Public Health
222 Upper Street

Report of: Director of Public Health

Meeting of: Health and Care Scrutiny Committee

Date: October 2024

Ward(s): All

Public Health Performance Q4 (Quarter 4), 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 4, 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 and Social Care Scrutiny Committee has responsibility.

2. Recommendations

2.1 To note performance against targets in quarter 4, 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 and 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 Q4 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	Q4 2023/24	On target?	2023/24 End of year position for comparison to last year.
Immunisation	**PHI1**	**Immunisation - Population Coverage**								
	PHI1a)	DTaP/IPV/Hib3 at age 12 months.	- Improvement on 89%	89%	87%	86%	87%	86%	Similar	87% (average)
	PHI1b)	MMR2 - 1st and 2nd dose (Age 5)	- Improvement on 70%	70%	68%	68%	68%	68%	Similar	68% (average)
Children & Young People	**PHI2**	**% Uptake of the NHS Healthy Start Scheme**	Now measured by actual uptake Annual uptake of 1692	N/A New Corporate KPI	1705	1757	1808	1781	Yes	N/A New Corporate KPI
Smoking	**PHI3**	**% of people quitting successfully who use the stop smoking service**	55%	62%	56%	59%	65%	63%	Yes	61% (average)
Health Checks	**PHI4**	**% of eligible population (40-74) who have received an NHS Health Check.**	10%	12.10%	3.70%	4.50%	4.10%	3%	Yes	15.3% (cumulative)
Substance Misuse	**PHI5**	**Number of adults accessing treatment in a 12-month rolling period – by Q4 2023/24**							Yes	N/A New Corporate KPI
	5a	Alcohol	389	N/A New Corporate KPI	370	407	413	428		
	5b	Alcohol and non-opiate	222		203	226	211	272		
	5c	Non-opiate	128		116	126	190	169		
	5d	Opiate	1033		866	899	926	944		
		Total	**1772**		**1555**	**1658**	**1740**	**1813**		
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**							No	N/A New Corporate KPI
	6a	Alcohol	150	N/A New Corporate KPI	140	146	145	125		
	6b	Alcohol and non-opiate	81		61	47	56	52		
	6c	Non-opiate	54		40	35	43	46		
	6d	Opiate	55		43	49	41	40		
		Total	**340**		**284**	**277**	**285**	**263**		
Sexual Health	**PHI7**	No of Long-Acting Reversible Contraception (LARC) prescriptions.	1200 based on 22/23 baseline.		296	339	358	340	Yes	1333 (cumulative)

5. Quarter 4/End of Year 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.

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

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

5.2.1 In quarter 4 (Q4), 86% of children aged 1 year had received a complete course of the 6-in-1 DTaP/IPV/Hib/HepB vaccine. Coverage in this period is therefore slightly lower to the previous quarter when it was at 87%.

5.2.2 The data for Q4 is for children aged one year (i.e. any age between 12 and 24 months) in March 2024 (i.e. born between April 2022 and March 2023). This cohort of children were due their first vaccinations between June 2022 and May 2023 and 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 In Q4, the rates of coverage reported through COVER for all 3 doses of 6-in-1 DTaP/IPV/Hib/HepB vaccination at age 12 months were 87% in Islington, 86% in London and 91% in England. This highlights local vaccination rates are in line with the averages for London.

5.2.4 The overall performance at the end of this year (2023/2024 – 87%) is slightly lower when compared to the position at the end of 2022/2023 (89%).

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

5.3.1 The MMR vaccine (measles, mumps and rubella) is given in 2 doses, at age 12 months and at age 3 years and 4 months. The indicator reported, known as MMR2, is the percentage of children aged 5 who have had both doses of MMR vaccine.

5.3.2 The cohort of children were aged 5 in March 2024. These children were due their first dose vaccination (at age 2) between April 2020 and March 2021, and their second dose (at age 3 yrs 4 months), between August 2022 and July 2023.

5.3.3 In Q4, 68% of children aged 5 had received both doses of the MMR vaccination. Coverage for this quarter is the same as all previous periods of the year for 2023/24.

5.3.4 In Q4, the rates of coverage reported through COVER for both doses of the MMR vaccination at age 5 years were at 66% in Islington,74% in London and 85% in England, highlighting lower coverage than the regional and national averages for this period. The programmes COVER report may have also been affected by COVID -19 pandemic restrictions for 2023/24 and the fear of accessing health services 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 data issues which had been previously preventing reporting of the HealtheIntent MMR2 data were resolved and have been backdated to fill in data gaps in the previous two quarters.

