Public Health

222 Upper Street

Report of: Director of Public Health

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

Date: 20th March 2025

Ward(s): All

Public Health Performance Quarter 2 (July - September), 2024/25

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 2, 2024-2025 (reported one quarter in arrears due to data lags) progress against targets for those performance indicators that fall within the Health, Wellbeing and Adult 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 2, 2024/25 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 Q2 2024/25

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

Public Health Priority	PH Ref	Key Performance Indicator	Annual Target 2024/25	Actual 2023/24	Q1 2024/25	Q2 2024/25 position	On target (or within 5% threshold?	Q2 position for comparison to last year.
		Immunisation Coverage						
Immunisation	**PH1a)**	**DTaP/IPV/Hib3 at age 12 months.**	- Improvement on 89%	87%	86%	84%	Yes	86%
	PH1b)	**MMR2 - 1st and 2nd dose (Age 5)**	- Improvement on 70%	68%	67%	67%	Yes	68%
Children & Young People	**PH2**	**% Uptake of the NHS Healthy Start Scheme**	Now measured by actual uptake based on Q4 baseline 1781	1781	1822	1785	Yes	1757
Smoking		**Delivery Plan Indicator - DP25/PH3a**						
	PH3a DP25	**Numbers of people accessing the Stop Smoking Service for help and support to quit smoking**	1,330 by March 2025	N/A New Corporate KPI.	381	695	Yes	New Corporate Indicator
	PH3b	**% of people quitting successfully who use the stop smoking service**	55%	61%	62%	63%	Yes	59%
Health Checks	**PHI4**	**% of eligible population (40-74) who have received an NHS Health Check.**	10%	15.3%	4.2%	4.9%	Yes	4.50%
Substance Misuse		**Delivery Plan Indicator - DP25 /PH5.**						
	PH5	**Number of adults accessing treatment (in a 12-month rolling period)**						
	5a	Alcohol	459	428	433	442	Yes	407
	5b	Alcohol and non-opiate	282	272	301	321	Yes	226
	5c	Non-opiate	175	169	176	185	Yes	126
	5d	Opiate	974	944	956	984	Yes	899
		Total	1890	**1813**	**1876**	**1932**	**Yes**	**1658**
	PH6	**Number of people successfully completing drug and/or alcohol treatment of all those in treatment (12 month rolling).**						
	6a	Alcohol	150	125	146	112	No	146
	6b	Alcohol and non-opiate	81	52	47	56	No	47
	6c	Non-opiate	54	46	35	54	Yes	35
	6d	Opiate	55	40	49	35	No	49
		Total	**340**	**263**	**277**	**254**	No	**277**

Public Health Priority	PH Ref	Key Performance Indicator	Annual Target 2024/25	Actual 2023/24	Q1 2024/25	Q2 2024/25	On target?	Q2 position for comparison to last year.
Sexual Health	PH7	No of Long-Acting Reversible Contraception (LARC) prescriptions.	*Revised to 1200 (from 1300) – see paragraph 8.15	1333	310	281	Yes	339
Health Visiting	PH8a)	Health Visiting - proportion of new birth visits completed within 14 days	95%	*N/A New KPI	97%	97%	Yes	*New Corporate Indicator
	PH8b)	Health Visiting - proportion of infants receiving a 6-to-8-week review	85%	*N/A New KPI	84%	82%	Yes	*New Corporate Indicator

5. Quarter 2 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. This indicator is measured by 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. This indicator is measured by 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.

5.2 PH1a - DTaP/IPV/Hib3 at age 12 months

5.2.1 In quarter 2 (Q2), 84% of children aged 1 year had received a complete course of the 6-in-1 DTaP/IPV/Hib/HepB vaccine.

5.2.2 Coverage in this period is therefore slightly below the Islington target of 89% and there has been a fall in uptake since the last quarter by 2% (Q1, 24/25).

5.2.3 When compared to the same period last year, the uptake of DTaP/IPV/Hib3 vaccine is similar to Q2,2023/24 which was at 86%. The current period Q2, 2024/25 also reflects a similar rate across North Central London (NCL) at 85%.

