Public Health
222 Upper Street

Report of: Director of Public Health

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

Date: December 2024

Ward(s): All

Public Health Performance Q1 (Quarter 1), 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 1, 2024-2025 (reported one quarter in arrears due to data lags) progress against targets for those performance indicators that fall within the Health and Social Care outcome area, and for which the Health, Wellbeing and Adult Social Care Scrutiny Committee has responsibility.

2. Recommendations

2.1 To note performance against targets in quarter 1, 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 Q1 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	On target?	Q1 position for comparison to last year.
	Immunisation Coverage						
Immunisation	**PH1a)**	**DTaP/IPV/Hib3 at age 12 months.**	- Improve-ment on 89%	87%	86%	On course	87%
Immunisation	**PH1b)**	**MMR2 - 1st and 2nd dose (Age 5)**	- Improve-ment on 70%	68%	67%	On course	68%
Children & Young People	**PH2**	**% Uptake of the NHS Healthy Start Scheme**	Now measured by actual up-take based on Q4 baseline 1781	1781	1822	Yes	1705
Children & Young People	**Delivery Plan Indicator - DP25/PH3a**						
Children & Young People	**PH3a DP25**	**Numbers of people accessing the Stop Smoking Service for help and support to quit smoking**	1529 by 2026	N/A New Corpo-rate KPI.	381	Yes	New Indicator
Smoking	**PH3b**	**% of people quitting successfully who use the stop smoking service**	55%	61%	62%	Yes	56%
Health Checks	**PHI4**	**% of eligible population (40-74) who have received an NHS Health Check.**	10%	15.3%	4.2%	Yes	3.7%
Substance Misuse	**Delivery Plan Indicator - DP25 /PH5.**						
Substance Misuse	**PH5**	**Number of adults accessing treatment (in a 12-month rolling period)**					
Substance Misuse	5a	Alcohol	459	428	433		370
Substance Misuse	5b	Alcohol and non-opiate	282	272	301		203
Substance Misuse	5c	Non-opiate	175	169	176		116
Substance Misuse	5d	Opiate	974	944	956		866
Substance Misuse		**Total**	1890	**1813**	**1876**	Yes	**1555**
Substance Misuse	**PH6**	**Number of people successfully completing drug and/or alcohol treatment of all those in treatment (12 month rolling).**					
Substance Misuse	6a	Alcohol	150	125	146		140
Substance Misuse	6b	Alcohol and non-opiate	81	52	47		61
Substance Misuse	6c	Non-opiate	54	46	35		40
Substance Misuse	6d	Opiate	55	40	49		43
Substance Misuse		**Total**	**340**	**263**	**277**	Yes	**284**
Sexual Health	**PH7**	**No of Long-Acting Reversible Contraception (LARC) prescriptions.**	1300	1333	310	Yes	296

Public Health Priority	PH Ref	Key Performance Indicator	Annual Target 2024/25	Actual 2023/24	Q1 2023/24	On target?	Q1 position for comparison to last year.
Health Visiting	PH8a)	**Health Visiting - proportion of new birth visits completed within 14 days**	95%	*N/A New KPI	97%	Yes	*New Indicator
	PH8b)	**Health Visiting - proportion of infants receiving a 6-to-8-week review**	85%	*N/A New KPI	84%	Yes	*New Indicator

5. Quarter 1 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 PH1a - DTaP/IPV/Hib3 at age 12 months

5.2.1 In quarter 1 (Q1), 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 below the Islington target of 89% for Q1 2024/25, however reflects the same rate across North Central London (NCL).

5.2.2 When compared to previous periods, there has been a very gradual increase in uptake for DTaP/IPV/Hib3 uptake in Islington since Q1 23/24, and a 1% increase in DTaP/IPV/Hib3 since Q4 23/24.