5.4.4 During Q4 2023/24, the national catch-up programme continued. Messages went out to families of under 5's via the Bright Start, Bright Ideas newsletter and health visitors reinforced these messages and checked vaccination status at every routine health review.

5.4.5 MMR information leaflets were provided to community events, and there was close co-ordination with the Childhood Immunisation Project Outreach Worker who started working with HealthWatch in Q3. This has enabled greater outreach to community events and to under-served communities.

5.4.6 The Integrated Care Board (ICB) continued to collaborate with the General Practitioners (GP) Federation to provide targeted telephone recall to children identified as unvaccinated.

5.4.7 Key challenges faced this quarter and year 2023/24 include:

- During Q4, the outbreak of measles in North-West London began to spread to other areas of London, with 217 confirmed cases across the capital, although there were no confirmed cases in Islington. As a single dose of the MMR vaccine provides a high level of protection, the focus has shifted to ensuring as many children as possible receive their first dose of MMR (at age 1) to provide protection from the current outbreak of measles. Rates of MMR1 at age 2 have been rising steadily since a low of 76% in early 2022. The rate in Q4 2023-24 at age 2 was 81%.

5.4.8 The focus for 2024/25:

- Over the summer, there was continued emphasis on building awareness of the current outbreak of measles and starting to prepare for summer holiday travel and new school starters in September. Summer travelling to and from abroad brings particular risks of infection in countries where vaccination rates are low. Parents of children starting school in September have been targeted for information to ensure that children have had all their childhood vaccinations before starting school.

- Other opportunities with parents are being 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 includes health visitor contacts, newsletters to parents and childcare settings.

6. Children and Young People's Health

6.1 PHI2 - 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. Most of the eligible population live in highly deprived areas. The data reported is usually % uptake by eligible beneficiaries.

6.1.4 This indicator is normally measured by % uptake by eligible beneficiaries. However, due to data quality inconsistencies regarding the number of eligible beneficiaries, this report will only report the average number of actual beneficiaries for the quarter.

6.1.5 In Q4, there were 1781 Islington residents who benefitted from the programme. Performance over the year has been on an upward trajectory to Q3, with increasing number of families signing up. Despite a slight decrease in the fourth quarter, the overall growth reflects the effectiveness of outreach and the various health promotion and support initiatives in promoting the programme.

6.1.6 Promotional resources are available at all children's centres in Islington, whilst resources are also being shared more widely. The Healthy Start Co-ordinator has been delivering ongoing awareness training for all new receptionist staff at children's centres. In addition to the system-based approach, the local team have shared a briefing about the scheme with local councillors in Islington.

6.1.7 The Healthy Start scheme can be a significant source of income for low-income families. A family with 3 children under age 5 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.

6.1.8 Key challenges faced this quarter:

- Missing data feeds between DWP & HMRC have led to underestimating the numbers of eligible beneficiaries from centrally produced sources since July '23. This is an ongoing issue, which means a denominator against which to calculate the percentage uptake is not available. Islington continues to promote the scheme, aiming to increase the number of eligible residents receiving financial support through strategic coordination, targeted efforts, and universal outreach.

6.1.9 The focus for the next quarter:

- This year, the primary focus is on increasing the programme's uptake. A breakdown of uptake by ward has been obtained to help guide targeted interventions through the Early Years/Bright Start Network. To support this goal, communication and health promotion resources will be reviewed and improved. Additionally, there will be more frequent training and resources provided to health professionals in the Bright Start network and via the Voluntary, Community Sector (VCS) to better promote the scheme.

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 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).

7.1.4 The new Breathe provider, Central and North West London NHS Foundation Trust, began delivery on 1st April 2023.

7.1.5 In Q4, 311 smokers set a quit date. The success rate is above target across the service in Q4 (63%) and it is slightly lower than Q3 (65%). Overall, in 2023/24, 1,262 smokers set a quit date and 764 successfully quit. This represents a success rate of 61%, above the target of 55%.

7.1.6 The service has supported more people to quit in 2023/24 compared with the previous year (1,131 smokers set a quit date in 2022/23 and 691 quit). The quit rate was similar between the two years: 61% in 2023/24 compared with 62% in 2022/23.

