Public Document Pack

Health and Wellbeing Board

Date: **THURSDAY, 29 JUNE 2023**

Time: 11.00 am

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

Members:
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
Ruby Sayed, Chairman, Community and Children's Services Committee
Gavin Stedman, Port Health and Public Protection Director
Deputy Randall Anderson, Court of Common Council
Helen Fentimen, Port Health and Environmental Services Committee
Tony de Wilde, City of London Police
Matthew Bell, Policy and Resources Committee
Mary Durcan, Court of Common Council

Enquiries: **Julie.Mayer@cityoflondon.gov.uk**

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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. **ORDER OF THE COURT**

To receive the Order of the Court of Common Council dated 27 April 2023.

For Information
(Pages 7 - 8)

4. **ELECTION OF CHAIRMAN**

To elect a Chairman in accordance with Standing Order 29.

For Decision

5. **ELECTION OF DEPUTY CHAIRMAN**

To elect a Deputy Chairman in accordance with Standing Order 30.

For Decision

6. **MINUTES OF THE PREVIOUS MEETING**

To approve the public minutes and non-public summary of the meeting held on 24th March 2023.

For Decision
(Pages 9 - 16)

7. **HEALTHWATCH UPDATE TO FOLLOW**

For Information

8. **COMMERCIAL ENVIRONMENTAL HEALTH SERVICE PLAN 2023-24**

Report of the Executive Director, Environment.

For Information
(Pages 17 - 54)

9. **CARE QUALITY COMMISSION (CQC): ADULT SOCIAL CARE INSPECTION FRAMEWORK**

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

For Information
(Pages 55 - 58)

10. **CHILDREN AND YOUNG PEOPLE (CYP) COMMISSIONING UPDATE**

Report of the Director of Public Health, City and Hackney and Executive Director, Community and Children's Services.

For Information
(Pages 59 - 74)

11. **NORTH EAST LONDON JOINT FORWARD PLAN**

Report of the NHS North East London Integrated Commissioning Board.

For Information
(Pages 75 - 146)

12. **ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH FOR THE LONDON BOROUGH OF HACKNEY AND THE CITY OF LONDON CORPORATION**

Report of the Director of Public Health.

For Information
(Pages 147 - 196)

13. **CONSULTATION ON THE PROPOSED CITY AND HACKNEY SEXUAL AND REPRODUCTIVE HEALTH STRATEGY (2023-2028)**

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

For Decision
(Pages 197 - 200)

14. **PAN LONDON ONLINE SEXUAL HEALTH SERVICE CONTRACT**

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

For Information
(Pages 201 - 208)

15. **AN INTRODUCTION TO THE POPULATION HEALTH HUB AND HOW WE CAN SUPPORT WORK IN THE CITY OF LONDON**

Joint report of the Executive Director of Community and Children's Services and Director of Public Health.

For Information
(Pages 209 - 216)

16. **BETTER CARE FUND END OF YEAR REPORT 2022/23**

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

Due to formatting issues, the appendix to this report will be attached separately and made available on the Health and Wellbeing Board's web page:
https://democracy.cityoflondon.gov.uk/ieListMeetings.aspx?CommitteeId=994

For Decision
(Pages 217 - 220)

17. **A VERBAL UPDATE ON THE HIDDEN WORKFORCE**

Director of Public Health, City and Hackney, to be heard.

For Information

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

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

20. **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

21. **NON PUBLIC MINUTES**

To agree the non-public minutes of the meeting held on 24th March 2023.

For Decision

(Pages 221 - 222)

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

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

LYONS, Mayor	**RESOLVED:** That the Court of Common Council holden in the Guildhall of the City of London on Thursday, 27th April, 2023, doth hereby appoint the following Committee until the first meeting of the Court in April, 2024

HEALTH & WELLBEING BOARD

1. **Constitution**
A Non-Ward Committee consisting of,
- three Members elected by the Court of Common Council (who shall not be members of the Health and Social Care Scrutiny Sub-Committee)
- the Chairman of the Policy and Resources Committee (or his/her representative)
- the Chairman of Community and Children's Services Committee (or his/her representative)
- the Chairman of the Port Health & Environmental Services Committee (or his/her representative)
- the Director of Public Health or his/her representative
- the Director of the Community and Children's Services Department
- a representative of Healthwatch appointed by that agency
- NHS representative of the City and Hackney Place of the North East London Integrated Care Board ("**ICB"**) appointed by that agency.
- a representative of the Safer City Partnership
- the Port Health and Public Protection Director
- a representative of the City of London Police appointed by the Commissioner

2. **Quorum**
The quorum consists of five Members, at least three of whom must be Members of the Common Council or officers representing the City of London Corporation.

3. **Membership 2023/24**

7 (4) Marianne Bernadette Fredericks, Deputy

5 (3) Mary Durcan

2 (2) Randall Anderson, Deputy

Together with the Members referred to in paragraph 1 above.

Co-opted Members
The Board may appoint up to two co-opted non-City Corporation representatives with experience relevant to the work of the Health and Wellbeing Board.

4. **Terms of Reference**
To be responsible for:-

a) carrying out all duties* conferred by the:- Health and Social Care Act 2012, Health and Care Act 2022 ("the HSCA") and Section 128A of the NHS Act 2006 for the City of London area, among which:-

i) to provide collective leadership for the general advancement of the health and wellbeing of the people within the City of London by promoting the integration of health and social care services; and

ii) to identify key priorities for health and local government commissioning, including the preparation of the Joint Strategic Needs Assessment and the production of a Joint Health and Wellbeing Strategy.

*All of these duties should be carried out in accordance with the provisions of the HSCA 2012 and 2022 concerning the requirement to consult the public and to have regard to the statutory guidance issued by the Secretary of State including "Statutory guidance on joint strategic needs assessment and joint health and wellbeing strategies (JHWBS)" https://www.gov.uk/government/publications/jsnas-and-jhws-statutory-guidance and non-statutory guidance " Health and wellbeing board – guidance" https://www.gov.uk/government/publications/health-and-wellbeing-boards-guidance/health-and-wellbeing-boards-guidance ;

b) mobilising, co-ordinating and sharing resources needed for the discharge of its statutory functions, from its membership and from others which may be bound by its decisions; and

c) appointing such sub-committees as are considered necessary for the better performance of its duties.

d) to carry out the statutory duty to assess needs for pharmaceutical services in the City Corporation's area and to publish a statement of its first assessment and of any revised assessment.

e) to be involved in the preparation of the joint forward plan for the ICB and its partner bodies including consideration of whether the draft takes proper account to of the Joint Local Health and Wellbeing Strategy.

f) Approval of the Better Care Fund plan for the City of London area

5. **Substitutes for Statutory Members**

Other Statutory Members of the Board (other than Members of the Court of Common Council) may nominate a single named individual who will substitute for them and have the authority to make decisions in the event that they are unable to attend a meeting.

HEALTH AND WELLBEING BOARD

Friday, 24 March 2023

Minutes of the meeting held at Guildhall at 11.00 am

Present

Members:
Mary Durcan (Chairman)
Deputy Marianne Fredericks (Deputy Chairman)
Gail Beer - Chair of Healthwatch
Matthew Bell - Policy and Resources Committee
Nina Griffith - NHS representative of the City and Hackney Place of the North East London Integrated Care Board
Steve Heatley - City of London Police
Ruby Sayed - Chair of the Community and Children's Services Committee
Rachel Pye - Assistant Director, Public Protection
Deputy Randall Anderson - Court of Common Council
Helen Fentimen – Port Health and Environmental Services Committee

In Attendance

Bob Roberts	-	Deputy Town Clerk
Chris Lovitt	-	Deputy Director of Public Health – City and Hackney
Liane Coopey	-	Community and Children's Services
Ellie Ward	-	Community and Children's Services
Froeks Kamminga	-	Public Health – City and Hackney
Dianna Divajeva	-	Public Health – City and Hackney
Claire Giraud	-	Public Health – City and Hackney
Julie Mayer	-	Town Clerks
Amelia Ehren	-	Bridge House Estates

1. **APOLOGIES FOR ABSENCE**
   Apologies were received from Claire Chamberlain – Interim Executive Director, Community and Children's Services, and Sandra Husbands – Director of Public Health. Both Members joined the meeting remotely.

2. **DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**
   There were no declarations

3. **MINUTES**
   RESOLVED, that - the minutes of the public-meeting and non-public summary of the meeting held on 15th July 2022 be approved.

4. **MINUTES OF INQUORATE MEETING**

RESOLVED, that – the public minutes and non-public summary of the inquorate meeting on 25th November 2022 be received.

Members noted that, following the death of HM Queen Elizabeth 11, the meeting scheduled for on 16th September 2022 did not take place.

Matters arising

Members noted that there had been an informal briefing with the City Corporation Members of the Neighbourhood Health and Care Board about resources and decision making in integrated care. A further briefing would be held, together with a written format.