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. 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 Q1, 67% of children aged 5 had received both doses of the MMR vaccination. There has been a very gradual decrease in MMR2 uptake since Q1 23/24, and a 1% decrease in MMR2 uptake since Q4 23/24. Q1 coverage is also below the Islington target for 24/25 of 70% and lower than the average coverage across North Central London (NCL) at 72% for this quarter.

5.3.3 In Q1, the UK Health Security Agency (UKHSA) moved from following up all cases of measles notified in London, to follow up of vulnerable contacts and higher risk settings only (formally, this is known as level 3 health protection management). This was due to rising numbers of cases across the capital – while Islington has had sporadic cases, some other parts of London have had higher numbers of cases and outbreaks. In response, Islington Public Health proactively sent information about increased measles cases and importance of MMR vaccine into the school and Early Years bulletins, and via a direct email to all primary school heads. This included a request to send out an UKHSA letter on measles / MMR to parents of those starting school in September.

5.3.4 During this quarter, Islington Public Health also developed an evidence review on MMR uptake, and the most effective interventions to increase MMR uptake in schools and children's centres in Islington.

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 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 In Q1 24/25, Public Health and the Healthwatch Childhood Immunisation Project Outreach Worker have been delivering training sessions for front line, non-clinical staff working in children's centres/Early Years settings on the importance of vaccination and starting the conversations with families. This is being followed up with the distribution of resources. Training sessions were well attended (around 60 attendees), with positive feedback. This in effect means that 60 staff who interact regularly with Islington parents are now more able and informed to have conversations about the importance of childhood vaccinations.

5.4.4 Public Health Officers also engaged the head teachers of council-run nurseries to understand how they use immunisations records collected on registration, and conversations they have with parents and carers about immunisations. We have identified good practice and will explore options to standardise this across all settings.

5.4.5 Benefits and impact of programme

- **Evidence reviews on MMR uptake, and the most effective interventions to increase uptake**:

  - This review highlighted inequalities in MMR uptake by ethnicity, main language spoken, deprivation quintile and location in the borough.
  - It identified specific groups which are low-uptake for MMR, and therefore would benefit from targeted interventions (e.g. Somali and Tigrinya speakers, those of Black Caribbean, Black African and Arab ethnicity).
  - This is helping to inform future work in the borough to tackle inequalities in MMR uptake, working with the NHS, VCS and others.

5.4.6 Key challenges faced this quarter (Q1, 2024/25) include:

- With Q2 approaching, there is higher risk during and after the summer holiday period with the possibility of un-vaccinated children travel to countries with high rates of infection.

5.5 The focus for the next quarter:

5.5.1 The focus for Q2 is to send outreach and communications directly to parents, raise awareness with schools and Early Years settings to increase uptake of childhood immunisations (in particular MMR) in September and October. Plans also include:

- **Preparation for Health fun day at family hub on 31 October (pre-school immunisations).**

- Support with organisation of a health fun day at family hub on 31st October, and work to ensure a vaccination focus.

- **Support to Whittington Hospital with MMR community clinics in Children's Centres.**

- The Whittington Vaccination Team are able to offer weekly visits / pop-up vaccination clinics in desired NCL community venues throughout August. Public health support will identify and secure appropriate venues for Islington which can host the team on a weekly basis. Public Health Officers will also support to help promote the clinics amongst partners and residents and evaluate the work.

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. Most of the eligible population live in highly deprived areas. The data reported is usually % uptake by eligible beneficiaries. However, due to data quality inconsistencies regarding the number of eligible beneficiaries, this indicator will only report the number of actual beneficiaries for the quarter/year 2024/25.

6.1.4 While there are issues relating to the data systems nationally, these are being resolved by the national team. This has not prevented the scheme locally from identifying and contacting those who may be eligible and has not prevented anyone from joining the scheme or continuing to access the scheme.

6.1.5 In Q1, there were 1,822 Islington residents who benefitted from the programme. This is higher than the previous quarter (1,781) and when compared to this time last year (1,705). The Healthy Start scheme has continued to deliver significant benefits for service users and residents in Islington, especially in the borough's more deprived areas.

