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Health and Wellbeing Board

Date: **FRIDAY, 2 FEBRUARY 2024**

Time: 11.00 am

Venue: **COMMITTEE ROOMS - 2ND FLOOR WEST WING, GUILDHALL**

Members:
Mary Durcan, Court of Common Council (Chairman)
Ruby Sayed, Chairman, Community and Children's Services Committee (Deputy Chairman)
Deputy Marianne Fredericks, Court of Common Council
Gail Beer, Healthwatch
Nina Griffith, City and Hackney Place Based Partnership and North East London Integrated Care Board
Dr Sandra Husbands, Director of Public Health
Gavin Stedman, Port Health and Public Protection Director
Deputy Randall Anderson, Court of Common Council
Helen Fentimen, Port Health and Environmental Services Committee
Simon Cribbens, Safer City Partnership
Tony de Wilde, City of London Police
Matthew Bell, Policy and Resources Committee
Judith Finlay, Executive Director, Community and Children's Services

Enquiries: **emmanuel.ross@hackney.gov.uk - Agenda Planning**
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https://www.youtube.com/@CityofLondonCorporation/streams

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Ian Thomas CBE
Town Clerk and Chief Executive

AGENDA

Part 1 - Public Reports

1. **APOLOGIES FOR ABSENCE**

2. **DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**

3. **MINUTES**

   To agree the public minutes and non-public summary of the previous meeting held on 24 November 2023.

   For Decision
   (Pages 7 - 14)

4. **SPECIAL EDUCATIONAL NEEDS AND DISABILITY (SEND) IN THE CITY OF LONDON LOCAL AREA**

   Report of the Executive Director of Community and Children's Services.

   For Information
   (Pages 15 - 22)

5. **THE CITY & HACKNEY SAFEGUARDING CHILDREN PARTNERSHIP (CHSCP) ANNUAL REPORT 2022/23**

   Report of the Independent Chair of the City & Hackney Safeguarding Children Partnership (CHSCP).

   For Information
   (Pages 23 - 24)

6. **CITY & HACKNEY SEXUAL AND REPRODUCTIVE HEALTH STRATEGY, ACTION PLAN AND CONSULTATION REPORT**

   Report of Director of Public Health.

   For Decision
   (Pages 25 - 148)

7. **DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT - 2023**

   Report of Director of Public Health.

   For Information
   (Pages 149 - 208)

8. **TRADING STANDARDS UPDATE - NICOTINE INHALING PRODUCTS**

Report of Interim Executive Director of Environment.

For Information
(Pages 209 - 214)

9. **HEALTHWATCH CITY OF LONDON PROGRESS REPORT**

Report of Healthwatch, City of London.

For Information
(Pages 215 - 220)

10. **NORTH EAST LONDON INTEGRATED CARE BOARD: FORWARD PLAN REFRESH 2024/2025**

Report of NHS North East London (NEL) Integrated Care System.

For Information
(Pages 221 - 288)

11. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**

12. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**

13. **EXCLUSION OF PUBLIC**

MOTION - That under Section 100A(4) of the Local Government Act 1972, the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A of the Local Government Act.

For Decision

Part 2 - Non Public Reports

14. **NON PUBLIC MINUTES**

To agree the non-public minutes of the previous meeting held on 24 November 2023.

For Decision
(Pages 289 - 290)

15. **NON PUBLIC QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**

16. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE BOARD AGREES SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**

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HEALTH AND WELLBEING BOARD

Friday, 24 November 2023

Minutes of the meeting of the Health and Wellbeing Board held at Committee Rooms - 2nd Floor West Wing, Guildhall on Friday, 24 November 2023 at 11.00 am

Present

Members:
Mary Durcan (Chair)
Ruby Sayed (Deputy Chairman)
Deputy Marianne Fredericks
Gail Beer
Johnathan McShane - City and Hackney Place Based Partnership and North East London Integrated Care Board
Helen Fentimen
Judith Finlay

In Attendance

Officers:

Chris Lovitt	-	City and Hackney Public Health Service
Froeks Kamminga	-	City and Hackney Public Health Service
Emmanuel Ross	-	City and Hackney Public Health Service
Ellie Ward	-	City and Hackney Public Health Service
Chris Pelham	-	Community and Children's Services
Deborah Bell	-	Community & Children's Services Department
Kate Doidge	-	Town Clerk's Department

1. **APOLOGIES FOR ABSENCE**

   Apologies were received from Deputy Randall Anderson and Matthew Bell.

   Johnathan McShane attended on behalf of Nina Griffith, North East London Integrated Care Board.

   Dr Sandra Husbands (Director of Public Health), Gavin Stedman (Port Health and Public Protection Director), and Tony de Wilde (City of London Police) observed the meeting virtually.

2. **DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**

   There were no declarations.

3. **MINUTES**

It was requested that the anacronym CCLA within item 6 of the minutes of the previous meeting be clarified. This stood for Churches, Charities and Local Authorities (CCLA).

Under matters arising, the street triage hours for suicide prevention would be followed up and confirmed. The waiting times for therapies would be followed up with East London NHS Foundation Trust.

RESOLVED – That the public minutes and non-public summary of the previous meeting held on 22 September 2023 be approved as a correct record.

4. **BETTER CARE FUND Q2 RETURN**

The Board received a report of the Executive Director of Children's and Community Services, concerning approving the Better Care Fund Quarter 2 return. The Board heard that the chronic ambulatory care conditions target was not on track as this and how the conditions were managed within a community were the responsibility of an NHS Outcome Framework.

Following questions, the Board heard that it was social care that assisted with maintaining independence for patients within the community, which again was an NHS Outcome Framework on how conditions were managed within a community. There were some issues with the figures from the Integrated Care Board (ICB), due to when Clinical Commissioning Groups (CCGs) merged and what information could be released and provided. Officers would follow up with the ICB on this point.

RESOLVED – That the Board approve the Better Care Fund Q2 return.

5. **THE CHILD Q UPDATE REPORT**

The Board received a report of the City & Hackney Safeguarding Children Partnership, concerning a summary and update on the Local Child Safeguarding Practice following Child Q report.

RESOLVED – That the report be received and its contents noted.

6. **CITY AND HACKNEY SAFEGUARDING ADULTS BOARD (CHSAB) ANNUAL REPORT 2022/23**

The Board received a report of the Group Director Adults, Health and Integration at London Borough of Hackney, concerning the City and Hackney Safeguarding Adults Board (CHSAB) Annual Report for 2022-23.

It was asked if a patient believed that a Local Authority was failing in its safeguarding duties could self-refer. The response was confirmation that patients could self-refer to organisations including health, the police, and any other social care organisation. This was actively being encouraged by CHSAB.

Officers would follow up with CHSAB to ensure that other organisations, aside from Homerton Healthcare NHS Foundation Trust (Homerton) and East London NHS Foundation Trust (ELFT), were captured within its annual report.

RESOLVED – That the report be received and its contents noted.

7. **HOMELESSNESS & ROUGH SLEEPING STRATEGY 2023-27**

The Board received a report of the Executive Director of Children's and Community Services, concerning the Homelessness & Rough Sleeping Strategy 2023-27, which had been endorsed by the Homelessness & Rough Sleeping Sub-Committee and approved by the Community and Children's Services Committee.

RESOLVED – That the report be received and its contents noted.

8. **INTRODUCTION TO CITY OF LONDON HOMELESS HEALTH WORK**

The Board received a report of the Executive Director of Community and Children's Services, concerning an introduction to the Homelessness Health Workplan. Following an introduction to the report, questions and comments were raised as follows:

The Board heard that there was no current capacity to change the day that the mobile primary care clinic was deployed, but a clinical outreach service was run on Wednesday mornings.

It was asked whether other health services, such as dentistry and podiatry, would be offered at the mobile clinic. On dentistry, the response was that dental referrals were offered, however generally there were difficulties accessing that health service within the City. The Board also later heard that oral hygiene packs were provided in the mobile clinic. Hygiene packs were also provided on the outreach service.

On podiatry, the Board heard that there was a priority within the workplan for access to extended services such as podiatry, but the mobile clinic focused on a 'wrap-around' service. At the Greenhouse Surgery, a podiatrist was attended monthly, but that space had to be shared with other services and was further away in distance from the City. It was later commented that there was a podiatry clinic at the Artesian health centre which could link to services within the City.

It was raised that weight was a key health concern among homelessness. The Board heard that patients were assessed and prescribed as necessary and would direct to other pathways such as access to food for those with weight concerns.

The Board raised its concerns that the Homeless Health Coordinator role was only funded until 2025 by the Department for Levelling Up, Housing and Communities (DLUHC) Rough Sleeping Initiative (RSI). The response was that continued funding was a priority, and DLUHC had not provided great assurance of its continuation. For the workplan to continue, it needed to be considered within the wider health modelling. The Board encouraged the gathering of data for an evidence base to DLUHC for the funding to continue. It was questioned whether the data should be reported quarterly rather than bi-annually to the

Homelessness and Rough Sleeping Sub-Committee, to which the response was that this could be considered but was likely reported bi-annually due to capacity restrictions.

Finally, following queries on the mental health service provision, the Board heard that there was a low-threshold service that could assist with low-level cases. There was also a psychotherapy service. There was a need to build engagement and trust with patients for continued use of the mental health service.

RESOLVED – That the report be received and its contents noted.

9. **CLIMATE & HEALTH - OPPORTUNITIES FOR COLLABORATION**

The Board received a report of the Director of Public Health, concerning opportunities for collaboration within climate and health. The Board received a presentation as set out within the agenda papers. The presentation summarised the impacts of climate change on public health; health benefits to climate action; the climate action strategy; and the role of the North East Lindon Integrated Care Strategy (ICS).

It was suggested and agreed that this topic be a regular item at the Health and Wellbeing Board, as climate and health needed to be linked together. It was commented that climate action had not yet become embedded, and there needed to be stronger links and focus on practical, and realistic, actions. It was also said that there needed to be more proactiveness rather than mitigation of impacts of climate change.

The Board heard that there needed to be an understanding between the objectives on climate change and its link to health inequalities, and that the Board should provide a strategic steer for opportunities for collaboration on the two topics. It was therefore agreed that this topic should return to future meetings of the Board. It was also raised that Members met regularly with the Director of Public health. Priorities for future actions and opportunities for collaboration could be considered during those meetings.

The Board also discussed actions taken in Housing and the impacts of housing conditions on health. This was a matter which the Housing department were aware and were considering direct actions.

Finally, the Board heard that the report templates were to be updated to capture the implications on climate and health. Further information would be provided to the Board once available.

RESOLVED – That the report be received and its contents noted.

10. **HEALTHWATCH CITY OF LONDON PROGRESS REPORT**

The Board received a report from Healthwatch, City of London, to consider a progress update.

The Board heard from the Healthwatch representative who provided a summary of the progress update. This included updates regarding Healthwatch's Annual Group Meeting; appointments; overprescribing issues; Covid-19 vaccination rollout; patient panels; digital apps; and reviews at the primary care practices.

A Member queried the maximum patient list number for the Goodman's Field Medical Centre. The response was that the area covered more than one surgery so there would be more than one practice list. The maximum number would be checked and provided. The Board later heard that work had been undertaken in previous years for the Goodman's Field Medical Centre catchment area, and practice partners had indicated that it had not wanted to change the catchment area. This would be followed up.

The Board discussed the Neaman Practice, and that the location and condition of the space needed to be improved. The Board heard that the lease had not yet concluded, and the responsibility for providing the practice was the Integrated Care Board (ICB), who paid rent. There were hopes to utilise the third floor of the practice and upgrade the condition. The Board heard that its views had been articulated on long-term estates strategy for primary care. It was suggested that an update on the primary care strategy could be requested to be presented at the future meeting. This update could include plans from commissioners on models for their primary care plans, including linking to population flow and changes to primary care.

The Board heard that issues relating to communications on neurodiversity were being dealt with by the Town Clerk and Executive Director of Community and Children's Services.

The Board also discussed podiatry and footcare, and that Healthwatch had been discussing with AgeUK on matters such as toenail clipping services. The Board heard that there needed to be a broader look at foot healthcare. The Board also heard that options had been suggested for mainstream funding, but foot healthcare had been reduced to care for specific foot health conditions.

RESOLVED – That the report be received and its contents noted.

11. **ANNUAL REVIEW OF THE TERMS OF REFERENCE OF THE HEALTH AND WELLBEING BOARD**

Note: During this item, the Board agreed that, under Standing Order 40, the meeting be extended by ten minutes to conclude its remaining items of business.

The Board received a repot of the Town Clerk, concerning the Annual Review of the Terms of Reference of the Health and Wellbeing Board. The Board noted possible amendments for discussion, which were amending the quorum; and increasing the number of co-opted members or extending the external membership of the Board to East London Foundation Trust (ELFT), St Bartholomew's Hospital (Barts Health NHS Trust), and Homerton Healthcare NHS Foundation Trust).

The Board agreed to reduce the quorum to three. It was also agreed to extend the membership of Members from the Court of Common Council. It was raised that this would assist with quoracy and provide more continuity from members of the Board.

The Board considered its previous discussions on co-opted members, and discussed whether those organisations identified (ELFT, St Bartholomew's. And Homerton Healthcare) should be full external members of the Board. It was raised that there would be a benefit of a broader conversation with the membership of the health providers. The Board agreed to amend the membership of the Board to include those organisations, as listed above.

The Board agreed to delegate the revisions to the Terms of Reference to the Town Clerk, in consultation with the Chairman and Deputy Chairman. It was also agreed by the Board that the revisions should be made in time for its next meeting in order for the new external members to attend.

RESOLVED, That:

(i) Approval of the final wording of the revisions to the Terms of Reference, as described above, be delegated to the Town Clerk, in consultation with the Chairman and Deputy Chairman of the Health & Wellbeing Board.

(ii) The revisions to the Terms of Reference be approved subject to any comments for submission to Policy & Resource Committee and/or Court of Common Council.

12. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**

There were no public questions.

13. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**

There were no public items of urgent business.

14. **EXCLUSION OF PUBLIC**

RESOLVED – That under Section 100A(4) of the Local Government Act 1972, the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A of the Local Government Act.

15. **NON PUBLIC MINUTES**

RESOLVED – That the non-public minutes of the previous meeting held on 22 September 2023 be approved as a correct record.

16. **SEXUAL HEALTH SERVICES IN THE CITY OF LONDON**

The Board received a report of the Director of Public Health, concerning discussion on the sexual health service provision within the City of London.

17. **SPECIAL EDUCATIONAL NEEDS AND DISABILITY (SEND) IN THE CITY OF LONDON AREA**
RESOLVED - That this item be deferred until the next meeting of the Health & Wellbeing Board.

18. **NON PUBLIC QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**
There were no non-public questions.

19. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE BOARD AGREES SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**
There were no non-public items of urgent business.

The meeting ended at 1.15 pm

Chairman

Contact Officer: emmanuel.ross@hackney.gov.uk - Agenda Planning
kate.doidge@cityoflondon.gov.uk - Governance Officer/Clerk to the Board

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Committee Health & Wellbeing Board	**Dated:** 02/02/2024
Subject: Special educational needs and disability (SEND) in The City of London Local Area	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	• Contributing to a flourishing society • Support a thriving economy • Shape understanding environments
Does this proposal require extra revenue and/or capital spending?	**N**
If so, how much?	**N/A**
What is the source of Funding?	**N/A**
Has this Funding Source been agreed with the Chamberlain's Department?	**N/A**
Report of: Judith Finlay, Executive Director of Community and Children's Services	**For Information**
Report authors: Theresa Shortland Head of Service – Education and Early Years Sharon Cushnie Lead SEND Advisor – Education and Early Years	

Summary

- This report provides statistical information about the number of children and young people with special educational needs and disability (SEND) in the City who are known to the local authority (LA), those who receive additional support from the LA through an Education, Health and Care Plan (EHCP) due to their complex needs, and those who are receiving SEN Support.
- This information is set against the national statistical information as reported by the Department for Education (DfE) publication, *Special educational needs in England 2023: January 2023*, published June 2023 (https://explore-education-statistics.service.gov.uk/find-statistics/special-educational-needs-in-england.) This publication is based on data for the January 2023 caseload, and for activity during 2022. From 2023 this data changed from aggregated figures at LA level, to person-level data.

- By the end of the Foundation Stage, children are at least at the expected level in communication and language so that they have the best academic start. In terms of early identification and responding to speech and language needs at the earliest opportunity, the City of London Talks and Listens Enthusiastically (COLTALE) programme continues to offer Early Years practitioners improved knowledge and skills in identifying children who may have SLCN. This also provides links between the home learning environment and early education settings in the earliest years.

Recommendation

Members are asked to:

- Note the report

Main Report

Background

The National Picture

1. The DfE report – *Special educational needs in England: January 2023* – provides data from the January 2023 school census on pupils with SEND, and information about special schools in England. The data is a national data set and presents a picture of SEND in England.
2. The percentage of pupils with EHCPs has increased from 4.0% in 2022 to 4.3% in 2023, continuing a trend of increases since 2016.
3. The percentage of pupils with SEN Support has increased from 12.6% in 2022 to 13.0% in 2023, continuing an increasing trend.
4. In January 2022, pupils with an EHCP made up one quarter (25%) of all pupils with SEN.
5. The most common type of primary need for those on SEN Support is speech, language, and communication need (SLCN). This is followed by social, emotional and mental health needs, and moderate learning difficulty.
6. For pupils with an EHCP, almost one in three pupils identified autism spectrum disorder (ASD) as a primary need.
7. The number and percentage of pupils with an EHCP has increased across all school types.
8. In terms of gender, SEND continues to be more prevalent in boys: 72.4% of pupils with an EHCP are boys; 62.8% of pupils with SEN Support are boys – although, both rates have been decreasing slowly in recent years.

Current Position – September 2023

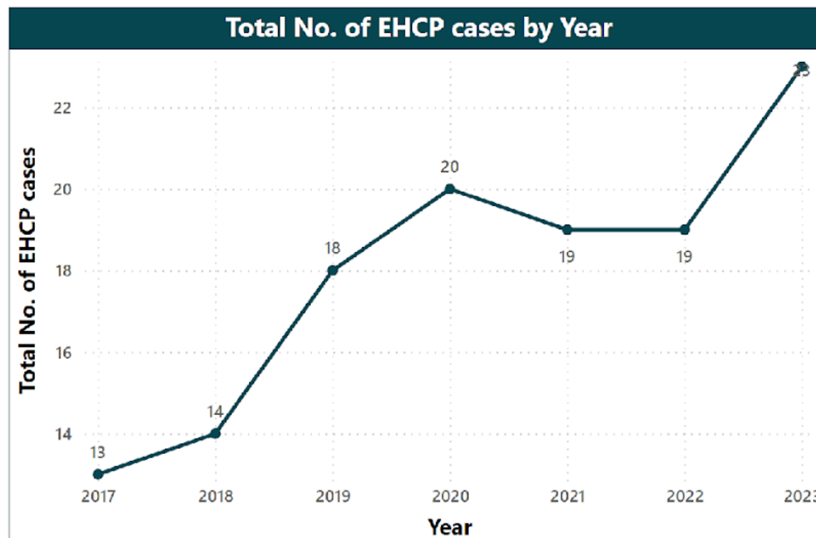
The Local Picture in COL and Key Data

9. Key data is captured by the Community & Childrens Performance team.

Table 1 below, presents the number of children for whom COL maintains an EHCP. The number of EHCPs has increased from 13 in 2017 to 23 as at December 2023,

the highest number to date in the COL. This is approximately 0.9% of the population of resident children and young people aged 0–25 years (GLA Population Projections (london.gov.uk)).

Table 1. EHCP cases by year



10. Several factors have contributed to the increase, including the number of pupils moving into the COL, early identification of needs, and parental requests for assessments. In 2022, referrals and assessments also increased to meet the needs of the Afghan and Ukrainian communities who lived in the City at this time, although assessments that were initiated (two Afghan children) and EHCPs issued (one Ukrainian child), have all been transferred to the receiving LAs as these families have moved out of the COL. Specialist SEN Support was also provided to a small number of other children from these communities. Had all these children and young people remained here, the COL would be maintaining a further four EHCPs.
11. The most common type of primary needs for pupils with an EHCP in the COL is ASD, at 60% (14 children and young people), which is higher than the national average, where almost one in three pupils have ASD as a primary need. Children and young people with an SLCN make up the second highest at 17% (four children and young people).
12. The COL and Hackney's Autism Strategy 2020–2025, which was co-produced with autistic residents and their families and carers, and the City and Hackney Children and Young People's Emotional Health and Wellbeing Partnership –Neurodevelopmental Subgroup, provides a framework for us to plan and improve services for autistic people in the COL. The City Parent Carer Forum is represented on this group.
13. Table 2 below, shows that there are more children and young people in the upper age range than in previous years. Preparation for adulthood has been a key area for development that we have focused on over the last two years. A transition guide, *Steps to Adulthood*, was co-produced with partners, including the City Parent Carer Forum. The purpose of this guide is to support parents and young people through the preparation for adulthood pathways. A COL Transitions Forum meets termly to consider the needs of children and young people (aged

14+) across education, health and social care. Pathways into supported internships are being developed for young people with EHCPs.

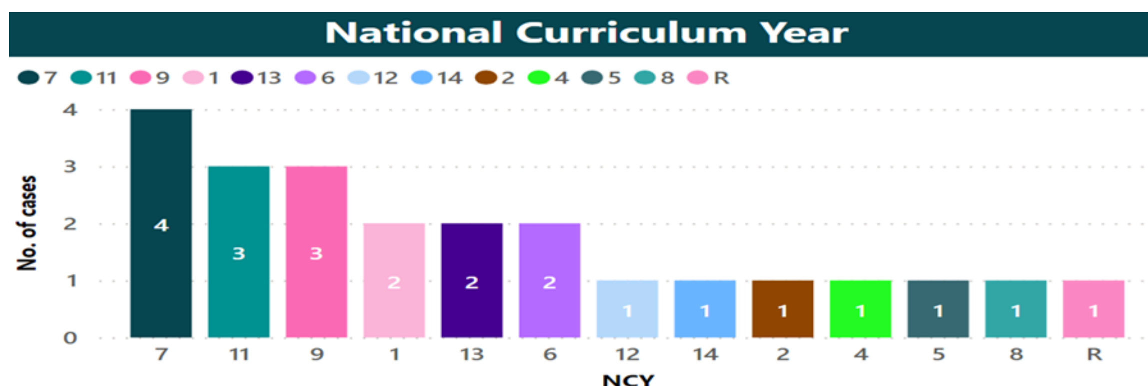


Table 2. EHCP pupils by National Curriculum year

14. Most COL resident children and young people with EHCPs are boys: 19 out of 23 (83%), compared to the national average of 72.4%. As with the national figures, this rate has decreased. Previously there were two girls with EHCPs. During 2022/2023 two secondary aged girls who are on the autistic spectrum received an EHCP. Many autistic girls remain undiagnosed because the signs of autism are less obvious than they are in boys. Recent research suggests that girls with autism may be under-identified or given another diagnosis, such as anxiety or Attention Deficit Hyperactivity Disorder (ADHD), because their symptoms can be easier to miss as they are more likely to 'mask' their autistic traits.
15. The Children and Families Act 2014 is clear that children and young people with SEND should be educated in mainstream provision, unless their needs require more specialist provision. In COL, 17 of the 23 children and young people attend mainstream settings. Six children and young people attend special schools, of which two attend a special residential setting.
16. Out of 23 children and young people, 22 attend maintained educational settings rated Good or Outstanding by Ofsted, or independent settings at which standards are met. One young person attends a further education college which has been judged as “requires improvement”, although learners with high needs are reported to be well supported to make progress. Although the LA advised the family of the LA’s standard for all children and young people to attend good or outstanding settings, the young person and parent made the decision to attend this setting.
17. Statutory timescales in COL for issuing EHCPs are consistently met, with 100% of EHCPs being issued within 20 weeks. This has been the case since September 2014. This is higher than the national figure of 49.2% for EHCPs issued within 20 weeks in 2022. This figure demonstrates that national timeliness has reduced in recent years.
18. Parents and young people (children over 16 years) have a right of appeal to the SEND Tribunal if:
    - the LA has refused to carry out an EHC needs assessment
    - the LA refuses to issue an EHCP following an assessment, or if they are not happy with the content of an EHCP.

In COL in 2023, one appeal was lodged with the SEND Tribunal. This concerns

the provision specified in the EHCP. There was one appeal in 2022, two in 2020, one in 2019 and three in 2018. In terms of these seven appeals: one moved out of the area, three were resolved without the need for a hearing, two were upheld by the SEND Tribunal, and one was not upheld.

Pupils on SEN Support

19. An area for development and challenge since the last Ofsted and Care Quality Commission (CQC) Area SEND inspection in 2018 has been around data collection. This relates to children and young people who receive SEN Support, particularly those educated outside of the COL. During the last academic year, we delivered a data collection project to identify and monitor children and young people in receipt of SEN Support, who were also attending schools within and outside of the COL. The SEND team contacted all known schools (83 schools) where COL children and young people attend, and data was collected from 92% of those schools contacted.

20. SEN Support is the process that schools and other settings use to initially identify and meet the needs of children with SEND, and to provide extra help to the support provided as part of the school's usual arrangements. This assistance is provided from the school's own resources, sometimes with advice or support from outside specialists. These pupils do not have an EHCP. This data shows that 49 COL resident pupils are in receipt of SEN Support (13% of the pupils who are statutory school age and attending an educational setting). This is in line with the national average of 13%. (DfE: *Special Educational Needs in England 2022/23*).

Outcomes

21. Outcomes for pupils with EHCPs are reported through the annual review of their EHCP. Annual reviews are closely monitored, with the SEND Officer and/or the Principal Educational Psychologists attending all meetings. Progress and any concerns are addressed at the LA's SEND Panel as appropriate.

22. Pupils make good progress towards their aspirations and preparation for adulthood outcomes, and in line with their special educational needs. At the end of the academic year 2022/23, there was no movement of any young people into further education placements for the first time, although one young person moved to a different placement that is best suited to them for meeting their personal aspirations. This was a well-planned and smooth transition, with the young person providing positive feedback on their experience.

Early Years

23. In terms of early identification and responding to speech and language needs at the earliest opportunity, the City of London Talks and Listens Enthusiastically (COLTALE) programme continues to offer Early Years practitioners improved knowledge and skills in identifying children who may have SLCN. This also provides links between the home learning environment and early education settings in the earliest years. The programme also links to literacy, early reading and writing skills. The main aim of the programme isto ensure that practitioners, teachers, and parents have a secure understanding of language development and how it relates to a child's development

24. By the end of the Foundation Stage, children are at least at the expected level in communication and language so that they have the best academic start. Inclusion audits were carried out between May and July 2023 across all Early Years

settings in the COL. Evidence was supported through dialogue, policies, practice, and observations. Settings were asked to be reflective and look at their SEN and inclusion systems and practices. Judgments were agreed on by the Special Educational Needs and Disabilities Co-ordinators (SENDCO)/Manager and Early Years Advisor. Discussions demonstrated that SENDCOS had a clear understanding of the needs of children, including those with SEND, and knew their children and families well.

25. All staff are aware of children with additional needs and are involved in supporting them. Therefore, children make good progress. One-to-one support is effective in extending children's learning when support staff have been trained and are included in the child's targets. In some nurseries, there was discussion on how temporary or new staff were provided with information to ensure that children's needs were consistently supported. Individual Outcome Plans (IOPs) show targets which are specific, measurable, achievable and time-bound (SMART), with identified outcomes.

26. All Safeguarding policies and procedures include children with SEND, and appropriate Early Help referrals are made to support children's and families' needs. Overall policies are personalised to the individual setting, even within settings that are part of a chain of nurseries. All stakeholders – such as parents, governors and advisors – are involved in the development and review of policies, and one smaller playgroup is planning to develop this more in the autumn term. Policies refer to current legislation and SEND policies identify a named SENDCO. The Local Offer from settings is available on the COL Family Information Services (FIS) website and updated annually.

27. Feedback received from families following transition to primary school or Key Stage 1 has been very positive and shows that support from the Early Years' Service is valued. From 26 referrals made to the Early Years Service between May 2021 and September 2023, only five have led to a request for an Education, Health and Care (EHC) needs assessment. Of these, only two were COL residents. All requests made by Early Years settings to the COL for an EHC needs assessment have been accepted, showing that these requests were made appropriately. This shows that our work is having an impact on identifying needs early and addressing the needs of all children, including those with a greater level of needs.

28. The purpose of the SEN (Early Years) Inclusion Fund (SENIF) is to support Early Years providers to address the needs of individual children, and to make it easier for families of children with SEND to take up their free entitlement to nursery provision. All Early Years providers in the COL who are eligible to receive funding for the early education entitlement (for 2-, 3- and 4-year olds) are also eligible to receive support from the SENIF, and £ 8,762 inclusion funding was allocated in the academic year 2022–23 for two children.

29. The Early Years Advisor is in regular contact with the COL Health Visitors to ensure that, where a child's development causes concerns at a health review, their details are shared so that a suitable Early Years place can be sought and educational support can be provided as early as possible.

Corporate & Strategic Implications

30. Strategic implications – Corporate outcome: Contribute to a flourishing society by ensuring that all children and young people with SEND and their families have equal opportunities to enrich their lives and reach their full potential.

31. Resource implications – The SEND functions are resourced through the Dedicated Schools Grant – High Needs Block.
32. Financial implications – The SEND functions are resourced through the Dedicated Schools Grant – High Needs Block.
33. Legal implications – The duties on local areas regarding provision for children and young people with SEND are contained in the Children and Families Act 2014. This legislation sits in the context of the Equality Act 2010. The Ofsted/CQC inspection framework sets out the legal basis and the principles of inspection.
34. Risk implications – If children's and young people's SEND issues are not identified early, assessed and supported, this will impact on their educational attainment, progress and wider lifetime chances.
35. Equalities implications – All children and young people, regardless of their SEND issues, will be part of a community where they can learn, achieve and participate in activities with other children and young people, and will be prepared to have a fulfilled adult life.
36. Disability and race are protected characteristics in the Equality Act 2010.
37. Climate implications – n/a
38. Security implications – n/a

Conclusion

39. The number of EHCPs has increased from 13 in 2017 to 23 as at December 2023, the highest number to date in the COL. We have strengthened the data around children and young people at SEN Support who attend educational settings outside of the COL. We are also strengthening the early identification of children in early years which Is supported by the SENDCOs and COLTALE activities.

Theresa Shortland

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Committee(s):	Dated:
CCS Committee – For Information Health & Wellbeing Board – For Information Safeguarding Sub Committee – For Information	25th January 2024 2nd February 2024 TBC
Subject: The City & Hackney Safeguarding Children Partnership (CHSCP) Annual Report 2022/23	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	1,2,3 and 4
Does this proposal require extra revenue and/or capital spending?	**N/A**
If so, how much?	**N/A**
What is the source of Funding?	**N/A**
Has this Funding Source been agreed with the Chamberlain's Department?	**N/A**
Report of: Jim Gamble – Independent Chair, CHSCP	**For Information**
Report author: Rory McCallum - Senior Professional Adviser, CHSCP	

Summary

The City & Hackney Safeguarding Children Partnership annual report for 2022/23 sets out examples of the evidence, impact, assurance and learning of the statutory safeguarding arrangements in the City of London and the London Borough of Hackney. It reports on the following activity:

- The governance and accountability arrangements for the CHSCP's safeguarding arrangements alongside a summary of progress against the CHSCP's priorities.
- The context for safeguarding children in the City of London, highlighting the progress made by the City of London partnership.
- The context for safeguarding children in the London Borough of Hackney, highlighting the progress made by the Hackney partnership.
- The lessons that the CHSCP has identified through its Learning & Improvement Framework, the key messages for practice and the actions taken to improve child safeguarding and welfare as a result of this activity.
- The range and impact of the multi-agency safeguarding training delivered by the CHSCP.
- The CHSCP's priorities going forward and the pledge of safeguarding partners.

In line with statutory requirements, the CHSCP annual report 2022/23 has been sent to the Child Safeguarding Practice Review Panel and Foundations, the What Works Centre for Children & Families.

Recommendation(s)

Members are asked to note the report.

Main Report

The Annual Report can be accessed via the CHSCP website: **HERE**

Corporate & Strategic Implications

Strategic implications – The publication of an annual report by the CHSCP is a statutory expectation defined in Working Together to Safeguard Children 2023 .

Financial implications - None

Resource implications - None

Legal implications - None

Risk implications - None

Equalities implications – The annual report contains no proposals relevant to the City's public sector Equality Duty 2010

Climate implications - None

Security implications - None

Rory McCallum

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Committee(s) Health and Wellbeing Board	Dated: 02 February 2024
Subject: City & Hackney Sexual and Reproductive Health Strategy, Action Plan and Consultation Report	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	*2) People enjoy good health and wellbeing.* *3. People have equal opportunities to enrich their lives and reach their full potential.* *4. Communities are cohesive and have the facilities they need.*
Does this proposal require extra revenue and/or capital spending?	Not at this stage
If so, how much?	To be determined
What is the source of Funding?	N/A
Has this Funding Source been agreed with the Chamberlain's Department?	N/A
Report of: Sandra Husbands, Director of Public Health	For Decision
Report author: Froeks Kamminga, Senior Public Health Specialist Chris Lovitt, Deputy Director of Public Health	

Summary

Following an in-depth and extended consultation period the draft five year City & Hackney strategy for sexual and reproductive health (SRH) has been finalised, alongside an action plan for the first year, covering the financial year 2024-2025.

The strategy and action plan are ambitious in the intention to strengthen partnership working and foster a joint, system wide approach to improving outcomes in sexual and reproductive health.

An oversight mechanism will be needed to assess progress of implementation and to support the annual preparation of the next year's action plan.

The Health and Wellbeing Board is asked to a) approve the strategy b) approve the action plan and c) confirm the partnership and reporting process.

Recommendations

Members are asked to:

- Note the consultation report
- Review and approve the revised strategy
- Review and approve the first year action plan
- Confirm the partnership and reporting process

Main Report

1. Background

1.1. Following approval by the Health and Wellbeing Board in June 2023, the draft five year City & Hackney strategy for sexual and reproductive health (SRH) went out for consultation, with an action planning process taking place alongside it.

1.2. The consultation on the strategy consisted of an online survey (1 July-20 September 2023, 102 responses), an Easy Read survey (13 responses), and a range of online and in-person engagement events (July-November 2023, total of 94 participants), and two workshops (23 participants) with commissioned providers and other key partners. Considering the life course nature of sexual and reproductive health, and the variety in need between different population groups and demographics, it was important that the consultation was as inclusive as possible.

1.3. The consultation findings and feedback are captured in a consultation report, with a process overview captured in a presentation, both of which are attached to this report as appendices. Some key findings from the consultation include:

- strong agreement on all themes and priorities identified
- affirmation of the importance of relationship and sex education in schools
- lack of knowledge of and access to services named as key barriers
- stigma and shame attached to sex and STIs, and HIV, persist
- services remain fragmented across the wider sexual and -especially- reproductive health pathway, often due to fragmented commissioning responsibilities

1.4. The consultation was done in tandem with an action planning process. Consultation feedback, recurring themes as well as suggestions from commissioned services and key partners were taken into consideration and shaped the action plan and the revised strategy. The strategy and action plan are attached to this paper as appendices.

1.5. Issues and topics that were suggested or expanded on include:

- a central online resource for SRH to provide information, advice and signposting to all relevant SRH services in City and Hackney with booking links where possible, linked with:

- a communications and engagement strategy, and a SRH awareness campaign
- stronger focus on co production of materials/resources/ campaigns with specific population groups and/or service users, in relation to e.g. STIs or contraception
- joint working and (re)commissioning in areas of e.g. young people and education, substance misuse, communication and health literacy, inclusion groups
- strengthening of the inclusion communities and complex needs theme
- fertility and assisted conception
- sexual assault referral centres (SARC, also known as Havens)
- increased focus on living well with HIV

2. Current Position

2.1. The finalised strategy and first year action plan are the culmination of an extended period of engagement and consultation, while at the same time being the starting point of a new approach to delivering services in a more joined up way to improve outcomes in sexual and reproductive health. This approach is not without risks, and it is important to recognise these risks, such as:

2.1.1. Co-production is a central part of the strategy but is an approach that requires time and resources

2.1.2. Relationship and sex education elements of the action plan are still being confirmed as an approach with Young Hackney

2.1.3. Lack of engagement from NHS place on wider commissioning and alignment of services

2.1.4. London SH and HIV programmes not delivering on wider commissioning alignments

2.1.5. Other NEL LAs taking a different approach to commissioning of specialist clinical services using the newly approved Provider Selection regime (PSR)

2.1.6. Increased “ambition” against a backdrop of Public Health savings and inflationary increases not reflected in the PH grant allocation to Local Authorities

2.2. To ensure oversight of the implementation of the action plan and its continuous alignment with the strategy, as well as the management of the aforementioned risks, it is important to have a partnership and reporting process in place. This would involve regular meetings to assess progress against the key outcomes as well as at least one annual planning exercise to agree the next year’s action plan for submission to the Board.

2.3. Considering this new approach to delivering on sexual and reproductive health, it is suggested this process be flexible and adaptable to the demands.

Mechanism	Membership	Purpose
City & Hackney Sexual and Reproductive Health Strategy and Action Plan Sub Group *(joint subgroup for C&H HWBs)*	- Public Health team members - Commissioned services representation - ICB and other place-based system partners (Place Based Delivery Group) - Wider services such as ToPs, Fertility, Havens and HIV treatment services - CVS partners such as Healthwatch (City & Hackney) and Hackney CVS	- Overseeing action plan implementation (with dedicated ToR - to be developed) - Prepare end of year progress report - Prepare new action plan for the subsequent (financial) year - Quarterly meetings - One annual planning meeting
Public Health Reporting	All Public Health teams involved in implementation of the action plan as leads or partners	Progress report to Public Health Senior Management team annually, at the end of Q1 Joint planning exercise during Q3 (in conjunction with the Sub Group)

3. Recommendations for discussion

3.1. The Health and Wellbeing Board is asked to:

3.1.1. a) approve the strategy

3.1.2. b) approve the action plan and

3.1.3. c) confirm the partnership and reporting process.

4. Corporate & Strategic Implications

- *Strategic implications*

1. Contribute to a flourishing society
2. People enjoy good health and wellbeing
3. People have equal opportunities to enrich their lives and reach their full potential
4. Communities are cohesive and have the facilities they need.

- *Financial implications*

  None. Within the allocated Public Health grant
- *Resource implications -*
- *Legal implications -*
- *Risk implications -*
- *Equalities implications -*

  The strategy highlights that inequalities exist in access to services and health outcomes based on ethnicity, age and sexual orientation. The action plan includes appropriate actions to address and reduce inequalities.
- *Climate implications*

  Service providers are required to address sustainability as a key issue in procurement and delivery of services.
- *Security implications -*

5. Conclusion

5.1. The five year City & Hackney strategy for sexual and reproductive health (SRH) and action plan offer a comprehensive and ambitious intention to strengthen partnership working and foster a joint, system wide approach to improving outcomes in sexual and reproductive health.

5.2. The Board is asked to review and approve the strategy and the action plan and to confirm the proposed partnership and reporting process through a joining HWB sub group.

6. Appendix

- Appendix 1 - A presentation on the Sexual & Reproductive Health Strategy consultation
- Appendix 2 - The draft City & Hackney Sexual & Reproductive Health Strategy Consultation Report
- Appendix 3 - The draft City & Hackney SRH Strategy January 2024

Froeks Kamminga

Senior Public Health Specialist

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City & Hackney
Sexual and Reproductive Health Strategy

Overview and consultation presentation

Froeks Kamminga
City & Hackney Public Health

Overview

- Themes of the strategy
- Process and timeline
- Consultation
- Action planning
- Governance
- Implementation

Themes

1. Healthy and fulfilling sexual relationships
2. Good reproductive health across the life course
3. STI prevention and treatment
4. Getting to Zero new HIV transmissions
5. Vulnerable populations and those with complex needs

Themes 1-4 align with the priorities of a NEL-wide strategy on Sexual and Reproductive Health (SRH) that is also under development

- June 2023, City HWB & Hackney HWB decide to approve the consultation and action planning process
- Online survey consultation period: 1 July - 20 September
- Online and in person engagement: July - November
- Collate survey and consultation findings and feedback (November)
- Revise strategy and finalise action plan (December)
- Adoption by HWB: January / February 2024
- ICB (NEL strategy)

Consultation promotion

Channels (online/social media)

- Consultation webpage launch promoted on Twitter and Facebook - City and Hackney channels, and Business Healthy (BH)
- Consultation promoted in Hackney e-newsletter and Love Hackney magazine, and staff internal newsletter
- Twitter posts promoting online and in-person sessions on Hackney's Social media channels
- Posts on Hackney Council's instagram stories to target younger audiences
- Posts on City of London social media prompting the consultation
- Coverage in City AM
- Posts on BH twitter, Barbican Library, and City of London X (Twitter) to promote in-person
- Online promotion on Hackney Council's Instagram for a final call to complete the consultation
- Final call to complete the consultation in Hackney Council's newsletter
- E-newsletters (external and internal staff newsletter)

Consultation promotion

Email

- Community Champions and other community partners
- Community centres
- CVS organisations such as Healthwatch Hackney and Hackney CVS
- Pharmacies and GP Practices (newsletter)
- Youth hubs
- All commissioned services
- Key contacts with wider networks

Attending meetings to promote the survey and inform/involve a broad range of stakeholders

- Health Inequalities Steering Group
- Healthwatch Hackney: LGBTQ+ Community Voice in Health & Care Public Forum
- Hackney CVS Special Interest Group on Sexual Health
- Place Based Partnership Delivery Group

Consultation

- Online survey for any resident, service user or partner to complete

- Easy Read version of the online survey
  - Hackney Ark Captains (young people with learning disabilities)
  - Open Doors (service users)

- Theme-based online consultations (8 sessions) plus audience focused sessions
  - Community African Network (CAN) members and volunteers
  - Healthwatch Hackney public reps
  - LGBTQ+ representatives

Consultation

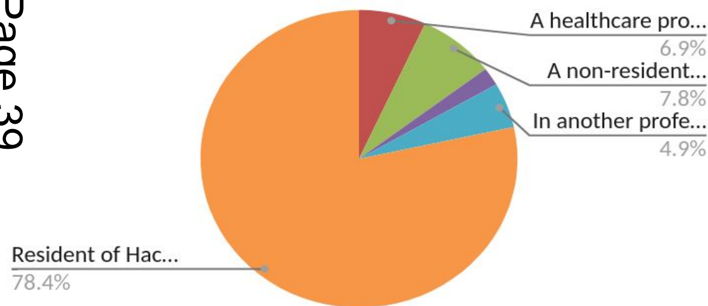
- Face to face focus group discussions/informal engagement
  - Barbican Library, CoL residents/service users
  - Hackney People First (adults with learning disabilities)
  - STEPS brunch drop-in (service users)
  - Young People

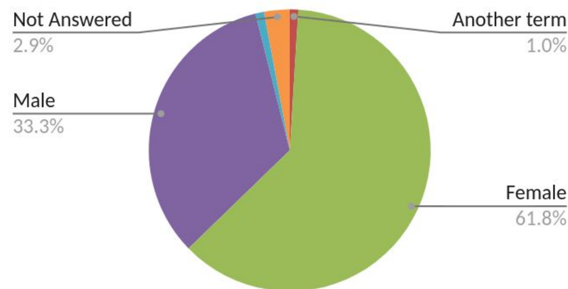
- Workshops with commissioned services and key partners with thematic focus (hybrid of in person and online)
  - Young people and sexual health
  - Contraception and reproductive health

- NEL strategy workshops

Consultation survey

- 102 responses to online survey
- 13 completed Easy Read surveys and 13 C&H responses to the NEL survey
- Analysis of findings in consultation report

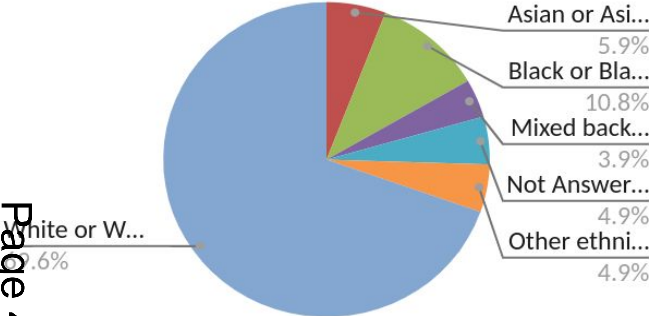


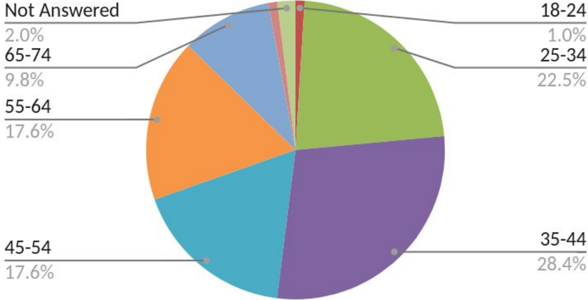


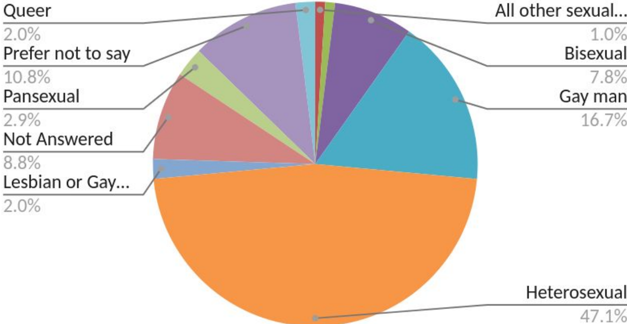
A healthcare provider or health related professional: 7
A non-resident of City or Hackney who uses local C&H services: 8
A representative of a community or voluntary service organisation (CVS): 2
In another professional capacity: 5
Resident of Hackney or City of London: 80

Another term: 1
Female: 63
Male: 34
Non Binary: 1
Not Answered: 3

Survey: respondent information



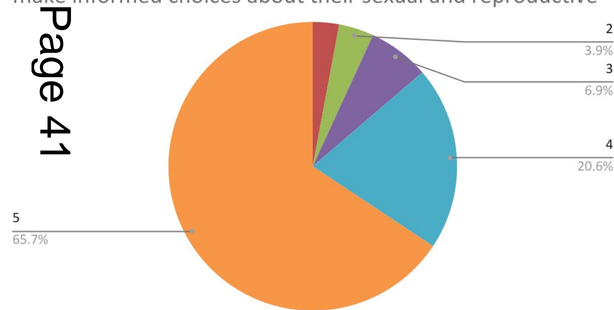




Survey: views on priorities

Overall: majority approval of selected themes and priority areas

5=very important 4=important 3=neutral 2=not very important 1=not important at all



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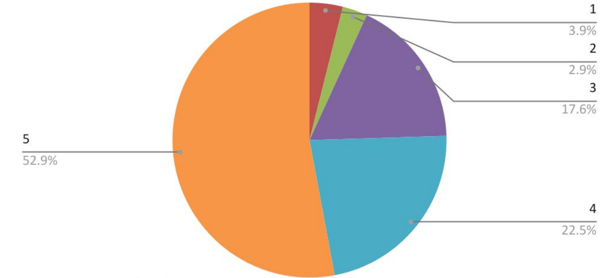
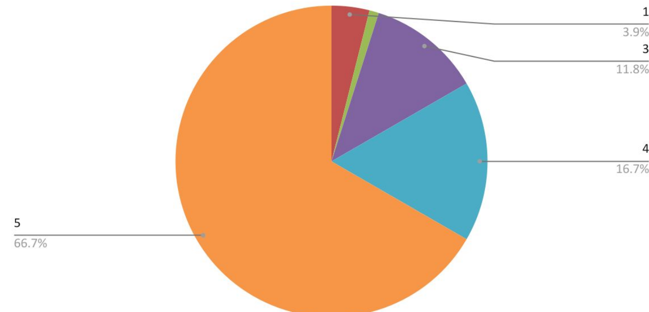
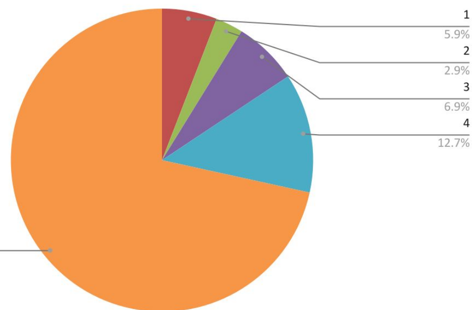
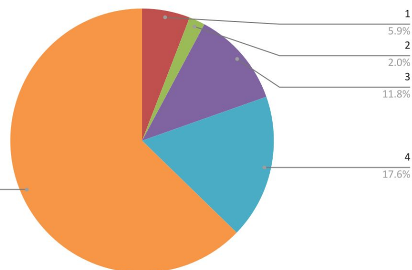
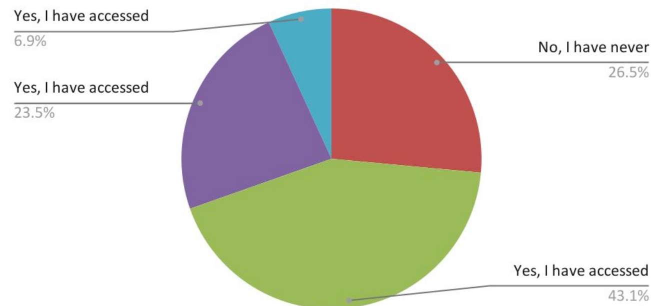




Survey: views on priorities



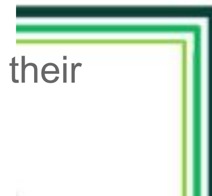




Red=never
Green=in C&H
Purple=elsewhere
Blue= NEL

5=very important 3=neutral 1=not important at all

Priority 1: Residents in the City of London & Hackney are able to make informed choices about their sexual and reproductive health



	All young people should have access to high quality Relationship and Sex Education (RSE)	All residents should be able to recognise whether a relationship is abusive or unhealthy	People in unhealthy or risky sexual relationships should be appropriately supported	Reproductive health and wellbeing is just as important as preventing and treating STIs
Not sure	1.96%		1.96%	0.98%
Disagree	2.94%	1.96%	0.98%	5.88%
Agree	95.10%	98.04%	97.06%	93.14%

(Y-axis: 0%, 25%, 50%, 75%, 100%)

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Priority 2: Residents of City of London & Hackney have good reproductive health across the life course.

	Agree	Disagree	Not sure
Residents are empowered to make informed choices that support good reproductive health	78.43%	12.75%	8.82%
Residents have access to timely, high-quality, inclusive & holistic services to support their reproductive health needs	80.39%	8.82%	10.78%

Priority 3: Residents of City of London & Hackney have access to high quality and innovative testing and treatment for Sexually Transmitted Infections (STIs)

	Agree	Disagree	Not sure
Our residents have easy access to high quality, innovative and confidential STIs testing services	84.31%	5.88%	9.80%
Transmission of STIs and repeat infections among our residents are reduced	71.57%	6.86%	21.57%
Stereotypes and stigma associated with STI infections are challenged	74.51%	9.80%	15.69%

Priority 4: Towards Zero - there will be no new HIV infections in the City of London & Hackney by 2030

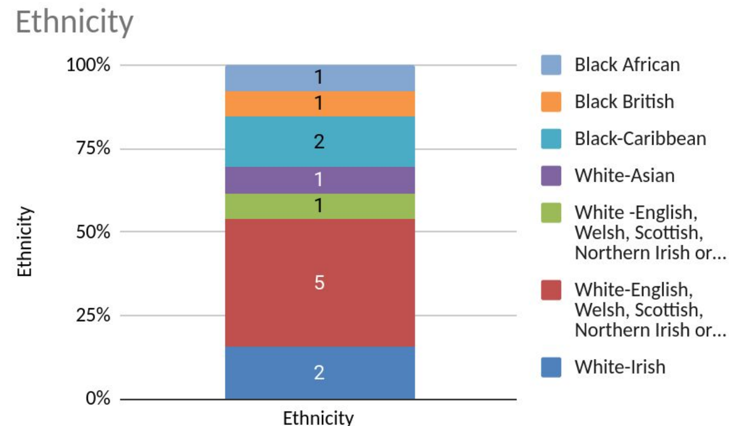
	Agree	Disagree	Not sure
Our residents living with HIV have access to the best treatment and care	83.33%	1.96%	14.71%
Our residents at higher risk for HIV are informed about prevention measures and have access to HIV prevention methods	85.29%	3.92%	10.78%
All our residents have access to rapid HIV testing across North East London	87.25%	1.96%	10.78%
Stereotypes and HIV related stigma are addressed and challenged	77.45%	11.76%	10.78%

Priority 5: The sexual and reproductive health needs of vulnerable people and people with complex needs are recognised and met within the overall service provision

	We collect more data to ensure we better understand the sexual and reproductive health needs of people with higher vulnerability or more complex needs	We are better at connecting communities with different services and communicating between them to support people	Tailored sexual and reproductive health services are available for transgender and non-binary residents	Information is designed and available in acceptable and appropriate ways
Not sure	19.61%	13.73%	19.61%	11.76%
Disagree	3.92%	4.90%	7.84%	7.84%
Agree	76.47%	81.37%	72.55%	80.39%

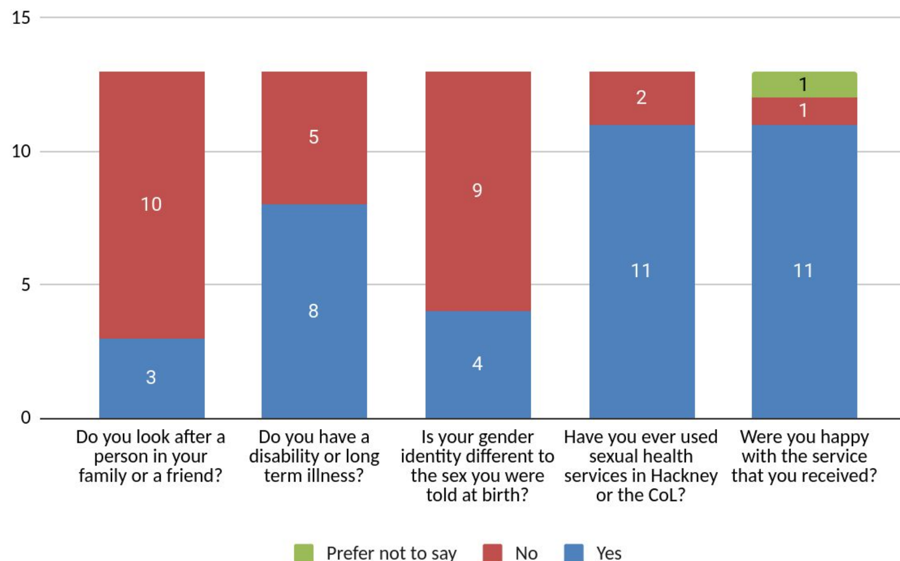
Easy Read survey - demographics (*small sample*)

- All respondents were or identified as women, with four indicating they were a different gender than what they were told at birth
- Majority were 35 and over, with two respondents aged 18-25.
- 11 out of 13 identified as heterosexual, with one bisexual and one not providing an answer
- Predominantly Christian (10 out of 13)
- Ethnically mixed
- Partial postcode indicated Hackney for 12 respondents (one not answered)

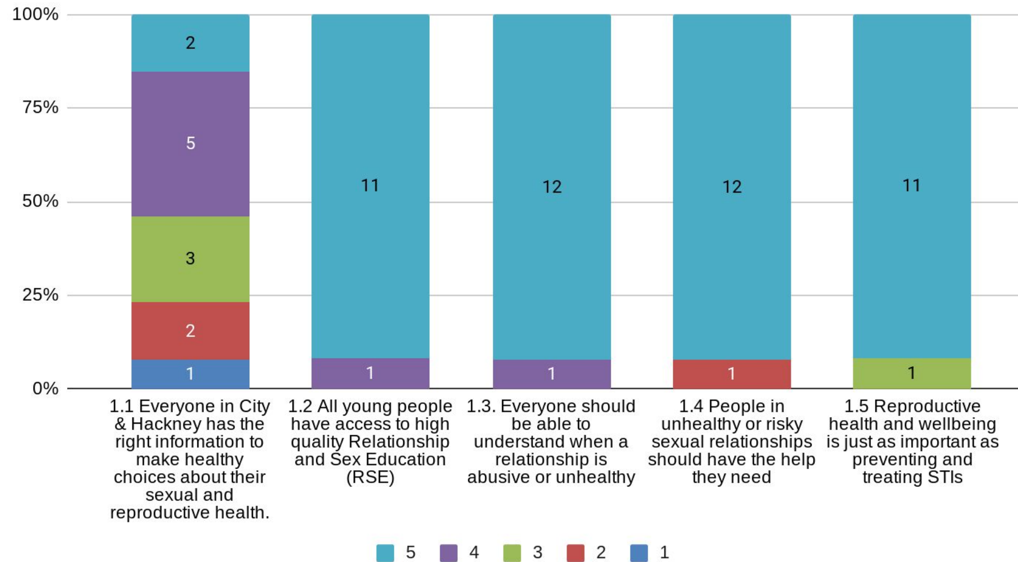


Easy Read survey - demographics

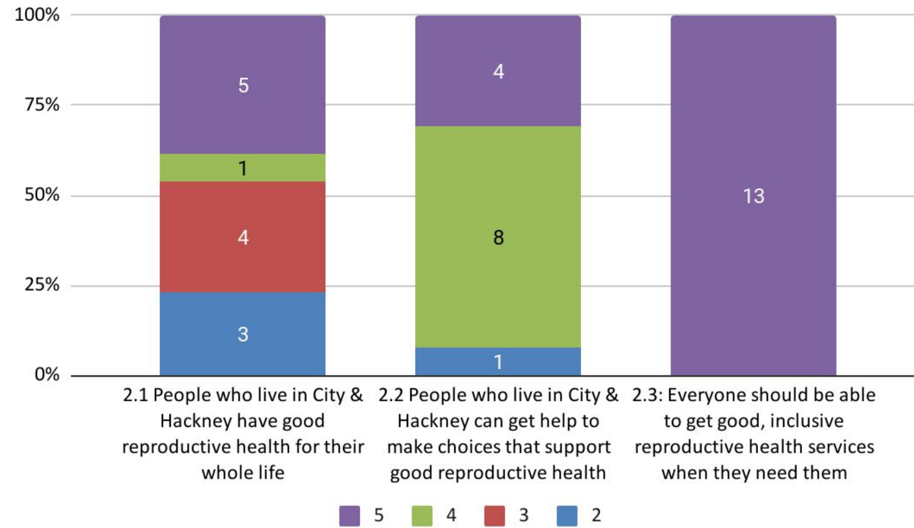
- Majority of respondents had used sexual health services and were happy with services received
- Majority stated to have a disability or long term condition
- Three out of 13 had a caring responsibility



Easy Read survey feedback, Theme 1



Easy Read survey feedback, Theme 2



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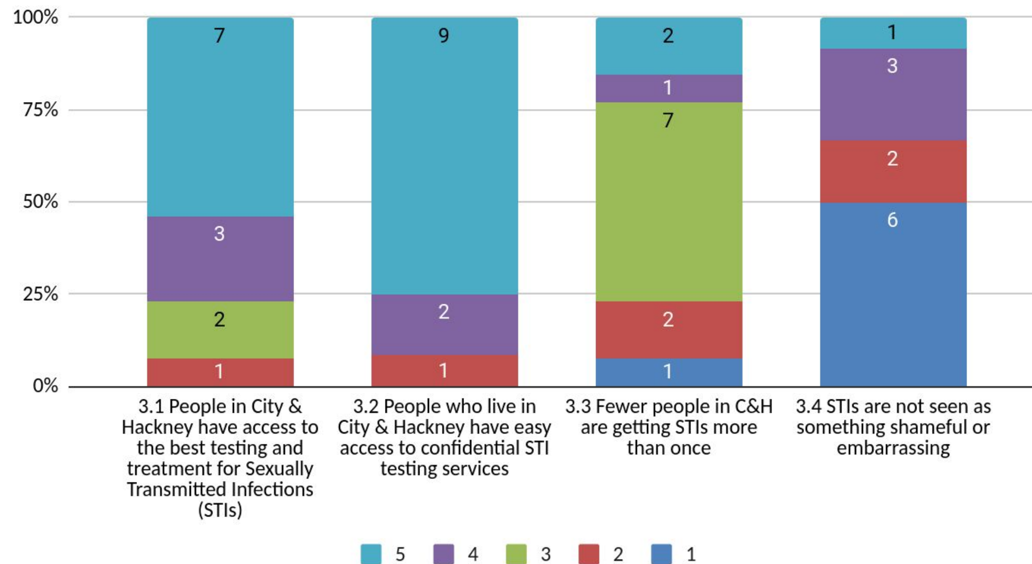
Easy Read survey feedback, Theme 3



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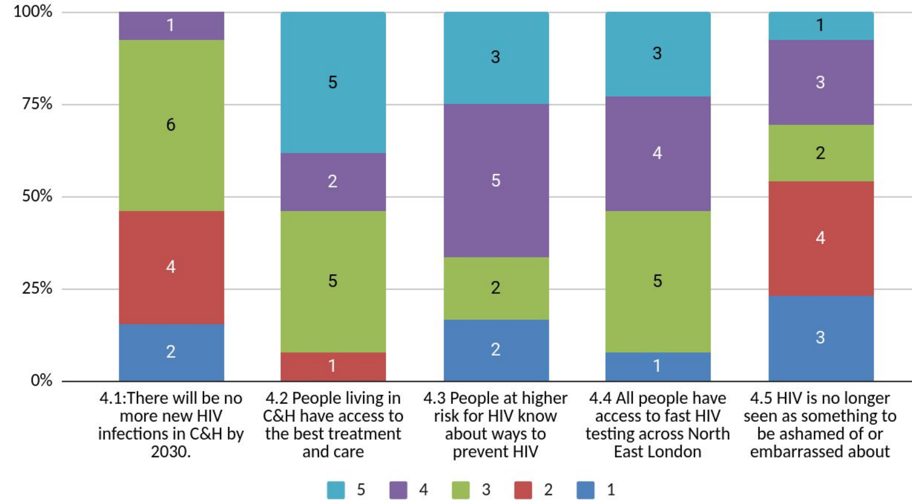
Easy Read survey feedback, Theme 4



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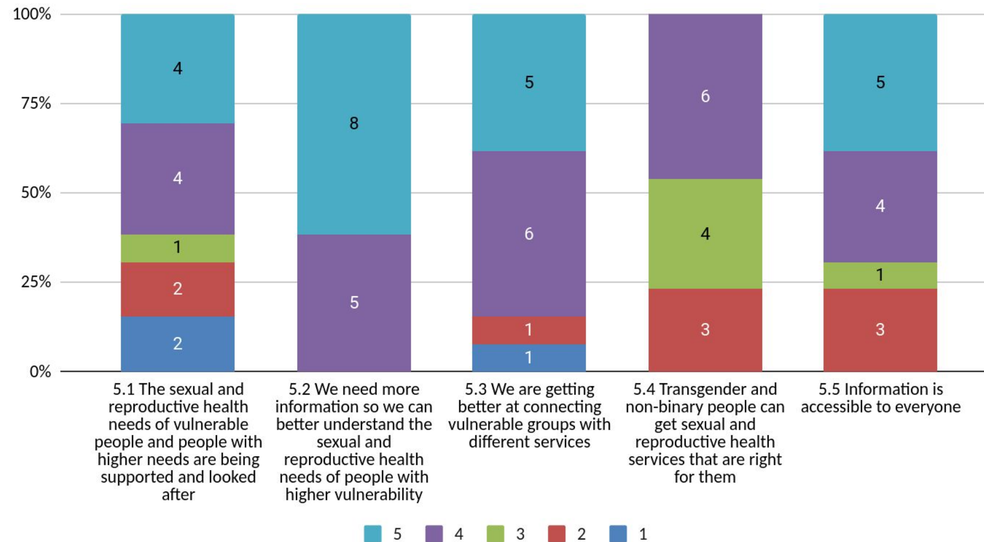
Easy Read survey feedback, Theme 5



Key observations from overall engagement

- Strong agreement on all themes and priorities identified
- Affirmation of the importance of relation and sex education in schools
- Lack of knowledge of and access to services named as key barriers
- Stigma and shame attached to sex and STIs, and HIV, persist
- Services remain fragmented across the wider sexual and -especially- reproductive health pathway, often due to fragmented commissioning responsibilities

Action Plan

The action planning process was informed by

- Survey findings
- Feedback given in all consultation sessions
- Written feedback (strategy)
- Engagement with stakeholders
- NEL wide engagement

Action planning format:

City and Hackney Sexual and Reproductive Health Strategy Action Plan (Year 1: 2024 – 25)

Themes

1 - Healthy and fulfilling sexual relationships

2 - Good reproductive health across the life course

3 - STI prevention and treatment

4 - Getting to Zero new HIV transmissions

5 - Vulnerable populations and those with complex needs

Theme	Outcome	Action	Strategic Lead *(name)*	Delivery Lead	Partners	Milestones *(aim for a date)*	Indicators	Priority
1) Healthy and fulfilling sexual relationships	A) Young people (YP) in City and Hackney have equitable access to good quality, comprehensive and inclusive **relationship and sex education (RSE)** in schools and settings of alternative provision	Promote and increase uptake of Young Hackney's free Personal Social and Health Education in secondary schools and settings of alternative provision, while respectful dialogue is continually maintained with schools and other educational institutions where RSE is not deemed appropriate and acceptable for religious or cultural reasons Foster collaboration with and between different entities doing SRH-related school outreach, such as Homerton Sexual Health Services, in order to enhance reach and coverage						
1	B) Young people have access to appropriate and specialist sexual health **services**	HSHS clinics are welcoming to young people and offer booked and walk up appointments with evening/weekend clinics. Dedicated young people's services such as youth hubs and/or the 'super youth hub' offer safe spaces for SRH advice Pharmacies provide a low barrier range of SRH services including condoms, EHC, Chlamydia screening/treatment and Gonorrhoea screening, as well as routine oral contraception (under development) and are trained to make safeguarding referrals						

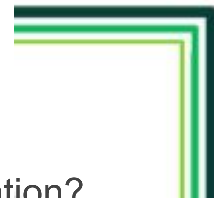
Process

- Collate all consultation findings (November)
- Rewrite the draft strategy (December)
- Finalise action plan (December)
- Share strategy and action plan with key stakeholders for (final) feedback (December)
- Link outcomes to the sexual health dashboard (2024)

Governance

- Present the finalised strategy and action plan to HWBs for approval: Jan/Feb 2024
- Hackney: Cabinet Decision
- ICB decision for NEL Strategy

Implementation and oversight



- Oversight mechanism - Sexual Health Forum reviews progress of action plan implementation?
- Sexual Health Forum leads on annual action plan refresh?
- Internal oversight within Public Health?
- A sexual health dashboard will support this from a data perspective
- Collaborate on commissioning with the ICB
- Annual progress update to the HWBs
- Annual approval of action plan by the HWBs

Hackney
CITY
OF
LONDON

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City & Hackney Sexual and Reproductive Health Strategy Consultation Report (draft)

Report Date: January 2024

Report authors:

Froeks Kamminga
Senior Public Health Specialist

Patience Quarcoo
Consultation & Engagement Officer

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Introduction

This report presents the findings of the consultation on the City and Hackney Sexual and Reproductive Health (SRH) Strategy.

