Public Health
222 Upper Street

Report of: Director of Public Health

Meeting of: Health, Wellbeing and Adult Social Care Scrutiny Committee

Date: July 2024

Ward(s): All

Public Health Performance Q3, 2023/24

1. Synopsis

1.1 The council has in place a suite of corporate performance indicators to help monitor progress in delivering the outcomes set out in the council's Corporate Plan. Progress on key performance measures is reported through the council's Scrutiny Committees on a quarterly basis to ensure accountability to residents and to enable challenge where necessary.

1.2 This report sets out the quarter 3, 2023-2024 (reported one quarter in arrears due to data lags), progress against targets for those performance indicators that fall within the Health and Social Care outcome area, and for which the Health, Wellbeing and Adult Social Care Scrutiny Committee has responsibility.

2. Recommendations

2.1 To note performance against targets in quarter 3, 2023/24 for measures relating to Health and Independence.

3. Background

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

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

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

Public Health Performance Q3, 2023/24

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

Public Health Priority	PI Ref	Key Performance Indicator	Annual Target 2023/24	Actual 2022/23	Q1 2023/24	Q2 2023/24	Q3 2023/24	On target?	Q3 Last year?	Better than Q3 last year?
Immunisation	**PHI1**	**Immunisation Population Coverage:**	**Improvement to 22/23**							
	PHI1 a)	DTaP/IPV/Hib3 at age 12 months.	- Improvement on 89%	89%	87%	86%	87%	Near target	89%	Similar.
	PHI1 b)	MMR2 - 1st and 2nd dose (Age 5)	- Improvement on 70%	70%	68%	Data not available.	Data not available for Q3	N/A	70%	N/A as no data available for this quarter.
CYP	**PHI2**	**% Uptake of the NHS Healthy Start Scheme**	Improvement to 64% baseline.	N/A New Corporate KPI	66% uptake (1,716 of 2,590 eligible).	69%	TBC	TBC pending confirmation of data errors being resolved.	N/A New Corporate KPI	N/A New Corporate KPI.
Smoking	**PHI3**	**% of people quitting successfully who use the stop smoking service**	55%	62%	56%	59%	65%	Yes	57%	Yes - higher.
Health Checks	**PHI4**	**% of eligible population (40-74) who have received an NHS Health Check.**	10%	12.1%	3.7%	4.5%	4.1%	Yes	2.7%	Yes – higher.
Substance Misuse	**PHI5**	**Number of adults accessing treatment in a 12-month rolling period – by Q4 2023/24**							N/A New Corporate KPI.	N/A New Corporate KPI.
	5a	Alcohol	389		370	407	413			
	5b	Alcohol and non-opiate	222		203	226	211			
	5c	Non-opiate	128		116	126	190			
	5d	Opiate	1033		866	899	926			
		Total	**1772**		**1555**	**1658**	**1740**	**Yes**		
Substance Misuse	**PHI6**	**No. of people successfully completing drug and/or alcohol treatment of all those in treatment (12 months rolling) – by Q4 2023/24**							N/A New Corporate KPI.	N/A New Corporate KPI.
	6a	Alcohol	150		140	146	145			
	6b	Alcohol and non-opiate	81		61	47	56			
	6c	Non-opiate	54		40	35	43			
	6d	Opiate	55		43	49	41			
		Total	**340**		**284**	**277**	**285**	**No**		
Sexual Health	**PHI7**	**Number of Long-Acting Reversible Contraception (LARC) prescriptions in**	1200 based on 22/23 baseline for		296	339 (635 cumul	358 (993 to date -	Yes	423	No – lower.

		local integrated sexual health services.	integrated care.			ative, to date).	cumulati ve)			

5. Quarter 3 Performance Update – Public Health

5.1 Immunisation population coverage

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

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

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

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

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

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

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

5.2.1 In quarter 3 (Q3), 87% of children aged one year old had received a complete course of the 6-in-1 DTaP/IPV/Hib/HepB vaccine. Coverage in this period was slightly higher than the previous quarter (Q2, 2023-24) at 86% and slightly lower than this time last year (Q3, 2022-23) at 89%.

