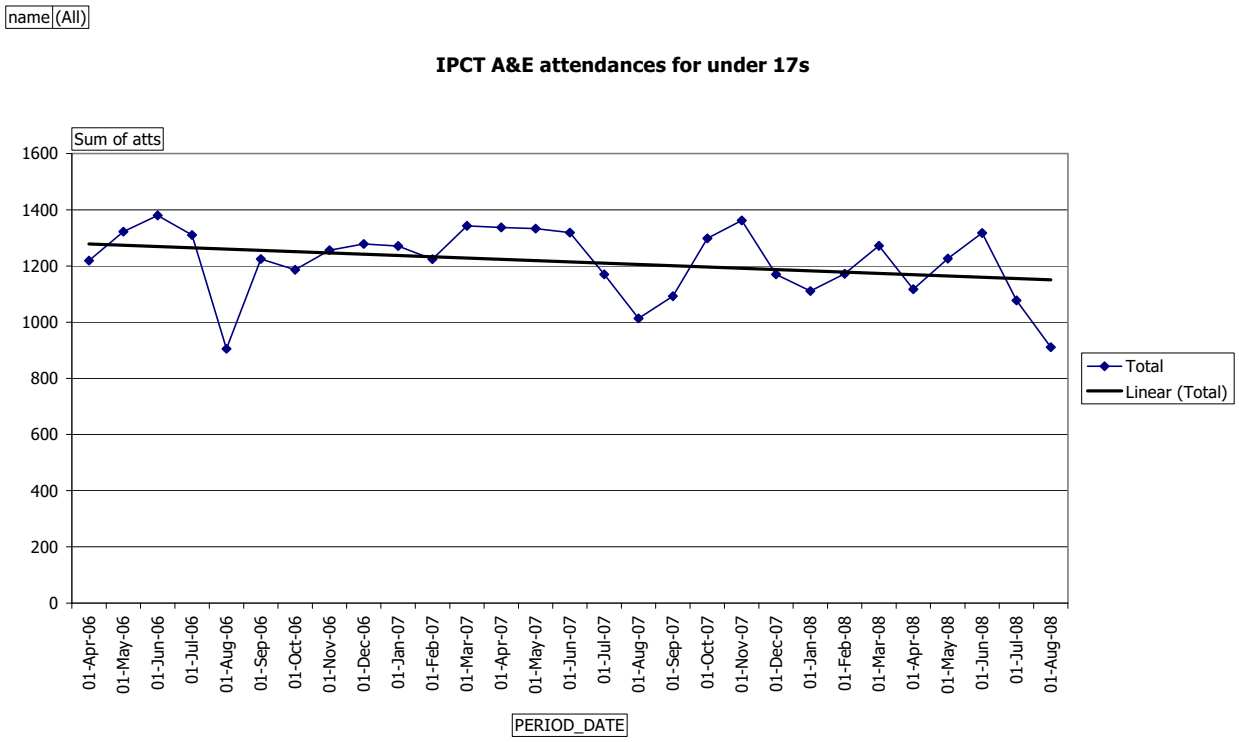


A&E attendance and Emergency Admissions

4.11 The majority of Islington's A&E attendances are provided at the Whittington NHS Trust (46%), with UCLH second (22%). Moorfields as a specialist eye hospital accounts for 16% of attendance to an A&E department, but this is exclusively for the treatment of eye conditions..

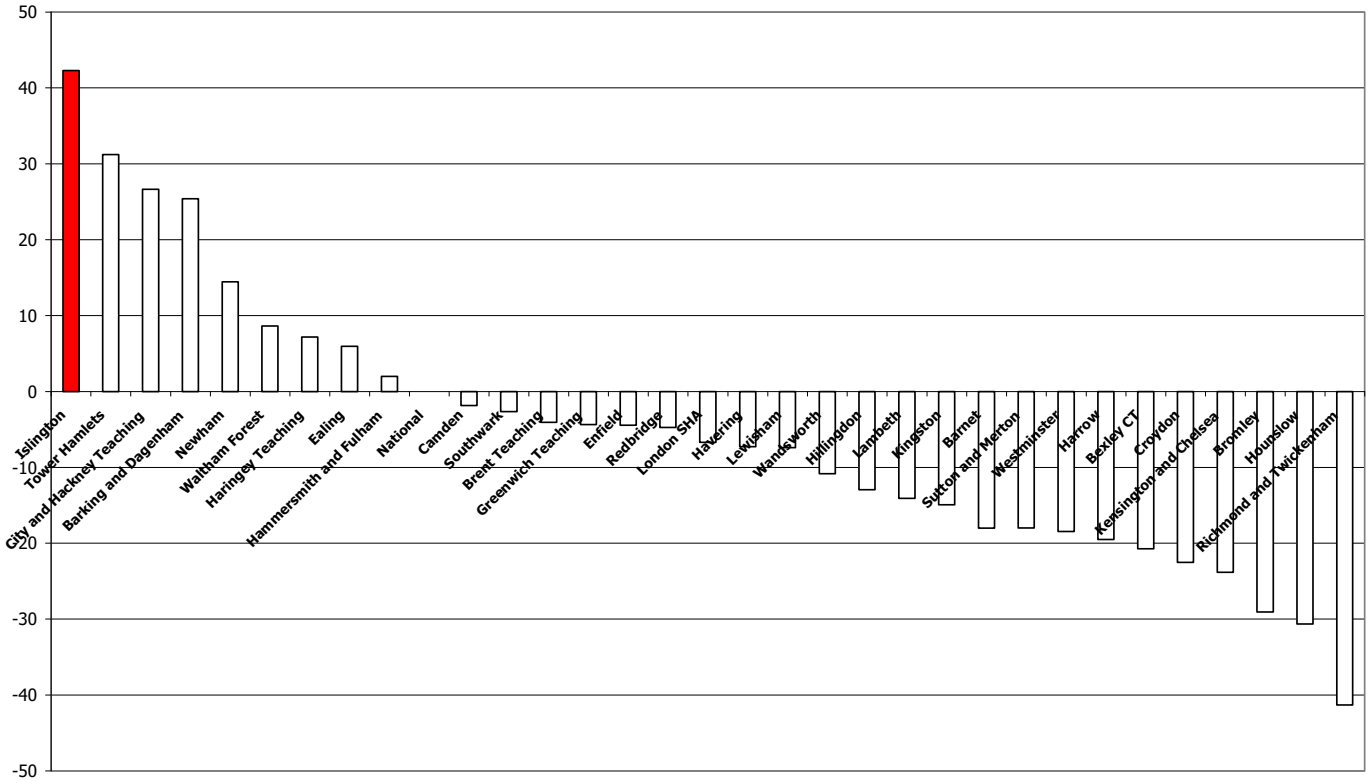


4.12 In relation to children to the number of A&E attendances has averaged about 1,200 per month between April 2006 to August 2008.



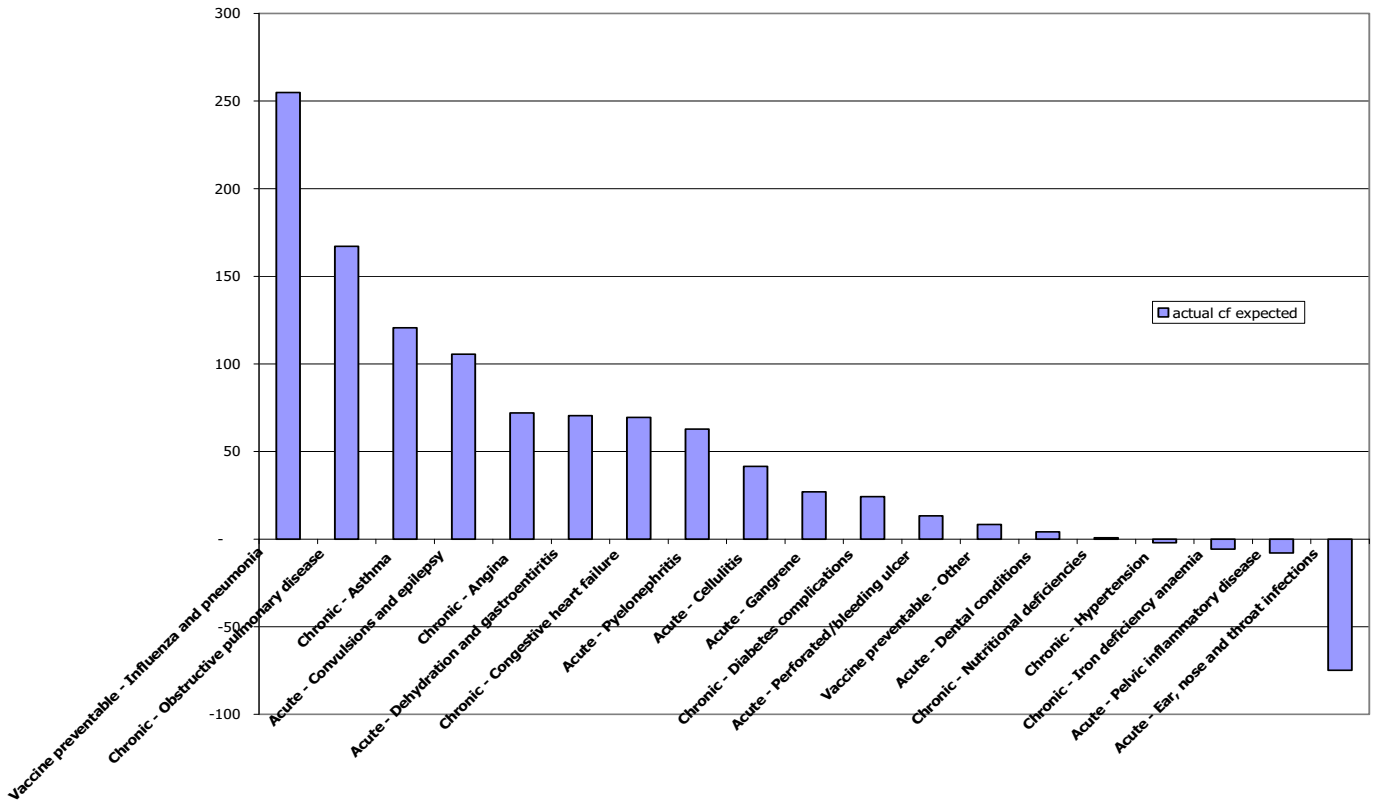
4.13 Islington has the highest rate of emergency admissions in London. It is 40% above the national average for admissions for the 19 ambulatory care sensitive (ACS) conditions. These are long-term health conditions that can often be managed with timely and effective treatment without hospitalisation, for instance COPD or influenza