The online survey was hosted on the Hackney Council consultation web pages and was open from 1 July to 20 September 2023. It was also promoted on the City of London corporate web pages. In total, 102 completed responses were received.

An Easy Read survey was developed to allow people with learning disabilities or other barriers to accessing the online survey to participate. A total of 13 completed Easy Read surveys were received.

Background

The City of London Corporation and London Borough of Hackney have a statutory responsibility to protect and promote the sexual and reproductive health of our local populations. We invest over £8m per year in clinical services as well as services to promote good sexual health.

City and Hackney continue to have a high level of unmet need with significant inequalities in sexual and reproductive health, both within communities and compared to the other areas in London and across England.

A five-year strategy for City and Hackney will ensure a coordinated approach that brings together commissioned services and explores linkages with other services and providers, including the NHS and the voluntary sector as well as cross-local authority initiatives, to highlight and address the most pressing issues and gaps in provision and uptake of care.

Rationale for consultation

- To ensure the right priorities were identified and agreed on
- To ensure a sense of ownership and importance around the subject area
- To receive a mandate for more integrated and joined up working across the system

A consultation and engagement plan was developed in partnership with the engagement team. In addition, a communications plan was developed to ensure the consultation was promoted effectively.

Considering the life course needs for sexual and reproductive health, and the variety in need between different population groups and demographics, it was important that the consultation was as inclusive as possible. A number of approaches and channels were used to promote the survey and other consultation elements were added such as online consultation events. This report presents the findings of the online survey and the Easy Read survey.

Promoting the survey

Channels (online/social media)

- Consultation webpage launch promoted on Twitter and Facebook - City and Hackney channels, and Business Healthy (BH)
- Consultation promoted in Hackney e-newsletter and Love Hackney magazine, and staff internal newsletter
- Twitter posts promoting online and in-person sessions on Hackney's Social media channels
- Posts on Hackney Council's instagram stories to target younger audiences
- Posts on City of London social media prompting the consultation
- Coverage in City AM
- Posts on BH twitter, Barbican Library, and City of London X (Twitter) to promote in-person
- Online promotion on Hackney Council's Instagram for a final call to complete the consultation
- Final call to complete the consultation in Hackney Council's newsletter
- E-newsletters (external and internal staff newsletter)

Email

- Community Champions and other community partners
- Community centres
- CVS organisations such as Healthwatch Hackney and Hackney CVS
- Pharmacies (newsletter)
- GP practices (newsletter)
- Youth hubs
- All commissioned services
- Key contacts with wider networks

Meetings

To promote the survey and inform and involve a broad range of stakeholders, e.g.

  - Health Inequalities Steering Group

    - Healthwatch Hackney: Community Voice LGBTQIA+ Public Forum
    - Place Based Partnership Delivery Group
    - Hackney CVS Special Interest Group on Sexual Health

Easy Read survey

An Easy Read version of the online survey was created to allow participation by people with learning disabilities and others who may have found the online survey difficult to use. This was available online and in print. This allowed participation by

- Hackney Ark Captains (young people with learning disabilities)
- Open Doors service users (sex workers)

Consultation events

Online and in person engagement

In addition to the survey, people were invited to actively participate in the consultation and action planning by attending online consultation events, which were promoted alongside the survey. There were also a number of in person engagement events.

- Theme-based online consultations around the five themes of the survey. These were promoted alongside the survey with a signup form. Participation by residents/volunteers was compensated with a £20 voucher.

- Audience focused online consultations sessions (voucher compensation provided)
    - Community African Network (CAN) members and volunteers (Black African population groups)
    - Healthwatch Hackney public reps (resident representation)
    - LGBTQ+ representatives (Positive East/LoveTank)

- In person focus group discussions/engagement (voucher compensation provided)
    - Barbican Library, City of London residents/service users
    - Hackney People First (adults with learning disabilities)
    - STEPS brunch drop-in (STEPS service users)
    - Young People

- Workshops with commissioned services and key partners with thematic focus (hybrid of in person and online)
    - Young people and sexual health
    - Contraception and reproductive health

Online consultations were attended by a total of 71 people, in-person consultations had a total of 23 participants, and the workshops with commissioned providers and key stakeholders had 20 participants.

Online and in-person sessions allowed deeper engagement on the themes and the proposed outcomes, and resulted in for example making outcomes more ambitious, or having more concrete or practical suggestions on actions to undertake to achieve proposed outcomes (e.g. a joint online information resource on sexual and reproductive health with booking options and direct links to relevant services).

All of the consultation findings and feedback contributed to the formation of the first year action plan.

Executive summary

A total of 102 responses were received to the online survey, while a further 13 people completed the Easy Read survey.

There was strong agreement on priorities and outcomes across the five themes. For example, 95% of respondents (strongly) agreed with the proposed priority that all young people should have access to high quality Relationship and Sex Education (RSE). Even higher was the agreement (98%) for the aim that all residents should be able to recognise whether a relationship is abusive or unhealthy. This feedback was echoed in the Easy Read survey.

On average, proposed priorities and outcomes received around 80-90% agreement on importance, indicating 'important' or 'very important'. The lowest agreement was related to reducing reinfection of sexually transmitted infections (72%) and making tailored sexual and reproductive health services available for transgender and non-binary residents (72.5%).

Respondents also had the opportunity to provide written comments which provided an important insight into issues that are important to people, as they often reflected personal experiences. Access to services was an often mentioned barrier, balanced by many comments that the quality of service received was friendly, professional, confidential and non-judgemental.

Below is a summary of the findings.

I am answering this survey as a: (Base 102)
    - The majority of respondents stated that they were a Resident of Hackney or City of London (80, **78.43%**)
- Have you ever accessed Sexual Health Services?: (Base 102)
    - The majority of respondents stated that they have accessed local Sexual Health Services in City & Hackney (44, **43.14%**) with another 31 (30.39%) having accessed them elsewhere or in North East London (NEL).

Priority 1: Residents in the City of London & Hackney are able to make informed choices about their sexual and reproductive health.

- Using the scale below (where 1 is the lowest and 5 is the highest) please rate how important this priority is for you?: (Base 102)
    - The majority of respondents stated that the above statement was of highest importance (67 - **65.69%**), with a further 21 (20.59%) scoring at 4 (important).

Priority 2: Residents of City of London & Hackney have good reproductive health across the life course.

- Using the scale below (where 1 is the lowest and 5 is the highest) please rate how important this priority is for you?: (Base 102)
  - The majority of respondents stated that the above statement was of highest importance (54 - **52.94%**) with a further 23 (22.55%) scoring at 4 (important).

Priority 3: Residents of City of London & Hackney have access to high quality and innovative testing and treatment for Sexually Transmitted Infections (STIs).

- Using the scale below (where 1 is the lowest and 5 is the highest) please rate how important this priority is for you?: (Base 102)
  - The majority of respondents stated that the above statement was of highest importance (68 - **66.67%**) with a further 17 (16.67%) scoring at 4 (important).

Priority 4: Towards Zero - there will be no new HIV infections in the City of London & Hackney by 2030

- Using the scale below (where 1 is the lowest and 5 is the highest) please rate how important this priority is for you?: (Base 102)
  - The majority of respondents stated that they “agree” on the importance of no new HIV infections in C&H by 2030 (73 - **71.57%**) with a further 13 (12.75%) scoring at 4 (important).

Priority 5: The sexual and reproductive health needs of vulnerable people and people with complex needs are recognised and met within the overall service provision

- Using the scale below (where 1 is the lowest and 5 is the highest) please rate how important this priority is for you?: (Base 102)
  - The majority of respondents stated that the above statement was of high importance (64 - **62.75%**) with a further 18 (17.65%) scoring at 4 (important).

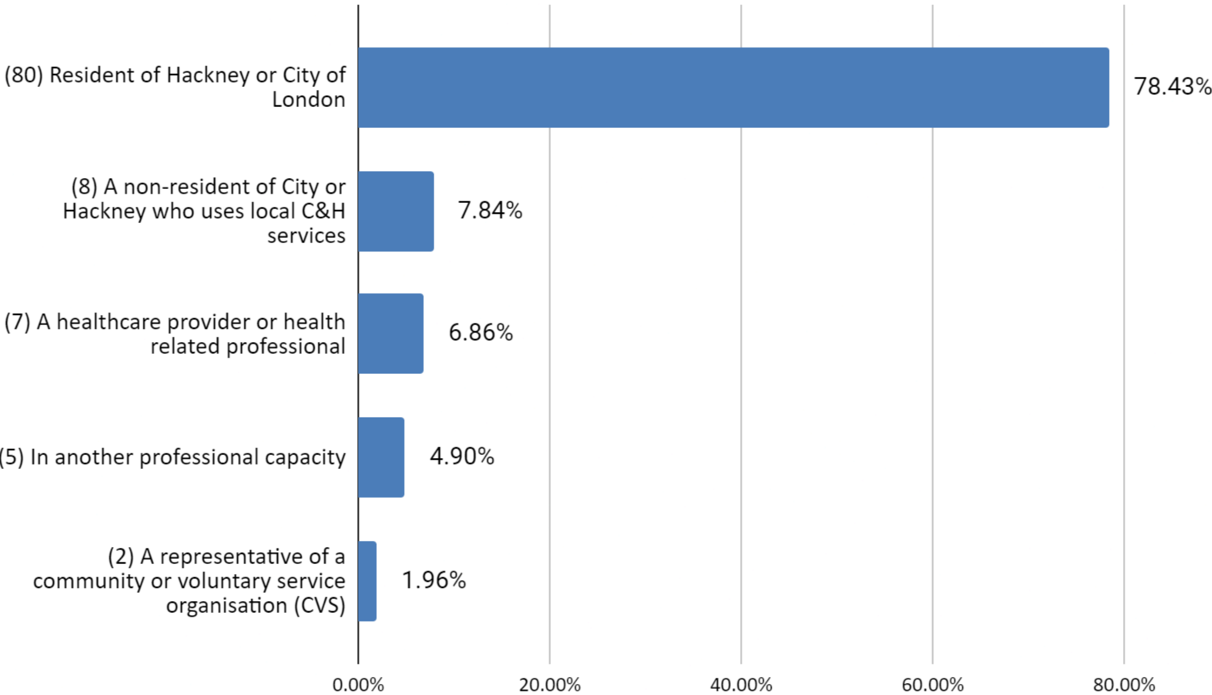
Overview of findings

When analysing the responses, there is always a caveat about how people interpreted the questions. A consultation sets out to present priorities related to *what is to be achieved*, and to what extent residents agree on those priorities. It is possible that some respondents interpreted the questions as a stocktake of the present situation, as if they were asked to comment on the *current state,* and to rate the statements accordingly. Both interpretations would likely lead to different answers.

The online introduction to the survey did explain the purpose of the survey and the priorities presented but it is possible people varied in their understanding of it. This is a lesson learned in terms of wording of a statement (priority or aim) to make it less subject to interpretation. This is underscored by a comment of a respondent: *This survey is confusing. When asking about the aims, are you asking whether we agree those aims are important or agree those aims are being met?*

Question 1: I am answering this survey as a... (Base 102)

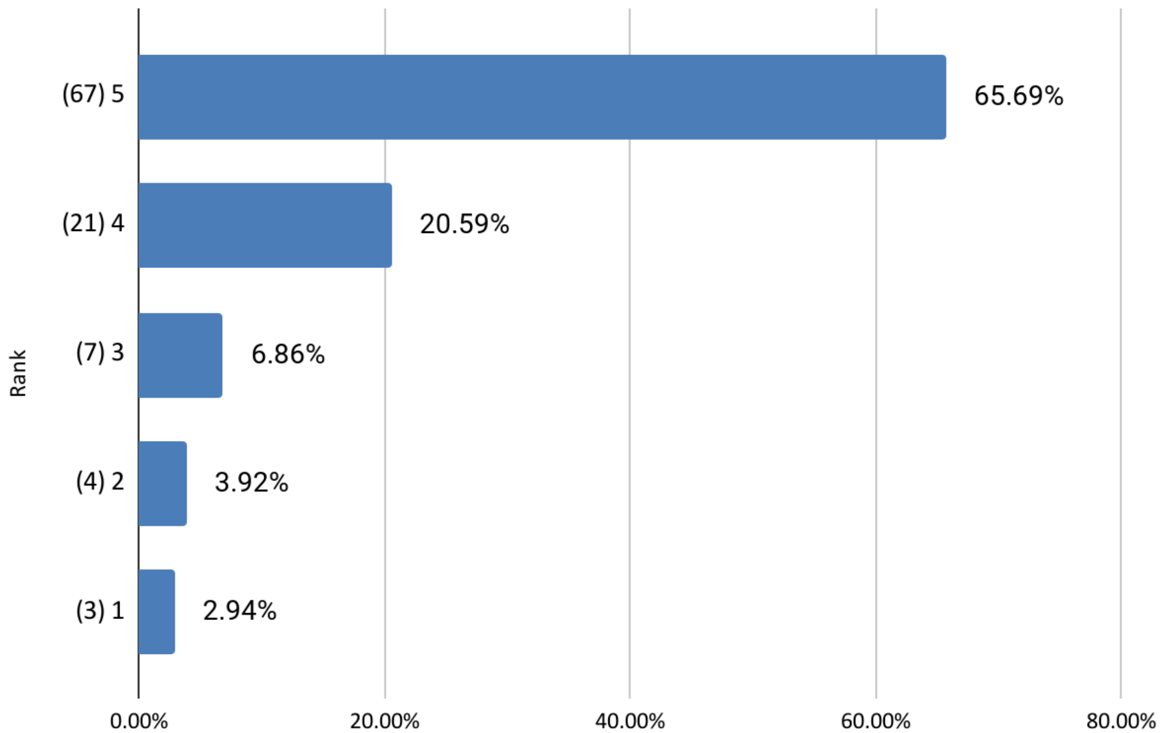
The majority of survey respondents (78%) were City and Hackney residents, with a smaller number identifying as service users or healthcare professionals. No postcode data was requested so it is not feasible to filter out whether someone was a City of Hackney based resident.



Those who selected 'In another professional capacity', said they were:

- Nightlife worker/business owner
- Practitioner within a charity
- CoLC Community Safety Team
- Tax Payer

Question 2: (Priority 1) Residents in the City of London & Hackney are able to make informed choices about their sexual and reproductive health. (Base 102)

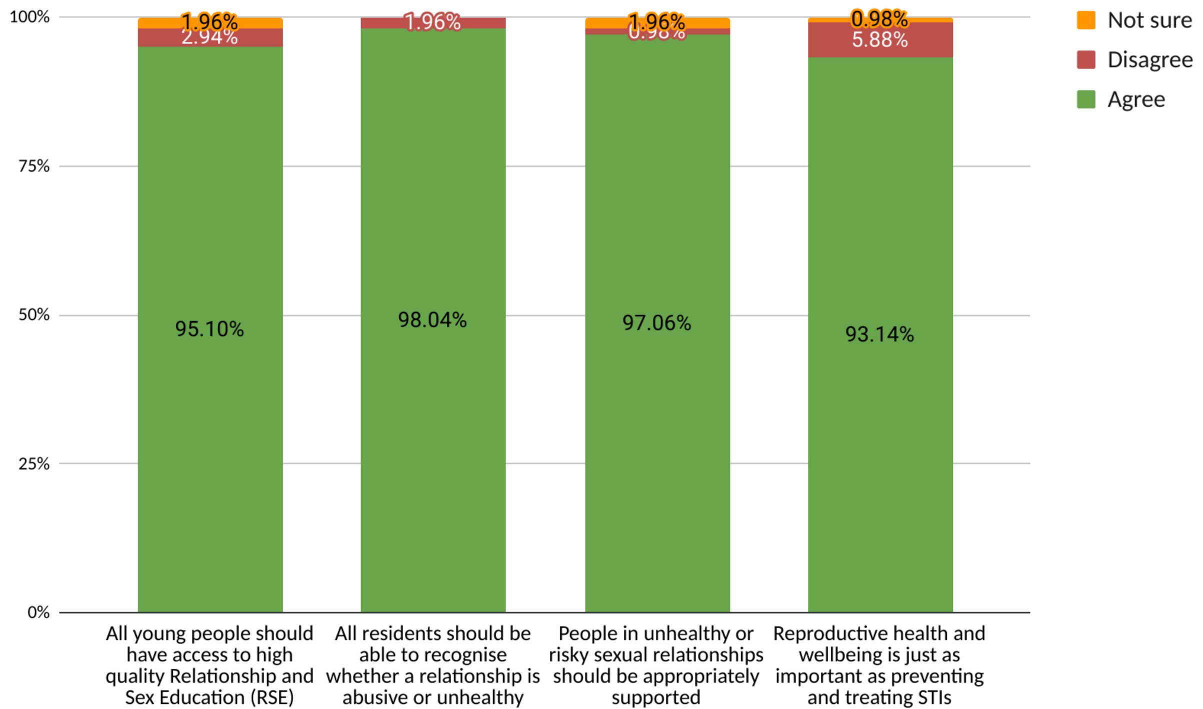


The survey presented five priorities. For each of the priorities respondents were asked to rate them from 1 to 5, with 1 being lowest importance to five being highest importance.

67 (65.69%) respondents ranked the ability to make informed choices as being of the highest importance, while 7 (6.86%) respondents were neutral, and 3 (2.94%) respondents ranked it as of lowest importance.

Within each priority, a number of aims were then presented. Respondents were asked to express their agreement or disagreement with the aims.

To what extent do you agree or disagree with the following aims we have identified for this priority? (Base 102 across each statement)



2.1 All young people should have access to high quality Relationship and Sex Education (RSE)

The majority of respondents (97, 95.10%) stated they agreed or strongly agreed with the proposed aim that all young people should have access to high quality RSE. 3 (2.94%) respondents (strongly) disagreed, and 2 (1.96%) respondents were not sure.

2.2 All residents should be able to recognise whether a relationship is abusive or unhealthy

Only 2 (1.96%) respondents did not (strongly) agree that all residents should be able to recognise whether a relationship is abusive or unhealthy, 100 (98.04%) of respondents felt this was (very) important.

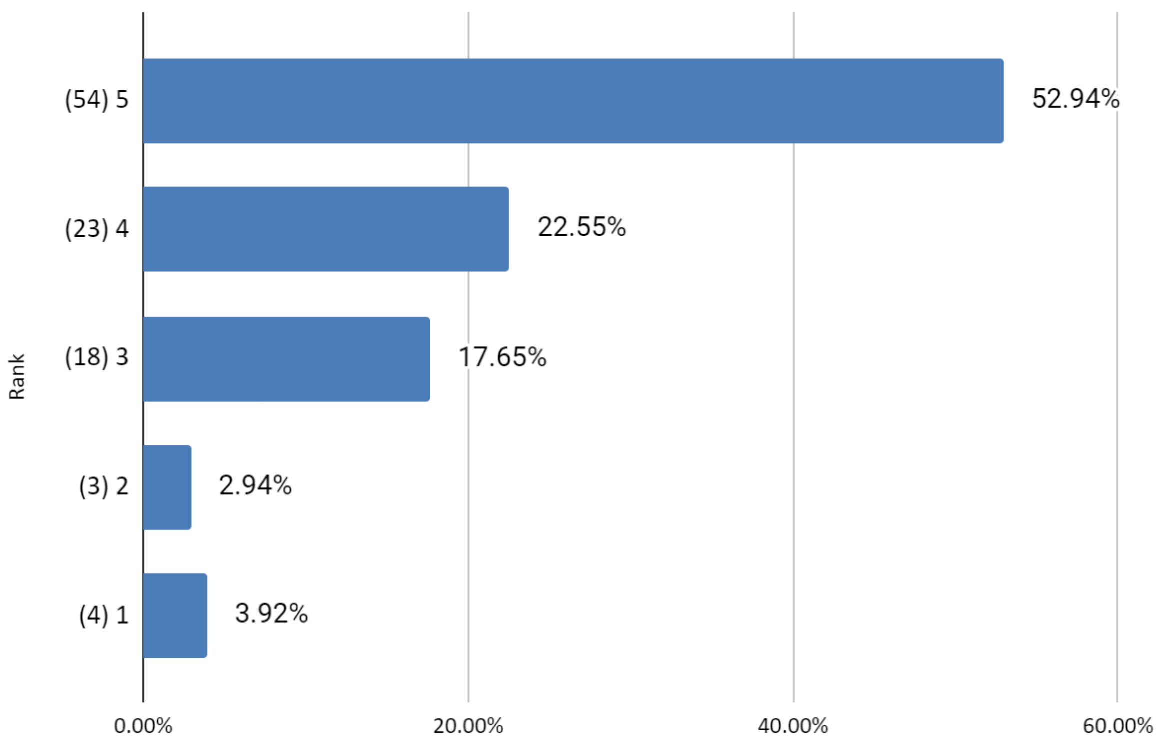
2.3 People in unhealthy or risky sexual relationships should be appropriately supported

Equally, a very large majority (99, 97.06%) of respondents agreed it was (very) important that people in unhealthy or risky sexual relationships should be appropriately supported.

2.4 Reproductive health and wellbeing is just as important as preventing and treating STIs

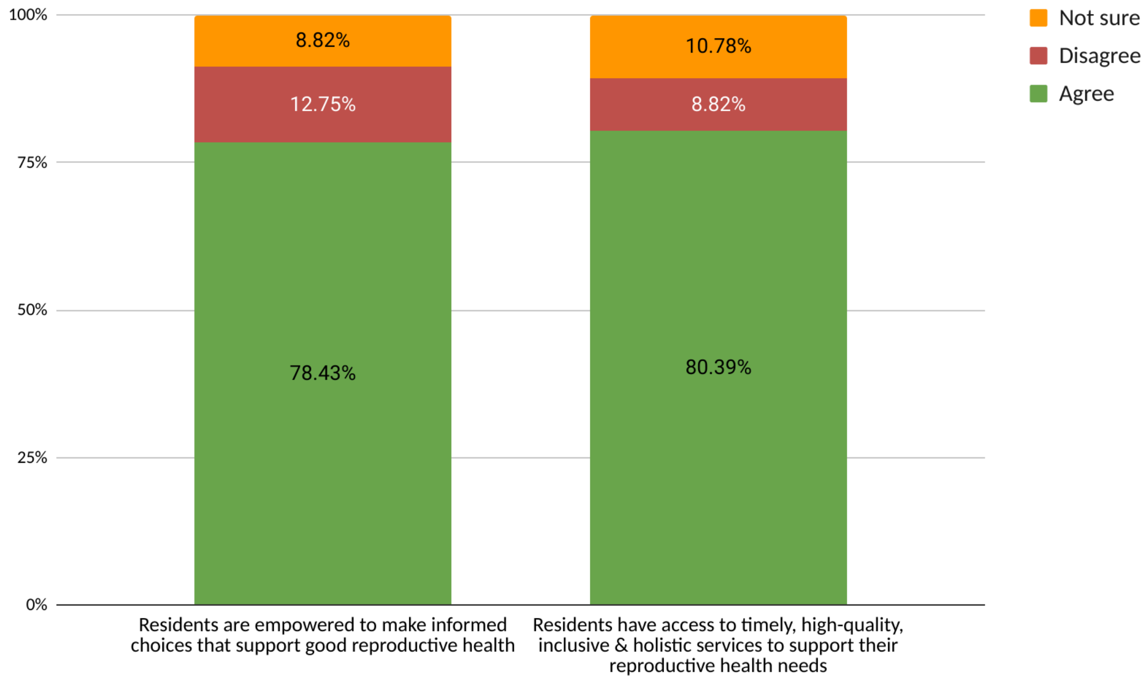
This aim also had strong agreement from 95 (93.14%) respondents, with 6 (95.88%) not agreeing.

Question 3: (Priority 2) Residents of City of London & Hackney have good reproductive health across the life course. (Base 102)



For the proposed priority of all residents having good reproductive health across the life course, 54 (52.94%) respondents ranked it as being of the highest importance, while 18 (17.65%) respondents were neutral, and 4 (3.92%) respondents ranked it as being of the lowest importance.

To what extent do you agree or disagree that the following aims we have identified for this priority? (Base 102 across each statement)



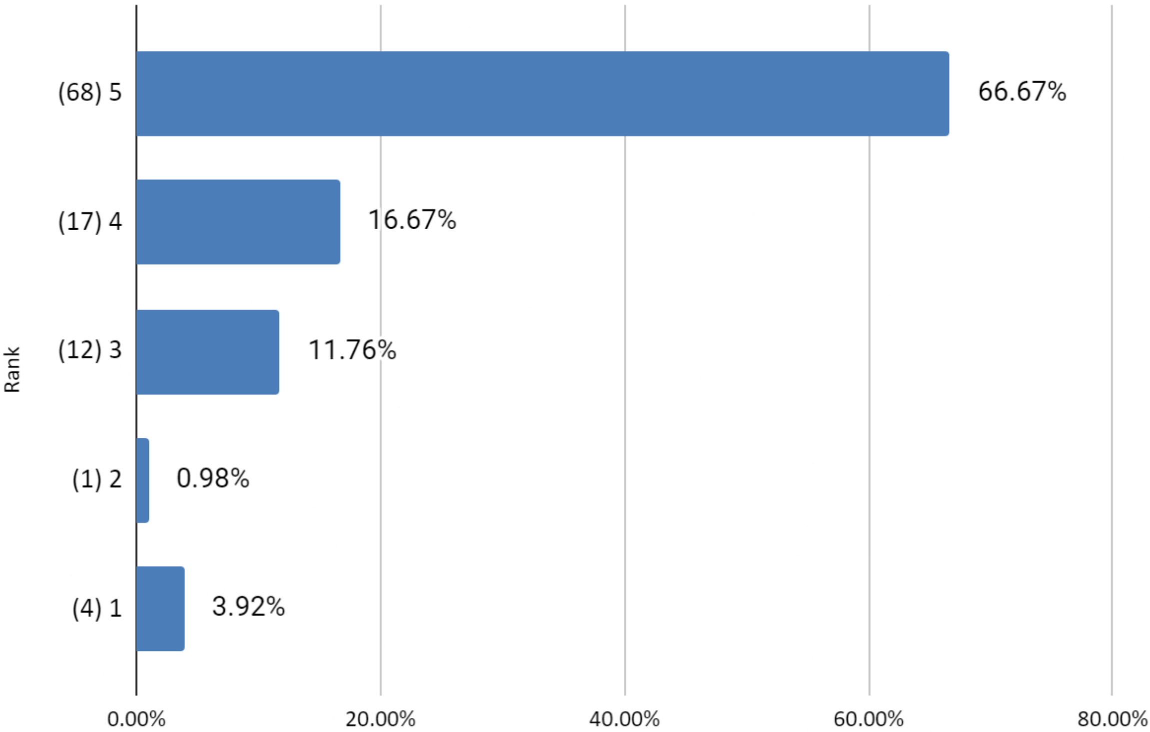
3.1 Residents are empowered to make informed choices that support good reproductive health

80 (78.43%) respondents agreed this was important but 13 (12.7%) (strongly) disagreed with this aim, which is a sizable minority.

3.2 Residents have access to timely, high-quality, inclusive & holistic services to support their reproductive health needs

82 (80.39%) respondents stated their (strong) agreement with this statement, but 9 (8.82%) (strongly) disagreed.

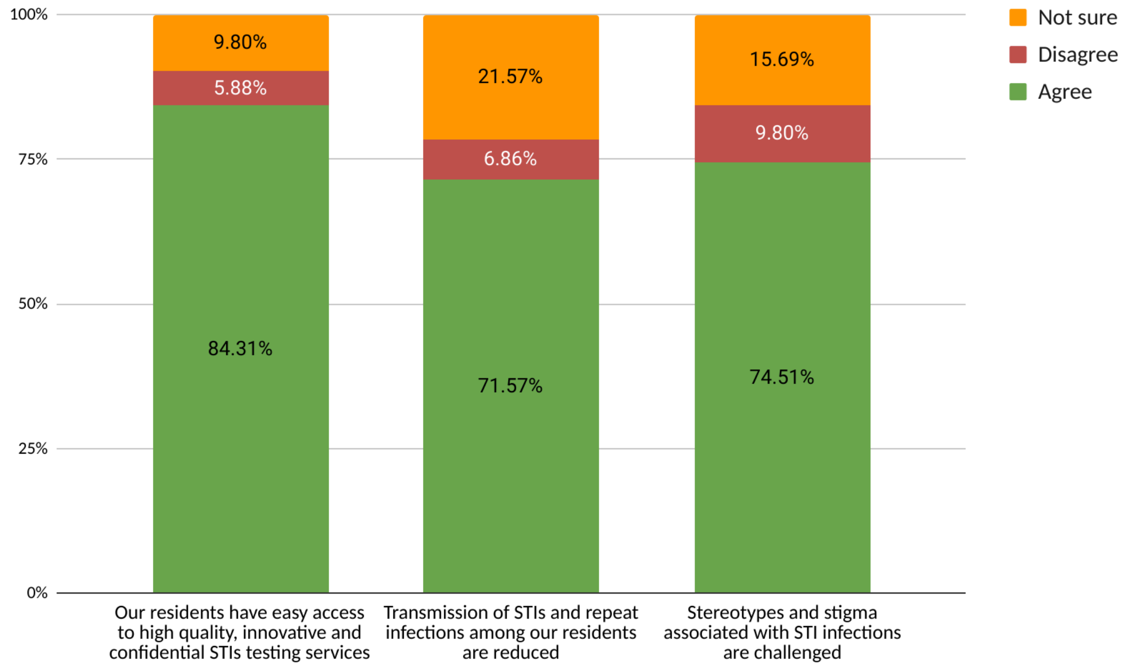
Question 4: (Priority 3): Residents of City of London & Hackney have access to high quality and innovative testing and treatment for Sexually Transmitted Infections (STIs). (Base 102)



For the key priorities, respondents were asked to rank them from 1 to 5, with 1 being lowest importance to five being highest importance.

68 (66.67%) respondents ranked this priority as being of high importance, 12 (11.76%) respondents were neutral, and 4 (3.92%) respondents ranked it as low importance.

To what extent do you agree or disagree with the following aims we have identified for this priority? (Base 102 across each statement)



4.1 Our residents have easy access to high quality, innovative and confidential STIs testing services

86 (84.31%) respondents (strongly) agreed with this aim and 6 (5.88%) respondents (strongly) disagreed, while 10 (9.80%) were not sure.

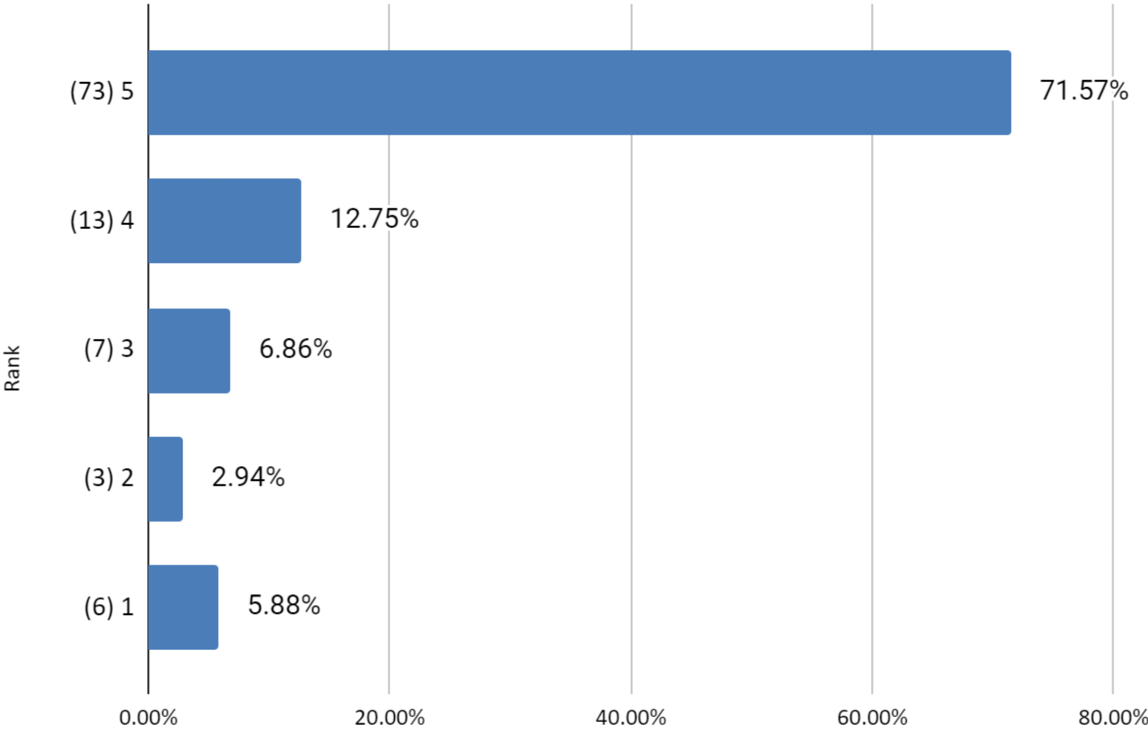
4.2 Transmission of STIs and repeat infections among our residents are reduced

73 (71.57%) respondents (strongly) agreed with this aim, while 7 (6.86%) did not agree.

4.3 Stereotypes and stigma associated with STI infections are challenged

76 (74.51%) of respondents agreed this was important, 10 (9.80%) did not think this was important and 16 (15.69%) were not sure.

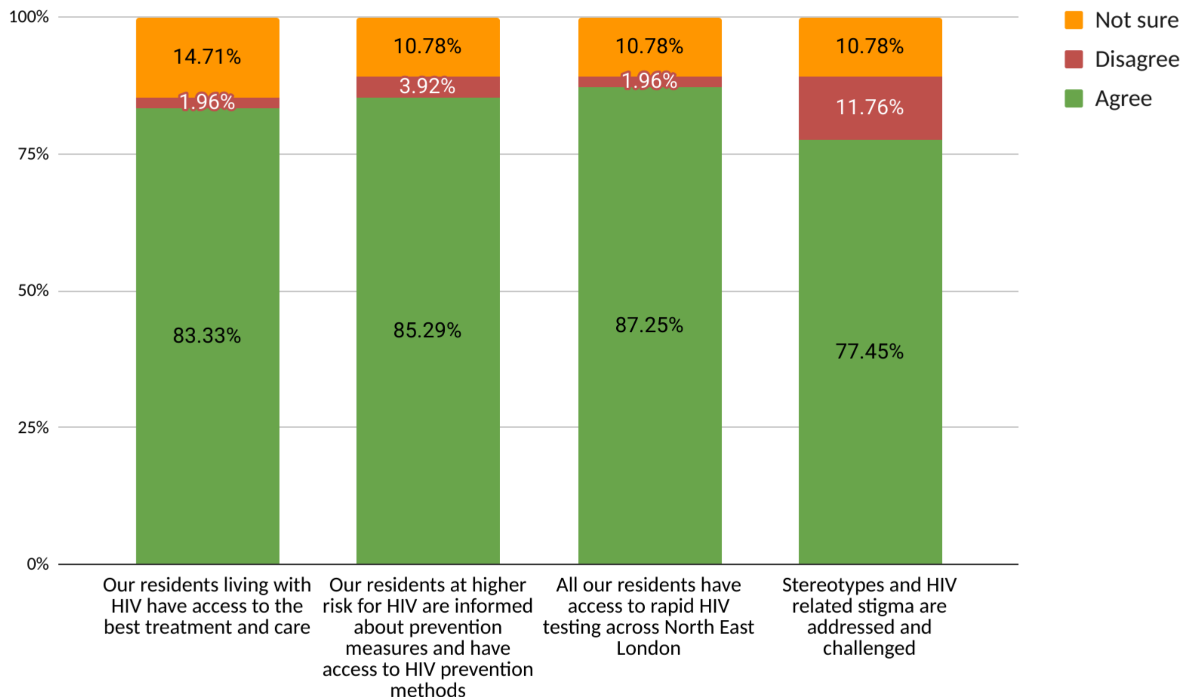
Question 5 (Priority 4): Towards Zero - there will be no new HIV infections in the City of London & Hackney by 2030 (Base 102)



For the key priority questions, respondents were asked to rank them from 1 to 5, with 1 being lowest importance to five being highest importance.

73 (71. 57%) respondents ranked the priority of achieving zero new HIV infections as being of the highest importance, while 7 (6.86%) respondents were neutral, and 6 (5.88%) respondents ranked it as the lowest importance.

To what extent do you agree or disagree with the following aims we have identified for this priority? (Base 102 across each statement)



5.1 Our residents living with HIV have access to the best treatment and care

85 (83.33%) respondents (strongly) agreed that people living with HIV should have access to the best treatment and care. 2 (1.96%) respondents (strongly) disagreed, while 15 (14.71%) were not sure.

5.2 Our residents at higher risk for HIV are informed about prevention measures and have access to HIV prevention methods

Similar to the previous findings, 87 (84.31%) respondents (strongly) agreed on the importance of information about and access to HIV prevention measures for people at higher risk of HIV. 4(3.92%) respondents (strongly) disagreed, while 11 (10.78%) were not sure.

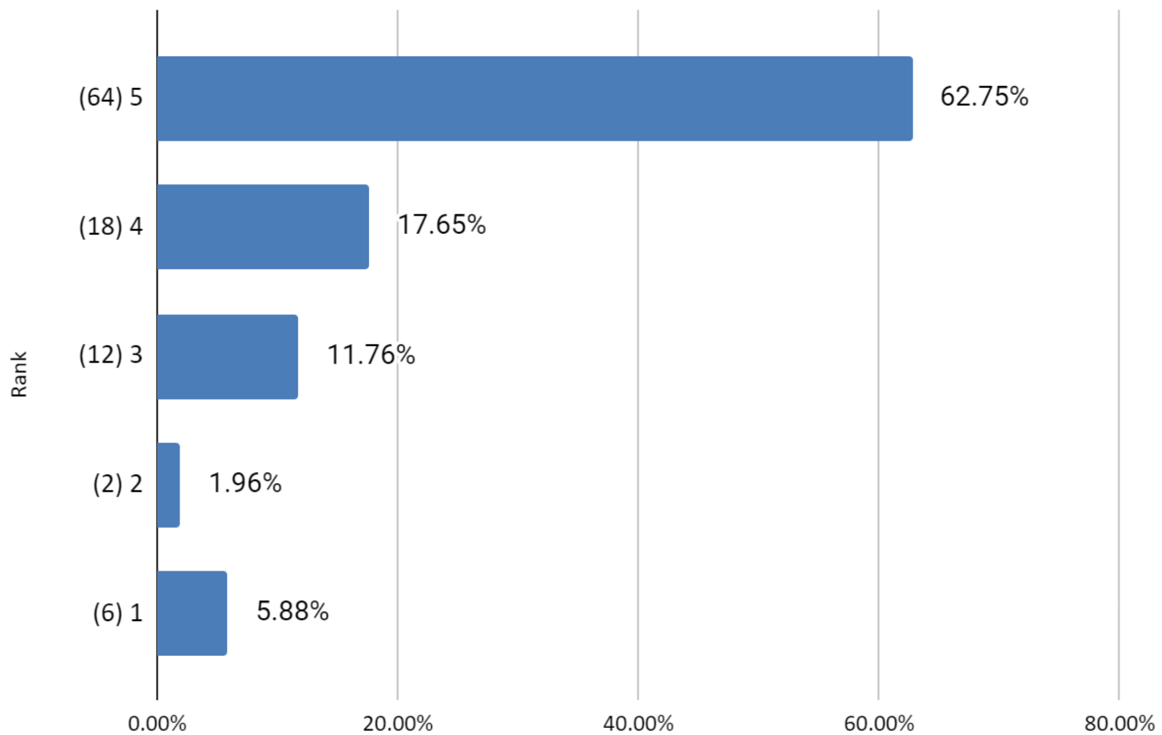
5.3 All our residents have access to rapid HIV testing across North East London

Access to rapid testing was viewed as (very) important by 89 (87.25%) respondents, 2 (1.96%) respondents (strongly) disagreed, while 11 (10.78%) were not sure.

5.4 Stereotypes and HIV related stigma are addressed and challenged

Again when interpreting the responses, the answers in this section give the impression that people answered based on their perception of the current situation, rather than as an aim to work towards: 79 (77.45%) respondents (strongly) agreed with this aim and 12 (11.76%) respondents (strongly) disagreed, while 10 (9.80%) were not sure.

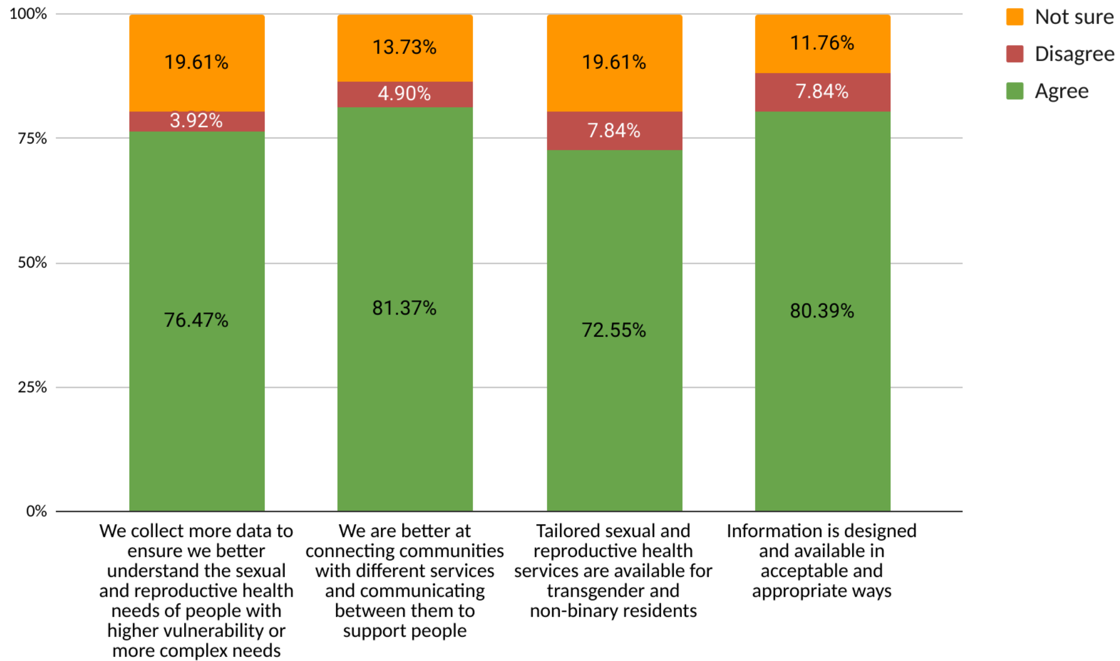
Question 6: (Priority 5): The sexual and reproductive health needs of vulnerable people and people with complex needs are recognised and met within the overall service provision



For the key priority questions, respondents were asked to rank them from 1 to 5, with 1 being lowest importance to five being highest importance.

64 (62.75%) respondents ranked this priority as being of the highest importance, while 12 (11.76%) respondents were neutral, and 6 (5.88%) respondents ranked it as the lowest importance.

To what extent do you agree or disagree with the following aims we have identified for this priority? (Base 102 across each statement)



6.1 We collect more data to ensure we better understand the sexual and reproductive health needs of people with higher vulnerability or more complex needs

78 (76.47%) respondents (strongly) agreed with this aim and 4(3.92%) respondents (strongly) disagreed, while 20 (19.61%) were not sure.

6.2 We are better at connecting communities with different services and communicating between them to support people

83 (81.37%) respondents (strongly) agreed with this aim and 5 (4.90%) respondents (strongly) disagreed, while 14 (13.73%) were not sure.

6.3 Tailored sexual and reproductive health services are available for transgender and non-binary residents

74 (72.55%) respondents (strongly) agreed with this aim and 8 (7.84%) respondents (strongly) disagreed, while 20 (19.61%) were not sure.

6.4 Information is designed and available in acceptable and appropriate ways

82 (80.39%) respondents (strongly) agreed with this aim and 8 (7.84%) respondents (strongly) disagreed, while 12 (11.76%) were not sure.

Qualitative insights

People were also asked a number of open-ended questions to gather some qualitative insights. The answers to these questions were grouped according to themes that were identified in the answers.

Question 7.1: Have we missed anything? Please outline in the text box below any additional priorities you think we should consider for the sexual and reproductive health strategy.

Forty people (39% of all respondents) answered this question, and the variety of the suggestions and comments was wide. There were 12 responses that related to PSHE and RSE in school, with five asking explicitly for it to be open, inclusive and comprehensive. One other respondent was very adamant that gender ideology is taught in RSE and that the focus should be on biological sex, which cannot be changed. Overall, comments related to trans persons were polarised. For example, one comment specifically asked for SRH services to be actively countering disinformation about trans, and to stop online hatred. In total, five respondents mentioned trans persons or services in their answer - two of them were supportive, one was neutral and two were anti-trans. Four of the five were City or Hackney residents and one (anti-trans response) answered the survey as 'in another professional capacity', which they had specified as taxpayer. Some of their full comments have been included in a text box below.

A range of answers related to people's own experiences in some area of SRH, either testing or removal or coils, or access to services. HIV related work and stigma was mentioned, in terms of training of all healthcare staff and testing for HIV of all health care users. The importance of working with Community based and Voluntary Services organisations (CVS) was also raised, as well as free condoms for all, accessibility of services for people with disabilities, the needs of intersex people, and appropriate support for survivors of rape and sexual assault.

Suggestion	Number
PSHE/SRE including outreach services/funding	7
SRE for all YP, inclusive and comprehensive (reflecting variety of family models, sexual orientation etc.)	5

SRH campaign at community level/work with CVS	2
Condoms for all	2

Verbatim comments question 7.1

<table>
<tr><td colspan="2">All residents need to be able to access appropriate, free, reproductive health services regardless of immigration status. This must include access to fertility, abortion and maternity services.

Sex and relationship education in schools needs to be reflective of the range of different family models and sexualities within Hackney's population. Young people should be given information about a range of services, including sexual health and abortion services.

Helping rape / sexual abused victims appropriately.

Please ensure that men who have sex with men and who engage in Chemsex have access to high quality help and support

Crucial to put the strategy in the context of the importance of good stable relationships particularly marriage and family. Crucial also not to encourage children in any way to be sexually active or expose children to unhelpfully sexualised material.

Education at school- sexual education in all its diversity esp in LBH where STI's amongst 18-25 yo are very high!

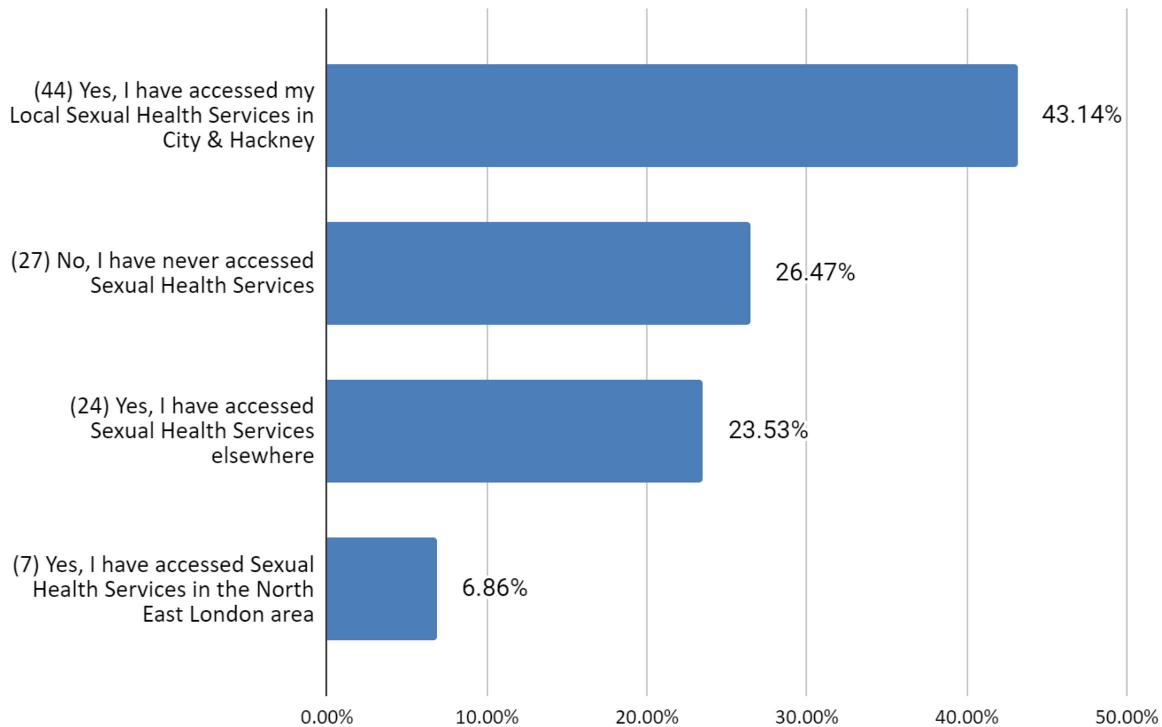
I know this will have been considered already, but the vital importance of ensuring that age-appropriate sex and sexual health education happens in all schools and colleges across City & Hackney cannot be stressed enough. I hope this will play a large part in your strategy. There needs also to be consideration given to how to reassure those parents who resist this to understand, overcome their reservations and fears and see the benefits. Many children are excluded from sex education classes because their parents don't want them to take part. We need to respect parental wishes, of course - but it is nevertheless worrying that a whole section of our young population may never hear factual information that they need. How can the new strategy address this?</td></tr>
<tr><td>"I'm extremely concerned about aspects of the sexual health and relationships advice being delivered in many Hackney schools at all levels. The notion that 'gender identity' is real and is more significant than biological sex is a travesty. Teaching that sex is 'assigned at birth' rather than a biological reality is actively lying to children and the notion that they may decide they are really the</td><td>I am concerned about the misinformation and prejudice spread about non-binary and transgender issues on social media. I think it has become a kind of cyber war of misinformation where otherwise usually discerning and intelligent [people] are groomed to believe that transgenderism is the new thing to fight against, despite the consequences of their actions</td></tr>
</table>

other sex, 'social transitioning', is highly dangerous. No one is 'born in the wrong body' and to suggest that is highly damaging and should be a high-profile safeguarding issue. It supports young people onto a pathway that can lead to a lifetime of puberty blockers and cross-sex hormone treatment as well as potentially devastating surgery. This is highly lucrative for some drug companies and certain medics, which may well explain the powerful lobby funding. In addition, the rigid notions of gender role-stereotypes that underlie extreme trans ideology make it much harder for young people to come out as lesbian or gay - this identity is suppressed by the notion that non-conformity equates to being born in the wrong body. Of course, it's also vitally important that young people who identify as trans are not subjected to any harassment or discrimination - but that does not mean we have to accept their notion that they are really the other sex (or can flow between the two sexes). We know that teaching of gender ideology is very prevalent in schools in Hackney, and that much of it is being delivered by external organisations using non-scientific and highly questionable resources. This issue needs to be treated as a safeguarding issue and given very high priority in schools and all services for young people. I'm very concerned that it has been omitted from this questionnaire.	affecting them very little, and the people they are fighting against rather a lot. I would like this to be something that is considered within the service: how will you help turn the tide against this social media driven movement of disinformation and hate directed towards this vulnerable minority of people, particularly young people?

A full list of issues/themes can be found in the appendix.

Question 7.2: Have you ever accessed Sexual Health Services?

This question was useful to see how many of the respondents had actually used our local or other SH services, and quite interestingly, more than a quarter of respondents had *never* accessed sexual health services. Around 43% had accessed SH services within C&H, around 7% had accessed them within NEL and almost a quarter elsewhere. This highlights the open access nature of SH services, and also that views on sexual and reproductive health are relevant to all, not just those who attend and use services.



If people answered yes to having accessed SH services, they were then asked:

Question 7.3 What do you think works well in the Sexual and Reproductive Health Service Provision that you received?

A total of 74 respondents (73% of all respondents) provided some feedback, though in 17 cases there were inconclusive replies such as not sure or can't remember, or listing a bad experience, while two of those stated they did not think services worked well.

Among the other replies, many mentioned multiple qualities, such as the service being fast, the staff being friendly and/or professional, and the fact that multiple services can be accessed in one place (e.g. testing as well as contraception or cervical

smear). Over a quarter (27%) of people providing feedback committed on the friendly and professional service or staff, and 15% mentioned the services felt safe and/or non-judgemental: *Culturally competent services that are free from judgement and stigma.*

Quality	**Number of replies**
Friendly/professional service/staff	20
Non judgemental/safe	11
Easy/accessible	8
Online/SHL	8
Fast and effective (tests, services)	9
Confidential/private	7
Timely appointments/easy to book	6
Walk in service (plus: combined walk in and appointments)	5 (2)
Education/advice/info	5

Other comments included: free; choice; good quality of care; LGBTQ+ friendly; culturally competent; one stop shop. A few direct quotes on what works well are posted in the box below for illustration.

Verbatim comments question 7.3

Easy to check in at Reception. Short waiting time. Kind, friendly and reassuring health professionals.

Facilities are available but there is a need for campaigns and sensitization

The staff were great. Supportive and non-judgemental. The biggest hurdle was easily finding clinics that were available and getting seen.

Easy access with online booking and information. Safe and no judgemental sex positive space, tailored care for LGBT+ sexual health away from imposition of religious or straight oppression/frameworks.

Time is given during the appointments to explore current concerns and provide relevant options and advice.

Question 7.4 Is there anything that could be improved in the Sexual and Reproductive Health Service Provision that you received?

A total of 75 people (74%) provided a response here, though again, many (27, or 36%) did not give any actual feedback, stating n/a, no, or that they had no issues with the service. Some made mention of their positive experience with the Dean Street clinic.

As with the previous question about what worked well, many people provided an example of a personal experience that had been negative, and then advocated for a service or intervention to be introduced or done better (e.g. no penile swabs, get reminder when coil needs replacing, painful to take bloods for self test, inclusion of non-latex condoms).

Often a recommendation was made to seek the betterment of the entire service delivery. Some examples:

- Better treatment for excessive/constant bleeding
- Staff training on gender diversity/LGBTQ
- Joined up services across London - a single website/app where you can access information about STIs, contraception and services; a single point of access for appointments for sexual health services across London
- Test results available in a phone app
- Tailored information for your condition provided through an app
- Joined up ways of informing partners and letting them access appointments
- A mixture of walk-in and appointment services
- Offer of vaccines to heterosexual people (HPV, Hep)

The issues most mentioned as needing improvement are listed in the table below.

Issue	**Replies**
Access/getting appointments	15
Waiting times	5
Better info provision on clinics/opening times	4
Free condoms for all	4

This shows that access remains a key issue, as raised by 20% of the respondents for this question.

A few direct quotes in the box below, on what can be improved:

Verbatim comments question 7.4

Free condoms for all ages More and better located physical premises with longer hours of operation shorter wait times more walk in slots 7 days a week Gender sensitive and inclusive care Clear path for moving from another area or London borough into the borough re. Sexual health services, especially if you have an ongoing case or condition, eg. How is handover of your file handled and communicated to you? Maybe longer hours and or more clinics - especially for 'minority groups'

People who answered they had not accessed SH services were asked:

Question 7.5 What stopped you from accessing Sexual Health Services?

In total, 56 people provided some form of answer to this question (55%). The majority (26 out of 56; 46%) stated nothing or they had not needed to use it. Some did add comments to qualify those statements, such as ‘not needed because I protect myself’, or saying they are ‘Confident of leading a good sexual lifestyle absolutely devoid of risks’. Such statements can suggest a level of judgement of those who do use sexual health services. On the more extreme side, some statements were disparaging of people identifying as trans.

Access issues were a factor in 15 of the answers (27% of people who answered this question), mostly to do with making an appointment or opening times. Distance and age restrictions were also mentioned. Staff attitudes and feeling judged can work as a deterrent. In other cases, GPs provided the service.

Issue	**Replies**
Lack of or difficulty in making appointments	6
Opening times	4
Don’t know where to go or where the services are	4
Seen/supported by GP	4
Staff attitude/rudeness	3
Feeling judged/uncomfortable	3

A few comments on what stopped people from accessing sexual health services are included in the box below.

Verbatim comments question 7.5

<table><tr><td>Lack of appointment availability

Age restrictions on clinics, clinics far-away or no appointments.

I have not yet had any issue in relation to sexual health

Having to wait too long

Not knowing it's there

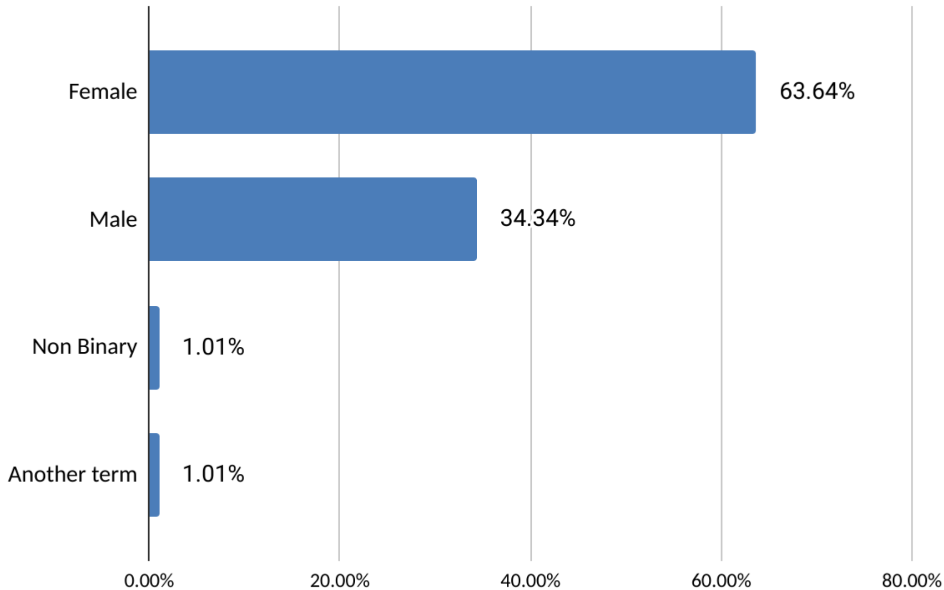
I didn't have because I was always careful
But I scared for my children because
Now life is very hard
And very sensitive
I don't want nothing happen to my children
I try to teach them every day
But I don't trust strangers ore who is behind the corner

Lack of confidence about how I would be treated. I got over it and used them but I did find it hard and I worried a lot.</td></tr></table>

Demographic information (online survey respondents)

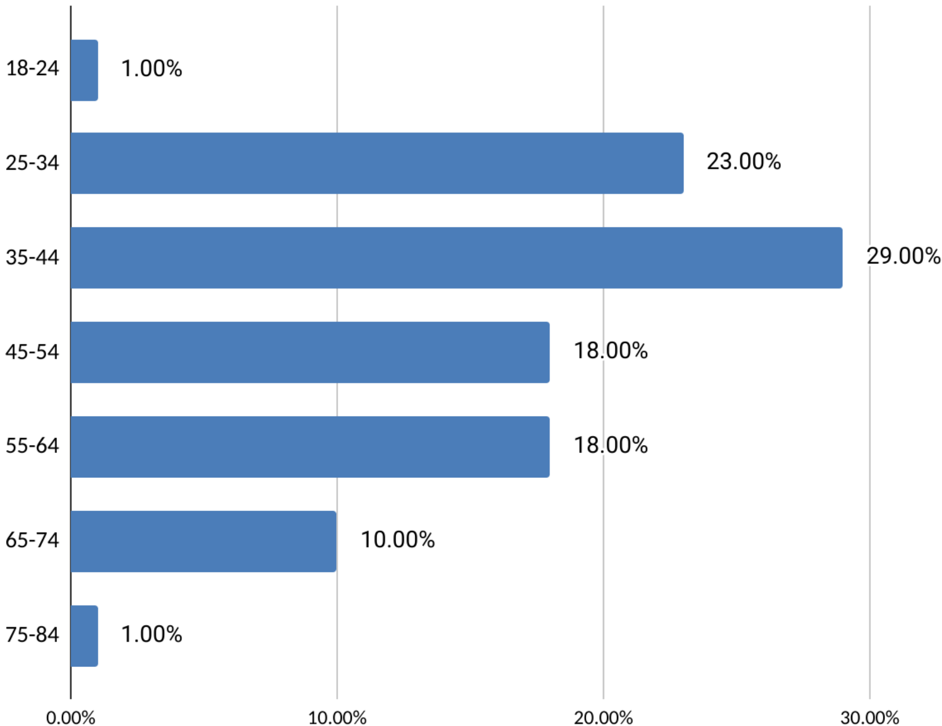
Demographic information on the online survey respondents (102).

Gender



The majority of respondents stated that they were female (63), followed by male (34), another term (1) and non-binary (1)

Age group: Are you… (Base 100)



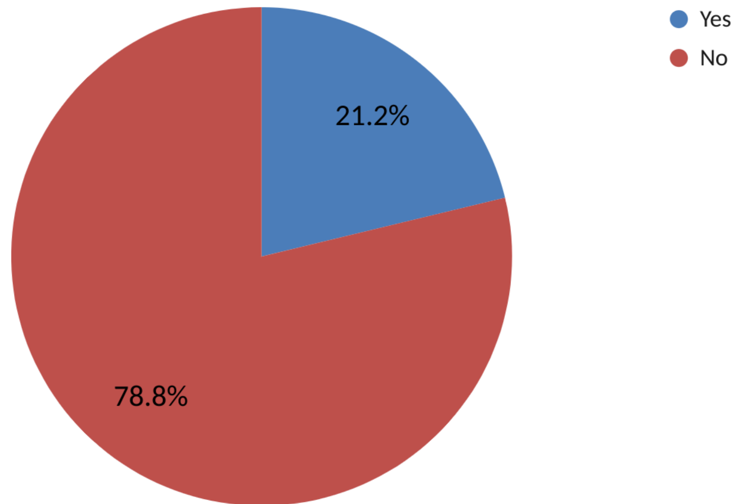
The age group with the highest number of respondents was 35-44 (29), closely

followed by 65-74 (7), 45-54 and 25-34 (4 each), 55-64 (3) and 75-84 (1).

In terms of age, only one young person 24 or under (1%) completed the survey, while 28% of respondents were aged 35-44, with 46% aged 45 or older. Overall, a mature audience that does not fully reflect the demographic make-up of City and Hackney.

Disability

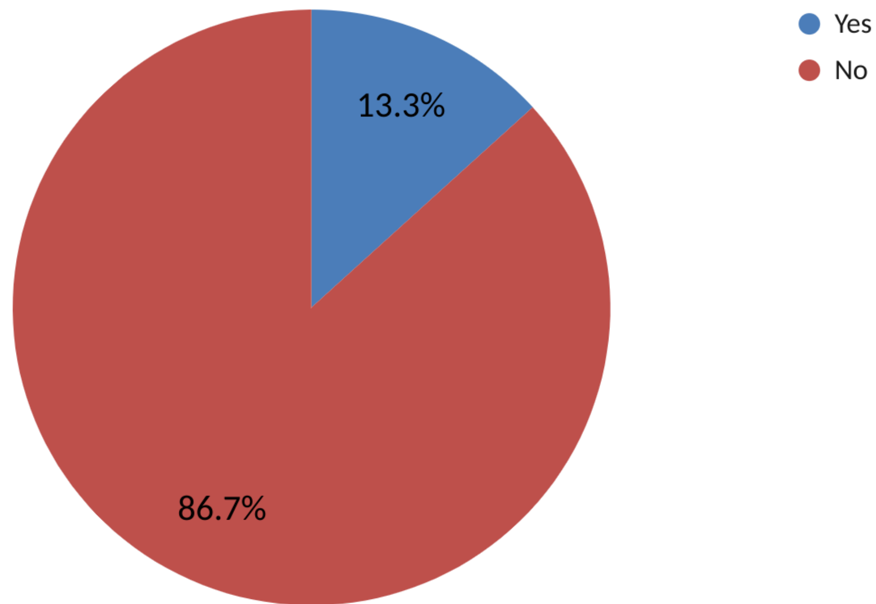
(Base 99)



The majority of respondents stated that they did not have a disability (78), with 21 respondents stating that they do. That represents 20.6% of this sample, or one in five respondents.

Caring responsibilities

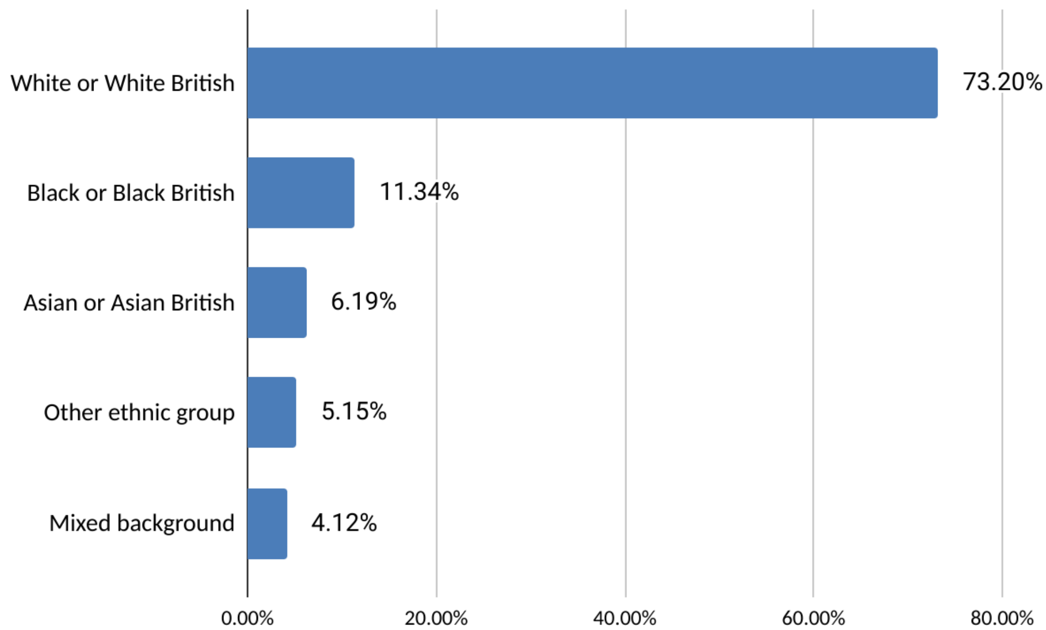
(Base 98)



The majority of respondents stated that they did not have a caring responsibility (85), with 13 respondents stating that they do. This represents almost 13% of the respondents or about one in eight.