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

5.2.3 The rates of coverage reported through COVER for quarter 3 - for all three doses, was at 87% in Islington, 86% in London and 91% in England. This highlights vaccination rates have levelled this quarter and are in line with average London rates.

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

5.3.1 This indicator is for children aged five in December 2023. These children were due their first dose vaccination (at age two) between January 2020 and December 2020, and their second dose (at age three years, four months), between May 2022 and April 2023.

5.3.2 MMR vaccination data is unavailable from the NHS's HealtheIntent system this quarter, due to data quality issues (identified during the previous quarter). The reasons for this discrepancy are being investigated by primary care officers from the Integrated Care Board (ICB), in order to remedy the problem. It is suspected that there may be errors when uploading vaccination codes from EMIS (GP patient data systems) to Healtheintent (the population health platform). The ICB are working with primary care practices to try and identify and resolve the issue for the next quarter.

5.3.3 The rates of coverage reported through COVER however is available and performance for both doses of the MMR vaccination at age five years were 63% in Islington, 74% in London and 84% in England for quarter 3. The COVER report figures are likely to be underestimates of the actual vaccination levels for the same reasons as described for DTaP.

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

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

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

5.4.3 The second phase of the national catch-up programme continued throughout Q3, focussing on delivery of the polio vaccine (part of the 6-in-1) and MMR to children aged one to eleven years of age. Catch-up for children under age five was through the normal route i.e. their GP practice. Public health officers were able to amplify national messaging through early years communication channels such as

Bright Start, Bright Ideas (newsletter to parents), via under-five (years) settings such as children's centres and nurseries and community partners.

5.4.4 During Q3, there was also an outbreak of measles in parts of North West London. Messaging was targeted at families of under five-year-olds via the Bright Start, Bright Ideas newsletter, with health visitors reinforcing the messaging, and checking for vaccination status at every routine health review. MMR information leaflets were provided to community events, and there was close co-ordination with the new Childhood Immunisation Project Outreach Worker, who had started working with HealthWatch in the same quarter.

5.4.5 A 'community conversation' around child health and immunisations took place with community leaders in October and public health attended the Early Years forum in November to ensure settings are aware of the risk of measles and were able to pass on messages to parents about the safety and importance of vaccines.

5.4.6 The ICB has also been working with the GP federation to provide targeted telephone recall to children identified as unvaccinated.

5.4.7 Key challenges faced this quarter include:

- Data issues have prevented accurate analysis of the MMR2 uptake from Q2, to this quarter (3). This is being reviewed by the NHS who are responsible for the HealtheIntent system.

- This may be linked to codes for MMR2 not being uploaded from GP practice systems into the North Central London (NCL) Integrated Care Board's HealtheIntent system, which is used to calculate the vaccination coverage. This issue is currently under investigation and does not seem to be affecting other vaccinations.

5.4.8 The focus for the next quarter:

- The national focus on MMR catch-up will continue into Q4. This will be matched by local resource to raise awareness and provide information, as well as continued attendance at community events to raise awareness, provide information and encourage vaccination for those that are not fully protected.
- All possible touch points with parents will be used to check vaccination status and to remind parents of the importance of vaccines, sources of trusted information, and the availability of catch-up at any age. This will include health visitor contacts, newsletters to parents and at childcare settings.

6. Children and Young People

6.1 PHI2 - Uptake of the NHS Healthy Start Scheme.

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

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

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

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

6.1.4 Key challenges faced this quarter:
There have been significant data quality issues which have affected the reported uptake for Q2 to present for the year 2023/24. This is due to an issue with a data feed at the Department for Work and Pensions (DWP), where the number of eligible beneficiaries reported between July 2023 and Feb 2024 was incorrect. In turn, this means the calculated uptake percentage has been overstated. The eligible data and uptake percentage have been removed from the national portal for those months, since the historical data could not be matched. This is a reporting issue and does not impact NHS Healthy Start individual applicants, existing beneficiaries, new beneficiaries or claim payments.