5. **ANNUAL REVIEW OF TERMS OF REFERENCE**

Members noted a report of the Town Clerk in respect of the Annual Review of the Board's Terms of Reference. The Deputy Director of Public Health recommended some significant changes, to bring them up to date with new Health and Social Care Act (2022) statutory guidance, non-statutory guidance and additional legislation, all of which will confer duties on the Health and Wellbeing Board (HWB). Members noted that it had not been possible to do this at the last meeting of the Board, as it had been inquorate. However, the need for these changes had only recently materialised due to late receipt of the guidance.

The Town Clerk advised that any recommendations in respect of the City Corporation's Committees and Boards' Terms of Reference will need to be approved by the Annual Meeting of the Court of Common Council on 27th April 2023. They would also need to be taken to the Policy and Resources Committee under Urgency. Members agreed to delegate approval of the final wording to the Town Clerk, in consultation with the Chair and Deputy Chair of the Health and Wellbeing Board, noting that the City Solicitor would also be consulted on the report.

The Board agreed with the Deputy Director of Public Health's suggestion that there should be a Co-optee from either the East London Foundation Trust, St Barts, Homerton and Shoreditch, and/or the City's Primary Care network, with a preference for at least one clinical representative from those organisations. Whilst Members accepted that it would not be possible to include all partners, it was noted that there is currently no clinical representation. Members welcomed strengthening the arrangements in relation to the Integrated Care Board, as the City and Hackney are major contributors and this might not have been reflected previously. Members were invited to comment further after the Board meeting

RESOLVED, that - approval of the final wording of the revised Terms of Reference for the Health and Wellbeing Board be delegated to the Town Clerk, in consultation with the Chair and Deputy Chair of the Health and Wellbeing Board.

6. **THE HEALTH AND WELLBEING OF THE CITY'S HIDDEN AND ESSENTIAL WORKERS**

The Board considered a report of the Director of Public Health in respect of the "hidden workforce". The report asked the Board to give consideration as to how the recommendations could be implemented within the City of London Corporation, in order to improve their health and wellbeing and reduce health inequalities. Members commended a helpful and insightful report and, during the discussion, the following points were noted:

a) The report has been shared with the Living Wage Foundation and the Chair would be meeting with them shortly.

b) The report had been to the Community and Children's Services Department's Senior Leadership Team but not to any Member Committees, as officers would like a steer from the Health and Wellbeing Board.

c) In response to a question as to how departments are addressing policies in terms of public health duty and health and wellbeing, the Deputy Town Clerk agreed to take this as an action point, as part of other related, strategic works. Members noted that the City Corporation's Executive Leadership Board works across all departments and institutions and, in the first instance, it would be helpful to present the report to this group.

d) Some of the recommendations in respect of Terms and Conditions might apply to outsourced services; for further consideration by our partners. It was suggested that this be raised with the City Corporation's new EDI Head.

e) It would be helpful for the Corporate Services and Policy and Resources Committees to receive the report in terms of encouraging ethical procurement policies. The City Corporate always stipulates London Living Wage

f) The report might be a helpful basis for training sessions across health and care partners and for future consideration at the Integrated Care Board. The Chair of Healthwatch advised that this had been raised at Community Diagnostic Hubs.

g) Could the City Corporation use mobile screening units for its workers? This could then be an exemplar to other City employers.

h) Where food is provided to workers, then this should be of reasonable quality with appropriate break times.

i) The London Borough of Tower Hamlets is working with Canary Wharf on their diagnostic hub. The City Corporation are in discussion with North East London in terms of a regional approach. A Member advised that large developers are required to devote space to community/public benefit.

j) During the pandemic, the City's Business Intelligence Team held data on where workers travelled from. Therefore, they might, therefore, be able to source data in respect of the number of workers employed via outsourced/third party contracts in the City and where they travel from.

RESOLVED, that – the report and actions above be noted in terms of the further promotion of this report at the City of London Corporation's Executive Leadership Board and the Corporate Services and Policy and Resources Committees.

7. **UPDATE ON THE JOINT STRATEGIC NEEDS ASSESSMENT WORK PROGRAMME**

The Board received a report of the Director of Public Health in respect of the Joint Strategic Needs Assessments (JSNAs) 2022/23 work programme.

Members welcomed the helpful format of the report and noted that some aspects of the evidence base for strategy and service planning had been carried forward. Any suggestions form the Board in respect of further topics should be forwarded to diana.divajeva@hackney.gov.uk

During the discussion, the following points were noted:

a) The City's Homelessness and Rough Sleeping Team could add value, noting that 'Doctors of the World' are often the street population's first point of contact.

b) Given there are a number of cases of long covid and more recent winter viruses that have led to post viral fatigue and longer term debilitating conditions, should this be added as a specific health need?

c) Officers are seeking to resolve the gaps in health data through better access and sharing at a regional level about. The Population Health Hub has been particularly helpful in identifying gaps.

d) There will be a stand-alone piece of work by the Suicide Prevention Steering Group in respect of mental health assessments. Due to the small numbers in the data, it cannot be made public as part of the Mental Health Needs Assessment.

e) Healthwatch have been working on a mental health needs assessment, looking at young people and adults who might fall through the net.

RESOLVED, that – the report be noted.

8. **DAMP AND MOULD IN OUR SOCIAL HOUSING STOCK - UPDATE REPORT**

The Board received a report of the Interim Executive Director, Community and Children's Services, which updated Members on work underway in dealing with damp and mould in the City of London Corporation's Social Housing Stock

and our response to recent national concerns raised by government. Members noted that the Housing Management and Almshouses Sub Committee had scrutinised this report in some detail. The Town Clerk agreed to circulate the draft minutes from this meeting, together with a leaflet which had been sent to all residents and Members of the City of London Corporation. DONE

During the discussion, the following points were noted:

a) A City-wide approach is required to address both social and private rented housing across the City, noting that private rented properties tend to be in a worse condition than City Corporation ones.

b) Damp and Mould as a danger to health has technical categorisations of 1 & 2. Officers visited the Golden Lane Estate and did not find any category 1 or 2 cases.

c) Damp and mould caused by structural issues will not be helped by opening windows.

d) Housing Act enforcement matters fall within the remit of the Environmental Health Team. All housing complaints in respect of damp and mould are prioritised and responded to within a day. Following the recent Directive from the Department of Levelling-up, all officers have been trained accordingly. All historic cases reported over the past 4 years have been checked to ensure that any interventions have been sustained. Members asked if this could be emphasised in the various communication channels, in order to give reassurance to residents.

e) Works to roofs and windows, as part of City of London Corporation's Major Works Programme, will seek to address this on a permanent basis.

f) The Board asked for an action point to the NHS, in terms of health professionals visiting residents in their homes and how they will support patients in reporting cases of damp and mould. Members asked if the leaflet referred to above could be circulated to all health practitioners who undertake home visits.

RESOLVED, that – the report be noted.

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

The Board received a report of the Chair of the City of London Healthwatch, which provided an update on progress against contractual targets and the work of Healthwatch City of London (HWCoL) with reference to Quarter 3 and 4. 2022/23.

Members noted that there would be a new appointment made under 'Resident Reset' and suggested that it would be helpful for the postholder to work with Healthwatch.

Members also welcomed the recent improvements at the Neaman Practice and to the app. Further improvements are in hand in respect of the Patient Participation Group.

RESOLVED, that – the Report be noted.

10. **JOINT LOCAL HEALTH AND WELLBEING STRATEGY UPDATE**

Members received a verbal update and noted that this was out for consultation until 12 May 2023 and there would be a further push on communications and consultation to shape the action plan. The Officer agreed to resend the links to the survey and web page. Members noted that they would receive the final document for sign off at the next meeting.

During the discussion, the following points were noted:

a) The volunteer peer researchers include some researchers from the East of the City. Anyone who completes a survey will be asked if they wish to participate in resident focus groups.

b) Officers are working with commissioned providers, City Advice, Connections and libraries. The consultation strategy will be kept under review, to ensure all resident groups are captured. A Member suggested contacting the Chairs of the various resident associations across the City's Estates.

c) The consultation document did not include an action plan - this would be developed during engagement and consultation. It was noted that the current consultation was focused on aim and outcomes and therefore succinct. There was a suggestion that the on-line surveys could be more user-friendly.

d) There is a challenge across Government departments in terms of pitching consultation correctly. Members noted a new Resident Engagement Manager is in post and work is underway to improve communications with workers and residents.

At 12.55 agreed to extend to 1.10 to conclude business on agenda.

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

A Member asked the following question, which had been put by a resident: *'How integrated and proactive is the support from health and social care for city residents with severe mental health conditions*'

Members noted that this would be the subject of a future report covering integrated care and mental health services. The Deputy Chair, also Chair of the HRS Sub Committee asked if the HWB could also receive a presentation on the Street Triage Nursing service at its next meeting.

12. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**
There were no items.

13. **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.

Item nos	**Para nos**
14-18	1,2 & 3

14. **NON PUBLIC MINUTES**
RESOLVED, that - the non-public minutes of the meeting held on 15th July 2022 be approved.

15. **NON-PUBLIC MINUTES OF INQUORATE MEETING**
RESOLVED, that – the non-public minutes of the meeting held on 25 November 202 be received.

16. **FINDINGS AND RECOMMENDATIONS FROM THE CITY OF LONDON PUBLIC PROTECTION STUDY**
The Board received a report of the Deputy Town Clerk.

17. **NON-PUBLIC QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**
There were no items.

18. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE BOARD AGREES SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**
There were no items

The meeting ended at 1.10 pm

Chairman

Contact Officer: julie.mayer@cityoflondon.gov.uk

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Committee: 1) Port Health & Environmental Services Committee (For Decision) 2) Health & Wellbeing Board (For Information)	**Dated:** 1) 30 May 2023 2) 29 June 2023
Subject: Commercial Environmental Health Service Plan 2023-2024	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	**1, 6**
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: Juliemma McLoughlin, Executive Director Environment	**1) For Decision** **2) For information**
Report authors: Gavin, Stedman, Port Health & Public Protection Director Peter Brett, Commercial Environmental Health Team Manager	

Summary

This report seeks approval for the Commercial Environmental Health Service Plan 2023/24 and the Port Health Service Plan 2023/24. The service plans are an important part of the process to ensure that national priorities and standards are addressed and delivered locally.

National Codes of Practice allow local authorities flexibility over how to deliver their regulatory functions for food and occupational health and safety. Service plans set out how and at what level regulatory controls will be provided, in accordance with those Codes of Practice.

This year's Service Plans update Committee on the recovery planning processes laid out over the last two years. It also takes into consideration the Food Standards Agency (FSA) plans for local authorities and the updates they have provided in terms of their modernisation programme.

Recommendation(s)

Members are asked to:-

a) note the work done to-date; and
b) approve the Commercial Environmental Health Service Plan 2023-24 at Appendix 1.
c) approve the Port Health Service Plan 2023/24 at Appendix 2.

Main Report

Background

1. As an enforcement authority the City Corporation has obligations for the delivery of certain food and health and safety controls arising from existing legislation, statutory Codes of Practice and related guidance, and in the Framework agreements that set out requirements for the planning, management and delivery of the requisite local authority enforcement services.

2. To help to ensure local transparency and accountability and to show our contribution to the authority's corporate plan, both FSA and the Health and Safety Executive (HSE) advise that service plans and performance reviews should be approved at the relevant level established for the authority. Our service plans have traditionally been presented to this Committee annually.

3. Realising all the public health and COVID-19 related work that local authority officers were being asked to do, in April 2020, the FSA relinquished the requirement for local authorities to undertake a comprehensive programme of official control inspections in relation to food hygiene and simply required them to carry out certain specific interventions.

4. As a result, in July 2020 we submitted to this Committee a different form of Service Plan, which outlined certain specific priorities and a graduated timetable for return to normality post the pandemic.

5. In November 2020, Members approved a further interim Service Plan for the team taking into account all the additional duties that had been placed upon local authorities. Re-occurring lockdowns caused the team to review this already revamped Service Plan and it was re-presented in a shorter report to this Committee in May 2021.

6. In May 2021, the FSA's Board endorsed a Local Authority Recovery Roadmap strategy or "Recovery programme" covering the period September 2021 to March 2023. The suggested aim was to assist local authorities to tackle any backlogs in their food hygiene inspection programmes as the country began recovering from the pandemic.

7. In November 2021 Member approval was sought for a further revision to the Service Plan that would stretch to March 2023, the same period as the above recovery programme and which set out enforcement work in key areas for food safety and health & safety.

8. The planned food activities set out for the Team are in line with the activities and milestones set out in the recovery programme including the expectation that we moved at a faster pace in realigning with the Code of Practice requirements where we were able.

9. The FSA have continued to set out how they would work with local authorities to bring down the backlogs, starting with those businesses which pose the

highest risk. FSA have been assessing progress against agreed milestones using “temperature check” surveys, as well as adapted end of year surveys.

10. The FSA’s Chief Executive recently wrote to local authority leaders, including our Town Clerk to extend her thanks to teams for engaging with the recovery programme, completing the monitoring surveys and verification assessments and for our ongoing vital work in striving to return to pre-pandemic levels of service.

11. The City of London along with all local authorities are required to report on their progress towards the reset programme.

Current Position

Commercial Environmental Health

12. Commercial Environmental Health are still prioritising their work to ensure that City businesses in a variety of sectors operate and remain safe for their customers.

13. We met the significant milestones in the recovery programme to bring interventions at the highest risk businesses back on track and have made significant progress towards returning to the normal inspection frequencies for lower risk businesses too.

14. The FSA have now brought the recovery programme to an end. The expectation is therefore that we will deliver a programme of interventions that aims to meet the full requirements in the existing Food Law Code.

15. In ending the recovery programme the FSA have also confirmed that they will now work with local authorities in a more bespoke way, to help ensure the return to delivery of pre-pandemic levels of service and because further changes are planned in the delivery models for both food hygiene and food standards.

16. We still have a backlog of food hygiene work in lower risk food businesses to work through, alongside a return to the normal performance expectations. There are a minimum number of inspections and interventions that we must deliver. The challenge remains the numbers of ‘D’ rated premises. These are scored ‘lower’ risk but in reality, a significant proportion, though compliant could also be large and/or complex. City hospitality is some of the largest around having traditionally catered for many thousands. We will therefore continue to integrate a proportion of these ‘D’ rated premises into the programme throughout the whole period.

17. In terms of the more detailed programme of other work objectives for the whole team (i.e., not just food safety) this was outlined in our last Plan. But we are also mindful of further significant changes in the delivery of food controls.

18. FSA are working through their Achieving Business Compliance (ABC) Programme to develop these further regulatory reforms; the reforms will affect both food hygiene and food standards delivery. We trust that any such reforms

will help us to target available regulatory resources at the areas which pose the greatest risk.

19. This year, FSA expect to begin implementation of a more risk-based, intelligence-driven delivery model for food standards intervention work, which has been developed with, and piloted by, local authorities. FSA will also be working with local authorities to develop the new approach to the delivery of food hygiene in a similar way.

20. We have now therefore refreshed our objectives and set out what we plan to achieve in the coming year, mindful of the above pending changes. The revised Service Plan is at Appendix A. Our plans and objectives may need to be refined as further details of delivery reforms emerge.

Port Health Service

21. The Port Health Service has focussed its attention on undertaking border controls on food and feed that have been imported from countries outside of the EU.

22. In addition, the Service has been preparing for border controls on EU food and feed imports and has responded to the Draft Border Target Operating Model (BTOM); a high-level plan that outlines the new regime for SPS checks on all food, feed and live animals entering the UK. Further details on the BTOM are provided in a separate report for this Committee.

23. Food premises interventions on river vessels and within the Ports and Airport will be done in accordance with the same requirements outlined above for Commercial Environmental Health; there are a smaller number of food businesses that need inspections in the Port Health area. Details can be found in Appendix 2.

Corporate & Strategic Implications

24. Strategic Implications - The Service Plan continues to support two of the main aims of the City Corporation's Corporate Plan 2018 to 2023:

- ***Contribute to a flourishing society***
  1- People are safe and feel safe.

- ***Support a thriving economy***
  6 - We have the world's best legal and regulatory framework and access to global markets.

25. Financial implications - None. The Service Plan will be met from within existing local risk budgets.

26. Resource implications - None.

27. Legal implications - Failure to plan and implement a programme of Official Food Controls interventions could result in sanctions by the FSA, in extremis

taking over the operational control of the City Corporation's Food Authority functions.

28. Risk implications - Potential reputational risk to the City Corporation if the above happens.

29. Equalities implications – None following a test of relevance.

30. Climate implications - None.

31. Security implications - None.

Proposals

32. Commercial Environmental Health will continue to undertake the work set out in their Service Plan for 2023-24.

33. The Port Health Service will continue to:

    a) focus on imported food and feed controls at the border,
    b) prepare for the implementation of the new border control regime for food and feed; and
    c) undertake the work set out in their Service Plan for 2023-24.

Conclusions

34. The Service Plans outline a programme of work objectives and how these will be delivered. We will continue to ensure our work is risk-based, supportive to businesses where they are, or seek to be compliant, but providing protection to workers, consumers and the public.

35. At the same time, the City Corporation will continue to meet its obligations to central Government and its agencies as outlined in the various Codes.