5.3 PH1b - MMR2 - 1st and 2nd dose (Age 5)

5.3.1 The MMR vaccine (measles, mumps and rubella) is given in two doses, at age 12 months and at age 3 years and 4 months. By 24 months of age, 79% of young children had had their first MMR, which is similar to the London average of 80%, but below the national average of 88%. The indicator reported, known as MMR2, is the percentage of children aged 5 who have had both doses of MMR vaccine.

5.3.2 In Q2, 67% of children aged 5 had received both doses of the MMR vaccination. There is the same for MMR2 uptake when compared to last quarter (Q1 24/25), and similar when compared to this time last year (Q2 23/24) when it was at 68%. Q2 24/25 uptake of 67% is below the Islington target for 24/25 of 70% although within the 5% target range threshold.

5.4 Population vaccination coverage (PH1a and PH1b) - 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 Islington is holding its position on these vaccinations and meeting local targets and with an extensive programme to help raise vaccinations rates, in the context of a cohort of young children with an increasing proportion experiencing deprivation. In Q2 24/25, Islington continued with implementing its delivery plan to support an increase in vaccination. This work is being done in collaboration with partners across the NHS and VCS. Public Health Officers have been providing a range of information on the importance of childhood immunisation to parents through a range of communication channels e.g. MMR information was included in the September QuickTips and Bright Start Bright Ideas newsletters for parents.

5.4.3 Public Health Officers also collaborated with Whittington Hospital, Healthwatch and Learning and Achievement colleagues to deliver pop-up MMR vaccination clinics in Islington Children's Centres throughout August. In total, 25 visits to 6 centres were completed, plus one street party event and one local church. 310 parents were engaged, helping to provide information and encouragement about the benefits of vaccination, but relatively few unimmunised children were identified and 12 immunisations were given.

5.4.4 In Q2 24/25, Public Health were also working with Healthwatch and Whittington hospital to plan for a family hub Health Fun Day, where childhood immunisations information and "on the spot" vaccinations would be available.

5.4.5 Other Islington Public Health's childhood immunisation work in Q2 24/25 aimed to prepare schools and parents for flu vaccination clinics scheduled to take place between September and December, with targeted support for schools which have had lower uptake last year and training of parent champions to support other parents with accurate information, discuss the importance of flu vaccination and to encourage other parents to complete and return consent forms. We have

also been using these interactions to emphasise the importance of the wider childhood vaccination programme.

5.5 Benefits and impact of immunisation programmes

5.5.1 **Distribution of MMR information to parents via newsletters:**

This informed a large number of local parents about the increased risk of measles, the importance of MMR vaccination, and acted as a reminder for parents to arrange MMR vaccination for their children.

- **Pop-up childhood vaccination clinics in children's centres and family hubs:**

  Community vaccination clinics enables local parents / carers to have an informative conversation about vaccination with a clinician at a familiar and trusted location, that is convenient for them and without an appointment. If desired, their child can also receive any overdue vaccinations "on the spot", without the need to book an appointment.

  The approach aims to enable clinicians to engage on vaccination with parents and carers who are unlikely to attend a vaccination appointment in other healthcare settings due to competing priorities, concerns around vaccination, or lack of GP registration.

- **Support to schools to encourage flu vaccination uptake:**

  Islington has ten parent champions, who are well integrated into schools and have good relationships with other parents. During this quarter, Public Health worked with the parent champions in preparation of the flu vaccination autumn programme in schools.

5.6 Impact on inequalities/health inequalities

5.6.1 Pop-up childhood vaccination clinics in community settings aim to help increase awareness of importance of childhood vaccination and extend offer of vaccination to those who are unlikely to attend a vaccination appointment in other healthcare settings due to competing priorities, concerns around vaccination, or lack of GP registration. 310 parents were engaged in the community pop-ups that Islington Public Health arranged with the Whittington Health Trust. Locations have been informed by data on areas and groups with lower uptake of the immunisations.