6.1.5 The lack of percentage uptake data means it is not possible to benchmark our local uptake against statistical neighbours or national uptake. The DWP are not able to provide historical data, meaning there will be a gap in the availability of the uptake percentage from July 2023 to February 2024. This should be corrected by March onwards but may affect how we report on this indicator in the future (possible change from % to actual numbers as below).

6.1.6 The data provided for the number of people enrolled in the Healthy Start Scheme is correct, and the only accurate information that can be reported for Q3. This shows an increase of 51 in the number of people enrolled on the scheme compared to Q2, and an increase of just over 100 since the first quarter. Despite the data quality issues, there has been a steady increase in the number of residents accessing this benefit over the course of the year to date:

- Q1 – 1705
- Q2 – 1757
- Q3 – 1808

NB: It is worth noting that the number of eligible residents may vary slightly each quarter, but based on the previous data, there has not been a significant change in eligibility.

6.1.7 The multi-disciplinary working group has worked collectively to raise awareness of Healthy Start among residents and frontline health and early years staff who have key touchpoints with families. The multi-disciplinary working group meets regularly and is well-attended by key stakeholders. All members have the will and commitment to improve uptake.

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

6.1.9 The focus for the next quarter: A review is planned for the Healthy Start programme health promotion efforts and how impact will be monitored and measured longer term.

7. Healthy Behaviours

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

7.1.1 The community stop smoking service 'Breathe' offers behavioural support and provides stop smoking aids to people who live, work, study or who are registered with a GP in Islington. The three-tiered service model ensures that smokers receive the support that is appropriate for their needs. Breathe also trains, supports, and monitors a network of community pharmacies and GP practices to deliver stop smoking interventions under the Locally Commissioned Service provision (LCS).

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

7.1.3 The new Breathe stop smoking service provider, Central and North West London NHS Foundation Trust, began delivery on 1st April 2023 and continued to mobilise during Q3.

7.1.4 In quarter 3, 299 smokers set a quit date. The success rate is above target across the service at 64.5%. This is a significant improvement over Q2 performance (59%) and when compared to the same period last year (57%).

7.1.5 NHS Digital reports on the cumulative stop smoking data for quarters one to three in London and England. In the same period, the Islington service performed better (60%) than the average quit rate in London (53%) and England (54%).

7.1.6 77% of all four-week quits in Q3 were achieved by the community service (Breathe) with an excellent quit rate of 72%. A third (35%) of Breathe service users received intensive personalised tier 3 support, which is intended for people with the highest level of need for support during a quit attempt. Activity levels across GPs and pharmacies remained relatively low, although there was improvement in overall success rates in these settings compared with the previous quarter: an average 45% from GPs and 54% in from community pharmacies. Lower activity levels can be attributed to ongoing challenges in recruitment and retaining of staff to deliver stop smoking work, competing work pressures which add to the difficulties in engaging smokers in the service in these settings, among other factors.

7.1.7 The community service is well placed to reach smokers from target populations and has worked closely with secondary care trusts to support the implementation of the NHS Long Term Plan's goal of offering tobacco dependency treatment to all smokers who are admitted to hospital as part of their care. Almost half (48%) of all service users seen by the community service in Q3 were referred by secondary care after having started a quit attempt in hospital, and 71% successfully quit smoking.

7.1.8 Smokefree pregnancy continued to be a strong focus for the service which delivered excellent results in Q3. This work is embedded within an NCL programme which drives improvements in how maternity services record smoking and support pregnant smokers to quit. 26 pregnant women accessed the service in Q3. An exceptional four-week quit rate of 84.6% was achieved and 86% of quits were verified with carbon monoxide (CO) breath testing.

7.1.9 It is worth noting that the Islington quit rate for pregnant women in quarters 1 to 3 was significantly higher (84%) than the London (59%) or England (50%) averages and was the highest in London, jointly with Newham. Islington also had the highest number of pregnant women quitting smoking (78) among London boroughs and 73% of quitters were CO validated.