Appendices

- Appendix 1 - Commercial Environmental Health Service Plan 2023/24
- Appendix 2 – Port Health Service Plan 2023/24

Background Papers

- Port Health & Environmental Services: July 2020 Agenda Item 14 - Commercial Environmental Health Team Service Plan 2020-2021
- Port Health & Environmental Services: November 2020 Agenda Item 7 - Amendments to the Commercial Environmental Health Team Service Plan 2020-2021 with respect to Food Safety
- Port Health & Environmental Services: May 2021 Agenda Item 10 - Commercial Environmental Health and Port Health Service Plans 2021-2022
- Port Health & Environmental Services: 23 November 2021 Agenda Item 9 Commercial Environmental Health Service Plan 2021-2023
- Port Health & Environmental Health Services: May 2022

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Appendix 1

Environment Department
Port Health & Public Protection Division
Commercial Environmental Health Service Plan 2023-24

Foreword

This year's Service Plan updates previous Committee reports, it builds on the recovery planning processes laid out over the last two years. It also takes into consideration the Food Standards Agency (FSA) plans for local authorities and the updates they have provided in terms of their modernisation programme.

The FSA Recovery Plans (the Plans) which took effect from 1 July 2021 ran through to April 2023. The Plans focussed on re-starting the regulatory delivery system in line with the Food Law Code of Practice (the Code) for the highest risk establishments, while providing greater flexibility for lower risk establishments.

The Plans set key milestones and we built our food regulatory service delivery around those. FSA have now determined that official food control delivery should be set to meet the full requirements of the Code including the more limited flexibilities still available for lower risk establishments. In considering delivery of appropriate interventions, we also remain mindful of the national changes to the food standards delivery model, expected to be introduced in 2023-24 and planned details on changes to the food hygiene delivery model, details of which are also expected this year. These are part of the overall modernisation programme planned by the FSA. The wider context has changed significantly too, with Government working on a new Borders Target Operating Model (BTOM) and the introduction of the Retained EU Law Bill. Both have placed additional resourcing demands on Government, despite recent announcements regarding further amendments to the latter.

In terms of our more detailed programme of work objectives for the whole Commercial Environmental Health team (i.e. not just food) these are outlined in further detail in this Service Plan. This latest version of the plan updates and refreshes the more detailed objectives and sets out what we plan to achieve in the coming year.

The City of London has now completed the final stages of realigning its services and implementing our target operating model to enable substantial organisational efficiencies.

Gavin Stedman
Port Health & Public Protection Director

May 2023

Introduction

The Commercial Environmental Health Team regulates food safety, occupational health and safety and some public health control arising from commercial businesses' activities for which we are the enforcing authority.

This plan has been prepared to accord with Food Standards Agency (FSA) and Health & Safety Executive (HSE) current frameworks on the planning and delivery of our services. As outlined in the foreword the food framework remains subject of further change as the FSA effects the modernisation programme, known as Achieving Business Compliance (ABC); the Recovery Plans reflect the transitions to new intervention delivery models for both food standards and food hygiene.

The delivery of our overall team goals and guiding principles will consider the various changes in these delivery models; the new food standards model is expected to be introduced this service year and details on the requirements of the food hygiene model are also expected. The current health and safety delivery model is driven by LAC67-2 (rev. 12)

Our plan is also guided by the City Corporation's Corporate Plan 2018-23 and the City & Hackney Joint Strategic Needs Assessment. It will consider the revised Health and Wellbeing Strategy 2023-27 as this develops. Work on our next Corporate Plan (2025-2030) is also currently in development, with a narrative annex for 2024 to be added to the current 2018-23.

The current Corporate Plan outcomes on which we can have a direct impact are…

- Outcome 1: People are safe and feel safe.
- Outcome 2: People enjoy good health and wellbeing.
- Outcome 5: Businesses are trusted and socially and environmentally responsible.
- Outcome 6: We have the world's best legal and regulatory framework and access to global markets.
- Outcome 8: We have access to the skills and talent we need.
- Outcome 11: We have clean air, land and water and a thriving and sustainable natural environment.

Our team goals are that:

- We promote and support a risk based, goal setting regulatory regime.
- Higher risk activities are properly managed, and employers are committed to developing healthier workplaces
- Food is hygienically prepared, safe to eat and what it says it is;
- We regulate in a way that supports businesses to comply and where necessary evolve, whilst not losing sight of the integrity and assurance of safe food for consumers and safe workplaces needing to be at the heart of what we do.

Our guiding principles are:

- working with partners to make workplaces safer and healthier, providing a level playing field for responsible employers, by advising, promoting, and where necessary, enforcing good standards of risk control;
- developing services that contribute to improved management and control of risks, sharing our knowledge;
- continuing our dialogue and conversation with stakeholders to improve the service, always looking to provide simple,
- pragmatic advice and support;
- using the range of tools at our disposal effectively to influence duty holder behaviour and keep the interests of consumers at the heart of what we do;
- focusing our resources based on risk and using the range of tools at our disposal effectively
- ensuring our workforce is adequately resourced and experienced, enabling the service to fulfil the objectives set in the Department's Business Plan and this local Service Plan.

Resources, Service Delivery and Recovery- what's changed?

In 2022/23 the new Target Operating Model for the City Corporation was implemented.

We are now in a transition phase for the new intervention delivery models for food. The FSA recognised in a recent Board Paper that during this period there would be a significant amount of work for LAs and the FSA to undertake in preparation. The FSA originally confirmed that the Recovery Plan priorities would continue to 2023-24 but have more recently indicated a return to full Code of Practice interventions.

We will be introducing a new management information system which goes live in this service plan year. Officers in the team were heavily involved in the transition work that was required in the latter part of 2022-23 but will now be freer to resume 'business as usual' activities. Revisions to food intervention models will however require further (major) changes to our systems to enable operation of the new standards risk matrix and to capture the revised data that will be required for reporting and KPIs, this will then likely be repeated for food hygiene.

We will continue to consider the best way to collect information on the Regulated activities that we need to perform, learning from some of the lessons acquired during the pandemic restrictions to ensure that we have as full a picture as possible.

Decisions about how and where we work are made gradually and deliberately, something we developed during the pandemic. The focus on productivity and effectiveness and a view towards building a more flexible workforce remains.

Performance and monitoring

Our enforcement activity and certain key performance Indicators (KPIs) are reported to the Port Health & Environmental Services Committee along with other planned activities and key highlights, as part of the regular oversight of our work.

The four-monthly Committee reports include;

- The enforcement Activity undertaken for food safety and health and safety intervention work.
- A narrative update on any FHRS '0 rated' establishments.
- Highlighted activities undertaken in the relevant period.
- An FHRS premises profile of all food businesses in the scheme.
- Progress against certain performance indicators.

Service Plan objectives

Our more detailed programme of work objectives for the Team are set out below. This latest plan updates and refreshes the more detailed objectives and sets out what we plan to achieve in the coming year.

Objective	Activities
1. **Manage the impacts as the regulatory landscape continues to evolve, including ongoing issues around; EU Transition; the FSA's ABC Programme; and our need to 'make adequate provision' for health and safety enforcement.**	▪ Continue to evaluate the impact of proposed new Regulatory regimes. ▪ Continue to explore and develop our strategic networking; lobby and inform relevant stakeholders of the perceived impact of proposed workstreams, the framework programme as a whole and its likely effect on PH&PP and them. ▪ Prepare and align the Commercial EH Team to new regulatory frameworks for the delivery of food and health and safety and where relevant public health, ▪ Strengthen and maintain long-term Member commitment to delivery of our duty as enforcers of workplace health & safety.

Outcome – Corporate Plan objectives are in **bold**	**Responsibility**
Outcome 5: Businesses are trusted and socially and environmentally responsible. **Outcome 6: The best legal and regulatory framework - (6b.) we will help promote regulatory confidence and influence UK policy and regulation to protect and grow the economy**. The Commercial EH Team continues to be aligned to take advantage of relevant new regulatory frameworks and is structured and designed so that it; • is dynamic enough to keep pace with the changes; • can harness new technologies and; • can adapt to future circumstances. Publicly committed to the HSE / Local Authority Statement of Commitment on health & safety regulation and embed the principles within this service plan.	Assistant Director (Regulation and Compliance) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety)

Objective	Activities
2. **Deliver official food controls.** Meet the revised service delivery expectations for LAs. An FSA Board Paper in August 2022 highlighted a number of challenges in Local Authority delivery. Since that time the FSA Recovery Plan has been revised and local authorities are encouraged to return to the interventions and intervals outlined in the Food Law Code of Practice Continue to prioritise planned interventions for high-risk category and non-compliant establishments in specific subordinate objectives and their activities. Lower risk premises will be returned to the programme using the guidance from FSA. To improve hygiene and standards compliance and reduce risks by focusing activity where non-compliance is identified and by undertaking appropriate follow-up and enforcement action. Manage any transition to the new food standards delivery model and plan similarly for the revised food hygiene model.	• Official controls are undertaken where the nature and frequency are prescribed in specific legislation and official controls recommended by FSA guidance are undertaken to support trade and enable export •Reactive work including; enforcement in the case of non-compliance, managing food incidents and food hazards, and investigating and managing complaints • Sampling in accordance with the local authority sampling programme or as required in the context of assessing food business compliance, and any follow-up necessary in relation to the FSA Surveillance Sampling Programme • Ongoing proactive surveillance to obtain an accurate picture of the local business landscape and to; identify open/closed/recently re-opened/new businesses; as well as businesses where there has been a change of operation, activities, or food business operator. • Prioritisation of 'new businesses' for intervention based on risk. • Responding to FHRS requested re-visits in line with the timelines specified in the FHRS Brand Standard for England.