Ethnicity

(Base 97)



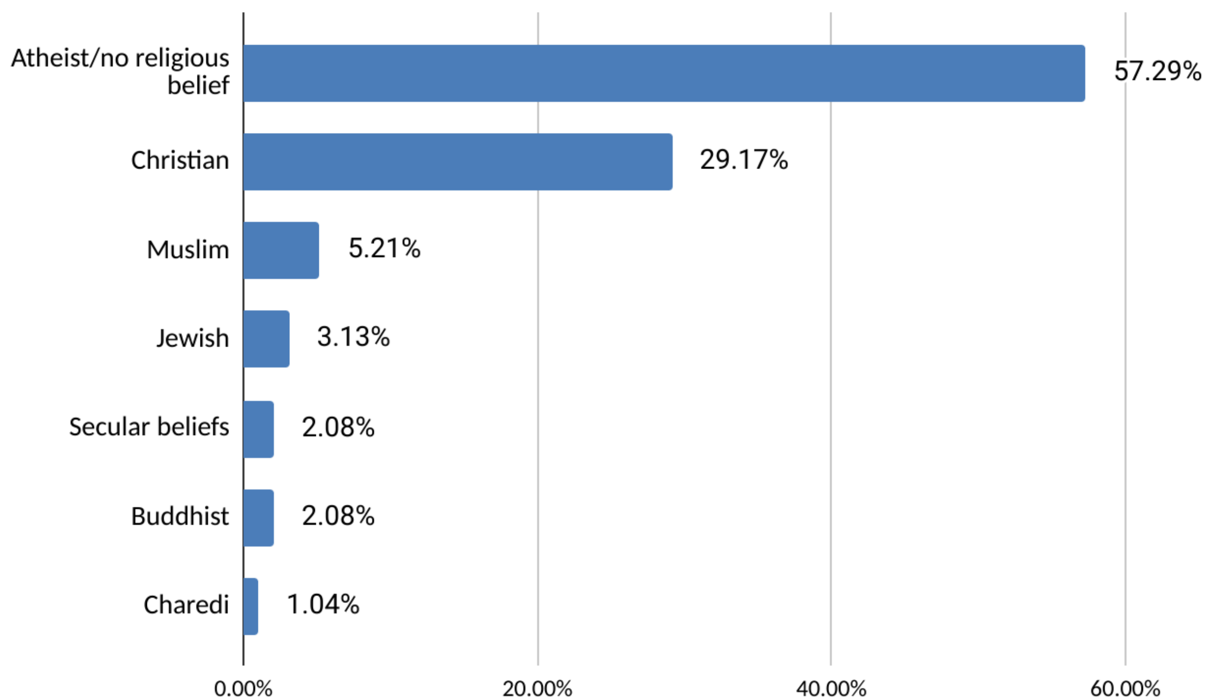
The majority of respondents stated that they were white or white British (71

respondents, or almost 70%). All others accounted for a much smaller number. For example, 11 respondents (11%) stated they were Black or Black British and six stated they were Asian (6%). The demographic makeup of Hackney is 57% white or white British, 20% Black or Black British and 10% Asian, for example, so the survey respondents don't reflect the population's makeup, with white people over-represented. That said, respondents are from both City and Hackney and City has a 69% white population, with 13% Asian and 4% Black residents.

No postcode data was recorded so it is not known what the distribution between City and Hackney residents was.

Religion

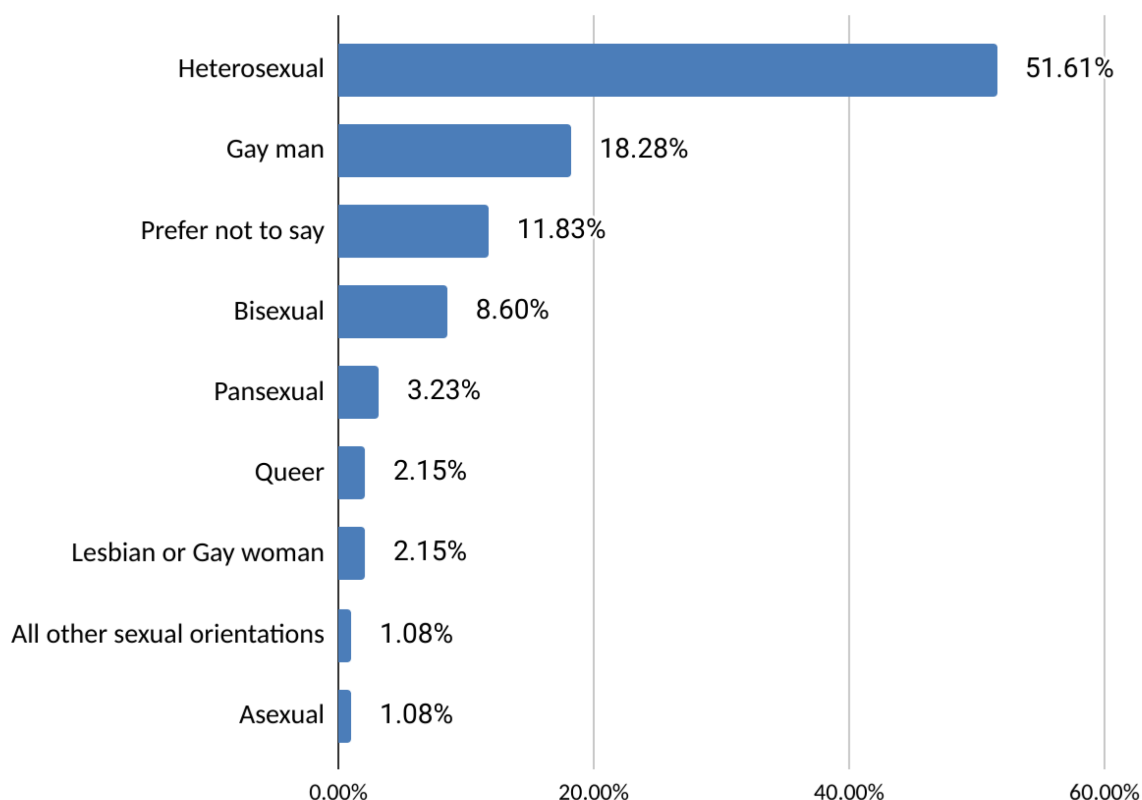
(Base 96)



The majority of respondents stated that they were Atheist/no religious belief (55), followed by Christian (28). Five people stated they were Muslim (5). Fewer than five people stated they were Buddhist, Jewish and/or Charedi.

Sexual orientation

(Base 102)



The majority of respondents stated that they were Heterosexual (48), with all others accounting for much smaller numbers.

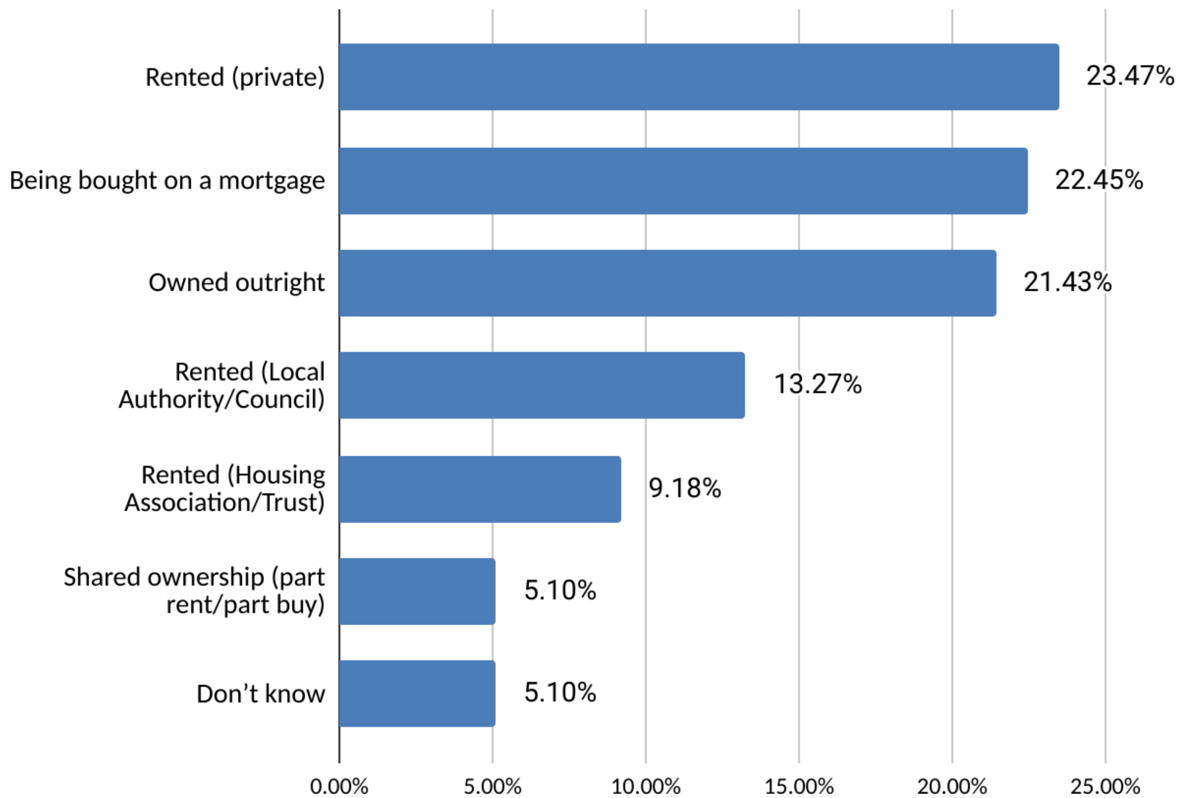
Even though the majority described themselves as heterosexual, this was less than 50% of all respondents, with gay men making up 16.7% of respondents and 7.8% bisexual. This means together, LGBTQ+ representation made up 33.3% of respondents.

Still, 11 people (10.8%) preferred not to state their sexual orientation and nine people did not answer the question (8.8%).

Even though City & Hackney have a relatively high proportion of the population that identify as LGBTQ+, this is an overrepresentation. This could indicate that many LGBTQ+ people feel very strongly about sexual health and want their voices to be heard, or the focus of the promotion of the survey was in some way skewed towards LGBTQ+ audiences, for instance it may have been amplified through LGBTQ+ networks.

Housing Tenure

(Base 98)



The tenure with the highest number of respondents was those who rent privately (23), followed closely by those who are buying on a mortgage (22) and Owned outright (21). Other respondents are renting from the Council (13), a Housing Association/Trust (9). Shared Ownership and don't know (5 each).

Easy Read survey

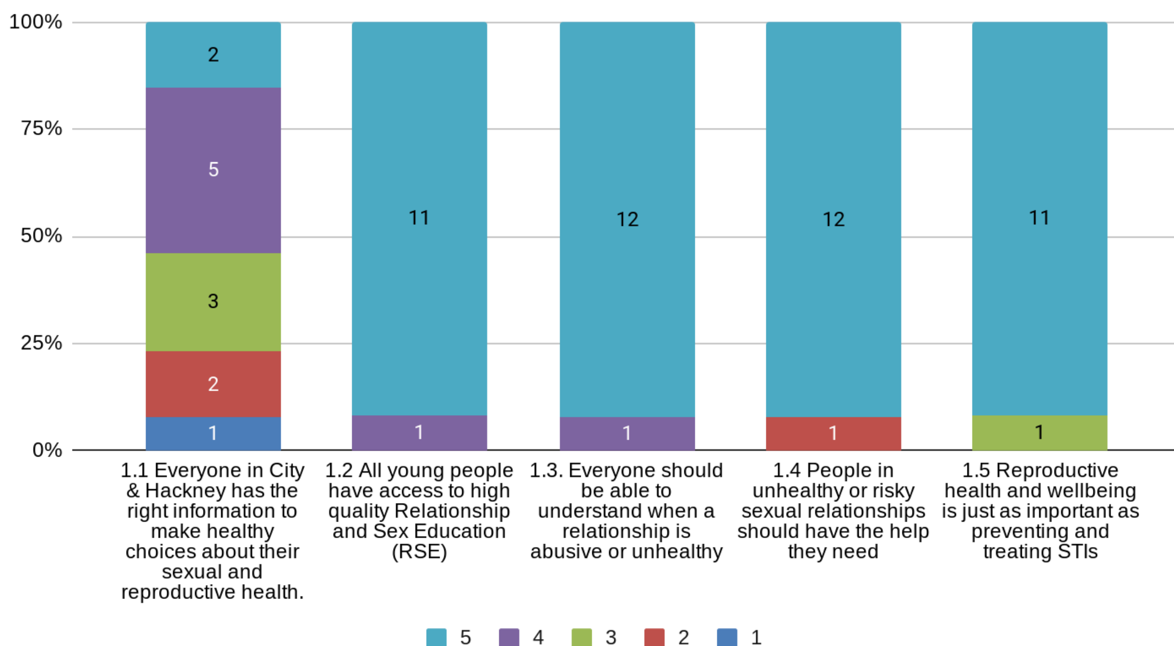
An image-based Easy Read survey was made available for people with learning disabilities or others who preferred this over a fully word-based survey. A total of 13 responses were collected. The findings are reflected in this section. The questions were in essence the same as in the online survey but the wording had been adapted, while every tick box question had an option for someone to make additional comments. Respondents made use of this option frequently, and their views largely support the views expressed in the online survey.

The issue of how questions were framed and interpreted - as a statement of an ideal to be reached or as a reflection of the current situation- was probably more challenging. It is a lesson learnt for future consultations.

Theme 1: Healthy and fulfilling sexual relationships

The first set of questions related to theme 1, about healthy and fulfilling sexual relationships. There was very strong agreement on most of these, as per the chart below, except the one about people having the right information. To illustrate the answers, some comments from respondents have been included. Any direct comments have been copied without editing.

The scoring was as follows:
Scoring: Agree a lot=5 Agree a little=4 Don't know=3 Disagree a little=2 Disagree a lot=1



1.1 Everyone in City & Hackney has the right information to make healthy choices about their sexual and reproductive health.

Respondents had very mixed views on this and provided the following feedback, which are similar to comments made in the qualitative section of the online survey. (comments have been copied without editing):

- There should be an app that we can download and be able to go onto and look at our own records and if needed be able to speak to someone face time, if your not sure (about something)?!
- Not everyone knows about their sexual health and don't make healthy choices

- Some people don't have access to online information
- There is a good bit of info if your registered with a GP especially its available in different languages
- They have the information they just don't use it
- I'm not sure if everyone knows there are condoms available within Young Hackney

1.2 All young people have access to high quality Relationship and Sex Education (RSE)

This was deemed very important by most.

- Young people should be aware of the problems that come with unsafe sex and about safe sex to!
- Too much domestic violence. Women being killed
- I think teenage boys should know more about the impact of relationships and sexual health
- Schools are talking about it now!
- Sexual health clinics should be in schools or advice about it in schools
- So they can make the right choices

1.3. Everyone should be able to understand when a relationship is abusive or unhealthy

This aim also had very strong agreement, and respondents held very pertinent views.

- It not always obvious if it is going to be an unhappy or an abusive relationship until your halfway through or it might not show at all
- Women being killed every day
- More should be done with young people in education to be able to recognise unhealthy relationships
- People should be able to recognise the red lights, alarm and not think that someone is beating me because they love me. Recognise the alarm bells.
- It has to be taught from a young age what you should not be tolerated. Anyone abusing should be charged right away.

1.4 People in unhealthy or risky sexual relationships should have the help they need

Respondents had observations around holistic support, and that accessing services is not always easy for people.

- From police, hospitals, prisons, probation and services that can help like housing
- More money should be put into young people services to support this work
- I think that people feel uncomfortable talking to professionals
- So that people won't experience trauma as much

1.5 Reproductive health and wellbeing is just as important as preventing and treating STIs

This aim also had strong agreement from respondents.

- People need to understand more about their bodies
- Preventing STIs should include understanding of abusive relationships/coercion/control in sexual relationships

Theme 2: Good reproductive health for your whole life

The scoring was as follows:
Scoring: Agree a lot=5 Agree a little=4 Don't know=3 Disagree a little=2 Disagree a lot=1

Clearly, the respondents were of the same mind in saying that everyone *should* be able to get good, inclusive reproductive health services when they need them. The wording of the other questions show that they were likely interpreted to mean ‘at this present moment', as also illustrated by some of the direct comments copied below:

2.1 People who live in City & Hackney have good reproductive health for their whole life

- Vast majority do, i think
- I agree emencely with that
- Support vulnerble people
- I’m not sure

2.2 People who live in City & Hackney can get help to make choices that support good reproductive health

- Only if u know where to go
- It's knowing where they can get that information and help that meets cultural, educ, knowledge needs in an easy to understand way
- Absolutely
- They can if they know where to look
- I'm not sure

The observations about access and knowing where to look/go echo comments made in the online survey.

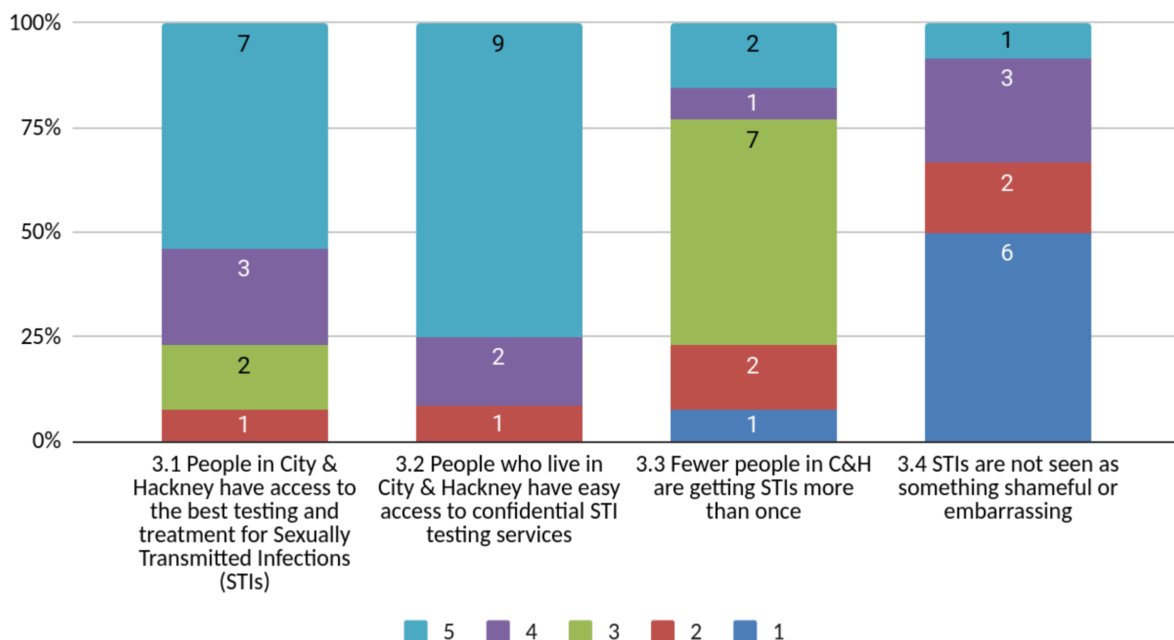
2.3: Everyone should be able to get good, inclusive reproductive health services when they need them

This was strongly agreed on by all.

- Especially to prevent pregnancys
- Absolutely

Theme 3: Preventing and treating sexually transmitted infections (STIs)

In this section it became clear that for many, having an STI is still seen as something to be ashamed or embarrassed about, but also agreement that there is/should be access to good testing and treatment services, with confidentiality especially rated as very important.



3.1 People in City & Hackney have access to the best testing and treatment for Sexually Transmitted Infections (STIs)

- Younger generations need something different from adults because they are the most vulnerable

3.2 People who live in City & Hackney have easy access to confidential STI testing services

- I think parents should be informed about sexual health to help them, in schools as well
- I know they have to tell your parents if you're not 18

3.3 Fewer people in City & Hackney are getting STIs more than once

- Not enough information out there for children, they should have sexual health in schools, and a specific class that does it
- I don't know

3.4 STIs are not seen as something shameful or embarrassing

The feedback indicates there is still a lot of work to do around normalising conversations about sexual health and reducing the stigma attached to STIs.

- It is shameful, I wouldn't tell anyone!
- Catch it you catch it!
- Children & young people will be bullied, as there is not enough information for kids
- I wouldn't even say to anyone anything about it
- No one wants to reveal they've had an STI

Overall, there is a concern especially for children and young people to have access to the right information, and for their specific needs to be taken into account.

Theme 4: Getting rid of HIV

What was apparent in this section is that people felt getting to zero new infections or no stigma was unlikely. In fact, people felt having HIV was highly stigmatised. The issue of access (to testing) and clear information was also raised. Overall, the scoring was varied, with quite a few respondents not being sure about their answers.

4.1 There will be no more new HIV infections in City & Hackney by 2030

- No idea with this one?
- Its here & its here to stay
- You never know
- It seems unlikely. But it's a good goal

4.2 People living in City & Hackney have access to the best treatment and care

- If u go to services at hospital already yes - if not then I am not sure about those people
- Some people do, some people don't

4.3 People at higher risk for HIV know about ways to prevent HIV

- I think they sometimes take condoms more seriously
- Many people don't think it could ever happen to them + don't know how to prevent it
- Not always so - information not always easy to read and understand

4.4 All people have access to fast HIV testing across North East London

- If they can get an appointment
- No, not enough information on it

4.5 HIV is no longer seen as something to be ashamed of or embarrassed about

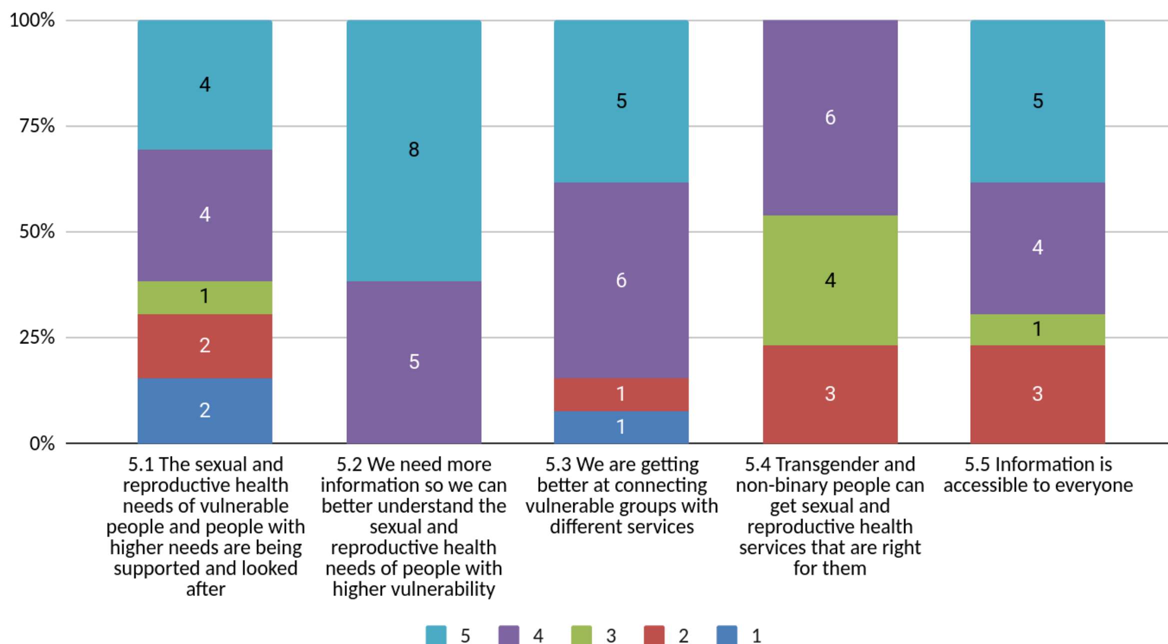
- There's still a stigma around HIV
- Quite a stigma about it
- If you get it you get it, don't get bitten on the arse

- It is, not everyone is going to think like that. With some people they will see it as shameful. That includes families.
- Yes it is shameful & people that have it are treated badly because of it

The feedback to 4.5 especially, indicates there is still a lot of work to do around dismantling HIV stigma, similarly to the stigma attached to STIs in general.

Theme 5: People who are vulnerable or have higher needs

This theme elicited empathy and a degree of insight that likely comes with lived experience. For example, accessing support is often not as easy as it may seem, and some people need support in order to access support. The feedback also underscores that information cannot just be available in one way or format, and may not be easy to access.



5.1 The sexual and reproductive health needs of vulnerable people and people with higher needs are being supported and looked after

- People need support to access support from services if there is no support they won't go
- More outreach to vulnerable people
- Very hard to access mental health services, if you can't access mental health you can't access nothing because you are all over the place

5.2 We need more information so we can better understand the sexual and reproductive health needs of people with higher vulnerability

- That's true

5.3 We are getting better at connecting vulnerable groups with different services

- More could be done - outreach
- Sometimes, but it's different depending which place or person you are talking to & their knowledge of services
- I wouldn't be 100%. I presume in this day and age.
- I agree emencely
- There is a group of people you can't target, like the homeless.

5.4 Transgender and non-binary people can get sexual and reproductive health services that are right for them

- Services are far and few for these communities
- It's a new world we are in today where its safe - we are in London but what's available outside London
- I think non binary people struggle

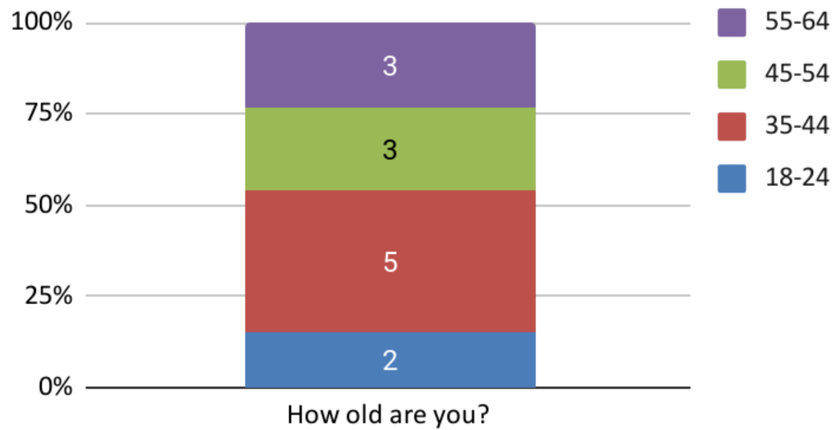
5.5 Information is accessible to everyone

- Information could be better explained and advertised. more information
- Not always, it depends
- Not to those with no access to IT or easy to read information
- It has to start in school
- It is but people don't know where to look for it

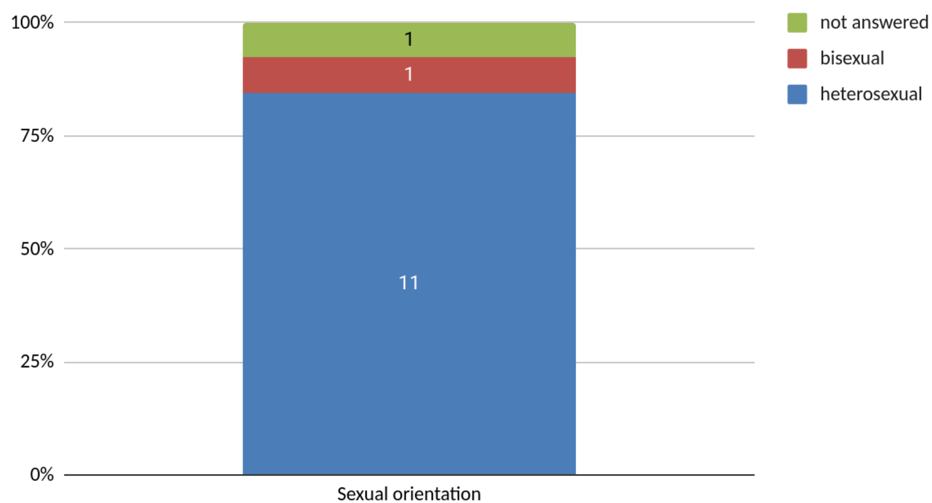
Demographic information

Respondents had a choice to provide demographic information and most did, though this was a very small sample size..

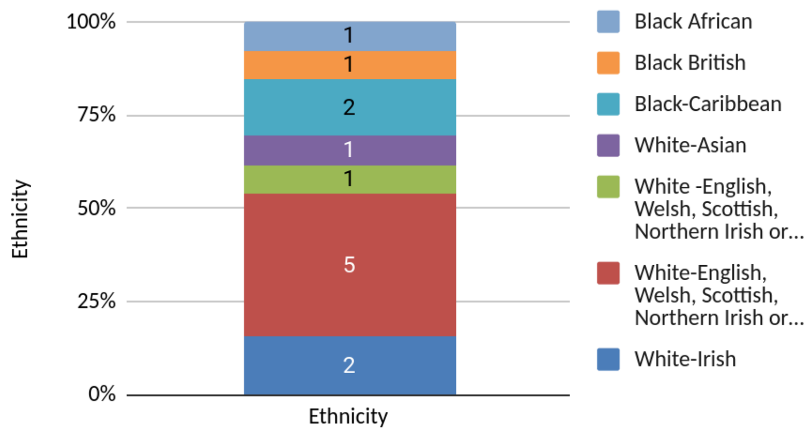
For the Easy Read survey, all 13 respondents were or identified as women, most of whom were in the 35-44 age range, or over 45. There were only two younger respondents. For 12 respondent 5s, a partial postcode was provided which indicated they lived in Hackney.

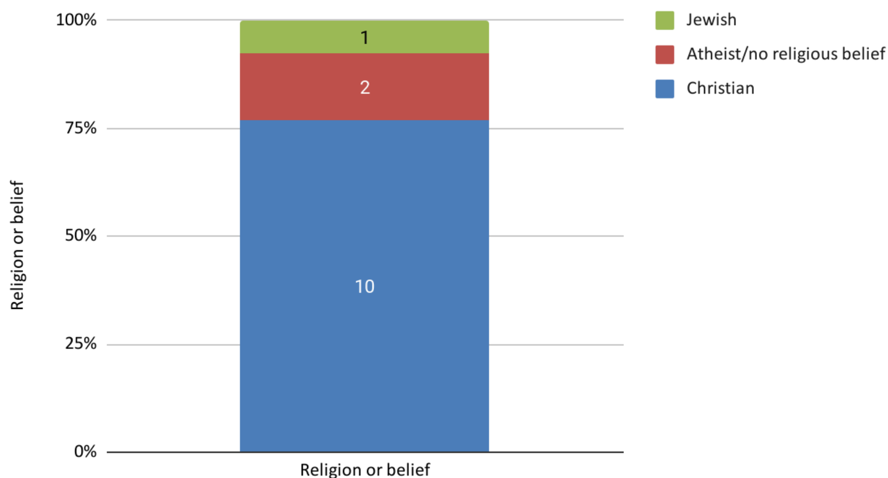


In terms of sexual orientation, the majority identified as heterosexual, with one person stating bisexual and one person not answering the question.



The ethnicity of respondents was fairly mixed and in terms of religion, 10 out of 13 identified as Christian.

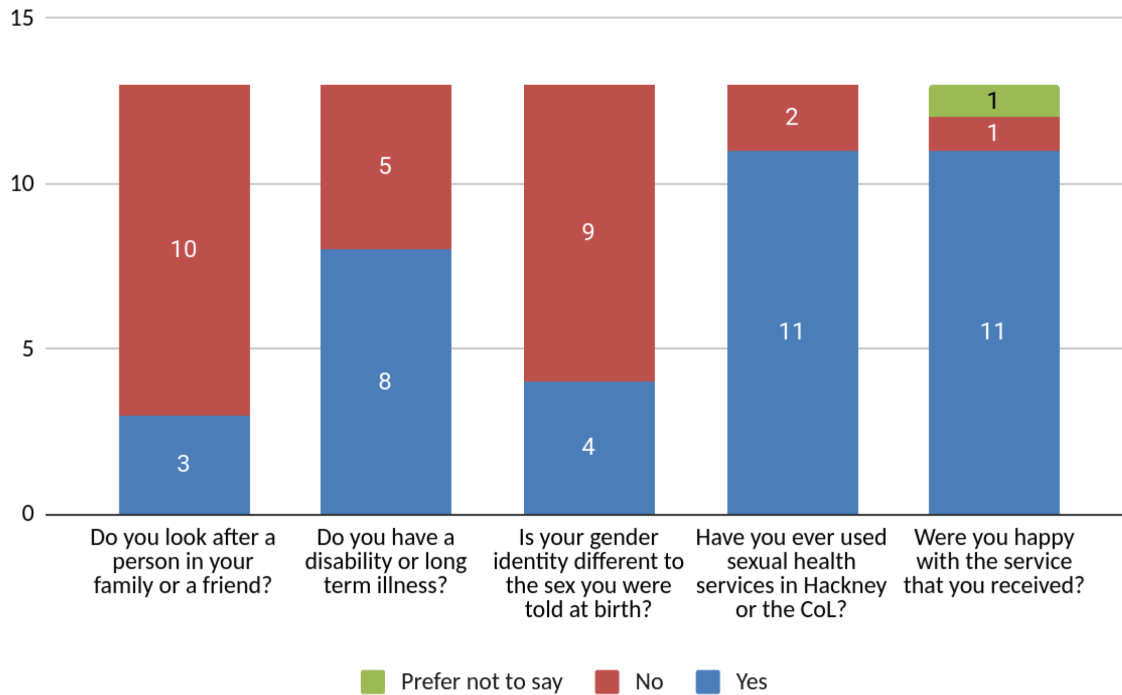




When asked if people had caring responsibilities, three answered they did, while eight respondents said they had a disability or long term illness. This represents 61.5% of a small sample, but is an indication that the Easy Read survey did provide a platform for people with potentially more complex needs or vulnerabilities.

Four of the respondents indicated their gender identity was different to the sex they had been told at birth. This would indicate 31% of this small sample were trans.

When asked if they had ever used sexual health services in Hackney or the City of London, 11 said they had and 11 respondents also stated they were happy with the service they had received.



When asked if they thought there were things that could be done better done better, the following feedback was provided

- Waiting times, not mixed waiting areas
- Better appointment system. GP services are awful having to phone at 8am in the morning
- I go to Open Doors - speed up the process
- Start teaching at a young age
- Send me free condoms so I don't have to go to the GP for them

Appendix: summary of written feedback in the online survey

Q: Have we missed anything? Please outline any additional priorities you think we should consider for the sexual and reproductive health strategy.

- No clarity on where to go for testing.
- Better signposting
- Access to clinics/opening times
- Free condoms for all
- Appropriate support for rape/sexual abuse survivors
- Space/clinic for trans patients
- PSHE/SRE incl. Outreach services/funding
- YP services/YP with SEND/LD, incl. accessibility
- HIV Stigma
- HIV test for everyone accessing health care services
- Training of healthcare staff on HIV stigma
- Privacy and confidentiality
- Intersex people's needs
- Access needs people with disabilities
- Comms/social media (innovative)
- Languages/information
- Invest in prevention
- SRH campaign at community level/work with CVS
- SH for mature population
- Context of family and stable relationships
- Self-conducted smear test trial
- Painful periods/routine checks for endometriosis and fibroid
- Menopause/perimenopause
- Better coil removal services
- Repro health services free for all and comprehensive (include maternity, fertility etc)
- RSE for all YP reflecting a variety of family models,sexual orientation etc. Inclusive and comprehensive
- Support for chemsex users (MSM)
- Sexual health should be NHS responsibility not LA
- Counter disinformation and hate against trans people
- No teaching of gender ideology in RSE, stick to biological sex

Q: What do you think works well in the Sexual and Reproductive Health Service Provision that you received?

- Good service
- Walk-in/drop in service

- Combination of walk in and appointments
- Confidential/private
- Friendly/professional service/staff
- Quality of care
- Fast and effective
- Timely appointments/easy to book
- Online/SHL
- LARC
- Non judgemental/safe
- One stop shop (testing, repro health, etc)
- Free
- Choice
- Easy/accessible
- Good communication/supportive
- Education/counselling/info
- Results by text
- LBGTQ+ friendly
- GP
- Culturally competent

Q: Is there anything that could be improved in the Sexual and Reproductive Health Service Provision that you received?

- Access/getting appointments
- Waiting times
- Longer opening times
- Walk in services
- In person testing for those who have difficulty bleeding for self-test
- Free condoms for all/all ages
- More trained staff
- Better/modern facilities/buildings
- Non-judgemental service and communication
- More clinics/facilities or better located
- Coil fitting reminders (expiry)
- Better phone access
- Joined up services across London (single point of access for appointments, test result etc)
- Tailored info on results/conditions via app
- Mix of walk in and appointments
- Inappropriate of packed waiting area
- Staff attitude/rudeness/impatience/not welcoming
- No penile swabs
- Better info provision on clinics/opening times
- Guidance on clinic visits (what happens during your visit)

- Overall provision of/access to info/guidelines etc
- Gender sensitive/inclusive care
- More 'minority group' clinics
- Stigma
- Offer of vaccines to heterosexual people (HPV, Hep)
- Staff Training on gender diversity/LGBTQ_
- Better info on contraceptive choices
- More resources for reproductive health
- Better menstrual services (heavy, constant bleeding)
- No STI test before psychosexual counselling
- Connection/comms between GPS and SHS
- Increase number of SH service pharmacies
- More condoms per pack, better variety of condoms including non-latex and XL (Skyns)
- Include oral and anal swabs for heterosexual people
- Improve VCS capacity/more innovative
- More services outside of clinical settings
- Better guidance on how to use test kits (urine)

Q: What stopped you from accessing Sexual Health Services?

- Not needed/nothing
- Access/opening times HSHS
- Access/lack of appointments
- Access/distance
- Access/age restrictions
- Access/waiting times
- Services to be culturally aware/sensitive
- Lack of confidence/worried about how I would be treated
- Don't know about the services
- Staff attitudes/judgement
- Text reminders re SRH
- GP service used
- Free condoms for all

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City and Hackney Sexual and Reproductive Health Strategy
2024 - 2029

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Executive Summary

The Health and Wellbeing Boards (HWBs) of the City of London Corporation and the London Borough of Hackney work across partner organisations to improve the health and reduce inequalities of their local populations. This includes sexual and reproductive health (SRH), where no one partner can act alone if we are truly to address poor sexual health and high levels of unmet need. This SRH strategy lays out our ambitions across all of our partners and in partnership with our communities to ensure we make the changes over the next five years that will improve health whilst reducing inequalities.

Significant improvements have been achieved in improving SRH in the City and Hackney. However we continue to have high levels of unmet need with significant inequalities, both within communities and compared to other areas in London and across England.

A five-year strategy will ensure a coordinated approach that brings together health promotion and education as well as commissioned services, and explores linkages with other services and providers, including the NHS and the voluntary sector. Each of the local authorities in North East London are undertaking a similar strategic process to enable a coordinated approach across the Integrated Care Partnership so that the most pressing issues and gaps in provision and uptake of care can be addressed.

The strategy is informed by a local needs assessment[1] and Women's Reproductive Health Survey, and will help deliver on national strategies, including the Women's Health Strategy for England (2022), the National HIV Action Plan (2021) and Strategic Direction for Sexual Assault and Abuse Services (2018).

This strategy has four thematic areas which are also reflected in the NEL sexual and reproductive health strategy. We have added an additional theme of "inclusion communities" to ensure we not only provide universal open access services but also better understand and address the needs of communities with increased inequalities in sexual health, or more complex needs.

The five overarching themes are:

a) **Healthy and fulfilling sexual relationships**
b) **Good reproductive health across the life course**
c) **STI prevention and treatment**
d) **Living well with HIV and zero new HIV infections**
e) **Inclusion communities and those with complex needs**

For each theme, a brief overview of the local situation is described. Each thematic section then has a set of outcomes and aims that seek to address the key issues identified.

a) Healthy and fulfilling sexual relationships

Sexual and reproductive health and wellbeing is a fundamental human right. All of the partners of the HWB have a significant, often mandated, role in improving SRH through commissioning and/or providing services.

We must make available easy to access, comprehensive sexual and reproductive health services not just to all residents but also to the "benefit of all people present in the local authority's area". Services must be able to meet the needs of people across the lifecourse

[1]https://cityhackneyhealth.org.uk/wp-content/uploads/2023/06/CH-Sexual-Health-Needs-Assessment-__-May-2023.pdf

from young people who are still to have their sexual debut as well as more mature people who are embarking on new sexual relationships in middle or older age.

Psycho-sexual support and resources must be available as part of our local service offer so that residents who experience sexual difficulties, whether due to (past) trauma, addiction issues or psychological issues can go on to experience and enjoy fulfilling sex lives.

The Havens provide a specialist sexual assault referral service and offers support for women, men and children who have been raped, sexually assaulted or abused. Access to and awareness of the Havens should be strengthened to ensure that this safe space service can provide crisis care, medical and forensic examinations, emergency contraception and testing for sexually transmitted infections.

Within the City of London and Hackney the highest rates of STIs are in young people and young adults. Supporting young people to adopt healthy sexual behaviours while at the same time ensuring welcoming and appropriate services are available to them is of key importance.

Central to this will be the provision of comprehensive and inclusive sex and relationship education in schools and places of alternative provision, with close collaboration with schools and communities where this is sensitive for cultural or religious reasons.

To achieve more healthy and fulfilling sexual relationships the strategy will focus on achieving the following outcomes:

Outcome 1: Young people (YP) in City and Hackney have equitable access to good quality, comprehensive and inclusive relationship and sex education (RSE) in schools and settings of alternative provision.

Outcome 2: Young people have access to appropriate and young people friendly sexual health services

Outcome 3: People have access to clear and appropriate information and resources to help them make informed choices about their sexual and reproductive health.

Outcome 4: Increased professional knowledge and skills in sexual health and wellbeing among people working in YP services and in wider sexual health services and along referral pathways

Outcome 5: Psychosexual support and high-risk sex counselling services are an integral and adequately resourced part of sexual health provision

Outcome 6: Sexual assault services pathways are robust, well communicated with easy to access services.

b) Good reproductive health across the life course

Reproductive health comprises much more than just contraception. Many of these services sit outside those that the local authority commissions, e.g. fertility services, terminations, menopause and sexual assault services. To support better reproductive outcomes it is key that commissioning streams, pathways and referral systems between different services are clear with a focus on integration wherever possible.

The provision of contraception is widely recognised not only as a human and legal right but also as a highly cost-effective public health intervention. Contraception reduces the number of

unplanned and unwanted pregnancies that bear high financial costs to individuals, the health service and wider society. Low barrier access to contraception is important because there are inequalities in the use of services and reproductive health outcomes, often linked to ethnicity and age.

In order to offer reproductive choice, the full spectrum of contraceptive options needs to be available: Long Acting Reversible Contraception (LARC), injectables, user-dependent oral and barrier method contraception, support for “natural family planning” or rhythm method, Emergency Hormonal Contraception (EHC), and termination of pregnancy (TOP) services.

Alongside contraceptives we must also ensure that residents who want to start a family have information that enables healthy conceptions by focusing on preconception health. For residents who have difficulty in conceiving, information, support and access to fertility services must be easily and widely available. Barriers remain for some communities to access assisted fertility services and these should be reviewed and progressively reduced.

The strategy will focus on the following outcomes to ensure good reproductive health across the life course:

Outcome 1: Reproductive health services consider the life course from adolescence to the post-menopausal stage

Outcome 2: Reproductive health services are cognisant of inequalities in service provision and uptake in different ethnic population groups and work to ensure anyone can access services in their preferred setting and equally, to address those inequalities

Outcome 3: The role of all services in providing comprehensive reproductive care and services to residents is clear, promoted and optimised while pathways into and out of non-LA-commissioned services are optimised and integrated, including: fertility services, period poverty; perimenopause/ menopause; community gynaecology; termination of pregnancy; maternity and post-partum care and complications; cervical screening; endometriosis, genital dermatology, incontinence, heavy menstrual bleeding, Female Genital Mutilation (FGM), and sexual assault services

Outcome 4: Inequalities in access and uptake of services have decreased over time and are not a reflection of socio-economic background

Outcome 5: Assisted fertility services review and reduce barriers to access (‘fertility friendly City & Hackney’).

c) STI prevention and treatment

Sexually transmitted infections (STIs) can cause serious health issues beyond the immediate impact of the infection itself, especially as some STIs may not be symptomatic but can still have serious long term impacts, e.g. causing infertility, cancer and sexual dysfunction. The most commonly diagnosed STIs in Hackney and the City of London are chlamydia and gonorrhoea.

Overall, the high incidence of STIs remains a challenge that is associated to having both a young population, as young adults are demographically the age group with highest infection rates, and a large proportion of the population that are gay, bisexual or men who have sex with men (GBMSM) who also demographically tend to have higher rates of infection.

A multi-pronged approach will be required to achieve a reduction in STI infection and reinfection rates, including good quality and inclusive sex and relationship education, appropriate and available information and accessible resources, developed with and alongside those at highest risk. Easy and confidential access to STI testing through various routes (online, pharmacies, GPs and sexual health clinics), along with effective partner notification and treatment are essential. Services need to be non-judgemental and welcoming.

The following outcomes will contribute to STI prevention, testing and treatment.

Young people

Outcome 1: Young people have access to accurate, inclusive and appropriate information and education on sexual health

Outcome 2: Young people know where to source free condoms and STI tests and have no barriers to access and uptake

Outcome 3: Young people have access to appropriate and young people friendly sexual health treatment services

General population

Outcome 4: STI testing is available through multiple pathways so people with different preferences can access them on their own terms and with no barriers

Outcome 5: Better understanding of drivers of risky sexual behaviour in different population groups

Outcome 6: Functioning and efficient partner notification systems are in place within all testing pathways

Outcome 7: Reinfection rates in young people and adults are reduced

Outcome 8: Vaccination coverage has improved

d) Living well with HIV and zero new HIV infections

Both Hackney and the City of London are areas of extremely high prevalence of HIV. Great strides have been made in both prevention and treatment, resulting in fewer new diagnoses every year and people with HIV living longer and healthier lives. However, in order to get to zero HIV, meaning zero new HIV infections by 2030, it is crucial that testing continues at scale to find new cases, especially late diagnosis cases where people are more likely to have worse health outcomes.

Alongside widespread testing, including opt-out testing in both acute and primary care, it is equally important that people are supported to start and maintain effective treatment and re-engage with treatment when lost to care.

Continuing a strong HIV response through prevention, testing, treatment and care is an essential part of the overall sexual and reproductive health work as HIV impacts on people's reproductive lives, is linked to poorer socio-economic outcomes, and is associated with other infections such as Tuberculosis and viral Hepatitis.

In City and Hackney, overall testing rates for HIV have dropped and women are more likely to be diagnosed late. In terms of prevention, the promotion and uptake of Pre-Exposure

Prophylaxis (PrEP) has been very successful amongst older gay and bisexual men (GBMSM) and more needs to be done to ensure other groups who may benefit from PrEP are aware and accessing this service.

The following outcomes will contribute to living well with HIV and getting to zero new HIV infections by 2030:

Outcome 1: People living with HIV no longer experience stigma and discrimination

Outcome 2: All diagnosed people with HIV receive treatment and care to achieve best possible health outcomes and viral suppression.

Outcome 3: All communities who would benefit from HIV prevention interventions including condoms and PrEP are easily able to access services.

Outcome 4: All people with HIV know their status and are linked in to care and treatment.

Outcome 5: The Fast-Track Cities London goals are achieved locally by 2030

e) Inclusion communities and those with complex needs

Sexual and reproductive health and wellbeing are a right like all other human rights but some people have greater difficulty in achieving good SRH outcomes, and require additional or tailored support. This can be for very diverse reasons. The purpose is to reduce inequalities in sexual and reproductive health and ensure people with more complex needs are recognised and met within a proportionately universal service provision.

A key challenge is that both sexual and reproductive health are still stigmatised within some communities and there can be cultural or religious norms that can act as barriers to access to information and services. Some communities with higher complexity or vulnerability can be relatively small in size and limited information is known about their specific needs.

The following outcomes will contribute to achieving better sexual and reproductive health outcomes for inclusion communities and those with complex needs:

Outcome 1: Increased access to services by those with higher or more complex needs

Outcome 2: Improved data collection to inform service delivery

Outcome 3: Transgender and non-binary residents' sexual and reproductive health needs are met

Outcome 4: Information is designed in acceptable and appropriate forms

Implementation

An annual action plan will be developed, published and an update presented to the City and Hackney HWBs which will highlight progress on the strategic outcomes and the next year's priority actions.

To monitor implementation of the strategy, an SRH dashboard will be developed and published by the Public Health Intelligence Team (PHIT) in 2024. The potential to widen this to include reproductive indicators will be explored in collaboration with the ICB for subsequent years.

Subject to adoption of similar strategies by the other places based partnerships in NEL an overarching strategy will be recommended to the Integrated Care Partnership for formal adoption.

[Placeholder for oversight mechanism that is to be agreed]

1 - Introduction

The Health and Wellbeing Boards (HWBs) of the City of London Corporation and the London Borough of Hackney work across partner organisations to improve the health of and reduce inequalities within their local populations. This includes sexual and reproductive health (SRH), where no one partner can act alone if we are truly to address poor sexual health and high levels of unmet need. A broad approach to sexual and reproductive health is not only necessary but essential. This SRH strategy lays out our ambitions across all of our partners and in partnership with our communities to ensure we make the changes over the next five years that will improve health whilst reducing inequalities.

Sexual and reproductive health present a significant burden of disease and cost to the health system related to sexually transmitted infection (STI) prevention, testing and treatment, and the need for a range of contraceptive options. Yearly, City and Hackney Local Authorities invest over £8m in clinical services as well as services to promote good sexual health, with currently 12 services directly commissioned. The NHS commissions and provides termination of pregnancy services, gynaecological services, maternity services, fertility services, HIV treatment and sexual assault services, all of which play an important part in improving SRH.

Significant improvements in SRH have been achieved, in partnership with the NHS, education providers, the voluntary sector and local communities e.g. the reduction in teenage pregnancies and reduction in new HIV diagnoses. However, City and Hackney continue to have a high level of unmet need with significant inequalities in sexual and reproductive health, both within communities and compared to the other areas in London and across England. This strategy seeks to forge a coherent and comprehensive direction that will meet the needs of our diverse populations in Hackney and the City of London. It draws upon the findings and analysis of the Sexual Health Needs Assessment[2], the 2022 City and Hackney Women's Reproductive Health Survey, service reports and user engagement, and mystery shopping exercises of sexual health and pharmacy services.

It is further informed by national strategies in development and already published including the Women's Health Strategy for England, which was published in 2022, the National HIV Action Plan (2021), the Fast Track Cities goals of no new HIV infections by 2030 and Strategic Direction for Sexual Assault and Abuse Services.

The strategy has been developed alongside the other local authorities, voluntary sector and clinical services in North East London (NEL) so whilst each place-based strategy responds to local needs, where there are opportunities for joint approaches to identified needs, these are highlighted.

Four of the five key thematic areas of this strategy are broadly reflected in the NEL Sexual and Reproductive Health (SRH) strategy, ensuring alignment with the priorities of other local authority areas in North East London that have similar types and levels of SRH need within their populations. The five overarching themes are:

- Healthy and fulfilling sexual relationships
- Good reproductive health across the life course
- STI prevention and treatment
- Living well with HIV and zero new HIV transmissions
- Inclusion communities and those with complex needs

The ambition is for this strategy to lay the foundation for the reimagining, (re)commissioning and integration of sexual, reproductive health and HIV services that are comprehensive and inclusive,

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[2]https://cityhackneyhealth.org.uk/wp-content/uploads/2023/06/CH-Sexual-Health-Needs-Assessment-__-May-2023.pdf

recognising synergies with other services and providers, and contributing to better sexual and reproductive health outcomes for all residents.

It will help us to work in closer partnership with other organisations with legal duties to commission SRH services, such as the North East London Integrated Care Board (NEL ICB), NHS partners, neighbouring local authorities, and other place-based partners within the Integrated Care Partnership (ICP). Having a strategy will provide a rationale for decision-making with internal and external stakeholders and, most importantly, help us to better communicate our ambitions around SRH to our residents.

Although the text will often refer to women when talking about reproductive health and contraceptive choices, it is acknowledged that this may also affect and apply to trans men and non-binary people who were born with female reproductive organs but who do not identify as women.

1.1 Vision

The overarching ambition of this strategy is for all residents in Hackney and the City of London to lead healthy and fulfilling lives in which they have knowledge and agency to make informed choices about their sexual and reproductive health and can access high quality services to support them in doing so.

The strategy recognises that there are currently inequalities in need, access and quality of care and it therefore sets out to:

- Improve the quality of care provided to all residents
- Improve outcomes and/or reduce variability in outcomes
- Achieve more efficient and sustainable delivery

As such, the vision is to work collaboratively with residents and partners from across the spectrum of integrated SRH in order to deliver high quality, easy-access and equitable provision across the City of London and Hackney, with the prevention of illness and the promotion of healthy relationships at the core of all activity. Whilst wider determinants of health such as employment, education, housing, immigration status, to name but a few, are also fundamental to improving SRH these are outside of scope of this strategy.

1.2 Core principles

This strategy is underpinned by the following core principles:

- Proportionate universalism (focus and resources proportionate to need) embedded across all actions to ensure equity of outcomes.
- A life-course approach recognising the importance of the wider determinants of health.
- Right care, right time, right place. Making every contact count.
- Co-development of services with ongoing resident/patient and stakeholder participation.
- Safety and safeguarding highest quality offer (for staff and patients) and highest standards in London.
- Whole-system approach: partnership working and system leadership from providers of integrated SRH (e.g. primary care, education, substance misuse, domestic abuse services, sexual assault services, community health and acute health services etc.).
- Commitment to developing sustainable and cost-effective services.
- Innovative, research and evidence based approach that makes the best use of emerging technology.
- Outcomes-focused with an annual action plan, aligned to regional/national strategies and with plans to monitor and evaluate success, as well as system enablers and barriers of further improvement (embedding a learning system).

1.3 Scope

SRH cross cuts across sectors and beyond clinical settings. Not all elements of sexual and especially reproductive health, e.g. fertility, termination of pregnancy services and sexual assault services, are within the commissioning remit of local authorities. It is therefore important to define the scope of each partner within this overarching partnership strategy, noting that some responsibilities overlap or are jointly held.

The local authorities are responsible for:

- Specialist sexual health services, including genitourinary medicine (GUM), sexual wellbeing support and advice, STI testing and treatment, most aspects of contraception (including Long Acting Reversible Contraception, LARC and Emergency Hormonal Contraception, EHC but excluding oral contraception), Hepatitis A and B and HPV vaccinations provided within SRH services and HIV prevention (PrEP)
- Enhanced sexual health services within primary care from both GPs and pharmacies, including STI Screening, LARC and EHC (pharmacy only)
- Online sexual health services including STI testing and EHC
- HIV prevention (excluding the pharmaceutical costs of PrEP)
- HIV social care support
- Condom distribution schemes and sexual health resource provision
- The sexual health elements of psychosexual services and Chemsex support services
- Promoting the wellbeing of children and young people
- Commissioning health visiting and school nursing services
- Commissioning of substance misuse services

The following areas are commissioned by the NHS at either a local, ICB or national level. Joint commissioning can improve outcomes and integrate pathways and as all North East London Local Authorities are seeking to take a similar approach to the development of SRH strategies there will be further opportunities to collaborate on these areas at a North East London ICP footprint:

- Fertility services and assisted conception
- Termination of Pregnancy Services (ToPS)
- Routine oral contraception in primary care and online
- Cervical cytology
- HIV treatment, care and PrEP medications
- HIV, Hepatitis B & C testing emergency departments
- Mental health elements of psychosexual services
- Havens and Sexual Assault Support Services (SARS)
- Maternity services
- Gynaecological services
- Vaccinations

Beyond health and health services, a key partnership is with education. Within primary and secondary schools it is a statutory requirement to teach Relationships Education at key stages 1 and 2 and Relationships and Sex Education (RSE) at key stages 3 and 4. Partnership work will include collaborating with colleagues and stakeholders in education, including in special educational needs (SEND), people referral units and places of alternative provision.

Out of scope are:

- Actions and/or organisations outside of local authority or health services' sphere of influence.

1.4 Strategic priorities

This strategy is built around five themes that have a number of underlying aims and intended outcomes. These themes represent the fulfilment of the definitions of SRH and address the key challenges in the City of London and Hackney.

1) **Healthy and fulfilling sexual relationships**

   People are empowered to have healthy and fulfilling sexual relations:

   • People make informed choices about their sexual and reproductive health
   • People in unhealthy, risky sexual relationships or victims of sexual assault, rape or abuse are supported appropriately

2) **Good reproductive health across the life course**

   People effectively manage their fertility and contraceptive choices, understand what impacts on it and have knowledge of and access to contraceptives:

   • Reproductive health inequalities are reduced
   • Unwanted pregnancies are reduced
   • Knowledge and understanding of contraceptive choices and preconception health are increased
   • Barriers to accessing assisted conception are reduced

3) **High quality STI testing and treatment**

   The local burden of STIs is reduced, in particular among those who are disproportionately affected:

   • There is equitable, accessible, high-quality testing, treatment, vaccination and partner notification that is appropriate to need
   • Transmission of STIs and repeat infections are reduced

4) **Living well with HIV and towards zero new HIV infections**

   The full implementation of the national HIV action plan of zero new HIV transmissions by 2030 focusing on prevention, testing, rapid access to treatment and retention in care whilst improving the quality of life for people living with HIV, and ending HIV related stigma and discrimination.

5) **Inclusion communities and those with complex needs**

   To reduce inequalities in sexual and reproductive health and ensure those people with more complex needs are recognised and met within a proportionately universal service provision, and that information is made available in accessible and appropriate ways.

The following considerations underpin the themes:

- A commitment to tackling and reducing inequalities whilst ensuring services are open and accessible to all
- Service innovation and improvement
- Developing workforce capacity and skills
- Ensuring that services are delivering value-for-money
- Considering the development of technology and technological solutions
- Broader issues, such as antimicrobial resistance, assets and estates, and facilities such as pathology laboratories

- Working in partnership with key stakeholders, including VCS organisations and other commissioning bodies
- Developing and implementing more comprehensive data collection on protected characteristics and inequalities
- To support integration of services such as fertility, termination of pregnancy, HIV care, psychosexual support, Sexual Assault Referral Services at both a local and NEL level.

2 - Healthy and fulfilling sexual relationships

2.1 Importance to public health

Good SRH is not just about having clinical treatment and services available and accessible to all. The World Health Organisation (WHO) definition:

> Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

This definition goes well beyond clinical health and makes clear that respect, pleasure and consent are key elements of a healthy sexual relationship. It also means people must have agency to choose and make informed decisions about their personal sex life and that those choices should not be detrimental or harmful to any other person.

Relationship and Sex Education (RSE) in secondary schools, and Relationship Education (RE) in Primary Schools has been nationally mandated since 2017. Research has shown that good sex education has benefits beyond physical health outcomes, preventing teenage pregnancy or STI infection, but can also reduce harm (including sexual violence), promote gender equitable attitudes, encourage people to speak out and make it more likely that sexual debut is consensual[3].

The sexual and reproductive health of younger populations in City & Hackney was reviewed as part of the 2022 0-25 year-olds Joint Strategic Needs Assessment (JSNA). A small survey among young people aged 14+ who either lived in or attended school in the City and Hackney found that 93% of respondents had received RSE education, but of those only 52% said that the education they received was sufficient (CYP JSNA). Some comments from qualitative data from this JSNA suggested a narrow focus on heterosexual messaging and condom promotion, with a need for broader education and the consideration and inclusion of LGBTQIA+[4] relations during education programmes.[5]

A recommendation from this assessment was a need for a school health and behaviour survey such as the School Health and Education Unit (SHEU) to verify the actual needs of the school age population.

Encouraging healthy and fulfilling sexual choices is not only relevant for young people. Across the life course, people can be exploited or coerced, may be dealing with past or current traumatic experiences, or have inadequate knowledge, agency or resources to ensure their own or others' sexual and reproductive health and wellbeing. Or people encounter (psychological) issues or the victims of crime that impact on their physiological ability to enjoy or experience fulfilling sex lives.

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[3]https://www.sexeducationforum.org.uk/sites/default/files/field/attachment/RSE%20The%20Evidence%20-%20SEF%202022.pdf

[4] LGBTQIA+ stands for Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexual + any other identity or orientation

[5] 2022 Children and Young People JSNA made the following recommendations: 1) New PHSE Curriculum implemented in all schools; 2) Schools review their PHSE/ RE/ RSE Curriculum and consulted with Parents/Carers; 3) Ensure RSE is effective by ensuring it is grounded in an understanding of how to act in real life situations; knowledge, skills and personal qualities

It is therefore important to ensure (psycho-sexual) support and resources are available for residents who experience sexual difficulties, have encountered an unsafe relationship, or who have been coerced, sexually assaulted, raped or abused, including for instance through modern slavery or the practice of Female Genital Mutilation (FGM). There is also scope to consider the high risk sexual pathway for those who find it difficult to make safe sexual choices, for example due to substance misuse (chemsex). Equally, it is important that services have good safeguarding practices in place and that professionals are equipped to recognise and act upon signs and behaviours linked to modern slavery, harmful sexual health experiences and outcomes.

2.2 Local need and inequalities

As section 4 on STI prevention and treatment will elaborate, young people, young adults and GBMSM in City and Hackney have the highest rate of STI infections within the overall population. This suggests that the greater use of condoms, more frequent STI testing, increased uptake of vaccinations and enhanced partner notification will help reduce the increased burden of disease. Equally, it may require greater openness in talking about sexual health and placing sexual health care within overall health and self care to reduce stigma and shame still associated with sex.

From a life course perspective, it is important to keep in mind that needs and activity can change over time. Increasingly, people in mid or later life are starting new relationships and engaging in sexual activity in a changed environment, without necessarily recognising their risk and vulnerability. A rise in STIs in older people has been observed as a result.

With regards to psychosexual support, this covers many different areas from erectile dysfunction, premature ejaculation, pain during sex, lack of sexual arousal to more complex psychosexual issues perhaps related to past or recent sexual trauma. There has been a sustained increase in demand for services for this highly specialised service in City and Hackney that underscores the importance of provision to support healthy and fulfilling SRH across the lifecourse, including recovery from trauma such as sexual assault and FGM.

Like many services, sexual assault services, known as the Havens, were significantly disrupted during COVID-19. The awareness of services provided as well as access arrangements need to be strengthened in order to ensure both immediate health needs following a sexual assault can be met as well as forensic evidence obtained.

2.3 Aims and outcomes for healthy and fulfilling sexual relationships

The aims and outcomes section will present a number of desired outcomes with underlying aims that contribute towards that outcome. The intended outcomes and aims will be further broken down into outputs and activities in the annual action plan.

Outcome 1: Young people in City and Hackney have equitable access to good quality, comprehensive and inclusive relationship and sex education in schools and settings of alternative provision.

This requires information on current coverage and uptake in schools, and across the local authorities, as well as an assessment of the quality and relevance of the PSHE provided.

Aims

1. All primary and secondary schools provide relationship and sex education that complies with the statutory guidance and meets the needs of children and young people

2. Schools are supported to develop policies, content and resources that provide children and young people with knowledge that enables them to make informed decisions about their wellbeing, health and relationships whilst building their self-efficacy.
3. Promote and increase uptake of support to all schools through local commissioned services such as Young Hackney's free [Personal Social and Health Education] in secondary schools and settings of alternative provision,
4. Engage with schools and other educational institutions where RSE is not deemed appropriate for religious or cultural reasons to support them in delivering the basic requirements of PSHE and RSE as defined by national statutory guidance
5. Develop collaboration between providers of SRH-related outreach where direct delivery is relevant, such as places of alternative provision, SEND, Pupil Referral Units and working with youth justice and social care order to enhance reach and coverage
6. Develop a C&H engagement programme for parents/ guardians to increase awareness and confidence in SRE provision within schools to help reduce withdrawal of children from RSE provision.

Outcome 2: Young people have access to appropriate and young people friendly sexual health services

Aims

1. HSHS clinics are welcoming to young people and offer booked and walk up appointments with evening/weekend clinics.
2. Sexual health clinics offer young people discussion and support around consent, and choosing positive and pleasurable sexual experiences
3. Dedicated young people's services such as youth hubs and/or the 'super youth hub' offer safe spaces for SRH advice, access to condoms and sexual health inreach clinics
4. Pharmacies provide a low barrier range of SRH services including condoms, EHC, chlamydia screening/treatment and gonorrhoea screening, as well as routine oral contraception and are trained to make safeguarding referrals where appropriate
5. Service quality and access information is regularly reported including mystery shopping exercises or surveys, to inform our knowledge about inequalities in access, experience and outcomes
6. Sexual assault and sexual abuse services are welcoming to young people with access arrangements well communicated.

Outcome 3: People have access to clear and appropriate information and resources to help them make informed choices about their sexual and reproductive health.

Aims

1. A central online resource for SRH will be developed to provide information, advice and signposting to all relevant SRH services in C&H with booking links where possible (through building on/expanding an existing online resource or portal). Explore potential for London wide or NEL wide approachPeople know where to access sexual and reproductive health services.

2. Development of information materials and/or SRH health promotion campaigns is tailored to and developed through co production with the groups they are aimed at (in particular when at risk of poorer SRH outcomes)Prevention activities are culturally sensitive, appropriately targeted and tailored to those at greatest risk of poor SRH outcomes

3. Key materials and resources will be made available in appropriate non-digital formats to serve those who do not or cannot use online services

4. Provision is made for engagement on sexual and reproductive health with residences and hostels that accommodate care leavers and other young people in supported accommodation circumstances including asylum seeker/refugees in temporary accommodation

Outcome 4: Increased professional knowledge, skills and collaboration in sexual health and wellbeing among people working in YP services and in wider sexual health services and along referral pathways

Aims

1. Ongoing training/CPD of youth workers and health professionals using MECC and safeguarding training to ensure early identification of harmful sexual relationships/coercion and appropriate referral
2. Expand the making every contact count training programme to include sexual and reproductive health with supporting information on services included in the directory of services
3. Co-working between sexual health and contextual safeguarding teams to understand and address specific local risks of harm from Child Sexual Exploitation (CSE) in context of places, groups and gangs
4. Agree a NEL wide approach to improving identification, immediate harm reduction (e.g. needle exchange, naloxone) and referral pathways between sexual health and substance misuse services

Outcome 5: Psychosexual support and high-risk sex counselling services are an integral and adequately resourced part of sexual health provision

Aim

1. HSHS offers a regular psycho-sexual support clinic and is able to manage referrals with funding agreed between the LA and mental health commissioners (ICB)

2. Adequate pathways and services are in place for more complex cases and people who need longer term support. e.g. linkage with mental health services, substance misuse services, etc.

3. People in unhealthy or risky sexual relationships and those who have experienced domestic violence, sexual exploitation, trauma, sexual assault, abuse and rape are appropriately referred and/or supported

4. Early and targeted support is available for those engaging in higher-risk sexual behaviours, such as chemsex, and people who are experiencing chemsex related health issues are supported to access services to address needs

Outcome 6: Sexual assault services pathways are robust, well communicated with easy to access services.

Aim

1. Access to and awareness of the Havens should be strengthened to ensure that this safe space service can provide crisis care, medical and forensic examinations, emergency contraception and testing for sexually transmitted infections.
2. The services provided by the Havens for children and adults who have experienced sexual assault, rape or abuse are easy to access, well known and trusted.

3 - Good reproductive health across the lifecourse

3.1 Importance to Public Health

Reproductive health implies that people (...) have the capability to reproduce and the freedom to decide if, when and how often to do so. - WHO

Reproductive health is important to the public's health because if and when and how often a pregnancy occurs should be a matter of choice, in line with the WHO definition. Having access to methods and information on not only preventing pregnancy but also on preconception health, conception and assisted conception is important.