Emergency admissions for the 19 ACS conditions jul-jun 2006/07 - % variation to the National rate



4.14 The ambulatory care sensitive conditions that result in the highest number of emergency admissions are vaccine preventable admissions including influenza, and long term conditions such as COPD and Coronary Heart Disease.

IPCT - number of emergency admissions jul-jun 2006/07 above/below expected compared with National rate



5. So, why is further change required?

5.1 There are a number of factors that have pushed urgent care to the top of NHS Islington's agenda and prompted a look at how our local services are organised. Some are to do with work that is happening at a national and London level, and others are to do with the way that things work locally and our priorities for Islington.

5.2 There was a shared view amongst stakeholders that although there are real strengths in the current system, there are also areas where improvements need to be made.

Stakeholder views

5.3 As part of the preparatory work for this strategy a local group of stakeholders came together, including both the Whittington and UCLH, the London Ambulance Service and a patient representative, to look at how services work at the moment, the strengths that are there to build on and the areas where further work is needed. They identified the following:

5.4 *Strengths to build on:*

- The *Right Care: Right Place,* triage and redirection model that is in place at the Whittington has been a success*;*
- Admission avoidance; redirection; and, prevention work well locally;
- Improvements in hand-over between different parts of the NHS and social services and associated information exchange;
- Two strong local A&E departments;
- Improved working relationships between all providers;
- Move to towards reconfiguration of GP surgeries;
- That the London Ambulance Services is able to respond to patient choice when responding to calls; and
- Introduction of the pharmacy minor ailments scheme.

5.5 *Challenges to address:*

- Lack of a clear vision of 24/7 Urgent Care;
- Access to – and the role of – Primary Care as part of Urgent Care;
- Inconsistent sharing of information – between hospital and primary care and between primary care and hospital;
- Inadequate sign posting for patients of where they can go to receive care;
- Lack of coordination between providers;
- An understanding of the reasons why patients access care in the places and ways that they do; and
- There is limited monitoring and evaluation of changes once they happen.

National and London drivers for change

5.6 Over the last eighteen months there have been a number of pieces of London and national work that have changed the context within which urgent care services are being delivered, and pushed PCTs, as commissioners of services, to ask some searching questions about the organisation of local services and whether they are delivering the best quality services for local residents.

5.7 First came *A Framework for Action* written by Professor Lord Darzi about Healthcare in London that was published July 2007. This formed the basis of the *Healthcare for London* (HfL) public consultation that was led by 31 London PCTs (plus Surrey) and closed 7 March 2008. Lord Darzi concluded that community services are not providing a satisfactory alternative to

hospital and therefore many Londoners are accessing A&E departments for urgent care instead. He also concluded that very specialist areas, such as acute stroke and major trauma, need to be carried out in very specialist centres so that patients can get the very best, high quality, modern care. Lord Darzi's London work was followed up at a national level by the NHS Next Stage Review *High Quality Care for All*, which came out in June 2008.

5.8 The *Healthcare for London* team has taken the principles set out in Lord Darzi's work and come up with a model for urgent care that local PCTs have been asked to look at in the context of their own services. We have been involved in the development of this model at a London-level and have used this model as the starting point for this strategy; working with local stakeholders as part of our development process to see how the London-wide model could be adapted to fit our local needs and circumstances.

5.9 As a result of Lord Darzi's work the Government has made the connection between primary and community services and the way that patients access services for their urgent needs. He has also made a powerful case for an improvement in the quality of care in the NHS, with consistent clinical input from appropriately skilled doctors and nurses.

5.10 In order to improve access to urgent care for less severe problems, all PCTs are being asked to procure a GP led-health centre that is open for extended hours (8am to 8pm) all week long (including the weekends), which will see patients who are registered with a local GP and those that are not. We have also been asked to think about how NHS Islington will respond to the model of a polyclinic (a community based resource providing a wide variety of services which will include urgent care and GP services) that is set out in Lord Darzi's vision for the health service. These national requirements will need to be combined with Islington initiatives that are already up-and-running. These will include initiatives to encourage GPs to stay open for longer and to encourage the growth of larger practices in Islington to get the benefits that GPs working together can deliver.

5.11 In order to look at all of these initiatives as a whole, NHS Islington is developing a strategy and vision for Primary and Community Services for the next five years; which will go out to consultation in early 2009. Given the links between primary care services and when care becomes urgent, this document and the Primary and Community Services Strategy when it is completed will need to be seen as complementary, as well as standalone documents.

<u>Local impetus for change</u>

5.12 As a starting point for any strategy we need to go back to NHS Islington's long-term vision, this is:

> "In 2013 local people are healthier and live longer, living independently and participating in society. Local people know their voice is heard in how health services are provided. There are more services delivered closer to people's homes; the quality is higher and the standards more consistent; fewer practices provide a wider range of services; targeted and tailored services are provided to particular groups in the population and those with specific needs; and hospitals only do what they do best. All local people have easy access to services and make choices about their care."

5.13 This vision is translated into a number of objectives. These are:

- **Improve the health of local people**, especially targeting those with the worst health outcomes, through initiatives on CVD, mental health and obesity;

- **Improve the quality of the patient experience and health outcomes**, through benchmarking health needs and outcomes, and implementing the communications and engagement strategy, and aligning investment;

- **Ensure people and services work together to design and deliver the best care pathways**, focussed on end of life care, urgent care, mental health, and the Collaborative Commissioning Intentions of the North Central London sector PCTs;

- **Improve and expand services delivered closer to home and commission acute and specialist hospitals to provide only those services that they do best**, through implementation of the PCT's primary and community services strategy; and

- **Act as guardians of local NHS finances** through ensuring the best use of available resources to deliver improved health.

5.14 When tested against NHS Islington's strategic objectives the need to develop a new model for urgent care, implemented with a new vision for primary care, meets each one of these tests.

Improve the health of local people
5.15 We know that many of those residents accessing urgent care are those with the worst health, and that if the system was redesigned they would have a better experience. Islington has a very high number of patients with Long Term Conditions, like heart failure of COPD (Chronic Obstructive Pulmonary Disease, what used to be called emphysema). One way of measuring how well PCTs are doing at managing care in and out of hospital settings is to look at a cluster of nineteen conditions that have been termed Ambulatory Care Sensitive and to look at admission rates for all nineteen as a grouping as well as each of the individual indicators, these include preventable influenza and pneumonia, chronic asthma and acute dehydration following gastroenteritis. We know that NHS Islington has the highest rates of admission of any London PCT for these conditions when looked at as a whole, and is an outlier for lots of the individual conditions (see the detailed graphs in section 4.9) and it is an area highlighted by the recent Healthcare Commission review. We believe that if we improved the model for urgent care within Islington we could improve the quality of care for those with the worst health and provide high quality, responsive care for them within their own home.

Improve the quality of the patient experience and health outcomes
5.16 As part of the work developing their model of care *Healthcare for London* carried out patient surveys about why they access care in the way that they currently do. One was carried out in our neighbouring PCT, Camden. Although this evidence is by its nature subjective, these findings do mirror other evidence that suggests that people often default to A&E because they are confused about how to access care. The Healthcare for London survey showed that there is duplication and poor utilisation of the existing services; for example across London 20% of the patients surveyed visiting A&E had seen a GP in the previous three days for the same condition.