6.1.6 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 enabling healthier food choices.

6.1.7 There is a systematic approach to promoting and raising awareness about the scheme in Islington. For example, promotional resources are available at all children's centres, and some more resources were printed and shared this quarter. The Healthy Start coordinator has ongoing awareness training for all new receptionist staff at the children's centres.

6.1.8 This quarter, the working group has met, the action plan was updated, and awareness letters were sent to over 1,000 families who were potentially eligible for the scheme.

6.2 Key challenges faced this quarter:

- Due to the national data challenges highlighted above, the lack of key data on how many people are on the eligible population list has been a challenge. The working group is still working to promoting the scheme universally and through various targeted interventions so eligible residents do not miss out on the scheme.

6.2.1 The focus for the next quarter:

- The next quarter’s focus will be to enhance the promotional effort of the scheme through the borough and the working group both universally and through target interventions via key networks.

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), since 1 April 2023.

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 Q1, 381 smokers accessed the service for help and support to quit smoking and set a 'quit date'. The number of people setting a quit date has increased by 27% over Q1 23/24 levels (301 in 23/24). The success rate is above target across the service in quarter 1 (62%) and it is slightly lower than quarter 4 2023/24 (63%). The success rate in Islington in quarter 1 (62%) is also higher than the London (55%) and England (57%) rates.

7.1.6 Our community service, Breathe, continued to perform at a high standard, delivering a flexible, tailored, evidence-based service. All people referred were contacted within two working days by the service. In Q1 2024/25, the Breathe service was responsible for 75% of people successfully quitting in contact with stop smoking services, with an excellent success rate of 68%.

7.1.7 A significant factor contributing to increased activity in Q1 was a 33% increase from Q4 23/24 in referrals to Breathe from the NHS Trusts' Tobacco Dependency Teams, and particularly UCLH and Royal Free NHS Hospital Trusts.

7.1.8 In Q1 2024/25 local NHS Trusts continued to deploy their new Tobacco Dependency in-house services for pregnancy. During the quarter, Breathe continued to receive a high number of referrals, similar to previous quarters. It is expected that pregnancy referrals will reduce in following quarters once the Trusts' in-house services are fully operational and able to provide continuing stop smoking support in pregnancy.

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. Amongst residents who successfully quit in Q1 2024/25:

- 58% were sick, disabled, or unable to work, long-term unemployed, unpaid carers and/or routine and manual workers,
- 27% were from ethnically minoritised communities,
- 25% had health conditions caused or made worse by smoking, including COPD, coronary heart disease, diabetes and hypertension,

- 21% 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: 52% opted for telephone support only, with 23% opting for face-to-face support and the remainder a mix of remote and in-person.

- Low carbon monoxide (CO) validation rates are a national issue. In Q1 2024/25, only 15% of successful quits were verified with a CO test, lower than the 20% in London and England in 2023/24. The service is being monitored to ensure wider community access and efficient delivery although the service model does not require carbon monoxide (CO) testing to verify quit outcomes, as it could discourage ongoing engagement.

- Activity levels within GPs and pharmacies settings were lower, with success rates averaging 49% in Q1 2024/25, similar to 47% in 2023/24. Lower activity levels can be attributed to ongoing challenges which include staff recruitment and retention, and competing work pressures. While the number of active GP providers increased slightly in Islington, overall pharmacy performance decreased. Five new pharmacy staff attended stop smoking advisor training in Q1.
- 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.

7.2.3 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 people experiencing homelessness, community mental health services, family hubs, Access Islington, and others from local VCS venues, to improve their reach into communities.

- The new government Local Stop Smoking Services and Support Grant for 2024-25 aims to support the government's smokefree generation plans by providing additional ring-fenced funding for local authorities. This funding will help Islington Public Health explore various options to increase access to stop smoking support through the Breathe community service, GPs, and community pharmacies. The grant will enable a significant scale-up of service capacity and demand from 2024/25 onwards.