Unplanned pregnancies can negatively affect someone's life chances and outcomes, for instance in education or job opportunities. The development of the unplanned pregnancy metric currently being piloted within maternity services is welcomed and has the potential to bring greater focus to how we can support families across the pregnancy and pre-pregnancy lifecourse to increase planned parenthood.

The local authority is responsible for the commissioning of many elements of contraception, with a particular focus on the provision of long acting reversible contraception (LARC) and emergency hormonal contraception (EHC), to support people with prevention of unintended pregnancies during the reproductive stages of their lives. The commissioning and provision of oral contraception is undertaken by the NHS and approaches to widen access across primary care e.g. through the NHS Pharmacy Contraception Service are welcome and provide an opportunity to increase access.

The provision of contraception is widely recognised as a highly cost-effective public health intervention, which reduces the number of unplanned pregnancies that bear high financial costs to individuals, the health service, and to the state. For every £1 invested in LARC, £13.42 is saved in averted outcomes. For every £1 invested in contraception generally, £11.09 is saved in averted costs (Public Health England, 2018).[6]

In order to offer contraceptive choice, the full spectrum of options needs to be available: LARC (including intrauterine devices and systems, and implants), injectables, user-dependent oral and barrier method contraception, the 'natural' or rhythm method, EHC and termination of pregnancy (TOP) services. If the uptake of this looks like an inverted pyramid, it suggests contraceptive education and choice is working: the more people use reliable and long acting contraception methods, the fewer people will need EHC or TOP. Educating and providing easy access to information about options, especially to young people, and making access to services as low-barrier as possible is key to laying a solid foundation for reproductive health and wellbeing across the lifecourse.

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6 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730292/contraception_return_on_investment_report.pdf

Low barrier provision of reproductive health services is important because there are inequalities in use of services and reproductive health outcomes, often linked to ethnicity and age. The Sexual Health Needs Assessment (2022) and the Women's Reproductive Health Survey (2022) provide a detailed overview of these and the strategy will not repeat those analyses but highlight some key trends in the next section.

3.2 Local need and inequalities

In terms of overall use of HSHS, black women are overrepresented in relation to their proportion of the population, while white women and Asian women are underrepresented.[7] Equally, taking population size into account, black populations recorded the highest use of EHC via pharmacies, while white and Asian populations recorded much lower EHC rates. Among survey respondents, 22% reported ever having had an abortion (ToP), out of which 36% of black Caribbean respondents reported this, versus 22% of white British and only 8% of South Asian respondents. In as much as EHC and TOP are essential parts of the overall reproductive offer, disproportional high uptake in any group indicates a potential barrier in knowledge of or access to reliable forms of contraception.

The survey also found that women who had a lower education attainment and who had ever had an abortion were almost nine years younger at the birth of their first child, compared with women who had a degree, or equivalent-level education, and who had never had an abortion. This underlines the importance of appropriate, high quality and inclusive sexual and reproductive health education in schools, sixth form colleges and settings of alternative provision to ensure young people have a good understanding of what reproductive health means, the options that are available and where and how they can be accessed.

The survey further found that respondents under 25 and over 45 were more likely to report heavy bleeding, which was a source of discomfort and distress to many. Disabled, unemployed and women with lower educational attainment were more likely to report heavy bleeding. In terms of ethnicity, black Caribbean (47%), black African (48%) and south Asian (48%) respondents were significantly more likely to report heavy bleeding than white (32%) respondents.

For almost 80% of women who accessed EHC through pharmacies in 2022/23, the reason for needing EHC was not using any form of contraception. This suggests more needs to be done around education and promotion of all forms of contraception and ensuring easy access, including for LARC.

For accessing contraception, the survey found that women aged 40 and under preferred to get LARC at a sexual health clinic, while women aged 40 and above preferred to access it at a GP practice. This was backed up by HSHS data that showed that the highest LARC appointment rates at HSHS were recorded among 20-24 year-olds. White women are more likely to opt for primary care while black women are more likely to use HSHS. The survey also found that Asian women were least likely to use LARC, though due to the sample size this was not statistically significant. Black African women were most likely to use LARC in the survey.

Attendance at HSHS by Primary Care Network (PCN) of residence correlates strongly with distance from HSHS clinics. This means people who live closer to the Homerton-provided clinics are more likely to use them. This should not disadvantage those living at greater distance, and makes it even more important that essential face-to-face reproductive services can be accessed at GPs, pharmacies and for example the newly created community gynaecology services, commissioned by the NHS, more commonly known as the Women's Health Hubs[8]. In addition, community pharmacies have been contracted at national level to provide oral contraception. Even if this may take some time to take

[7] 2022 HSHS Equity Audit, Dr Sarah Creighton

[8] Community Gynaecology service: https://mail.google.com/mail/u/0/?ogbl#search/elsdal/GTvVlcRzDfnTJDsfzQxRpvNvcZsGwjfsFWZlFQmBFKPgxlWDdWWTbZBXWHhnPQBxRWDLRgvKDnQKg?projector=1&messagePartId=0.1

shape, it would create a direct opportunity for e.g. women who access EHC to be engaged about and start on routine oral contraception.

3.2.1 Long Acting Reversible Contraception (LARC)

Ensuring increased uptake of LARC (excluding injectable contraception) is a key element of this strategy, especially as uptake of LARC is low compared to the England average, though above the London average. LARC is important because it is long-acting and not user dependent, which means it works continuously and the user does not have to remember to take it.

LARC fittings dropped significantly as a result of the COVID-19 pandemic but have since seen a strong recovery, though not back to pre-COVID levels. In 2021, the overall prescribing rate for LARC in Hackney was 37.5 per 1,000 women aged 15 to 44 years and for the City of London 20.8 per 1000 women aged 15-44. For comparison, the England rate for 2021 was 41.8, respectively. Reported performance figures from 2022 suggest the upward trajectory is not being sustained with numbers both at HSHS and GPs plateauing or dropping.

In terms of delivery, traditionally, HSHS provide the majority of the LARC fittings, around 65% compared to 35% by GPs. This is different from the national picture, where delivery via GPs is much more common.

Interestingly, the 2022 WRH survey found that LARC was popular and used by 24% of those reporting a method of contraception, though it needs to be taken into account that higher educated white women were overrepresented in the survey. It also reported the highest satisfaction levels, with 83% being satisfied to very satisfied.The survey further reported a match between the preferred and actual place of supply, with those wanting to get it at a SH clinic getting it there, and similarly for GPs. This is backed up by a finding from the Needs Assessment that IMD (Index of Multiple Deprivation) of residence has little impact on the route of prescription for LARC.

3.2.2 Fertility and assisted conception services

Approximately one in six heterosexual couples will struggle to conceive and this often has a significant impact on an individual and/or couple's health and wellbeing. However, this number does not include same-sex couples, single or trans people who must also be afforded the right to try for a family. Although often seen as a women's health issue, the reality is that both men and women are just as likely to face fertility problems. Data from the fertility regulator, the Human Fertilisation and Embryology Authority, shows that male infertility is the most common reason for a couple to start treatment.

A wide range of treatment and support for infertility is commissioned and provided by the NHS with fertility services provided at both the Homerton and St Barts Hospital. Eligibility and access arrangements for different treatments is dependent on specific criteria with referral following an initial consultation with a GP or a Consultant. Local NHS fertility services provide a mix of free and self funded treatments with private providers also offering services throughout London. The variability in eligibility and access arrangements to fertility treatments across different areas continues to create inequalities in access. The local implementation of the recommendations in the national Women's Health strategy to remove additional financial barriers to In-Vitro Fertilisation for female same sex couples would remove an additional access barrier.

An annual fertility awareness week will be undertaken across City and Hackney to increase information and options available for those individuals and couples who wish to conceive.

3.3 Aims and outcomes for reproductive health across the life course

Outcome 1: Reproductive health services consider the life course from adolescence to the post-menopausal stage

Aims:

1. Ensure health literacy includes sexual and reproductive health
2. Improve awareness of and access to the full range of contraception including LARC, with a focus on younger women and groups that see relatively high uptake of EHC and TOP and/or low uptake of LARC.
3. Ensure life course access to abortion care locally and in a timely (early) manner, particularly among under-18s, and those aged 40-55.
4. Explore ways to engage and create more support in different settings, e.g. primary care, businesses and workplaces, for women experiencing the (peri)menopause.
5. Identify and share support pathways for girls and women experiencing heavy bleeding or painful periods to improve their access to and quality of care.
6. Alleviate period poverty
7. Ensure clear signposting, referral and reduce barriers to access assisted conception and fertility services
8. Provide information and support on prenatal health, birth spacing and maternal/parental health before, during, and after birth.
9. Enable easy access to contraception throughout the maternity pathway

Outcome 2: Reproductive health services are cognisant of inequalities in service provision and uptake in different ethnic population groups and work to ensure anyone can access services in their preferred setting and equally, to address those inequalities

Aims:

1. Improve understanding of and address barriers to contraception among groups where EHC use is disproportionately high (such as young people, and among black ethnic groups)
2. Assess why mixed (especially white and black Caribbean) and black residents have a disproportionately high uptake of abortion services and work to bridge the gap in reproductive knowledge and uptake of especially LARC to prevent repeat abortions, and explore the link with socio-economic deprivation/poverty
3. Understand why Asian - particularly south Asian - and “other” ethnicities record a lower-than-average LARC appointment rate than other ethnic groups, and ways in which this can be made more equal
4. Ensure that support for reproductive health is accessible to all communities, such as the Charedi Orthodox Jewish community, the Traveller community or the Turkish and Kurdish community, through tailored and religiously/culturally sensitive engagement.

Outcome 3: The role of all services in providing comprehensive reproductive care and services to residents is clear, promoted and optimised while pathways into and out of non-LA-commissioned services are optimised and integrated, including: fertility services, period poverty; perimenopause/ menopause; community gynaecology; termination of pregnancy; maternity and post-partum care and complications; cervical screening; endometriosis, genital dermatology, incontinence, heavy menstrual bleeding, Female Genital Mutilation (FGM), and sexual assault services

Aims:

1. Ensure visibility and high quality delivery of sexual health services in community pharmacies contracted to provide sexual health services (including access to condoms, oral contraception, EHC, STI screening)
2. Ensure that women who need LARC are able to access this in primary care, including inter-practice LARC hubs, Women's Health Hub, sexual health clinic or maternity – regardless of whether this is for contraception, management of perimenopause or heavy menstrual bleeding.
3. Increase (timely) access to the full range of contraception including in maternity settings (post-delivery) and reduce the need for abortions and repeat abortions (especially among under-25s), as well as unplanned/unintended pregnancies
4. Ensure Women's Health Hubs and primary care collaborate with sexual health to offer seamless pathways of care in a way that is mutually supportive
5. Health care professionals and commissioned services have easy to use guidance on pathways and referral processes
6. Collaborative commissioning

Outcome 4: Inequalities in access and uptake of services have decreased over time and are not a reflection of socio-economic background

Aims:

1. Regularly re-run the women's reproductive health survey (without an upper age limit) to track change/progress over time and seek to increase representative sample of the population
2. Increase access to primary care
3. Increase equity of access
4. Monitor progress and increase activity where issues are identified

Outcome 5: Assisted fertility services review and reduce barriers to access ('fertility friendly City & Hackney').

Aims:

1. Residents are aware of support services available and how to access
2. Strengthen community engagement with local fertility services
3. Reduce barriers to accessing fertility services

4 - STI prevention and treatment: access to high quality and innovative testing and treatment services

4.1 Importance to Public Health

Sexually transmitted infections (STIs) are predominantly spread through sexual contact, including vaginal, anal and oral sex. They can cause serious health issues beyond the immediate impact of the infection itself, especially as some STIs may not be symptomatic but can still have serious long term impacts, e.g. causing infertility. STI testing is important for early detection: reducing the spread and

long-term consequences of STIs. The most commonly diagnosed STIs in the UK are chlamydia and gonorrhoea and this is also the case in Hackney and the City of London.

4.2 Local need and inequalities [9]

Hackney and the City of London have very high rates of new STI infections; higher than the London and England average. For all newly diagnosed STIs in London in 2021, the City of London and Hackney recorded the third and fourth highest rate with 2,130 and 1,998 per 100,000, respectively[10].

Overall, the high incidence of STIs remains a challenge that is associated to having both a young population, as young adults are demographically the age group with highest infection rates, and a large proportion of the population that are gay, bisexual or men who have sex with men (GBMSM) who also demographically tend to have higher rates of infection.[11]

In terms of chlamydia, City and Hackney have both high testing rates and high positivity, which is strongly suggestive of high prevalence rates and reinfections. By increasing the number of young people adopting safer sexual behaviours, increased partner notification and treatment, and ensuring information and services are easily accessible we aim to reduce the prevalence of disease not just in City and Hackney but across North East London.

To practically prevent STIs, correct and consistent use of condoms is key, especially when frequently changing partners or in casual relationships.[12] Uptake of free condoms in under-25s condom distribution schemes is proportionally higher among black ethnic groups with underrepresentation from young Asian and white people. This implies either higher need or good awareness about free condom schemes and where to access them among young black adults. Conversely, white and Asian individuals may not know about or make use of these schemes, or source their condoms elsewhere.

Pharmacies play a key role in condom uptake, as 50% of under-25 source their free condoms here. This underscores the important low-barrier access pharmacies offer, and the potential to strengthen this pathway across the sexual and reproductive health spectrum.

4.2.1 Testing

Residents are currently testing for STIs in different places, depending on age, ethnicity, gender and/or sexual orientation. We need to continue to provide and expand testing access and uptake across multiple pathways alongside awareness campaigns to ensure people are testing at intervals commensurate with their sexual behaviours[13].

We need to better understand if the current testing rates amongst different communities/ populations reflects need or if there are barriers to access that need addressing e.g. through targeted promotions or outreach. The use of regular equity audits and development of annual access uptake plans by local

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[9] Data sources for this chapter are SPLASH, Fingertips, UKHSA Spotlight on sexually transmitted infections in London: 2021 data

[10] This compared to 1,127 per 100,000 in London and 551 per 100,000 in England.

[11] According to the 2020 GP patient survey, 5% of people in Hackney identified as gay or lesbian, 2% as bisexual, 2% as other and a further 10% preferred not to say. This is well above the England (2018) estimates of 1.4% and 0.9% for gay/lesbian and bisexual, respectively. In the reproductive health survey, for example, 54% of respondents identified themselves as exclusively attracted to males, which implies much greater fluidity in sexual attraction than national averages.

[12] https://www.nice.org.uk/guidance/ng68/resources/sexually-transmitted-infections-condom-distribution-schemes-pdf-1837580480197

[13] https://www.nice.org.uk/guidance/ng221

services alongside analysis of infection and reinfection data from UKHSA is key to ensuring services meet local needs.

The online home STI sampling service offered by Sexual Health London (SHL)[14] has increased in popularity especially during Covid-19 and use continues to be an important component of local testing with potential for further expansion and integration into local services.

4.2.2 Infections

Positivity rates and positivity by STI type have large variations between age groups, by gender, sexual orientation and by ethnicity.

Chlamydia is most prevalent among young people under 20, followed by gonorrhoea. People from black ethnic groups recorded the highest positivity rates for chlamydia and gonorrhoea via SHL, and the joint highest positivity rates for HIV with mixed ethnicities.

Gonorrhoea infections have been showing an upward trend since 2017, save a dip in testing and positivity as a result of the Covid-19 pandemic, and are most commonly diagnosed in the 20-24 and 25-35 year old age groups. Cases of gonorrhoea were almost exclusively seen in men, and men who attended HSHS were twice as likely to have an STI than women.

Data from SHL makes it possible to compare positivity rates across listed gender, although the actual numbers in the gender categories outside of male and female are small. Between 2018 and 2021, the highest positivity rate for chlamydia was recorded among trans people, at 8.3%, and the highest positivity rate for gonorrhoea and syphilis was recorded among trans men, at 7.5% and 9.5% (Preventx).

Where patterns vary by STI type, different approaches are needed to increase equity for each individual STI. This could be achieved by increasing the availability of certain tests through certain testing channels, as different groups access tests through different means.

4.2.3 Reinfection

STI reinfection rates in City and Hackney are well above the national average[15]. Young people are more likely to become re-infected with STIs, contributing to infection persistence and health service workload. These high re-infection rates in young people indicate that further work needs to be undertaken on ensuring effective partner notification and treatment.

Initial appointments present an opportunity for providing good SRH advice and (free) provision of condoms. Reinfection could suggest there is no change in sexual behaviour after the first infection, and/or that there is insufficient knowledge or awareness about healthy sexual behaviours, not enough access to free condoms, and/or lack of knowledge about where to source them. Reinfection may also relate to misconceptions about risk, a lack of agency about safe sex choices, or other behavioural practices that warrant further investigation and direct engagement with young people.

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[14] https://www.shl.uk/

[15] For example, gonorrhoea reinfection within 12 months in Hackey was an estimated 7.7% of women and 16.9% of men, versus an estimated 4.1% of women and 11.2% nationally (2016-2020).In the City of London among 15-19 year olds, an estimated 23.5% of women and 22.4% of men presenting with a new STI at a sexual health clinic (2015-2019) became re-infected with a new STI within 12 months. That is more than one in five, though likely to be based on small numbers due to low population figures.

4.2.4 Treatment and partner notification (PN)

The majority of STI-related treatment accessed by residents of the City of London and Hackney is provided by HSHS, and the remainder by specialist centres in other London NHS services, GPs or pharmacies. Pharmacies can seek accreditation to provide chlamydia treatment to people with a positive diagnosis and their partners. This accreditation process was disrupted by Covid-19 and there has been a delay in reinstating it. It is anticipated that chlamydia screening and treatment via pharmacies will increase in 2023-24.

Partner notification is a key element of STI prevention: by promptly tracing and contacting partners of a positive index case, they can be invited to test and treated if required, preventing any further onward transmission. Where there is no positive test result, it still offers an opportunity to engage people regarding STI prevention and healthy sexual choices. We need to better understand how to increase effective partner notification/ treatment across all services where STIs are diagnosed and in doing so seek to reduce reinfection rates as well as the overall prevalence of infections.

4.3 Aims and outcomes for STI prevention and treatment

City and Hackney have a considerable task ahead to reduce the rate of new infections and reinfections, especially in communities with high burden of disease such as young people and GBMSM, combined with the challenge of increasing distribution and use of condoms. With a large young population, 31% of the Hackney population is under 25[16], having good quality and inclusive sex and relationship education, appropriate and available information and accessible resources, and clear pathways for services are of key importance. The services need to be available, accessible, non-judgemental and welcoming.

The traditionally high uptake of condoms at pharmacies shows this is a popular route for young people, while the increase of SHL tests in young people can encourage a good habit of regular testing. Having multiple avenues to access testing and treatment is key.

The fact that the burden of STIs, e.g. chlamydia is disproportionately affecting black communities whilst gonorrhoea is largely prevalent among GBMSM shows there is still much ground to cover in making sure different groups can access services when and where they prefer to get it. It also reinforces the importance of engaging with those most impacted on prevention and treatment.

4.3.1 Young people

*Outcome 1: Young people have access to accurate, inclusive and appropriate **information and education** on sexual health*

Aims:

1. All primary and secondary schools provide relationship and sex education that complies with the statutory guidance and meets the needs of children and young people
2. Dedicated young people's services such as youth hubs and the 'super youth hub' offer safe spaces for sexual health information and advice and inreach of clinical services
3. Young people are engaged in designing or improving pathways, services, promotional materials and/or campaigns to ensure relevance and suitability (coproduction)
4. Provision is made for engagement on sexual health with residences and hostels that accommodate care leavers, youth justice and other young people in supported accommodation circumstances

[16] 2021 ONS Census https://hackney.gov.uk/population

*Outcome 2: Young people know where to source **free condoms and STI tests** and have no barriers to access and uptake*

Aims:

1. The Young Hackney free condom distribution scheme is embedded and promoted within wide range of outlets and recognised by young people
2. Pharmacies provide a range of sexual and reproductive health services including condoms, EHC and STI screening (chlamydia and gonorrhoea) and treatment (chlamydia) and are trained to make safeguarding referrals where appropriate
3. SHL is promoted, especially among groups that have shown lower uptake of their testing offer
4. Young people are engaged in designing or improving pathways, services, promotional materials and/or campaigns to ensure relevance and suitability (coproduction)

*Outcome 3: Young people have access to **appropriate and young people friendly sexual health treatment services***

Aims:

1. HSHS clinics are welcoming to young people and offer no appointment, face-to-face walk-in services
2. Chlamydia treatment can be accessed at selected community pharmacies and SHL

3. Dedicated young people's services such as youth hubs and/or the 'super youth hub' offer safe spaces for sexual health advice and treatment through inreach sexual health clinics

4.3.2 General population

Outcome 4: STI testing is available through multiple pathways so people with different preferences can access them on their own terms and with no barriers

Aims:

1. SHL testing is promoted as primary source of STI testing (asymptomatic, uncomplicated, regular testing, including for PrEP)
2. Access to in-person STI testing is improved for those who do not use online services, including in pharmacies and GPs. Face to face appointments/walk in testing services at sexual health clinics are available for under 16s, those who prefer this (e.g. due to difficulty to self test), those who can not access online services, those who are symptomatic, or who have other complexities.
3. Smart STI testing kits (for collection) are available at (selected) community pharmacies with high uptake of sexual health services

Outcome 5: Better understanding of drivers of risky sexual behaviour in different population groups

1. Reduction in STI rates in specific populations e.g. GBMSM, black communities
2. Explore ways to reduce STI rates and encourage uptake of STI testing among heterosexual males, especially those from ethnic groups that have lower testing uptake

Outcome 6: Functioning and efficient partner notification systems are in place within all testing pathways

Partner notification is of key importance to ensure the chain of transmission is stopped. It requires a clear pathway and process, and good communication with the presenting patient.

Aims:

1. Increase effectiveness and outcomes of partner notification

Outcome 7: STI reinfection rates in young people and adults are reduced.

Aims:

1. Improve prevention outcomes from partner notification
2. Reduce reinfection rates
3. Active engagement with communities with highest rates of STIs
4. Respond to changing sexual behaviours amongst residents

Outcome 8: Vaccination coverage has improved

1. Residents are protected from vaccine preventable diseases

5 - Living well with HIV and zero new HIV infections

5.1 Importance to Public Health

Great strides have been made in both prevention and treatment of HIV, resulting in fewer new diagnoses every year and people with HIV living longer and healthier lives. However, in order to get to zero HIV, meaning, zero *new* HIV infections, by 2030 it is crucial that testing continues at scale. This includes opt-out testing in hospital and primary settings to find new cases, especially late diagnosis cases where people are more likely to have worse health outcomes.

Continuing a strong HIV response through prevention, testing, treatment and care, including re-engaging those who have been lost to care is an essential part of the overall sexual and reproductive health work as HIV impacts on people's sexual and reproductive lives, is linked to poorer socio-economic outcomes, and is associated with other infections such as Tuberculosis and viral Hepatitis. Data on people accessing psychosexual counselling and care further suggests that newly diagnosed people, in particular GBMSM, are at higher risk of engaging in problematic Chemsex use, highlighting the need for seamless pathways into care, support and counselling, after a new diagnosis is made.

5.2 Local need and inequalities

Both Hackney and the City of London are considered areas of extremely high prevalence of HIV, with 6.4 and 9.8 (2021 data) per 1,000 people aged 15-59, respectively, with diagnosed HIV. This compares to around 2.3 per 1000 in England.

In numbers, 1,560 residents were known to be living with diagnosed HIV in Hackney and the City of London in 2021, while 1,519 (97%) were accessing antiretroviral treatment. In the London region, the City of London is ranked third highest in terms of people living with HIV, relative to population size, and Hackney is placed 12th among 30 local authorities.

London is a signatory to the Fast-Track Cities initiative, aiming to end the HIV epidemic globally by 2030, through the UNAIDS targets of 95-95-95: 95% of people living with HIV know their HIV status; 95% of people who know their HIV-positive status access treatment; and 95% of people on treatment have suppressed viral loads. In Hackney and City, and London as a whole, these targets have already been met overall, but are falling below in certain vulnerable groups of people with HIV. Stigma against

people living with HIV both within mainstream health/ social care services and in wider society continues to be a barrier to effective services and must be addressed.[17]

5.2.1 Prevention

The options for HIV prevention have much improved beyond condom use, which remains the key barrier method to prevent HIV infection, as well as many other STIs.

Testing is an important prevention strategy: through diagnosing cases early, people who test positive can be connected to treatment and care, which will prevent onward transmission. Once people receive treatment and maintain adherence, most will become undetectable, which means they can no longer transmit HIV, which represents the Undetectable=Untransmissable arm of prevention. Lastly, PrEP (pre-exposure prophylaxis) is a combination of antiretroviral drugs that can prevent HIV from infecting someone, and is taken by someone who is HIV-negative but could potentially be at high risk of contracting HIV.

The testing offer and uptake for HIV in City and Hackney has been traditionally high and above England averages, although there has been a decrease in recent years which may have been due to the COVID-19 pandemic with reduced access to services. HIV testing is especially low among women, and late diagnoses are most frequently made in women and heterosexual men. This suggests that prevention and testing strategies tailored towards GBMSM need to be complimented by other work to serve and include different audiences.

This adjustment also applies to PrEP. Currently, PrEP is available and free within the NHS but levels of awareness and uptake of PrEP has been greatest amongst white ethnicities and residents who identify as gay or bisexual. Access to and uptake of PrEP needs to be improved amongst black and mixed ethnic backgrounds so that the protective benefits are more widely felt across local communities.

Opt-out testing for blood borne viruses (BBV) including HIV was introduced in A&E departments across London in April 2022. This built on work piloted in East London in 2014 and has been very successful in diagnosing HIV, including people that had been lost to care. This is a crucial element of the overall effort to get to zero new HIV infections by 2030 and work needs to be continued to increase those people diagnosed with HIV and/or Hepatitis B and C who are successfully connected to care.

Equally, opt-out testing for HIV for new registrants at GPs needs to be re-encouraged, as this had good uptake in previous years. Including HIV (and potentially other BBVs) opt-out testing in the NHS Health Check would also add significantly to going the last mile in identifying positive cases without adding to stigma and singling out people or groups that are perceived to be at higher risk of contracting HIV.

5.2.2 Diagnosis, treatment and virological suppression

Although most diagnoses of HIV are made in white men who have sex with men, black African communities face the second highest level of HIV burden in the UK. In Hackney in 2021, a third of new infections were in white people, a third in black African people and a third in black Caribbean, Asian and other/people of mixed heritage combined.

In terms of treatment, City and Hackney perform well in getting people on treatment promptly, with 100% and 84.8%, respectively, of residents diagnosed between 2019 and 2021 being prescribed

[17] https://fasttrackcities.london/our-work/ending-stigma/

Antiretroviral treatment (ART) within 91 days of diagnosis.[18] However, there are differences in viral suppression by sexual orientation and ethnicity, with 97% of white people and those who identify as GBMSM meeting the criteria for virological success, compared to 92% for heterosexual people and 93% for black African people, for example.

This illustrates that overall, white gay men who have sex with men have better outcomes once diagnosed with HIV and on treatment. This is a clear inequality in outcomes that needs to be addressed to bring all other people living with HIV to the same high levels of viral suppression.

5.3 Aims and outcomes for HIV prevention, access to care and treatment

Outcome 1: People living with HIV no longer experience stigma and discrimination

Aims:

1. City and Hackney sign up to the HIV confident charter and implement training throughout statutory and voluntary organisations to end stigma and discrimination
2. Encourage sign up to the HIV ambassadors programme to ensure the voice of people living with HIV is central to the provision of services across City and Hackney

Outcome 2: All diagnosed people with HIV receive treatment and care to achieve best possible health outcomes and viral suppression.

Aims:

1. Support people who are living with HIV to know their status and access appropriate care, including retention within care services and ongoing adherence to antiretroviral treatment (ART), to improve outcomes.
2. Facilitate more joined-up working on HIV between primary and secondary care services locally especially in relation to ageing related comorbidities
3. Ensure immediate connection to holistic care pathways (VCS organisations) after a positive diagnosis (including as a result of the opt-out testing initiatives), especially for people with added vulnerabilities and/or poor mental health and history of trauma
4. Peer support and navigators are embedded into local services to ensure continued connection to care and support for people lost to follow up
5. Increase equity in terms of successfully achieving virological suppression, e.g. among global majority and heterosexual residents, and individuals with complex needs and higher levels of vulnerability
6. Regularly update HIV needs assessment and ensure focus on equity of outcomes

Outcome 3: All communities who would benefit from HIV prevention interventions including condoms and PrEP are easily able to access services.

Aims:

1. Increase awareness and uptake of PrEP among all eligible groups, particularly those with low current take-up.
2. Reduce barriers to access to condoms for young people and other communities
3. Have HIV rapid tests and pilot rapid start PrEP in community settings including community pharmacies and substance misuse services

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[18] In comparison to 81% in London and 83.5% in England (SPLASH).

4. Support people who are living with HIV to know their status and access appropriate care, including retention within care services and ongoing adherence to antiretroviral treatment (ART), to improve outcomes.
5. Increase access amongst MSM communities, particularly where individuals are younger and/or from a black, Asian, or ethnic minority background or new arrivals to C&H to NHS PrEP and uptake of free condoms
6. Undertake tailored and appropriate engagement with non-MSM communities at higher risk of acquiring HIV to promote NHS PrEP P
7. Ensure awareness of and access to/delivery of PEPSE (Post-exposure prophylaxis after sexual exposure to HIV) and linking to PrEP pathway

Outcome 4: All people with HIV know their status and are linked in to care and treatment.

Aims:

1. Reduce late diagnosis of HIV
2. Increase uptake of HIV testing in populations where there is low testing and high rates of late diagnosis
3. Improve systematic HIV screening of newly-registered patients to GP practices in the City and Hackney in order to diagnose cases as early as possible
4. Ensure effective connection to care and treatment

Outcome 5: The Fast-Track Cities London goal are achieved locally by 2030

Aims:

1. Zero new HIV infections
2. New migrants living with HIV are supported to access HIV treatment and care without stigma or discrimination
3. No people living with HIV die from a disease that could have been prevented by receiving HIV related treatment and care
4. End HIV related stigma and discrimination

6 - Inclusion communities and those with complex needs

6.1 Importance to Public Health

Poorer sexual and reproductive health is often concentrated in specific communities or subsets thereof, and some people have greater difficulty in achieving good sexual and reproductive health outcomes, and require additional or tailored support. This can be for very diverse reasons. It is essential that those with more complex needs or greater vulnerabilities are not stigmatised but that their additional needs are recognised and met within the overall service provision. To do so, we do need to be explicit about their needs and vulnerabilities.

From the sexual health needs assessment it is clear that for instance some trans people have higher STI infection rates and lower testing uptake. People who are homeless or sleeping rough may lead more chaotic and itinerant lives that are not conducive to healthy sexual choices. People who inject drugs may be at higher risk of contracting blood borne viruses including HIV and Hepatitis.

Women who have had children taken into care may need more intensive and long-term support with their reproductive health. People who use drugs during sex may come to a point where they can no longer safely manage their sexual health and mental wellbeing. There are consistently higher rates of STI infections in gay and bisexual men than in the general population.

Young people who have been in the care system are known to have poorer health outcomes, and this also translates in their sexual health with earlier sexual debut and lower use of condoms or contraception. People with learning disabilities may find it difficult to find resources and information in Easy Read or other appropriate formats. Migrants and asylum seekers may experience language barriers or worry about accessing NHS services for fear of information about their status being shared with other authorities.

It is also important to keep in mind that vulnerability depends on context. Heterosexual males are not the first group we think of when discussing vulnerability. Yet heterosexual men have traditionally low health seeking behaviour, and this is no different in sexual health. Low health seeking behaviour of heterosexual males can make them vulnerable to STI infection, as they are less likely to test and may not consider themselves at risk. Finding ways to increase their STI testing uptake, for example, could prevent onward transmission to women and lead to an overall decrease in new STIs.

As a local partnership and with two health and wellbeing boards, it is our responsibility to ensure everyone has access to the information, services and support they need, and to minimise and mitigate harm and adverse outcomes. Equally, as certain interventions or services are often not solely within the remit of one organisation, it is important to have clear pathways and linkages to other services, whether within the local authority, the NHS, voluntary sector or the larger integrated care partnership (ICP).

6.2 Local need and inequalities

Many of the groups included in this section of the strategy are relatively small in size and limited information is known about their specific needs, yet in their representation at services it becomes clear there is unmet need. This section is not meant to be exclusive of other potentially vulnerable groups, but should be seen as an effort to ensure greater inclusivity in our consideration of the SRH needs of all of our local residents and communities.

As indicated, a key challenge is that we do not always have the best data and information available for some of these groups, and better or more appropriate forms of data collection are needed to address needs. For some groups, the 2021 ONS Census provided much more detailed insight into population numbers, in particular regarding sexual orientation. This can help with planning service models and delivery.

6.2.1 LGBTQI+

Both Hackney and the City of London have a proportionally large LGBTQ+ population. The 2021 ONS Census found that in both areas around 80% of the population identified as heterosexual[19], which was the lowest nationally, while for the City, 7.6% identified as gay -the highest percentage nationally-, and 2.3% as bisexual. For Hackney 4.1% identified as gay and 2.8% as bisexual, and 0.24% as queer, which was the second highest percentage nationally. This in effect means that over 17,000 residents

[19] For Hackney, 12.6% did not answer the question about sexual orientation, for City of London, 10.4% did not answer the question.

in City and Hackney do not identify as heterosexual and may have different needs in terms of their sexual and reproductive health

Men who have sex with men (MSM), for example, have greater engagement with sexual health services for STI testing compared with heterosexual residents and rates of STIs are known to be higher among MSM.

Yet need is not only expressed or measured through STI infection rates. Feedback in the consultation for this strategy found mixed experiences for people in accessing services, with some feeling judged, or uncomfortable, due to their sexual orientation or gender presentation. As such, it is appropriate to ensure all health provision, especially sexual health services, are welcoming and accommodating to people of all sexual orientations and gender identities.

For trans persons, SHL data (2018-2020) reports the highest positivity rates for chlamydia among trans people, at 8.3%, and highest positivity rates for gonorrhoea and syphilis among trans men, at 7.5% and 9.5%, although it needs to be kept in mind that actual numbers were low, which can skew results. Overall, SHL data suggests that unmet need for STI testing is largely concentrated in males and trans people. Also, while trans people living with HIV experience similar levels of HIV-related care and viral suppression as people living with HIV in the general population, they may have higher or more complex health needs overall. This suggests there could be a need for greater consideration of transgender specific needs within SRH services.

6.2.2 Chemsex and substance users

Chemsex, sexualised drug use, is strongly associated with increased prevalence of STIs and HIV, problematic drug and alcohol use, and poorer mental health outcomes. It is most common among some GBMSM. Patients referred into the chemsex/high-risk sex pathway are likely to have higher and more complex levels of unmet need than the general population. In many cases these needs have been amplified by the COVID-19 pandemic.

Of referrals made to the chemsex service between April 2020 and March 2021, higher referral rates were seen among people living with HIV (PLHIV), and people from ethnic minority groups, compared with the general population. 99% of referrals were among cisgender populations, despite chemsex being evidenced to affect trans individuals more.

Among those who have reported having used drugs on a recreational basis within the past three months, and who have accessed HSHS, a much larger proportion of activity was for Hepatitis, PrEP, and HPV, and a lower proportion was for HIV and chlamydia, compared to other service users.

Among GBMSM, a recent diagnosis with HIV can increase the likelihood of risky engagement with chemsex, which is why immediate linkage with care and holistic support after a positive HIV diagnosis is important.

The number of referrals for individuals engaging in chemsex made to HSHS decreased after 2019/20 due to instability in provision and Covid-19, rather than lack of need, but averaged close to 100 people per year per service level (peer mentor support and psychological counselling). Based on the size of the local MSM population and the estimated use of Chemsex within that population (approximately 10%), it can be projected that annually, around 700 MSM in City and Hackneyper might engage in chemsex use, of which a proportion would require support if they are no longer able to do so safely, and/or it compromises their mental and sexual health. It also needs to be considered that chemsex use and users are not static; there is movement within and between NEL boroughs and collaboration

Using alcohol or other substances at levels harmful to health is often associated with increased risk of poorer sexual and reproductive health. For the wider group of people who access substance misuse services for either alcohol or other substances there is also an opportunity to better integrate the provision of the full range of BBV testing, rapid start PrEP and provision of contraception through inreach from the specialist sexual health services, provision of SHL smart kits and strengthened partnership working. Specialist sexual health services should also introduce both alcohol and substance misuse screening and brief intervention alongside needle exchange and naloxone provision for all patients.

The City and Hackney combating drugs partnership has received significant funding to increase uptake of substance misuse services. This provides an opportunity to ensure services not only more effectively meet the needs of chemsex clients but also the wider SRH needs of substance misuse clients by creating a stronger interservice linkage between sexual health and substance misuse services.

6.2.3 Homeless people and rough sleepers, asylum seekers and migrants

STI positivity rates for homeless patients in north east London remained relatively stable between 2017 and 2021, apart from in 2020, which saw a spike in positivity.

No specific sexual or reproductive health data is available for rough sleepers and homeless people in City and Hackney, though service uptake at the Greenhouse Practice, a GP service that provides care to people living in hostels or supported accommodation, rough sleepers, and people who spend a significant amount of time on the streets may act as a proxy indicator of need. These often include refugees or migrants who have an insecure status and are wary of engaging with statutory services. Their vulnerability profile is potentially high, as they may be engaging in sexual activity but unfamiliar with the open access nature of sexual health services and fearful of government interaction, they may forgo testing, and not access treatment when they need it.

The Greenhouse Practice delivers health care, including sexual health screening, to adult single people in two asylum seeker hotels in Hackney and will also support the newly established Rough Sleepers Assessment Centre in the City of London.

6.2.4 Commercial sex workers

Open Doors is a commissioned service that provides holistic support to commercial sex workers (CSW). Between April 2019 and March 2022, 1,510 unique CSWs were supported by the Open Doors service: 1,110 Hackney residents, 65 City residents, and 335 residents from other local authorities. The majority of these were street based female sex workers, though there has been an increase in engagement with off street and male sex workers, especially since COVID-19.

As part of the Open Doors drop in service, a sexual health nurse is available for STI testing, contraception, vaccination and advice on a weekly basis. Service users can also attend HSHS with priority access. The testing undertaken at the drop in continues to find high prevalence of STIs. For example, during one Quarter in 2022-23, 75 individual sex workers engaged with Open Doors, of which 21 were assessed as needing clinical health services. Out of the 21, 18 were tested and a total of 20 STIs were diagnosed.

At the drop in there is also opportunity for service users to engage with substance misuse services (Turning Point). A high percentage of on-street sex workers are substance users, and strong partnership work between substance misuse and sexual health services can help to improve outcomes.

The combination of sex work and substance misuse makes for challenging life circumstances for this vulnerable group and contraception, condom use, PrEP and regular testing and treatment are a key offer, alongside more holistic support to facilitate a move away from substance use and sex work that is detrimental to good health outcomes. It is equally important that this is based within a trauma-informed approach.

6.2.5 People with disabilities (learning and physical)

Between 2017 and 2021 service users who were recorded as having a disability were no more or less likely to receive a positive STI test result than the general population. However, data collection is very poor, e.g. HSHS does not routinely collect data on disability among its attendees. Therefore, lack of data may obscure any potential inequalities in access or outcomes.

In Hackney, the Right Choice Connect Hackney clinic offered confidential SRH services to people with learning disabilities but attendance was relatively low and the clinic has not reopened since the COVID pandemic.

Relationship and sex education is offered at schools for young people with special educational needs and/or disabilities (SEND).

For the purpose of the strategy consultation, an Easy Read version of the survey and summary of the themes of the strategy was prepared to enable participation from people with a learning disability. An in-person consultation session was also held. The participants highlighted that accessibility can take on different forms: physical accessibility and signage for partially sighted people, for example, but also how friendly or welcoming a service is. Although there was strong agreement around the importance of relationship and sex education in schools, including special education, views on other proposed priorities and outcomes diverged, for example with regards to termination of pregnancy (ToP).

6.2.6 PAUSE and STEPS service users

PAUSE and STEPS are programmes delivered by Hackney Council and the City of London via the Public Health team.

PAUSE works to improve the lives of women who have had, or are at risk of having, more than one child removed from their care. Many of the women accessing the service have experienced significant trauma in their lives. The programme aims to support women holistically, while they commit to a 'pause' in pregnancy during the programme. Pause works with local sexual health services to support women to make an informed choice about contraception and understand more about their sexual and reproductive health. Women who participate in PAUSE can benefit from immediate referrals to HSHS but more work needs to be done to ensure pathways are well understood, trauma experiences taken into consideration and comprehensive sexual and reproductive health support is provided.

STEPS offers support for rough sleepers, who are often dealing with added challenges such as substance use and mental ill health.

For the consultation, a brunch club for STEPS and PAUSE service users was attended to seek their views and ask about their experience of services, or awareness and accessibility of services. Some helpful feedback was provided in terms of how information should be designed and communicated, and for services to be available and accessible in the community or within the services they attend.

6.2.7 Young people: Social Care and Youth Justice

Young people in foster care or who are leaving care are known to have worse health outcomes throughout life and an assessment in Wales found that young people in foster care were significantly more likely to report ever having had sexual intercourse and to report an early age of first intercourse. Young people in foster care also had three times higher odds of not reporting condom use at last intercourse and nearly five times higher odds of not reporting contraceptive pill use, compared to those with a different type of living arrangement.[20]

Young people known to the Youth Justice Service often have added vulnerabilities, with some having special educational needs or disabilities (SEND) and speech and language issues. This can potentially put them at higher risk for exploitation or abuse within intimate relationships. This would also apply to young people with SEND who are not involved with the Youth Justice service.

Other young people who may be at increased risk of poorer sexual health outcomes are those who misuse substances, or who are homeless or vulnerable with their housing status. Young people affected by or involved in gangs, especially young women, may also be particularly vulnerable.

Even though teenage pregnancy rates have fallen dramatically over the past few decades, there may be areas with higher teenage pregnancy rates where focused action be warranted.

6.3 Aims and outcomes for inclusion communities and those with complex needs

The key task and challenge will be to ensure services are open and truly accessible to those with increased or complex needs. Co-production with communities on both service provision but also awareness campaigns will remain essential to ensure health inequalities are reduced. Outreach and inreach to non SRH settings is important alongside broadening professional willingness to raise sexual and reproductive health through MECC training and increased awareness of referral pathways into SRH services.

Annual equity audits provide a powerful tool for services to ensure services are meeting the needs of inclusion communities and those with complex needs. The equity audits should then be used to develop and publish specific access plans ideally co-produced with communities where uptake of services needs to be improved. Data collection, surveys and user feedback is key to creating a more comprehensive picture of the needs of and barriers facing those with more complex lives or vulnerabilities.

Outcome 1: Increased access to services by those with higher or more complex needs

Aims:

1 - Implement annual equity audit action plans to ensure greater uptake of services amongst those communities with sexual health inequalities and complex needs

2 - Improve understanding and functioning of pathways to support those with higher or more complex needs, for providers/services and service users

3 - Tailored services for people with learning disabilities (within overall service)

4 - Improve visibility/accessibility of services from multiple & intersectional perspectives (physical disability, learning disability, homeless, substance misuse, mental health, LGBTQ+)

[20] See Louise Roberts, Sara Jayne Long, Honor Young, Gillian Hewitt, Simon Murphy, Graham F. Moore, Sexual Health Outcomes for Young People in Care in *Children and Youth Services Review*
Volume 89, June 2018, Pages 281-288

5 - Encourage GP registration

6 - Sexual health and primary care services are trauma informed including sexual assault, abuse and rape

Outcome 2: Improved data collection to inform service delivery

Aims:

1 - Explore alternative ways of data collection

2 - All relevant services collect data on all protected characteristics, implement equality duty

4 - Reduce the gradient between the most and least advantaged across a range of defined process and outcome measures.

Outcome 3: Transgender and non-binary residents' sexual and reproductive health needs are met

Aims:

1 - Specific, welcoming, knowledgeable and safe clinical spaces for sexual health care, with provision of STI testing and treatment, contraception and cervical cytology, and appropriate harm reduction interventions.

2 - Promotion of 'Standards of Care for the Health of Transgender and Gender Diverse People' guidelines in primary care

3 - Respond to the consultation on the national Guidelines for schools on gender identity and transition to highlight importance of compliance with the equality duties

Outcome 4: Information is designed in acceptable and appropriate forms

Aim:

1 - Coproduction of resources and materials (print and online, as relevant)

7 - Way forward

Having a strategy in place will promote joined up working, integration, providing a more coherent approach to SRH commissioning and foster stronger collaboration with stakeholders and partners. However, if it remains confined to words on paper, it will have been a fruitless exercise.

An annual action plan will be developed that will take the outcomes and aims from this strategy and translate them into workstreams, activities and outputs. The latter will include better communication mechanisms, pathways or signposting. Long awaited changes to the legal requirement to competitively procure health services, the Provider Section Regime (PSR), were finally enacted in 2024. The PSR regulations will apply to the procurement of "health services" but for health promotion, social care and education services the regulations remain unchanged from the existing Public Contracts Regulations 2015. Better integration of plans for both procurement and how services are commissioned across the broad areas of this strategy will help achieve desired outcomes. Plans for commissioning and procurement will be included in the annual action plan.

The **annual action plans** will be jointly prepared by the SRH Forum membership of commissioned services and the Public Health team, in consultation with other system stakeholders and resident participation groups and presented along with an update on progress to the City and Hackney Health and Wellbeing Boards, to ensure that every year, priorities are revisited and agreed gaps or inequalities are addressed.

The first action plan was developed alongside the consultation process for this strategy, so as to engage stakeholders directly and simultaneously on strategic priorities and approaches to implement them.

7.1 Strategy status and updates

The City and Hackney Sexual and Reproductive Health Strategy was presented for formal adoption by both the Hackney and City Health and Wellbeing Boards (HWB) in early 2024 and is envisaged to run until 2029. The strategy was developed and consulted on in 2023 and included a 12 week statutory consultation and engagement with communities and professional stakeholders. The annual action plan update to both HWBs will also provide an opportunity to highlight any areas of the strategy that may need to change to reflect new opportunities or challenges.

7.2 Monitoring

In the first year of the strategy a **sexual health dashboard** will be developed to help with monitoring progress over time and identifying where gaps or inequalities are present.

The dashboard will be created by the Public Health Intelligence team (PHIT) and draw on existing (national) data sources such as GUMCAD, Fingertips and SPLASH; locally used platforms such as Pathway Analytics, Preventx and Pharmoutcomes to reflect activity by Homerton Sexual Health Services, SHL and pharmacies, as well as performance data derived from performance reports submitted by commissioned services. Regular mystery shopping of services and patient experience measures will also be incorporated into the dashboard.

The potential for the scope of the sexual health dashboard to be widened to include the broader objectives around reproductive health will be assessed during the first year. As many of these services are commissioned by the NHS the broadening of the sexual health dashboard to include other services will be dependent on the NEL ICB health intelligence strategy.

Appendix 1: Overview of commissioned services

- Specialist sexual health clinics via the Homerton Sexual Health Services (HSHS)
- Primary care: GP practices (includes Long Acting Reversible Contraception (LARC), STI and HIV testing) and community pharmacies (Emergency Hormonal Contraception (EHC), condoms, chlamydia screening and treatment)
- Online services via Sexual Health London (SHL) (STI testing, routine oral contraception and EHC)
- Young Hackney (young people: condom distribution, sexual health resources, training, signposting)
- Voluntary and community sector commissioned partners:
    - Positive East: HIV prevention and support services (adults); Project Community (sexual health resources, engagement and PrEP promotion among black and other minoritised communities)
    - Community African Network (CAN) (condom distribution among predominantly black African communities)
    - Body & Soul (HIV support services for families and children)
- Open Doors (commercial sex workers: outreach, holistic support and signposting, clinical sexual health services, substance misuse services)
- Support for Vulnerable Babies (baby milk for mothers with HIV)
- London HIV prevention programme including Do it London

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Agenda Item 7

Committee(s): Health and Wellbeing Board	**Dated:** 02/02/2024
Subject: Director of Public Health Annual Report (2023). “Sexually Healthy" & announcing the Director of Public Health Annual Reports (2024 & 2025) on Social Capital.	Public
Which outcomes in the City Corporation’s Corporate Plan does this proposal aim to impact directly?	1, 2, 3, 4
Does this proposal require extra revenue and/or capital spending?	N
If so, how much?	N/A
What is the source of Funding?	N/A
Has this Funding Source been agreed with the Chamberlain’s Department?	N/A
Report of: Dr Sandra Husbands, Director of Public Health for The City of London and London Borough of Hackney.	For Information
Report author: Sandra Husbands, Director of Public Health Chris Lovitt, Deputy Director of Public Health Danny Turton, Public Health Registrar *All City & Hackney Public Health Service*	

Summary

The Director of Public Health annual report 2023 ‘Sexually Healthy: working hand-in-hand to improve the sexual and reproductive health of young people in the City of London and Hackney’ has now been published.

The Board is asked to take note of the recommendations and continue their support of work in the field of sexual and reproductive health.

The Director of Public Health (DPH) has a statutory responsibility to prepare an annual report on the health of the local population.

This is an independent report, with the DPH responsible for its content and structure. It is an opportunity to draw attention to an aspect of the local population’s health and to consider areas where further action might be recommended.

Members are also asked to note that the topic for the upcoming DPH reports for 2024 and 2025 will be on Social Capital in the City of London and Hackney.

Recommendation(s)

Members of the City of London Health and Wellbeing Board are asked to:

- Note this year's DPH annual report and the recommendations it contains
- Consider what actions may be taken to contribute to the implementation of the report's recommendations
- Support dissemination of the DPH report to appropriate partners
- Be aware of the topic for the upcoming DPH reports for 2024 and 2025 on social capital and to make any observations or suggestions pertaining to this topic for the City of London
- Suggest potential representatives from the City of London for the project advisory group

Main Report

Background

1. The 2023 report looked at sexual and reproductive health (SRH) with a particular focus on young people under 30 and on testing for sexually transmitted infections (STIs).

2. The report was developed in liaison with stakeholders across the City of London and Hackney, including local and regional NHS partners and voluntary sector organisations

3. The recommendations were tested at the City of London's Community and Children Services Directorate Leadership Team (CCS DLT) meeting on 1 March 2023 and an early draft was shared with stakeholders for their comments.

4. The report benefited from the SRH Needs Assessment 2023 and the development of a five year SRH Strategy for 2023-2028.

Current Position

5. The Sexually Healthy DPH Report recommendations are as follows:

    a. Community involvement is essential to providing high quality services: health providers and commissioners should reconfirm, and put into action, their commitment to collaborate with young people in the co-production of services.

    b. Services must be easily accessible to young people: refine existing SRH services and explore new initiatives in collaboration with young people to make accessing services as easy as possible.

    c. Young people must be aware of when and how to access support: improve young people's awareness of services and their willingness to access them.

d. Focus on enhancing collaboration and partnership working: continue to develop collaborative working practices across SRH and beyond to mitigate pressures on services and improve user experiences.

e. Continue to identify and address inequalities in SRH: ongoing research and audit, undertaken in collaboration with communities, is recommended to identify inequalities and communicate findings to all concerned partners. Such research should be coupled with a commitment to address inequalities that are identified.

Proposal

6. The 2024 and 2025 DPH reports will focus on the topic of social capital. A two year project was proposed due to the complexity of the topic, the breakdown for the two years is as follows

    a. In the first year, the work will be focused on the evidence base of how to build social capital at the community level and the role that the public health team and the wider system can play in doing so.

    b. The second year will then look at working with the City of London and Hackney community to turn that evidence into an action plan that can have a practical impact on the health and wellbeing of our population.

7. Across the two year period we will also run two supporting groups to aid the production of the DPH reports. The first will be a focused working group to guide logistical planning and finalise content. The second will be a wider advisory group to seek insights from interested partners. We are actively seeking further members to the advisory group to ensure the City of London is represented.

Conclusion

8. The members of the Health and Wellbeing Board are asked to note the recently published 2023 DPH annual report and the proposal for the upcoming 2024/2025 reports.

Appendices

- Appendix 1 - Director of Public Health Annual Report (2023). Healthy Sexually: working hand-in-hand to improve the sexual and reproductive health of young people in the City of London and Hackney

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Holding Hands, Hoxton Square, STIK 2020

Sexually Healthy

Working hand in hand to improve the sexual and reproductive health of young people in the City of London and Hackney

Annual report of the Director of Public Health for the City of London and the London Borough of Hackney

Summary 2023/24

The full report can be viewed at cityhackneyhealth.org.uk.

For further information please contact public.health@hackney.gov.uk.

Sexually Healthy

Sex is a vital part of life, and people's sexuality is an important source of pleasure and wellbeing.

This year's Director of Public Health's annual report is about the sexual and reproductive health of people in Hackney and the City of London. It is about making sure we have the right information, support and services available so we can enjoy enriching and pleasurable relationships, choosing when and if to have sex, when and if to get pregnant.

There are, of course, certain risks to do with sex. In fact, there are significant concerns around sexual health in our part of London and these are described in the report. For example, Hackney and the City have extremely high rates of **sexually transmitted infections** and this is a particular focus of the report.

The report provides an overview of the situation in Hackney and the City but looks more closely at issues relating to younger people. We know that people under 30 use sexual health services more often than others. We know younger people are more likely to have sexually transmitted infections. The report explores how we can improve **young people's access to sexual and reproductive health services**.

The report provides **five recommendations** to address local needs and reduce health inequalities. While the recommendations focus on young people, the principles they contain apply across sexual and reproductive health. These must also inform work with other specific groups and communities. The first recommendation is about ensuring real collaboration with local communities. It is the most important recommendation because it determines how to approach all the others.

Berlin Wall with NOIR, STIK 2019

Sexually transmitted infections

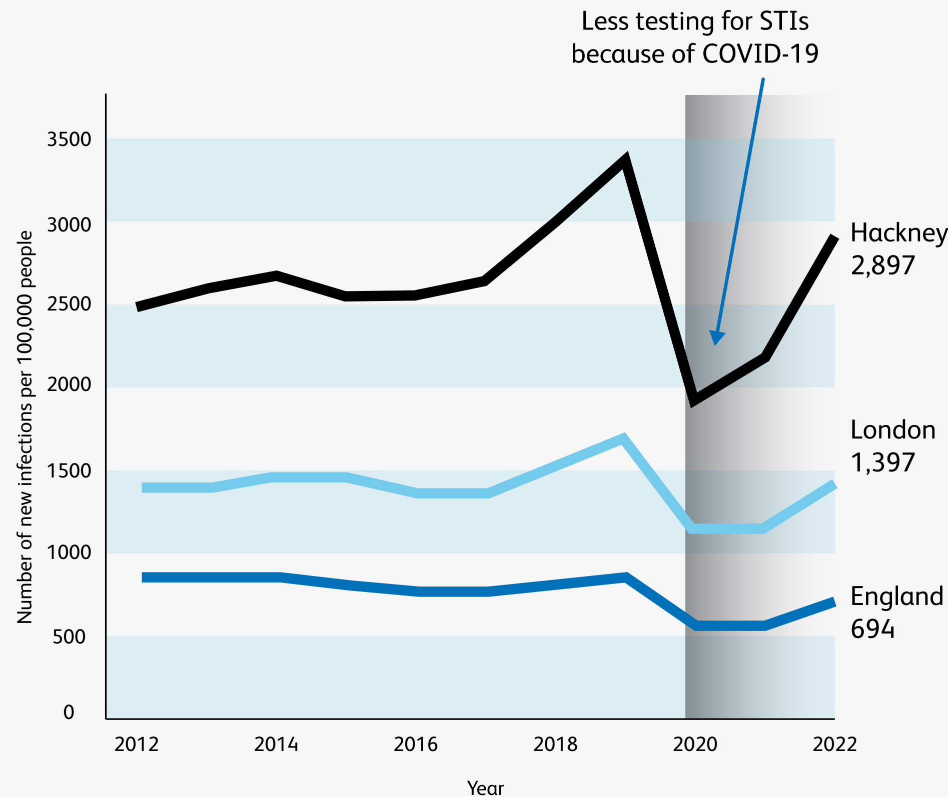
The number of sexually transmitted infections diagnosed in Hackney and the City each year is extremely high (see Figure 1). These infections can be treated and managed but the earlier they are diagnosed the better.

Early diagnosis means fewer health complications for individuals, less chance of other people being infected, and cheaper, more effective, treatment. Unfortunately, we are not testing for these infections as much now as we did before the COVID-19 pandemic and this is contributing to the ongoing high rates in the community.

Ensuring prompt diagnosis and treatment of sexually transmitted infections, as well as notification of sexual partners who may be at risk, is a fundamental principal of effective sexual and reproductive health services. It is an area where further improvements can, and must, be made.

New diagnoses of sexually transmitted infections

Figure 1: Sexually transmitted infections by area of residence



In 2022, the rate of new diagnoses of sexually transmitted infections in Hackney was more than double the average rate for London and more than four times the average rate for England. Hackney had the fourth highest rate of new infections out of all the 150 local authorities in England.

The rate of new sexually transmitted infections in the City of London was even higher, indeed the highest in England (3,655 per 100,000). We have not, however, included these figures in the chart because the number of residents in the City is relatively small compared to other areas. The 2022 data for both the City of London and Hackney can be viewed ***here****.*

Improving young people’s access to sexual and reproductive health services

One important way to improve the sexual and reproductive health of people living in Hackney and the City is to make sure they have easy access to sexual and reproductive health services.

There are two aspects to this: first, we need to make sure that our services are the best they can be; and second, we need to make sure people are aware of the services and feel comfortable using them. People need to know where they can go for help when they don’t feel right, when things go wrong, or when they just need advice.

The report examines the challenges facing young people and provides recommendations for how we can improve access to sexual and reproductive health services. In this way, we also throw light on wider issues affecting sexual and reproductive health in Hackney and the City and propose general principles to guide future work.

Broome and Lafayette, LA2 and STIK 2016

Keith's Garage, Bentley Road, 2008

Recommendations

The five recommendations made in the report will enhance sexual and reproductive wellbeing. They are addressed to the people and organisations that provide sexual and reproductive health services and those that fund them, as well as the communities and individuals who use those services. The report emphasises the importance of everyone working together - putting collaboration at the centre of our strategies.

Work hand in hand with communities…

1. **Community involvement is essential to providing high quality services:** we need the people who provide services, and the people who fund them, to work more closely with the communities they serve. People need to work together to design services, to increase people's awareness of those services, and to improve attitudes to sex and sexual health in our communities. This is the most important recommendation in the report because it determines how to approach all the others.

to help people, especially younger people, access services when they need them…

2. **Services must be easily accessible to young people:** refine existing sexual and reproductive health services and explore new initiatives in collaboration with young people to make accessing services as easy as possible.

3. **Young people must be aware of when and how to access support:** improve young people's awareness of services and their willingness to access them. Relationship and sex education in schools and colleges is essential but we need to go further so that we can have sex positive conversations throughout our communities.

with everyone collaborating to improve those services despite financial and staffing pressures…

4. **Focus on enhancing collaboration and partnership working:** continue to develop collaborative working practices across sexual and reproductive health services and beyond, in order to mitigate pressures on services and improve user experiences.

never forgetting to identify and combat inequalities.

5. **Continue to identify and address inequalities in sexual and reproductive health:** we need ongoing research and audit, undertaken in collaboration with communities, to identify inequalities, with findings communicated to all concerned partners. Efforts to enhance research and audit activities must be coupled with a commitment to address those inequalities that are identified. Focus on enhancing collaboration and partnership working: continue to develop collaborative working practices across SRH and beyond to mitigate pressures on services and improve user experiences.

Key messages

Public health is concerned with health creation – our approach must be community based and participatory. We need to find a shared purpose with the communities we serve and be guided by meaningful collaboration and a desire for the true co-production of services.

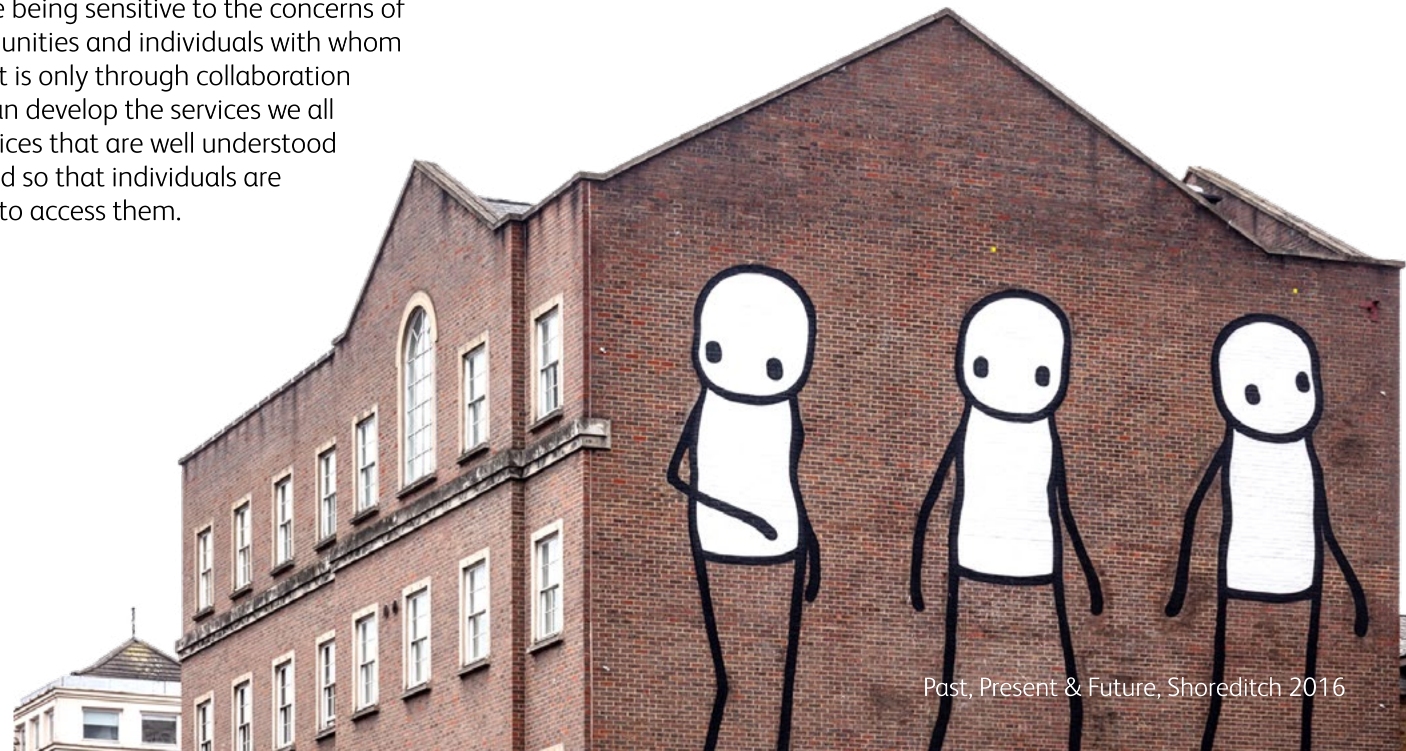
We need to recognise how important sexual and reproductive health is to our entire population. Sexual and reproductive health goes beyond the presence or absence of an infection. It involves choice, consent, pleasure, and good relationships. The World Health Organisation describes sexual health as "fundamental to the overall health and well-being of individuals, couples and families". It is fundamental to the wellbeing of our communities.

We must support every individual's right to enjoy a fulfilling sexual life and loving relationships. We need to empower people and foster their sense of control. People have sex for lots of different reasons but they should always be able to choose whether or not to have sex, free from coercion or violence; choose whether to get pregnant; and know what to do and where to go if they have problems.

We must adopt a sex-positive approach that is "open, frank and positive about sex, that challenges negative societal attitudes to sex and that emphasises sexual diversity at the same time as emphasising the importance of consent". **(Pound & Campbell, 2017)**

Issues related to sexual and reproductive health are deeply linked to our individual identities and cultures; and this is why it so important that we work together with communities. We need to normalise conversations about sex – so people feel comfortable asking for help – while at the same time being sensitive to the concerns of the communities and individuals with whom we work. It is only through collaboration that we can develop the services we all need: services that are well understood and trusted so that individuals are confident to access them.

We want to have the best sexual and reproductive health services possible. Services that improve the health of our communities through promoting healthy behaviours and giving people good information; preventing ill health; treating concerns quickly and effectively; and reducing inequalities. All with the aim of promoting the enjoyment of rich and fulfilling lives. We must remember that "high-quality sexual health services are the cornerstone of ensuring good population health." **(BASHH, 2019)**


Past, Present & Future, Shoreditch 2016

This is a summary of the 2023/24 Annual Report of the Director of Public Health for the City of London and the London Borough of Hackney.

The full report can be viewed at **cityhackneyhealth.org.uk.**

For further information or to view the full report, please visit **cityhackneyhealth.org.uk** or contact the Public Health team at **public.health@hackney.gov.uk**

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Holding Hands, Hoxton Square, STIK 2020

Sexually Healthy

Working hand in hand to improve the sexual and reproductive health of young people in the City of London and Hackney

2023/24

Annual Report of the Director of Public Health for the City of London and the London Borough of Hackney

North Pallant 2013

Introduction

This year my annual report focuses on sexual and reproductive health (SRH). It coincides with, and draws upon, work being undertaken by the City of London and Hackney Public Health team on a SRH Needs Assessment and a SRH five-year strategy. It has also benefited from interviews conducted with a wide range of stakeholders, commissioners, and service providers.

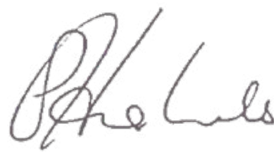
Promoting good sexual and reproductive health throughout our communities is an overarching goal for the many organisations and individuals who work to improve public health. Enhancing access to existing SRH services is a key element of achieving that goal. The quality of access is determined, on the one hand, by the design of the services themselves; and on the other hand, by people's awareness of those services and willingness to access them. Access is, therefore, a two-way street, with both aspects deserving attention.

While the issue of access is relevant to all services and all communities, this report focuses on young people, meaning those under 30 years old, and our strategies for reducing sexually transmitted infections (STIs). This is not to deny the importance of other aspects of SRH. Rather, it is recognition of the large number of young people already accessing services and the high level of STIs among this group. By addressing STIs, other issues such as access to contraception can also be improved and will be covered in more depth in the SRH five-year strategy.

The City of London and Hackney have recorded higher rates of newly diagnosed STIs than the London or England averages for the past eleven years of available data. The rate in 2022 was almost five times the average for England and more than double the average for London.[1] At the same time, we have seen a large reduction in the number of STI tests being performed. Over ten thousand fewer tests were undertaken in 2021/22 compared to before the pandemic.[2]

Ensuring prompt diagnosis, partner notification and treatment of STIs is the mainstay of SRH services and an area where improvements can, and must, be made. Furthermore, initiatives taken to promote SRH among young people can provide wider benefits to our communities. By examining current challenges facing young people and considering how to address them, we throw light on other aspects of SRH and propose general principles to guide future work.

There are five areas in which recommendations are proposed to address the high levels of local need and reduce health inequalities. The first relates to embedding collaboration and co-production principles and is the cornerstone for implementation of the other recommendations. While these recommendations focus on young people, the principles are applicable across SRH and should be applied to work with other specific groups and communities.