Outcome – Corporate Plan objectives are in **bold**	**Responsibility**
Outcome 1: People are safe and feel safe. **Outcome 5: Businesses are trusted and socially and environmentally responsible** ▪ We improve hygiene and standards compliance and reduce risks by focusing activity where non-compliance is identified and by undertaking appropriate follow-up and enforcement action. ▪ Receive and investigate appropriately all requests for service, food incidents and complaints about food and food premises. ▪ Ongoing proactive surveillance to obtain an accurate picture of the business landscape. ▪ New businesses receive an appropriate and timely intervention. ▪ Where required establishments receive an onsite intervention and are thereafter back in the system for interventions in accordance with the Food Law Codes of Practice.	Assistant Director (Regulation and Compliance) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety)

Objective	Activities
2a: Appropriate food hygiene interventions are completed. New and refreshed food hygiene ratings are given [where possible*].	▪ The Table in this objective shows all the hygiene inspections due to year end 2023-24. The figures indicated in red in the table in Objective 2d are higher risk premises. ▪ All higher risk establishments receive an onsite intervention in accordance with the Food Law Codes of Practice. ▪ New premises receive an appropriate intervention within 28 days of registration (or opening). This will be triaged if other higher risk work is required. ▪ Lower (rated) risk premises are brought back into the programme and appropriate on-site interventions are completed where this is possible; the focus will be on larger/complex D rated establishments. ▪ We will use Alternative Enforcement Strategies and other interventions to gather intelligence/information on all lower risk establishments – this includes those in category D - broadly compliant or better (FHRS 3, 4 or 5) for hygiene, and category B for standards. ▪ When intelligence suggests risks have increased (irrespective of the risk category) we will undertake interventions to assess and address those risks The requirements on allergen labelling for products prepacked for direct sale will be considered at appropriate hygiene interventions rather than any separate food standards intervention. **[*Where an appropriate inspection/audit intervention has been completed].**

Category	*Interventions*	
	Due to end March 2024	***Done 2022-23***
New (unrated)	75	**158**
A (*due every 6 months)	8	**12**
B (*due every 12 months)	49	**83**
C (less than broadly compliant)	15	
C	186	**260**
D	648	**232**
D (less than broadly compliant)	1	
E	225	44
Total	1206	789

Outcome	Responsibility

▪ Complete the required risk-based food hygiene interventions: ▪ All establishments in Phase 2 of the FSA Recovery Plan receive an onsite intervention per the above timetable ▪ Higher risk new premises receive an intervention within 28 days of registration (or opening). ▪ Target *>90%* of other food establishments selected for an intervention are completed.	Assistant Director (Regulation and Compliance) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety)

Objective	**Activities**
2b: Focused follow up activity is conducted in food businesses that are not compliant [in the lower tiers of FHRS (0, 1 & 2)] This is more important than ever as we emerge from the Coronavirus Pandemic, and we look to support the recovery of compliant businesses and protect consumers from non–compliant establishments	▪ Reinforce our intervention strategy with additional follow-ups, including visits, coaching and advice. ▪ Use agreed national food safety managements systems such as "Safer Food, Better Business" where these are appropriate. Use on-site inspection reports and mobile working systems. Support the use of ethical business regulation principles. ▪ Formal enforcement action will be informed by our current Policy Statement on Enforcement.

Outcome –	**Responsibility**
▪ Action is taken against food businesses that fail to fulfil their obligations. ▪ Improving standards in riskier food businesses. ▪ Reduction in the number of non-complaint food businesses through improved food hygiene performance and with the confidence this will be sustained.	Assistant Director (Regulation and Compliance) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety)

Objective	**Activities**
2c: Appropriate food standards interventions are completed We are responsible for verifying compliance with food law in the majority of food business establishments. The FSA anticipate that the new food standards model will help better target LA resources towards the highest risks. The new (currently pilot) model is set to ensure that the frequency of food standards controls is based on a better understanding of the level of risk a food business poses.	▪ The backbone of our regulatory work remains a targeted (risk-based) intervention program developed in accordance with national requirements. ▪ All high-risk premises are rated in accordance with the existing intervention rating scheme in part 5 of the Food Law Code; all others including any overdue inspections are picked up when the next relevant Food Hygiene intervention falls due. ▪ Reinforce our intervention strategy with additional follow-ups, including visits, coaching and advice. Formal enforcement action will be informed by our current Policy Statement on Enforcement.

Outcome –	**Responsibility**

▪ Action is taken against food businesses that fail to fulfil their obligations. ▪ Improving standards in riskier food businesses. ▪ Reduction in the number of non-complaint food businesses through improved food standards performance and with the confidence this will be sustained.	Assistant Director (Regulation and Compliance) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety).

Objective	Activities
2d: Maintain support for the national Food Hygiene Rating Scheme (FHRS) We will continue to support FHRS and any development of mandatory display and endeavour to complete interventions that enable an updated rating to be provided; keeping the system relevant for businesses and consumers.	▪ It is important for consumer and business confidence that the FHRS system remains credible and objective; **the central tenet of the scheme remains a risk-based intervention programme that meets the required FSA standard**. ▪ Consumers see mandatory display of ratings as a necessary part of any new regulatory model. Our intervention work will therefore endeavour to continue to establish compliance even in lower risk premises. ▪ We will therefore consider adaptions to our interventions to ensure lower risk premises remain compliant. This will include interventions that allow formal rating, where this is possible. ▪ We will support the re-rating visits according to the process outlined on our website.

FHRS Rating	No premises	Category, %
0	3	Non-compliant 3.7
1	17	
2	43	
3	44	Broadly compliant 2.6
4	130	Good or better 93.7
5	1452	
Unrated/outside program	80	
Total	1769	

Outcome	Responsibility
▪ Improvements in the number of businesses that meet minimum compliance levels and, in the number, evidencing 'very good' standards of compliance. ▪ We deliver the required (risk based) intervention programme outlined in this plan. ▪ Food Business Operators want a 5 FHRS rating, they achieve it and then show it by displaying their sticker enabling customers to see that food safety is a top priority and foremost in their minds.	Assistant Director (Regulation and Compliance) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety)

▪ The further development of the re-rating scheme is supported in the City as FHRS itself moves towards alignment with the ones in the devolved Governments of Wales and Northern Ireland (where FHRS is mandatory).	

Objective	**Activities**
2e: Develop and implement a risk-based food sampling programme	▪ Consider our Sampling Policy and local, regional, and national priorities utilising all intelligence available. ▪ Take part in relevant regional/national identified studies where we are able. ▪ Exchange intelligence and findings on sampling results using relevant local and national intelligence, a key element to a robust system of Official Food Controls. ▪ If requested, we will acknowledge and respond to any originating local food authority, in respect of inland referrals, confirming any action taken.

Outcome	**Responsibility**
▪ Delivery of a risk-based sampling programme. This work was drastically scaled back during the pandemic, but the intention is to reinvigorate programmed sampling work in 2023-24 where it supports other workstreams. ▪ We comply with the FSA Data Standard for the collection of food and feed sampling intelligence. ▪ Contribute to relevant sampling projects selected by UKHSA and the public analyst services.	Assistant Director (Regulation and Compliance) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety)

Objective	Activities
3. Ensure adequate arrangements are in place for the enforcement of health and safety. **Focus on duty-holder business and activities where risks are highest** Section 18(4) of the Health and Safety at Work Act etc. 1974 places a duty on Local Authorities to make 'adequate arrangements for the enforcement' of health and safety and the Code sets out what is meant by 'adequate arrangements for enforcement'. **Consider activities in the sectors identified in LAC 67/2 (rev 12);** Setting Local Authority Priorities and Targeting Interventions including local intelligence. **Subordinate objectives and their activities are outlined in 3a-f below**	▪ Planned proactive health and safety interventions which focus on national priority topics; ▪ Undertaking targeted initiatives based on local intelligence and evidence of risk; ▪ Evidence-based education of employers, employees and contractors through guidance and information; ▪ Promoting proportionate and sensible health and safety through business engagement and partnership working; ▪ Undertaking and participating in health and safety promotion campaigns; ▪ Working with and liaising with other internal stakeholders and external organisations ▪ Devising material to help businesses comply with the law and promote good practice