- Working with the Breathe provider (CNWL), commissioners finalised the grant allocation to Breathe for 2024/25 in Q2, to create new staff roles, increase the budget for provision of stop smoking aids and scale up the targeted promotion of the service.

- Islington Public Health will work with colleagues across the Council, the NHS and VCS 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.

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 Islington, approximately 3,889 people are living with coronary heart disease (CHD) (the most commonly diagnosed type of heart disease). 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 2010s and increased slowly in the early 2020s.

7.3.5 In the first quarter of the financial year (Q1, 2024/25), the percentage of the eligible population completing an NHS Health Check (4.2%) was above the London average (3%) and above the England average (2.1%), highlighting Islington has strong uptake of the service and performance is better than the London and England average this quarter.

7.3.6 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.

7.3.7 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.

7.3.8 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.

7.4 The focus for the next quarter:

- Islington has started reviewing its locally commissioned services, including NHS Health Checks. Public Health Officers will audit the quality of these health checks at selected practices to identify strengths and areas for improvement, such as discussions on alcohol intake and healthy weight with service users. They are also participating in the London

Health Check network and the NCL Heart Health network to learn from other boroughs, including with Camden.

- The Department of Health and Social Care and NHS continue to recognise the importance of prevention of Cardiovascular Disease (CVD) 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 and plays a role in 'Core20PLUS5' which is the NHS's national approach to reducing health care inequalities.

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.

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

7.6.1 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.

7.6.2 The service is committed to increasing the number of individuals accessing treatment for drug and alcohol use, supported by new initiatives funded by additional grants. The focus is on maintaining and building on the progress made in 2023/24 and ensuring that referral pathways from key partners, particularly in criminal justice, continue to be effective.

7.6.3 Improvements in service access are evident from the increased number of people seeking support. This has been driven by better awareness among stakeholders and a strong partnership approach. Enhancements in service quality are expected to improve the experience for individuals accessing support, leading to a higher rate of successful treatment completions.

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

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

7.7.1 The number of people successfully completing treatment in Q1 was slightly higher than the same quarter last year, but lower than the previous quarter, and below our local target. Public Health Officers have collectively reflected on this with the service. There are some known issues regarding outcome measures, which are defined nationally. In particular, data on people leaving

and completing treatment services do not fully take account of longer treatment periods which reflect the complexity of cases entering structured treatment, requiring extended time for pharmacological, psychosocial, or recovery support. Given the focus and progress over the last two years, there is greater complexity in the local service given higher numbers of people with opiate dependency and from the criminal justice system coming into the service. This has happened at a greater pace than we had originally expected, and is positive, meaning that we are reaching residents with some of the highest needs and helping to intervene in cycles of drug use and the criminal justice system, including time in prison. However, our target was set locally without anticipating the pace of change which has occurred in this complexity, which OHID confirms is progressing substantially faster than in most other high prevalence areas.

7.7.2 Many individuals with alcohol and opiate dependencies need long-term interventions due to established dependencies and co-morbidities. This is important, since we are committed to ensuring that residents can make and sustain changes to their drug and alcohol use.

7.7.3 We have articulated this as an area for improvement for 2024/25 and the provider has committed to focussing on this, including by: auditing caseloads to ensure the most effective interventions are being offered; effectively re-engaging those that may 'drop out'; and auditing data quality to ensure treatment completions are being reported accurately.