7.1.7 The community service, Breathe, continued to perform at a high standard, delivering a flexible, tailored, evidence-based service. In 2023/24, 74% of people successfully quitting using stop smoking support in Islington accessed Breathe directly, with an excellent success rate of 68%. Half (48%) of service users received intensive personalised tier 3 support.

7.1.8 The community service, Breathe, 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 offer to start people on tobacco dependency treatment in hospital and in some outpatient services. Half of all service users seen by the community service in Q4 (47.5%) and in 2023/24 (53%) were referred by secondary care. 72% successfully quit smoking in Q4 and 70% in 2023/24.

7.1.9 Established partnership meetings with secondary care trusts were instrumental in ensuring that all referrals are effectively contacted and that no one is missed. A Breathe advisor attends clinical ward rounds twice weekly at the Whittington Hospital and offers bedside support to clients as part of the partnership.

7.2 Key successes and impact on inequalities /health inequalities:

7.2.1 NHS Digital reports on cumulative stop smoking data for 2023/24 in London and England by local authority. In the same period, the Islington service performed better (61%) than the average quit rate in London (53%) and nationally for England (54%).

7.2.2 In 2023/24 Islington achieved the 3rd highest rate of persons setting a quit date (8,567) and quitting (5,186) per 100,000 smokers in London. This was significantly higher than the London averages (3,160 and 1,670 respectively).

7.2.3 In 2023/24 Islington achieved the highest rate (83%) of pregnant women successfully quitting (closely followed by Newham and Tower Hamlets at 82%).The service's quit rate is significantly higher than London (58%) and England (50%) rates for this group. Over half of pregnant women successfully quit (61%) were verified with a carbon monoxide (CO) monitoring test.

7.2.4 In Islington, the estimated smoking rate amongst routine and manual occupations (24.7%) is double the rate of its adult population (13.2%) [Annual Population Survey estimates, average for 2020 to 2022]. Adults with long-term mental health conditions and residents on low incomes have smoking rates that are higher than the borough average. These are contributing to higher rates of long-term conditions, thus widening health inequalities.

7.2.5 In 2023/24, the service successfully reached groups that experience health inequalities due to higher smoking rates.10% of all successful quit attempts during the year were for people who disclosed a mental health condition either current or past (a quit rate of 57%), and 11% were for people with Chronic Obstructive Pulmonary Disease (a quit rate of 54%). In aggregate, 48% of people from ethnic minority communities setting a quit date successfully quit.

7.2.6 More than half (59%) of successful quits were also amongst residents with higher smoking rates, including those who are sick, disabled, or unable to work, long-term unemployed, unpaid carers and routine and manual workers. Ethnic minority groups with higher-than-average smoking prevalence successfully reached by the service included Bangladeshi men, Black Caribbean, and Black African residents:

- 18 Bangladeshi men quit with a success rate of 69%.
- 39 people of Black African ethnicity quit with a success rate of 78%.
- 32 people of Black Caribbean ethnicity quit with a success rate of 60%.
- 41 residents of Irish ethnicity quit smoking, a quit rate of 55%.
- 177 residents in 'White other' ethnic groups (which is a broad group and includes communities with higher rates of smoking, such as Turkish and Polish speakers) with a quit rate of 64%.

7.2.7 Key Challenges in 2023/24:

- 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. However, this does not allow the service to verify the quit outcome with carbon monoxide (CO) testing. This is an ongoing issue for stop smoking services and reflective of national trends. 16% of all successful quits were verified with a CO test in 2023/24, which was slightly lower than London and England (20%).

- Activity levels across GPs and pharmacies remained relatively low compared with the pre-Covid period. Quit rates were lower within GP practices (42%) than in community pharmacies (61%) over the whole of 2023/24. 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, amongst other factors.

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

7.2.8 The focus for the next quarter:

- Breathe are expanding their work with voluntary and community sector (VCS) partnerships, drug and alcohol services, services working with homeless people, community mental health services, family hubs, Access Islington, and others from local VCS (Voluntary Community Sector) venues, to improve their reach into communities.

- 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 us to look at a range of options to increase access to stop smoking support through our stop smoking community provider, the Breathe service, and GPs and community pharmacies.