5.17 In the Camden-specific findings patients made the following suggestions about how they would like their needs to be met in the future: 69% wanted a generally quicker faster service with less waiting time; 51% wanted more readily available GP appointments; 34% wanted extended GP opening hours; 26% wanted to see an improved level of treatment; around 10% wanted better information about treatment options.

Ensure people and services work together to design and deliver the best care pathways
5.18 One of the reasons for the very fragmented experience of patients is that there is no clarity or simplicity about care pathways and where care is available. It is entirely understandable that because as healthcare professionals we have not make the system work for patients they default to accessing care at the only place that is open 24/7, is open to everyone and can guarantee to see patients within a four hour window. We have seen an increasing number of patients accessing hospital for relatively simply, or primary care, needs. Over a third of the attendances at the Whittington hospital fall into this category and over the years we have seen a huge increase in numbers of attendances at A&E.

5.19 The aim of this strategy is to design simple care pathways, and access points for care, that meet patients needs at the places they need them and that staffed appropriately for the complexity of their condition. These pathways also need to make sense to the care professionals who will be delivering them.

Improve and expand services delivered closer to home and commission acute and specialist hospitals to provide only those services that they do best
5.20 The Primary and Community Services Strategy will set out the NHS Islington's vision for extending the scope of services available through general practice, achieving responsive and integrated access to care, particularly with social services.

5.21 We know that lots of patients attending A&E have already seen their GP, or are attending because they perceive access to their GP surgery to be a barrier. We also know that a very large proportion of patients attending A&E are presenting with a problem that could be dealt with by their GP or someone else in a community setting like a pharmacist. In order to make this shift there will need to be extended access to primary care and community care services, particularly changes to operating hours and a remodelling of the way that urgent cases are dealt within the day in primary care.

5.22 At the other end of the spectrum, the Darzi report and *Healthcare for London* have made clear that some services are much better provided in very specialist settings, for instance the immediate care for people who have had a stroke, and those that have experienced major trauma, for example a serious car accident. These services will be provided in smaller specialist centres and the London Ambulance Service will take patients there direct. This model already works very well for patients who have had a heart attack, who are taken directly to UCLH.

Act as guardians of local NHS finances
5.23 In order to make this model work the financial flows in the system will need to be changed, with different models of care funded in community and primary care settings. At the other end of the spectrum there will also need to be different models of costing for the much more complex care, like stroke and trauma. We believe that new funding flows will help to cement a new model of care by freeing up resources. This is not about reducing the amount of money spent, and at least initially we may need to invest some additional funding to get the step change in the quality of care that we want to see. Before proceeding to implementation, and after consultation, detailed financial modelling will need to be undertaken for each aspect of the model.

6 What will urgent care services look like in the future?

6.1 This section of the strategy sets out at a high-level the changes that would happen to local services and the differences that resident and the public would be able to see, compared to current services. The model is based on the one that has been developed by *Healthcare for London*, and puts it into an Islington setting. There has been extensive input from local stakeholders, including primary care the two local hospitals, as well as patient representation.

6.2 This group, plus a number of other stakeholders, spent a day together in June and identified a vision for urgent care in Islington in 2013. In looking at the Healthcare for London model this was the vision that we were seeking to implement.

Our vision for urgent care in 2013:

- Patients are better informed;
- Patients feel safe and satisfied;
- Patients have 24/7 access to professionals within a Primary Care and Community Care setting to support both diagnostics and treatment;
- There is consistency in the management of risk across different urgent care pathways;
- Urgent care is planned, designed and delivered in response to current and future needs;
- Urgent care services are affordable and value for money;
- Urgent care services in Islington dovetail with those in neighbouring boroughs, especially Camden and Haringey;
- Better coordination overall with a single patient record shared across the health system with links as appropriate to Social Care;
- Professionals have a greater knowledge about the range of services and associated access points and are therefore better placed to sign post patients; and
- The whole system is staffed appropriately with trained professionals.

6.3 Over the next few sections we will explain in summary the models of care, describe the main changes that will need to occur to make the new system work and then set out the model in diagrammatic form.

A summary of the *Healthcare for London* models of care

Care in hospital

6.4 *Healthcare for London* has put forward two model of care: one for adults and one for children. Both are based on some fundamental changes to the way that patients currently access urgent care in hospital. This strategy focuses mainly on the model for adults, although the model for children is also set out. We recognise that there is much more complexity about how to deliver services for children and we are therefore proposing a phased approach with a roll out for adults services initially, allowing time for further discussion about how to implement the children's model. For this reason there is limited discussion about the children's model in this document.

6.5 First all hospitals that currently have an A&E will host an Urgent Care Centre (UCC) on the hospital site; this might be right next door to the current A&E but would be physically separated from it. The UCC will see both adults and children and will be staffed by people with primary care skills, primarily GPs and nurses working with adult social care. This will be

the place where patients will be able to self-refer at any time of the day or night, 24/7. Patients will be able to receive care, as quickly, if not more quickly than in A&E. The care provided in Urgent Care Centres is not intended to be a replacement for patients accessing care through their GP, particularly for patients with complex Long Term Conditions. However, some patients may choose to make UCCs their main access point for care and the system needs to be able to respond and accommodate this too, although those doing so regularly will be encouraged to register with a local GP.

6.6 A&E will become more specialised and patients will not be able to have direct access to A&E, which will now only be for those with more serious or life threatening and complex cases. It will take patients who are very unwell and come in by ambulance or those that have been fast tracked by the Urgent Care Centre, or referred by their GP. Severely ill patients arriving at the Urgent Care Centre will be fast tracked to the A&E. The need for doctors and nurses in both the Urgent Care Centre and A&E to be very skilled at triage and assessment, and to make fast and accurate judgements, is one of the underpinning principles of the new model. This strategy will need to be accompanied by a sophisticated approach to the management of the workforce and training to ensure that this is delivered and very robust clinical governance arrangements particularly around the time of implementation and transition between different services.

6.7 Next door to A&E will be an Acute Assessment Unit and Paediatric Assessment Unit where patients seen in the A&E who need to stay for a short time for observation or tests will be admitted. These short stay wards already exist and allow patients – for instance someone needing intravenous antibiotics – to be kept for a short period of time while their condition stabilises and the medication begins to work.

6.8 Some A&Es will take on additional specialised responsibilities for their area to deal with even more complex conditions like the very first stages of stroke and major trauma, such as car accidents. The London Ambulance Service will take patients direct to these centres; this already happens and works well for heart attacks, and increasingly also for acute stroke. Work is underway through *Healthcare for London* to decide where these specialised centres will be located.

6.9 These changes will mean that everyone attending hospital with an urgent care need will be seen by the kind of health professionals with the most appropriate clinical skills to help resolve their problem, in the faster and most cost-effective way.

Summary of Healthcare for London model for urgent care and acute assessment (adults)

1. Patients conveyed by ambulance would be delivered straight to the Urgent Care Centre (UCC) or to the A&E; more complex patients could be delivered directly to the Acute Assessment Unit (AAU)
2. Patients can self refer ONLY to the UCC; there would be no direct access to A&E and patients assessed to require A&E treatment would be referred via the UCC
3. Patients referred by GPs would be referred directly to the AAU (although could be referred to the UCC in some cases)

Summary of Healthcare for London model for paediatric assessment

1. Children conveyed by ambulance would be delivered straight to the Paediatric Assessment Unit (PAU)

2.	Patients can self refer ONLY to the UCC; there would be no direct access to the PAU and patients assessed to require paediatric assessment would be referred via the UCC
3.	Children referred by GPs would be referred directly to the PAU

Diagrams setting out the *Healthcare for London* model for when services should be available and indicative models for both adults and children are set out at appendix 1

Care in a community setting

6.10 Alongside different ways of care working in a hospital setting there will be some changes to the way that care works in a community setting. The *Healthcare for London* model is based on patients having greater access to urgent care within a community setting alongside Urgent Care Centres. This will come in part through the GP led-heath centres, which will see registered and unregistered patients, and also from existing GP services increasing access to their services by extending their opening hours.

6.11 Coupled with increased access to primary care is a presumption that community services, including social services, need to be able to offer a much more immediate response to enable packages of care to be put in place very quickly to help patients stay at home, rather than being admitted to hospital, including outside normal office hours. For this to work GPs will need to look at how quickly they are able to manage day-time emergencies.

6.12 There is also a place in the new model of working for other health professionals, particularly pharmacists, to take on a much more extended role and provide treatment advice to patients with primary care needs earlier and helping them to avoid needing to see a GP either at their own practice, a GP led-health centre, or the UCC.

6.13 These changes will mean that over time, the default option for patients who assess their needs as urgent will not necessarily be a hospital setting, although this will still be an option. The access offered at an UCC will be complemented by a network of more community based options that will be able to offer the same standards of access, nearer to patients' homes. For vulnerable patients, many with long term conditions (the Ambulatory Care Sensitive Conditions that we talked about earlier) there will be a different kind of response within a community setting which will be able to rapidly assess their needs and if they are well enough, care for them at home, rather that being admitted to a hospital bed.