5.6.2 Public Health Officers have used 23/24 data on low uptake from schools, to inform targeted support and communications for certain schools with the objective to reduce inequalities in flu vaccination uptake amongst children.

5.6.3 Key challenges faced this quarter (Q2, 2024/25)

- In Q2 24/25, trying to balance the competing priorities of preparing schools and parents for seasonal flu vaccination offer, whilst also delivering a programme to support improving uptake of routine childhood vaccinations, including MMR and DTaP/IPV/Hib3

5.6.5 The focus for the next quarter:

The focus for Q3 24/25 is outreach and communications around childhood immunisations with parents and local schools and Early Years settings. Plans include:

- Delivery of Health Fun Day at family hub on 31st October (pre-school immunisations). The fun-day will include the opportunity to get vaccinated "on the spot", book a vaccine for a more convenient time, or have a conversation about vaccinations.
- New "infectious diseases and immunisation" information page for schools and Early Years staff
- Support with promotion of flu vaccination amongst Early Years, primary and secondary school aged children.

6. Children and Young People's Health

6.1 PH2 - Uptake of the NHS Healthy Start Scheme

6.1.1 The NHS Healthy Start programme 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. The main priority is to maximise uptake of the scheme, thereby decreasing poverty and increasing consumption of health foods, particularly in pregnancy and very young children.

6.1.4 Nationally and regionally, the scheme supports low-income families by providing financial aid for nutritious food and free vitamins. Since going digital in 2021, uptake has increased to 62.7% nationally, enhancing accessibility, however over a third of eligible children do not receive it.

6.1.5 The impact for residents can be significant. A pregnant woman with two other children aged under 5 could be receiving payments of £17 per week to spend on healthy food for herself and her children.

6.1.6 In Q2, 1785 Islington families benefited from the scheme, a little lower than Q1 (average 1822). This quarter's uptake may have been affected by the summer holiday period. Percentage uptake of those eligible is not currently available (see key challenges below).

6.1.7 The move of the national scheme from vouchers to payment cards decreases any stigma associated with the scheme but has led to the potential for increased digital exclusion from the scheme. The application process is lengthy and can be complex and confusing. Support in accessing the scheme is given in children's centres and other community settings to reduce levels of exclusion.

6.1.8 The Department of Health and Social Care (DHSC) has launched a consultation to gather views on whether Healthy Start eligibility should be extended to individuals who are prevented from accessing public funds due to immigration controls.

6.1.9 By providing eligible families with access to free fruit, vegetables, and vitamins, the scheme promotes better nutrition and supports the health of pregnant women and young children. This not only reduces the risk of health inequalities on low-income families, but also enables healthier food choices.

6.2 Key challenges faced this quarter:

- It is not possible to compare Islington resident uptake of the scheme uptake against London and England averages due to a long-standing national data issue. The national team has removed the percentage uptake and issued the following statement: "The issue has only affected the data on the number of people eligible for the scheme. It has not prevented anyone from joining the scheme or continuing to access the scheme if they were eligible."

- The ongoing national data issue limits our understanding of how many eligible residents may be missing out on this potential benefit.

6.2.1 The focus for the next quarter:

- There will be a focus on involving Family Hub Navigators and Access Islington Hubs to assist with Healthy Start applications and working with maternity services in University College Hospital (UCH) to discuss how best to promote the scheme. The Citizen's Advice Bureau will be holding a healthy start training session for staff.

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' provides an evidence-based offer of behavioural support and stop smoking aids to people who live, work or study in Islington or Camden and those who are registered with a GP in the borough.

7.1.2 The three-tiered service model ensures that smokers receive the support that is appropriate for their needs and suited to their lifestyle and circumstances. Breathe also supports, trains and monitors a network of community pharmacies and GP practices to deliver stop smoking support under the Locally Commissioned Service (LCS).

7.1.3 The Breathe service is provided by Central and North West London NHS Foundation Trust (CNWL).

7.1.4 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).