- The new government grant will enable us to focus on significantly scaling up service capacity and increasing service demand from 2024/25 onwards. Working with the Breathe provider (CNWL), commissioners are finalising the grant allocation to Breathe for 2024/25, to create new staff roles, increase the budget for the provision of stop smoking aids and scale up the targeted promotion of 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 2023/24, 15.3% (7,986 individuals) of the eligible population received an NHS Health Check compared with a locally set target of 10%. In Q4 this was 3% (1,554 individuals) of the eligible population. The performance this quarter is lower than in Q3 (4.1%), but the overall performance in 2023/24 (15.3%) is higher than in 2022/23 (12.1%). This indicates a strong overall performance for the programme.

7.3.5 In Q4 2023/24, the percentage of the eligible population completing an NHS Health Check (3.0%) was slightly below the London average (3.2%) but above the England average (2.4%). When looking at 2023/24 as a whole, the percentage of the eligible population completing an NHS Health Check (15.3%) surpasses both the London average (12.0%) and the England average (8.8%).

7.3.6 The Department of Health and Social Care and NHS continue to recognise the importance of CVD prevention and the opportunity that the NHS Health Check offers to support this. For example, the NHS Long Term Plan (2019) describes CVD as 'the single biggest area where the NHS can save lives over the next 10 years. Health Checks play an important role in achieving England's 10-year CVD ambitions, through prevention and early diagnosis.

7.3.7 CVD causes just over a quarter (26 per cent) of all deaths in England. In Islington, approximately 14,000 people are living with CVD and CVD kills more than 1 in 5 people. Premature (under 75 years) deaths from CVD in Islington are higher than the London and England average. In Islington, across London and nationally, long-term downward trends in early preventable deaths from CVD slowed in the 2010's and have begun to increase slowly since the start of the 2020's.

7.3.8 The majority of CVD is preventable, so there is a significant opportunity to improve outcomes; risk factors, such as obesity, physical inactivity, smoking and drinking at unsafe levels, 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.

7.3.9 Impact on health inequalities:

- To address inequalities, Public Health Officers ensured that the offer of health checks to residents on the mental health and the learning disability registers is prioritised, along with residents with a predicted very high risk of developing cardiovascular diseases (CVD). As a result, 12.5% (214 residents) of the eligible population on the learning disability and

mental health registers and 35.9% (267 residents) of the eligible population with a very high risk of CVD have received a health check during 2023/24.

- 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.

7.4 The focus for the next quarter:

- During Q4, Public Health started a review of all of Islington's Locally Commissioned Services, including for NHS Health Checks. Opportunities to improve the quality of delivery and equity of access to health checks have been identified, and Public Health will use these findings to inform the future development of the service.

- Public Health also plan to do a more in-depth audit of the quality of health checks delivered (e.g. having conversations around alcohol intake or healthy weight), to understand what aspects of the check are being undertaken well, and where there may be scope for improvement. Based on the findings, Public Health will then develop a package of training or support to help improve quality.

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 or have problem alcohol use, 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 (in operation since 2021) provide 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, pharm-reduction support including Naloxone; which can save lives by reversing the effects of an overdose, as well as referring 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 a quarter-on-quarter increase in individuals accessing treatment in 2023/24, surpassing the annual target. Notably, 310 more structured treatment journeys have commenced compared to 2022/23. Additionally, there has been an increase in individuals seeking help across all substance categories, ensuring that the service is accessible to those with diverse drug and alcohol support needs.

7.6.2 There has been a significant increase in the workforce within the drug and alcohol service offer using grant funding, with supportive monitoring and oversight by Public Health commissioners. This is translating into more people being reached and coming into treatment and support.

7.6.3 Islington has a broad and dynamic service offer delivered by a range of providers. The service offer includes options for people who are still actively using substances (and seeking support to manage and reduce this use), and those in abstinence-based recovery. On top of universal drug and alcohol services (open to anyone) there are also specific services focused on individual cohorts where there is higher need, such as individuals who are rough sleeping.

7.6.4 Additional investment in services for men from Black heritage communities, through outreach with people who are street homeless and in hostels, and increased focus on prevention and early intervention with young people is addressing health inequalities within these groups.

7.6.5 Partnership working has improved over the last 12 months, through dedicated efforts to build relationships and work together around our most vulnerable cohorts, with notable progress in work with the criminal justice system, Police and Community Safety and through outreach activities. This has helped to improve our continuity of care rate, i.e. the proportion of people leaving prison who continue drug or alcohol treatment in the community post release, and further increased the number of people accessing treatment from 25% in Q4 22/23 to 45% in Q4 23/24.