Outcome – Corporate Plan objectives are in **bold**	**Responsibility**
Outcome 1: People are safe and feel safe. **Outcome 2: People enjoy good health and wellbeing.** **Outcome 5: Businesses are trusted and socially and environmentally responsible.** ▪ **Planned interventions are evidence based.** Proactive inspection are only used for the activities in the sectors contained in the list of priority topic areas which is embodied in the National Code and LAC 67/2 (rev 12), or where there is local intelligence of failure to manage risk or for making it a specific local priority.. ▪ All reactive and proactive work is underpinned by local, regional, and national liaison. An appropriate mechanism for ensuring consistency between enforcers, for sharing good practice, for sharing information and for informing other enforcers of potential difficult situations	Assistant Director (Regulation and Compliance) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety)

Objective	Activities
3a; Management of legionella in cooling towers. A Local Priority and Targeting Interventions including local intelligence. The risk of a Legionnaires' disease outbreak affecting the Square Mile is considered an unacceptable public health and reputational risk, especially when compared with any perceived burden from our intervention activity. One hundred and twenty sites are due an intervention in the period to end March 2024. Fifty-two are in the higher risk categories and will receive an on-site intervention	▪ Proactive interventions are considered necessary based on local intelligence and following the considerable upheaval of the pandemic and potential impact on the management of legionella, e.g. building occupancy and use during various Lockdown iterations ▪ Risk-based interventions at sites with cooling towers; revisits and enforcement action taken as necessary; ▪ Review status of decommissioned tower sites and follow up accordingly. ▪ Engagement with duty holders at new / proposed cooling tower sites: Advice to Principal Designers and Designers including at the pre-application or Planning Application stage of development. ▪ Focus attention on sites that have:- o not yet demonstrated the ability to manage their Legionella risk in a sustained manner, and includes new cooling towers / evaporative condensers; and/or o relevant enforcement action in the last 5 years and have not yet demonstrated sustained control of Legionella risk. ▪ Legionella Control Association attend quarterly meetings ▪ Deliver training for inspectors on legionella and cooling towers (in conjunction with ALEHM and wider). ▪ Host / support further professional development events for the regulatory and public health community.

Outcome –	Responsibility
Planned interventions are evidence based for cooling tower systems. Proactive inspections are a reliable means of intelligence gathering. This type of intervention remains broadly supported by duty-holders who value our input and oversight	Assistant Director (Regulation and Compliance) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety)

Objective	Activities
3b; Electrical safety in hospitality settings. The Electricity at Work Regulation 1989 requires that any electrical equipment which has the potential to cause injury is maintained in a safe condition	▪ Consider matters of evident concern and raise at on site food hygiene interventions.

Outcome –	Responsibility
Planned interventions are evidence based. Proactive inspection are only be used for the activities in the sectors contained in the list of priority topic areas which is embodied in the National Code and LAC 67/2 (rev 12), or where there is local intelligence of failure to manage risk.	Assistant Director (Regulation and Compliance) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety)

Objective	Activities
3c: Gas safety in commercial catering premises. The proper installation, maintenance and inspection by a competent Gas Safe registered engineer is essential to ensuring that staff and customers at commercial catering premises are protected from exposure to carbon monoxide gas.	▪ **Gas safety in commercial catering premises.** The proper installation, maintenance and inspection by a competent Gas Safe registered engineer is essential to ensuring that staff and customers at commercial catering premises are protected from exposure to carbon monoxide gas. ▪ Continue to survey food premises likely to be using solid fuel appliances (at the time they become due for an on-site food hygiene inspection). ▪ Follow-up enforcement in premises where there are matters of evident concern

Outcome	Responsibility
Planned interventions are evidence based. Proactive inspections are only be used for the activities in the sectors contained in the list of priority topic areas which is embodied in the National Code and LAC 67/2 (rev 12), or where there is local intelligence of failure to manage risk.	Assistant Director (Commercial Services) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety)

Objective	Activities
3d: Crowd management & injuries/fatalities to the public Event Safety / Crowd control at large scale public gatherings/ events remains a National Priority for 2023-24. The City Corporation host many high-profile events, and the City are also the enforcement authority for some of the larger higher risk events.	▪ Work with Licensing, Operational and Safety Planning Groups to better understand proposed event plans ▪ Work as part of the City Corporation's Safety Advisory Group (SAG) to advise on and help promote risk management and good practice with event organisers. ▪ Visits to events to verify the application of appropriate risk control measures. ▪ Where necessary intelligence is shared between appropriate stakeholders, e.g. City of London Police, London Fire, London Ambulance, City Corporation's Highways service.

Outcome	Responsibility
Lack of suitable planning, management and monitoring of the risks arising from crowd movement and behaviour as they arrive, leave, and move around a venue is addressed where this is necessary.	Assistant Director (Regulation and Compliance) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety)

Objective	Activities
3e: All London Borough Health & Safety Liaison Group (ALBHSLG) Under LAC67/2 LAs should consider whether they can gain regulatory efficiencies by planning activity collectively e.g. with members of their local LA liaison groups.	▪ Any planned activity programme formulated by ALBHSLG for 2023-24 will be considered and resourced appropriately. ▪ Work with relevant signatories of the Work-related deaths protocol to clarify and set demarcation arrangements and promote cooperation.

Outcome	Responsibility
▪ Work with a potential range of agencies to develop partnership approaches that improve compliance and help duty-holders to manage health and safety. **Note**: Planned project activity was paused following Coronavirus measures	Assistant Director (Regulation and Compliance) Commercial EH Team Manager

	Lead Officers (Food Safety and Health & Safety)

Objective	Activities
3f: Reactive health and safety interventions .	▪ Investigating reported accidents, occupational diseases and dangerous occurrences that meet the appropriate criteria for follow up; ▪ Responding to complaints and requests for service; ▪ Permissioning work; o In MST premises (in liaison with Licensing colleagues); o Asbestos notifications; and, o Thorough examination (usually lift) reports; ▪ Responding to consultations, e.g. from Licensing; ▪ Providing or signposting advice and information to duty holders; ▪ Prioritised and targeted health and safety promotional campaigns.

Outcome – Corporate Plan objectives are in **bold**	**Responsibility**
▪ Incidents / Accidents: a decision to investigate is made in accordance with the appropriate Incident Selection Criteria Guidance LAC 22/13[1] ▪ Initial enquiries are completed to national guidelines: establishing or verifying key facts and further information to inform a decision on whether to investigate further and to what extent. ▪ Investigation and any follow-up enforcement action is taken in accordance with the HSE guidelines including the Enforcement Management Model (EMM)	Assistant Director (Regulation and Compliance) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety)

1 Health & Safety Executive and Local Authorities Enforcement Liaison Committee (HELA) Incident Selection Criteria www.hse.gov.uk/lau/lacs/22-13

Objective	Activities
4. Help promote and support the growth and successful delivery of workplace health and wellbeing in City businesses. Using: a. Promotion of the London Healthy Workplace Charter (external link) a good practice framework aimed at improving the health and well-being of employees. b. Awareness raising of the work-related stress and mental health campaign 'Working Minds' this launched in November 2021 and is still running. c. The Healthier Catering Commitment (HCC), a voluntary scheme promoted by local authorities to help caterers and food businesses make simple, healthy improvements to their food. We spent time developing an enhanced HCC scheme for food businesses in the City of London and launched the scheme in 2019-20. d. Where appropriate we will align this work with the evolving public health agenda (including regulation) on food.	▪ Encourage sign up to the community Business Healthy network. ▪ Encourage development and use of the good practice framework for the workplace charter. ▪ Raise awareness of the work-related stress and mental health campaign. Signpost the 'Working Minds' campaign which is relevant to all businesses but is aimed particularly at SMEs and is encouraging employers and employees to use the five 'R' approach to: o make stress and mental health ROUTINE, as part of employee engagement o REACH out to their colleagues, o RECOGNISE the signs of stress, o RESPOND to reduce the risk, o REFLECT on how these experiences can be used to improve the workplace ▪ We still need to reinvigorate the HCC scheme and develop and promote the initiative anew in relevant food establishments. ▪ Maintain and enhance our links with the pan London development of HCC.

Outcome – Corporate Plan objectives are in **bold**	**Responsibility**
Outcome 2: People enjoy good health and wellbeing In October 2018, the City Corporation formally pledged to tackle obesity and promote healthier choices by signing the **Local Government Declaration on Sugar Reduction and Healthier Food**. Evidence suggests a healthy workforce can reduce sickness absence, lower staff turnover and boost productivity -good for employers, workers, and the wider economy. More food businesses are signed up to the HCC Award. Engagement with and buy in from, potential businesses using referral mechanisms, existing networks, and resources such as Public Protection Team Business Healthy initiative. Work is part of the City & Hackney's Joint Health and Wellbeing Strategy, including mental health and is supported by the 'Business Healthy' initiative.	Assistant Director (Regulation and Compliance) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety)

Objective	Activities
5. Develop Primary Authority Partnership work	▪ Pursue our on-going Primary Authority Partnership (PAP) work, where benefits remain for the partnership.