The main changes that will need to happen to make this work

6.14 The next few sections go through the changes highlighted in the *Healthcare for London* document and what they would mean in an Islington context. Underpinning all of the changes is a fundamental shift from the delivery of urgent care being managed and led by hospitals, to urgent care being led and shaped by PCTs from a community perspective.

Change 1, Healthcare for London:
Community provision needs to expand to increase delivery of pre-emptive care (especially for older people, people with long-term conditions and home support), through integrated multi-disciplinary (health and social) care teams working across organisational boundaries.

Recommendations 1: Community Provision

This change accords with the findings from the Islington stakeholder day in June, where increased responsive community care was cited as a big gap for Islington. Specifically we will:

We know that in Islington many people are admitted to hospital for conditions that could be cared for in a community setting, if services were organised differently (see the ambulatory care sensitive conditions). We think that this is because services are not organised in a way that enables GPs and other community clinicians a rapid response to assess a person's needs and organise an appropriate package of care, either at home or perhaps in a short-term bed in a care home.

First, we want to explore the feasibility of establishing a rapid response community team to operate outside working hours, this will be integrated with social services with a particular focus on vulnerable groups like the elderly. This will enable GPs and other community health professionals to get a quick response – in and out of hours – to make a decision about how to best care for a patient's needs and to quickly organise care for those needs through one professional who will coordinate with all of the other care agencies, including social services. Subject to a costed business case we will go out to tender for the service.

Second, community care needs to be organised and managed differently to enable patients who might have been admitted to hospital a level of support and nursing care for them to be able to be cared for at home with some conditions. We will explore the feasibility of establishing a 'hospital at home' model of care in Islington to provide intensive packages of support for patient to be cared for safely at home rather than being admitted to hospital if that is clinically appropriate. Subject to a costed business case we will go out to tender for the service.

We will also:

- Look at business process redesign work within Primary Care to establish new models of dealing with in-hours urgent cases within practices; a second phase may be to establish a bespoke home visiting team;
- Ensure rapid and appropriate primary care referrals to intermediate care beds;
- Review current arrangements and secure alternative models as required for specialist medical input within a community setting; and
- Work with the Whittington and UCLH, to give GPs rapid on-the-day access to outpatient appointments, including diagnostics and imaging.

For patients this will mean improved access to community support. Enabling patients to be

rapidly assessed and cared for in their own home, or community setting, rather than being admitted to a hospital bed.

Change 2, Healthcare for London
Acute assessment services should be developed to ensure prompt access to enhanced assessment and decision-making skills and to prevent admission or facilitate early discharge wherever possible. This needs to be supported by 24/7 access to diagnostics. The needs of older people and children require a particular focus.

Recommendation 2: Enhanced assessment and decision-making skills

The Islington stakeholder group agreed that the implementation of the new model was dependent on the quality of clinical decision-making skills. Specifically we will:

- Be very specific about the levels of seniority and skill-set of clinicians dealing with cases through the UCC and any other tendered component of the service;
- Ensure service specifications make clear the need for service providers to work together and share education and training expertise. This will need to link with work that is already underway developing skills within primary care;
- Encourage providers to work together to provide integrated care pathways.

For patients this will mean that they should have confidence about the skill set of clinicians managing their care, and be accessing care at a place which is appropriate to their level of need and the complexity of their case. There are skills shortages and developing different skill sets, particularly within a primary care setting, will take time and we need to be realistic as well as ambitious.

Change 3, Healthcare for London
M*ore capacity is required in primary care services and there needs to be greater support for people to self care.*

Recommendation 3: Primary Care Services

The group of Islington stakeholders agreed with this assessment. This does not mean that we need additional numbers of GP surgeries but that we need to increase the expertise and provision within a primary and community setting. This is mainly cover through Recommendation 1. We would also look to:

- Commission additional analysis to look at the reasons behind repeat attendances at GPs and A&E. Use this analysis to plan and rollout a social marketing campaign – by which we mean a focus on health prevention messages, early detection, encouraging knowledge and understanding of signs and symptoms, plus a focus on GP registration – to change patterns of use and help to embed knowledge about how to access services when the need is perceived as urgent; and
- Link the social marketing campaign with NHS Islington's self-care agenda, particularly around Long Term Conditions, through the Expert Patient Programme to understand patient behaviour and ensure that services are designed around patients' needs. This will help patients to feel confident and reassured when seeking care.

For patients this will mean two things: first at the points where they access services, particularly

the UCC, those services will be designed to be appropriate to their levels of need. Second, NHS Islington will work with patients to make sure that they understand where and how to access the services that are appropriate to their needs, to reduce duplication and confusion.

Change 4, Healthcare for London
Primary care led Urgent Care Centres (UCCs) should be established to deal with urgent undifferentiated caseload; An UCC should be co-located with every A&E to meet need in the place of choice. UCCs in community settings are more likely to meet un-met demand (and increase costs) consequently development should be limited and based on an evaluation of need across the system; demand management protocols should be put in place.

Recommendation 4: Establishing Urgent Care Centres

The UCC is the pivot point of the Healthcare for London model, with the assumption that there will be an UCC on every hospital site that currently has a general A&E. These will be run by clinicians with primary care skills with clinical leadership from GPs. Islington is responsible for commissioning (or buying) care for its residents for all their healthcare needs. This means that we are responsible for making this change in Islington.

This strategy is recommending that NHS Islington should tender for an UCC on the Whittington hospital site, working with Haringey PCT to make sure that it meets the needs of its patients in West Haringey. The Whittington Hospital have been involved in the development of the strategy and have been very explicit that whilst they support the direct of travel in the urgent care strategy they do not agree with the principle of tendering for the UCC on the Whittington site.

NHS Islington will be mindful to ensure equity of access to Urgent Care Centres for all its residents and will work with other PCTs to ensure that UCCs are being commissioned at hospitals accessed by Islington residents, specifically UCLH, Barts and The London, Royal Free and Homerton hospitals.

It is anticipated that Camden as lead for UCLH will be responsible for a similar exercise with UCLH. NHS Islington will aspire to align timescales for the implantation of an UCC on the Whittington site with the rollout of similar initiatives at other local providers led by neighbouring PCTs in order to make the system as clear as possible and to minimise any confusion for patients.

We already know that a large number of patients go to A&E for their primary care needs. This change will mean that whichever hospital they attend they will be able to clinician with exactly the right skills appropriate to their needs 24/7

Change 5, Healthcare for London
Evaluation of newly commissioned capacity is required for unscheduled and scheduled care in primary care services and within routine weekday hours and extended hours. New ways of delivering care are needed and an increase in access points; this is recognised in developments already underway e.g. polyclinic proposals and GP led health centres - these should be supported and further expansion, or acceleration, may be needed.

Recommendation 5: Expanding capacity in primary care

Islington part way through a process of procuring a GP led health centre which will open by March 2010. Our approach for polyclinics will be included within the Primary and Community Services Strategy that is being developed; it is not expected to see a polyclinic open in Islington for another two to three years. This strategy and the Primary and Community Services strategy should be read as complementary documents. In particular the Primary and Community Services Strategy will set out:

- Exploring whether the UCC at the Whittington can form the centre of a different kind of network primary care in North Islington linked to the polyclinic model;
- Working with colleagues in Haringey PCT, to ensure that the models of care set up in north Islington meet the needs of the West Haringey GP population and their patients;
- Working with colleagues in Camden PCT, to input into their models of care around UCLH, to ensure that the models of care meet the needs of South Islington GPs and their patients; and
- Keeping under review whether additional GP led-health centres or alternative models of care need to be commissioned to meet patient needs in other parts of the borough to ensure equity of access to primary care led urgent care services.

For patients this will mean that the way there should be a greater alignment between the way that they access care for their urgent and more routine needs. All care should be able to take place closer to a patient's home and we will see an increased range of services available within the community, as well as further integration with social services to join up care.

Change 6, Healthcare for London
There needs to be faster and extended access to diagnostic tests and prompt (within 4 hours) return of results in and out of hospital settings and which are easily accessible to a wide range of primary care services. Access to diagnostics needs to be matched to related services; the aim should be to ensure access 24/7.

Recommendation 6: Expanding access to diagnostics

Access to diagnostics – like ultrasound, x-ray, pathology and echo, rather than CT or MRI scans – was seen by Islington stakeholders as being of vital importance in ensuring that the new model of care is able to work. To enable this to happen:

- Carry out an assessment of the diagnostics needed a within primary care setting, taking into account the need for diagnostic capacity as part of the development of any polyclinic model within the borough;
- NHS Islington will be working with local acute providers to offer rapid access (4-hour) direct access diagnostics and will invest in the infrastructure to enable this to happen;
- Rapid access direct access diagnostics will be extended to a range of other health professionals in a community setting, for example Community Matrons and Specialist Nurses; and
- NHS Islington will invest in further direct access diagnostic capacity in community and primary care settings and work with NHS London to improve the turn around times for the independent sector diagnostics service.