Dr Sandra Husbands
Director of Public Health
for City and Hackney

Recommendations

1. **Community involvement is essential to providing high quality services:** health providers and commissioners should reconfirm, and put into action, their commitment to collaborate with young people in the co-production of services.

2. **Services must be easily accessible to young people:** refine existing sexual and reproductive health (SRH) services and explore new initiatives in collaboration with young people to make accessing services as easy as possible.

3. **Young people must be aware of when and how to access support:** improve young people's awareness of services and their willingness to access them.

4. **Focus on enhancing collaboration and partnership working:** continue to develop collaborative working practices across SRH and beyond to mitigate pressures on services and improve user experiences.

5. **Continue to identify and address inequalities in SRH:** ongoing research and audit, undertaken in collaboration with communities, is recommended to identify inequalities and communicate findings to all concerned partners. Such research should be coupled with a commitment to address inequalities that are identified.

Key Messages

Public health is concerned with health creation - our approach must be community based and participatory.

We need to find a shared purpose with the communities we serve and be guided by meaningful collaboration and a desire for true co-production of services.

We need to recognise how important sexual and reproductive health (SRH) is to our entire population.

SRH goes beyond the presence or absence of an infection. It involves choice, consent, pleasure, and good relationships. The World Health Organisation describes sexual health as "fundamental to the overall health and well-being of individuals, couples and families".[3]

We must support every individual's right to enjoy a fulfilling sexual life and loving relationships.

We need to empower people and foster their sense of control. People engage in sexual activity for different reasons, but they should be able to choose whether or not to have sex, free from coercion or violence, choose whether or not to get pregnant, and know what to do and where to go if they have problems. We must adopt a "sex-positive" approach that is "open, frank and positive about sex, that challenges negative societal attitudes to sex and that emphasises sexual diversity at the same time as emphasising the importance of consent".[4]

Issues related to sexual and reproductive health are deeply linked to our individual identities and cultures; and remembering this underlines the importance of working with communities.

It is only through collaboration that we can develop the services we all need. Services that not only prevent ill health but can also address problems when they arise or refer people to other services that can help. SRH services need to be trusted so that individuals are confident and comfortable accessing testing and treatment. As one person interviewed during the preparation of this report observed, *"we are good at commissioning services but there is something beyond creating services, it's about talking to people and communities, it's about how to engage"*. Without ongoing engagement with individuals and communities, SRH services cannot flourish.

We need to normalise conversations about sex while at the same time being sensitive to the concerns of the communities and individuals with whom we work.

Our aim should be to reduce embarrassment and by doing so help communities and individuals feel comfortable accessing the services they need. Services that reduce inequalities and promote the enjoyment of rich and fulfilling lives.

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Background - where are we now?

What is special about the City of London and Hackney? What characterises this area of London and the people who live here? We will consider how the City of London and Hackney differs from other areas of London, and the nation, in terms of sexual and reproductive health (SRH).

The City of London and Hackney is young; ethnically, linguistically and sexually diverse; and proud

Approximately 260,000 people live in Hackney and around 9,000 people live in the City of London.[5] In addition to these residents, it is thought that over 400,000 people commute into the square mile to work on many weekdays.

The City of London and Hackney has a young population, with almost two thirds of the population 40 years old or less.[6] According to the 2021 census, 54% of the population are white but only 34% are white British.[7] There are large black African and black Caribbean communities, and the Charedi, or Orthodox Jewish, community makes up approximately 7% of Hackney's total population.[8] The Turkish and Kurdish communities are also large, with around 6% of Hackney's residents born in Turkey. In the City, which has a less diverse, albeit much smaller, population there is a large Bangladeshi community. Across the City of London and Hackney, there are a range of other distinct communities, including Chinese, Somali and Vietnamese. In short, there is a rich cultural mix as demonstrated by the 100 different languages that are estimated to be spoken across the City of London and Hackney.[9]

According to the 2021 Census, 7% of the population in the City of London and Hackney was lesbian, gay or bisexual (LGB). A further 0.9% responded as having an "other sexual orientation" and 12.5% chose not to answer.[10] Taking the 2021 census data for England and Wales as a whole, 2.8% of the population was LGB, 0.3% responded as "other" and 7.5% chose not to answer. The proportion of the local population that is LBG is, therefore, much higher than the national average. Furthermore, according to the 2021 Census data, the percentage of men in the City of London and Hackney who are gay or bisexual was 8.23% compared to the average over England and Wales of 2.74%.[11]

Notwithstanding the vibrance and wealth of communities living in the City of London and Hackney, there is considerable socio-economic deprivation present across the local authorities. Hackney as a whole had, in 2019, an Index of Multiple Deprivation (IMD) score[12] of 32.5 which was the 18th worst in England (out of 152 areas) and the second worst in London (out of 33 local authorities).[13] The City of London, however, had a score of 14.7 which was the 26th best in England and the sixth best in London.[14] Recognising the level of deprivation affecting the local population is important when considering sexual health because deprivation is associated with a range of poor health outcomes, including sexual health problems.[15]

People who live and work in the City of London and Hackney are proud of their communities and their colleagues. There is a strong sense of place and of history. There is a civic pride that stems from these roots and an earnest belief in the important role public, private and community organisations play in fostering change and improving conditions for the community as a whole. Many of the people interviewed while preparing this report talked with pride about the services that have been provided in the context of sexual health and the initiatives being taken. There is a recognition of the challenges but also hope and determination. Without forgetting that optimism, let us turn now to look at some of the challenges.

How does the City of London and Hackney compare with other parts of London?

In this section we consider areas in which the

data from the City of London and Hackney differ from other areas of London and England. We are interested in where we are an outlier, understanding why this may be the case, and where we need to focus our attention.

The City of London and Hackney have been relative outliers compared to other London local authorities in two key areas of SRH, namely the provision of long-acting reversible contraception (LARC) and the prevalence of sexually transmitted infections (STIs).

While it is true that the most recent data available suggests that rates of LARC prescription are coming back in line with London averages, Hackney remains with above average rates of abortions in certain demographics and ensuring good access to contraception options, including LARC, is a key requirement. Here we outline some of the key data relating to LARC provision and STIs, as well as key data on teenage pregnancies and abortions.

Long-Acting Reversible Contraception (LARC)

LARC is considered the most effective method of contraception.[16] It can help people to plan pregnancies as they wish, resulting in better outcomes for mother, child and the wider family.[17] In 2020, the total rate of LARC prescribed in Hackney was 19.3 per 1,000 women, and 13.6 per 1,000 women for the City of London.[18] These figures were considerably lower than the rate in England as a whole which was 34.6 per 1,000 women, and lower than the London average of 27 per 1,000 women.

New data made available in February 2023 shows, however, that in 2021, rates of LARC prescriptions rose in both the City of London and Hackney to 20.8 and 37.5 respectively. Hackney was, therefore, once more above the London average of 30.4 for the same period, although still lower than the England average of 41.8 per 1,000 women.[19] While the provision of LARC has started to recover, and Hackney at least is no longer below the London average, it has not yet returned to pre-pandemic levels when, in 2019, the rate of prescription was 45.9 per 1,000 in Hackney and 24.3 per 1,000 in the City of London.

The data on LARC prescriptions highlight two areas that warrant further research. First, that there is a large, and longstanding, discrepancy between the rate of LARC prescriptions made in primary care in Hackney (8.3 per 1,000 in 2021) compared to the rate of prescriptions made in primary care in England as a whole (25.7 per 1,000).[20] Second, that the City of London has relatively low rates of LARC prescription: in 2021 it had the third lowest rate in London and the 12th lowest in England.[21] These areas are worth investigating because increasing access to and, where appropriate, uptake of LARC can help people to plan their pregnancies. The recommendations made in this report are relevant to those efforts to increase access.[22]

Teenage pregnancies and repeat abortions in women under 25 years of age

Teenage pregnancy is associated with significantly poorer outcomes for both young parents and their children.[23] The City of London and Hackney have been effective at reducing the rate of teenage pregnancies over the last ten years of available data and has, since 2018, seen a rate consistently below the average for England.[24] At the same time, figures show that the percentage of teenage conceptions ending in abortion is higher than London and national averages (70.5% in Hackney and the City compared to 63.2% in London and 53% in England). While it would be desirable to help people prevent unwanted pregnancies, the relatively high proportion of teenage conceptions ending in abortion is an indication of good access to abortion services.

The available data on the rate of teenage pregnancies is encouraging but only goes up to 2020. More recent data is available for the under 18s abortion rate in Hackney, which rose in 2021 for the first time since 2016. From 2020 to 2021, Hackney saw a 29.7% increase in the number of women under 18 years old needing an abortion, with a rate of 8.3 per 1,000 women[25] compared to a London average of 5.5 and an average in England of 6.5.[26] It is possible, therefore, that the number of conceptions in women under 18 will also be seen to have risen when 2021 data becomes available.

Another area of concern is the data relating to abortions in women under 25 years old where the women have had one or more previous abortions. This is a key indicator of a lack of access to good quality contraception services and advice for a group of women who have, by definition, previously been in contact with SRH services. In 2021, 34.1% of abortions involving women

under 25 in Hackney were repeat abortions. Hackney had the third highest rate compared to its 15 statistically nearest neighbours.[27] In the City of London, however, the 2021 figure for repeat abortions under 25 was 28.6%, lower than both the London and England averages (31.6% and 29.7% respectively).

Notwithstanding relatively high rates in Hackney for abortions in under 18s, and repeat abortions in under 25s, the absolute abortion rate in Hackney was similar to that in its closest comparable neighbours and lower than the London average, although higher than the England average. This suggests that interventions should be targeted to support women under 18, and those under 25 who have already had an abortion, in order to redress this difference between them and the rest of the population.

Sexually Transmitted Infections (STIs)

The detection and treatment of STIs is a fundamental component of Sexual and Reproductive Health services. Even when treated, STIs can cause long-term complications affecting health and some require ongoing management. Detection is necessary to ensure effective treatment and timely partner notification to prevent onward transmission.[28] Prompt detection can also reduce the significant costs of treatment and management.

The City of London and Hackney have recorded a significantly higher rate of newly diagnosed STIs than the London or England averages for the past eleven years of available data (see Figure 1). In 2022, Hackney ranked fourth highest out of the 150 local authorities across England for new STI diagnoses and the City ranked top, although care must be taken with the City data because of the relatively small number of residents. The rate in Hackney was more than four times the England average: 2,897 per 100,000 residents compared with a rate of 694 per 100,000 for England as a whole.[29] Furthermore, both the City of London and Hackney are areas of high prevalence of HIV.[30]

Access to testing for STIs is key for treatment of individuals and their partners and to prevent further infections. The COVID-19 pandemic has seen a large reduction in the overall number of tests being performed with fewer than half the number of tests being performed in 2021 compared to 2019.[31] This is notwithstanding the welcome increase in the numbers of people self-testing through the Sexual Health London digital service (SHL).[32] The shift away from face-to-face appointments that occurred in both primary and secondary care as a result of the pandemic seems to be a major factor explaining the reduction in the level of testing for STIs across the City of London and Hackney. While it is true that the number of new STIs diagnosed has also dropped between 2019 and 2021, and this might appear to be encouraging, it is in the context of a much larger drop in the amount of testing being performed.[33] This means that the fall in the number of new STIs diagnosed in 2021 was most likely a reflection of the reduction in testing rather than due to a reduction of disease in the community. This is borne out by the fact that when testing increased in 2022, so too did the number of new STI diagnoses. Recently released data shows an increase of 34% in the number of new STI diagnoses in Hackney and the City of London between 2021 and 2022.[34]

In the following chapter, we focus on the successes and challenges relating to providing services in these areas and how we can encourage and promote appropriate access, with a particular focus on young people.

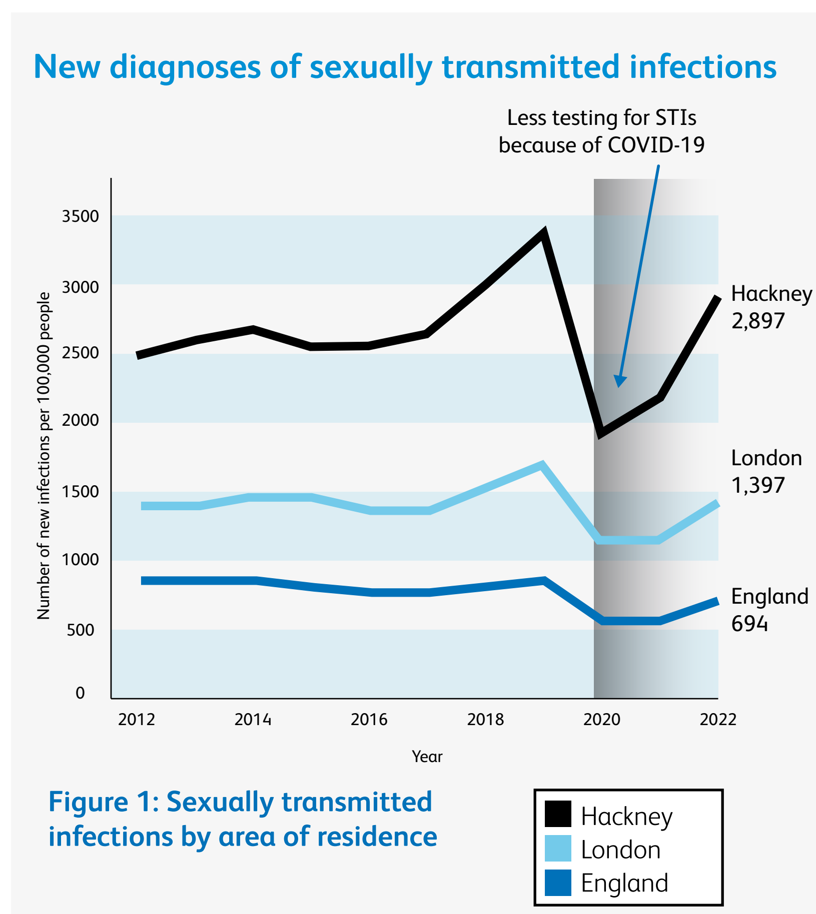


Figure 1: Sexually transmitted infections by area of residence

Page 169

Scriven Street, Hackney 2012

How do we improve access?

"Every report talks about improving access" (stakeholder)

While it is true that there is frequently a call to improve access to services, in this section we will discuss why this is central to SRH services and what barriers exist. We will consider what impact the COVID-19 pandemic has had, both on the services themselves and how people access them. We will then briefly explore which groups or communities have higher needs before explaining why, for the rest of the report, we will focus predominantly on the experiences of younger people.

What are the services we're talking about?

We should consider services as activities that promote the wellbeing of communities rather than using the medical model where we focus on treating the ill health of individuals. As such, SRH services include initiatives to raise awareness and knowledge - steps taken to empower people so that they are more in control of their sexual health and wellbeing.

There are many services across the range of SRH but they all require people to choose to access them. Access can be in a variety of ways. They can be through self-referral or attendance at a drop-in clinic, or may require referral by a professional. Some services proactively seek engagement from individuals and communities.[35]

Services are provided in many different settings including GP surgeries, pharmacies, specialist clinics, in schools and the community, and online through platforms such as **Sexual Health London**. Services may be funded through local authorities and regional NHS bodies working within the integrated care system, by national NHS bodies, or by individual grants provided to voluntary, community and social enterprise organisations.

Often, the same organisation is commissioned by different bodies to run multiple services. The SRH field is, therefore, complex.[36] Services cover a wide range of activities including:

- testing, treatment and management of infections, including contact tracing and partner notification[37]
- provision of routine and emergency contraception
- **maternity** and **gynaecology** care, including support for menopause symptoms and abortion services
- psychology services, including psychosexual services, and services focusing on high-risk behaviours including the use of drugs, domestic violence, and sexual assault
- social support services including mentoring and health advice
- health promotion, such as Relationships and Sex Education (RSE) in schools; and awareness campaigns such as **"Can't Pass It On"**
- disease prevention, such as pre-exposure prophylaxis[38] for HIV (PrEP), and immunisations that can prevent infections that may be spread through sexual contact, such as HPV,[39] Mpox, and Hepatitis A and B.

In this report, some services will necessarily be discussed in greater detail than others. It is important, nonetheless, to acknowledge the complexities and interconnected nature of activities undertaken in the sexual and reproductive health (SRH) field. We use the term "sexual and reproductive health" precisely because of its breadth. Initiatives taken to improve outcomes in one area of SRH will often have positive outcomes throughout the wider system.

What are the potential barriers to accessing services?

Staff working in the City of London and Hackney are rightly proud of the SRH services they provide and for the history of service innovation and development in this field. Both staff and users generally agree that services are good but there are issues about accessing these services and who can benefit from them. These concerns have become particularly pronounced since the COVID-19 pandemic. In this section we will briefly explore the nature of access before, in the next section, considering the impact of the pandemic.

Access to services is a two-way process. Services must be available and people must be able and willing to access them. Ensuring access, particularly to SRH services, therefore involves considering both (1) the services that are being provided; and (2) the willingness of people to access those services - their access potential.

Barriers to service provision

While people can only access services that are being provided, there is a wide range of services available in the City of London and Hackney and, furthermore, residents are able to use services across London. Gaps may exist because a specific service has not been created, or as a result of how services define their access criteria, but these concerns are relatively rare and affect small numbers of people.[40] Potential barriers to accessing those services that already exist may relate to any of the following issues:

- location: people must be able to access the service and feel comfortable doing so
- opening hours: the timing of services affects how accessible they are and will impact different patients to varying degrees[41]
- booking process: where appointments are required, booking systems must be in place that are easy to navigate, support different languages and meet accessibility standards[42]
- capacity: services must have the capacity to provide support to the numbers of people trying to access them in a time-appropriate manner[43]

Increasing collaboration between the many organisations working in the SRH field - service providers and commissioners - and with the communities they serve, will help mitigate many of these potential barriers (see **Recommendation 4**). Where new services need to be commissioned, configured or promoted then they should be designed in collaboration with the communities they aim to serve, not least in order to reduce the risk of creating any unintended barriers to access (see **Recommendation 1** below).

Barriers to access potential

Going beyond the design of the services, there are issues relating to people's awareness of services and their willingness to use them. We describe this as a service's "access potential".

Knowing about services, and where to find them, is often more complex in the SRH field than in other areas of healthcare. This is why public awareness and information is so important. A recent evaluation of SRH services in North East London noted difficulties with accessing accurate information on websites and by telephone.[44]

Furthermore, while all health issues are personal, SRH issues are often deeply related to identity and culture. This means that people can feel discouraged from accessing services for reasons related to their individual, or their community's, beliefs rather than because of the services themselves. Stakeholders report that social norms in some communities act as a barrier to individuals accessing services.

Addressing these issues around knowledge, attitudes and reducing stigma will provide benefits in terms of health promotion and prevention of ill-health that go beyond enhancing access to a specific service. These issues relate to **Recommendation 3** below.

What has changed because of COVID-19?

The COVID-19 pandemic and the lockdowns have had a huge impact on healthcare provision and on society in general. As one stakeholder in primary care explained when interviewed for this report, *"the impact of COVID is always the big issue in the room"*.

Direct impacts on healthcare provision

There was a reduction in the number of face-to-face appointments in both primary and secondary care due to the impact of the COVID-19 pandemic and the associated lockdowns. GPs have integrated online and text communication with their patients and in sexual health clinics there was a move away from "walk-in and wait" services to appointment-only systems and a greater use of STI testing ordered online.[45] Both of these factors led to a fall in the number of STI tests being carried out at face-to-face appointments.

While there has been a welcome increase in the number of STI tests being provided by digital services,[46] namely through **Sexual Health London** (SHL), this has not made up for the reduction seen in primary and secondary care. The overall number of STI tests across the sector, taking into account primary and secondary care as well as SHL, fell by 57% from 2019/2020 to 2021/2022.[47] This is despite the number of STI screens distributed by SHL more than doubling during the same period.[48]

The number of sexual health attendances in secondary care, at Homerton Sexual Health Services (**HSHS)**, dropped dramatically during the pandemic and is still only around 55% compared to pre-pandemic levels.[49] The number of sexual health attendances in primary care is more difficult to quantify due to difficulties with data capture. What all stakeholders report, however, is that face-to-face appointments have reduced.[50] This is partly as a result of changing practices in terms of using more telephone consultations. For example, while the number of HIV attendances at HSHS is 40% lower than before the pandemic, the number of HIV positive patients receiving care has nevertheless gone up by 6% due to the increased use of telephone consultations.

This change in practice does not appear to have affected all services equally. In particular, the level of LARC provision is returning towards pre-pandemic levels.[51] Nevertheless, stakeholders are concerned that this move to telephone and virtual consultations has an impact on important aspects of sexual and reproductive health provision. In primary care, for example, concerns around sexual health are often brought up incidentally during consultations for other issues.

While text messaging is an invaluable tool for communicating with patients, not everyone is comfortable receiving text messages to do with sexual health. As one primary care stakeholder observed, "some communities would be horrified if GP surgeries sent a text message to 16 year olds inviting them for a chlamydia screen" Furthermore, digital services may not always be effective at picking up safeguarding issues or instigating conversations around behaviour change and risk modification. There can also be barriers to accessing digital services for some people. While such barriers are reducing, they are likely to remain significant for some time. Although SHL has been highly successful and is effective at reducing the burden on other service providers, there is also recognition that it cannot replace the need for a wide range of services to ensure equitable access for all.

Some stakeholders in primary care report that more people are accessing SRH services through their GPs because access to specialist clinics has reduced since COVID-19 and it is difficult to get appointments. While they welcome this shift to primary care, they are also concerned because general demand for primary care services is "higher than ever before". At the same time, stakeholders in secondary care have a perception that less SRH care is being provided in GP practices because, again, it is more difficult to get face-to-face appointments and when patients are seen, they are less likely to have blood tests and STI swabs. These viewpoints are not entirely contradictory since data mentioned above does suggest that SRH activity has reduced in both GP practices, community pharmacies and secondary care, albeit more so in secondary compared to primary care. At the same time, primary care stakeholders suggest that many GPs do not view SRH as their primary responsibility and are perhaps not always as comfortable or skilled in this area. If this is a more recent trend it would explain the concerns voiced by clinicians in secondary care.

Notwithstanding these various perspectives, before the pandemic, there was more testing for STIs including HIV. Several experts suggest that the historic high rates of STIs in the City of London and Hackney were explained by having high levels of testing in a relatively deprived area of London with a young population and higher proportion of gay and bisexual men. Their concern is that now, with lower rates of testing, we will see lower rates of detection that do not reflect the true burden of disease in the community and that rates of infection will increase still further. Detection of STIs, along with highly effective partner notification, is vital for both treatment and prevention of onward transmission. Testing needs to increase not only to reach pre-pandemic levels once more but also ensure that the SRH activity in both primary and secondary care is fully reinstated.

Stakeholders interviewed for the preparation of this report point to staffing issues as the single most important factor explaining the reduction in SRH provision since the pandemic. This message was repeated by stakeholders in secondary care, general practice, outreach services and pharmacy, who all described staffing shortages as limiting services.[52] Indeed, they argue that there were already problems around staffing even before the pandemic[53] and so the impact of COVID-19 was to make a bad situation worse. As one stakeholder reported, "even if we did want to increase capacity [and had the funding to do so] we don't have the staff". They argue that a key strategy, therefore, must be further integration and better collaboration between partners.

Wider impacts on the population

As well as direct impacts on SRH provision, the pandemic has had a negative impact on people's wider mental health and wellbeing.[54] This pressure has continued with the cost of living crisis. Clinicians report that people are now more willing to discuss their wellbeing and mental health, and with growing awareness there is also more willingness among staff to proactively ask people about mental wellbeing. This means that there is more disclosure of trauma and mental health issues but there is not, however, an equivalent increase in the provision of mental health services. This is leading to significant waiting times for services. Stakeholders are concerned that higher levels of mental illness and financial stresses hamper people's ability to access and engage with services. It can also contribute to risk-taking behaviours and sexual exploitation or violence, thereby directly impacting people's health.

Of course, the pandemic has not only impacted the adult population. Many stakeholders also report the significant impact of school closures on children's development, particularly their emotional maturity. Furthermore, the pandemic seems to have disproportionately affected children from disadvantaged backgrounds, at least in terms of their academic learning.[55] For more discussion of the impact of COVID-19 on young people in the City of London and Hackney, see last year's Director of Public Health Annual Report, **"Children, young people and COVID-19 in the City of London and Hackney"**.

There is no doubt that the pandemic has had a major impact on SRH services - reductions in availability of appointments and provision of STI testing being just two examples, both of which due, at least in part, to staffing pressures. At the same time, the social and financial impact of the pandemic appears to have led to greater need in the population and, possibly, an adverse effect on health behaviours. Nevertheless, as one senior clinician told us during the preparation of this report, reflecting on the challenges of recent years, "we have a strong and proud tradition of supporting sexual health in the City of London and Hackney - let's regain it!"

Communities with high levels of unmet need

It is not surprising that some communities are over or under-represented in how they access specific SRH services compared to the population as a whole.[56] There can be many reasons for such disparities - some communities may have greater need, some may find it difficult to access services, and some may simply choose to access services in different ways, for example through a GP or pharmacist rather than a sexual health clinic. To try and understand these issues, and get beyond the bare data, we are indebted to the experts and stakeholders consulted during the preparation of this report.

People affected by poverty

One expert interviewed strongly believes that, within the City of London and Hackney, poverty is the major driving force behind inequalities relating to SRH rather than other attributes such as ethnicity.[57] While data is available for the ethnic background of people accessing services locally, there is no equivalent quantitative data for individual patients' financial situation. Nevertheless, we can see at a national level that deprivation is associated with worse SRH.[58] For example, 2021 data shows that the most affluent 40% of local authorities in England all had lower rates of new STI diagnoses than the national average. More deprived local authorities, on the other hand, all had rates above the England average.[59] Poverty, then, is associated with poor SRH outcomes[60] but the relationship is two-way.[61] Improving SRH in the community can help tackle poverty by reducing morbidity, improving relationships, and reducing financial burdens.

Identifiable groups

The communities most often cited by stakeholders as currently requiring additional support include: young people, people with mental health difficulties, non-English speakers or people with communication difficulties, trans people, migrants, and for certain services specific ethnic groups. It is important to note that inequalities relating to accessing services vary according to the service in question.

For example, there is a concern that heterosexual people who may be at increased risk of acquiring HIV are not accessing PrEP as much as other groups in the population,[62] and there are suggestions that Turkish-speaking communities may not be accessing menopause services through primary care.[63]

Even in areas where local performance is good, inequalities between groups may exist that need to be addressed. For example, late diagnosis[64] of HIV is the most important predictor of HIV morbidity and short-term mortality. In Hackney, the percentage of HIV diagnoses made at a late stage of infection in the three-year period between 2019-2021 was 30.7%[65] which is considerably better than the England average of 43.4%. The discrepancy between the percentage of late diagnoses among men who have sex with men (MSM) as opposed to heterosexual people is, however, much greater than it is nationally. The percentage of late diagnoses among MSM in Hackney during this period was 16.7%, much lower than the England average of 31.4%, but among heterosexual people the diagnosis of HIV was made late more than half of the time.[66] This may indicate a relatively lack of awareness of HIV risk in the heterosexual community or difficulties in accessing services. The welcome fact that late diagnosis is relatively rare in the gay and bisexual community suggests that more can be done to raise awareness, or improve access to testing, among specific heterosexual communities at increased risk of acquiring HIV.

Potential gaps in services

During interviews conducted for this report, stakeholders have drawn attention to potential gaps in services which affect specific residents. For example, stakeholders highlight that the withdrawal of walk-in services at sexual health clinics is disproportionately affecting people who find it more challenging to arrange appointments. These may be people with low-level mental health issues or with other pressing health or financial concerns. One stakeholder suggested that the loss of walk-in services means that clinics are "increasingly serving the middle classes". Similarly, the reduction in out-of-hours clinics and outreach activities is likely to be impacting younger people's ability to access services, particularly those of school-age.

Another area of concern that has been highlighted relates to psychological support and psychosexual therapy. Since the COVID-19 pandemic, staffing issues coupled with funding restraints have left services finding it difficult to support those needing help. Stakeholders are concerned that the limited capacity of psychological services, and the different treatment criteria they adopt, are causing some patients to fall between gaps. For example, people with previous untreated trauma may be considered too complex for psychosexual therapy or the NHS Talking Therapies programme[67] but not urgent or complex enough to warrant secondary psychological care. This issue relates to the distinction drawn between "mental health" and "sexual mental health". Practitioners report that they aim to treat patients holistically but are hamstrung by complex commissioning arrangements.[68]

In some cases, the appropriate service may not exist. Clinicians in both primary and secondary care have raised concerns regarding the lack of available support to trans patients who are waiting for gender affirmation appointments. It is not clear to clinicians how to respond to this concern. Some have suggested a secondary care service should be established to provide support during the long waiting times, often several years, but others have expressed concern that without sufficient expertise it is not appropriate to assume the levels of risk involved. They argue it would be better for funds to be directed to the affirmation services to reduce waiting times.

Primary care stakeholders report that some patients with gender dysphoria are buying drugs on the internet, including hormones, but that GPs are not comfortable monitoring or supporting them.[69] Primary care practices do not have sufficient expertise but do not want to turn people away. Furthermore, it is not always clear to clinicians if the journey these patients, who are often young, are embarked upon is informed by sufficient clinical guidelines. There is sometimes concern around what is driving their decision making. As one stakeholder stated, "all services need to have better conversations with non-binary people but the gender dysphoria issue is a small subsection of those conversations and one that needs a specialist pathway - we need to establish that pathway".

One area that represents a lost opportunity rather than a gap in services is the health promotion and prevention work done within schools. According to stakeholders, shortages in school nursing are even more pronounced than in nursing in general. This means that school nurses, and other nurses working in the education field, have to focus on healthcare plans and safeguarding and do not have the time to do health promotion work. Stakeholders call for more information to identify schools needing particular support, and better alignment of the educational and clinical support provided to pupils. This is an area affecting large numbers of people and goes to the heart of public health objectives - promoting good health for the present and the future.

Why focus on young people?

The population of the City of London and Hackney is relatively young compared to other areas. Over 65% of residents are aged 40 or under, over 34% aged 30 or under, and over 32% aged 25 or under.[70] It is young people that access SRH services the most.[71] The highest proportion of both men and women attending HSHS fell within the 25-29 year old age group and 54% of all women accessing HSHS were under 30 years old.[72] Not only are young people disproportionately accessing services, they are also more likely to be diagnosed with an STI when they are seen.[73] Furthermore, stakeholders report specific challenges for young people to access services, particularly since the COVID-19 pandemic. Some of these issues will be discussed in the following chapter.

For the purposes of the report, "young people" is taken to mean all people up to the age of 30 years old,[74] who make up over a third of the estimated population of the City of London and Hackney.[75] This is not intended to negate the need for specific age-appropriate services designed for sub-groups within that demographic. Services appropriate for a 25 year old may not be appropriate for a 15 year old, and safeguarding considerations must always be at the forefront of service design. Proposing a focus on "young people" is not, therefore, meant to imply that this group is homogenous. On the contrary, the implication should be that we need to ensure there is a sufficient range of services and approaches to respond adequately to the

different needs of various sub-groups within the broad category of “young people”, including those sharing particular cultures, genders or specific narrowly defined age-groups.

When considering SRH services, the provision available to young people is a central concern. They access services more than others and have the highest rates of disease. Working with young people to empower them to make their own choices, to protect their own health and exercise their rights, will provide benefits in both the short and the longer term. Not all young people are the same and we need to work with specific communities to ensure that services are as effective as possible. This echoes the first recommendation in this report: that co-producing services is central to improving the quality of SRH in our communities.

Broome and Lafayette, LA2 and STIK 2016

Recommendation 1.

Community involvement is key to providing high quality services

Health providers and commissioners should reconfirm, and put into action, their commitment to collaborate with young people in the co-production of services.

In this report, we use the term "young people" to refer to everyone under the age of 30. We realise this is a broad category and when talking about co-production, different approaches will be required for different groups. Nevertheless, the principles of co-production apply regardless of the age of service users.

The need to involve people in the design of the services is recognised in the 2022 NICE guidelines on reducing STIs. These recommend that interventions aimed at reducing STIs should be planned, designed, implemented and evaluated "in consultation with the groups that they are for".[76] The same guidelines note that commissioners and service providers should "regularly evaluate interventions, including the methods used to co-produce them, to determine their effectiveness and acceptability and identify gaps to make service improvements".[77]

Organisations in the City of London and Hackney recognise the importance of involving those they serve. In 2017, Healthwatch City of London and Healthwatch Hackney developed a co-production charter with the involvement of all stakeholders including the City of London Corporation and the London Borough of Hackney. The charter was reviewed in 2021 and presented to the health and social care partnership organisations.

This **co-production charter**[78] should form the basis of a renewed commitment to co-production with service users and the wider community as part of a community-centred public health approach[79] to ensure new initiatives are culturally appropriate, well targeted and effective. Specific activities, such as peer-led participatory action research,[80] should be undertaken to explore the concerns and needs of young people in relation to SRH services; and to ensure that co-production is integrated and sustained in both the commissioning and provision of services aimed at addressing these issues.

Recommendation 2.

Services must be accessible to young people

Refine existing SRH services and explore new initiatives in collaboration with young people to make accessing services as easy as possible.

This recommendation is about the design and provision of SRH services. It highlights the importance of working with young people to make sure that appropriate services exist and that they are as easy as possible to access.[81]

The common aim of all interventions should be to support young people, regardless of their background or situation, to establish good SRH behaviours in the short term and for later life. There are, however, specific areas of concern highlighted by the available data. These relate to two key aspects of SRH – STI testing and the provision of contraception. Some of this data is outlined in the section: "How does the City of London and Hackney compare with other parts of London". We will highlight here issues of concern relating specifically to the provision of services as they relate to STI testing services and availability of contraception.

Testing for sexually transmitted infections (STIs)

STI testing is available in primary and secondary care and using self-test kits available online for those over 16 years old and in pharmacies. There are also outreach services provided by both the NHS and the charitable sector.

Young people access SRH services more than other sections of the community and, when they do, are more likely to have a positive test result for an STI.[82] Furthermore, data available for the City of London shows that reinfection rates for young people are much higher than the national average.[83] In the five year period between 2016-2020, looking at data for 15-19 year olds an estimated 24.1 % of women were reinfected within a year and an estimated 22 % of men. This compares to England averages of 10.9 % and 9.8 % respectively. Data for Hackney has not been provided for 15-19 years olds specifically but general reinfection rates are approximately 50 % higher than national averages.[84] Reinfection rates are an indicator that people are finding it difficult to protect their sexual health even after having been in contact with sexual health services.

As mentioned above, the COVID-19 pandemic has caused a large reduction in the number of STI tests being performed. In the financial year 2021-2022, the number of STI screens performed in the City of London and Hackney was less than half of the number carried out in the year before the pandemic.[85] Stakeholders interviewed for this report strongly believe that increasing the number of tests will increase the number of positive diagnoses and thus enable more timely treatment to limit medical complications and reduce the likelihood of onward transmission. They argue that increasing the levels of testing, at least getting back to pre-pandemic levels, is vital. Otherwise, the progress made in SRH in the years before the pandemic may be lost.

Before the pandemic, the vast majority of STI screens were conducted through the clinics run by **HSHS**. Since the pandemic, the majority of screening tests have been provided through the online service, **Sexual Health London**.[86] The largest fall in the number of STI screening tests has been at HSHS but there has also been a large reduction in general practice. While STI testing kits are available through pharmacies, they only account for a small proportion of the overall number of tests, although they do have some of the highest positivity rates.

The reduction in testing at HSHS and CHYPS Plus is because fewer people are attending the services. As noted above, the number of sexual health attendances at HSHS is still only around 55% of pre-pandemic levels.[87] Stakeholders believe that the reduction in attendance does not reflect a reduction in need but rather is due to the limited capacity of HSHS, largely caused by staffing issues. For example, walk-in clinics have stopped[88] and out-of-hours clinics reduced. Booking systems are under pressure and there are reports that both online and telephone booking can be difficult to navigate with a lack of appointments available.[89]

Beyond HSHS, testing must also be increased in primary care and pharmacies. Data from 2018-2021 show that STI testing in primary care and pharmacies varies across the City of London and Hackney. During this four-year period, almost 4,000 STI tests were undertaken through 37 GP practices in the City of London and Hackney but just three practices accounted for more than 50% of the tests completed.[90] Similarly, during the same period, STI self-test kits were available at 25 pharmacies in the City of London and Hackney but 50% of those STI kits were distributed via just five pharmacies.[91]

The reasons for why so few locations are responsible for so many of tests needs further research but the concern is that it may be more difficult to access tests at some practices and pharmacies than at others.[92] This means that if levels of testing were increased to match the most active GP practices and pharmacies, it would significantly contribute to increasing the number of tests overall. Stakeholders suggest encouraging more routine use of STI testing, including HIV, for new patients registering with GPs and at NHS Health Checks;[93] and providing additional support to pharmacies. They argue that additional training, for both GP and pharmacy staff, would be an important element of new initiatives.[94]

Other avenues for increasing the level of testing relate to outreach services that are provided by the NHS and the charitable sector, in particular to school-aged people. Stakeholders from both the NHS and the charitable sector have noted that there is duplication of effort in these areas. For example, not only do **CHYPS Plus** and **Young Hackney**[95] undertake outreach into schools and colleges, but **HSHS** also attend schools when asked. There are also other health professionals working in schools and colleges, such as school nurses and public health nurses, that might be involved with health promotion and testing if they had sufficient capacity. As one stakeholder explained, describing outreach services for younger people, “it’s all a bit random”. Indeed, the charity **Positive East**, which amongst other things is commissioned to provide outreach testing services for the general public, has made similar observations, noting that they and other providers are sometimes doubling up.[96]

Two specific elements of STI testing in primary care have been highlighted as areas of concern by stakeholders. They are partner notification (PN) and the communication of test results.

Partner notification has been used to help contain STIs since the early 1900s. It refers to informing the sexual contacts of people who test positive for an STI. Good PN helps to break the chain of infection and reduce re-infection rates as well as offering health education opportunities to encourage positive behaviour change.[97] There are reports, however, that PN is not working effectively in primary care, with several stakeholders reporting that PN is not routinely being provided. There is an online platform that GPs can use when patients are unable or unwilling to notify sexual contacts themselves but it is difficult to use and expensive. There is discussion regarding whether secondary care can provide support in this area but stakeholders agree that commissioners have responsibility for ensuring an effective system is in place. This is supported by standards published by the British Association for Sexual Health and HIV on the management of STIs (2019) which recommend that commissioners should ensure that PN is a core requirement for service providers.[98]

Communication of STI test results is also discussed in the British Association for Sexual Health and HIV standards. These stipulate that people should have access to their STI test results, “both positive and negative within eight working days”.[99] Stakeholders in primary care, however, report that negative STI test results are not routinely provided to patients. While these patients may theoretically have access to their results, this represents a lost opportunity for promoting safe sexual practice and providing support to people who may be at risk. Communicating negative STI test results

might, for example, be an appropriate time to recommend when, and in what circumstances, to consider further testing. One senior stakeholder suggests that a "status neutral" approach[100] should be adopted with regards to all STIs. This would involve, for example, considering whether to use negative test results to start a conversation around behaviour change, risk adjustment or even the use of PrEP.

Provision of contraception services

Contraception is concerned with helping people plan when they want to become pregnant rather than simply helping them to avoid unwanted pregnancies. Planned pregnancies have fewer complications and better outcomes for mother and baby. Routine and emergency contraception is made available through GP surgeries, sexual health clinics, community pharmacies, the sexual health e-service SHL[101] and through outreach services. Local data relating specifically to long acting reversible contraception (LARC), teenage pregnancies and repeat abortions are discussed earlier in this report in the section **"How does the City of London and Hackney compare"**. In this section we draw attention to issues regarding how services are currently being provided for LARC, emergency contraception and condoms.

Services providing long acting reversible contraception (LARC)

LARC can be accessed through sexual health clinics and other secondary care settings, such as postnatal wards, with primary care complementing these services by providing fittings in uncomplicated cases. Although improving, LARC prescriptions have still not yet recovered to the levels seen before the pandemic. For example, attendances for LARC at HSHS were, in January 2023, only 70% of the number seen three years previously in January 2020 (297 as opposed to 425).[102]

In general practice, we see a similar pattern to the one described above regarding STI testing. While 22 of Hackney's 39 GP surgeries provided

Triangle Road, Hackney 2011

a LARC service in 2021, over 70 % of the fittings were carried out in just five practices.[103] This is not entirely unexpected given that the plan is for there to be one GP LARC hub within each of the eight primary care networks (PCNs) in the City of London and Hackney. These 'hubs' then take referrals from other practices within their PCN. Nevertheless, there is a recognition among stakeholders that LARC fitting in primary care could be increased. They explain that practices find it expensive to provide the service as it requires training for staff and backfilling of their roles while that training is completed. With high staff turnover, many practices are reluctant to make this investment.[104] Furthermore, each practice must offer sufficient fittings to maintain the skills of their staff who have a minimum number of fittings they must perform each year.[105] There are, nevertheless, positive initiatives in this area including an NHS England commissioned community gynae pilot project to establish a "Women's Health Hub" that is starting to deliver reproductive health services, including LARC clinics and LARC training to GPs.[106]

Provision of emergency hormonal contraception (EHC)

Emergency contraception can be in the form of pills or intrauterine devices (IUDs). While intrauterine devices are only available through primary care or sexual health clinics, emergency contraception in the form of pills is also available through pharmacies and, since January 2021, via the online platform, **Sexual Health London** (SHL). "Emergency Hormonal Contraception" (EHC) specifically refers to pills which, in the City of London and Hackney, are primarily accessed through pharmacies. In 2021, 70.0 % of EHC was accessed via pharmacies, 16.4 % through SHL, and 13.6 % through HSHS.[107]

We can see a similar pattern emerging with regard to EHC as we have demonstrated in other areas of SRH provision, with a relatively small number of locations providing a disproportionate amount of the service. In the three years from 2019 to 2021, more than 33 % of the EHC accessed through pharmacies were accessed through just five of the 34 pharmacies that distributed any EHC during that period.

Two recent reviews of EHC availability through pharmacies in Hackney and North East London have both reported problems with accessing the service. A mystery shopping exercise specifically looking at this issue was conducted by Healthwatch Hackney between May and September 2022.[108] The 38 community pharmacies in Hackney which had signed up to provide free access to EHC were included in the study. When contacted by phone, only 40 % of these pharmacies were able to offer a free service on the day[109] and 40 % said that they would charge for the service. These findings were largely confirmed by in-person visits to 16 of the pharmacies,[110] eight that had offered a free service on the phone and eight that had offered a paid service. Information about future options for contraception was only provided in four of the 16 visits. Recommendations stemming from this report include the need for further training of staff. The importance of ensuring a welcoming and confidential service for young people is underlined by the fact that it is young people that need to access EHC the most,[111] and they do so primarily through pharmacies.

Provision of free condoms

Condoms are an effective form of contraception that can also help prevent the transmission of STIs whether or not contraception is required. In the City of London and Hackney, young people under-25 are able to access free condoms and lubricant from a range of outlets, including pharmacies, sixth form colleges, youth hubs, GP practices and sexual health clinics through a scheme coordinated by Hackney Council (**Young Hackney**).[112]

It is striking that more than 50 % of the distributions between 2019 and 2020 were recorded in just six out of more than 45 local outlets registered to offer condom distribution to under-25s.[113] Nevertheless, between 2019 and 2021, the majority of condom distribution for people under 25 in the City of London and Hackney were in pharmacies (51.3 %).[114] This again highlights the central importance of pharmacies.[115] In particular, young men appear to prefer using pharmacies. While men represented a lower proportion of encounters for condoms at HSHS and Hackney Council's Children and Young People services compared to the population as a whole (19.2 % and 17.2 % respectively), they were overrepresented in terms of accessing condoms via pharmacies (60.2 % of pharmacy condom distributions were to men). While pharmacy stakeholders report some confusion regarding the condom distribution scheme caused by changes in commissioning

over the last few years, which is being addressed through additional training and information provision, it is clear that pharmacies are already and must continue to be a vital resource for the provision of easily accessible walk-in SRH services.

Putting the recommendation into practice

Refine existing SRH services and explore new initiatives in collaboration with young people to make accessing services as easy as possible.

Priorities for how services should be changed or developed must be determined through co-production with young people. Nevertheless, we outline here three areas which warrant particular attention and may form the basis for future conversations and plans.

a. Reviewing the timing and location of services

Services are provided in a wide range of locations: clinics, GP surgeries, pharmacies, in youth hubs, online and through outreach activities, including in schools and colleges. Since the COVID-19 pandemic, there has been a general move away from face-to-face appointments. Furthermore, opening hours have changed and clinics have been rearranged. Working with young people, priorities may be identified regarding: the opening hours of clinics or restarting walk-in and wait options;[116] the location of hubs and outreach services;[117] and ways of improving appointment availability and booking systems.[118]

b. Enhancing coordination between providers so that interventions can be more effective

Together with young people, opportunities should be explored for how to better coordinate services and where appropriate, co-locate them. For example, Young Hackney's health and wellbeing team do outreach in schools and colleges to support the statutory requirements to provide Relationships and Sex Education (RSE).[119] These services might be better coordinated with outreach activities conducted by other services such as CHYPS Plus, HSHS or charitable organisations. Work in schools and colleges might further be enhanced through increased coordination with school nurses and public health nurses. Another area that might be explored could be coordinating charitable sector testing services with pharmacies and GP practices.

c. Investigating inconsistencies in SRH provision around contraception provision and STI testing;[120] exploring how to strengthen systems for partner notification[121] and STI test result notification[122]

By exploring the reasons for inconsistencies between GP practices and between different pharmacies, it may be possible, while working together with partners and young people, to identify opportunities for increasing STI testing[123] and improving access to contraception through sharing best practices and mutual support. Addressing both of these issues (contraception and STI testing) may involve further training and awareness sessions for staff. Similarly, working on improving partner notification and test result notification may involve collaboration between primary and secondary care, as well as working with specific communities to ensure that partner notification methods are acceptable and that health promotion messages that may be included with negative test results are culturally appropriate and effective.

Redchurch Street, Shoreditch, 2011

Recommendation 3.

Young people must be aware of when and how to access support

Improve young people's awareness of services and their willingness to access them.

This recommendation focuses on how to empower young people to have control of their sexual and reproductive health choices and to access the services they need.[124] This involves people knowing what services are available to them, or at least being able to easily find the necessary information, and knowing when it is appropriate to access those services. It recognises that barriers to accessing SRH can often arise from the individuals and communities themselves. Exploring these issues will necessarily involve collaborating with young people and their communities.

Initial consultation might explore three areas: (a) young people's existing attitudes to SRH and their knowledge of services;[125] (b) their preferred sources of information including the accuracy of the information that is currently available; and (c), the factors that may make young people unwilling to access services or uncomfortable doing so. Examples of possible activities, depending on the outcome of consultations, are provided below, grouped under these three areas.[126]

a. Increase awareness of available services and when to access them.

   i. Co-produce information campaigns with specific groups using appropriate media and involving community champions and leaders. Subjects may include what services are available, that services are free and confidential and how to access them,[127] levels of STIs in the community, recommendations on frequency of STI testing, the importance of sexual self-efficacy[128] and the impact of stigma.

   ii. Review the implementation and quality of Relationships and Sex Education (RSE) provision in schools. High quality RSE is a vital tool that has been shown to provide many benefits including encouraging young people to seek help when they need it.[129] Some stakeholders suggest that the amount and quality of RSE provided may vary between different schools.[130]

   iii. Explore initiatives to ensure people are proactively offered information on SRH by GPs, pharmacists and other staff working in healthcare and public organisations. Staff must be well-informed and confident to initiate conversations about SRH.[131]

b. Ensure information is clear and that signposting is accurate and streamlined.

   i. Depending on how young people are accessing information, consider establishing systems to monitor and improve the information on service provider websites as well as on national NHS websites.

   ii. Explore having a single telephone number for accessing information and booking appointments with SRH services. This could be at the Hackney and City level, North East London level, or even London-wide utilising the 111 system.[132] Consider the use of text and chat methods for accessing information about available services.[133]

c. Increase young people's confidence to access services.

   i. With the benefit of insights from young people, ensure that services are welcoming and inclusive;[134] and better understand how and where different people like to access services.[135]

   ii. Explore interventions, in collaboration with young people and their specific communities, to normalise discussions around SRH and to tackle stigma;[136] and to increase familiarity with services, for example through videos showing what a sexual health clinic is like and introducing their staff.

Recommendation 4.

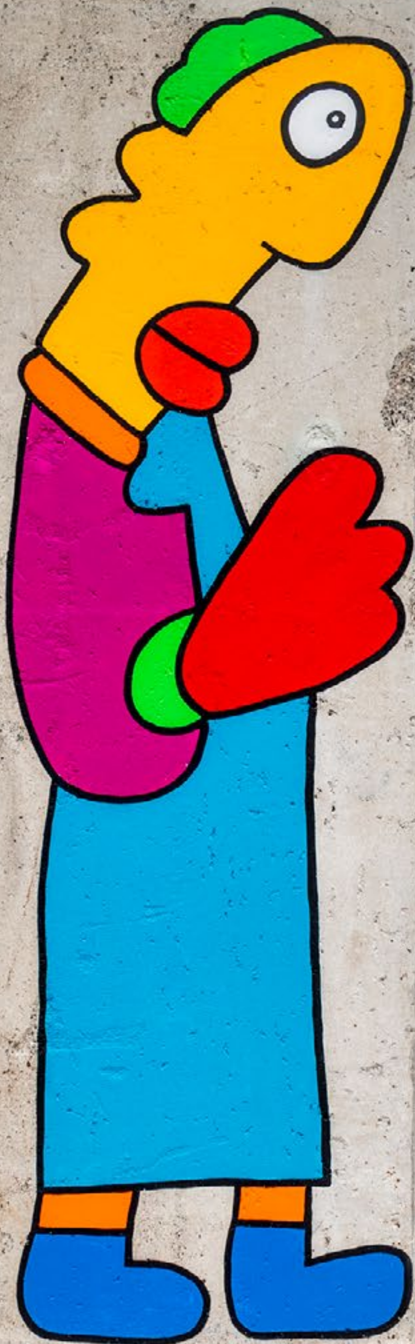
Focus on enhancing collaboration and partnership working

Continue to develop collaborative working practices across SRH and beyond to mitigate pressures on services and improve user experiences.

Stakeholders report that problems with staffing coupled with increasing need in the population is a major issue currently affecting SRH service provision. These pressures make the integration of care, and "whole system commissioning",[137] all the more important. Working relationships must continue to be fostered between commissioning organisations, between primary and secondary care, and between sets of service providers, sometimes working in the same organisation but with different commissioning arrangements.

The 2022 NICE guideline on reducing STIs notes the importance of delivering interventions across a range of services "including within broader support interventions and community services (for example, in drug and alcohol services, abortion care services, HIV care and mental health services)".[138] This is an approach that requires ongoing effort from service providers and commissioners alike and the complexities should not be underestimated. Indeed, there are sobering reports from stakeholders that even in primary care sexual health is widely considered to be a "walled-off service". The consequent "silo mentality" is being tackled, for example in the management of perimenopause,[139] but there is room to improve collaboration across the range of SRH services, including in primary and secondary care, in children's services, in mental health services, in pharmacies and with the charitable sector. Much of this work may be led by commissioning organisations, recognising the support that service providers might need to enhance their levels of collaboration.[140]

Collaboration should be promoted at the level of service provision without significant structural change, for example to facilitate co-location of services,[141] but there needs to be recognition from all actors that coordinating services is a priority that requires time and commitment. Instigating new ways of working in a system already under stress is, of course, challenging. It is recommended that all stakeholders consider how they might enhance collaborative working with their key partners and across the sector, including with the communities they serve. One specific area where service providers have called for greater collaboration regards improving data sharing while maintaining confidentiality. This would enable interventions to be better targeted to reduce inequalities.



Berlin Wall with NOIR, STIK 2019

Recommendation 5.

Continue to identify and address inequalities in SRH

Ongoing research and audit, undertaken in collaboration with communities where possible, is recommended to identify inequalities and communicate findings to all concerned partners. Such research should be coupled with a funded commitment to address those inequalities that are identified.

Inequalities in the SRH field vary according to the particular service being considered. Individuals or communities may become disadvantaged because of attributes such as gender, sexual orientation, age, culture or ethnicity, or due to their specific circumstances. Furthermore, the individuals or communities that experience relative disadvantage will change over time. Ongoing research and evaluation, preferably participatory research, is therefore necessary to identify communities with higher levels of need.[142]

Once inequalities have been identified, it is necessary to take steps to address them. For example, it is not enough to note the low levels of PrEP update among black African communities, or women in general; we need to go further and engage communities and partners to try and build momentum for change.[143] Where research has been undertaken collaboratively with communities and stakeholders, being ready to act on the results of that research is vital to building trust and productive partnerships.

It should be noted that when seeking to address health inequalities, we should not focus exclusively on disadvantaged groups. Such an approach may offer advantages for monitoring and evaluation but can also have significant drawbacks, such as leading to stigmatisation and resentment. Furthermore, a narrow approach may act to shift relative disadvantage to other communities rather than mitigate inequalities in general.

This is particularly true in the field of SRH where relative needs can rapidly change. Instead, the principles of proportionate universalism[144] should be adopted.

The concept of proportionate universalism states that:

"Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage"

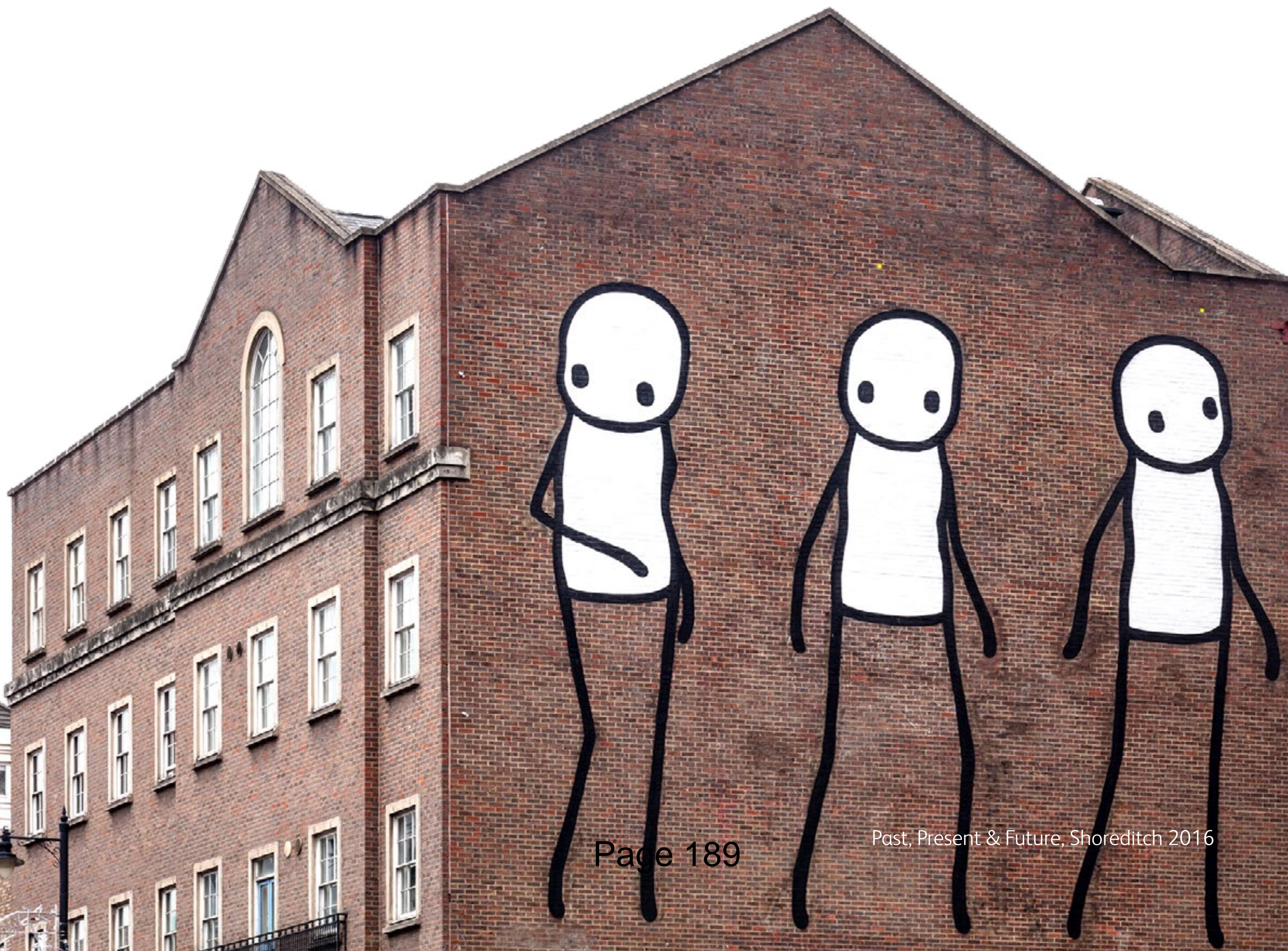
Fair Society, Healthy Lives (The Marmot Review), 2010, p.15.

Our aim must be, therefore, to optimise health and wellbeing through services that are both universally available yet also weighted in favour of those portions of society that have the greatest need.[145]

Conclusion

We must remember that "high-quality sexual health services are the cornerstone of ensuring good population health".[146] The City of London and Hackney have a strong history of promoting sexual and reproductive health throughout the population and stakeholders agree that there is a positive culture of encouraging and supporting innovation. The disrupting effects of the COVID-19 pandemic are, nevertheless, still being felt. Our response must be to redouble efforts to support people's rights to enjoy sexual and reproductive health through working collaboratively across the sector and hand in hand with the communities we serve.

The recommendations made in this report offer concrete suggestions for enhancing sexual and reproductive wellbeing through putting collaboration and a community-centred public health approach at the centre of our strategy.[147]



Past, Present & Future, Shoreditch 2016

DPH Annual Report (2023) Appendices

Appendix 1.

Update on recommendations made in last year's Director of Public Health annual report (2022)

Last year's Director of Public Health annual report (DPHAR) was published in April 2022 and looked at the impact of the COVID-19 pandemic on children and young people in the City of London and Hackney. It is available **here**. Last year's report made recommendations in five areas. These are listed below, with brief updates about ongoing related activities.

1. As the pandemic still has the potential to disrupt crucial services for children (such as education and healthcare) and affect children directly, it remains important to control COVID-19 and prevent illness through vaccination.

Over the winter months, the Public Health team worked with NHS North East London and colleagues in communications and primary care to increase access to and awareness of the COVID-19 vaccine for all residents, including children and young people. We provided regular updates to Education and Early Years colleagues (including headteachers) on local trends in COVID-19 infection rates and vaccination uptake. Direct support, advice and guidance for the prevention and management of acute respiratory infections, including COVID-19, was provided by Public Health's infection prevention and control capacity.

Targeted communication campaigns continue to maximise uptake of the first and second doses of COVID-19 and the Spring booster for those who are eligible. Since the DPHAR's publication in April 2022, there have been no full or partial school closures as a result of COVID-19.

2. This opportunity must be taken to strengthen and improve our vaccination uptake from all immunisations.

Stakeholders working in the field of immunisations from across the City of London and Hackney meet regularly to discuss operational challenges, as well as strategic opportunities to achieve a sustained increase in routine vaccination coverage. Activities undertaken include public webinars with local clinicians, specific communication campaigns and targeted events. A new Children and Young Persons Immunisation Coordinator has been recruited to lead further work with communities to increase uptake. Beyond routine vaccinations, significant work has been undertaken to maximise uptake of the polio booster, including with specific groups such as the Charedi community in Stamford Hill. Further, in response to a pertussis outbreak in the Charedi community, Public Health has worked with colleagues from UKHSA, NHS London, NHS North East London, local maternity services and primary care, as well as with Charedi community organisations and residents, to coordinate a system response to increasing uptake of maternal and childhood vaccines.

However, routine vaccination coverage has declined across London. Vaccination fatigue, reduction in trust of public services, impacts from COVID-19 and reduced access to care (e.g. high waiting times) are likely to have contributed to this. Concerningly, the reduction in vaccine uptake in the City of London and Hackney is more pronounced than in the rest of London. For example, comparing 2018/19 figures with 2021/22, the uptake of one dose of the MMR

vaccine in two-year-olds dropped by 8.9%, from 74.3% to 65.4%. This is much greater than the reduction across London of 3.1% and across England of just 1.1%.[148] As well as the reduction being greater, the overall proportion of vaccine uptake is also lower in the City of London and Hackney than in the rest of London. In 2021/22, 65.4% of two-year-olds received one dose of MMR vaccine in the City of London and Hackney, while across London the figure was 79.9%, and across England it was 89.2%.

The continued reduction in childhood vaccination coverage will undoubtedly increase the number of children in the City of London and Hackney who are at risk of contracting vaccine preventable diseases which can cause lifelong morbidity and even mortality. There remains an increased partnership focus on increasing vaccination coverage and further work and regular progress updates should be prioritised by the HWB, and NHS and Local Authority place-based partnerships.

3. To reduce inequalities that could have been widened by the pandemic, it is vital that catching up on what's been missed in education and healthcare should be approached in an equitable way. Getting education and healthcare services back on track will be key.

Government funding to support schools to help pupils make up for missed learning during the pandemic finished in the summer of 2021. It was replaced with a time-limited recovery premium grant providing over £300 million of additional funding for state-funded schools in 2021-2022; and £1bn across 2022-2023 and 2023-2024. Schools are targeting pupils on the basis of assessments of need, focusing the recovery premium grant where needs are greatest.[149] Work continues on developing curriculum implementation (recall, retrieval, live marking), tutoring, catch-up classes and the development of approaches, including use of additional resources and alternative provision.

Across England, the disadvantaged gap index[150] for pupils at both Key Stages 2 and 4 has widened in 2022 to the highest levels since 2012.[151] Locally, schools are reporting that performance gaps for disadvantaged and lower attaining pupils did not widen as expected, but that the attainment and progress of more able pupils was not as strong. Ongoing work is required, locally and nationally, to address inequalities to achieve - and surpass - pre-pandemic levels of educational progress.

Within the Early Years setting, among other activities, support has been given to providers to register with the Department for Education funded "Early Years Professional Development Programme" which aims to address the effects of the pandemic on young children. This online training focuses on communication and language; and personal, social and emotional development. Training is for Early Years settings that have children with SEND or have funded two-year-olds.

4. New needs have arisen as a result of the pandemic, and these should be recognised and addressed. These include:

   a. Addressing obesity by supporting children and young people to eat healthily and move more. Interventions and system-wide efforts that can help children and young people (and their families) maintain a healthy weight will be vital.

   b. Making sure children and young people can access mental health support is essential, especially in the context of those who may have been impacted by trauma.

On addressing obesity:

City and Hackney Public Health have commissioned a new Tier 2 family-based community intervention, starting in March 2023, to support families which have children above a healthy weight. This behaviour change programme is aimed at young people and families in the City of London and Hackney to help them create long-term, healthy habits relating to diet and physical activity. Public Health also launched a new Healthier Hackney physical activity community grants programme in February 2023. The programme aims to support less active residents in Hackney to become more active, building on what we have learned from residents and local organisations over the

past year. Children and families are one of the target groups for this new grants programme. The learning from this programme will provide opportunities for a similar approach to be considered for the City of London.

Ongoing activities have also been recommissioned. For example, the 0-5 healthy lifestyles service that provides lifestyle education to families and oversees the universal Healthy Start vitamin distribution scheme. Training is provided online and in early years settings to both families and staff. Other activities include the "cook and eat" community classes which are being recommissioned for a further 2.5 years, starting from April 2023. These classes focus on developing cooking and nutrition skills among families. There are also ongoing initiatives to promote healthy food in schools,[152] to establish healthier practices in food businesses,[153] and to ensure sufficient outdoor play areas in new developments.[154]

The City and Hackney Neighbourhoods team have been facilitating joint working at a place-based level to understand childhood obesity barriers and opportunities for collaboration and intervention. For example, in Well Street Common primary care network (PCN), which has the highest levels of obesity at reception and year six, childhood obesity was identified as a priority. A series of meetings with a wide range of stakeholders was convened and a joint action plan has been established. The learning from this will be shared with other PCN/ Neighbourhood areas including Shoreditch and the City.

Future activities include a Healthy Weight Needs Assessment that is being developed to identify unmet needs, inequalities and areas of good practice in the delivery of services and wider system actions related to healthy weight in City and Hackney. There are also plans to appoint a Healthy Schools Coordinator, who can support schools to embed activities that improve the wellbeing of children, young people and their families.

<u>On ensuring access to Mental Health Support for Children and Young People</u>:

We are in year 3 of the delivery of the City and Hackney Integrated Emotional Health and Wellbeing Strategy 2020-2025, overseen by the Emotional Health and Wellbeing Partnership. Priorities include addressing the post-pandemic surge in crisis presentations, maintaining momentum around integration of the different Children and Adolescent Mental Health services and creating 'a single point of access'. Subgroups of the Partnership include families, neurodiverse/ learning disabilities, schools, education, training and employment. There are also a number of system wide Task and Finish Groups to address Crisis and Eating Disorders.

An update on implementation of the C&H Mental Health Strategy and a mental health needs assessment will be provided to the HWB during 2023. This will provide an opportunity to consider how any gaps in provision can be addressed.

3. Closing the gaps: Many impacts of the pandemic have worsened existing inequalities that were already on a poor trajectory - such as increasing child poverty. Partners in The City of London and Hackney must continue using evidence-based efforts to tackle poverty due to its far-reaching implications for children's health.

The London Borough of Hackney (LBH) has developed a Poverty Reduction Framework which sets out the Council's strategic approach to poverty reduction. It aims to meet the immediate needs of people already in poverty whilst working towards preventing poverty for future generations. While it was developed by LBH, it has wider applicability across the City and Hackney place-based partnership and many elements of it require a partnership approach.

LBH has established four workstreams to respond to the cost of living crisis, the first of which is providing support to residents. This includes establishing a "Money Hub" with a £800k package to support those who have no other source of monetary support, targeted support using the government's Household Support Fund (£2.8M), and embedding financial assistance into all aspects of the Children and Education directorate's work.

Co-locating welfare advice services within GP practices will be funded for an additional year and then evaluated to assess the impact and consider whether this service should be expanded to all primary care networks, including Shoreditch and the City.

Work being undertaken in the City of London to address poverty and the rising costs of living includes general communication activities to promote services such as access to energy advisors, access to warm places and support for accessing work through the **Connecting Communities** programme. Targeted financial assistance is also being provided through an Energy Grant Scheme for people on prepayment meters and through the government funded Housing Support Fund. On tackling food poverty, there are plans to commission the charity **Family Action** to deliver a food pantry service for City of London residents and those residing in bordering boroughs.

The impact of poverty and the cost of living crisis on children and families in City and Hackney is ongoing. Continued monitoring of this impact and ensuring that services are able to meet identified needs must continue.

Appendix 2.