7.1.5 In Q2, 314 smokers accessed the service for help and support to quit smoking and set a 'quit date'. The success rate is above target across the service in Q2 (63%), slightly higher than the same quarter last year (60%).

7.1.6 The number of people setting a quit date during the quarter decreased by 12% when compared to the same time last year (314 in 24/25 vs 351 in 23/24), but year to date progress

remains on track for the increased target for 24/25 of 1,330, which rises to 1,529 for the following year 25/26.

7.1.7 The new government grant for stop smoking support will enable us to focus on significantly scaling up service capacity and increasing service demand in 2024/25 onwards. Public Health Officers are working with Breathe to create new staff roles, increase the budget for provision of stop smoking aids and scale up the targeted promotion of the service. The impact of this work on service performance should be seen from Q3 onwards.

7.1.8 Our community service, Breathe, continued to perform at a high standard, delivering a flexible, tailored, evidence-based service. 100% of persons referred were contacted within two working days by the service. The community service, Breathe, is also well placed to reach smokers from target populations and worked closely with hospitals to support the implementation of the NHS Long Term Plan that has placed tobacco dependency treatment at the heart of the NHS agenda. Almost half of all service users seen by the community service in Q2 (45%) were referred from hospital services. 71% successfully quit smoking in Q2.

7.1.9 In Q2 2024/25 local NHS Trusts continued to staff and deploy their new tobacco dependency in-house services for pregnancy. However, Breathe received some referrals and 9 people set a quit date with a 89% quit rate. It is expected that pregnancy referrals will remain low from now on as hospital in-house services fully establish themselves, and our services will work closely with the hospital services to ensure we continue to meet the needs of residents.

7.2 Key successes and impact on inequalities /health inequalities

7.2.1 Population groups that experience health inequalities due to higher rates of smoking are defined as priority groups for the service. Among residents who successfully quit in Q2 2024/25:

- 58% were sick, disabled, or unable to work, long-term unemployed, unpaid carers and/or routine and manual workers
- 28% were from ethnic minority communities
- 24% had health conditions caused or made worse by smoking, including COPD, coronary heart disease, diabetes and hypertension
- 13% disclosed a mental health condition either current or past

(To note: there is intersectionality – some residents belong to more than one group, and so are counted more than once in the figures above.)

7.2.2 Key Challenges faced this quarter:

- Despite the increased offer of face-to-face support in accessible community locations, most service users continue to prefer the model of telephone and other remote support instigated during the pandemic: 58% opted for telephone support only, with 23% opting for face-to-face support and the remainder a mix of remote, in-person and/or digital app support.

- This service model does not allow the service to verify the quit outcome with carbon monoxide (CO) testing, a motivational tool which also enables a validated quit outcome. CO monitoring is not mandatory so that it does not become a barrier to continued engagement

with the service. Low rates of CO validation are an ongoing issue for stop smoking services and reflective of national trends.

- Public Health Officers continue to monitor how the service is being accessed and work with the provider to ensure wider access in community locations, and effective and efficient delivery.

- Activity levels across GPs and pharmacies remained relatively low and success rates in these settings averaged at 50% in Q2 2024/25, which is similar to 2023/24 (47.5%). 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.

- Public Health officers have completed a comprehensive review of how stop smoking support is delivered within GPs and community pharmacies and are working on options to increase access to stop smoking support through these settings.

7.2.3 The focus for the next quarter:

- The new government Local Stop Smoking Services and Support Grant for 2024-25, aims to support the delivery of outcomes of the government's smokefree generation plans and offers additional ring-fenced funding for local authorities to increase stop smoking support. This enables Public Health Officers to review a range of options to increase access to stop smoking support through our stop smoking provider for Breathe community service, and through GPs and community pharmacies.
- Public Health Officers will provide leadership across the Council to enable Islington to capitalise on the opportunity that forthcoming legislative and policy changes around tobacco and vaping present, enabling us to achieve a step-change in smoking behaviours and health impacts for Islington residents.
- In Q3 Breathe are expanding their work with voluntary and community sector (VCS) partnerships, drug and alcohol services, services working with people experiencing homelessness, community mental health services, family hubs, Access Islington, and others from local VCS (Voluntary Community Sector) venues, to improve their reach into communities and increase demand for the service.