For patients this will mean that their GP, and other community based clinicians, will be able to make a rapid assessment of their care needs and put in place appropriate arrangements for their care either in their home, community setting or a hospital depending on the level of complexity.

Change 7, Healthcare for London
Pharmacies need to be firmly integrated into unscheduled care systems. Enhanced availability of dispensing facilities (potentially 24/7) is needed to improve access to prescription medicines. There should be wide roll out of the Minor Ailments Scheme, medicines management linked to admission prevention/discharge, plus self-care advice.

Recommendation 7: Minor Ailments Scheme

NHS Islington already has a Minor Ailments Scheme; however this is only available to patients who have already presented at their GP practice. As part of the Primary and Community Services Strategy NHS Islington will:

- Extend the scope and open up the access to the current Minor Ailments Scheme, this will involve additional investment;
- Ensure that pharmacists receive extra training and support in assessment skills to take on new and extended roles;
- Explore increasing the role of community pharmacists in the management of urgent presentations, building on the current CVD (Cardio Vascular Disease) case finding and ensuring extended opening times and access; and
- Through the Primary and Community Services Strategy look at the availability of medicines 24/7 and whether different access arrangements are needed.

By using community pharmacies in this extended way, patients will have an additional access point for treatment advice and support for needs that they identify as urgent.

Change 8, Healthcare for London
Primary care access/GP registration function (or direct access to it) is required at every access point to steer the non-registered population to universal primary care services.

Recommendation 8: GP registration

A GP registration officer is already in place at the Whittington and this model works well. As well as providing easily accessible care to all patients wherever they present NHS Islington also needs to make it easier for patients to register with a GP. In order to take this forward, NHS Islington will:

- Work with neighbouring PCTs, like Camden for UCLH, around the establishment of their UCCs – to ensure that GP registration is embedded in the model of care; and
- As part of the Primary & Community Care Strategy look at whether it is possible to simplify the GP registration process and link with national work that is being undertaken in this area.

For patients this will mean that it should be easier to register for a GP, in addition to being able to access care at other points in the system.

Change 9, Healthcare for London
Greater integration and consistency is needed to bring primary, secondary and social care processes and working arrangements closer together; challenges that will need to be addressed include working across boundaries, effectiveness and compatibility of IT systems and funding mechanisms; there should be an integrated approach to training and education, including staff rotations between access points.

Recommendation 9: Integration

Islington already has a high level of integration between health and social care. The steps set out in this strategy should further enhance this integration. The need for joint-working will need to be a key component of any tender specifications for new services, as will expectations around joint-approaches to training and education. Adult social care already plays a part in urgent care through the rapid response teams that are situated within A&E, this will continue in the new model with rapid response available in both the UCC and A&E and a focus on integrated pathways of care.

Change 10, Healthcare for London
A whole system and extended service model must include mental health, substance misuse and maternity care and be more responsive to the needs of vulnerable people e.g. with disabilities and complex needs.

Recommendation 10: A whole system approach

The specific needs to vulnerable groups will need to be specified within any tender documentation for new services. In addition the Islington stakeholder group felt that two specific issues that would need to be addressed are:

- Care pathways for adolescents particularly those presenting who self-harm and people with drugs and alcohol dependencies; and
- Working with Camden around pathways for mental health service users at UCLH.

The Steering Group set up to contribute to the development of this strategy added two important recommendations in addition to those taken directly from the *Healthcare for London* model.

Recommendation 11: Financial modelling.

Following consultation and before implementation further detailed work is required to ensure that the model is underpinned by a robust financial assessment. This will involve:

- Developing a detailed business case for an Urgent Care Centre, this would need to model changes to financial flows within the system as highly specialised work around major trauma or stroke moves to specialist centres funded outside of the tariff; and
- Carrying out a feasibility studies for both a hospital at home and rapid response community team and subject to a costed business case go out to tender. This will need to model how funding might over time move from a hospital to a community setting in order to support patients' being cared for at home but also the step-change in the quality of care set expected from the new model of care set out in the strategy.

Recommendation 12: Monitoring, information and implementation.

The changes proposed at a high-level in this document will make a fundamental shift in the way that patients who need to see a doctor or nurse immediately, or perceive their need to be urgent, are treated. In order to make these changes the Islington stakeholder group recommended that:

- Work is undertaken to ensure that the new models of care are underpinned by very strong information and management support, and if initiatives to integrate and ensure compatibility of systems across NHS providers, health and social care;
- Pilots are going to take place across London of a single telephone number to access urgent care services, so that 999 is reserved for emergencies. Work is also going on locally in Islington by the council to look at a single point of telephone access for social services. Both of these initiatives will need to be evaluated with a view to extending over time to the new model of care in Islington set out in this document;
- Working with colleagues in public health, the models of care set out in this document will need to be evaluated over time, to ensure that they are meeting their objectives, and as part of adding to the national evidence and literature base about models of urgent care.

7 What is change dependent upon?

7.1 This section sets out the significant factors on which change is dependent, and which will determine the success of this strategy.

7.2 NHS Islington has agreed a market management and procurement strategy in line with the Department of Health's new guidance on competition and co-operation in the NHS, which requires commissioning organizations to hold an open tender when developing new services. The development of an Urgent Care Centre and many of the other developments envisaged within this strategy, are of sufficient value to trigger this requirement and NHS Islington is of the view that an open tender is the best way to secure a quality service that is value for money. NHS Islington will need to follow the Department of Health procurement rules when procuring these services. It will also be looking to ensure that the new services it procures are of a high quality, cost effective and build on the care pathways that already exist and work that has already been undertaken.

7.3 Delivering this strategy is built upon the need to understand why patients make the choices that they currently do and to design services that will over time impact on their behaviour. The models described need to be realistic about the degree of change that is possible – supported through social marketing and patient education – and creating a model that works around patient behaviour rather than trying to change it completely. As the money will follow the patient the new models need to be flexible enough to shift with actual as well as envisaged patterns of use.

7.4 A big determinant of this strategy is the successful rollout of the *Healthcare for London* strategy including successful implementation of big changes for more complex conditions, particularly stroke and major trauma work. The five PCTs in North Central London (Barnet, Enfield, Haringey, Camden and Islington) are in the process of establishing an acute agency to manage all acute commissioning and deliver on these big areas of service redesign. The successful implementation of this agency will be crucial.

7.5 Two other dependencies which will affect the strategy are first the successful implementation of the Primary and Community Services Strategy which will be completed in early 2009 and go out for consultation. The two strategies are complementary documents and integral to each other's success. Second, is the need for other neighbouring PCTs to pick up the Healthcare for London model and run with it in their local area, as this will be one of the determinants in establishing equity of access for Islington residents. The rollout of the Primary and Community Services Strategy will need to be flexible enough to compensate for any differential rollout by neighbouring PCTs, and by over time compensating by looking at where to site additional capacity within Islington, for example additional GP led health centres.

7.6 The Islington stakeholder group identified as one of their strategic aims 'better coordination overall with a single patient record shared across the health system with links as appropriate to social care'. It is undoubtedly true that improving information management and connectivity between providers would vastly improve the ability of organisations to work together and improve integration. The key dependency here is the successful implantation of Connecting for Health, a series of IT systems and a single spine that enables information sharing in a structured and secure manner between acute services, primary care, NHS Direct and social services. It is acknowledged that slippage has occurred, although it is currently envisaged that Connecting for Health should be implemented within in the lifetime of this strategy.

7.7 This strategy is dependant on changes to the financial flows within the system. In order to implement the Healthcare for London models of care, there will need to be new tariff structures for care in Urgent Care Centres at one end of the spectrum and the specialised trauma and stroke work at the other.

7.8 Finally, NHS Islington will over the next few years be looking at the future configuration of GP out-of-hours services. This is subject to a separate process and as part of this NHS Islington will want to look at the longer term alignment of out-of-hours services and how this would fit with the model of care described in this strategy.

8 What will happen when?

8.1 If Islington is to implement the model of care described in this strategy a number of changes will be required to current local services.

8.2 The strategic proposals for change outlined below will be implemented in a phased way between now and 2012/13.

Proposals for Change	**Timetable for Implementation**				
	2008 - 2009	**2009 - 2010**	**2010 - 2011**	**2011 - 2012**	**2012 -2013**
Governance					
Establish an Urgent Care Steering Group to manage and co-ordinate care across Islington					
Recommendation 1:					
1. Explore the feasibility of establishing a rapid response community team to operate outside working hours, this will be integrated with social services with a particular focus on vulnerable groups and subject to a costed business case go out to tender;					
2. Explore the feasibility of establishing a 'hospital at home' model of care in Islington, and subject to a costed business case go out to tender;					
3. Looking at business process redesign work within Primary Care to establish new models of dealing with in-hours urgent cases within practices; a second phase may be to establish a bespoke home visiting team					
4. Ensure rapid primary care access to intermediate care beds					
5. Review current arrangements and secure alternative models as required for specialist medical input within a community setting					
6. Work with the Whittington and UCLH, to give GPs rapid on-the-day access to outpatient appointments, including diagnostics and imaging					
Recommendation 2:					
7. Be very specific about the levels of seniority and skill-set of clinicians dealing with cases through the UCC and any other tendered component of the service					
8. Ensure service specifications make clear the need for service providers to work together and share education and training expertise. This will need to link with work that is already underway looking underway developing skills within primary care					
9. Encourage providers to work together to provide integrated care pathways.					