7.6.6 A new online and weekend Peer Support programme has been commissioned and commenced in June 2024, with a new provider mobilising the service. This will extend the opportunities for people using substances or in recovery to access a 7-day peer support, holistic offer.

7.6.7 There is a national and regional emphasis from the Office for Health Improvement and Disparities (OHID) on increasing the number of individuals in treatment, supported by the Supplementary Substance Misuse Treatment and Recovery Grant (SSMTRG) funding as part of the ten-year national drug strategy. Islington's local performance is ahead of regional and national trends, with many areas experiencing increased treatment numbers due to the additional national funding. Notably, Islington has seen a steeper increase in 'new presentations' compared to the London regional average, demonstrating success in the local focus on reaching and getting new individuals into structured treatment.

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

7.7.1 PH16 numbers are lower than projected for 2023/24, and the number of individuals successfully completing treatment is similar to that of the same period last year. While this initially

appears to reflect static performance, reviewing service performance overall (indicator PH15) shows that there has been an increase in the number of individuals in treatment (both new and existing) who were retained in the service compared with the previous year.

7.7.2 Further lengthy periods of treatment can reflect the complexity of cases entering structured treatment; with extended time needed for pharmacological, psychosocial, or recovery support. Many individuals with alcohol and opiate dependencies require long-term interventions due to established dependencies and co-morbidities.

7.7.3 Recognising that there are limitations of only measuring 'successful exits' due to the complexity of the treatment population and that a proportion of service users, particularly with opiate dependency, remain in treatment for long periods of time, the National Drug Treatment Monitoring System (NDTMS) has introduced a new performance measure called 'treatment progress.' This metric allows us to assess individuals' progress during treatment, rather than focusing only on their exit status and will be used to closely review the proportion that are not showing substantial progress going forward.

7.7.4 At the end of 2023/24, the successful completion rate is currently lower than the regional and national averages: Islington – 15%, London Regional- 20%, National- 21%. This is reflective of the previous year, when the completion rate for Islington was at 18%, London at 22% and national averages at 20% for 2022/23.

7.7.5 As detailed in the PH15 narrative, significant effort has been put into accessibility of those entering treatment, with the expectation that this will lead to more successful treatment completions in the coming year. There are several service improvements being implemented to enhance the quality of interventions, which will likely increase successful treatment completions. These improvements include:

- Lower caseloads (through grant-funded investment in additional staff roles within the service).
- Caseload segmentation – service improvement delivered by the provider.
- Increased availability of long-acting Buprenorphine for individuals with problematic opiate use, which can improve adherence with opiate substitute therapy treatment compared to more frequent regimens.
- Expanded access to residential rehabilitation for individuals where community treatment has not been effective.
- Improved pathways supporting people with co-occurring mental health and substance use issues.
- Introduction of a structured day programme and enhanced psychological services.
- Launch of a new online and weekend peer support service providing 7-day access to peer-led recovery support in Islington.
- Enhanced local data capture through a revised suite of KPIs, a referral log to better understand reasons for unplanned exits, and improved data tracking of deaths among individuals in treatment, which will enable Public Health commissioners more effective oversight and monitoring of service delivery.
- Collaboration with system partners and service users to identify additional service elements that may improve the local offering. This includes remote/digital options, same-day prescribing, and enhanced outreach in hotspot areas.

- Dedicated resource to support 'in reach' to supported accommodation settings; and other community settings where the presence of drug and alcohol services would support engagement in treatment e.g. Access Islington.

7.8 Summary for 2023/24 for PH15 and PH16:

7.8.1 Working collaboratively with the service providers, Public Health have developed an ambitious programme of work (funded by the aforementioned grants) to increase the breadth of the offer and increase the number of people accessing drug and alcohol treatment and recovery support in Islington. There include 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 specific 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 support for women following their release.
- 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 'Swap to Stop' scheme which is a pioneering initiative designed to encourage people with drug misuse needs to switch from cigarettes to vapes, recognising that rates of smoking are much higher in this cohort than in the general population.
- Support When it Matters (SWIM) has delivered bespoke tailored interventions to 36 Black and African Caribbean men in the borough, assisting them with drug use and navigating the criminal justice system.

7.8.2 The enhancement of our service offerings aims to improve the user experience of drug and alcohol services, thereby increasing the likelihood that individuals will make and sustain positive changes in their drug and alcohol use. This will benefit not only the individuals themselves but also their close networks and the wider community.