7.2 Service user feedback/testimonials/impact on inequalities /health inequalities.

7.2.1 An example of testimonials received this quarter:

"I would like to say a big, big thank you for all your encouragement and support. You have been a God send with helping quit smoking. For the last 3 months I have taken all of your advice on board with fantastic support. Hopefully, we can encourage others to follow with your expert advice. It has not been easy, however with your help I feel more confident each day that goes by. If I do need any help, you will be my first source of contact." Service user from Islington.

7.2.2 The service successfully reached groups that have health inequalities due to higher smoking rates. Three quarters (76.5%) of these successful quits in Q3 were amongst residents who are sick, disabled, unable to work, long-term unemployed, unpaid carers and routine and manual workers. 91 people who work in 'routine and manual' occupations accessed the service and 64 quit successfully in Q3 (70% success rate).

7.2.3 Racially minoritised groups with high smoking prevalence successfully reached by the service have included Bangladeshi men, Irish, Other White, Black Caribbean, and Black African residents. In total, 178 people from racially minoritised groups successfully quit in Q3 (with a quit rate of 59.5%) compared to 151 in Q2.The Breathe service provide translators through Language Line, in order to ensure that residents receive an accessible service with the necessary assistance and resources.

7.2.4 In addition, out of 36 service users who had disclosed a history of mental health problems (either current or past), 20 have quit (56% success rate). Out of 30 service users with a COPD (Chronic Obstructive Pulmonary Disease) diagnosis, 16 have quit (53% success rate).

7.2.5 Key issues faced this quarter: Despite the increased offers of face-to-face support, service users continue to prefer the model of telephone and other remote support instigated during the pandemic. However, this does not allow the service to verify the quit outcome with carbon monoxide (CO) testing. 23% of all successful quits were CO-verified in Q3, a small increase from Q2 (19%). This is an ongoing issue for stop smoking services and reflective of national trends whereby 19% of successful quits were CO verified in England in Q1 and Q2.

7.2.6 The focus for the next quarter:

- The service is keen to understand and resolve barriers that contribute to their clients opting for remote or telephone support over face-to-face appointments. They are looking to conduct a thorough review to identify specific issues and incentives to encourage face to face attendance. This work will be completed by the end of Q4.

- Breathe stop smoking service has been working successfully with some of their key target populations, such as racially minoritised ethnic groups, routine and manual workers and smokers with a mental health or COPD diagnoses. However, their reach into some communities, such as LGBTQ+, could be improved through partnership work with local voluntary and community organisations. Breathe is exploring options to deliver the service from local VCS (Voluntary Community Sector) venues, to improve their reach into communities – this should be in place in Q4.

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

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

7.3.2 The programme aims to improve the health and wellbeing of adults aged 40-74 who do not have a diagnosed long-term condition, and who may benefit from advice and the promotion of early awareness, assessment, and where needed, treatment and management of risk factors for cardiovascular disease (CVD).

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

7.3.4 In quarter 3, 4.1% (2,137 individuals) of the eligible population received an NHS Health Check which is in line with the previous quarter. Additionally, the annual target has already been met. When compared to this time last year, the current delivery is 1.4% higher (with 673 additional health checks delivered) than Q3 last year (2.7%).

7.3.5 This quarter, the percentage of the eligible population completing an NHS Health Check in Islington surpassed both the London average (2.8%) and the England average (2.1%).

7.4 Impact on health inequalities.

7.4.1 To address inequalities, the service commissioners (Public Health) ensured that providers prioritised the offer of health checks to residents on the mental health and the learning disability registers, and residents with a predicted very high risk of developing cardiovascular diseases (CVD). As a result, for this quarter, 59 residents on the learning disability and mental health registers have received a health check and 71 health checks were completed by residents with a very high risk of CVD.

7.4.2 Key issues faced this quarter include a data quality issue identified in the returns from the ICB, which significantly under-reported the number of invitations for health checks being sent by practices (one of the key performance indicators).