A model of Sexual and Reproductive Health services

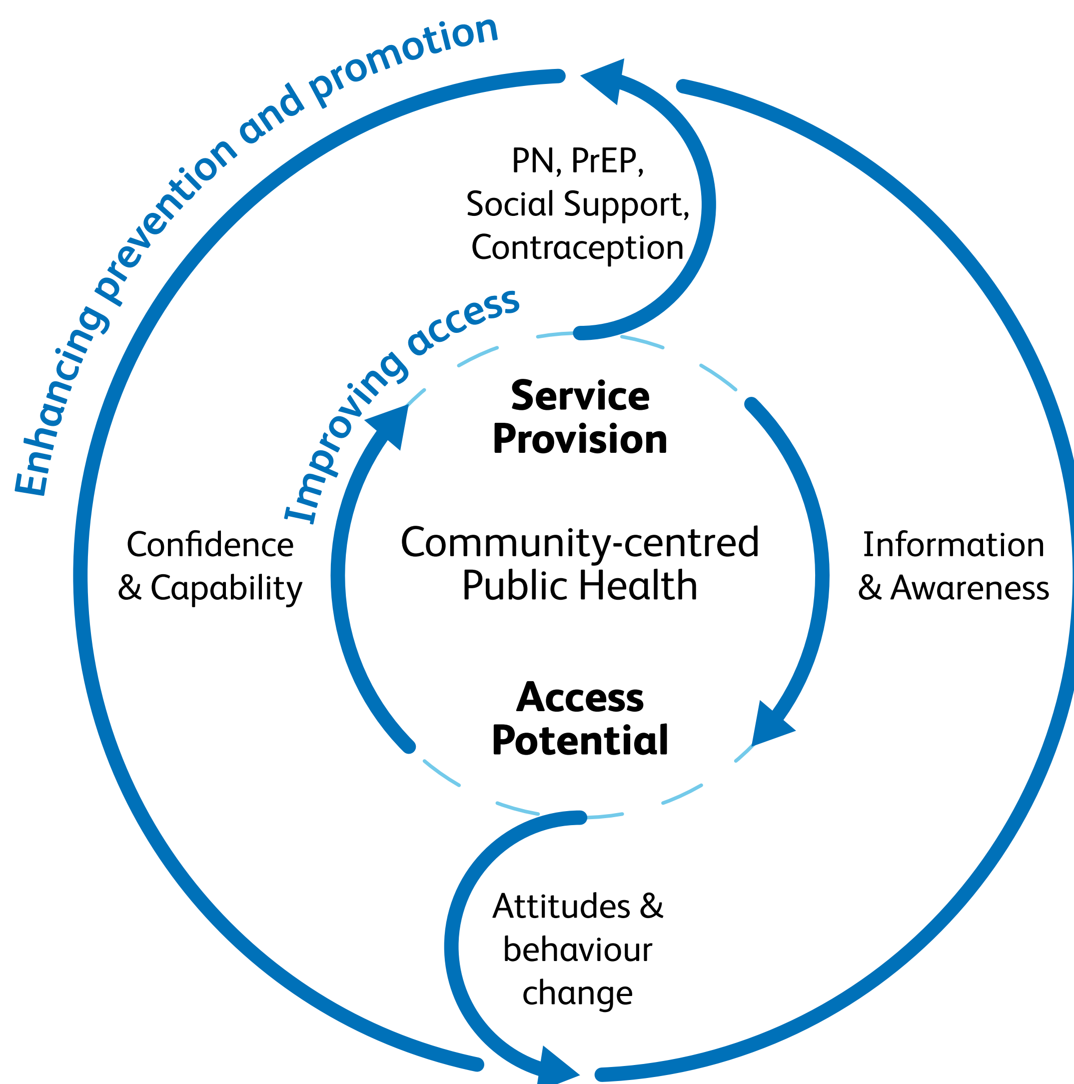
The model outlined here (see Figure 2) illustrates the linked nature of the recommendations made in this report, particularly recommendations 2 and 3 which relate to the design of services on the one hand and people's ability and willingness to access them on the other hand. The model demonstrates how initiatives taken in different areas are mutually supportive and the importance of keeping a focus on collaboration with communities at the centre of our work.

Many public health models look at the determinants of health, either from the perspective of the individual or the public, or they examine how best to implement and provide services to a population.[155] This model, however, aims to draw attention to the linked nature of service provision on the one hand and willingness, or ability, to access those services on the other hand. The issue of whether or not people have the potential, capability or willingness to access services is perhaps more relevant to sexual health than any other aspect of healthcare. It is in sexual health that, according to practitioners in the field, many of the barriers to access come from the individuals and communities themselves. This model, therefore, specifically applies to sexual health: where cultural and community norms are so paramount; and factors relating to personal choice, identity and individual circumstances are so significant. There are few fields of healthcare where the capacity to access services is so dependent upon issues that go beyond simply being aware that a service is available.

Applying this model to "young people" helps to illustrate that efforts to improve access must take into account many factors. The model can act, therefore, as a checklist when trying to address issues of access and, in turn, improve a population or community's sexual health generally.

For the model to be most useful, it would be best to apply it to a single community rather than "young people" in general. Stakeholders are encouraged to consider specific community-orientated approaches to designing, commissioning and implementing services - an approach which this model may help facilitate. For example, the model might be used to explore issues relating to Turkish-speaking communities, or to the Charedi community, or to other distinct communities.

Figure 2: a model of sexual and reproductive health services



Cycles of positive reinforcement

The outer circle: preventing ill health and other negative aspects while promoting enjoyment of sexual wellbeing, agency and freedom.

The inner circle: improving Access to services. This illustrates two aspects that need to be considered to improve access: the appropriateness of services provided (service provision) and the ability/willingness to access them (access potential).

As the inner circle spins, access improves which in turn helps widen the circle of prevention and health promotion at a population level.

Service provision: the right services, that are appropriate and sufficient, are available.

Information & Awareness: there is clear and accurate **information** available; and people are **aware** of that information and the services.

Access potential: an individual's willingness to access services, influenced by RSE, community & individual attitudes, religious and cultural contexts.

Confidence & Ability: people are **confident** to access services (not blocked by confidentiality, embarassment or stigma issues); and people are **capable** of accessing services (appropriate times and locations). As more people from a community access a service, word of mouth spreads and attitudes change.

Notes on terms used in the diagram

At the centre of the diagram

"Community-centred Public Health" is a community-centred approach to tackling public health issues which is increasingly being adopted "to enhance individual and community capabilities, create healthier places and reduce health inequalities" (PHE 2020[156]). It strongly advocates, among other things, a commitment to co-production and community-based participatory research.

The inner circle - improving Access

"Service provision": appropriate services, and arrangements, designed in collaboration with the community/ies of concern.

"Information & Awareness": appropriate services must be communicated to potential users of those services through high quality information (***better***, not more, information).

"Access potential": ensuring knowledge of services through, for example, public information campaigns, community champions, and relationships and sex education (RSE). Access potential can also be enhanced by addressing stigma and embarrassment and through mitigating any logistical or financial barriers that are identified (for example, some young people may not be able to cross gang lines).

"Confidence and capability": addressing issues around "access potential" should result in more willingness and ability to access the services available.

Ensuring appropriate "service provision" (for example, providing easily accessible comprehensive STI testing) while at the same time increasing the "access potential" among the population, will lead to benefits relating to the prevention of ill health and promotion of healthy sexuality. This will be self-reinforcing, with positive effects maximised by addressing as many aspects of the model as possible.

The outer circle - enhancing Prevention and Promotion

This circle represents the wider community - the population level - and the role of public health to promote wellbeing and prevent illness. The reach of this circle is increased by work to improve both "service provision" and "access potential".

"Service provision" helps achieve population level health promotion through elements such as patient notification (*PN*);[157] provision of ***contraception*** services; ***social support*** (including psychosexual, high risk behaviour and trauma therapies); and *PrEP* (albeit this involves relatively small numbers).

"Access potential" helps achieve population level health promotion through helping to change attitudes and health behaviours. Shifting people's attitudes, including stigma or prejudice, as well as their health behaviours, can both have the potential for positive knock-on effects on people who are not directly addressed by the original interventions (for example, the effects on parents as a result of their children's attendance at RSE, or positive health behaviours modelled by some individuals being adopted by others in their peer groups).

Efforts made to enhance s*ervice provision* and those made to increase *access potential* will both, together and separately, help support the prevention of ill health and the promotion of healthy and enriching relationships at a population level. Health promotion at the population level is fundamental to a community-centred public health approach. Focusing on prevention and promotion is about health ***care*** as opposed to a medical model of ***sick*** care. And not only is prevention better than cure for the individual, it is also cheaper for both the individual and the community.

Holding Hands, Hoxton Square, STIK 2020

Endnotes

1 Data is available from the Office for Health Improvement & Disparities (OHID) on their Fingertips platform (see **here**). The rate of "new STI diagnoses" excludes diagnoses of chlamydia in the under 25s because those numbers are so high it makes comparison between Local Authorities more difficult. However, even including all new STI diagnoses (see **here** for data), the rate in Hackney in 2022 was over four times higher than the England average, at 2,897 compared to 694 per 100,000. The value for the City of London was even higher, at 3,655 per 100,000 but it must be borne in mind that the absolute number of cases in the City of London is low (the total count was 315).

2 In 2021/22, approximately 10,000 STI screens were conducted across the sector, compared to over 23,000 in 2019/20 (Homerton Sexual Health Services, Sexual Health Equity Audit 2021/22).

3 "Sexual health-related issues are wide-ranging, and encompass sexual orientation and gender identity, sexual expression, relationships, and pleasure. They also include negative consequences or conditions such as: … sexually transmitted infections ... ; unintended pregnancy and abortion; sexual dysfunction; sexual violence; and harmful practices (such as female genital mutilation)." WHO website, Overview of "Sexual Health", available **here**.

4 Pound and Campbell (2017) **Policy Report** on the delivery of sex and relationship education, University of Bristol.

5 Hackney's population is estimated at 259,956, while the City's is 8,618. These figures are from the Office for National Statistics (ONS) mid-year 2021 population estimates, based on 2021 Census data (ONS **Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland**).

6 The 2021 ONS estimate, available **here**, suggests 65.5% of the population of the City of London and Hackney is 40 years old or under.

7 2021 Census data gives the following percentages for ethnic groups within the City of London and Hackney: white British 34.2%, black 20.5%, white other 19.46%, Asian 11%, other ethnic group 8.55%, mixed/multiple 6.71%,

8 **https://hackney.gov.uk/knowing-our-communities** accessed 25 January 2023.

9 **https://hackney.gov.uk/knowing-our-communities** accessed 25 January 2023.

10 2021 Census data on sexual orientation by sex available **here**. Data was released on 4 April 2023 and is for persons aged 16 and above.

11 This is particularly relevant to the provision of sexual health services because local data shows that men who have sex with men (MSM) are three and half times more likely to attend sexual health clinics than other men (HSHS Sexual Health Equity Audit 2021).

12 The "Index of Multiple Deprivation" combines several deprivation indicators relating to income, employment, crime, living environment, education, health, and barriers to housing and services, in various proportions to produce an overall figure which can be used to compare different regions.

13 The scores in London ranged from 9.4 for Richmond Upon Thames (the best) to 32.8 for Barking and Dagenham (see 2019 IMD scores on OHID Fingertips **here**).

14 It is important to note, when considering this contrast between the relative affluence of the City of London as opposed to Hackney, that the estimated residential population of the City of London is just 3.7% of the combined population of the City of London and Hackney. This means that more than 96% of the combined population of the City of London and Hackney live in the relatively deprived borough of Hackney.

15 "Strong links exist between deprivation and sexually transmitted infections (STIs), teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), trans community, teenagers, young adults and black and minority ethnic groups", DoH & PHE (2018) **Integrated Sexual Health Services: A suggested national service specification**, p.5.

16 PHE Guidance **Health matters: reproductive health and pregnancy planning**, 26 June 2018. Note that IUSs can, as well as being used for contraception, also be used as part of Hormone Replacement Therapy (HRT) to manage perimenopausal symptoms.

17 PHE Guidance **Health matters: reproductive health and pregnancy planning**, 26 June 2018.

18 These figures are for women aged 15-44 and exclude prescriptions for contraceptive injections.

19 From 2014 to 2021, Hackney was only below the London average in 2020.

20 See OHID Fingertips data available **here**. While increasing LARC provision through General Practice in Hackney may, therefore, represent an opportunity to enhance access to LARC for the local population, it is also possible that many people have historically simply preferred to access LARC through specialised sexual health clinics, and access to such clinics may be easier in Hackney and the City than in other parts of the country.

21 See 2021 data from OHID Fingertips, available **here**.

22 The provision of contraception, including LARC, is considered in more detail in the upcoming City and Hackney Sexual and Reproductive Health Five-Year Strategy.

23 Teenage mothers are less likely to finish education, more likely to bring up their child alone and in poverty, and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers (Office for Health Improvement and Disparities, available **here**).

24 See data available **here**. It must be noted that comparison with national averages is hampered by the relatively small absolute numbers involved. For 2020, the absolute number of conceptions in women under 18 years old in the City of London and Hackney was 44, indicating a rate of 10.1 per 1,000 women aged 15-17 living in the area.

25 Data for the City of London is not available.

26 In 2021, Hackney had the 3rd highest rate of abortions in women under 18 compared to its 15 nearest neighbours (UKHSA **Summary profile of local authority sexual health Hackney**, 1st Feb 2023).

27 UKHSA **Summary profile of local authority sexual health Hackney**, 1st Feb 2023.

28 Partner notification is the system by which sexual contacts of people diagnosed with an STI are informed that they should be tested and may require treatment. This can be done by the patient themselves but should also be available as an anonymous service through the healthcare provider. Effective partner notification systems are essential for timely treatment of those who may be infected but asymptomatic and to prevent further transmission. See further discussion of partner notification in the section on **testing for STIs** under **Recommendation 2** below.

29 OHID Fingertips, data available **here**. The value for the City of London was even higher, at 3,655 per 100,000 but it must be borne in mind that the absolute number of cases in the City of London was low (the total count was 315).

30 The City of London is the local authority with the second highest prevalence of HIV in England, while Hackney has the 13th highest prevalence. This is according to the most recent available data (**see here**) which is for 2022.

31 Data which includes primary care, secondary care and SHL, show that in the reporting year 2019/20 there were 23,568 STI screening tests performed compared to just 10,189 in the year 2021/22 (Homerton Sexual Health Services, Sexual Health Equity Audit 2021/22).

32 It must be borne in mind that not everyone can access SHL as it is only for people aged 16 and above and requires both access to online resources to book tests and an address where testing kits can be received.

33 The number of all new STI diagnoses in Hackney fell by 40% from 9,432 in 2019 to 5,614 in 2021 (UKHSA **Summary profile of local authority sexual health Hackney**, Feb 2023). However, the amount of testing across the sector dropped by 57% and at the same time the ratio of positive results to tests performed has increased slightly from 1:3.5 to 1:3.1 (HSHS, Sexual Health Equity Audit 2021).

34 Data for 2022 were released by OHID on 6 June 2023. These show that the number of new STI diagnoses in Hackney and the City of London increased in 2022 compared to the previous year. At the same time, the amount of STI testing (excluding chlamydia in the under 25s) also increased, albeit not by as much as the increase in new STI diagnoses. The inference that STI testing is still not matching the level of disease in the community is supported by the fact that the positivity rate for tests (again excluding chlamydia in the under 25s) for both Local Authorities is now slightly higher than before the pandemic (although this increase does not meet criteria for statistical significance). See **here** for OHID Fingertips Sexual Health data.

35 Examples of proactive engagement include teaching RSE in schools and the virtual engagement events organised by the Community Gynae pilot project commissioned by NHS England.

36 Indeed, there is debate in the field regarding the appropriate terminology to describe different services. Terms such as sexual health, reproductive health, women's health, gynaecology and maternity care all overlap with one another and can lead to confusion. The discussion around these, and other, terms is significant because of the implications for commissioning and determining where responsibility lies for funding. In this report, the term Sexual and Reproductive Health (SRH) has been adopted in order to mitigate some of these concerns and maintain a wide frame of focus on the issues.

37 The majority of STI-related care accessed by residents of the City of London and Hackney is provided by Homerton Sexual Health Services (HSHS). Between 2018 and 2020, 101,485 activity codes registered at the HSHS GUM service were for STI-related care (e.g. treatments prescribed and partner notification). During the same period,

7,560 SH patients were seen by GPs in the City of London and Hackney and only 9 appointments were provided by pharmacies in the City of London and Hackney for chlamydia treatment. This equates to HSHS providing 93.1% of care, GPs providing 6.9%, and pharmacies providing <0.1% (GUMCAD, CCG GP data, Pharmoutcome), as per the draft SRH Needs Assessment, Hackney & City Public Health Intelligence Team 2022.

38 Local information on PrEP is available on the Homerton Healthcare NHS Foundation Trust website **here** and general information at the **Prepster** website.

39 See UKHSA **Information on HPV vaccination** (updated 10 Aug 2022) for background on the human papillomavirus (HPV) vaccination programme (accessed 10 Feb 2022).

40 Stakeholders are nevertheless concerned about potential gaps and these are discussed below in the section "groups requiring particular attention".

41 For example, services available in evenings and weekends can reduce the cost of accessing services associated with lost earnings or facilitate access for those with caring responsibilities or in full-time education.

42 The Future Insight Partnership Project's evaluation of SRH services describes considerable problems at specialist clinics with appointment booking systems and telephone access (Future Insight Partnership Projects report, **East London Mystery Shopping**, Dec 2022).

43 Several service providers consulted during the preparation of this report expressed frustration with long waiting times as a result of staffing capacity. Issues relating to staffing are well known and present across the system, including in the voluntary sector.

44 Future Insight Partnership Projects report, **East London Mystery Shopping**, Dec 2022.

45 While HSHS continues to offer walk-in appointments to children under 19, this is only at one clinic. There is a specific service for young people aged 11-19 (CHYPS Plus) but it has not been able to maintain its level of service due to staffing issues.

46 Between 2018 and 2021, Hackney residents recorded a 390.1% increase in the number of tests completed through the sexual health e-service, while City residents recorded a 235.7% increase.

47 HSHS Sexual Health Equality Audit 2022.

48 The increase in the use of online sexual health services is dramatic and likely to continue. Evolving AI technology, such as ChatGPT, may facilitate the provision of additional information and advice via online services.

49 In January 2020, there were a total of 6,331 attendances at HSHS compared with just 3,470 in January 2023 (HSHS Equity Audit 2022 and HSHS Activity Report, January 2023). Comparing attendances specifically for LARC, in January 2023, HSHS had 70% of the attendances it had in January 2020 (297 as opposed to 425).

50 Although primary care stakeholders report a significant drop in face-to-face appointments, data from NHS NEL suggests that this has not been as dramatic as in secondary care. NHS NEL report that in February 2023, 76% of GP appointments were face-to-face as compared to 82% in February 2020 although they also note that the pre-pandemic data is not as reliable as they would like. It is important to bear in mind that a move to larger numbers of telephone consultations is welcomed by many patients and may represent improved efficiency. Nevertheless, there does appear to have been a significant reduction in the number of STI tests being carried out in primary care although again, stakeholders report considerable concerns regarding the reliability of the data.

51 The number of LARC prescriptions per 1,000 women in Hackney was 37.5 in 2021 after dropping to just 19.3 during 2020. In 2019, before the pandemic, the figure was 45.9 compared to a London average that year of 39.6 (OHID Fingertips data available **here**).

52 Staffing shortages have been described in almost all interviews conducted with stakeholders during the preparation of this report. In particular, nursing shortages, including school nurses, are impacting service provision. Staff shortages and high levels of turnover are reported in secondary care, general practice, pharmacies and the charity sector.

53 Some stakeholders felt that the impact of Brexit locally was to exacerbate staffing difficulties within healthcare.

54 "Self-reported measures of personal well-being dropped to record lows during the first and second waves, with some groups experiencing particularly poor or deteriorating mental health - including women, young people, disabled people, those in deprived neighbourhoods, certain ethnic minority groups and those who experienced local lockdowns" (quote from Living with COVID, referring to: Office for Health Improvement and Disparities, COVID-19: mental health and wellbeing surveillance report, 18 November 2021.

55 A Department of Education report notes that "pupils from disadvantaged backgrounds (primarily those eligible for free school meals at some point in the last six years) experienced greater learning losses than their more affluent peers as a result of

the pandemic." DfE **Understanding Progress in the 2020/21 Academic Year: Extension report covering the first half of the autumn term 2021/22**, March 2022. (p.8 accessed 20 Feb 2023).

56 For example, the proportion of men who have sex with men (MSM) accessing services at HSHS is higher than the proportion in the general population; and the number of white people accessing services at HSHS are lower (HSHS Sexual Health Equity Audit 2021).

57 Highlighting poverty as the overarching cause of inequalities in SRH does not undermine the importance of ongoing efforts to address racism, including structural racism. The UK Faculty of Public Health declared in 2020 that, "[n]ot enough is being done to rectify the inequalities experienced by Britain's minority ethnic population, as most recently demonstrated by **PHE's COVID-19 disparities review** and **stakeholder engagement**" (see Faculty of Public Health Statement on racism and inequalities, available **here**).

58 Office for Health Improvement & Disparities (2023) **Integrated sexual health service specification**.

59 2021 data on new STI diagnoses excluding chlamydia arranged by District and UA deprivation (IMD2019). Data source Fingertips accessed **here**. This trend is also seen in chlamydia detection rates in 15-24 year olds, see **here**.

60 This may partly be because financial issues act as a barrier, both directly and indirectly, to accessing services or continuing to engage with them. Service providers describe individuals who face financial difficulties losing touch with services because of their other concerns. This particularly affects people requiring longer term treatment or support.

61 As one local expert commented, "Hackney still has a deprived population and good sexual health goes hand in hand with addressing that deprivation".

62 The Homerton Sexual Health Services Equity Audit 2022 notes that 96% of PrEP prescriptions were for MSM. Furthermore, from July 2020 to March 2021, only 12% of individuals attending HSHS for initiation of PrEP were black, yet black people made up 33% of all clinic attendances suggesting that black communities are not accessing PrEP as might be expected. By contrast, during the same period, white people accounted for 63% of PrEP initiations but only 41% of patients seen at the clinic. It is important to bear in mind that the City of London is the local authority with the third highest prevalence of HIV in England, and Hackney has the twelfth highest prevalence (data available **here**).

63 Stakeholders in primary care report discussions with colleagues and reasling none of them have prescribed HRT for menopausal symptoms to Turkish-speaking patients. The Community Gynae Project Pilot has also recognised this potential gap and has plans to hold future events on menopause specifically for Turkish-speaking patients.

64 Late diagnosis is defined here as having a CD4 count <350 cells/mm3 within 91 days of first HIV diagnosis in the UK.

65 Data from the UKHSA Summary profile of local authority sexual health, Hackney, 1 Feb 2023. The report notes that data may refer either to Hackney or both Hackney and City of London combined.

66 In Hackney, 2019-2021, late diagnosis of HIV in heterosexual men occurred 53.3% of the time, similar to the 58.1% in England; in heterosexual women it was slightly higher than national average at 55.0% compared to 49.5% in England as a whole (UKHSA **Summary profile of local authority sexual health, Hackney**, 1 Feb 2023).

67 The NHS Talking Therapies programme was previously known as the Improving Access to Psychological Therapies (IAPT) programme and was developed as a way to improve access to evidence-based psychological therapies.

68 One clinician explained that, "splits in commissioning impact how we conceptualise and deliver care … in my experience, the commissioners don't talk to each other and it is beyond frustrating".

69 The **National LGBT Survey: Summary Report**, 2019 from the Government Equalities Office notes that "[o]f the 2,900 respondents who discussed gender transition and gender identity services … a picture was painted of hard-to-access services, a lack of knowledge among GPs about what services are available and how to access them, and the serious consequences of having to wait … trans people reported going abroad, using the internet to purchase hormones or turning to prostitution to raise the money needed to access private medical treatment" (accessed 26/1/2023). It further notes that trans people have high rates of self-harm, citing the **Trans Mental Health Study 2012**.

70 These figures are from the Office for National Statistics (ONS) mid-year 2021 population estimates, based on 2021 Census data (ONS **Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland**).

71 2021-2022 data from the Homerton Sexual Health Service (HSHS) show that 20-29 year old women are overrepresented in terms of accessing HSHS compared to the population as a whole.Similarly, 25-34 year old men are also overrepresented as users of HSHS services (Homerton Sexual Health Services, Sexual Health Equity Audit 2021/2022).

72 The peak age for men accessing services at HSHS is slightly higher than women. 38% of men accessing the services were under 30, but 62% of men were under the age of 35.

73 People aged 20-24 attending the service were more likely to have an STI diagnosis than any other age group.

74 Different organisations adopt different cut-offs. The

HSHS, for example, defines young people as those aged 25 and below.

75 ONS 2021 mid-year population estimates, available **here**.

76 NICE guideline [NG221] **Reducing sexually transmitted infections** Published: 15 June 2022, p.8. The same guideline gives recommendations for possible topics for discussion when working with communities on reducing STIs. The pdf version of the guidelines is available **here**.

77 NICE guideline [NG221] **Reducing sexually transmitted infections** Published: 15 June 2022, p.11.

78 The final version of the charter was published in 2022 with the cooperation of the London Borough of Hackney, the City of London Corporation, Hackney CVS, Mind in the City, Hackney and Waltham Forest, East London NHS Foundation Trust, Homerton Healthcare NHS Foundation Trust and the North East London Clinical Commissioning Group (now NHS North East London Integrated Care Board).

79 Community-centred Public Health is an approach to tackling public health issues which is adopted "to enhance individual and community capabilities, create healthier places and reduce health inequalities" (PHE 2020 briefing, Community-centred public health: Taking a whole system approach available **here**). See further **Health Matters** (28 February 2018) and the PHE/NHS England **guide to community-centred approaches** (2015).

80 This may follow the model adopted by the Hackney Young Futures Commission for their 2019/20 consultation using peer researchers supported by a project team (see **Valuing the Future Through Young Voices**); or the model be adopted by the Community Gynae Pilot Project in which members of the public are invited via their GPs to participate in virtual meetings of up to 100 people.

81 The issue of young people's awareness of services and their willingness to access them is dealt with under recommendation 3.

82 The 20-24 year old age group has recorded the highest number of STI tests per 100,000 people in the City of London and Hackney over the last five years of available data (2016 to 2020). This data is from the GUMCAD STI Surveillance System, a mandatory surveillance system for STIs that collects information on STI tests, diagnoses and services from all commissioned sexual health services in England.

83 Reinfection rates refer to the likelihood of someone testing positive for an STI within one year of previously testing positive.

84 In Hackney, an estimated 10.9% of women and 16.4% of men presenting with a new STI from 2015 to 2019 became re-infected with a new STI within 12 months. Nationally, during the same period, 7.1% of women and 9.9% of men became re-infected (SPLASH supplementary reinfections report).

85 In the year 2019/20, 23,568 STI tests were performed across the system compared to just 10,189 in the year 2021/22. The ratio of positive diagnoses to tests performed is similar post-pandemic, at 1:3.1 as it was pre-pandemic (1:3.5) (HSHS Health Equity Audit 2022).

86 The source of this data is the HSHS Sexual Health Equity Audit 2022. According to this audit, in 2021/22, SHL performed 6054 STI screens, HSHS 2128 and primary care 2007. These figures have been discussed with the GP Confederation who noted that it is possible that some negative test results in primary care were not recorded.

87 In January 2020, there were a total of 6,331 attendances at HSHS compared with just 3,470 in January 2023 (HSHS Equity Audit 2022 and HSHS Activity Report, January 2023).

88 The reason given on the website for moving to appointment only clinics is the need to maintain social distancing. Staff report that they have not been restarted due to staffing issues and concerns that people can become frustrated with long waits. Walk-in appointments are still available to children under 19 but only at one clinic. The specific service for young people aged 11-19 (CHYPS Plus), which is also run by the Homerton Healthcare NHS Trust, has unfortunately struggled to maintain its level of service post-pandemic due to staffing issues.

89 This was one of the main findings of the "East London Mystery Shopping" report, December 2022, by Future Insight Partnership Projects. Mystery Shoppers contacted 13 different SRH services across North East London. Mystery Shoppers reported telephone numbers not working; a lack of queuing system; extremely long waits in excess of one hour; and the phone ringing off unexpectedly. Difficulties were also reported when trying to book online. In total, 33.9% (n=20) of "shoppers" were able to get an appointment on their first attempt, 28.8% (n=17) needed to make five or more attempts to book an appointment, and 37.3% (n=22) were unsuccessful in booking an appointment despite trying on multiple occasions.

90 This is from CCG GP data quoted in the Hackney and City Sexual Health Needs Assessment 2023.

91 This data is from Pharmoutcomes and only applies to the 44 Hackney and City pharmacies that recorded information using the Pharmoutcomes system. As noted previously, the absolute number of STI kits provided in pharmacies is relatively small, with 921 self-test kits distributed in the four year period 2018-2021.

92 It is worth noting that the use of secondary care SRH services provided by Homerton Sexual Health Services (HSHS) does not, according to 2016-2020

data, vary considerably by geography, at least not within Hackney, which suggests that variations between GP practices and pharmacies is unlikely to relate to differences in the level of local need. While it is the case that the lowest appointment rate at HSHS services was recorded for City of London residents, this is most likely because these residents are relatively far from HSHS services and are probably seeking care elsewhere (data source: SRHAD).

93 Stakeholders from primary care have noted that new patient checks have, in many practices, stopped altogether because they were time consuming and poorly remunerated. STI testing, including for HIV, was commonly offered at these checks and they offered a good opportunity for providing health promotion information.

94 The need to provide training and information to staff is highlighted by stakeholders who report that, in primary care "there is definitely a lot of residual belief that there are counselling barriers to wider testing [for HIV]"; and that in pharmacies, high staff turnover means that staff are sometimes unaware of services or do not have the skills to counsel patients effectively.

95 Young Hackney's Health and Wellbeing Team attend schools to support the delivery of the Relationship and Sex Education (RSE). A list of the RSE sessions they offer in schools and colleges can be seen **here**.

96 Positive East uses a community based testing model: going into a range of venues where people can test to increase access. They report that around 30% of the people they help to test are not in primary care, and 20-25% of people are first time testers.

97 See **Society of Sexual Health Advisers** Guidance on Partner Notification, Aug 2015 available **here**.

98 The **British Association for Sexual Health and HIV** Standards for the management of sexually transmitted infections (STIs), (April 2019), states that "Commissioners should ensure that all providers of services commissioned to manage STIs: … instigate PN as a core requirement either by patient referral … or by provider referral …The form of PN utilised should be the choice of the person diagnosed with a STI" (p.37, available **here**).

99 **British Association for Sexual Health and HIV** Standards for the management of sexually transmitted infections (STIs), (April 2019).See p.36, available **here**.

100 The "status neutral" approach was first introduced in the US in relation to HIV prevention. It is described on the US CDC website (see **here**) as defining "the entry point to care as the time of an HIV test. At this entry point, clients' needs are assessed and they are engaged and linked to appropriate services based on these needs, regardless of whether their HIV test is positive or negative".

101 Residents aged 16+ can access contraception through SHL. This can be delivered to their home or collected from a pick-up point. 16-17 year-olds must collect their prescription from a pharmacy.

102 HSHS Equity Audit 2022 and HSHS Activity Report, January 2023.

103 City & Hackney GP Confederation data, 1 April 2021 to 1 January 2022.

104 Stakeholders also noted that GP surgeries pay a higher price for the coils themselves than the price offered to sexual health clinics.

105 Stakeholders suggest that if sufficient momentum could be established for training LARC fitters in primary care, individual practices would perhaps have less concern about the costs of establishing a service and the risk of staff leaving because they would be able to draw on a community of local fitters that could be employed on an ad-hoc basis to cover clinics when required.

106 The community gynae pilot project setting up a women's health hub stems from the government's **Women's Health Strategy for England** 2022. As well as LARC, it offers menopause services and organises virtual events, peer support networks and group consultations. For further information see the case study **Setting up a Women's Health Hub in Hackney** (May 2022) prepared by Primary Care Women's Health Forum.

107 Data from Pharmoutcomes, Pathway analytics, and Preventx.

108 Healthwatch Hackney, Mystery Shopping exercise of Access to Emergency Hormonal Contraception in Hackney, February 2023.

109 23 of the pharmacies confirmed that the service was free but three were unable to provide it for staffing or stock issues and five gave conflicting or confusing information.

110 One pharmacy that had offered free services on the phone, requested payment for the service during the visit.

111 Pharmacy data shows that EHC usage is highest among 15-24 year olds (Pharmoutcomes).

112 The Community African Network (CAN) is also commissioned to provide condoms to adults in The City of London and Hackney from black African and other ethnic minority groups.

113 Data from Pharmoutcomes and Therapy Audit Condom distribution data. In 2019 there were 60 registered outlets in The City of London and Hackney and 46 in 2020. The highest number of encounters was at the Clifden Centre (HSHS) followed by CHYPs Plus.

114 Homerton Sexual Health Services combined with CHYPS Plus accounted for 29.6% and Hackney's children and young people's services (Young Hackney) accounted for 15.2%.

115 Stakeholders report that condom distribution through primary care is, in contrast, largely ineffective because GP Practices are discouraged from participating in schemes because of requirements to be part of a pilot scheme and to record all distributions.

116 Homerton Sexual Health Services note on their website that walk-in appointments are still available at the Clifden Centre for people under 19 years old. However, this is only one out of their four centres and even there, only two clinics operate after 4pm: a GU evening clinic on Wednesdays 5-7pm and an MSM clinic 5-7pm on Thursdays. All other clinics finish at 4pm.

117 Some stakeholders have expressed concerns that youth hubs and clinics are not always universally accessible due to problems relating to gang lines. Also, young people have expressed concerns relating to risks to confidentiality when accessing some services: they are not always offered private consultation rooms in pharmacies, and the waiting room at the Clifden centre is currently shared with the hospital's general phlebotomy service.

118 Issues regarding booking systems and appointment availability were highlighted by the NEL Mystery Shopping exercise.

119 See **here** for the type of RSE support provided by Young Hackney's Health and Wellbeing Team.

120 Levels of LARC and STI testing vary considerably from GP practice to practice and between pharmacies; and specific concerns around provision of EHC in pharmacies have been identified.

121 Stakeholders in primary care report that partner notification systems are cumbersome and expensive, and consequently rarely being used. This creates the risk that people that may have been infected are not being notified which delays their treatment and increases the chance of onward transmission.

122 Primary care stakeholders report that negative STI tests are not routinely communicated to patients which is a missed opportunity for instigating behaviour change and making every contact count.

123 For example, HIV testing may be increased in primary care as part of new patient checks, where these are ongoing, or NHS health checks.

124 In 2018, Public Health England published **A consensus statement: reproductive health is a public health issue** which outlines six pillars of reproductive health. The "Knowledge and Resistance" pillar was described as having two elements, (1) to "[i]ncrease user awareness and knowledge about reproductive health over the life course, how to remain healthy, have positive fulfilling relationships and access care when needed." and (2) to "[f]acilitate access to sex and relationships education throughout the life-course, intergenerational learning and ensuring that reproductive health is part of wider public health messaging."

125 "Health promotion and education remain the cornerstones of STI prevention, through improving risk awareness and encouraging safer sexual behaviour." BASHH Standards for the management of sexually transmitted infections (STIs) in outreach settings, July 2016, p.4, available **here**.

126 NICE guidelines recommend that any interventions that are undertaken are delivered by people who share a culture or group background with the target group, and are "sex and identify positive", focusing on "self-worth and empowering people to have autonomy over their bodies and their sexual decision making" (see NICE Guidelines on **Reducing Sexual Transmitted Infections** [NG221] July 2022). The same guideline defines "sex-positive approaches" as being "non-judgemental, [and] openly communicating and reducing embarrassment around sex and sexuality. Recognising the diversity of sexual experiences that exists and that sex can be an important and pleasurable part of many people's lives." The full document is available **here**.

127 Stakeholders suggest that contraception, for example, could be better promoted throughout primary and secondary care. GPs were previously incentivised with Quality and Outcomes Framework (QOF) targets to provide advice to women whenever they had a contraceptive pill check or request a repeat prescription. This QOF target was not popular and has been removed but there are concerns that there may consequently be fewer conversations regarding LARC in primary care.

128 NICE defines sexual self-efficacy as a "person's sense of control over their sexual life and sexual health, and their ability as an individual to have safe, consensual and satisfying sex" (NICE guideline [NG221] **Reducing sexually transmitted infections** Published: 15 June 2022).

129 RSE became compulsory in all state-funded secondary schools in September 2020. The Sex Education Forum report, **RSE: The Evidence**, (Nov 2022) outlines evidence indicating that RSE can: reduce sexual violence; make children more likely to seek help; make them more likely to practise safe sex; make it more likely that 'first sex' is concensual; improve online literacy; and increase gender-equitable and inclusive attitudes.

130 Stakeholders have also emphasised the need to ensure that safeguarding is always considered when reviewing interventions, in particular issues of child sexual exploitation and possible problems relating to gangs.

131 This may, for example, follow the model of Making Every Contact Count brief interventions to affect behaviour change.

132 The recent Mystery Shoppers report on Sexual Health Services in North East London (December 2022) notes that service users were surprised that there is no single telephone or website access point for North East London SH services.

133 Stakeholders report the effectiveness of the **Shout Textline** run by Young Minds to provide mental health support to young people. It may be possible to offer a similar service regarding SRH if this was determined, by young people themselves, to be a popular way to access information and support.

134 This may include ensuring compliance with standards such as the **You're Welcome** criteria for young person appropriate services; reiterating commitments to anti-racism; effectively communicating commitment to confidentiality; or providing peer navigators/youth workers to help guide people through the process. One specific area of concern that has been raised by stakeholders is the co-location of SRH services with other services. For example, the co-location of general hospital phlebotomy services at the Clifden Sexual Health Clinic means that waiting areas are shared between people waiting for the sexual health services and those waiting for general blood tests. This may make people accessing the sexual health clinic feel less comfortable.

135 Different groups may have preferences for accessing services in GP practices, pharmacies, specialised clinics or online; and this should be taken into account.

136 Initiatives may involve schools, faith groups, Public Health Community Champions (now funded for a further 5 years), anchor institutions, youth hubs and VSOs. Public organisations in The City of London and Hackney may, for example, wish to engage with the Fast Track Cities **Anti Stigma HIV Charter**.

137 For a discussion of whole system commissioning and a useful set of key messages, see PHE **Making it Work: A guide to whole system commissioning for sexual health, reproductive health and HIV**, 2015. A whole system approach is also advocated in City and Hackney's integrated Children and Young People's Emotional Health and Wellbeing Strategy 2021-2026 available **here**.

138 NICE guideline [NG221] **Reducing sexually transmitted infections** Published: 15 June 2022.

139 While menopause services are primarily provided through primary care, it can be an area for fruitful collaboration between primary and secondary care, for example through the Community Gynae pilot project, and between public health and local employers through the City Corporation's Business Healthy network.

140 Some stakeholders interviewed for this report noted the need for commissioners to recognise the time commitment required by service providers to engage effectively not only with each other but also with the commissioners themselves. They also noted the importance of effective coordination between the various commissioning bodies whose work can impact the field of SRH.

141 Work is already being undertaken, for example, to enhance outreach from sexual health clinics providing LARC to postnatal wards and these efforts should be supported.

142 One stakeholder consulted in the preparation of this report gave the example that relative needs between different schools or colleges could be explored to determine whether STI infection rates or incidence of unplanned pregnancy is higher in some areas than others.

143 On the issue of PrEP, stakeholders discussed efforts to enhance collaboration between the charitable sector and secondary care, and to explore the possibility of PrEP being provided through primary care.

144 Proportionate universalism has been identified as one of the six pillars of reproductive health in a 2018 consensus statement from Public Health England (available **here**).

145 A Public Health Scotland 2014 briefing gives the following description: "Proportionate universalism aims to improve the health of the whole population, across the social gradient, while simultaneously improving the health of the most disadvantaged fastest. This approach recognises the continuum of need and addresses the possible disadvantage of a purely universal approach, which may result in disproportionate benefits for those groups most able to make use of services" (available **here**).

146 **BASHH Standards for the Management of STIs 2019**, at p.4.

Appendix Endnotes

147 See Appendix 2 for a model of sexual health services that illustrates the linked, and mutually supportive, nature of the recommendations made in this report.

148 Data provided **here** by the Office for Health Improvement and Disparities. The same trend is seen with routine vaccinations at five years old. The data from primary and secondary school aged children does not show such marked reductions.

149 Schools are following the approach outlined in the Education Endowment Foundation's **Guide to the Pupil Premium**.

150 The disadvantage gap index summarises the relative attainment gap between disadvantaged pupils and all other pupils. Pupils are defined as disadvantaged if they are known to have been eligible for free school meals at any point in the past six years (from year 6 to year 11), if they are recorded as having been looked after for at least one day or if they are recorded as having been adopted from care.

151 For further information see reports on **Key stage 2 attainment** (2021-22) and **Key stage 4 performance** (2021-22).

152 Hackney's Sustainability Team has been working with ProVeg International to promote use of plant-based, nutritious food in schools.

153 Public Health commissioned LBH's Environmental Health team to support Food Business Operators in Hackney to join the **Healthier Catering Commitment** and apply healthier cooking practices within their food businesses.

154 Hackney's Planning team has published '**Growing Up In Hackney: child-friendly places supplementary planning document**', which places a focus on outdoor play, and health and wellbeing within its design principles.

155 See for example, Figure 1 in PHE's 2020 briefing, Community-centred public health: Taking a whole system approach at p.6 available **here** (accessed 26 January 2023).

156 PHE's 2020 briefing, Community-centred public health: Taking a whole system approach available **here** accessed 26 January 2023. See also Public Health England and NHS England, A guide to community-centred approaches for health and wellbeing, Public Health England, Editor. 2015: London available **here**, which explains that community-centred approaches "are not just community-based, but about mobilising assets within communities, promoting equity, and increasing people's control over their health and lives." The February 2018 Edition of Health Matters, "community-centred approaches for health & wellbeing", available **here**, recommends commissioning across all four strands of the "family of community-centred approaches", which are summarised as: strengthening communities; volunteer and peer roles; collaborations and partnerships; and, access to community resources.

157 Patient notification refers here to both contact tracing and informing patients of test results. Note that, in primary care, negative STI tests are not routinely communicated to patients and there are reports of difficulties relating to contact tracing.

For further information or to view the full report, please visit **cityhackneyhealth.org.uk** or contact the Public Health team at **public.health@hackney.gov.uk**

HDS17072

Committee(s): Port Health and Environmental Services Health & Wellbeing Board	Dated: 09/01/2024 02/02/2024
Subject: Trading Standards Update – Nicotine Inhaling Products	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	1,2,5,6
Does this proposal require extra revenue and/or capital spending?	No
If so, how much?	**N/A**
What is the source of Funding?	**N/A**
Has this Funding Source been agreed with the Chamberlain's Department?	**N/A**
Report of: Bob Roberts, Executive Director Environment	**For Information**
Report author: Ian Dobson, Trading Standards Officer	

Summary

The purpose of this report is to inform members of the current situation with regards to sales of illegal nicotine inhaling products (vapes and e-cigarettes), the action currently being undertaken by the City of London's Trading Standards Service, including enforcement activity.

Recommendation(s)

Members are asked to note the report.

Main Report

Background

1. Nicotine inhaling products, often referred to as vapes or e-cigarettes, are battery-operated devices which heat a solution of nicotine and deliver it to the user in the form of an aerosol rather than through combustion of tobacco. The NHS claim that vaping is 95% safer than smoking tobacco and they, and The UK Health Security Agency (previously Public Health England), promote vaping as a safer alternative to smoking tobacco and as an effective smoking cessation aid for current smokers. The NHS do concede, however, that the long-term risks of vaping are not yet clear and discourage the use of vapes by persons who do not currently smoke tobacco.

2. There are concerns about the popularity of vaping among children and young people and the associated health risks. Nicotine is a poisonous and highly addictive substance which has been shown to harm adolescent brain development and can prove fatal in large doses.

3. A study by public health charity 'Action on Smoking and Health' (ASH) found that in March/April 2023 the proportion of children experimenting with vaping had grown by 50% year on year, from one in thirteen to one in nine. Children's awareness and the promotion of vapes has also grown and this is inevitably linked to the way that vape manufacturers make the products child appealing with packaging design and flavours.

4. Currently, vapes offered for sale are required to be notified to the Medicines and Healthcare Regulatory Agency and must comply with strict standards prescribed by the Tobacco and Related Products Regulations 2016 (TRPRs). The TRPRs stipulate the maximum strength and tank capacity of nicotine solutions, ban certain ingredients, and require specific labelling and health warnings. The TRPRs are defined as safety regulations for the purposes of the Consumer Protection Act 1987 and the enforcement responsibility sits with Trading Standards.

5. The sale of vapes to under 18s is also prohibited by the Nicotine Inhaling Products (Age of Sale and Proxy Purchasing) Regulations 2015.

6. Based on the findings of Trading Standards services around the UK, it is apparent that many vapes offered for sale do not comply with the strict requirements of the TRPRs, particularly with respect to maximum tank size, maximum strength of nicotine solution, labelling and presence of toxic metals such as nickel, cadmium and lead.

7. The Tobacco and Vapes Bill, announced in the King's Speech on 7 November 2023, seeks to reduce the appeal of vapes to children by regulating point-of-sale displays and restricting flavours, presentation and packaging of vapes. Restricting the sale of disposable vapes will also be considered. These products are not only attractive to children but are extremely harmful to the environment.

8. The BBC reports that around five million disposable vapes, which contain non-biodegradable plastics and toxic lithium batteries, are thrown away each week in normal bins or on the roadside and that recycling rates are low. Vapes can cause fires in refuse collection lorries and waste treatment facilities if not disposed of correctly, although this has not been an issue within the City to date.
9. The increased use of vapes is concerning from a waste production perspective, particularly single use vapes. Although vape recycling is possible, it is technically difficult due to the varied and complex nature of the products.

10. A recent government consultation on the subject recognised that although there are measures already in place to ensure responsible production and disposal of electronic items through the Waste Electrical and Electronic Equipment Regulations 2013 (WEEE) and obligations under the Waste Batteries and Accumulators Regulations 2009, compliance with these obligations is low, given the recent surge of businesses supplying disposable vapes.

11. There is further work in this area planned as both the WEEE and batteries regulations are being reviewed, with further consultations planned on the subject.

12. Information on disposing of vapes is on the City of London website under the recycling A to Z. Currently, there is a dedicated vape disposal point located in Tesco Cheapside. Additional drop off points will be added to the website as and when they become available.

Current Position

13. City of London Trading Standards Officers (TSOs) are authorised for the purposes of the TRPRs and the Nicotine Inhaling Products (Age of Sale and Proxy Purchasing) Regulations.

14. As part of a joint SLA with the Public Health Team and funded by the City's and Hackney's Public Health grants, TSOs have been conducting inspections of retailers selling vapes. Since November 2022 TSOs have carried out 28 visits to retailers to check that vapes sold in the City comply with the requirements of the TRPRs. Retailers are also being reminded of their legal obligation, under the WEEE (Waste Electrical and Electronic Equipment) Regulations, to provide facilities for safe recycling of vapes.

15. Out of the 28 premises visited, problems were found in ten premises. Around twelve thousand non-compliant vapes, and other related products such as oral tobacco and nicotine pouches, have been seized by City TSOs and taken off the market. The retail value of the seized, non-compliant stock is around £64,000. There have been three particularly large seizures of illegal products, one of which was reported on in February 2023 https://news.cityoflondon.gov.uk/40000-worth-of-illegal-vapes-taken-off-city-streets-set-to-be-destroyed/

16. Where illegal products are found, Trading Standards will decide on how to deal with the issues identified. In the case of significant seizures, retailers of non-compliant vapes are interviewed under caution with a view to possible prosecution. Where prosecution is not considered appropriate, having regard to the Port Health & Public Protection's Enforcement Policy, seized vapes have been surrendered voluntarily by the seller and safely destroyed by an authorised waste treatment company in accordance with relevant legal and environmental requirements. Sellers are required to meet the cost of secure destruction.

17. One recent inspection in October 2023 resulted in TSOs being obstructed while trying to carry out their duties. As a result, officers received excellent support from City of London Police and a large seizure was made. This matter is currently under investigation.

18. Currently, the Trading Standards Service is conducting a test-purchasing exercise to test retailers' age verification processes for the sales of vapes. An eighteen-year-old member of the trading standards team is visiting all retailers in the City that are known to sell vapes and attempting to make a purchase. Whilst a sale to an eighteen-year-old is not an offence under the Nicotine Inhaling

Products (Age of Sale and Proxy Purchasing) Regulations, it provides an indication that the seller's approach to age verification is not sufficiently robust because they have not effectively implemented a "Challenge 25" scheme, which requires a prospective purchaser of age-restricted products to provide documented proof of their age if they appear to be under the age of 25. Out of 14 purchases attempted, sales were made on 4 occasions without checking proof of age.

19. All schools/colleges within the City of London have been contacted by email to ascertain whether there are any concerns about students using vapes, but none have expressed any concerns.

20. Arrangements are being made for the Trading Standards Service to use fifteen- and sixteen-year-old volunteers for an under-age sales test-purchasing exercise. The exercise is planned to take place during 2024 and will focus initially on retailers that have previously failed a Challenge 25 test-purchase. Prior to commencing the exercise, these retailers will receive written notification of the Challenge 25 test-purchase failure and advice on good practice on sales of age-restricted products.

Corporate & Strategic Implications

21. None

Conclusion

22. The Trading Standards Service plays a significant role in ensuring that consumers in the City of London are not exposed to harm from non-compliant and dangerous nicotine inhaling products and that children and young people are protected from the health risks associated with nicotine consumption and being drawn into nicotine addiction through illegal sales of vapes.

23. If the proposals in the Tobacco and Vapes Bill becomes law, the Trading Standards Service will enforce the new provisions and this protection will be further strengthened.

Appendices

None

Background Papers

None

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Committee: Health and Wellbeing Board - For information	Dated: 02/02/2024
Subject: Healthwatch City of London Progress Report	**Public**
Report author: Gail Beer Chair, Healthwatch City of London	**For Information**

Summary

The purpose of this report is to update the Health and Wellbeing Board on progress against contractual targets and the work of Healthwatch City of London (HWCoL) with reference to November and December 2023

Recommendation

Members are asked to: Note the report.

Main Report

Background

Healthwatch is a governmental statutory mechanism intended to strengthen the collective voice of users of health and social care services and members of the public, both nationally and locally. It came into being in April 2013 as part of the Health and Social Care Act of 2012.

The City of London Corporation has funded a Healthwatch service for the City of London since 2013. The current contract for Healthwatch came into being in September 2019 and was awarded to a new charity Healthwatch City of London (HWCoL). HWCoL was entered on the Charities Commission register of charities in August 2019 as a Foundation Model Charity Incorporated Organisation and is Licenced by Healthwatch England (HWE) to use the Healthwatch brand.

HWCoL's vision is for a Health and Social Care system truly responsive to the needs of the City. HWCoL's mission is to be an independent and trusted body, known for its impartiality and integrity, which acts in the best interests of those who live and work in the City.

1 Current Position

The HWCoL team continues to operate from the Portsoken Community Centre and through hybrid working – both at the office and home working. Recruitment is underway to fill the Volunteer and Project Officer position, with interviews taking place later this month.

The communication platforms continue to provide residents with relevant information on Health and Social care services via the website, newsletters, bulletins and social media.

The recruitment of new Trustees to the Board is ongoing; and Trustees recently interviewed and made an offer in January. Activities continue to create a more diverse board that reflects all communities in the City of London

2 Healthwatch City of London Board

A private HWCoL Board meeting took place in November when Malcolm Waters was reappointed as a Trustee of Healthwatch City of London with immediate effect.

The term has been extended for four years.

3 Areas of concern

3.1 Over prescribing at the Portman Pharmacy

As noted in the last report, HWCoL have been made aware of over-dispensing of repeat prescriptions by the Portman Pharmacy. Dr Paul Gilluley, Chief Medical Officer at NHS North East London and the Neaman Practice were made aware of this.

The medicines optimisation team have looked into the matter and have reported back the following;

- The was reported to NHS England who manage complaints regarding community pharmacies, which will be reviewed and reported back to the medicines optimisation team
- The Neaman Practice and the pharmacy have met and put processes in place to prevent this from happening again. This includes the pharmacy identifying a specific member of staff to manage the repeat prescribing requests. Additional processes have been put in place by both the practice and the community pharmacy to ensure there is a robust process to managing requests. The practice is keen to continue to review this process.
- Senior pharmacists from the Portman Pharmacy attended the GP practice to ensure better communication is established to prevent this from happening again.
- The practice is very keen to develop and embed strategies to prevent this from happening again. They have identified risk mitigation and have established clearer communication routes with the pharmacy. They are also auditing this and looking for feedback to see meaningful change before they close the loop on this one.
- It should be noted that both the pharmacy and the Neaman practice have been very proactive to prevent this kind of error happening again.

4 Public Board Meetings

There were no public board meetings in the timeframe for this report.

5 Communications and Engagement

5.1 Patient Panels

Patient Panel – Cancer Screening

This panel was noted in the last report. The notes from the meeting can be read on our website. Patient Panel into Cancer Screening Programmes | Healthwatch Cityoflondon

Patient Panel – Cancer wait times standard.

This was held in November 2023 with the NHS North East London Cancer alliance with the focus on the new cancer wait times standard.

From 1 October 2023, changes have been made to cancer waiting times with the two weeks wait standard being removed and the remaining waiting times standards to be rationalised into three core measures. HWCoL were joined by Wayne Douglas, who is the lead for diagnosis and treatment at the NHS North East London Cancer Alliance, who explained these changes and answered questions on any of the concerns expressed during the session. The report from the session is on the HWCoLwebsite. Patient Panel into New Cancer Wait Times Standard | Healthwatch Cityoflondon

HWCoL will monitor the wait times and carry out a survey to measure patient satisfaction with the service.

There are three more panels scheduled for the Q4.

25th January – Deaf Awareness, with Jane Richardson, City Resident and Speech and Language professional.

9th February – Safeguarding – how to identify and report concerns in the City of London with Dr Adi Cooper, Chair City and Hackney Adults Safeguarding Board.

8th March – CPR (cardiopulmonary resuscitation) training with the London Ambulance Service

Further information can be found on the events page

5.2 An additional GP practice in the City

This has long been a desire of many residents and this issue was raised at the HWCoL AGM earlier this year with Ian Thomas CEO and Town Clerk CoL. Since then a number of residents have spoken in support about the possibility of not only an additional GP surgery, but a new surgery on one level and with more up to date facilities. The team will work with CoL and the NEL ICB to explore this further.

6 Volunteers

6.1 Training

Enter and View training took place for volunteers in November, giving HWCoL eight authorised enter and view representatives.

6.2 Christmas information leaflet

Working with the communications and engagement officer, one volunteer researched access and opening times for Health and Social Care services over the festive period. The information was collated into a leaflet that was distributed to our mailing list and available on the website.

6.3 Public Representatives

Healthwatch Hackney is funded to manage the City and Hackney public representatives programme. Public representatives attend focus groups giving their opinions on topics given by NHS North East London. Currently there are three City public representatives with two more scheduled to receive the training at the end of January. HWCoL have put forward the volunteers to the programme to ensure City representation and will hold quarterly feedback sessions with the group.

6.4 Barts Health NHS Trust PLACE Assessments

Members of the Board and staff undertook the recent place assessments held across Barts Health NHS Trust. The results from the assessments are due to be published in late February.

7 Projects

7.1 Mental Health Service Provision and Social Isolation

Scoping for this project is underway with ELFT and the Department of Community and Children's Services at CoL.

A meeting is scheduled for January for the project team to report back on their findings from the research activities identifying services available for the socially isolated and those affected.

7.2 Digital Apps

The project will focus on the plethora of apps used by both Primary and Secondary Care services and will commence in Q4. A team of HWCoL volunteers has been set up to work on the project and they will explore accessibility, integration and usefulness of the various apps and make recommendations to service providers.

8 Enter and View programme

Healthwatch has a statutory function to carry out Enter & View visits to health and care services to review services at the point of delivery. Following a halt in Enter and View due to Covid HWCoL have now recommenced this important activity.

8.1 Enter and View at Goodmans Fields Medical Centre

In September HWCoL, along with colleagues at Healthwatch Tower Hamlets carried out an Enter and View at the Goodman's Field Medical Centre.

The report has now been approved by the Board at Tower Hamlets Healthwatch and has been sent to the Practice for their comments. The final report should be published in Q4 and will be shared with this board at that time. .

8.2 Barts Health NHS Trust

The HWCoL team met with David Curran, Director of Nursing at St Bartholomew's Hospital to discuss an Enter and View at the hospital. Based on feedback from residents the Enter and View will focus on communication, the current administrative services and the impact on care.

The project brief has had approval from the HWCoL Board and will take place in Q4.

The team also met with Dr Neil Ashman CEO of the Royal London and Mile End sites to explore closer working and collaboration. Alongside colleagues at Tower

Hamlets Healthwatch it was agreed to set up much closer contact and work together to ensure the voice of City residents is heard at the hospital.

9 Q3 Performance Framework (Contractual Obligations)

There has been no significant change in performance as measured by the Key Performance Indicators. 20 green indicators and four amber indicators. The main concern is attendance of the public at HWCoL events; however, the Patient Panel series have proved popular with new people attending each time.

10 Neaman Practice

A meeting has taken place with the new Practice manager and a good dialogue is now open regarding PPG dates and attendance by users as mentioned in the last report.

11 Hoxton Health

As reported in many previous reports, foot health is a big issue for older residents in the City, and HWCoL has campaigned for the provision of a toenail cutting service and access to foot health in which we very much appreciate the support of the City of London officers. HWCoL is pleased to inform the Board that grant funding has been agreed for the service to continue at the Neaman Practice, Portsoken Community Centre and home visits.

12 Planned activities in Quarter 4 2023/24

In support of the delivery of the business plan during Q4 the team at HWCoL will:

- Recruit additional Trustees.
- Hold Patient Panels on Deaf Awareness, Safeguarding and CPR Training.
- Carry out an Enter and View visit at St Bartholomew's Hospital
- Digital Apps project
- Recruitment of new Volunteer and Project Officer.
- Campaign for an additional GP Practice in the City to be planned.

13 Conclusion

In conclusion it has been a busy few months at HWCoL increasing the number of volunteers, increasing engagement with City residents, working with NEL ICS to ensure that the City's voice is heard and reignited the Enter and View Programme.

Gail Beer
Chair
Healthwatch City of London
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Rachel Cleave
General Manager
Healthwatch City of London
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6

Committee(s):	Dated:
City of London Health and Wellbeing Board London Borough of Hackney Health and Wellbeing Board City and Hackney Neighbourhood Health and Care Board City and Hackney Health and Care Board	**02.02.2024** **25.01.2024** **Dates TBC** **Dates TBC**
Subject: North East London Integrated Care Board: Forward Plan Refresh 2024/2025	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	***Contribute to a flourishing society.*** *1. People are safe and feel safe.* *2. People enjoy good health and wellbeing.* *3. People have equal opportunities to enrich their lives and reach their full potential.* ***Shape outstanding environments*** *1. We inspire enterprise, excellence, creativity and collaboration.* *2. We have clean air, land and water and a thriving and sustainable natural environment.* *3. Our spaces are secure, resilient and well-maintained.*
Does this proposal require extra revenue and/or capital spending?	**N**
If so, how much?	**£0**
What is the source of Funding?	**NA**
Has this Funding Source been agreed with the Chamberlain's Department?	**NA**
Report of: NHS NEL Integrated Care System	**For Information**
Report author: Amy Wilkinson Director Partnerships, Impact and Delivery (City and Hackney Place Based Partnership / NHS NEL ICB)	

Summary

The NEL Joint Forward Plan (NEL JFP) 2024-2025 Refresh draft document, attached, follows on from the first JFP 23/24 submitted in June last year. The expectation is that our system's five-year plan is refreshed yearly and submitted to NHSE by the end of March each year. It will therefore continue to describe how we will, as a system, deliver our Integrated Care Partnership Strategy as well as core NHS services.

As a partnership, we continue to work towards developing a cohesive and comprehensive delivery plan for meeting all the challenges we face. As part of these annual refreshes going forward, we will work with local people, partners and stakeholders to iterate and improve the plan as we develop our partnership, to ensure it stays relevant and useful to partners across the system.

For next year's 2024/2025 refresh we have maintained much of the core information and headlines that are in the current iteration. Updating and amending statistics and information where relevant.

Key additions that will be made for next year's NEL JFP include dedicated slides for our Place-based Partnerships and the identified cross-cutting themes within our interim strategy, as well as all our system improvement portfolios.

At this stage it must be emphasised that this version of the JFP is drafted with refinements taking place until 23rd February.

The purpose of the paper is to inform the Health and Wellbeing Board of the intended process for refreshing the NHS NEL Joint Forward plan for 2024/25, and to discuss the contents of the plan.

Recommendation(s)

It is recommended that the HWBB:

- note why the JFP refresh is being undertaken and the approach being followed to deliver a refreshed NEL 24/25 JFP by March 2024.
- review and comment on the first JFP 24/25 draft document (Appendix 1- Draft JFP 24/25

Main Report

Background

1. NEL ICB was formed on 1 July 2022 following the Health and Care Act 2022, and we published our interim Integrated Care Strategy in January 2023. This was followed by the Joint Forward Plan 2023/24, our first five-year plan.
2. We are required to refresh the Joint Forward Plan (JFP) yearly, to reflect what we set out to deliver in the coming years.
3. We heard from our partners last year that they would like us to engage with them earlier in the process. These slides outline how we have structured our system planning process for 24/25 and where the JFP fits in, the steps we are taking to refresh the JFP for 24/25 as well as the main changes from the previous year.

4. Our Place-based Partnerships have been developing their plans for 2024/25, of which an overview is included in the JFP 24/25. To note, the City and Hackney Place slide is on slide 52.
5. We have included an unedited first DRAFT of the JFP 24/25 as an appendix, to indicate the direction of travel. A further draft will be available by the end of January 2024, with a final draft by the end of February. The ICB Board will be asked to approve the JFP 24/25 in March 2024.

Current Position

6. The NEL system planning cycle has been divided into three steps:
    1) integrated care strategy,
    2) delivery plan, and
    3) operational planning

   These are outlined in the paper with related deliverables included below each step. These are not comprehensive but indicate some of the key activities underpinning each stage.

7. **Joint Forward Plan (JFP) Refresh for 24/ 25 next steps:**

   Based on feedback and lessons learnt from this year's JFP development, we are now engaging with NEL System stakeholders earlier within the system planning cycle to ensure improved awareness and input to the 24/25 JFP.

   There will be annual refreshes of the JFP going forward in order to ensure that the document remains current. This JFP refresh continues to describe the challenges that we face as a system in meeting the health and care needs of our local people, but also the assets we hold within our partnership.

   Full timescales are outlined in the report.

Options

8. N/A

Proposals

9. NA

Key Data

10. NA

Corporate & Strategic Implications

11. Strategic implications:

The NHS NEL ICB Joint Forward Plan seeks to reflect and outline priorities that will improve health outcomes and reduce health inequalities for the City of London's population.

12. Financial implications:

None specifically outside of Business-as-usual arrangements

13. Resource implications:

None specifically outside of Business-as-usual arrangements

14. Legal implications:

None specifically outside of Business-as-usual arrangements

15. Risk implications:

None specifically outside of Business-as-usual arrangements

16. Equalities implications:

These will be considered by NEL ICB throughout the development and sign off of the plan.

17. Climate implications:

None specifically outside of Business-as-usual arrangements

18. Security implications:

None specifically outside of Business-as-usual arrangements

Conclusion

19. The Board is asked to note and discuss the process for development of the annual NHS NEL ICB Joint Forward Plan for 2024 - 2025.

Appendices

Appendix 1: Joint Forward Plan 24-25 - INITIAL DRAFT v1.0

The NEL Joint Forward Plan 2023/ 2024:

https://www.northeastlondonhcp.nhs.uk/ourplans/north-east-london-nel-joint-forward-plan/

Amy Wilkinson

Director of Partnerships, Impact and Delivery

NHS NEL ICB | City and Hackney Place Based Partnership

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North East London

Joint Forward Plan 24/25 Refresh:

Health & Well Being Board

02 February 2024

DRAFT

Introduction and considerations for the NEL HWBBs:

- NEL ICB was formed on 1 July 2022 following the Health and Care Act 2022, and we published our interim Integrated Care Strategy in January 2023. This was followed by the Joint Forward Plan 2023/24, our first five-year plan.
- We are required to refresh the Joint Forward Plan (JFP) yearly, to reflect what we set out to deliver in the coming years.
- We heard from our partners last year that they would like us to engage with them earlier in the process. These slides outlines how we have structured our system planning process for 24/25 and where the JFP fits in, the steps we are taking to refresh the JFP for 24/25 as well as the main changes from the previous year.
- Our Places-based Partnerships have been developing their plans for 2024/25, of which an overview is included in the JFP 24/25.
- We have included an unedited first DRAFT of the JFP 24/25 as an appendix, to indicate the direction of travel. A further draft will be available by end of January 2024, with a final draft by end of February. The ICB Board will be asked to approve the JFP 24/25 in March 2024.

Considerations for the HWBB membership:

Within the context of our interim integrated care strategy, members are asked to:

1) note why the JFP refresh is being undertaken and the approach being followed in order to deliver a refreshed NEL 24/25 JFP by March 2024.

2) note the amended content proposed

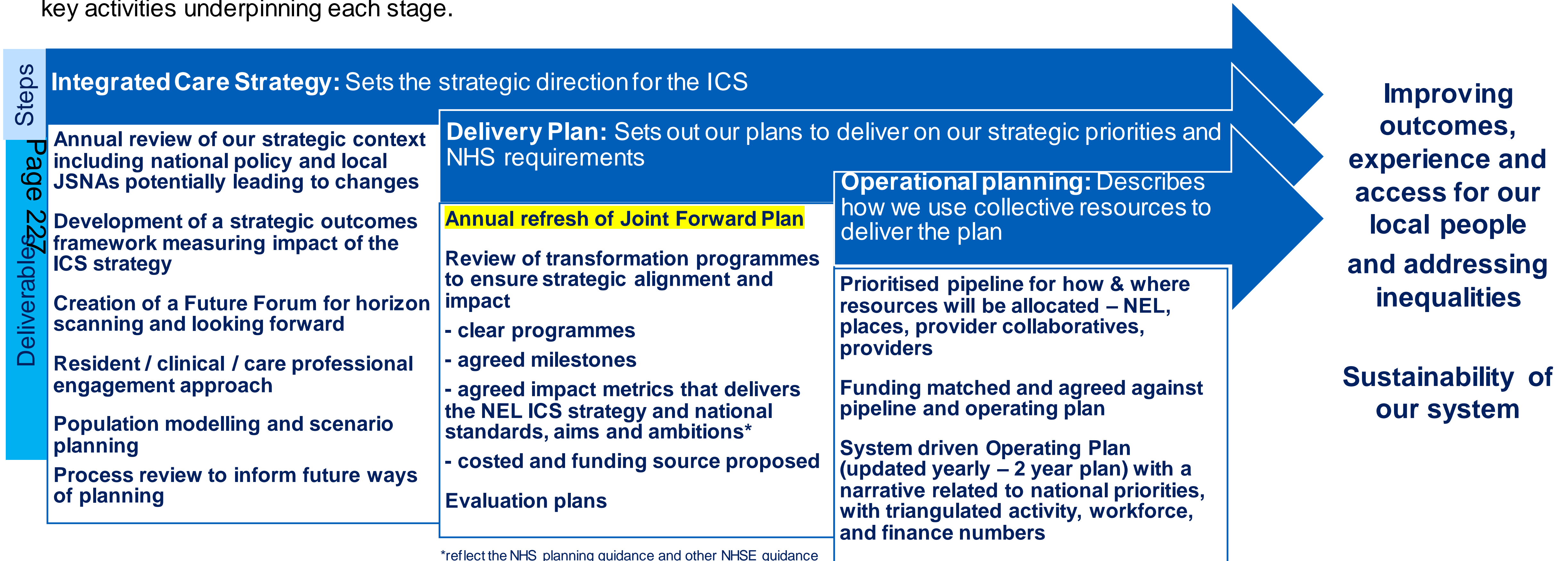
3) review and comment on the first JFP 24/25 draft document (Appendix 1 - Draft JFP 24/25)

Overview of system planning approach

The NEL system planning cycle has been divided into three steps:

1. integrated care strategy
2. delivery plan
3. operational planning

These are outlined below with related deliverables included below each step. These are not comprehensive but indicate some of the key activities underpinning each stage.