Recommendation 3:					
10. Commission additional analysis to look at the reasons behind repeat attendances at GPs and A&E. Use this analysis to plan and rollout a social marketing campaign – by which we mean a focus on health prevention messages, early detection, encouraging knowledge and understanding of signs and symptoms, plus a focus on GP registration – to change patterns of use and help to embed knowledge about how to access services when the need is perceived as urgent					
11. Link the social marketing campaign with NHS Islington's self-care agenda, particularly around Long Term Conditions, through the Expert Patient Programme to understand patient behaviour and ensure that services are designed around patients' needs. This will help patients to feel confident and reassured when seeking care.					
Recommendation 4:					
12. NHS Islington will tender for an UCC on the Whittington hospital site, working with Haringey PCT to make sure that it meets the needs of its patients in West Haringey					
13. NHS Islington will be mindful to ensure equity of access to Urgent Care Centres for all its residents and will work with other PCTs to ensure that UCCs are being commissioned at hospitals accessed by Islington residents, specifically UCLH Barts and The London, Royal Free and Homerton hospitals					
14. The unit cost for care provided at Urgent Care Centres will be less than the lowest band tariff for A&E attendances and neighbouring PCTs will be cross-charged for activity relating to their patients and residents					
Recommendation 5					
15. Exploring whether the UCC at the Whittington can form the centre of a different kind of network primary care in North Islington linked to the polyclinic model					
16. Working with colleagues in Haringey PCT, to ensure that the models of care set up in north Islington meet the needs of the West Haringey GP population and their patients					
17. Working with colleagues in Camden PCT, to input into their models of care around UCLH, to ensure that the models of care meet the needs of South Islington GPs and their patients					
18. Keep under review whether additional GP led-health centres or alternative models of care need to be commissioned to meet patient needs in other parts of the borough to ensure equity of access to primary					

care led urgent care services					
Recommendation 6:					
19. Carry out an assessment of the diagnostics needed a within primary care setting, taking into account the need for diagnostic capacity as part of the development of any polyclinic model within the borough					
20. NHS Islington will work with local acute providers to offer rapid access (4-hour) direct access diagnostics and it will invest in the infrastructure to enable this to happen					
21. Rapid access direct access diagnostics will be extended to a range of other health professionals in a community setting, for example Community Matrons and Specialist Nurses					
22. NHS Islington will invest in further direct access diagnostic capacity in community and primary care settings through the existing Independent Sector providers and work with NHS London to improve the turn around times for this service					
Recommendation 7:					
23. Extend the scope and open up the access to the current Minor Ailments Scheme, this will involve additional investment					
24. Ensure that pharmacists receive extra training and support in assessment skills to take on new and extended roles					
25. Explore increasing the role of community pharmacists in the management of urgent presentations, building on the current CVD case finding and ensuring extended opening times and access					
26. Through the Primary and Community Services Strategy look at the availability of medicines 24/7 and whether different access arrangements are needed					
Recommendation 8:					
27. Work with neighbouring PCTs, like Camden for UCLH, around the establishment of their UCCs – to ensure that GP registration is embedded in the model of care					
28. As part of the Primary & Community Care Strategy look at whether it is possible to simplify the GP registration process and link with national work that is being undertaken in this area					
Recommendation 9:					
29. The need for joint-working will need to be a key component of any tender specifications for new services, as will expectations around joint-approaches to training and education					

Recommendation 10:					
30. Care pathways for adolescents particularly those presenting who self-harm and people with drugs and alcohol dependencies					
31. Working with Camden around pathways for mental health service users at UCLH					
Recommendation 11:					
32. Developing a detailed business case for an Urgent Care Centre, this would need to model changes to financial flows within the system as highly specialised work around major trauma or stroke moves to specialist centres funded outside of the tariff and the impact of activity remaining at A&E funded at tariff					
33. Carrying out a feasibility studies for both a hospital at home and rapid response community team and subject to a costed business case go out to tender. This will need to model how funding might over time move from a hospital to a community setting in order to support patients' being cared for at home but also the step-change in the quality of care set expected from the new model of care set out in the strategy.					
Recommendation 12:					
34. Work is undertaken to ensure that the new models of care are underpinned by very strong information and management support, and if initiatives to integrate and ensure compatibility of systems across NHS providers, health and social care					
35. Pilots are going to take place across London of a single telephone number to access urgent care services, so that 999 is reserved for emergencies. Work is also going on locally in Islington by the council to look at a single point of telephone access for social services. Both of these initiatives will need to be evaluated with a view to extending over time to the new model of care in Islington set out in this document;					
36. Working with colleagues in public health, the models of care set out in this document will need to be evaluated over time, to ensure that they are meeting their objectives, and as part of adding to the national evidence and literature base about models of urgent care.					

9 How will these changes be managed?

9.1 NHS Islington will establish a small steering group that will meet, under the leadership of the Director of Strategy & Commissioning, to ensure that there is stakeholder engagement in the process going forward. Care will need to be taken to manage any potential conflicts of interest during the tendering process.

9.2 Delivery of the strategy will be managed through Strategy & Commissioning; some additional project management resource will be required to support the tendering process and this will come out of the additional investment that has been secured.

10 Resource implications

10.1 NHS Islington currently spends an estimated £11.30 million on services commonly associated with urgent care covering: A&E, the London Ambulance Service, GP out of hours, urgent care dentistry and the minor ailments scheme.

10.2 Additionally, it spends a further £26 million annually on emergency admissions to hospitals; some of which could be avoided if supported by the improved organisation and delivery of primary and community care. This cost excludes that for district and community nursing teams who provide a range of responses in the management of patient with a long term condition who are at risk of an exacerbation, and potentially could avoid admission to hospital.

10.3 It is recognised by NHS Islington that improvements in care will require not only efficiencies and the reorganisation of resources within current services, including district and community nursing, but additional investment that the Board is committed to providing. As part of NHS Islington's investment plans it has been recognised that additional funding will be required to support these changes in 2008/09 and 2009/10. The exact requirements will be presented within financial modelling to be calculated alongside the finalisation of the Strategy, which will incorporate any modifications required following consultation.

10.3 As well as investing additional money into the service NHS Islington, as part of the financial modelling there will be a review all current urgent care spend in its widest sense against the objectives set out in this strategy to make sure that they fit and will reprioritise spending where it is not felt to meet our strategic aims.

Urgent Care Service	Provider	Cost of service 2007/08
Minor Ailment Scheme	Local Pharmacists	£91,000
Primary Care Out of Hours	CAMIDOC	£1,100,000
Urgent Care Dentistry	CAMIDOC & Local Dentistry	£21,500
Ambulance Services	London Ambulance Service	£5,799,682
Accident and Emergency	The Whittington Hospital NHS Trust	£2,880,000*
	University College London Hospitals NHS Foundation Trust	£1,407,000*
	Sub-Total	**£11,299,182**
Emergency Admissions	The Whittington Hospital NHS Trust	£12,739,676
	University College London Hospitals NHS Foundation Trust	£8,449,149
	Royal Free Hampstead NHS Trust	£1,655,829
	Barts And The London NHS Trust	£1,102,926
	Homerton University Hospital NHS Foundation Trust	£1,020,677
	Other Trusts	£1,952,711
	Total	£38,220,150

* Accident and Emergency costs are based on the 2008/09 plan, because of changes in the de-hosting of A&E in London.

11 Next Steps

11.1 The Strategy went to the Finance and Commissioning Sub-Committee of the Board on 16 September and the Board meeting on 25 September and was approved to go forward for public consultation, subject to comments and input from the Urgent Care Steering Group at the end of September.

11.2 The consultation will start on Monday 5 January 2009 and stakeholders and the public are invited to comment on the standards, model and outcomes proposed, with a closing date for comment of Monday 30 March 2009.

11.3 The final strategy with any modifications following consultation will be recommended to the NHS Islington Board for approval.