Primary Authority enables businesses to form a legal partnership with one local authority, which then provides assured and tailored advice on complying with environmental health, trading standards and other regulations that local regulators must respect. The Regulatory Enforcement and Sanctions Act 2008, as amended by the Enterprise Act 2016 established Primary Authority as a statutory scheme.	▪ Consider further PAPs where this is likely to be a good fit and we have the capacity and resource to help make the difference. ▪ The enhanced development of our Primary Authority offering has not yet been pursued but we remain active in the development of individual partnerships and with the development of regional and sector specific national PA groups.

Outcome – Corporate Plan objectives are in **bold**	**Responsibility**
Outcome 6 (6a): we will promote regulatory confidence founded on the rule of law. **Outcome 8: We have access to the skills and talent we need.** **Outcome 9: We are digitally and physically well connected and responsive.** **Outcome 10: We inspire enterprise, excellence, creativity, and collaboration**. ▪ Improved support for businesses and economic growth to enable them to better manage their key health, safety, and food related risks. ▪ Ensuring progress towards the Government's better regulation agenda, providing streamlined and improved regulation. ▪ Increased Primary Authority work. With Increased income and enhanced reputation for the City of London. ▪ Improved working with national and other regulators on the provision of specific advice. ▪ Businesses that sign up to a Primary Authority partnership have access to reliable, timely and tailored regulatory advice.	Assistant Director (Regulation and Compliance) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety)

Objective	Activities
6. **Further develop the Commercial EH Team in line with the agreed objectives.** Focus on our people and work in collaboration with others. Produce training and development opportunities for peers.	▪ Continue to develop and enhance the competency of our frontline professionals. ▪ Further develop our succession and workforce plan and embed the Corporate mechanisms designed to support this process. ▪ Develop further (suitable) training arrangements; job shadowing; mentoring and coaching: using the revised performance development approach in our Corporate appraisal process. ▪ Specific training will be developed in line with the FSA and HSE competency frameworks. ▪ Further develop agreed meat hygiene training for London authorities in association with peer organisations, allied universities and food professionals utilising Smithfield Market. ▪ Further develop health & safety training for peers ▪ Continue to improve officers' awareness and understanding of business' needs, how to effectively communicate messages using a broad range of intervention strategies to influence the behaviour of organisations. ▪ Continue to support apprentices and graduates.

Outcome – Corporate Plan objectives are in **bold**	**Responsibility**
Outcome 8: We have access to the skills and talent we need. **Outcome 9: We are digitally and physically well-connected and responsive.** **Outcome 10: We inspire enterprise, excellence, creativity, and collaboration** ▪ Our workforce is adequately resourced and experienced, enabling the service to fulfil its key objectives. ▪ We have a more efficient service and improved staff morale, resulting in a better service for our customers. ▪ We are, and we remain an excellent, modern, and accountable regulator focused on delivering a better service for our customers. ▪ Our workforce will be well led and experienced, enabling the service to fulfil the objectives set now and for the foreseeable future.	Assistant Director (Regulation and Compliance) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety)

Objective	Activities
7. Further develop IT and information management systems and capabilities and improve our online service offer. Build on lessons learned during the pandemic The new Environment Department moves to the IDOX Uniform back-office system in late April 2023, replacing NEC M3 / Assure	▪ The project to replace the two current back-office systems with one shared Uniform system is scheduled for completion in mid-2023. ▪ We will continue to work collectively with the relevant Module Administrators/ Key People in order to embed and develop Uniform so that it matches the desired business processes of the team. ▪ Work to further improve our digital customer services streamlining both internal and external processes to everyone's advantage*.

Outcome – Corporate Plan objectives are in **bold**	**Responsibility**
Outcome 9: We are digitally and physically well-connected and responsive. ▪ Faster data and information capture, improved intelligence and targeting enforcement, more effective communication with businesses. ▪ The existing Service delivers a streamlined, accessible format with a clear focus on customer requirements ▪ The shared Uniform system will enable officers in different Divisions and their teams to share data more effectively and be sighted on the activities of the wider Department. ▪ Reduce the administrative and reporting burdens that we place on our front line, professionals, while improving for the longer term the information and intelligence we gather to aid our operational planning. We will be better able to identify poor performing businesses and sectors. ▪ More 'open data' provision is considered. *Activities still to include: Further Corporate website development; Online forms (inc. payments); use of the FSA food registration system; data gathering and development of data analytics (inc. the FSA work on performance management and segmentation); development of the Departments management information system (database)	Assistant Director (Regulation and Compliance) Commercial EH Team Manager Lead Officers (Food Safety and Health & Safety) Module Administrators (for the shared Uniform system)

Appendix 2 – Port Health Food Safety Enforcement Plan 23/24

Food Safety Enforcement Plan 2023/24 – Port Health

Service Aims and Objectives

Through this plan, the London Port Health Authority (LPHA) aims to:-

- Ensure compliance with legislation related to imported food and animal feed to protect food safety and animal health

- Deliver a high quality, accessible and responsive service to protect, enhance, and improve public, environmental, and animal health throughout the London Port Health district

This Plan aims to ensure that our enforcement remains targeted, proportionate, consistent and transparent, and sets out the framework for its delivery. It has been prepared as required by the Food Standards Agency (FSA) and the content of this Plan provides the basis upon which the LPHA will be monitored and audited by the FSA.

The LPHA also has responsibility for Animal Feeding Stuffs, Shellfish Classification, Infectious Disease Control, Pollution Control and Pest Control.

Food Hygiene and Food Standards Inspections

The Port Health Service undertakes food hygiene and food standards inspections of premises within the Port domain, including Approved premises. The Port is also responsible for the inspection of some fixed craft and moving vessels serving food and drink on the tidal Thames. Food premises airside at London City Airport also come under the Port. LPHA currently regulates 141 food businesses, of which 7 are non-compliant at the start of 23/24.

The number of Food Hygiene/Food Standards inspections undertaken in 2022/23 were 51 for Food Hygiene (including Alternative Enforcement Strategy) and 8 Food Standards. LPHA has followed the Food Standards Agency Recovery plan (following the Pandemic) but 23/24 will be a normal year in terms of food hygiene and standards inspection delivery.

The City has also entered into a Local Government (Miscellaneous Provisions) Act section 101 agreement with Thurrock Council to exercise Thurrock's functions under the feed and food laws in a section of the Logistics Park which has resulted in another area of responsibility for LPHA.

Alternative Enforcement Strategy

The LPHA has also exercised the advice in the Food Law Code of Practice (COP) which allows for an alternative enforcement strategy (AES) for low-risk premises, i.e. Food Hygiene category E based on the COP risk rating.

All new registrations will have an initial formal inspection and if rated as an E they will then come under the AES. Under the AES the premises will be due an intervention every 3 years and the intention is that a physical inspection will be carried out every 9 years.

Premises and vessels under the AES will receive a specific questionnaire which will be scrutinised by a competent officer to assess if enough information has been obtained. A follow up telephone call may be necessary. Some premises will receive a follow up visit to verify information on the questionnaire and visits, if necessary, will take place following complaints, ID notifications, changes of activity/management or non-return of questionnaire.

It is the intention that the larger E rated premises within the Port, which have comprehensive HACCP documentation, such as large-scale storage facilities and milling plants will still have a visit at each due intervention.

Feed and Food Complaints

The Service follows corporate policy in relation to any complaints and we aim to provide a same day response to all consumer complaints on food matters.

Home Authority Principle and Primary Authority Scheme

It is our policy to contact the Primary Authority when we become aware of an importer not conforming with the relevant import regulations. We also try to identify and contact Primary Authorities following adverse sample results.

The Primary Authority database is always examined to check for any partnerships in relation to any food premises that face interventions.

We also provide updates on current issues and offer advice and support in the use of electronic systems such as the IPAFFS system.

Business Recovery Plan

Due to the enforced closure of some food businesses under The Health Protection (Coronavirus, Business Closure) (England) Regulations 2020 and the time that this was in place some of our businesses inspected under the LPHA have required some assistance in order to get back up and running. This assistance has been in relation to re- opening and the action needed to be taken prior to this, advice on waste disposal, sanitisation, pest control, legionella controls due to stagnant water, training for staff. A pragmatic approach has been taken in order to assist these businesses, this is in line with the approach taken by colleagues within the Square Mile.

The service continues to:

a) focus on imported food and feed controls at the border,
b) prepare for the announcement of EU border controls later this year,
c) continue to support business recover from COVID related issues

Food and Feed Sampling

All samples in respect of Imported Food are taken in accordance with Port Health's Sampling Policy. Details regarding the selection, procurement and preparation of samples are contained in the Service's Sampling Plan.