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). It is a rolling programme, and over a five-year period all eligible patients should be invited for a check.

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

7.3.4 In Q2, (2024/25) 4.9% (2564 individuals) of the eligible population completed an NHS Health Check indicating a strong performance, higher than the previous period Q1, where 4.2% (2169 individuals) of the eligible population completed a health check and when comparing to the same period from last year Q2(2023-24), where 4.6% (2373 individuals) completed a NHS Health Check.

7.3.5 The Q2 2024/25 percentage of the eligible population completing an NHS Health Check (4.9%) was above the London average (2.6%) and above the England average (2.2%) highlighting Islington continues the high uptake of the service performing better than the national and regional averages for this quarter.

7.3.6 The majority of Cardiovascular Disease (CVD) is preventable, so there is a significant opportunity to improve outcomes; risk factors, such as obesity, physical inactivity, smoking and drinking, can all be modified to help reduce a person's risk of developing CVD. The NHS Health Check can help reduce inequalities by prioritising those at the greatest risk of CVD.

7.3.7 Reducing inequalities and impact.

- To address inequalities, the local programme is organised so that practices should prioritise those residents on the mental health and the learning disability registers, and residents with a predicted very high risk of developing cardiovascular diseases (CVD). Islington uses additional financial incentives on top of the standard payment for health check delivery to encourage this. As a result, for this quarter, 3.2% (55 residents) of the eligible population on the learning disability and mental health registers and 7.3% (53 residents) of the eligible population have received a health check.

- Residents who complete a health check are made aware of the risk factors for cardiovascular disease, given appropriate advice and support, and signposted or referred to clinical interventions, or other services appropriate to their needs. For example, weight management services, diabetes services, advice on physical activity, smoking cessation services, alcohol advice or support services.

- To improve the quality and equity in health check delivery, Public Health Officers continue to monitor the performance to further gain insight and understanding of activity across practices. Additionally, there has been some coding issues in the way the data is recorded by practices. We are exploring ways to enhance data extraction to reduce data quality issues and improve the process for coding.

7.3.8 The focus for the next quarter:

- The focus for 2024/25 is to continue to monitor the performance, to gain further insight and understanding of why a small number of practices are not completing as many health checks as others, in order to work with them to improve take up of the offer.

- During Q4 in 2023-24, we started a review of all of Islington's locally commissioned services, including NHS health checks. So far, we have found that some aspects of the quality of delivery and equity of access to health checks are not consistent and could be improved, but are doing further review.

- In addition, we are also undertaking a Cardiovascular Disease (CVD) needs assessment and are in early conversations about possibly being a pioneer organisation for the pan-London "Million Hearts and Minds" CVD prevention programme, which is being led by OHID (Office of Health Improvement and Disparities) London.

7.4 Substance Misuse

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

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

7.5.1 The service has consistently increased the number of people accessing support in Q2, with 1932 adults accessing the service for treatment for drug and alcohol use. This demonstrates the improvements made in accessibility, including significant amounts of outreach and work across the criminal justice system. The service remains co-located with key stakeholders, including police, probation, prison, supported accommodation, and assertive outreach. This co-location supports the ongoing development of pathways with these partners and the identification of individuals who need support.

7.5.2 The services continue to expand the number of people accessing support, building on the success of the previous quarter across all substance categories. Islington's treatment numbers have improved significantly, with our opiate numbers exceeding regional and national averages. The additional staff in the service are enhancing pathways and improving access for individuals. The initial focus of the increased investment in services has been directed into outreach in the community and the prison and criminal justice system. This has resulted in the identification of substantially greater numbers of people with opiate dependency compared with, say, problem alcohol use, and is consistent also with the focus of the early goals in the ten-year national strategy. People with opiate dependency given the nature of the treatment and recovery support they receive also tend to remain under the care of the treatment service for substantially longer than people with other drug or alcohol use needs. Thus, while the numbers of people in all treatment cohorts have increased compared with the previous year, the cohort of patients with opiate dependency remains the single largest group. It is anticipated that development of the liaison service working in Whittington Health will result in increases in people with problem alcohol use entering local services and receiving treatment.