7.4.3 The focus for the next quarter:

- The focus for the next quarter: Public Health Officers will work closely with ICB colleagues to identify the source of the data quality issue to resolve the issue.

7.5 Substance Misuse

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

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

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

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

7.5.5 All services collaborate closely with criminal justice partners to ensure effective pathways into treatment from prison, probation and police, which includes co-locating of services and in-reach support.

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

7.6.1 There has been an increase in the numbers in treatment across most substance groups from Q2 23/24 as highlighted in Table 2. Performance is encouraging and indicates that the service is on track to meet its target numbers by the end of Q4. The targets for alcohol and non-opiates have already been exceeded.

7.6.2 During Q3, there has been progress in the number of opiate and non-opiate cohorts in treatment. Opiate numbers will continue to be a strong service focus in the final quarter.

Table 2 - Number of adults accessing treatment in a 12-month rolling period to Q3 2023/24.

Number of adults accessing treatment in a 12-month rolling period -	Target	Q2	Q3	Performance compared with last quarter (Q2 to Q3)
Alcohol	389	407	413	+Increase of 6
Alcohol and non-opiate	222	226	211	- Decrease of 15
Non-opiate	128	126	190	+Increase of 64
Opiate	1033	899	926	+Increase of 27
Total	**1772**	**1658**	**1740**	**+Increase of 82**

7.6.3 The service continues efforts to increase the numbers of people accessing drug or alcohol treatment, and new initiatives funded by the Supplementary Substance Misuse and Treatment Grant (SSMTRG) are supporting this. The service is reducing barriers to accessing treatment and improving in-reach/ outreach for pathways such as hostels, supported accommodation, police custody, probation and prison release, to increase the likelihood of people feeling able to engage with support and treatment via these referral routes.

7.6.4 Improved accessibility and referral pathways will support more residents to engage with support around drug or alcohol use and reduce the harm caused by this. Proactive engagement will also increase the likelihood of people maintaining contact with services. Increasing street outreach work in 'hotspot' areas supports the wider community in those locations.

7.6.5 More people engaged with support for their drug or alcohol use will help to reduce drug and alcohol related harm, as well as improving treatment outcomes and responding better to people and families who require support. Outreach work aims to support those experiencing the greatest inequalities, such as people sleeping rough or living in supported accommodation. The treatment service has tailored programmes and / or workers specialising in working with women, families, and LGBTQ+ groups.

7.6.6 The numbers in treatment are increasing which is an optimistic sign that service improvements and the creation of new roles are having an impact on the number of residents with drug and alcohol needs who are receiving treatment and support. Recruitment to new roles funded by SSMTRG and the implementation of new initiatives will enhance pathways into treatment.

7.6.7 Public Health Officers with the service are working through service development plans and actions to ensure we meet nationally set targets around the number of people accessing treatment in Islington. This includes:

- Improving referral pathways
- Enhanced outreach
- Review of local data capture and introduction of new reporting measures
- Service awareness and promotion plan
- Collaborative working with key stakeholders

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

7.7.1 In quarter 3, there was a small overall increase in the number of successful completions compared with Q2 23/24, with an increase in the number of successful outcomes in the non-opiate and alcohol and non-opiate cohorts, and a decrease in alcohol and opiate groups. Taking the year to date as a whole, numbers of people with successful completions has remained steady.

Table 3 Number of people successfully completing drug and/or alcohol treatment in the last 12 months:

No. of people successfully completing drug and/or alcohol treatment of all those in treatment (12 months rolling)	Target	Q2	Q3	Performance compared with last quarter (Q2 to Q3)
Alcohol	150	146	145	-Decrease by 1
Alcohol and non-opiate	81	47	56	+Increase by 9
Non-opiate	54	35	43	+increase by 8
Opiate	55	49	41	-Decrease by 8
Total	**340**	**277**	**285**	**+Increase by 8**

7.7.2 The service has implemented a caseload segmentation approach which is supporting with targeting interventions and level of support based on the assessment of risk. The introduction of a dedicated 'non-opiate worker' seems to be supporting successful outcomes for this cohort as planned, and the alcohol and non-opiate cohorts are also showing an increase in successful treatment completions.