7.8.3 Key challenges /issues this year:

- Many new roles have been introduced to the drug and alcohol workforce; however, these are fixed term contracts funded by the Supplementary Grant. There is uncertainty surrounding the future of this supplementary funding beyond March 2025.
- Capacity challenges in certain parts of the system limit the contribution these partners can make to borough-based Combating Drugs Partnerships and local delivery plans. For example, the Probation Service is a key partner in our work to improve criminal justice system pathways into treatment and the London service continues to experience significant capacity and resourcing challenges. This brings practical issues for partnership working.

7.8.4 Focus for the new year 2024/2025 and the next quarter:

- Public Health is working with services in developing a Communication and Engagement Strategy, which aims to increase visibility and knowledge of drug and alcohol services and improve access to harm reduction advice and information for all residents. Deliverables include a double page spread in the Islington Life winter edition (December) and associated digital content; a wider workforce training offer, and closer partnership working with VCS organisations work-

ing with people currently underserved by treatment and recovery services. We are also reviewing the information and process to make available online referral as an option. Critically in addition to communicating out, we will create more opportunities for service users, residents, and those working in services to feed into service development so we can better understand and address barriers to access.

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 Q4, 340 women had a LARC device fitted in Integrated Sexual Health services. The annual target for the financial year 2023/24 was 1200 LARC fittings. The provider has delivered 1333 LARC fittings, exceeding their target by 133 and continued to provide good access to LARC for local women through the service.

8.1.5 The most recent national data shows that Islington has the third highest rate in London of LARC fitted within Integrated Sexual Health Services (31 per 1000 women aged 15-44) which is higher than the rate in London (23 per 1,000) and England (18 per 1,000).

8.1.6 In January 2024, CNWL launched a new online booking platform integrated into their website which allows service users to book appointments for LARC fittings and removals and other services online, making the service more accessible across all sites within North Central London (NCL). Appointments can also be made by contacting the service directly.

8.1.7 North Central London (NCL) have commissioned CNWL to deliver its PrEP programme to engage with communities at highest risk of acquiring HIV. (The programme aims to increase uptake of PrEP (Pre-exposure Prophylaxis) within these communities). In December, CNWL launched a service which enables people already accessing PrEP the option to order repeat prescriptions online. They have also launched two new awareness videos which include a Q&A about PrEP and how to access medication and a video to promote and demystify its use. In September, CNWL's PrEP programme was awarded the HSJ Patient Survey Award.

8.1.8 CNWL subcontracts various community groups working directly with communities to increase access and uptake of HIV testing. This includes Umoja Health Forum, a partnership of various African organisations concerned about health, housing and social welfare challenges experienced by Black African Communities, and Amaya, a social enterprise that aims to reduce inequalities

within minority communities and provides community HIV testing through a partnership with HIV Prevention England.

8.1.9 The service continues their health promotion outreach and in-reach services to people at risk of sexual ill health. These groups include sex workers, gay, bisexual and other men who have sex with men (GBMSM), racially minoritised groups, people who are experiencing homelessness or rough sleeping. In Q4, the service supported: 222 GBMSM, 104 sex workers, 60 people from Black African/Black Caribbean/Black other ethnic groups, and 61 people experiencing homelessness.

8.2 Key challenges faced in 2023/24:

- The challenge for the service this year has been recovery and increasing activity following the impacts of Covid -19 followed by Mpox. The service has been instrumental in the London and local response to the Mpox outbreak which predominantly affected GBMSM groups, including substantial vaccination delivery.

8.3 The focus for the next quarter and 2024/25:

- Public Health Officers are working with the Integrated Care Board on the development of a Women's Health Hubs initiative, which will offer opportunities for collaboration between women's health services, including co-location arrangements of the Haringey and Islington Gynae-Collab within the Archway Sexual Health Service.
- Public Health Commissioners for Barnet, Camden, Haringey and Islington are working on developing plans for the new sexual health contract and feeding into the developments of the City of London, pan-London sexual health e-service re-commissioning.
- For the new financial year, the PrEP programme has used data on local and national HIV transmissions and PrEP patients to identify three target groups for further outreach work. These are: young Gay, Bisexual and Men who have sex with men (GBMSM), GBMSM of colour and Black African heterosexuals. Public Health Commissioners are also working to identify other target groups for PrEP support.

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	September 2024
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