11.4 If you have any comments or suggestions to make regard this strategy please contact the following:

Anna Stewart
Deputy Director Strategy & Commissioning
Urgent Care Consultation
NHS Islington
338-346 Goswell Road
London EC1V 7LQ

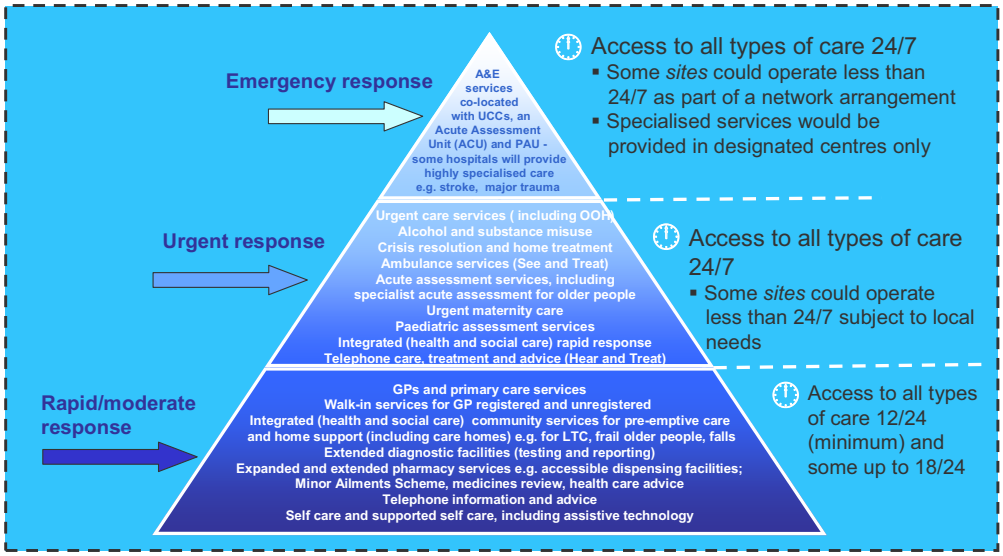
Email: nikki.bozdogan@islingtonpct.nhs.uk

Or comment via the PCT website
www.islington.nhs.uk

Appendix1: Healthcare for London models of care

When services should be available

Most services, as now, would be community based. Regardless of location, they should function as a single system, supported by shared processes and infrastructure



Healthcare for London

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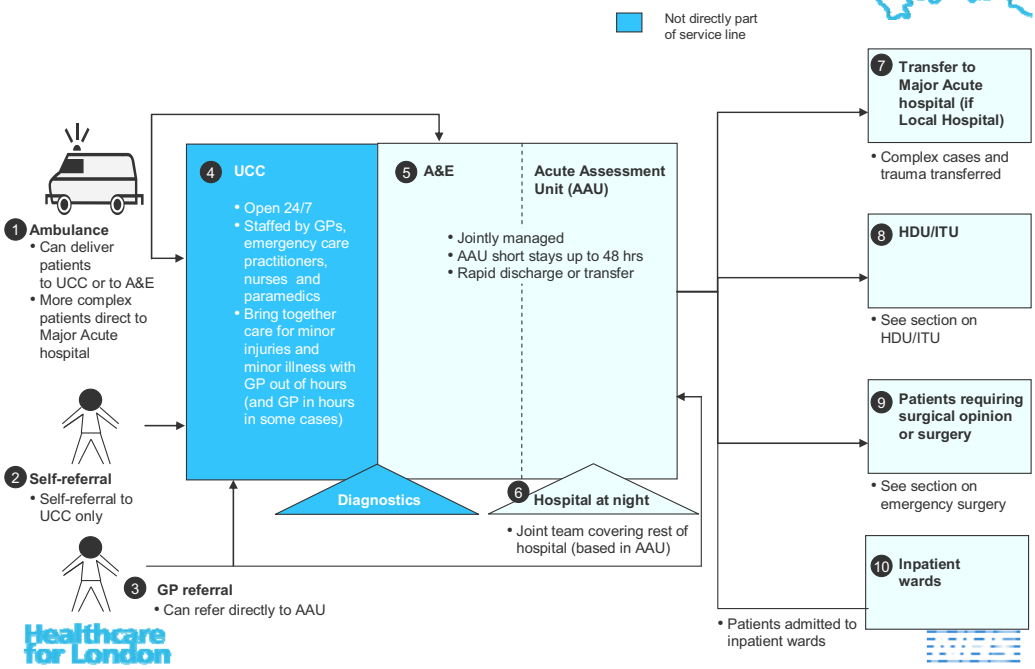
A&E, UCC, AAU

Indicative Model for Urgent Care and Acute Assessment



Healthcare for London

Source: Indicative model developed for discussion as part of the Local Hospital Feasibility Project

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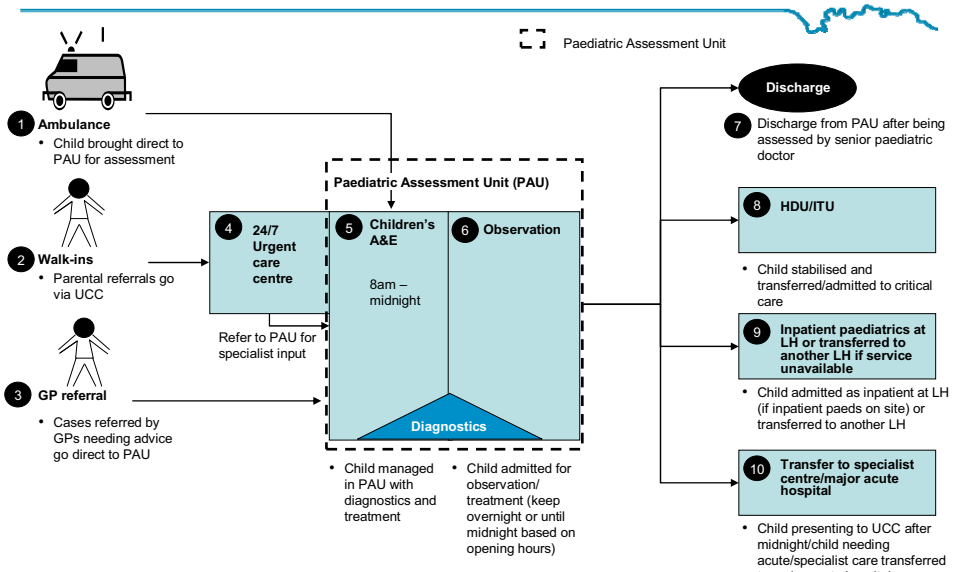
UCC, PAU

Indicative model for Paediatric Assessment



Healthcare for London

Source: Indicative model developed for discussion as part of the Local Hospital Feasibility Project

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Appendix 2: Glossary

Acute Assessment Unit	Short stay ward adjacent to the A&E where patients seen in the A&E who need to stay for a short time for observation or tests can be admitted
Acute Stroke	The first stages of stroke care where patients need hospital treatment rather than rehabilitation
A&E	Accident and Emergency (department of a hospital), used to be called casualty
Ambulatory care sensitive (ACS) conditions	Are long-term health conditions that can often be managed with timely and effective treatment without hospitalisation, for instance COPD or influenza
BME	Black and Minority Ethnic communities
Commissioning	Buying, purchasing or contracting for healthcare services
Community provision	Care outside a hospital setting, normally provided in Islington by the NHS Islington provider-arm e.g. district nursing or specialist nursing services
COPD	Chronic Obstructive Pulmonary Disease, what used to be called emphysema
CVD	Cardio Vascular Disease
Expert Patient Programme	Scheme to help patients feel confident to manage their own conditions and symptoms more proactively
Healthcare Commission	Government body that inspects and regulates healthcare services
Healthcare for London (HfL)	Programme of work looking at making significant changes to the way that healthcare is organised in the capital, based on the recommendations from Prof Lord Ara Darzi
Hospital at home	Service in the community to provide intensive packages of support for patient to be cared for safely at home rather than being admitted to hospital if that is clinically appropriate.
In-hours / out-of-hours	Care taking place during the normal working day or out-side of office hours (for GP out of hours this is normally after 6pm and before 8am)
Major trauma	Serious or life threatening injures e.g. those sustained in a major road traffic accident
Minor Ailments Scheme	Schemes for pharmacists to see and give advice and medication to patients with minor illnesses without them needing to see a doctor
NHS Islington	The operating name of Islington Primary Care Trust
PCT	Primary Care Trust
Polyclinic	Model of primary care set out in Healthcare for London, the Islington approach will be set out in the Primary and Community Services Strategy
Right Care: Right Place	Service set up by the Whittington and NHS Islington to redirect patients to alternative provision in the community and to ensure that patients with primary care needs attending A&E are registered with a local doctor
Social Services / Social Care	Services provided by local authorities, generally meeting the social care rather than health care needs of the local population
Social marketing	Focus on health prevention messages, early detection, encouraging knowledge and understanding of signs and

	symptoms, plus a focus on GP registration
Tender	Process by which organisations interested in providing a service, set out their proposals and NHS Islington as a commissioner (purchaser) of services considers all the proposals against published criteria and chooses one that will carry out the service for a contracted period of time.
Urgent Care Centre	Facility right next door to the A&E but physically separated from it. The UCC will see both adults and children and will be staffed by people with primary care skills, primarily GPs and nurses working with adult social care. This will be the place where patients will be able to self-refer at any time of the day or night, 24/7. Patients will be able to receive care, as quickly, if not more quickly than in A&E.
Urgent care	Care, excluding planned care, which the patient seeks access to on the same day that the patient perceives it is needed.
Walk in Centre / Minor Injuries Units	Services that offer walk-in services (ie no appointment is needed) for minor or primary care type illness and injuries. They are unable to care for patients with serious illnesses who would need to go to an A&E.