7.5.3 Increased awareness among stakeholders through partnership working and a flexible approach from the service and its staff have played important roles in facilitating treatment access. More individuals are now aware of the service offer and are seeking support, which helps residents when they need assistance.

7.5.4 Islington has been recognised by the national public health improvement agency, the Office for Health Improvement and Disparities (OHID), for significant improvements in the number of

people accessing treatment for opiate use, many of whom are new to treatment. The service has adopted an 'outward facing' model, incorporating outreach and co-location with various services within the Borough to enhance visibility, streamline service pathways, and remove barriers to support.

7.5.5 Treatment providers are delivering regular outreach work and working more closely with other Council teams, including street outreach, complex needs, and Community Safety.

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

7.6.1 The number of people successfully completing treatment is similar to the same quarter last year but has declined compared with the previous quarter. Since there are appreciably more people in treatment, the completion rate (or percentage) has dropped, and is not on target. This has been promptly recognised by officers and our core service provider. In collaboration with the provider, we are implementing a quality improvement plan to better understand and address the current lower level of completions.

7.6.2 While PH15 demonstrates the notable improvements in the number of people accessing treatment, Public Health Officers are committed to ensuring the effectiveness of our whole service offer and the quality of interventions provided. This will involve increased oversight, thorough data audits, and a review of provider processes to enhance outcomes for the service overall.

7.6.3 Islington's successful completion rate is currently lower than the regional and national average. We are using national data sources to benchmark our performance against comparators and identify areas for improvement. Public Health Officers anticipate that the service quality improvement plan and enhanced focus on treatment exits will positively impact PH16 figures in future coming performance quarters.

7.6.4 There are a number of contributory factors for the reduction in the percentage of successful completion rates:

- Many individuals in treatment need long-term interventions due to established dependencies and co-morbidities, and this is especially common among people with opiate use. This is important, since we are committed to ensuring that residents can make and sustain changes to their drug and alcohol use. They therefore stay with services for longer periods and so do not exit the service (which is when measures of successful outcomes are calculated).
- The expansion in treatment has particularly reached people with opiate-related needs through street and other outreach and through prison and criminal justice pathways which has contributed to increasing complexity among people in contact with drug and alcohol services. This increase is greater than expected when setting the local target of 340 successful completions by year-end, which was based on a less complex cohort.
- A proportion of people who exit the service do so due to offending behaviour - and at least a proportion are later picked up through the national drug treatment monitoring system in prison-based treatment services. Part of the reason for the focus on criminal justice is to help end cycles of reoffending. The emphasis on continuity of care from prison back into local community-based treatment and recovery services is a focus of our investment.
- New data sources on continuity and duration in treatment are therefore also being reviewed to build up a fuller overview.

7.7 Impact on inequalities/health inequalities

7.7.1 There are several initiatives being delivered within the Borough that specifically aim to address inequalities and health inequalities. These include:

- **A LGBTQ+/Novel Psychoactive Substances pathway** has been developed, aiming to address the unique needs of the LGBTQ+ community in relation to drug use and associated risks.
- **Dedicated women's groups** and enhanced collaboration with Bronzefield prison to provide more support for women on release from prison.
- **Physical Health Pathways** improvements, recognising that individuals using drugs and alcohol face physical health inequalities, encounter barriers to accessing primary and preventative care, and often have multiple co-morbidities.
- **Introduction of the new 'The Swap to Stop' scheme**, a pioneering initiative designed to encourage people to stop smoking by initially swapping from cigarettes to vapes, recognising that rates of smoking are much higher in people using drugs or alcohol than they are in the general population.
- **Promoting the Better Lives Family Service** – we have seen an increase in the number of people accessing family support in the last year.
- Public Health Officers are leading **communication and engagement work** that aims to reduce the stigma experienced by people with drug and alcohol treatment needs. Stigma serves as a barrier to help-seeking and contributes to the health inequalities experienced by this cohort.