7.7.3 Further work is planned to ensure that opiate and alcohol cohort completion targets are met. Additional initiatives brought in by the Supplementary Substance Misuse Treatment and Recovery Grant (SSMTRG) should support improvements, including through a new structured day programme and improved access to long-acting Buprenorphine pharmacotherapy.

7.7.4 The service has demonstrated success in its non-opiate and alcohol and non-opiate cohort's pathways and increases in the number of successful completions for these categories.

7.7.5 People with problematic drug and alcohol use have often experienced significant health and other inequalities in their lives, and drug and alcohol use are in themselves sources of health inequalities and poorer health outcomes and risks. More people successful completing treatment for their drug or alcohol use will help to reduce drug and alcohol related harm and broader inequalities, as well as improving treatment outcomes and responding better to people and families who require support.

7.7.6 Key challenges this quarter: With the additional grant funding, there is a focus on recruiting to new roles and staffing which are needed to ensure the service

capacity to maintain and build the quality of interventions is maintained together with the increasing numbers of people receiving treatment and recovery support.

7.7.7 The focus for the next quarter:

- A focus on opiates and alcohol successful outcomes in Q4.
- Evaluation of the impact of caseload segmentation on treatment outcomes – reviewing for improvement.
- Benchmarking against regional and national performance

8. Sexual Health Services

8.1 PHI7 Number of Long-Acting Reversible Contraception (LARC) prescriptions in local integrated sexual health services.

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

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

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

8.1.4 In quarter 3, 358 women from Islington had a LARC device fitted by the Integrated Sexual Health service. This is above the quarterly target (300) and is on track to meet the annual target (1,200).

8.1.5 In Q3, activity is slightly higher than in Q2, when 339 women had LARC fitted. However, activity is lower when compared to the same period last year (Q3, 2022/23), when 423 women had LARC fitted as part of 'catch-up' activity as the service recovered from the impacts on access during the Covid and Mpox periods.

8.1.6 The annual national data for LARC has recently been published. In 2022, Islington had the third highest rate of LARC per 1,000 women fitted in sexual health services (31 women per 1,000 aged 15 – 44). The rate was significantly higher than in London (23 per 1,000) and England (18 per 1,000). Following a significant reduction in activity during Covid -19 and the subsequent MPox outbreak in summer 2022, the service has sustained LARC activity at or above pre-pandemic levels throughout 2023/24. This is important because primary care in Islington, and across

most of London, contributes a relatively low proportion of overall LARC fittings compared with general practice in the rest of the country.

8.1.7 The service delivers extensive health promotion outreach to groups at risk of poorer sexual health outcomes, including men who have sex with men, sex workers, Black African communities and people who are homeless. They work in close partnership with community organisations working within these communities and attending a range of venues and locations to deliver outreach.

8.1.8 In Q3, CNWL conducted a patient survey which showed 97% of service users at the Archway site (the main ISH site in Islington) rated the service they received as good to excellent.

8.1.9 The focus for the next quarter and over the coming year will be on maintaining and improving access to LARC across different settings, including working with primary care partners. We are also preparing to recommission integrated sexual health services.

9. Implications

9.1 Financial implications:

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

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

9.2 Legal Implications:

There are no legal implications arising from this report.

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

There is no environmental impact arising from monitoring performance.

9.4 Resident Impact Assessment:

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

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

10. Conclusion

The Council's Corporate Plan sets out a clear set of priorities, underpinned by a set of firm commitments and actions that we will take over the next four years to work towards our vision of a more equal Islington. The corporate performance indicators are one of a number of tools that enable us to ensure that we are making progress in delivering key priorities whilst maintaining good quality services.

Signed by:	Jonathan O' Sullivan Director of Public Health	May 2024
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