Joint Forward Plan (JFP) Refresh for 24/ 25 - next steps

- Based on feedback and lessons learnt from this year's JFP development, we are now engaging with NEL System stakeholders earlier within the system planning cycle in order to ensure improved awareness and input to the 24/25 JFP.
- There will be annual refreshes of the JFP going forward in order to ensure that the document remains current. This JFP refresh continues to describe the challenges that we face as a system in meeting the health and care needs of our local people, but also the assets we hold within our partnership.

High-level timeline

24 November 2023
We asked all slide contributors to submit their initial draft plans for 2024/25 for the JFP, providing a summary list of projects, and resourcing requirements.

13 December 2023
A portfolio workshop will be held with leads from the system portfolios, Places, cross-cutting themes and enablers. We aim to develop greater cohesion between portfolios, identify any synergies or duplication we need to address, but also to allow everyone share feedback on each other's plans.

9 January 2024
We will ask for updated slides based on the feedback from the December workshop.

February 2024
By 23rd February, all JFP contributors will need to submit their final plans/ JFP slide input, ready for sign off via appropriate meetings prior to submission by end of March 2024.

Main changes from the previous JFP

As we published our first JFP on 30 June 2023, we propose to keep the 2023/24 structure of the JFP, with some minor adjustments, as outlined below. Where references are made to figures, these will be updated to reflect the latest position.

Main additions:

- New slides to ensure we cover:
    - all our strategic system improvement portfolios in addition to our four strategic system priorities
    - our Place plans
    - our six cross-cutting themes and
    - our enables
- We have also included new slides outlining:
    - what is important to our residents and how it impacts our plans
    - our successes to date
    - how we are developing a strategic outcomes framework to help us assess if we are having an impact

North East London

Appendix 1:

24/25 Joint forward plan - draft document

(Note: Not for wider circulation)

North East London Health & Care Partnership

NHS North East London

North East London (NEL) Joint Forward Plan - Refresh

2024 - 2025

DRAFT

ALL SLIDES WITHIN THIS PACK ARE DRAFT VERSIONS

1. Introduction

DRAFT

Introduction

- This Joint Forward Plan is north east London's second five-year plan since the establishment of NHS NEL. In this plan, we build upon the first, refreshing and updating the challenges that we face as a system in meeting the health and care needs of our local people, but also the assets we hold within our partnership.
- We know that the current model of health and care provision in north east London needs to adapt and improve to meet the needs of our growing and changing population and in this plan we describe the substantial portfolio of transformation programmes that are seeking to do just that. We have now also included new slides our cross cutting themes and each of our seven Place based partnerships.
- The plan sets out the range of actions we are taking as a system to address the urgent pressures currently facing our services, the work we are undertaking collaboratively to improve the health and care of our population and reduce inequalities, and how we are developing key enablers such as our estate and digital infrastructure as well as financial sustainability.
- Our Joint Forward Plan will be refreshed yearly to reflect that, as a partnership, we have continual work to do to develop a cohesive and complete action plan for meeting all the challenges we face together. We will work with local people, partners and stakeholders to update and improve the plan yearly as we develop our partnership, to ensure it stays relevant and useful to partners across the system.

Highlighting the distinct challenges we face as we seek to create a sustainable health and care system serving the people of north east London

In submitting our Joint Forward Plan, we are asking for greater recognition of three key strategic challenges that are beyond our direct control. The impact of these challenges is increasingly affecting our ability to improve population health and inequalities, and to sustain core services and our system over the coming years.

- **Poverty and deprivation** – which is more severe and widely spread compared with other parts of London and England, and further exacerbated by the pandemic and cost of living which have disproportionately impacted communities in north east London
- **Population growth** – significantly greater compared with London and England as well as being concentrated in some of our most deprived and 'underserved' areas
- **Inadequate investment** available for the growth needed in both clinical and care capacity and capital development to meet the needs of our growing population

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In January 2023, our integrated care partnership published our first strategy, setting the overall direction for our Joint Forward Plan

Partners in NEL have agreed a **collective ambition** underpinned by a set of **design principles** for improving health, wellbeing and equity.

To achieve our ambition, partners are clear that a radical new approach to how we work as a system is needed. Through broad engagement, including with our health and wellbeing boards, place based partnerships and provider collaboratives we have identified **six cross-cutting themes** which will be key to developing innovative and sustainable services with a greater focus upstream on population health and tackling inequalities.

We know that our people are key to delivering these new ways of working and the success of all aspects of this strategy. This is why supporting, developing and retaining our workforce, as well as increasing local employment opportunities, is one of our four system priorities identified for this strategy.

Stakeholders across the partnership have agreed to focus together on **four priorities as a system.** There are, of course, a range of other areas that we will continue to collaborate on, however, we will ensure there is a particular focus on our system priorities. We have been working with partners to consider how all parts of our system can support improvements in quality and outcomes and reduce health inequalities in these areas.

We recognise that a **well-functioning system** that is able to meet the challenges of today and of future years is built on **sound foundations.** Our strategy therefore also includes an outline of our plans for how we will transform our enabling infrastructure to support better outcomes and a more sustainable system. This includes some of the elements of our new financial strategy which will be fundamental to the delivery of greater value as well as a shift in focus 'upstream'.

Critically we are committed to a relentless focus on equity as a system, embedding it in all that we do.

Both the strategy and this Joint Forward Plan build upon the principles that we have agreed as London ICBs with the Mayor of London

Our integrated care partnership's ambition is to
"Work with and for all the people of north east London
to create meaningful improvements in health, wellbeing and equity."

Improve quality and outcomes	Deepen collaboration	Create value	Secure greater equity

6 Crosscutting Themes underpinning our new ICS approach

- Tackling **Health Inequalities**
- Greater focus on **Prevention**
- Holistic and **Personalised** Care
- **Co-production** with local people
- Creating a **High Trust Environment** that supports integration and collaboration
- Operating as a **Learning System** driven by research and innovation

4 System Priorities for improving quality and outcomes, and tackling health inequalities

- Babies, Children & Young People
- Long Term Conditions
- Mental Health
- Local employment and workforce

Securing the foundations of our system

Improving our **physical** and **digital infrastructure**
Maximising **value** through collective financial stewardship, investing in prevention and innovation, and improving sustainability
Embedding **equity**

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The delivery of our Integrated Care Strategy and Joint Forward Plan is the responsibility of a partnership of health and care organisations working collaboratively to serve the people of north east London

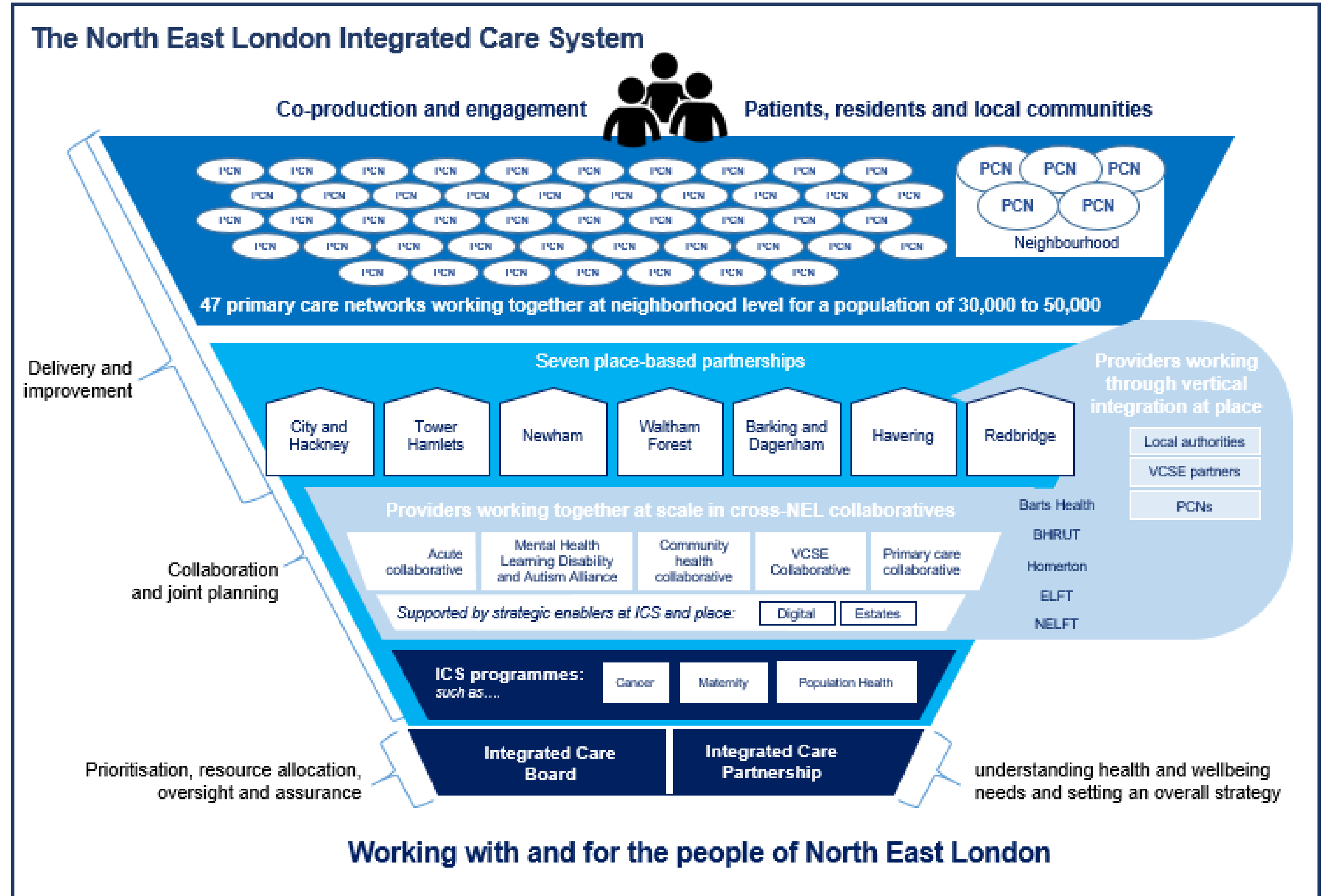
We are a broad partnership, brought together by a single purpose: **to improve health and wellbeing outcomes for the people of north east London**.

Each of our partners have positive impacts on the people of north east London – some providing care, others involved in planning services, and others impacting on wider determinants of health and care, such as housing and education. As we build upon and increase our collaboration and integrated ways of working the opportunity for greater impact will increase.

Our partnership between local people and communities, the NHS, local authorities and the voluntary and community sector, is uniquely positioned to improve all aspects of health and care including the wider determinants.

With hundreds of health and care organisations serving more than two million local people, we have to make sure that we are utilising each to the fullest and ensure that work is done, and decisions are made, at the most appropriate level.

Groups of partners coming together within partnerships are crucial building blocks for how we will deliver. Together they play critical roles in driving the improvement of health, wellbeing, and equality for all people living in north east London.



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2. Our unique population

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Understanding our unique population is key to addressing our challenges and capitalising on opportunities

NEL is a diverse, vibrant and thriving part of London with a rapidly growing population of over two million people, living across seven boroughs and the City of London. It is rich in history, culture and deep-rooted connections with huge community assets, resilience and strengths. Despite this, local people experience significant health inequalities. An understanding of our population is a key part of addressing this.

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Rich diversity

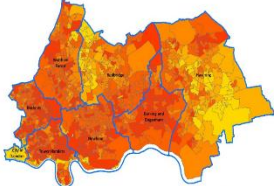
NEL is made up of many different communities and cultures. Just over half (53%) of our population are from ethnic minority backgrounds.

Our diversity means a 'one size fits all' approach will not work for local people and communities, but there is a huge opportunity to draw on a diverse range of community assets and strengths.

Young, densely populated and growing rapidly

There are currently just over two million residents in NEL and an additional 300,000 will be living here by 2040.

We currently have a large working age population, with high rates of unemployment and self-employment. A third of our population has a long term condition. Growth projections suggest our population is changing, with large increases in older people over the coming decades.



Poverty, deprivation and the wider determinants of health

Nearly a quarter of NEL people live in one of the most deprived 20% of areas in England. Many children in NEL are growing up in low income households (up to a quarter in several of our places).

Poverty and deprivation are key determinants of health and the current cost of living pressures are increasing the urgency of the challenge.

Stark health inequalities

There are significant inequalities within and between our communities in NEL. Our population has worse health outcomes than the rest of the country across many key indicators. Health inequalities are linked to wider social and economic inequalities, including poverty and ethnicity.

Our population has been disproportionately impacted by the pandemic and recent cost of living increase.

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What is important to our residents (Big Conversation themes)

PLACE

HOLDER

SLIDE

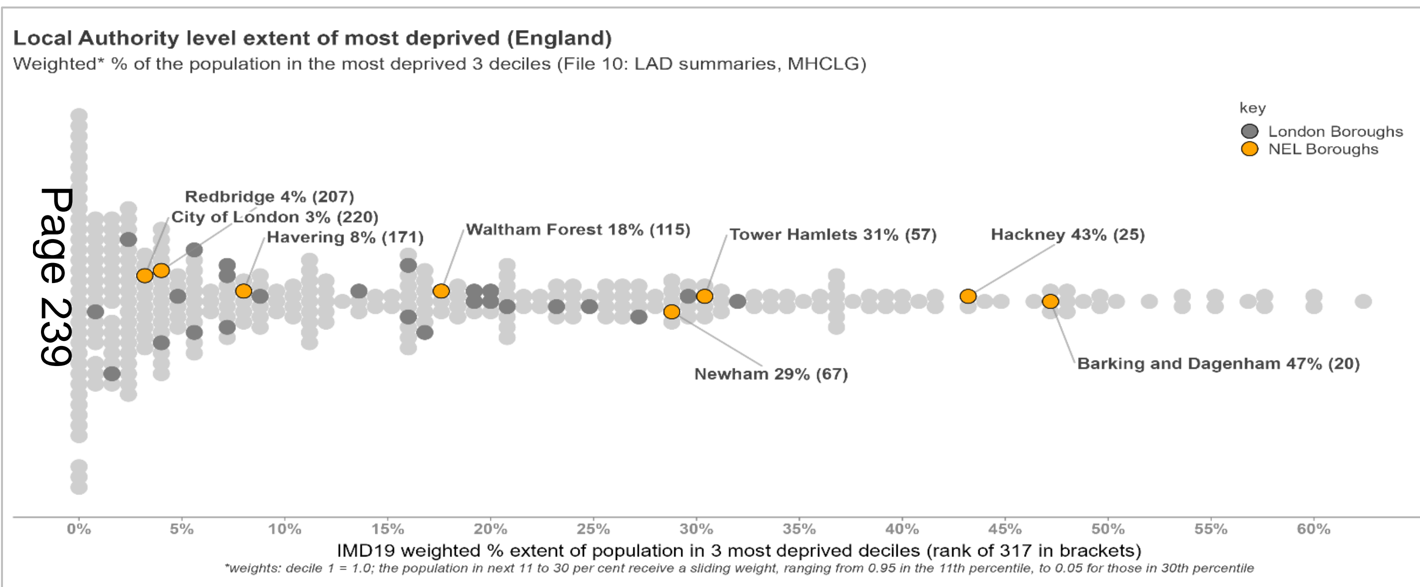
<SLIDE IN DEVELOPMENT>

DRAFT

Key factors affecting the health of our population and driving inequalities - poverty, deprivation and ethnicity

Large proportions of our population live in some of the most deprived areas nationally. NEL has four of the top six most deprived Borough populations in London, and some of the highest in the country, with Hackney and Baking and Dagenham in the top twenty-five of 377 local authorities (chart below).

By deprivation quintile, Barking and Dagenham (54%), City and Hackney (40%), Newham (25%) and Tower Hamlets (29%), have between a quarter and more than half of their population living in the most deprived 20% of areas in England (map and chart right).



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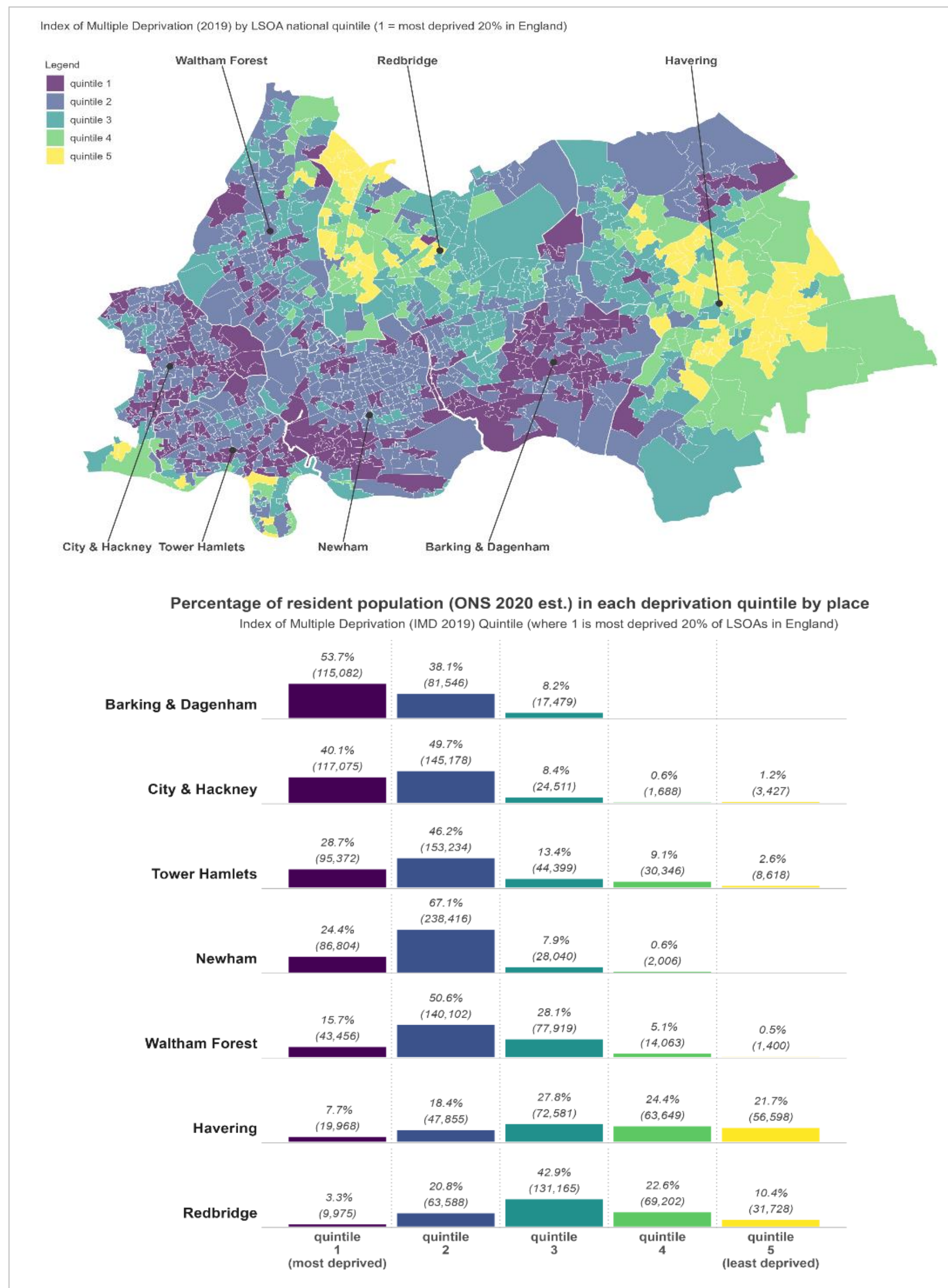

People living in deprived neighbourhoods, and from certain ethnic backgrounds, are more likely to have a long term condition and to suffer more severe symptoms. For example, the poorest people in our communities have a 60% higher prevalence of long term conditions than the wealthiest along with 30% higher severity of disease. People of South Asian ethnic origin are at greater risk of developing Type 2 Diabetes and cardiovascular disease, and people with an African or Caribbean family background are at greater risk of sickle cell disease.

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To meet the needs of our population we need a much greater focus on prevention, addressing unmet need and tackling health inequalities

Child Obesity

Nearly 10% of year 6 children in Barking and Dagenham are severely obese. Nearly are third of children are obese (the highest prevalence rate in London).

NEL also has a higher proportion of adults who are physically inactive compared to London and England.

Mental Health

It is estimated that nearly a quarter of adults in NEL suffer with depression or anxiety, yet QOF diagnosed prevalence is around 9%. Whilst the number of MH related attendances has decreased in 22/23, the number of A&E attendances with MH presentation waiting over 12 hours shows an increasing trend, increasing pressure on UEC services.

Tobacco

One in 20 pregnant women smokes at time of delivery. Smoking prevalence, as identified by the GP survey, is higher than the England average in most NEL places. In the same survey, NEL has the lowest 'quit smoking' levels in England.

Premature CVD mortality

In NEL there is a very clear association between premature mortality from CVD and levels of deprivation. The most deprived areas have more than twice the rate of premature deaths compared to the least deprived areas. 2021/22 figures showed for every 1 unit increase in deprivation, the premature mortality rate increases by approximately 11 deaths per 100,000 population.

Vulnerable housing

NEL has higher numbers of vulnerably housed and homeless people, including refugee and asylum seekers, compared to both London and England. At the end of September 2022, 11,741 households in NEL were in council arranged temporary accommodation. This is a rate of 23 households per thousand compared to 16 per thousand in London and 4 per thousand in England as a whole.

Homelessness

Shelter estimates in 2022 there were 42,399 homeless individuals in NEL inc. those in temp accommodation, hostels, rough sleeping and in social services accommodation. That's 1 in 47 people, compared to 1 in 208 people across England and 1 in 58 in London. People experiencing homeless have worse health outcomes & face extremely elevated disease and mortality risks which are eight to twelve times higher than the general population.

Childhood Poverty

Five NEL boroughs have the highest proportion of children living in low income families in London. In 2020/21, 98,332 of NEL young people were living in low-income families, equating to 32% of London's young people living in low-income families. Since 2014 the proportion of children living in low income families is increasing faster in NEL than the England average.

Childhood Vaccinations

The NEL average rate of uptake for ALL infant and early years vaccinations is lower than both the London and the England rates
There are particular challenges in some communities/parts within Hackney, Redbridge, Newham and B&D, where rates are very low with some small areas where coverage is less than 20% of the eligible population.

There is clear indication of unmet need across our communities in NEL

- For many conditions there are low recorded prevalence rates, while at the same time most NEL places have a higher Standardised Mortality Ratio for those under 75 (SMR<75) – a measure of premature deaths in a population – compared to the England average. Whilst some of this may be due to the age profile of our population, there may be significant unmet health and care need in our communities that is not being identified, or effectively met, by our current service offers.
- Analysis of DNAs (people not attending a booked health appointment) in NEL has shown these are more common among particular groups. For example, at Whipps Cross Hospital, DNAs are highest among people living in deprived areas and among young black men. Further work is now happening to understand how we can better support these groups and understand the barriers to people attending appointments across the system.

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Our population is not static – we expect it to grow by over 300,000 in the coming years, significantly increasing demand for local health and care services

The population of north east London (currently just over 2 million) is projected to increase by almost 15% (or 300k people) between 2023 and 2040. This is equivalent to adding a whole new borough to the ICS, and is by far the largest population increase in London.

The majority of NEL's population growth during 2023-2040 will occur within three boroughs: Barking and Dagenham (27%), Newham (26.3%) and Tower Hamlets (20.3%), all of which are currently home to some of the most deprived communities in London/England.

ICS	Increase in population 2023-2040
NEL	+303,365
SEL	+175,292
NWL	+169,344
NCL	+115,801
SWL	+90,220

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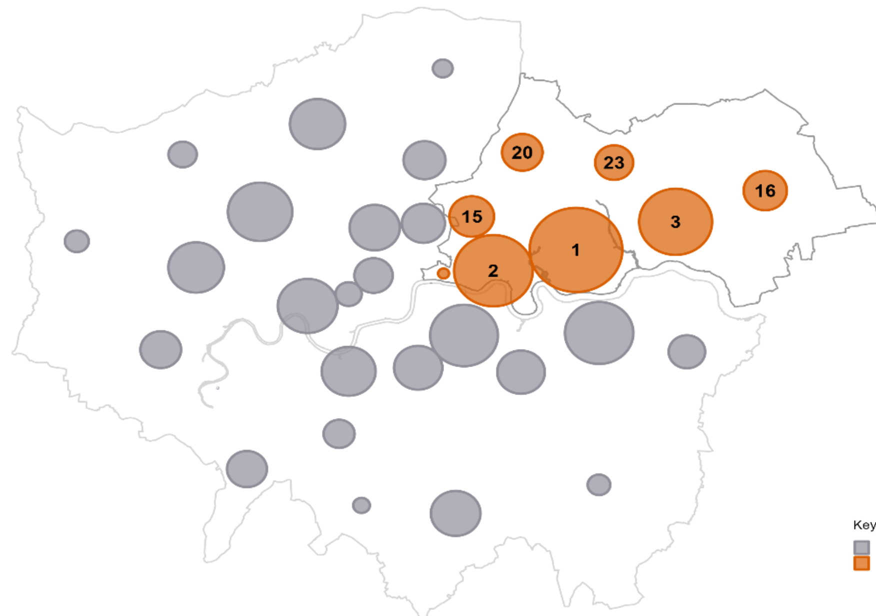
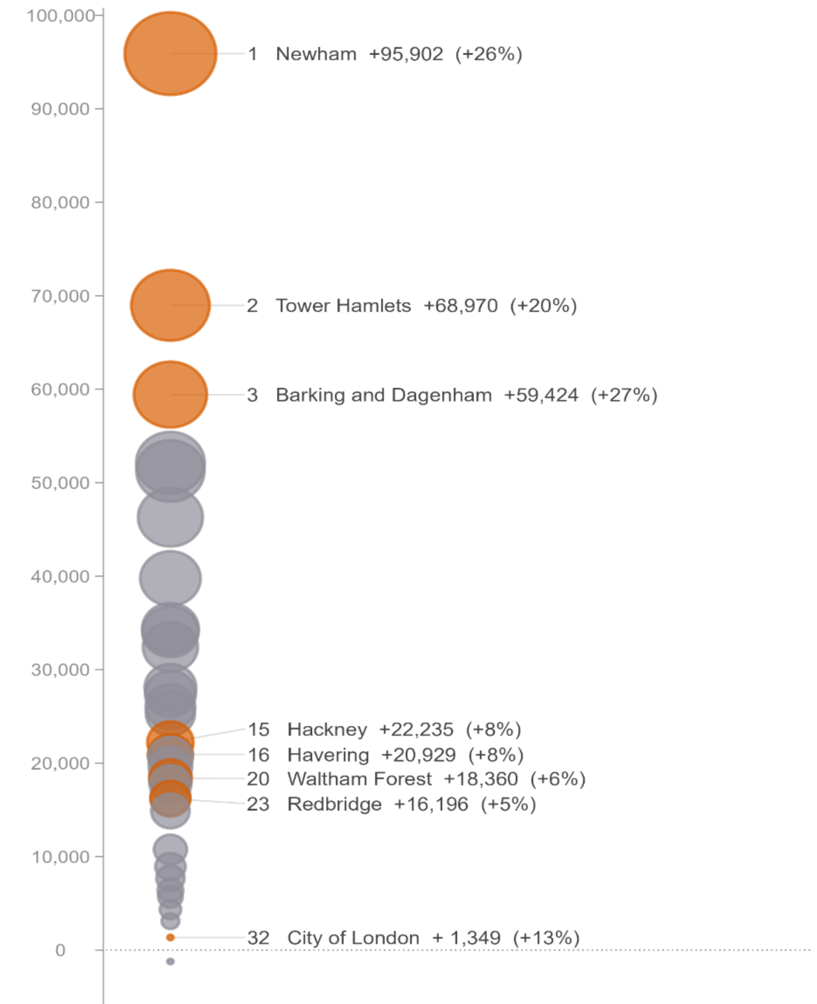
In addition, the age profile of our population is set to change in the coming years. Our population now is relatively young, however, some of our boroughs will see high increases in the number of older people as well as increasing complexity in overall health and care needs.





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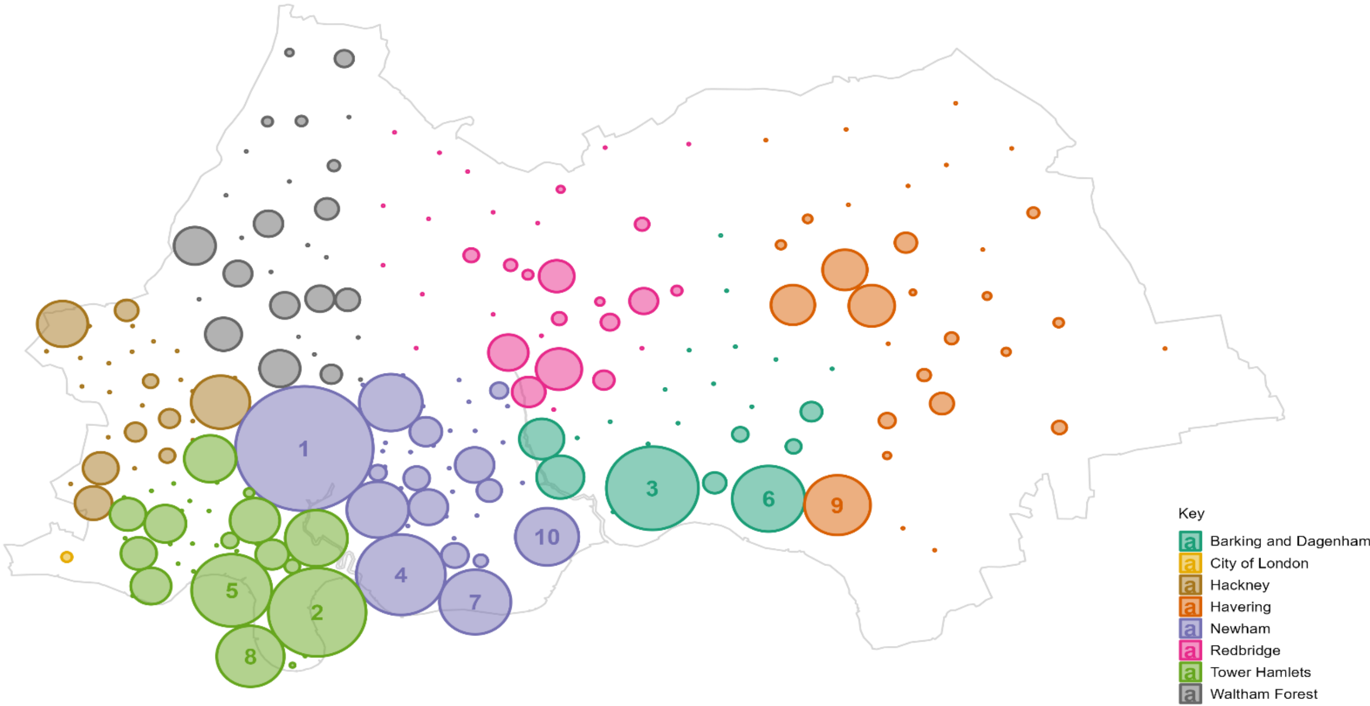
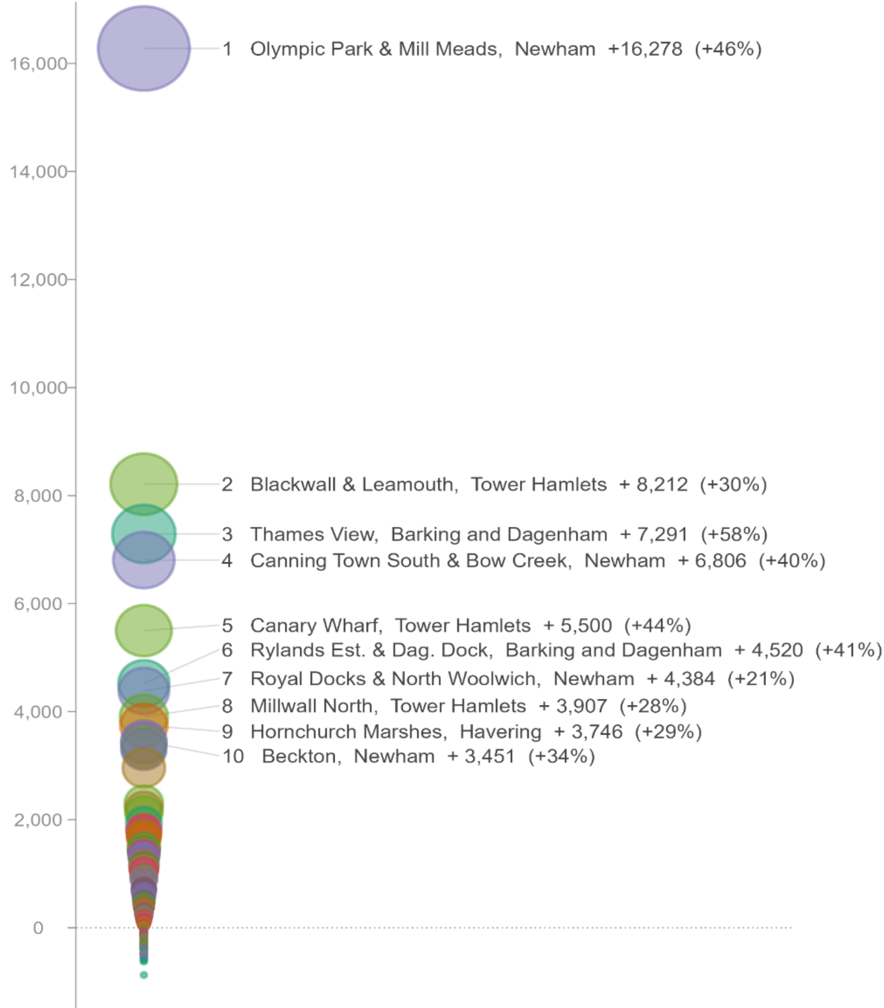
We need to act urgently to improve population health and address the impact of population growth

Across NEL the population is expected to increase by 5% (or 100k people) over the five years of this plan (2023-2028). Our largest increases are in the south of the ICS, in areas with new housing developments such as the Olympic Park in Newham, around Canary Wharf on the Isle of Dogs, and Thames View in Barking and Dagenham.

Sustaining core services for our rapidly growing population will require a systematic focus on prevention and innovation as well as increased longer term investment in our health and care infrastructure.





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3. Our assets

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We have significant assets to draw on

North east London (NEL) has a growing population of over two million people and is a vibrant, diverse and distinctive area of London, steeped in history and culture. The 2012 Olympics were a catalyst for regeneration across Stratford and the surrounding area, bringing a new lease of life and enhancing the reputation of this exciting part of London. This has brought with it an increase in new housing developments and improved transport infrastructure and amenities. Additionally, the area is benefiting from investment in health and care facilities with a world class life sciences centre in development at Whitechapel. There are also plans for the Whipps Cross Hospital redevelopment and for a new health and wellbeing hub on the site of St George's Hospital in Havering, making it an exciting time to live and work in north east London.

Our assets

- **The people of north east London** – bring vibrancy and diversity, form the bedrock of our partnership, participating in our decisions and co-producing our work. They are also our workforce, provide billions of hours of care and support to each other and know best how to deliver services in ways which work for them.

- **Research and innovation** – continuously improving, learning from international best practice and undertaking from our own research and pilots, and our work with higher education and academia partners, to evidence what works for our diverse communities/groups. We want to build on this work, strengthen what we have learnt, to provide world-class services that will enhance our communities for the future.

- **Leadership** – our system benefits from a diverse and talented group of clinical and professional leaders who ensure we learn from, and implement, the best examples of how to do things, and innovate, using data and evidence in order to continually improve. Strong clinical leadership is essential to lead communities, to support us in considering the difficult decisions we need to make about how we use our limited resources, and help set priorities that everyone in NEL is aligned to. Overall our ICS will benefit from integrated leadership, spanning senior leaders to front line staff, who know how to make things happen, the CVS who bring invaluable perspectives from ground level, and local people who know best how to do things in a way which will have real impact on people.

- **Financial resources** – we spend nearly £4bn on health services in NEL. Across our public sector partners in north east London, including local authorities, schools and the police, there is around £3bn more. By thinking about how we use these resources together, in ways which most effectively support the objectives we want to achieve at all levels of the system, we can ensure they are spent more effectively, and in particular, in ways which improve outcomes and reduce inequality in a sustainable way.

- **Primary care** - is the bedrock of our health system and we will support primary care leaders to ensure we have a multi-disciplinary workforce, which is responsive and proactive to local population needs and focused on increasing quality, as well as supported by our partners to improve outcomes for local people.

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Our health and care workforce is our greatest asset

Our health and care workforce is the linchpin of our system and central to every aspect of our new Integrated Care Strategy and Joint Forward Plan. We want staff to work more closely across organisations, collaborating and learning from each other, so that all of our practice can meet the standards of the best. By working in multi-disciplinary teams, the needs of local people, not the way organisations work, will be key. Where necessary, our workforce will step outside organisational boundaries to deliver services closer to communities.

Our staff will be able to serve the population of NEL most effectively if they are treated fairly, and are representative of our local communities at all levels in our organisations. Many of our staff come from our places already and we want to increase this further.

Our workforce is critical to transforming and delivering the new models of care we will need to meet rising demand from a population that is growing rapidly, with ever more complex health and care needs. We must ensure that our workforce has access to the right support to develop the skills needed to deliver the health and care services of the future, and to adapt to new ways of working, and, potentially, new roles. AI and digitalisation will play a major role in determining our workforce needs over the next ten years.

Our ICS People and Culture Strategy will ensure there is a system wide plan to underpin the delivery of our new Integrated Care Strategy and Joint Forward Plan, through adopting a joined up 'One Workforce for NEL Health and Social Care' across the system that will work in new ways, across organisational boundaries and be seamlessly deployed for the delivery of health and care priorities. The strategy will focus on increasing support for our current and potential workforce through the implementation of inclusive retention and health and well-being strategies, and creating innovative, flexible and redesigned heath and care careers.

It will ensure right enablers at System, Place, Neighbourhood and in our provider collaboratives, to strengthen the behaviours and values that support greater integration, and collaboration across teams, organisations and sectors. It will contribute to the social and economic development of our local population through upskilling and employing under-represented groups from our local people, through creating innovative new roles, values-based recruitment and locally-tailored, inclusive supply and attraction strategies in collaboration with education providers.

There are almost one hundred thousand people working in health and care in NEL, and our employed workforce is growing every year.

Our workforce includes:

- Over 5,600 people working in general practice (Aug 23)
- 47,638 people working in our Trusts (Aug 23)
- 46,000 people working in adult social care including the independent sector (22/23)
- These are supported by a voluntary sector workforce roughly estimated at over 30,000

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There are opportunities to realise from closer working between health, social care and the voluntary and community sector

Voluntary, Community, and Social Enterprise (VCSE) organisations are essential to the planning of care and to supporting a greater shift towards prevention and self-care. They work closely with local communities and are key system transformation, innovation and integration partners.

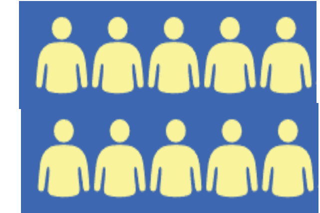
In NEL we are supporting the development of a VCSE Collaborative to create the enabling infrastructure and support sustainability of our rich and diverse VCSE in NEL, also ensuring that the contribution of the VCSE is valued equally.

Social care plays a crucial role in improving the overall health and well-being of local people including those who are service users and patients in north east London. Social care promotes people's wellbeing and supports them to live independently, staying well and safe, and it includes the provision of support and assistance to individuals who have difficulty carrying out their day-to-day activities due to physical, mental, or social limitations. It can therefore help to prevent hospital admissions and reduce the length of hospital stays. This is particularly important for elderly patients and those with chronic conditions, who may require long-term social care support to maintain their independence and quality of life.

In north east London 75% of elective patients discharged to a care home have a length of stay that is over 20 days (this compares to 33% for the median London ICS).

The **work of local authorities more broadly, including their public health teams,** as well as education, housing and economic development, work to address the wider determinants of health such as poverty, social isolation and poor housing conditions. As described above, these are significant challenges in north east London, critical to addressing health and wellbeing outcomes and inequalities.

In our strategy engagement we heard of the desire to accelerate integration across all parts of our system to support better access, experience and outcomes for local people. We heard about the opportunities to support greater multidisciplinary working and training, the practical arrangements that need to be in place to support greater integration, including access to shared data, and the importance of creating a high trust and value-based environment which encourages and supports collaboration and integration.



There are **more than 1,300 charities operating across north east London**, many either directly involved in health and care or in areas we know have a significant impact on the health and wellbeing of our local people, such as reducing social isolation and loneliness, which is particularly important for people who are vulnerable and/or elderly.

Thousands of informal carers play a pivotal role in our communities across NEL, supporting family and friends in their care, including enabling them to live independently.

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4. Our challenges and opportunities

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The key challenges facing our health and care services

Partners in NEL are clear that we need a **radical new approach to how we work as an integrated care system** to tackle the challenges we face today as well as securing our sustainability for the future. Our Integrated Care Strategy highlights that a shift in focus upstream will be critical for improving the health of our population and tackling inequalities. The health of our population is at risk of worsening over time without more effective **prevention** and **closer working with partners** who directly or indirectly have a significant impact on healthcare and the health and wellbeing of local people, such as local authority partners and VCSE organisations.

Two of the most pressing and visible challenges our system faces today, which we must continue to focus on, are the long waits for accessing **same day urgent care;** and a large backlog of patients waiting for **planned care**. Provision of urgent care in NEL is more resource intensive and expensive than it needs to be and the backlog for planned care, which grew substantially during Covid, is not yet coming down, as productivity levels are only just returning to pre-pandemic levels. Both areas reflect pressures in other parts of the system, and have knock-on impacts.

The wider determinants of health are also key challenges that contribute to challenges. Most of our places we have seen unemployment rise during the pandemic, although this number is dropping, and we still have populations who remain unemployed or inactive.

We currently have a **blend of health and care provision for our population that is unaffordable**, with a significant underlying deficit across health and care providers (in excess of £100m going into 23/24). If we simply do more of the same, as our population grows, our financial position will worsen further and we will not be able to invest in the prevention we need to support sustainability of our system.

To address these challenges and enable a greater focus upstream, it is necessary to focus on **improving primary and community care services**, as these are the first points of contact for patients and can help to prevent hospital admissions and reduce the burden on acute care services. This means investing in resources and infrastructure to support primary care providers, including better technology, training and development for healthcare professionals, and better integration of primary care with community services. In addition, there is a need for better management and **support for those with long-term conditions** (almost a third of our population in NEL). People with LTCs are often high users of healthcare services and may require complex and ongoing care. This can include initiatives such as care coordination, case management, and self-management support, which can help to improve the quality of care, prevent acute exacerbation of a condition and reduce costs.

Achieving this will require our workforce to grow. This is a key challenge, with high numbers of vacancies across NEL, staff turnover of around 23% and staff reporting burnout, particularly since the COVID-19 pandemic.

The following slides describe these core challenges and potential opportunities in more detail. Where possible we have taken a population health approach, considering how our population uses the many different parts of our health and care system and why. More work is required to build this fuller picture (including through a linked dataset) and this forms part of our development work as a system.

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We face substantial pressures on same day urgent care

Key messages	***Detail***
Demand for same day urgent care is growing rapidly as NEL's population grows	• Demographic and non-demographic changes to the NEL population are projected to increase demand for A&E attendance and unplanned admissions by 15-16% over the next 5 years
The status quo isn't viable. Doing more of the same will exacerbate existing pressures	• We have significant performance challenges across all three acute Trusts (e.g. average 60% on 4 hour A&E target) • Growing demand for unplanned care within acute settings risks undermining efforts to reduce backlog of patients waiting for planned care
Improvements in care pathways, including a shift of system resource to out of hospital services (primary and community care), could help reduce demand for expensive unplanned acute care for some patients	• Rates of avoidable admissions (for conditions that ought to be manageable through better primary care) are high at a large number of primary care practices within NEL (between 37 and 46 depending on the type of avoidable admission) • Mental Health patients are facing long waits in A&E (4,440 waited more than 12 hours during 22/23) • Non-conveyance from ambulance calls to care homes vary considerably and represent a higher proportion than the London average • Around 13% of A&E attendances leave without any significant investigation or treatment, suggesting they could have been better managed elsewhere in the system
Patients on waiting lists are causing pressures across other parts of the system	• A snapshot of the current elective waiting list indicates that 14% of the patients waiting for elective care have been responsible for 47,000 A&E attendances during their wait
There is an opportunity for improving UEC by better system working	• An analysis of NEL against other London ICSs indicates that moving to the median ICS performance for non-elective admissions would see a reduction of around 10%. This would be a substantial contribution to closing the projected gap created by growing demand and equates to around £65m per year

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We have a large backlog of people waiting for planned care

Key messages	*Detail*
Demand for elective care is growing, adding to a large existing backlog	• Demand for planned care is expected to grow by 19.7% between 2022/23 and 2027/28, or by around 4% per year. • There are currently around 174,000 people waiting for elective care As of December 2022, 18 people had been waiting longer than 104 weeks, 843 longer than 78 weeks and 8,646 longer than 52 weeks.
Activity levels vary week on week for many reasons and we haven't yet seen consistent week on week improvements in the total waiting list size	• The 'breakeven' point for NEL's waiting list (neither increasing nor decreasing) requires an activity level of 4,281 per week*. This breakeven point is expected to increase by around 4% per year due to projected increases in demand. • Activity levels vary throughout the year. For instance, in Sept-Dec 2022 trusts in NEL were reducing the overall number of waiters by 391 per week, whereas since then the overall number waiting has increased.
There are financial implications from over/under performance on elective care	• We have an opportunity to earn more income (from NHSE) by outperforming activity targets, thereby bringing more money into north east London. If the additional cost of performing that extra activity is below NHSPS unit prices then this also supports our overall financial position.
Tackling the elective backlog is a long-term goal and will require continuous improvements to be made	• A reasonably crude analysis of our elective activity suggests that delivering elective care at the rate of our peak system performance for last year (Sept-Dec 2022) would lead to no one waiting over 18 weeks by September 2027. This timescale would require an uplift in care delivery each year equivalent to expected demand increases (4% per year).
There may be opportunities for improvements in elective care, particularly around LOS	• An analysis of NEL against other London ICSs indicates that moving to the median LOS for elective admissions would reduce bed days by 13% and moving to the England median would reduce bed days by 31% (comparison excludes day cases).

* Activity calculations are based on assessment of those on waiting list for more than 18 weeks, at end of Feb 2023

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We need to expand and improve primary and community care, including improving care and support for those with long term conditions

- North-east London currently has fewer GP appointments per 100,000 weighted population than other ICSs in England. The national median is around 8% greater than in NEL, suggesting part of the cause of pressure on other parts of the system, including greater than expected non-elective admissions at the acute providers, may be due to insufficient primary care capacity.
- Across NEL there is wide variation in the number of delivered appointments or average clinical care encounters per week. For 2022/23 this ranges from 93.56 per 1000 (weighted registered) patients in Tower Hamlets, to 68.01 per 1000 (weighted registered) patients in Havering. The NEL average is 77.78 per 1000 (weighted registered) patients.**
- Between March 2022 and March 2023, booked general practice appointments across NEL increased by around 32% to 11 million appointments. 56% of appointments were delivered by other professionals such as nurses and 43% of all appointments were seen on the same day as they were booked*. This figure includes both planned and reactive care. 57% of appointments were patient-initiated contacts, booked and seen on the same day.***
- We are developing a set of principles to streamline patient access to the most appropriate type of appointment and advice, with clear signposting, for health care professionals and local people to ensure they are directed to the full range of services available at Practice and Place, in and out of general practice hours.
- Without substantial increases in primary care staffing the GP to patient ratio will worsen as demand for primary care increases in line with projected population growth. There are pockets of workforce shortages with significant variation in approaches to training, education and recruitment. We are committed to focusing upon retention initiatives such as mentoring and portfolio careers having developed SPIN (specialised Portfolio innovation) which is the basis for the national fellowship programme which we are offering to GPs and other professional groups.
- Community care in north east London is currently fragmented, with around 65 providers offering an array of community services. More work is required to understand the impact this has on patient outcomes and variability across NEL's places, but we know that for pulmonary rehab, for example, there is variation in service inclusion criteria and the staffing models used, and that waiting times vary between 35 and 172 days, with completion rates between 36% and 72% across our places and services.
- More children and young people are on community waiting lists in NEL than any other ICS (NEL is about average, across England, for the number of people on adult community waiting lists).
- There are opportunities to build on our best practice to further develop integrated neighbourhood teams, based on MDTs, social prescribing and use of community pharmacy consultation services, which will strengthen both our continuity of care of long term conditions and our ability to work preventatively.

Long term conditions

- Across north east London, one in four (over 600 thousand people) have at least one long term condition, with significant variation between our places (in Havering the figure is 33%, vs 23% in Newham and Tower Hamlets).
- Age and deprivation are strong predictors of long term conditions, so while north east London has a relatively young population, significant areas of deprivation drive our numbers up (those in the poorest areas, the bottom deprivation quintile, can on average expect to get a long term condition around 10 years earlier than those in the best off, the top deprivation quintile)
- In 21/22 those with long term conditions accounted for 139,213 A&E attendances; 53,676 emergency admissions and 488,057 bed days.

 Source(s): *GPAD, **Discovery, ***Edenbridge APEX

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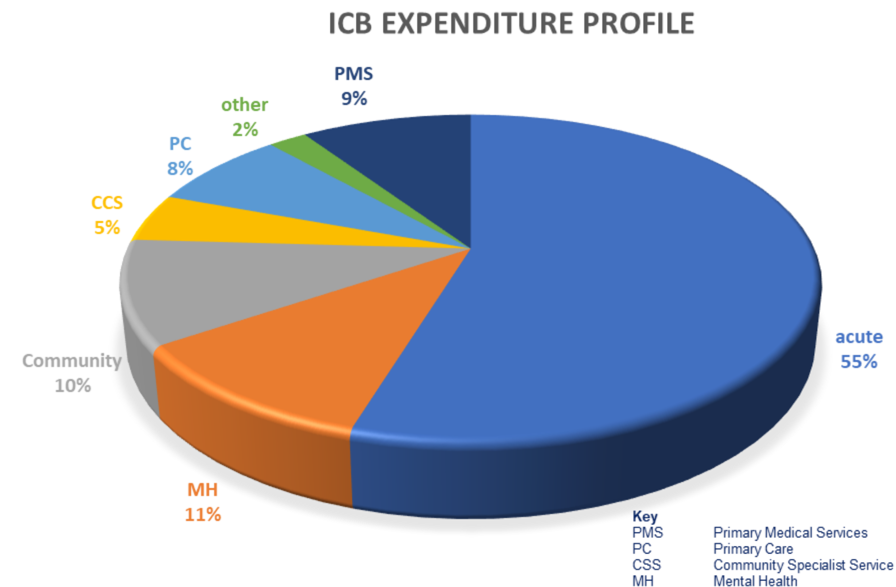
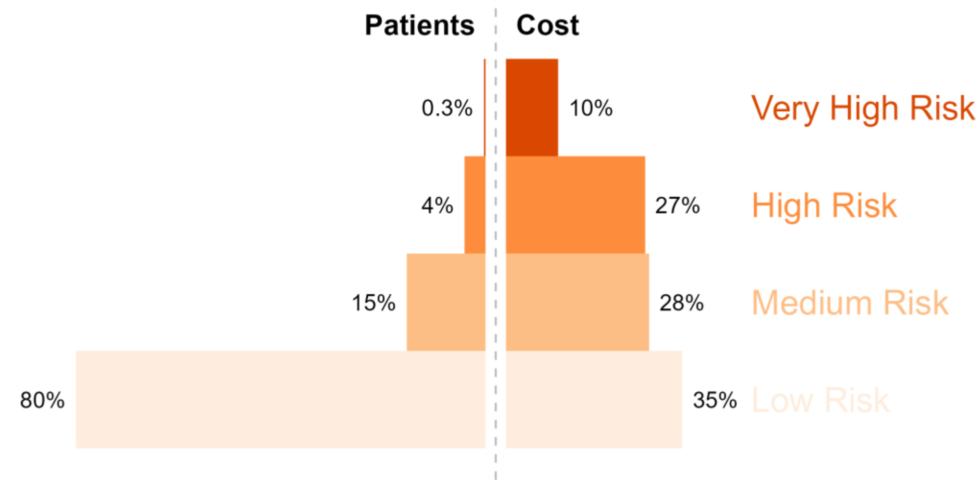
We need to move away from the current blend of care provision which is unaffordable

- The system has a significant underlying financial deficit, held within the Trusts and the ICB. Going into 2023/24 this is estimated to be in excess of £100m. This is due to a number of issues, including unfunded cost pressures.
- The system has therefore developed a financial recovery plan, which if delivered would result in a £31m deficit in 23/24.
- Current plans to improve the financial position, such as productivity/cost improvement programmes within the Trusts, are expected to close some of this financial gap and we know there are opportunities for reducing unnecessary costs, such as agency spend. The system is also looking at a range of further measures designed to improve the underlying run rate.
- In addition to a financial gap for the system overall, there are discrepancies between how much is spent (taking into account a needs-weighted population) across our places, in particular with regard to the proportion spent on out of hospital care.
- The system receives a very limited capital budget in 23/24 of £95m, significantly less than other London ICSs (which receive between £130m-£233m) and comparable to systems with populations half the size of NEL*. This puts significant pressure on the system and its ability to transform services, as well as maintain quality estate. In 24/25 the estimated budget is £86m.
- There is huge variation in the public health grant received by each of NEL's local authorities from central government. The variation is at odds with the government's intended formula (which is based on SMR<75) and is the result of grants largely being based on historical public health spend. This impacts on our ability to invest upstream in preventative services.
- As a system the majority of our spend is on more acute care and we know that this is driven by particular populations (0.3% of the population account for 10% of costs associated with emergency admissions; just under 20% account for 65%).





Percentage of emergency admission cost and patients attributable to risk bands for expected risk of admission for patients registered with a NEL GP in February 2023. Combined Predictive Model run on NEL SUS data estimates risk of admission. Cost of all emergency admissions to patients in each risk band in FY22/23 to January 2023 extracted from SUS. Patients with no risk score have been excluded from the analysis but follow a similar pattern to the low risk group. Data from NEL data warehouse.

* Capital figures are based on 2022/23. Norfolk and Waveney ICB received £98.5m capital in 22/23 and has a population of 1.1m people

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We are making progress – Our successes

PLACE

HOLDER

SLIDE

<SLIDE IN DEVELOPMENT>

5. How we are transforming the way we work

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Across the system we are transforming how we work, enhancing productivity and shifting to a greater focus on prevention and earlier intervention

- The previous section set out the challenges that the north east London health and care system needs to address to succeed in its mission to create meaningful improvements in health and wellbeing for all local people
- North east London's portfolio of transformation programmes has evolved organically over many years: rooted in the legacy CCGs and sub-systems, then across the system through the North East London Commissioning Alliance and the single CCG, and now supplemented by programmes being led by our place partnerships, provider collaboratives, and NHS NEL.
- It has never previously been shaped or managed as a single portfolio, aligned to a single system integrated care strategy.
- As part of moving to this position, this section of the plan baselines the system portfolio with programmes set out according to common descriptors – providing a single view never previously available across the system, with the scale of the investment of money and staff time in transformation clearer than ever before.

This section sets out how partners across north east London are responding to the challenges described in the previous section. It describes how they are contributing to our system priorities by considering five categories of improvement

1. Our core objectives of high-quality care and a sustainable system

2. Our NEL strategic priorities

3. Our supporting infrastructure

4. Place based Partnerships priorities x7

5. Our cross-cutting programmes

Urgent and emergency care

Portfolio vision, mission and key drivers:
The aim of our portfolio is to improve access to urgent and emergency care for local people that meets their needs and is aligned with the UEC national plan. The portfolio is structured around five strategic system goals: **Prevention** of conditions, **Management** of existing conditions and needs, **Timely intervention** for escalation of needs or new needs and conditions, **Timely and effective return** to community setting following escalation, underpinned by **data, governance, effective pathways and enablers.**
The national and local drivers focus on **increasing capacity**, **growing the workforce**, **speeding up discharge** from hospitals**, expanding new services in the community** and helping people access the **right care first time**.

Key stakeholders:
Place, PCNs, practices, pharmacy, Acute, Community and mental health collaboratives and Urgent and emergency care services. Healthwatch and patient groups.

Key programmes of work that will deliver the vision and mission
The work within the portfolio is mapped against our strategy goals and four outcomes. **1) strengthening provision and access to alternative pathways, 2) optimising flow through hospitals, 3) using population health management to keep people well in the community and 4) setting up governance and pathways to form system wide sustainable plans**.
There are a range of projects to deliver on these outcomes that have been divided into directly managed by UEC portfolio and those sitting in other portfolios.
UEC directly managed – 111 procurement and development, hospital flow, ambulance flow, system co-ordination centre, urgent treatment centres, virtual wards and winter planning.
Other delivery areas such as same day access, urgent community response, mental health pathways and planned care sit in other portfolios but will be monitored and reported to the UEC Board.
Additionally establishing the NEL UEC PMO and governance will provide infrastructure to deliver a measurable impact.

Details of engagement with places, collaboratives and other ICB portfolios
One to ones throughout the summer to understand local strategies and plans to build up the NEL UEC portfolio. Work underway to propose new ways of working and governance structures. Collaboration will be at the heart of the portfolio.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

April 2025:
- System co-ordination centre set up in line with specification
- Reduction in delayed discharges and improvements to A&E performance
- Elimination of ambulance handover waits over 45 minutes
- 111 provider working to a new specification following procurement process
- Expansion and coordination of virtual wards beds

April 2026:
-

April 2027:
-

Engagement with the public:
Engagement activities have taken plan at Place and Trust level which has informed plans and communications – to date there have been NEL UEC patient engagement activities

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Community Health Services

Portfolio vision, mission and key drivers:

- Develop a consistent community services offer across NEL
- Improving population health and outcomes, working closely with residents
- Supporting neighbourhoods and PLACEs to enable people to stay well and independent, for as long as possible, wherever they call home
- Creating wider system value by unlocking system productivity gains
- Using evidence to understand the totality of services, outcomes and resources across NEL, identifying opportunities for improved outcomes
- Create and facilitate collaborative partnerships with local authorities, primary care, health providers, and the independent voluntary and charitable sector
- Supporting wider system pressures by maximising CHS opportunities (i.e LAS call outs, UEC attendances, unplanned care, LA residential care pressures)

Key stakeholders:

- 7 PLACEs
- ELFT
- NELFT
- Homerton
- Barts
- 65 plus bespoke providers

Key programmes of work that will deliver the vision and mission

- Leading joint approach to Planning for the first time across NEL
- Coordinating finance discussions across NEL re pressures, risks and priorities
- Developing and evolving Improvement Networks, bringing together subject matter experts and creating a conducive environment to design best practice pathways and consistent offers across NEL
- BCYP Improvement network 15th November
- Rapid Response and Falls Network TBC January '24
- RR and Falls likely to lead to Improvement Network re Community Nursing/integration opportunities across health and social care workforce
- Discussions re MSK pathway in train with Planned Care colleagues
- Aligning with Digital work , Proactive Care, Universal Care Plan, Fuller
- Maximising opportunities for CHS blueprint/integration via Whipps X (WF and RB), St Georges HWB Hub (Havering) and Porters Ave (LBBD)
- Comprehensive CHS Diagnostic planned (to procure Dec '23) giving a bottom up approach from a PLACE perspective, to gain NEL wide understanding of resource, quality outcomes, user and carer experience, cost, workforce across health, local authorities, primary care, VCS

Details of engagement undertaken with places, collaboratives and other ICB portfolios

- Joint planning sessions 1st Nov and 11th Dec (45+ people across PLACEs and providers)
- 121 discussions with Place Directors, core provider leads
- Engagement across collaboratives and programmes (UEC, LTC, BCYP, Planned Care)
- Joint meeting with Primary Care Collab Dec '23

Co dependencies on other programmes

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- Developing Consistent pathways and models for CHS, minimising variances in outcomes and experience
- Maximising opportunities to integrate and avoid duplication

Engagement with the public:

- Patient engagement at an early stage but conversations with Patient experience leads Nov '23 to utilise existing forums
- Well established carer and user infrastructure in BCYP

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Primary Care

Portfolio vision, mission and key drivers:
Our vision is for north east London to be a place where you can access consistent high-quality primary care, from a dedicated, motivated and multi-skilled workforce enabling local people to live their healthiest lives
The aim of our portfolio is to deliver on ambitious plans to transform primary care, offering patients with diverse needs a wider choice of personalised, digital-first health services through collaboration with partners across the health and social care and communities. National and local plans place a focus on improving access, prevention, personalisation, tackling inequalities and building trusting environments.
Our local challenges include population growth, deprivation, exacerbating poor physical and mental health and workforce retention and development and a financial challenge urging cost effectiveness and efficiency

Key stakeholders:
Place, PCNs, practices, pharmacy, Acute, Community and mental health collaboratives and Urgent and emergency care services. Healthwatch and patient groups.

Key programmes of work that will deliver the vision and mission
There are a range of programme that make up the primary care portfolio to ensure the delivery of our goals.
Empowering patients - supporting patients to manage own health, stay healthy and access services. Improving access - providing a range of services and assistance to respond to patient needs in a timely manner. Modernising primary care - developing new and digital tools to support highly responsive quality care. Building the workforce - staff recruitment, retainment and develop plans in place to improve job satisfaction and flexibility. Working smarter - reduced workload across primary/secondary services and improvements to sustainable and efficient ways of working. Optimising enablers - estate, workforce and communication plans to support the implementation of our goals.

Integrated Neighbourhood Teams (INT) are pivotal to transforming Primary Care and will be delivered through work responding to the Fuller recommendations. **A framework** will offer a streamlined approach for the delivery by integrating Primary Care, including Pharmacy, Optometry and Dentistry, alongside wider health care, social care and voluntary sector organisations. INTs will facilitate care, through 'teams of teams' approach enabling **continuity of care**. These teams will also be instrumental in broadening the availability of care, providing **extended in and out-of-hours services**, including urgent care. A **single point of contact through advanced cloud-based telephony systems** will streamline access to care, while **improved signage and navigation** will guide patients to the right services.

The Fuller initiatives are accompanied by other enabling programmes. **People**, will bolster the **capacity of the ARRS roles**, **establish training and development opportunities**, and **determine the ideal workforce** for INTs. Infrastructure, including, Estates and Data will align current plans to INT requirements, as well as **Digital First** which aims to improve digital access (including remote consultation), NHS App usage, improving practice efficiency and increasing competence to use digital tools.

Wider programmes which are fully or partly delivered through primary care providers, include, **Pharmacy,** enhancing the role of the community pharmacy to improve access and patient self-management, **Long Term Conditions (LTCs),** including a range of interventions such as case-finding, annual or post-exacerbation reviews for targeted patients, as well as programmes that sit in other collaboratives such as **Personalisation** and **Vaccinations**. Other transformational projects to improve dental and optometry services will be developed in the future as their provider groups mature.

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Details of engagement undertaken with places, collaboratives and other ICB portfolios
A number on workshops with collaboratives, places and the UEC/ LTC / digital / workforce programmes.
The portfolio is overseen by a lead for UEC portfolio to strengthen interplay. Working in conjunction with other portfolios is a key improvement area following the deep dive in October
Webinars held for PCNs to promote digital tools

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

April 2025:
- Same day handling of all calls to practices
- All practices transferred to cloud based telephony
- Improvements to NHS app and practices websites and e-Hubs
- All practices offering core and enhanced care for people with LTCs
- Additional services from community pharmacies
- All Places have INTs established for at least one patient cohort

April 2026:
- All practices will be CQC rated as GOOD or have action plans to achieve this further equalisation of enhanced services (IN DEVELOPMENT)

April 2028:
- Streamlined access to a universal same-day care offer, with the right intervention in the right setting and a responsive first point of contact

Engagement with the public: Enhanced access engagement exercise with practices in 2022. London wide digital tools engagement involved NEL residents.
Fuller programme plans to engage on the SDA vision

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Planned Care

Portfolio vision, mission and key drivers:

- The aim of the programme is to reduce waiting times for elective care in line with the national recovery plan so that no one is waiting more than 52 weeks by March 2025
- This will be delivered through an integrated system approach to improving equity of access to planned care for the people of North East London by focusing on 3 primary drivers – managing demand, optimising capacity & creating new capacity.
- The portfolio of planned care recovery & transformation work spans the elective care pathway from pre-referral to treatment encompassing out of hospital services, outpatients, diagnostics and surgery.
- The planned care portfolio consists of three significant programmes of work – outpatient & out of hospital transformation; diagnostic recovery & transformation and surgical optimisation. The activities and interventions undertaken with these programmes are designed to improve the management of demand, optimise existing capacity and support and enable the creation of new capacity

Key stakeholders:
- Trusts
- APC
- ICB
- Place Based Partnerships
- Primary Care Collaborative including PCNs
- Community Care Collaborative
- Independent Sector Providers – acute and community
- Clinical and operational teams across all acute Trusts

Key programmes of work that will deliver the vision and mission

The portfolio of planned care recovery & transformation work spans the elective care pathway from pre-referral to treatment encompassing;

- **Outpatients and out of hospital services** - The aim of this programme is to optimise the use of our existing outpatient capacity whilst transforming how we work together across primary, community and secondary care to manage demand for services and create a sustainable outpatient & out of hospital system. Achieving this requires transformation across the whole pathway, as well as the way in which outpatient clinics are organised and delivered
- **Diagnostics -** The recovery and transformation of diagnostics includes a broad portfolio of work encompassing imaging, endoscopy, pathology and physiological measurement. The aim of the programme is to create resilient diagnostic services to support elective, including cancer, pathways
- **Surgical Optimisation** - The focus of this programme is to ensure we are using our available elective surgical capacity to increase volumes of activity and reduce waiting times. This includes Trusts improving the utilisation of their elective theatre capacity and optimising the use of NHS and ISP capacity to reduce waiting times. NEL has secured @ £33m investment from the target investment fund to open new theatres in Hackney, Newham and Redbridge, which are expected to operate as system assets.