7.7.2 Key Challenges faced this quarter:

- There has been increased demand for in-patient detox and residential rehabilitation amongst the treatment population compared with previous years. This created a short-term cost pressure within the service which has been met through the new grant monies. This is being kept under review.

7.7.3 Focus for the next quarter:

- Sustaining improvements in the number of people accessing the service while maintaining manageable caseloads.
- Enhancing the digital footprint of both the service website and the council website.
- Contract management focusing on the quality improvement plan related to outcomes data, benchmarking against regional comparators to ensure the service is making necessary improvements.

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. LARC can be offered as an injection, implant or device. Women are supported to understand the benefits and drawbacks of different methods and identify the most appropriate LARC for themselves.

8.1.2 LARC is available through the Integrated Sexual Health service, delivered by Central and North West London NHS Trust (CNWL). Sexual Health services are open access and provide a

number of services in addition to LARC such as STI testing and treatment, sexual health advice, emergency hormonal contraception and other short- term contraceptive offers.

8.1.3 In addition to open access sexual health services, LARC is also available in primary care through a Locally Commissioned Service (LCS) agreement.

8.1.4 In Q2, 2024-25 there were 281 LARC fittings in Integrated Sexual Health services. LARC activity has remained consistent. Women can book their LARC appointment online and up to two weeks in advance.

8.1.5 The annual target for 24/25 was originally set at 1,300, an increase of 100 from 23/24. However, this was erroneously misaligned with the contract baseline, and we have reduced the target to 1,200 to align with the expected activity levels for the service. Some of the catch-up activity after Covid in the previous two years – which included evidence-based changes in guidelines to allow longer use of LARC before a replacement is required – will have now worked their way through. The service continues to perform strongly and is the largest provider of LARC in the capital.

8.1.6 Access to LARC prevents unintended pregnancies. It is more effective than user dependant methods of contraception such as the pill and contraceptive patch which rely on the user to remember to use them and use them correctly. LARC provides a longer-term solution to reducing unintended pregnancies. Some women who access LARC through sexual health services have access to opportunistic cervical smears. For those that meet the criteria, opportunistic HPV vaccinations are also available.

8.2 The focus for the next quarter:

- For the next quarter and the next financial year, Public Health Officers will continue to work with NCL Integrated Care Board, CNWL and Islington GP Federation in the further development of the Women's Health Hub in Archway, part of a national initiative to better integrate key health services for women, initially focussed around sexual and reproductive health and community gynaecology, with a focus on improving patient experience and reducing inequalities.

9. Health Visiting

9.1 The Islington Health Visiting service is a universal service available to every child under age 5 in Islington. Delivery of the service includes five nationally mandated health and development reviews for every child as part of the delivery of the heathy child programme.

9.1.1These five mandated reviews take place at specified ages: Antenatal (from 28 weeks of pregnancy), New Birth Visit (within 10-14 days of birth), 6-8 week review, 1 year review, and 2 – 2½ year review.

9.1.2 The reviews provide an opportunity to assess various aspects of baby health and development and parental health and wellbeing, delivering a comprehensive and holistic assessment of the baby, mother and father's needs. Some key aspects of health and development included in these assessments, and advice given to parents include:

- Infant feeding and nutrition
- Healthy diet and weight

- Safer sleeping
- parental mental health and wellbeing.
- Parent-infant relationship
- Domestic violence
- Immunisations
- Checking routine screening test status and results
- Managing minor ailments
- Prevention of accidents
- Speech, language and communication
- Physical development and skills.

9.1.3 The reviews also provide an important opportunity to introduce families to the range of community services provided locally for under 5's within Bright Start.