7.7.4 A lot of the service improvements to date have also focussed on developing and sustaining new pathways and partnerships with other services and settings and improving the quality of the support which in turn is intended to improve outcomes for individuals. The service has implemented this in several ways including:

- Funding more treatment worker roles, enabling staff to hold lower caseloads, further enhanced by a caseload segmentation exercise to ensure manageable volumes.
- Increased availability of long-acting Buprenorphine (opiate substitute medication) and expanded access to residential rehabilitation.
- Improved pathways for co-occurring mental health and substance use issues, along with a structured day programme and enhanced psychological services.
- New online and weekend peer support service in Islington.
- Enhanced local data capture and tracking for better oversight.
- Collaboration with partners and service users for additional service elements, including remote/digital options, same-day prescribing, and enhanced outreach in hotspot areas.
- Dedicated resources for in-reach to supported accommodation and community settings.

7.7.5 Public Health Officers are confident that through these improvements, and renewed focus by the service, we will see rates of treatment completion increase through 2024/25, while recognising that we continue to need to focus on the outreach and the work with criminal justice system, bringing people into treatment and recovery support.

7.7.6 Impact on inequalities/health inequalities

- 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 are leading communication and engagement work that aims to reduce the stigma experienced by people with drug and alcohol treatment needs, and to help raise awareness and understanding of what services are available and how they operate. Stigma serves as a barrier to help-seeking and contributes to the health inequalities experienced by this cohort.

7.7.7 Key Challenges faced this quarter:

- The service has been successful in recruitment to new roles through additional funding as part of the substance misuse grant, but this brings the challenge of embedding new roles into the service. In some instances, staff in existing roles have been successful in moving into new roles, which is positive, but brings the practical challenge of needing to go out to recruitment to roles which have consequently become vacant.

7.7.8 Focus for the next quarter:

- Sustaining improvements to numbers being reached and in treatment by ensuring referral pathways are effective through existing networks.
- Enhancing awareness of the services through our communications and engagement plan.
- The commissioned provider plans to undertake an 'Unplanned Discharges Review' to understand and identify areas for improvement in the exit processes as one way to help improve outcomes.
- Contract Management will focus on treatment progress and outcomes data, benchmarking regional comparators to ensure service us making necessary improvements in this area.

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 Q1, 2024-25 there were 310 LARC fittings in Integrated Sexual Health services. With a newly adjusted end of year KPI target of 1,300, CNWL are on track to achieve this. The number of LARC fittings in Q1 24/25 by Integrated Sexual Health services was higher than in the same quarter last year when there were 296 LARC fittings. LARC activity has remained consistently high. LARC appointments are available to book online and available up to two weeks in advance.

8.1.5 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.

8.1.6 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.

8.2 The focus for the next quarter:

- Public Health Officers are working with the provider to review processes to maximise the number of appointments for LARC at the Islington based integrated contraception and sexual health service, the Archway Centre to ensure this continues to meet demand for this service.
- Work with the Islington GP Federation, CNWL and North Central London Integrated Care Board in beginning to establish a women's health hub, with a base at the Archway sexual health service site.

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 Q1 2024-25 the health visiting service saw 97% (533/550) of babies within the specified time period (within 14 days of birth). 17 babies were seen after 14 days, of whom 6 were still in hospital.

9.2.2 The 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.

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

9.3.1 84% (484/578) of babies were seen within the specified time constraints, and a further 50 babies were seen after 8 weeks.

9.3.2 Performance of the 6–8-week review is recovering, after a dip in performance following the pandemic period. This was partly due to a period of re-establishing home visiting and community arrangements after Covid -19, 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 and booking review dates early with reminders to parents through a sticker on their 'red book' (parent-held child health record).

9.3.3 The latest comparative data is for Q4 23-24. Islington's data shows 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%

9.3.4 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.

9.3.5 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.

9.3.6 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.

9.3.7 Key Challenges faced this quarter:

- Recruitment is a constant challenge for the service, a challenge shared with London and nationally, and in this quarter, vacancy levels were higher than usual at 30%, including one of the three locality lead posts. We are working with Whittington Health 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.

9.3.8 The focus for the next quarter:

- The service will be conducting a 2-week time and motion study to audit the service capacity that is required for those children and families with more complex needs.

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	December 2024
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