Details of engagement undertaken with places, collaboratives and other ICB portfolios

The planned care recovery & transformation programme is an integrated system programme with system wide engagement at its heart. Priorities, governance and delivery structures have been created over the last 2 years with primary care, the ICB, PBP and acute providers.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

In NEL, this will mean delivering reduction in waiting times and reducing the variation in access that exists. Key benefits include;

- Reduce variation in service provision and improve equity of access
- Improve referral pathways. Enable patients to get the right service at the right time
- Improve patient accessibility to diagnostics, in order to; reduce pressures on primary and unplanned care, reduce waiting times, reduce steps in patient pathway, reduce follow-up activity; reduce non-admitted PTL, improved utilisation of imaging capacity
- Increase surgical activity at all sites, avoid wasted capacity, enable patients to be offered surgery at sites with shortest wait

Engagement with the public:

The national elective recovery plan has been developed with widespread public engagement. Our programme reflects these priorities, which are adapted to meet the needs of our local population.

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Cancer

Portfolio vision, mission and key drivers:

The North-East London Cancer Alliance is part of the North East London Integrated Care System and is committed to **improving cancer outcomes and reducing inequalities for local people.**

Our aim is that everyone has equal access to better cancer services so that we can help to:

- Prevent cancer
- Spot cancer sooner
- Provide the right treatment at the right time
- Support people and families affected by cancer

- **Drivers**
- Our work enables the ICB to achieve its objectives, as set out in the strategy, across the ICB's six cross-cutting themes:

- Tackling Health Inequalities
- Greater focus on Prevention
- Holistic and Personalised Care
- Co-production with local people
- Creating a High Trust Environment that supports integration and collaboration
- Operating as a Learning System driven by research and innovation

Key stakeholders:

Patient and Carers
Providers, Partners, PLACE
Cancer board
APC Board and National / Regional Cancer Board

Key programmes of work that will deliver the vision and mission

- The programme consists of projects to improve diagnosis, treatment and personalised care.
- Key milestones to be delivered by March 2025 and 2026 include:
  - Deliver BPTP milestones in suspected prostate, lower GI, skin and breast cancer pathways:
  - Delivering the operational plan agreed for 28d FDS, combined 31d treatment and 62d cancer standards.
  - Deliver 100% population coverage for Non-Specific Symptoms (NSS) pathways.
  - Ensure sustainable commissioning arrangements for NSS pathways are in place for 2024/25
  - TLHCs provided in 3 boroughs with an agreed plan for expansion for all boroughs by 2025.
  - Develop and deliver coproduced quality improvement action plans to improve experience of care.
  - Support the extension of the GRAIL interim implementation pilot into NEL.
  - Ensure all patients are offered the personalised care package with equal access to psychological support, pre-habilitation and rehabilitation services.
  - Personalised stratified pathways can reduce outpatient attendance and allow patients to be monitored remotely reducing the need to attend clinics.
  - Improve the quality of life and support patients need to live beyond cancer.

Details of engagement undertaken with places, collaboratives and other ICB portfolios

- Weekly APG Operational delivery meeting
- Tumour specific Experts Reference Group (ERG)
- Project Delivery Groups (PDG)
- Cancer board – internal assurance
- Programme Executive Board – NEL operational delivery
- APC Board, CAB and National / Regional Cancer Board

Summary of the benefits/impact that North East London local people will experience by April 2025 and April 2027:

2025/26:

- Access to Targeted Lung Health Check service for 40% of the eligible population
- Invitation for up to 45,000 people into the GRAIL pilot
- Continued mainstreaming as part of the Lynch Syndrome pathway
- Improved quality of life and experience of care.

- **2027/ 28:**
  - Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.
  - Improved uptake of cancer screening
  - Every person in NEL receives personalised care and support from cancer diagnosis

Engagement with the public:

Patient Reference groups
Campaign workshops

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Maternity

Portfolio vision, mission and key drivers:

- Three year delivery plan for maternity and neonatal services: 2023-2026. . This has consolidated the improvement actions committed to in Better Births, the NHS Long Term Plan, the Neonatal Critical Care Review, and reports of the independent investigation at Shrewsbury and Telford Hospital NHS Trust and the independent investigation into maternity and neonatal services in East Kent. The expectations on Local Maternity and Neonatal Systems are that they focus on the following areas;
  - Listening to, and working with, women and families with compassion
  - Growing, retaining, and supporting our workforce
  - Developing a Culture of safety, learning and support
  - Standards and structures that underpin safer, more personalised and more equitable care

Key stakeholders:

All LMNS and APC board Stakeholders (PBC, LA, Trusts, MNVPs- service users, Third sector organisations) Regional Maternity Transformation Team, Chief Midwife Office, ICB BCYP, Public Health.

Key programmes of work that will deliver the vision and mission

- Pelvic Health Service: All women experiencing urinary incontinence to be able to access postnatal physiotherapy up to 1 year post delivery
- Increased breastfeeding rates, especially amongst babies born to women from black and minority ethnic groups or those living in the most deprived areas.
- Midwifery Continuity Care, prioritising the provision to women from Black and minority ethnic (BAME) groups who will benefit from enhanced models of care.
- Perinatal Optimisation Programme:
- Develop pathways to manage abnormally invasive placenta across NEL
- Workforce and Development Projects

Details of engagement undertaken with places, collaboratives and other ICB portfolios

All LMNS and APC board Stakeholders (PBC, LA, Trusts, MNVPs- service users, Third sector organisations) Regional Maternity Transformation Team, Chief Midwife Office, ICB BCYP, Public Health.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- By reducing stillbirth, maternal mortality, neonatal mortality, and serious brain injury in women and babies from BAME groups and women from deprived areas. National ambition to reduce by 50% by 2025
- By closely aligning maternity and neonatal care to deliver the best outcomes for women and their babies who need specialised care by achieving <27 weeks IUT.
- By improving personalised care for women with heightened risk of pre-term birth, including for younger mothers and those from BAME groups and deprived backgrounds
- By ensuring that all providers have full baby-friendly accreditation and that support is available to those who are from BAME groups and/or living in deprived areas who wish to breastfeed their babies
- Ensuring local maternity and neonatal voice partnerships (MNVPs) have the infrastructure they need to be successful and put service user voices at the heart of service improvement. This includes funding MNVP workplans and providing appropriate training, and administrative and IT support.

Engagement with the public:

MNVPs, Third Sector organisations and communities identified in the E&E LMNS report.

Babies, children and young people

Portfolio vision, mission and key drivers:

Vision: To provide the best start in life for the babies, children and young people of North East London.

Mission: The BCYP Programme aims to reduce unwarranted variation and inequality in health and care outcomes, increase access to services and improve the experience of babies, children, young people, families and carers and strengthen system resilience.

Through strong working relationships across health and social care partners, we will increase collaboration, enhance partnership working and innovation, share best clinical and professional practices with each other and deliver high quality services.

Drivers: NEL Integrated Care Strategy, NHS Priorities and Operational Planning Guidance, NHS Long Term Plan, Ongoing impact of COVID-19 pandemic, Royal College of Paediatrics and Child Health – State of Child Health, Academy of Medical Royal Colleges – Prevention is better than cure and NHS England (London Region) Children and Young People's mandated requirements.

Key stakeholders:

ICB Executive, BCYP SRO, Place Directors; Collaborative/ Programme Directors; Provider Directors; GP CYP Clinical Leads;
Directors of Children's Social Care; Designated Clinical/Medical Officers; NHSE (London) CYP Team; North Thames Paediatric Network; Safeguarding Team; Parent Forums

Key programmes of work that will deliver the vision and mission

Acute care - priorities are CYP elective care recovery, diabetes, allergy and addressing urgent and emergency care priorities for BCYP.
Community-based care -priorities are local integrated care child health pilots, increasing capacity (including 7 day access to children's community nursing and hospital@home), improving children's community service waiting times;
National/regional mandated priorities including long term conditions;
Primary care – priorities are BCYP unregistered with a GP, YP access to integrated health hubs; 'You're Welcome standards and Child Health training curriculum;
Special Education Needs and Disabilities (SEND) - SEND Inspection Readiness Group to ensure Places and ICB are prepared for new Ofsted Inspection framework and are meeting NHSE requirements. Focus Areas – Autism and Diagnostic pathways and Pre and Post offers of support for families.
Special cohorts including Child Sexual Abuse (CSA) hub, looked after children and care experienced young people.

Details of engagement undertaken with places, collaboratives and other ICB portfolios

Acute, community, mental health/learning disabilities and autism and primary care collaboratives. LTC and UEC Programmes. Places via NEL BCYP Delivery Group

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

Care is delivered closer to home as our children, young people, their families and carers have requested;
Enhanced quality of care for BCYP with asthma, diabetes and epilepsy;
Improved access to primary and integrated care for BCYP via integrated health hubs;
CYP with SEND will receive integrated support across education, health and care and reduced waiting times for SLT and autism;
Prescription poverty for our care leavers will be tackled.
Reduce the impact of child sexual abuse through improved prevention and better response.

Engagement with the public:

Via Providers.
SEND Parent's Forum
National Voices

Long Term Conditions

Portfolio vision, mission and key drivers:

Our vision - To support everyone living with a long-term condition in North East London to live a longer, healthier life and to work to prevent conditions occurring for other members of our community, and support communities to prevent LTC onset or progression

Mission - Listening to communities to understand how we can support patients in managing their own conditions

- Reduce working in silos and embed a holistic approach to LTCs
- Reduce unwarranted variation and inequality in health and care outcomes
- Increase access to services and improve the experience
- Working partners to prevent residents from developing more than one LTC through early identification of risk factors
- To ensure there are appropriate interventions and services that support a patient in preventing or managing an exacerbation of their condition
- Keep hospital stay short and only when needed
- To ensure we effectively plan and provide services that are value for money

Key drivers –

Long-term conditions have a national and regional focus as a core component of the Long Term Plan, with attention on Cardiovascular disease, stroke, diabetes, and respiratory. Furthermore, LTCs are entwined with us to address inequalities, and we support projects such as Core25Plus and Innovation for Healthcare Inequalities Programme

Long-term conditions (LTCs) is 1 of NEL's 4 System Priorities for improving quality and outcomes and tackling health inequalities. This is reflected in Place-based priorities which all have identified one or more LTCs

- Across NEL, one in four (over 600 thousand people) have at least one long-term condition, with significant variation between our places (in Havering, the figure is 33%, vs 23% in Newham and Tower Hamlets)
- NEL is the highest performing ICB in England for many outcomes related to CVD, stroke, and renal, but local social demographics put the system at risk of continued growth in demand
- Nationally, long-term conditions account for half of GP appointments, 64 percent of all outpatient appointments, and over 70 percent of all inpatient bed days.
- The most deprived areas, people acquired three or more conditions (complex multimorbidity) when they were 7 years younger, compared with the least deprived.

Key stakeholders:

- Residents and communities
- Place based teams
- Regional and National colleagues
- Organisation Delivery Networks
- Voluntary organisations
- Specialised Services
- Pharmacy and Medicine Optimisation
- Primary care
- Babies, Children and Young People
- Communities services
- Community collaborative
- Planned care
- Acute Provider Collaborative
- Mental health programme and collaborative
- Urgent Care programme
- BI and insights
- Communication and engagement
- Contracting and finance

Key programmes of work that will deliver the vision and mission

Primary LTC prevention & Early identification

Social determinants of health (SDOH) impact 80% of health outcomes from chronic disorders and across NEL we have areas of significant deprivation which is linked with increased prevalence of long-term health conditions and lower life expectancy

We want to work with our local population to empowering and enabling people to manage their own health and engage in healthy behaviours across their lives, so they don't develop a LTC.

Secondary prevention and avoiding complication

DH data has demonstrated that 9 out of 10 strokes could be prevented and up to 80% of premature CVD deaths are preventable, if risk factors could be controlled. Working with social communities, and ensuring we provided person focused early identification, secondary care and avoiding complication enables us to improve outcome and reduce exacerbation of an LTC

Co-ordinated care and equability of service

Across NEL, one in four (over 600 thousand people) have at least one long-term condition, with significant variation between our places. The feedback from the Big Conversation reflects the need to join-up care and move forwards person focused approach. Working with colleagues at place we aim to continue to review current provision and reduce unwarranted variation in care across the pathway, with an aim of improving health outcomes

Enabling people to live well with a LTC and tertiary prevention

The effective support and management of LTC will increasingly require the management of complexity, and moving away from a single condition approach. In NEL 3 in 5 patients with a diagnosed long term condition have only one condition, the other 2 in 5 have multiple co-morbidities, of which diabetes and hypertension were most common

Details of engagement undertaken with places, collaboratives and other ICB portfolios

Places – working with Heads of Live well across the 7 places who are responsible for LTCs

Clinical/improvement Networks – wider engagement with trusts, community providers, pharmacy, primary care and place

Organisation Delivery Networks (renal and CVD/cardiology)

Other programme directors including specialised service, community, mental health, BYCP.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

Work toward national targets including:

- Improve detection of atrial fibrillation and ensure appropriate stroke risk reduction through anticoagulation - by 2029 85% of expected numbers with AF are detected, and 90% of patients with AF and high risk of a stroke on anticoagulation.
- Improve detection of undiagnosed hypertension and ensure those with hypertension are controlled to target – by 2029 80% of expected numbers with hypertension are detected and 80% of people with high blood pressure are treated to target
- Improve access to and uptake of Cardiac Rehabilitation (CR) – by 2029 85% of eligible patients are accessing CR
- Reduction of type 2 diagnoses / delayed onset in residents developing Type 2 (T2) diabetes delivered through an increase the number of people referred and starting the National Diabetes Prevention Programme (DPP) 45% of eligible populations).
- nting with symptoms of Transient Ischaemic Attack will have access 7 days a week to stroke professionals who can provide specialist assessment and treatment within 24 hours of symptom onset thus preventing long term disability

Engagement with the public:

The big conversation which consists of 56 focus groups, 430 attendees of key community events and local survey focused on LTCs and the outputs are incorporated into priorisation for 24/25.

Furthermore, we have incorporated feedback at service level such PR and diabetes

Mental Health

Portfolio vision, mission and key drivers: the aim of the Mental Health, Learning Disability and Autism Collaborative is to work together to improve outcomes, quality, value and equity for people with, or at risk of, mental health problems and/or learning disability and autism in North East London. We do this by putting what matters to service users and their families front and centre of everything we do.

The service user and carer priorities that represent our key drivers include:
- Improving peoples' experience of accessing mental health services, including their first contact with services, and ensuring equity of access
- Children and young people can access different support from different people, including those with lived experience, when and where they need it
- People with a learning disability have the support they need and a good experience of care, no matter where they live

Key stakeholders: NHS North East London, East London NHS Foundation Trust, North East London NHS Foundation Trust, local authorities, primary care, voluntary, community and social enterprise sector organisations, service users, carers & residents

Key programmes of work that will deliver the vision and mission

1. Investing in and developing lived experience leadership across the MHLDA Collaborative so that experts by experience are active and equal partners in leading improvement and innovation across mental health, learning disability and neuro-developmental services
2. Continuing the work led by our children and young peoples' mental health improvement network to reduce unwarranted variation across boroughs, and to do more of what works to reduce self-harm and improve outcomes for young people
3. Accelerate the work of our talking therapies improvement network to improve access, and continue to transform and improve community mental health services, with a particular focus on improving equity of access for minoritised groups and people with neurodevelopmental needs
4. Continue our focus on improving mental health crisis services and alternatives to admission - while also working to ensure that quality inpatient services are available for those who need them - making sure that people get the right support, at the right time, and in the right place
5. Working to develop core standards for community learning disability services, with a view to reducing unwarranted variation between boroughs, and sharing good practice to support our specialist workforce better

Details of engagement undertaken with places, collaboratives and other ICB portfolios: Place based priorities for mental health are the cornerstone of our plans. We also connect closely with the Acute Provider Collaborative on mental health support in emergency departments and form part of their programme governance on UEC. We also have strong links into the BCYP programme and community health.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
- Improved access, outcomes and experience of NHS Talking Therapies for minoritised communities and other under-served populations
- Improved system-wide response to children and young people presenting with self-harm through the introduction of new evidence-based interventions, including better support to teachers, GPs and parents
- Improved offer of pre-diagnostic, diagnostic and post-diagnostic support for people with neurodevelopmental support needs
- Greater equity in the community learning disability support offer across boroughs
- Improved inpatient services with lower lengths of stay, and better options of high-quality supported housing / residential care for those who need it
- Widespread adoption of personalised and person-centred care planning processes with an emphasis on continuity of care and biopsychosocial assessment

Engagement with the public: Our Lived Experience Leadership arrangements ensure we are continually engaging with children and young people, adults with mental health needs and people with learning disabilities and their families, and coproducing our work with service users

Employment and workforce

Portfolio vision, mission and key drivers:
- Our vision is to create a transformational and flexible “One Workforce for NEL Health and Social Care” that reflects the diverse NEL communities and meets our system priorities.
- The mission focuses on developing a sustainable and motivated workforce, equipped with the right skills, competencies, and values, to improve the overall socio-economic outcomes of our NEL populations.
- The key drivers are responding to population growth and increasing demand, and developing meaningful and rewarding careers within health and social care services for local residents.

Key stakeholders:
- Provider CPOs
- People Board
- Place Directors
- Staff
- Local Authorities
- Care Sector

Key programmes of work that will deliver the vision and mission
- **System Workforce Productivity:** Continuing to address NEL’s difficult financial position through urgent investigation of workforce productivity drivers and implementation of productivity improvement initiatives.
- **System Strategic Workforce Planning:** Development of a strategic workforce planning function with the capacity, capability and digital enablers to provide the enable evidence-based decisions to ensure the long-term sustainability of the NEL Health and Social Care workforce. With the ultimate aim of developing of a system-wide health and social care workforce database and an integrated workforce planning system.
- **System Anti Racist Programme:** Embedding inclusive, anti-racist and empowering cultures across the system.
- **System wide scaling up and corporate services:** Identification of corporate services with scope for rationalisation. Streamlining operations, improving efficiency, standardising approach and reducing costs.
- **NEL Health Hub Project Programme:** Connecting local health and social care employers with colleges for employment opportunities. . Healthcare part is in partnership with Newham College and London Ambulance service and funded by GLA until March 2024. Social Care part is led by Care Provider Voice, aiming for 150 job outcomes, and funded until March 2025.
- These programmes are subject to approval by the People Board, Exec Committee, CPOS, Place, and collaboratives, aligning with the goal of enhancing socio-economic status in NEL through workforce development.

Details of engagement undertaken with places, collaboratives and other ICB portfolios
- Engaged with a broad spectrum of Health and Social Care partners through workshops and sessions.
- Involved Local Authorities, Voluntary and independent Care Sectors, Primary Care, NHS Trusts, Provider collaboratives, and Education Providers.
- More engagement is required.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
- **Integrated Health and Social Care Services:** Enhanced workforce development will lead to more integrated and effective health and social care services, improving overall care delivery.
- **Workforce Expansion and Skilling:** Initiatives like the NEL Health Hub and Social Care Hub are set to expand the healthcare workforce, providing training and development opportunities, leading to better staffed and skilled services.
- **Healthcare System Sustainability:** Focus on financial stewardship and innovation will contribute to a more sustainable healthcare system, ensuring long-term service delivery and effectiveness.
- **Equity in Healthcare Employment:** Targeted employment opportunities for under-represented groups in health and social care sectors will enhance workforce diversity, contributing to more inclusive and equitable healthcare services.
- **Enhanced Health and Well-being Services:** Programs like the Keeping Well Nel programme, funded until June 2024, will enhance health and well-being services, directly benefiting the ICS, workforce, and indirectly impacting local population health.

Engagement with the public:
- Actively engaged ICS staff via hackathons and NEL residents through community events and job fairs.
- Utilized feedback from the Big Conversation for inclusive strategy development.
- More engagement is required.

Specialist Commissioning

Portfolio vision, mission and key drivers:

Our vision:

- is to ensure that the population of north east London have good access to high quality specialist care that wraps around the individual, and ensures the best possible outcomes

Our mission and drivers:

- We are responsible for planning and commissioning of delegated specialised health services across north east London. We are responsible for specialised spend, performance and outcomes, and ensuring all parts of the local health system work effectively together to deliver exemplary specialist care
- We are responsible for integrating pathways of care from early intervention and prevention of LTC through to specialist provi sion, ensuring end to end pathways to improve outcomes and manage future demand of costly specialist care.
- We set priorities for specialised services and work with our local ICS, multi ICB partners and London regional partners to de liver world class specialised services to benefit patients within north east London, North London or London ensuring access to the right level of care.
- We will do this by working together with health partners, specialist providers, local authorities and the voluntary community and social enterprise (VCSE) sector, with residents, patients and service users to improve how we plan and deliver specialised services.

Key programmes of work that will deliver the vision and mission

From 2024/25, ICBs will have budget allocated to them on a population basis, and from April 25 this will be allocated on a ne eds based allocation basis. The specialised allocation will follow a similar formula to that of other nonspecialised services that ICBs hold, and **so can be considered and contracted for alongside the rest of the pathways we commission**. Delegation of specialised services and transformation of specialised services allows us to consider the totality of resources for our population, making it easier to ensure investmen t in the most optimal way to improve quality and outcomes, reduce health inequalities and improve value.

The key programmes of work are to:

1. Ensure safe delegation of specialised services working alongside the NHSE regional team
2. Joint work with NHSE, London ICBS and locally in NEL focussed on specialised transformation: sickle cell disease (Haemoglobin opathies), HIV and Hepatitis (including liver disease), Renal disease, Neurosciences, Cardiology, complex urogynaecology and specialist paediatrics
3. Working alongside other portfolios will deliver this mission, mainly LTC to ensure a whole pathway approach routed in place, cancer, planned care, critical care, BCYP and mental health

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

HIV

- People living with HIV will have improved follow up care with investment in a community led peer programme with an aim to reduce by 70% the number of eligible patients that are lost to care/failed by care. This follow up care will include regular testing, counselling, mentoring, group support, assurance and information and advice.

Renal

- Working towards maximise patient dialysing at home - 496 patients on home therapies by 31/32 (target of 28% of patients on home therapies by 2032).
- Working towards maximise patients being transplanted - 280 transplant operations completed in 31/32

Sickle Cell

- Local people with sickle cell will receive appropriate analgesia and other pain management measures (ideally within 30 minutes) when attending any acute A&E in NEL
- Residents will have timely access to multi-disciplinary team to support delivery of trauma-informed care based on the principles of safety, trust, choice, collaboration, empowerment and cultural competence.

Hepatitis and HIV

- To achieve micro elimination of HCV across NEL (2025).
- Improved access to diagnostics and increase local prevention programmes by aligning with the British Liver Trust optimal pathway. This will support the reduction in the growth rate of liver disease (currently 20%).

Neurosciences

- 10% of eligible stroke admissions will have consistent 24/7 access to mechanical thrombectomy to reduce the impact of stroke
- Improve detection of atrial fibrillation and ensure appropriate stroke risk reduction through anticoagulation - by 2029 85% of expected numbers with AF are detected, and 90% of patients with AF and high risk of a stroke on anticoagulation.

Cardiology

- Shorter waiting times and reduced elective and non-elective
- HF 30 day readmission rates have recently risen to more than 20%. We aim to reduce this to reduce this <15% with roll out of dedcated HF pharmacist to review and titrate patients post discharge

Key stakeholders:

- NHS London Region and London ICB partners
- NEL Provider Trusts
- North London ICB Programme Board partners (NCL/NWL)
- ODNs, mandatory and local clinical networks
- EoE Region
- Local authorities
- VCSE

Details of engagement undertaken with places, collaboratives and other ICB portfolios:

- APC Executive
- APC Joint Committee
- NEL Executive leads
- Close working with other ICB portfolios: LTC, Cancer, Planned Care, Critical Care, CYP, mental health

Engagement with the public:

- Engagement via regional and local clinical networks including Renal service users to inform dialysis provision
- Cardiac ODN: women, family
- HIV work with charities

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Digital

Portfolio vision, mission and key drivers: There are four key elements to the ICS digital strategy; patient access, population health, shared record access and provision of core infrastructure:

- **Patient Access** gives residents the ability to view their records and interact digitally with health and care providers. This is and will be provided through expanding use of the NHSApp, Online and Video consultation tools, online registration and the patient held record system, Patients Know Best
- **Population Health** utilises a variety of data sources to build a picture of care needs at various levels, primarily identifying specific cohorts of patients requiring intervention but also providing overviews at population level, allowing providers to alter service provision
- **Shared Records** is the mechanism for ensuring that clinicians and other care professionals have as full a picture as possible to allow them to provide the most appropriate care to individual patients / residents. This was pioneered in NEL and is now used across London and beyond
- **Core infrastructure** is the fundamental basis for all digital activity; the foundational work done at each provider that allows them to operate effectively and puts them on a sure footing to be able to contribute to and receive data from systems external to themselves

Key stakeholders:
All ICS health and care providers including NHS trusts, local authorities, GPs, community pharmacists, care home providers, third sector health and care providers, NHS England

Key programmes of work that will deliver the vision and mission
The largest investment currently taking place is the replacement of the core electronic patient record (EPR) system in BHRUT. This is being replaced by extending the existing Oracle Millennium system in use at Barts Health. Planning is underway, with the system expected to be live by March 2025. Other significant investments in Trusts include:

- The expansion of the functionality available via the NHSApp to include the ability to manage hospital and community appointments, and the ability for patients and clinicians to interact digitally where appropriate, thus improving the experience for digitally enabled patients and freeing up resource to support those wishing to use traditional methods. This is enabled by the PHR programme
- Use of artificial intelligence and robotic process automation to support diagnostics and faster completion of administrative tasks such as clinic management within trusts, thus improving patient experience and reducing the administrative burden on trusts
- All acute trusts using the same imaging platform to store and view x-rays, scans, etc., reducing the requirement for repeat diagnostic procedures and making them available to any clinician that needs access. ICS-wide cyber security plans are in place with funding having been secured
- Introduction of remote monitoring equipment to support expansion of virtual wards

Details of engagement undertaken with places, collaboratives and other ICB portfolios
Members of the digital team attend portfolio and collaboratives' meetings. A meeting has taken place with place directors but further meetings are needed.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- Residents can choose to interact with health and care professionals via the use of the NHSApp, Patient Held Record, online consultation and video consultation tools, which will smooth their interaction with the NHS and free up capacity to deal with people choosing to use other routes
- Patient level and aggregated information is provided to clinicians, managers and researchers, subject to a strict approval process. This helps change the planning and delivery of healthcare provision
- NEL hosted data is used across London and neighbouring ICS's, breaking down barriers by facilitating the sharing of information and good practice
- Information is provided to individual clinicians and other professionals from within their main system, giving access to information held by most London Trusts, which enables them to provide
- Key strategic programmes are co-ordinated by the ICS team, including Community Diagnostic Centres, Frontline Digitisation, Virtual wards, Care Sector, secondary care Appointment Systems and Primary Care Digital First, working with health, social care and third sector partners

Engagement with the public:
The One London programme has held various consultation meetings with patients across London, the results of which inform the strategies of each of the ICS' across London. Further engagement has been requested through further 'Big Conversations' planned in NEL

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Finance

The benefits that north east London local people will experience by April 2024 and April 2026:

- Improving quality and outcomes for local people of north east London
- Securing greater equity for our residents
- Maximising value for money
- Deepening collaboration between partners

How this transformation programme reduces inequalities between north east London's local people and communities:

- Incentivising transformation and innovation in clinical practice and the delivery of services to improve the outcomes of local people
- Supporting delivery of care closer to patients' homes, including investing in programmes that take place outside the hospital environment
- Refocus how the money is spent to focus on population health, including proactive measures that keep people healthier and to level up investment to address historical anomalies of funding
- Increasing investment in prevention, primary care, earlier intervention and the wider determinents of health, including environmental sustainability

Key programme features and milestones:

- Supporting our providers to reduce transactional costs, improve efficiency and reduce waste and duplication
- Support the financial stability of our system providers and underpinning a medium to long term trajectory to financial balance for all partners
- Recognising existing challenges, including that NEL is, as a SOF 3 ICS, financially challenged with a growing population and an acute provider (BHRUT) in SOF 4 for financial performance.
- Ensuring we do not create unnecessary additional financial risk, especially in the acute sector
- ICS investment pool to fund programs designed to reduce acute demand
- Finance development programme to agree overall budgets and develop place based budgets and budgetary delegation to place
- Effective integration of specialised commissioning, community pharmacy, dental and primary care ophthalmology services

Further transformation to be planned in this area:

- Supporting the integration of health and social care for people living with long term conditions who currently receive care from multiple agencies
- Ensuring that all partners are able to understand and influence the total amount of ICB resources being invested in the care of local people.

Programme funding:

- ICB plan submitted with a total budget of £4,218m in 23/24
- Specific transformation budgets, including health inequalities, virtual wards, physical, demand and capacity funding

Leadership and governance arrangements:

- Reporting to the ICB Board and Place Partnership Boards
- Finance, Performance and Investment Committee
- Audit and Risk Committee
- CFO lead monitoring of monthly and forecast performance

Key delivery risks currently being mitigated:

- Risk to delivery of a balanced financial position. Mitigated by delivery of efficiencies, delay of planned investments

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Physical infrastructure

Capital pipeline work to be completed Jan. Review in January 2024

The benefits that north east London local people will experience by April 2024 and April 2026:

- Across NEL ICS organisations, there are 332 estates projects in our pipeline over the next 5 /10 years, with a total value of c. £2.9 billion
- These include the redevelopment of Whipps Cross hospital and a new centre on the site of St George's, Hornchurch
- Formal opening of new St George Health and Wellbeing Hub – **Spring 2024**

How this transformation programme reduces inequalities between north east London's local people and communities:

- Infrastructure transformation is clinically led across the footprint whilst also achieving the infrastructure based targets set by NHSE.
- Our vision is to drive and support the provision of fit for purpose estate, acting as an enabler to deliver transformed services for the local population. This is driven through robust system wide Infrastructure planning aligned to clinical strategies, which is providing the overarching vision of a fit for purpose, sustainable and affordable estate.

Key programme features and milestones:

- Acute reconfiguration £1.2bn (includes estimated total for Whipps Cross Redevelopment of c. £755m)
- Mental Health, £110m
- Primary and Community Care, £250m
- IT systems and connectivity, £623m (inc. NEL Strategic digital investment framework c.£360m)
- Medical Devices replacement, £256m
- Backlog Maintenance, £315m
- Routine Maintenance inc PFI, £160m

Further transformation to be planned in this area:

- Construction will be undertaken where possible using modern methods in order to reduce time and cost and will be net carbon zero.
- Consider use of void spaces and transferred ownership of leases to optimise opportunity to meet demand and contain costs.
- Support back-office consolidation

Programme funding:

- Over the next 10 years there is expected to be a c£2.9bn capital ask from programmes across NEL

Leadership and governance arrangements:

- System-wide estates strategy and centralised capital pipeline
- Capital overseen by Finance, Performance and Investment Committee of NHS NEL.

Key delivery risks currently being mitigated:

- Recent hyperinflation has pushed up the cost of many schemes by as much as 30%. Currently exploring how to mitigate this risk, including reprioritisation
- Exploring opportunities for investment and development with One Public Estate, with potential shared premises with Councils

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Barking & Dagenham

Portfolio vision, mission and key drivers:

Vision

By 2028, residents in Barking and Dagenham will have improved physical and mental health and wellbeing, with a reduction in the gap in health inequalities between Barking and Dagenham resident and people living elsewhere. Our strategic aims are to:

- Enable babies, children and young people to get the best start in life
- Ensure that residents live well and when they need help they can access the right support at the right time in a way that works for them
- Enable residents to live healthier for longer and be able to manage their health, have increased opportunities to have an early diagnosis of health conditions and be provided with appropriate care to manage a condition before it becomes more serious

Key stakeholders:

NELFT
Primary care/PCNS
BHRUT/Barts
VCSE
Healtwatch
Local Authority- childrens and adults services; public health
Estates and housing teams

Interdependent ICB programmes

- Babies, Children and Young People; Maternity programme; Fuller programme; Population Health programme; Long Term Conditions programme; Urgent & Emergency Care programme; Estates

Interdependent Collaborative programmes

- Acute; Community Health; Mental Health, Learning Disability and Autism; Primary Care; VCSE

Key programmes of work that will deliver the vision and mission

- **Improving outcomes for CYP with SEND** with a focus on therapy support, ASD diagnosis and pre-and post-diagnostic support, mental health in schools
- **Tackling childhood obesity** leveraging the opportunities through family and community hubs for prevention
- **Development of Integrated Locality Health and Social Care Teams** (physical and mental health)
- **Developing a proactive and prevention approach to delivery of services** with targeted prevention approaches for falls prevention, dementia diagnosis and early support; long-term conditions identification and support and health outcomes for people who are homeless
- **Optimising outcomes and experience for pathways- d**eveloping a 24/7 Community End of Life Care Model; integrated Rehab and Reablement services; high Intensity User Services; demand and capacity management of high risk pathways (waiting list management)
- **Improving the physical health of people with SMI**

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Engagement with the public:

Best Chance Strategy for CYP and families; Just Say Parent Forum, engagement in Adults and Community strategy (ongoing)

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- BCYP get the best start, are healthy, happy and achieve, thrive in inclusive communities, are safe and secure and grow up to be successful young adults
- Providing accessible services and support for residents to prevent the development of health conditions wrapped around local communities
- Improving physical and mental health and wellbeing for residents, particularly those with long term conditions
- Reduced reliance on acute and crisis services
- Improved physical health outcomes for those with a serious mental illness

Havering

Havering Place based Partnership vision, mission and key drivers:

A Healthier Havering where everyone is supported to thrive; The vision of the Havering Partnership is to pool our collective resources to create person centred, seamless care and support designed around the needs of local people throughout their life course, with a strong focus on prevention, addressing inequalities and the wider determinants of health. This compliments Havering Council's vision for the 'Havering that you want to be a part of', with a strong focus on people, place and resources. We will do this by; Tackling inequalities and deprivation to reduce the impact that this has to access to services, and outcomes; Improving Mental and Emotional Support, Tackling Havering's biggest killers; Improving earlier care and support; coordinating and joining up care; working with people to build resilient communities and supporting them to live independent, healthy lives.

Key stakeholders:

- Local People
- Staff
- VCSE
- London Borough of Havering and their staff, who are coming together with the NHS Place team to form a joint team
- NELFT
- BHRUT
- Healthwatch
- Care Providers Voice (including Home Care and Care Home providers)
- PELC
- Primary Care including the GP Federation and PCNs
- NHS North East London partners
- Police and other community partners
- Wider NHS partners
- Wider Community partners and groups

Local People are at the heart of all of the work of the Place based Partnership

Interdependent ICB programmes

- Mental Health
- Long Term Conditions
- Urgent and Emergency Care
- Workforce and other enablers such as digital
- Planned Care
- Carers work and other cross place programmes

Interdependent Collaborative programmes

- Acute Provider Collaborative
- Community Provider Collaborative
- VCSE Provider Collaborative
- Mental Health Provider Collaborative
- Primary Care Collaborative
- North East London Cancer Alliance

Key programmes of work that will deliver the vision and mission

- **Start Well**; Children and young people get the best start in life, are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives
- **Live Well**; People enjoy and are able to maintain a sense of wellbeing and good health, supported by resilient communities. They can access care and information when needed.
- **Age Well**; People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks
- **Die Well**; People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people
- **Building community resilience programme and other key enablers**; including improvements to Primary Care and delivery of the recommendations in the Fuller review, roll out of the Joy App as our single database of services and referral mechanism for social prescribing, making better use of our estate and delivery of new models of care such as the St Georges project, improvements to urgent and emergency care, imbedding a prevention approach, addressing our key workforce challenges by working together, creating the enabling framework for place including information sharing agreements between partners to enable decisions and service improvement to be driven by joined up data.
- Built on a foundation of a **joint health and care team**, bringing together the Havering Place NHS team with the Local Authority Joint Commissioning Unit to deliver improved outcomes for local people and better value for money in our commissioned services

Engagement with the public:

A significant engagement programme has been underway with local people, VCSE groups, and stakeholders since the inception of the partnership. We are building an ongoing relationship with local people, and developing case studies to embed their experiences to drive improvements locally.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

Start Well Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Reduce the number of children and their families attending Emergency Departments for non-emergency care	Increase the number of Children and Young People receiving support for their emotional wellbeing through Primary Care	Increase the number of children and their families receiving best practice End of Life Care provision
Reduce the number of Children and Young People attending Emergency Departments in emotional or mental health crisis	Increase the number of children receiving timely Autism Spectrum Disorder (ASD) diagnosis and integrated family support	
Improve access to services and reduce wait times, particularly for Primary Care, non-elective care, and other services	Reduce the wait time of children for Special Educational Needs therapy provision	
Reduce spend on care for those with more complex needs by looking at innovative and local solutions for placements	Increase the use of Child Health Hubs to deliver integrated community care for children and their families	
Deliver greater value for money through joint commissioning of contracts where possible, which will also deliver more seamless, integrated services for local people	Reduce the percentage of children who are physically inactive and/or obese	
	Reduce the number of children and young people living in cold, damp or mouldy homes	

Live Well Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Improve access to services and reduce wait times, particularly for Primary Care, non-elective care, and other services	Increase diagnosis rates for type 2 diabetes and hypertension	Increase healthy life expectancy
Reduce the percentage of adults who are physically inactive and/or obese	Increase the percentage of adults with a learning disability living in settled accommodation	Reduce the gap in life expectancy between the most and least deprived areas of the borough
Reduce smoking prevalence in adults	Increase the percentage of cancers being diagnosed at an earlier stage	Reduce alcohol-related mortality
Increase the number of social prescribing referrals to support people to access wider wellbeing support	Reduce the number of people living in cold, damp or mouldy homes	Reduce the rate of suicides
Increase the number of people who provide informal and unpaid care who are registered with the Carers Hub and in receipt of information and support		Reduce early deaths from cardiovascular disease and respiratory disease
Increase use of digital enabled systems to support early detection for Atrial Fibrillation and Chronic Kidney Disease		Eliminate all inappropriate out of area mental health placements
Increase uptake of home testing including ACR and blood pressure		
Increase the number of people being referred to the national diabetes prevention programme		
Reduce wait times and increase support for those with lower level mental health issues to enable a preventative approach to mental health and wellbeing		

Age Well Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Increase the number of older people with a personalised care and support plan	Reduce the number of older people being referred for adult social care	Reduce permanent inappropriate admissions into residential care
Reduce the rate of emergency hospital admissions, including readmissions	Increase access for older people with a common mental illness to psychological therapies	Reduce the percentage of older people reporting that they feel lonely
Reduce the rate of acute length of stay for frail older people, returning them home sooner	Increase the number of volunteers supported to find a volunteering opportunity	
Reduce the rate of older people having discharge delays from hospital (delayed transfers of care)	Reduce the number of frail older people living in cold, damp or mouldy homes	
Increase the number of informal and unpaid Carers having a carer assessment and receiving appropriate support	Increase the number of older people who have their seasonal flu vaccination	

Die Well Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Increase the percentage of people who have, or are offered, a personal health budget towards end of life (fast-track)	Increase the percentage of people in the last 3 years of life who are registered on a local end of life register	Increase, in the recording of preferred place of death
Reduce the average number of patients per month who die in hospital whilst being delayed to be discharged	Increase access to Bereavement support in Havering	Increase the number of people who die in their preferred place of death
Reduce the percentage of older people who die within 7 days of an emergency hospital admission	Reduce the percentage of older people who die within 14 days of an emergency hospital admission	

Full details of the benefits are captured in the Havering Place based Partnership interim strategy

Redbridge

Place vision, mission and key drivers:

VISION: The Redbridge Partnership will relentlessly focus on improving the outcomes for the people of Redbridge and seek always to make a positive difference to people's lives. Together, we will build on what we have already achieved and use our combined resources to create person-centred, responsive care to build services around the needs of our communities within Redbridge. We will have a strong focus on prevention, addressing inequalities and the wider determinants of health.

KEY PRIORITIES: Babies, Children & Young People (BCYP)-Childhood Immunisations, **Housing & overcrowding, Multi-Disciplinary Team working(MDT)-**service integration, **Mental Health (MH)**– Access & wellbeing

DRIVERS: Good governance and accountability, a focus on the patient/resident's voice, a focus on Organisational Development, Commitment to working in partnership and beyond organisational boundaries, reliable data to inform impacts and adequate resourcing

Interdependent ICB portfolios

Long Term Conditions (LTC), Learning Disabilities (LD)/Mental Health (MH), Planned Care (PC), Health Inequalities (HI), Babies, Children and Young People (BCYP), Urgent and Emergency Care (UEC)

Interdependent Provider Collaboratives

Community Collaborative, Acute Provider Collaborative, Cancer, Collaborative, Primary Care Collaborative, Mental Health Collaborative

Key programmes of work that will deliver the vision and mission. (PLEASE NOTE THE PRIORTIES ARE PLANNED TO BE FORMALLY SIGNED OFF AT THE JANUARY 24 PARTNERSHIP BOARD.)

Start Well: Hospital at Home, Paediatric Integrated Nursing Service (PINs), Learning Disability Key workers, Integrated child health hubs, Special Education Needs & Disability (SEND), Children & Young People Asthma one stop shop

Live Well: Long Term Conditions Prevention/diagnosis, A Cardio renal and cardio vadcular programme, Increase health checks for residents with Serious Mental Illness (SMI) , Mental Health & Learning Disability, Review of Commissioning overlaps between organisations, Improve quality of life for residents of Redbridge.

Urgent & Emergency Care/Ageing Well: Keeping people well at home, Same day access to urgent care, Hospital flow -length of stay in hospital, Discharge from Hospital, End of Life Care, Avoidance of unnecessary attendance and admissions to hospital.

Primary Care: Fuller Programme (Integrated Multi-Disciplinary Care, Staying well for longer, Access to care & advice), Direct Enhanced Services, Local Incentive Schemes, Same Day Access and extended hours care, Asylum Seekers services, Homeless Services, Spirometry

Health Inequalities: Various schemes addressing Core 20+5

Ilford Exchange Health Centre: To develop and deliver a new health centre in Ilford town centre following an extensive public consultation in September 2022 The consultation was over 6 weeks and included a range of engagement tools and events such as public surveys, information stands, 4 public engagement events and 1 event with a local charity One Place East.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

By April 2025 and 2027 the Redbridge Place Based Partnership will:

- Significantly reduce the variation in undiagnosed Long Term Condition diagnosis rates and improve early treatment intervention.
- Significantly improve the uptake of childhood immunisations
- Improve the rate of Healthchecks for residents with Serious Mental Illness.
- Reduce the number of Children & Young People patients attending A&E through the hospital at homes programme
- Significantly reduce health inequalities underpin by the Core20+
- Improve same day access for residents across both health and care
- Have a new integrated health centre operational in the Ilford Exchange by 2025.

Key stakeholders:

- London Borough of Redbridge (LBR)
- Redbridge Community Volunteer Service (RCVS)
- Healthwatch
- Healthbridge (GP Federation),
- The Primary Care Networks (PCNs) in Redbridge
- North East London NHS Foundation Trust (NELFT),
- NHS NEL ICB
- Barking Havering & Redbridge University Hospitals NHS Trust (BHRUT)
- Barts Health NHS Trust (specifically Whipps Cross),
- Provider Collaboratives
- Care Provider Voice CPV)
- PELC
- LMC
- BHR CEPN

Engagement with the public:

The RBP will engage with local communities and organisations to create a strategic priorities programme that is informed by the views of local people. In particular we plan to have engagement workshops once the key priorities are signed off in January 2024, to shape the work programmes.
We will also have resident rep's on each Steering Group which are sub-committees of the Partnership Board.

Tower Hamlets

Portfolio vision, mission and key drivers:

- Tower Hamlets residents, whatever their backgrounds and needs, are supported to self-care, thrive and achieve their health and life goals
- Health and social care services in Tower Hamlets are accessible, high quality, good value and designed around people's needs, across physical and mental health and throughout primary, secondary and social care
- Service users, carers and residents and children are active and equal partners in health and care and equipped to work collaboratively with THT partners to plan, deliver and strengthen local services
- All residents - no matter their ethnicity, religion, gender, age, sexuality, disability or health needs - experience equitable access to and experience of services, and are supported to achieve positive health outcomes

Interdependent ICB programmes

- ICB anti-racism workstream
- ICB CYP workstream
- ICB long term conditions workstream
- ICB MH workstream
- Primary Care Access
- ICB Fuller workstream
- ICB urgent care review
- Access to data & insights

Interdependent Collaborative programmes

- Community collaborative model for health and care
- Primary care collaborative
- Supporting out of borough NEL discharges
- Mental Health collaborative
- Planned Care workstream

Key programmes of work that will deliver the vision and mission

- Improving access to primary and urgent care
- Building resilience and self-care to prevent and manage long term conditions
- Implementing a localities and neighbourhoods model
- Facilitating a smooth and rapid process for hospital discharge into community care
- Being an anti-racist and equity driven health and care system
- Ensuring that Babies, Children and Young People are supported to get the best start in life
- Providing integrated Mental Health services and interventions

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- Ensuring residents can equally access high quality primary and urgent care services when and where they need them
- Better prevention of long term conditions and management of existing conditions
- Ensuring that every resident can access the health and care services they need to support their continued health and wellbeing within their local area or neighbourhood, including GP, pharmacy, dental and leisure facilities
- A smooth and rapid process for discharging residents from hospital to suitable community-based care settings when they are ready for this transition
- Ensuring our health and care system and services are achieving equitable outcomes for all residents and addressing inequalities that exist, e.g. access, experience, representation and outcomes
- Ensuring babies, children and young people (and their families) are supported to get the best start in life, especially where they have additional needs
- Providing integrated services and interventions to promote and improve the mental wellbeing of our residents

Key stakeholders:

LBTH
NEL ICB
Barts Health Trust
TH GP Care group
ELFT
Healthwatch
TH CVS

Tower Hamlets residents and service users

Engagement with the public:

The workstreams and the THT Board include VCS and resident stakeholders who input into the design of the programme.

Newham

Portfolio vision, mission and key drivers:
Working with our diverse communities of all ages to maximise their health, wellbeing and independence. Supported by a health and care system that enables easy access to quality services, in your neighbourhood, delivered by people who are proud to work for Newham.

Key stakeholders:
ELFT
Healthwatch
LBN
NEL ICB
NUH
Primary Care
Residents
VCFS

Interdependent ICB programmes
- Babies, Children and Young People
- Fuller
- Long Term Conditions
- Maternity
- Population Health
- Urgent & Emergency Care

Interdependent Collaborative programmes
- Acute
- Community Health
- Mental Health, Learning Disability and Autism
- Planned Care
- Primary Care
- VCSE

Key programmes of work that will deliver the vision and mission
- Joint Planning Groups (JPGs) for Babies, Children and Young People; Mental Health; Learning Disabilities and Autism; Ageing Well; Primary Care; and Urgent Care
- Additional JPG for Long Term Conditions being explored
- Local Authority-led programmes across Health Equity and Well Newham (prevention)
- Population growth programme

Engagement with the public:
Residents and People & Participation Leads attend Partnership Board, JPGs and project groups

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
- Reduce the prevalence and impact of long-term conditions on residents' lives
- Enable people to stay well in their own homes by proactively organising and managing their care & support
- Improve the mental wellbeing of residents and ensure people have access to mental health support when and how they need it
- Involve, engage and co-produce all our plans with residents
- Ensure people stay in hospital for the optimum time and are supported to rehabilitate and recover
- Ensure when people need urgent help they can access it quickly and as close to home as possible
- Develop and integrate children's services to ensure children have the best start in life
- Prepare for significant population growth in Newham and North East London and strengthen prevention initiatives

Waltham Forest

Portfolio vision, mission and key drivers:

Our aim is for the population of Waltham Forest to have healthier lives by enabling them to **start well, live well, stay well and age well**, supporting each individual through to the end of their lives. We will do this by working together, as partner organisations and with our residents, **to improve health outcomes and reduce health inequalities.**

- We will engage and involve our residents to coproduce our interventions and services
- We will focus on supporting all residents to stay well and thrive throughout their lives
- We will use population health management approaches to understand the needs of our residents and target our resources to improve equity
- We will ensure when people need help, they can access high quality, good value services quickly and easily and are enabled to stay in their homes or return home as soon as possible.

Interdependent ICB programmes

- ICB anti-racism workstream
- ICB UEC workstream
- ICB CYP workstream
- ICB long term conditions workstream
- ICB MH workstream
- Primary Care Access
- ICB Fuller workstream
- ICB Digital workstream

Interdependent Collaborative programmes

- Whipps Cross redevelopment programme
- MH Collaborative
- Community Collaborative
- Primary care Collaborative
- Planned care workstream

Key programmes of work that will deliver the vision and mission

- Delivery of a programme of locality **prevention, wellbeing and self-care** to intervene earlier with residents to improve health outcomes dentification for intervention and support for residents with **LTCs.**
- Delivery of proactive anticipatory care through delivery of **Care Closer to Home** transformation programme and establishing **Integrated Neighbourhood teams and hubs.**
- Deliver alternative to unplanned attendances and admissions to acute hospital and improve discharge pathways through the delivery of the **Home First programme** of transformation and improving **same day access to primary care.**
- To publish a **children's health strategy** , improve access to **therapies** and reduce the need for children to attend hospital.
- To transform **EOL** services in Waltham Forest to ensure residents have the support to die in their choice of place.
- Publishing a strategy for **children's health**, improving access to children's therapies, and developing services to reduce the need for children to attend Whipps Cross Hospital in an emergency.
- Improving access to **Mental Health** support in community for all ages and promoting positive well-being for all.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

Key stakeholders:

Engagement with the public:

City & Hackney

Portfolio vision, mission and key drivers:

City & Hackney PbP Vision: Working together with our residents to improve health and care outcomes, address health inequalities and make City and Hackney thrive, by focussing on 3 key areas:

1. **Giving every child the best start in life (often by recognising the role of families)**
2. **Improving mental health and preventing mental ill-health**
3. **Preventing, and improving outcomes for people with long-term health and care needs**

Supporting our population health priority outcome areas (above), we are implementing 6 cross cutting approaches: Increasing social connection, ensuring healthy places, supporting greater financial wellbeing, joining up our local health and care services around resident's and families' needs, taking effective action to address racism and other discrimination, and supporting the health and care workforce. City and Hackney Neighbourhoods programme is about fostering community connections.

Our aim is to improve quality of care (clinical cost effectiveness, experience and safety) including access and waiting times for all our residents particularly those experiencing Health inequalities. We apply the principles of right time, right place, right support. We acknowledge that the solution lies at "whole-system" level and requires detailed collaboration with wider system partners including local authorities, public health and our voluntary sector partners and strengthening partnership working and synergies to maximise benefits in terms of outcomes and system sustainability. Residents and Families are at the heart of everything we do.

Key drivers: - national and regional policy frameworks, local needs, and addressing areas in C&H where we have poor outcomes and evidence of inequalities (as articulated in JSNAs, Population Health data, and more)

Key stakeholders:

- Residents / Carers
- Local Authorities and the CoL (ASC; PH; MH; LD&A)
- Voluntary & Community Sector;
- Homerton Hospital
- ELFT
- LBH / CoL – Adult Social Care
- LBH CoL – Children Social Care
- Hackney Education
- ELFT – CAMHS / Adults
- HUH CAMHS / Adults / Acute / Paediatrics
- C&H Public Health
- Primary Care / GP Confed
- VSO Partners / SIG

Interdependent ICB programmes

Start Well – BCYP programme priorities on Community Capacity (waiting lists, insights), Primary Care (new models, better integration) Acute care (capacity i.e.. diabetes, allergy)

Live Well - LTC and Specialised Commissioning; Planned Care; Urgent and Emergency Care; Personalised Care

Age Well - Palliative & End of Life Care; NEL Care Home / Care Provider Forum / Network; Continuing Healthcare: NEL Carers Network

Mental Health - Children (C&H); Unplanned / Crisis Care (C&H); Community Care (C&H); NEL MH Delivery Group

Interdependent Collaborative programmes

Start Well – APC, Community Collaborative (Waiting lists, SLT), Mental health collaborative, C&H CAMHS Alliance, Primary Care Collaboratives

Live Well – APC; Community Collaborative

Age Well - Mental Health Alliance; Primary Care Collaboratives

Mental Health - Mental Health Integration Committee (MHIC); C&H Children's Emotional Health and Wellbeing Partnership; C&H Psychological Therapies and Wellbeing Alliance (PTWA); C&H CAMHS Alliance; C&H Dementia Alliance; C&H Primary Care Alliance; Hackney SIG

Key programmes of work that will deliver the vision and mission

Start Well – CAMHS / Improving wellbeing and MH (ACEs), improving outcomes for CYP with SEND, complex health needs, ASD and LD, increasing immunisations and vaccinations, reducing maternity inequalities and improving perinatal mental health

Live Well - Neighbourhoods (Proactive Care, Community Navigation); Better Care Fund Partnership; Primary / Secondary Care Interface; Long Term Conditions Management

Age Well - Discharge Improvement Programme; Integrated Urgent Care - NEL Same Day Access Programme, Enhanced Community Response (Virtual Wards and Urgent Community Response), Frailty / Proactive Care

Mental Health - ADHD / ASD Assessment and Aftercare (All ages) – Backlog and Waiting times; Adult Talking Therapies – Integrated Pathways. Quality Improvement. Demand / Capacity and Waiting Times; Community Transformation / Continued Improvement with Neighbourhoods offer – aligning existing provision; Neurodevelopmental Pathways Review (CYP); Crisis / T3.5 Pathways Review (Including ICCS, Surge and IST); Whole System Approach (iThrive) – CYP Emotional Health and Wellbeing Continue to enhance THRIVE working with Schools (WAMHS / MHSTs integration) / Youth Hubs (Super Youth Hub); SMI Pathway Improvement Improving and optimising 117 Aftercare;

Engagement with the public:

- Healthwatch
- Programme / Project Service-user reps
- Engagement with the public
- Advocacy Project (MHIC)
- Alliance coproduction and Participation
- Maternity voices partnership
- SEND parent carer forum

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

All our work is aimed at improving the health and wellbeing of our local residents and reducing inequalities

Start Well

- Reductions in crisis mental health presentations to ED for CYP and Improvements in mental health and wellbeing outcomes for specific communities
- An increase % of children achieving good level of development - Improved health and educational outcomes for those at risk of exclusion and those with complex needs, SEND and autism and LAC
- Increase immunisation coverage
- A reduction in infant mortality rate, and in the rate of neonatal mortality and stillbirths, including a reduction in inequalities in maternity and birth outcomes for children and families. Improvements in patient experience.

Live Well and Age Well

- Patients will feel safe and supported with any ongoing care needs following a hospital admission
- Patients will know about services are available and have increased confidence in them to meet their needs
- Patients feel supported to access the care they need
- Patients will have more care being provided outside hospital, closer to their home, where appropriate

Mental Health

- ***Improved experience, waiting times and overall quality of care*** - Neurodevelopmental assessment (CAMHS and Adults); Psychological therapies intervention (CAMHS and Adults); 117 Aftercare; Wellbeing in School and Youth Hubs; Crisis Care including Crisis prevention and wellbeing
- ***Better meeting the needs of residents who experience greater health inequalities*** - Protected characteristics – Equalities act; Social deprivation; Serious mental illness; Neurodevelopmental (ASD / ADHD / LD); Looked After Children / Care Leavers].

Health Inequalities

Portfolio vision, mission and key drivers:
Health inequalities exist between NEL and the rest of the country – for example we have particularly high rates of children with excess weight and poor vaccination and screening uptake – but they also exist between our places and communities. These inequalities are avoidable and unfair and drive poorer outcomes for our population. We want to improve equity in access, experience and outcomes across NEL. To do this we have made reducing health inequalities a cross-cutting theme that is embedded within all of our programmes and services within places and across NEL – everyone has a role to play.

Key stakeholders:
Public health teams
Local authority departments
Voluntary and community sector
Primary care
NHS trusts
NHS E and TPHC
ICB

Key programmes of work that will deliver the vision and mission
- Dedicated health inequalities funding has been provided to each place-based partnership to lead locally determined programmes to reduce health inequalities within their local communities. These projects will be evaluated and the learning shared and showcased.
- Development of a NEL Health Equity Academy to support all people and organisations working in health and care in NEL to be equipped with the knowledge, skills and confidence to reduce health inequalities for the benefit of local people
- Implementation of a community pharmacy scheme to provide targeted pharmacist advice and free over the counter medicines for people on low incomes and experiencing social vulnerability across NEL, to support our communities in the context of cost of living pressures.
- Taking a Population Health Management (PHM) approach, led by places and neighbourhoods, will support frontline teams to identify high risk groups and identify unmet need. A PHM Roadmap has been developed for NEL and is being implemented.
- Embedding the NEL Anchor Charter, working with system partners to ensure we are measuring and creating the opportunities that being an anchor institution affords are leveraged for our local population, to address structural inequalities such as ensuring the NHS in NEL is a London Living Wage accredited employer, embedding social value in procurement process and better utilising our infrastructure to support community activation and supporting a greener, healthier future.
- Delivering our ICS Green Plan including developing an Air Quality Programme, ICS wide net zero training programme, and embedding net zero into our procurement processes to support our aim of reducing our collective carbon footprint by 80% by 2028 and to net zero by 2040.
- Improving access to primary care for health inclusion groups (homeless and refugee and asylum seekers) through safe surgery programme, supported discharge for homeless through the out of hospital care programme, supporting families in temp accommodation to access support out of borough, commissioning a NEL wide initial health assessment for those seeking sanctuary housed in contingency accommodation, and commissioning a needs assessment for health inclusion in NEL to identify needs for other underserved groups that require focus.

Details of engagement undertaken with Places, collaboratives and other ICB portfolios
- NEL Population Health and Inequalities Steering Group is made up of representatives from places and collaboratives, and leads from across the ICS.
- Significant engagement across the system on what is useful from a Health Equity Academy
- Engagement from across the system on Anchors, Net-zero and health inclusion around homelessness and refugee and asylum seeker programmes

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
- Reduced differences in health care access, experience and outcomes between communities within NEL, particularly for people from ethnic minority communities, people with learning disabilities and autism, people who are homeless, people living in poverty, and for carers.
- Improved health life expectancy for all communities across NEL, irrespective of who you are or where you live.
- Our population receives more inclusive, culturally competent and trusted services, underpinned by robust equity data.

Engagement with the public:
Engagement on specific topics, and in depth at place level.

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Prevention

PLACE

HOLDER

SLIDE

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Personalised Care

PLACE

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SLIDE

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Learning System

Portfolio vision, mission and key drivers:

The transition to an Integrated Care System has provided an opportunity to work in a different way in how we deliver and approach change to services within north east London. In order to improve the care we provide our residents, it is crucial to embed the improvement process of learning from the current delivery. As such the ICB needs provide an environment that facilitates the ability to deliver a systematic approach to iterative data-driven improvement

To ensure an effective learning system, the organisational culture must support a strong learning approach. The three stage learning cycle (learning before, during and after) describes how staff can interact with the learning system to inform their work. Each stage is informed by the following principles:

- We are well-informed – before we act, we fully consider the impact of our decisions on individual, community and system outcomes and equity.
- We are responsive – we are effectively monitoring our interventions and taking action in a timely manner
- We reciprocate –we work together sharing knowledge openly and valuing collaboration over competition

Key stakeholders:
Quality and safety
Complaints
Strategy
Programme Management Office
Place-based directors

Key programmes of work that will deliver the vision and mission

Initial scoping still to be concluded and so no programme of work has been developed/

Details of engagement undertaken with Places, collaboratives and other ICB portfolios

First discussion meeting yet to take place and so as yet no engagement has taken place

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

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- Participation in evidence-informed decision making, promoting legitimacy
- Development of a localised evidence-base, helping us to make decisions most suitable to our context and populations
- Reduction in duplication, improving productivity and sustainability
- Proportionate approaches to transformation, improvement and innovation, not driven by whim or external pressures

Engagement with the public:

First discussion meeting yet to take place and so as yet no engagement has taken place with Places, collaboratives and other ICB protfolios

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Co-Production

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High Trust Environment

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6. Implications and next steps

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Lessons Learnt (in development)

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('Early lessons from work to develop this plan' - slide being amended)

How will we know we have succeeded - NEL Outcomes Framework

- The interim North East London Integrated Care Strategy was published and adopted by the Integrated Care Board in January 2023.
- The strategy highlights our four system priorities for improving quality and outcomes and address health inequalities as well as our six crosscutting themes which are part of the new approach for working together across NEL.
- The strategy was developed in conjunction with system partners, along with a set of 61 success measures, which aimed to measure delivery against the priorities and crosscutting themes.
- This slide deck outlines the steps we are proposing to develop an outcomes framework.

What do we mean by an outcomes framework?

- An outcomes framework is a way for us to measure the effectiveness of our ICS strategy by focusing on the outcomes that are achieved, rather than just the activities that are carried out. That way we can assess whether our strategy is making a positive difference in people's lives.

In order to support the development of the outcomes framework, the below principles have been drafted to shape the design and implementation:

- **Assess delivery against ICS strategic themes and objectives**
- **Demonstrate current delivery on priority areas**
- **Develop outcome measures in conjunction with transformation leads, provider collaboratives, and ICS partner organizations**
- **Avoid developing an outcomes framework in the model of a performance framework**
- **Importance of recognising that outcomes are often long-term goals**
- **Assess wider population health measures rather than focus on statutory or mandated targets**
- **Make the system responsible for delivering metrics**

The NEL approach

- Start by mapping existing population health indicators aligned to each success measure
- Work with transformation leads to identify overarching transformation metrics which can provide system level outcomes
- Work with analytics team to assess whether data to support the measures current exists or new data sources need to be explored
- Test outcomes framework with senior leaders – does it meet their needs?

If no, refine measures

Where system level metrics do not currently exist, we may require a number of proxy measures which enable the system to accurately review delivery against the success measures.

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Next steps for our transformation programmes

- As the early analysis shows, all programmes within the portfolio can demonstrate alignment with elements of the integrated care strategy and operating plan requirements. The extent to which the portfolio responds to the more specific challenges described in the first half of this plan is more variable.
- Our shared task now is to prioritise (and therefore deprioritise) work within the current portfolio according to alignment with the integrated care strategy, operating plan requirements, and additional specific local challenges.
- This task is especially urgent in light of the highly constrained financial environment that the system faces, along with the upcoming significant reduction in the workforce within NHS North East London available to deliver transformation.
- The work required to achieve this is two-fold – part technical and part engagement – and will be carried out in parallel, with the technical work providing a progressively richer basis for engagement across all system partners and with local people.

Technical work

Tightening descriptions of the current programmes of work as the basis to inform prioritisation, especially:

- the **quantifiable beneficial impact** on local people, beyond the broad increases or decreases in certain measures currently signalled;
- the definition of **firm milestones** on the way to delivering these benefits;
- the **financial investment** in each programme and the anticipated returns on this investment; and
- quantifying the **staff resource** going into all programmes, and from all system partners.

Engagement

There is an important cross-system conversation needed, that enables us to create a portfolio calibrated to the competing pressures on it. Principle pressures to explore through engagement include:

- achieving early results that relieve current system pressures *and* creating the resources to focus on achieving longevity of impact from transformation around prevention;
- implementing transformation with a wide range of benefits across access, experience, and outcomes *and* ensuring, in the current financial climate, that we achieve the necessary short-term financial benefits;
- focussing on north east London's own local priorities *and* being open to additional regional or national opportunities, especially where new funding is attached;
- focussing on fewer large-impact transformation programmes *and* achieving a breadth that reflects the diversity of need and plurality of ambition across north east London; and
- ensuring that benefits are realised from transformation work already in train *and* pivoting to implementing programmes explicitly in line with current priorities.

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We will continue to evolve as a system

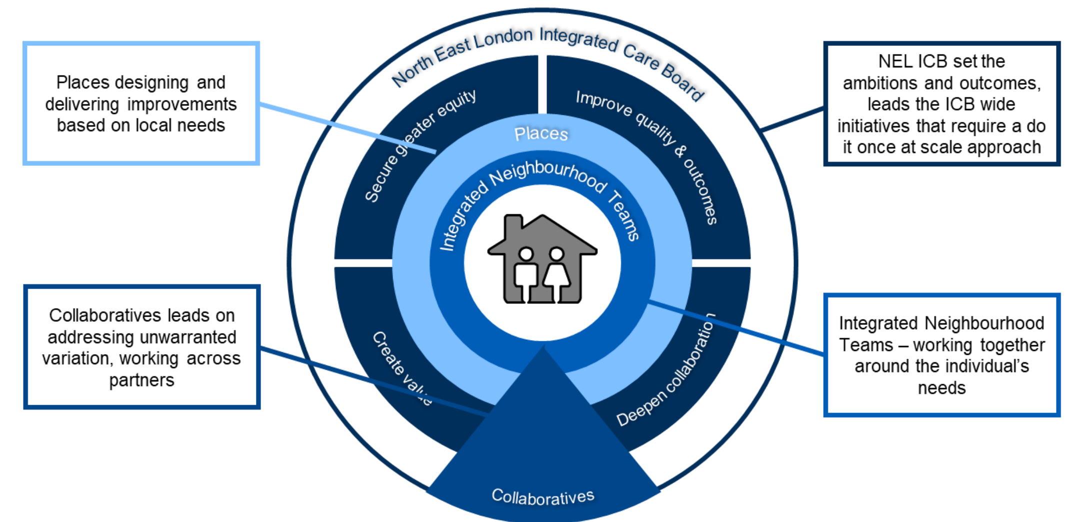
Our system has been changing rapidly over recent years, including the inception of provider collaboratives, the launch of seven place based partnerships, the merger of seven CCGs followed by the creation of the statutory integrated care board and integrated care partnership in July 2022.

Since becoming an ICS we have designed our way of working around teams operating:

- At **Place** delivering services and improvement for Neighbourhoods and Place;
- In **Collaboratives** reducing unwarranted variation, driving efficiency and building greater equity;
- For **NEL** sharing best practice, implementing NEL solutions for NEL work, providing programmatic support and oversight, and delivering enabling functions to our organisation and ICS through a business partner model.

Coordination between our Places, Collaboratives and NEL wide programmes is critical so that we:

- Operate as a learning system and spread best practice
- Ensure that activity, transformation and engagement happens at the most appropriate level, duplication is reduced and tensions are identified and resolved
- Identify where there is NEL work which should be done once for NEL
- Deliver value for money
- Deliver beneficial and sustained impact for the health and wellbeing of local people.



We are now looking to work with our partners to further develop how we work together, underpinned by our ambition to create a **High Trust Environment** that supports integration and collaboration and to operate as a **Learning System** driven by research and innovation.

Designing together *how* we want to work will be as critical as agreeing *what* we want to deliver.

This will help us get greater clarity on the responsibilities of different parts of the system, and critically how we want each part of the system to interact with another to enable integration and continuous improvement.

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