NHS Islington

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Website:
www.islington.nhs.uk

NHS Islington is the operating name of Islington Primary Care Trust (PCT)

Agenda Item 10

Haringey Council

Overview and Scrutiny Committee on 29 April 2009

Report Title: Proposal by Barnet, Enfield and Haringey Mental Health Trust (MHT) to Restructure Haringey Mental Health Acute Care Services – Response by MHT to Overview and Scrutiny Committee Response to Consultation	
Forward Plan reference number (if applicable): N/A	
Report of: Chair of Overview and Scrutiny Committee	
Wards(s) affected: **All**	Report for: **N/A**

1. Purpose

1.1 To receive a response from BEH MHT to the response by the Overview and Scrutiny Committee to its recent consultation on the reconfiguration of acute care within the Borough. A copy of the formal response by the Overview and Scrutiny Committee is attached.

2. Introduction by Cabinet Member (if necessary)

2.1 N/A

3. Recommendations

3.1 That the Committee receives the response by the MHT and responds accordingly.

Contact Officer: **Rob Mack, Principal Scrutiny Support Officer, 020 8489 2921**
rob.mack@haringey.gov.uk

4. Local Government (Access to Information) Act 1985

4.1 Background Papers:

Improving Mental Health Services in Haringey – Draft Consultation Plan and Document – Barnet, Enfield and Haringey Mental Health Trust

5. Report

5.1 Following approval at its meeting on 20 April, the Committee submitted its formal response to the MHT on 21 April. A copy of this is attached. Representatives from the MHT will be attending the meeting to respond to the Committee's response. Due to the short timescale involved, it has not yet been possible for a formal written response to be drafted by the MHT

Overview & Scrutiny Team
7th Floor, River Park House, 225 High Road, Wood Green, London N22 8HQ
Tel: 020 8489 6922 **Fax:** 020 8489 2533 **Minicom:** 020 8489 2535
www.haringey.gov.uk

Head of Policy & Performance Eve Pelekanos

Haringey Council

Andrew Wright
Director of Strategic Development
BEH Mental Health NHS Trust
Management Offices K1
St Ann's Hospital
St Ann's Road
London N15 3TH

Your ref:
Date: 21 April 2009
Our ref: SR/ POC
Direct dial: 0208 489 2921
Email: rob.mack@haringey.gov.uk

Dear Andrew,

Improving Mental Health Services in Haringey

I am writing to inform you of the conclusions and recommendations that have been reached by the Overview and Scrutiny Committee in response to your consultation on Improving Mental Health Services in Haringey.

The proposed changes were considered to represent a substantial variation or development to local services, as outlined in Section 7 of the Health and Social Care Act 2001. This requires that the Overview and Scrutiny Committee considers whether the Trust has properly consulted the Committee, conducted appropriate consultation and public involvement and presented proposals that are in the interests of local health services. A small panel of Members, chaired by my colleague Councillor Ron Aitken, was appointed by the Committee to undertake this detailed work and report back on its findings.

To assist in its deliberations, the Panel received evidence from a wide range of sources including Haringey Council's Adult and Housing Support and Options Services, the Metropolitan Police, MIND, Haringey Mental Health Carers Support Association, Haringey User Network, the Patients Council and the Mental Health Trust's Joint Staff Committee. It also considered relevant documentary information including statistical information provided by the MHT and reports from the Mental Health Act Commissioners and NCAT. Panel Members also visited St. Ann's Hospital.

From this evidence, the Panel has formed the following conclusions:

- They are satisfied that there has been appropriate consultation with the Overview & Scrutiny Committee. They are also satisfied that in developing the proposals for service changes, BEH MHT and NHS Haringey have taken into account the public interest through appropriate patient and public involvement and consultation. They are nevertheless concerned that the proposed closure of Finsbury Ward was initially only subject to consultation with staff and that the views of service users, carers, other stakeholders and the Overview and Scrutiny Committee were not actively sought. After this start, genuine efforts were made to involve those affected by the proposed changes. For example, two public meetings were arranged and officers

from the MHT attended relevant area assemblies. Efforts were also made to engage directly with service users at clinics and at meetings of the Haringey User Network. In addition, the MHT also employed an independent organisation – Healthlink – to evaluate the feedback received,

- The Panel is of the view that future proposed changes should be brought to the attention of Overview and Scrutiny Committee, service users and carers and stakeholders in a more timely and proactive manner so that their views can be taken into account at an early stage in the development of proposals. The Trust not only has responsibilities under Section 7 of the Health and Social Care Act 2001 to do this where substantial variations or developments to services are planned – it also has a general duty to involve under Section 242 of the NHS Act 2006, which covers developments that fall beneath this threshold. The Committee is particularly mindful that the Trust has specific aspirations to close another ward at St Ann's in 2009/10 and rationalise PICU. The Panel is of the view that the interests of transparency and openness would have been better served by the MHT if these had been shared more explicitly with the Panel, service users and their representatives when they were developed during the consultation period. Both of these proposals should be subject to appropriate levels of consultation in due course.

- The Panel has concluded that convincing evidence has been presented of the need to improve and modernise mental health services in Haringey and of the clear benefits of home treatment over in-patient care. Although no organisations or individual that the Panel received evidence from questioned the principle behind the proposed changes, concerns were raised about the pace of change.

- The Panel cannot yet support permanent closure of the ward or, at this stage, conclude that it is in the interests of the local health service. This is for the following reasons:

    1. The Panel notes the reductions in bed occupancy levels, lengths of hospital stay and delayed discharges, which are all welcome. However, it is mindful of the view of the Mental Health Act Commissioners that caution should be observed before making permanent reductions in beds due to the long term and ongoing nature of concerns about over occupancy at Ann's. It also notes that although the figures show an overall downward trend, there have been some fluctuations. It is therefore of the view that it would be premature to conclude at this stage that there has been a "proven sustained diminution of demand for in-patient beds." The Panel concurs with the view of the Commission that occupancy levels at St Ann's need to be below 100% for a consistent period before consideration of a permanent reduction in the number of acute inpatient beds.

    2. The Panel received evidence from key stakeholders in the course of the review that, when the proposals were initially made, there had been limited opportunities for partners to discuss their potential implications and to make the joint strategic and operational plans necessary to ensure that the range of services were in place to support the changes. The Panel is of the view that proposals of this nature should routinely be the subject of detailed discussion with partners at an early stage, even if this is merely for the purposes of reassurance. However, the Panel notes that some progress appears to have since been made, with discussion taking place with relevant partners and stronger links established with relevant housing services.

The Panel is of the view that the proposals will have an impact on the Trust's partners. Patients being treated at home are likely to require a range of services to support them, not all of which will be resourced or provided by the MHT. These will include social care and housing. In addition, the Panel notes the concerns of the Police Service about the potential for additional demands on its officers, particularly out-of-hours.

It is of the view that, before the ward is closed permanently, an integrated and costed plan should be jointly drafted by mental health partners. This should address fully the consequences of the ward closure as well as the potential for the enhancement of services. The plan should also address the range of resources and services provided by the Trust, such as home treatment teams, START, community mental health teams, rehabilitation services and the remaining wards; services provided and/or commissioned by the local authority such as housing, day services and rehabilitation, as well as the roles of A&E departments, primary care, the Police Service and informal carers, who are all potentially active stakeholders during mental health crises.

It is particularly important that mental health commissioners ensure that the necessary funding is in place to accommodate any additional financial pressures on partners that might occur as a consequence of the proposed changes. In addition, all financial savings made by the MHT as a result of the closure of the ward should be re-invested in providing treatment for Haringey patients – either through the home treatment teams or the provision of additional staff on the remaining wards. Any future ward closures should not take place until similar joint planning has taken place.

The Panel emphasises that, in saying that it does not yet support permanent closure, it is *not* proposing that the ward should be re-opened immediately and staff redeployed back onto it. It is of the view that, pending permanent closure once the above mentioned issues have been addressed fully, the ward should be available to accommodate patients should the need arise.

Overview and Scrutiny Committee has fully endorsed the findings of the Panel. It requests that the MHT and NHS Haringey respond formally to the issues highlighted above and that Overview and Scrutiny Committee are kept informed of future developments.

Finally, I would like to formally thank you and other officers from both the MHT and NHS Haringey for assisting the Panel and the Committee in consideration of this issue. Their co-operation is much appreciated.

Yours sincerely

Gideon Bull

Chair – Overview and Scrutiny Committee

c.c. Liz Rahim, NHS Haringey

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