9.1.4 All new birth visits and some 6–8-week reviews are carried out in the child's home (others are seen in clinic at a children's centre or heath centre), ideally with both parents present, and by a health visitor (a specialist community public health nurse). This gives an important opportunity to assess the home environment, contributing to the safeguarding of children, and a crucial opportunity to identify needs early and to provide or signpost to support.

9.2 PH8a) Proportion of New Birth Visits (NBV) completed within 14 days

9.2.1 In Q2, 2024-25 the health visiting service saw 97% (534/548) of babies within the specified time period (within 14 days of birth). 14 babies were seen after 14 days, among whom 6 were still in hospital and 5 parents chose a later date.

9.3 PH8b) Proportion of infants receiving a 6-to-8-week review

9.3.1 In Q2, 82% (455/552) of babies were seen within the specified time constraints (within 42-56 days of birth), and a further 42 babies were seen after 8 weeks, reaching 90% of babies.

9.3.2 Performance of the 6-8 week review is recovering after a dip in performance following the Covid -19 period. This was partly due to a period of re-establishing home visiting and community arrangements after the pandemic, but also impacted by staff shortages within the service. The service has made considerable improvements over the last year, through staff training to ensure complete data collection and emphasise the time constraints on the visit, booking review dates early with reminders to parents through a sticker on their 'red book' (parent-held child health record), and working with GPs to ensure parents understand the need for a 6 week postnatal check with both GP and with Health Visitor.

9.4 Summary of PH8a and PH8b)

9.4.1The service has a strong and consistent record of performance of new birth visits, normally reaching 94-97% of babies within the time frame. The service is required to exception report the reasons for babies not seen on time. The most common reason is that a baby is still in hospital, others may not be seen because the parents have travelled soon after the birth, or through parental choice of appointment time.

9.4.2 There is no national data is not available for this quarter. For Q4 23-24 the comparison data is given below. Islington's performance is significantly above national rates of delivery for new birth visits and higher than the national rate for the 6-8 week review. Comparable data is not available for London.

- **New Birth Visit**

Completed within 14 days
Islington = 95.2% London n/a England = 83.6%
Completed after 14 days
Islington = 4.4% London n/a England = 14.3%

- **6-8 week review**
  Islington = 83.8% London n/a England = 82.2%

9.4.3 The new birth visit and 6–8-week review are vital touchpoints for the parents of new babies. They are an opportunity for all parents to discuss any concerns about their baby or themselves and to reflect on their journey into parenthood with a health professional. The support available to families in Islington with young children is exceptional and wide-ranging.

9.4.4 Health visitors play a vital function in introducing all families to the support and activities available to support families and their baby at this time of transition, as well as the opportunity to review health and development and intervene early where needed. This can be particularly important in supporting maternal and paternal mental health, as well as any early signs of need for additional targeted support for the baby or parents.

9.4.5 Health Visiting is unique in being a universal service available to and taken up by nearly all families regardless of their situation immediately after birth. The service segments the caseload into universal, targeted and specialist, with additional support provided to those in the targeted and specialist caseloads. Those in these higher caseloads are normally also receiving support from other services, and the health visitor provides an important co-ordinating role and point of continuity for the family.

9.5.6 Key Challenges faced this quarter:

- Recruitment is a constant challenge for the service, but vacancy levels fell during Q2 to 12.8%, from 29.6% in Q1. The vacancy for one of the 3 locality lead posts has been filled. This is a challenge shared nationally and with London.
- We are working with the Whittington Health Trust on one of five national pilots developing and testing out new workforce models, recruiting local people into new types of family support roles to create a more blended health visiting and early years workforce.

9.5.7 The focus for the next quarter:

- A continued focus on improving timely uptake of the 6-8 week review. This will include ensuring greater flexibility for parents to be seen at home (rather than in clinic) to support access. This offer has been inconsistent across different teams.

10. Implications

10.1 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.

10.2 Legal Implications:

There are no legal implications arising from this report.

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

There is no environmental impact arising from monitoring performance.

10.4 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.

11. 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	March 2025
	Cllr Flora Williamson	Date:

	Executive Member	
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