The main aim of our sampling programme is to proactively detect foods outside specific regulation which may be a threat to public or animal health. In addition, we monitor and sample on a risk basis having regard to information from a range of sources including Border Notifications, FSA / Defra intelligence, previous adverse sample results, new products and random sampling.

POAO is checked at the frequencies set by the European Commission and as we follow the Border Operating Model (detailing the timeline for import controls) these will become GB led frequencies.

Sampling plans will change throughout the year to reflect emerging issues and evidence. Further details can be found in the Port Health Sampling Plans in Appendix 1 and 2.

In 2022/2023 the service took:

337 POAO samples (excluding Brazil) and 936 NAO consignments of food and feed were sampled for chemical and bacteriological contamination; and received:

9 POAO unsatisfactory results have been received. 45 NAO unsatisfactory results for chemical, biological and labelling issues.

This has resulted in further formal action, including detention and/or destruction of the consignment, for adverse chemical and biological results. Labelling issues are referred to the responsible Trading Standards service at consignment's destination.

Since 30 March 2017, the EU Commission implemented enhanced checks on consignments of meat and meat derived products from Brazil resulting in all consignments being subject to physical examination with 20% of the consignments being also subject to sampling for microbiological standards. This level of enhanced checks was in response to fraudulent activities in Brazil and continue in force at present. This has amounted to 773 samples taken in 22/23.

Selection of Consignments

The requirement and selection of a consignment for routine sampling is decided officers either during the documentary check process or at the time of the physical examination of the product. Officers can subject any consignment at any stage of the checks to any sampling and laboratory tests if it is considered necessary to ascertain that the consignment meets the import requirements. Officers are either a qualified Chartered/Environmental Health Practitioner or Official Veterinarian.

Information that can be used to help identify and prioritise risks includes:

1. Intelligence obtained from different national and international databases: IPAFFS, RASFF

2. Specific priorities and alerts issued by the different Regulators.

3. Local intelligence/professional expertise from results from previous years and type of imports.

The information sources listed above can be used to assess risks. The risk assessment is likely to be a combination of data, judgement and expert knowledge.

The plan specifies the types of products, origin of the products (if relevant) and the analysis or exam required. The sampling plan aims to proactively detect food or feed which may be a danger to public or animal health and to ensure compliance with food standards and relevant legislation. The sampling plan covers food and feed of POAO or NAO. The plan is not fixed, but is reviewed at regular intervals during the year, to adjust it to the fluctuations in trade and the on-going assessment of the existent and emerging risks.

Officers will undertake sampling in accordance with the standards required in the various Codes of Practice, and in compliance with any methodology when specified in the Regulations:

New products should be sampled if possible or where the AO suspects the consignment does not comply with the import conditions.

Feed, Food Safety and Standards promotional work, and other non-official controls interventions

Regular stakeholder events are held to update the trade and discuss current issues. This opportunity is taken to promote the use of Information Technology to speed clearance times.

Products of Animal Origin and Non-Animal Origin (Food & Feed) - Sampling Plan 23/24
The purpose of the plan is to specify the imported Products of Animal Origin (POAO) and Non-Animal Origin (NAO) food/feed that should be sampled for examination and analysis each year. The plan also includes locally sourced samples of shellfish from the Thames Estuary. The plan is devised using a risk-based approach when deciding which tests and products to be sampled, balanced with the requirement of randomisation in the selection of consignments.

The LPHA Imported Food Sampling Policy allows sampling of food and feed to be decided on a local basis according to product type, local knowledge, seasonal variation and historical import records at each individual port. Deviations from the sampling protocol are permitted to take account of an importer's history of non- compliance with legislative requirements, previous adverse sample results and intelligence received, for example, from inland local authorities, importers and consumer complaints.

2023/24 Sampling Plans

NAO Sampling

See Annex A for the plan for NAO food and feed samples being taken this year.

POAO Sampling

See Annex B for the plan for fishery products and POAO food and feed samples being taken this year.

FSA Food Sampling Survey

There is an additional FSA Food Sampling Survey to be carried out for this period, where funding is obtained directly from Central Government. The purpose of this survey is to supplement Local Government food sampling with specific priorities, so foods of national concern can be tested.

Laboratories used by Port Health are listed below:

1. Food Water and Environmental Microbiology Laboratory London 61 Colindale Avenue, London, NW9 5EQ
Telephone: 02083276550
Email: FWEM@ukhsa.gov.uk

2. Kent Scientific Services
8 Abbey Wood Road, Kings Hill, West Malling, Kent ME19 4YT Telephone 030004151000
Email : kss@kent.gov.uk

3. Public Analyst Scientific Services (Eurofins UK)
i54 Business Park, Valiant Way, Wolverhampton. WV9 5GB
Telephone 01902627200
Email: info@publicanalystservices.co.uk

4. Centre for Environment, Fisheries and Aquaculture Science (CEFAS) Pakefield Road, Lowestoft, Suffolk, NR33 0HT
Telephone 01502562244
Email : www.cefas.co.uk/contact-us

Results

When the results are received, they are entered in the City's database Port Health Interactive Live System (PHILIS) and UK databases, where appropriate.

For unsatisfactory results, officers will instigate further action which includes:

1. Notifying the food/feed business operator of the failure and issue the appropriate notifications to reject the consignment if still not released for import (for instance in the case of suspicious consignments). The possible options will be destruction or re-export, depending on the assessment of the risk posed by the failure.

2. Notifying the Local Authority of the premises of destination when the consignment was released pending the results, to allow them to take appropriate action for the non-compliant product in circulation.

3. Depending on the failure IPAFFS might trigger the issuing of an emergency notifications.

Feed and Food Safety Incidents

LPHA are committed to responding promptly to all food or feed safety incidents. The Service has arrangements in place to ensure that it is able to respond to Food Alerts issued by the FSA. Warnings are received electronically, and all urgent Food Alerts receive immediate attention and action where necessary. Out of hours arrangements are in place.
Border Notifications issued by the European Commission are sent to a designated Officer who is responsible for their distribution amongst LPHA Officers involved in Imported Food Enforcement. LPHA's database, Port Health Interactive Live Information System (PHILIS) can be used to issue reminders when specific products are subject to control.

Organisational Structure

The service is staffed by:

- 1 Assistant Director
- 5 Managers
- 3 Team Leaders
- 12 Port Health Officers
- 10 Official Veterinarians
- 15 Port Health Technical Officers (PHTOs)
- 10 Support Assistants
- 6 Launch Crew
- 1 Apprentice
- 56 staff in total at start of 23/24 financial year
- 8 additional staff continue to be funded by Central Government in 23/24

Annex A:

Proposed Imported FNAO NMP – sampling priorities table for 23/24 for food not of animal origin

	High priority
	Medium priority
	Low priority

[Text Wrapping Break]

Nuts & seeds products

Priority Ranking	Product Category	Hazard	Specific sampling guidance
High	Nuts & seeds products	*E. coli, Salmonella, Listeria monocytogenes*	Potentially **ready-to-eat** commodities: fresh coco**nut,** nut spreads, sesame seeds, cumin seeds; alfalfa sprouts, all bean sprouts, other sprouted seeds, tahini & halva (from Syria)
High	Nuts & seeds products	*Aflatoxins*	Almonds (including ground/flour), groundnuts (including spreads/flour), Brazil nuts, pistachios, hazelnuts, walnuts, other tree nuts and mixed nuts, nut spreads and butters, melon **seeds** (egusi), chia seeds
Medium	Nuts & seeds products	*Cyanide (hydrocyanic acid)*	Apricot kernels, bitter almonds
Medium	Nuts & seeds products	*Undeclared allergens*	Nut spreads and butters
Medium	Nuts & seeds products	*Pesticide residues*	Bean sprouts (mung beans)
Low	Nuts & seeds products	*Undeclared sulphites*	Coco**nut** (desiccated, dried, flour)

Herbs & spices

Priority Ranking	Product Category	Hazard	Specific sampling guidance
High	Herbs & spices	*Salmonella, Shiga toxin producing E. coli (STEC), Listeria monocytogenes*	Potentially **ready-to-eat** commodities: paan (betel) leaves, coriander leaves and other herbs (fresh or dried); pepper (black, pink & white), paprika powder, chilli powder, spice mixtures

High	Herbs & spices	*Aflatoxins*	Nutmeg (whole & ground), paprika, chilli powder
High	Herbs & spices	*Sudan dyes*	Turmeric (from Bangladesh), crushed pepper (from China), paprika (from Russia), spices and sumac (from Turkey)
Medium	Herbs & spices	Undeclared allergens, colours/dyes or sulphites	Spice mixtures, curry powder
Medium	Herbs & spices	*Pyrrolizidine alkaloids (PAHs)*	Cumin, oregano (from a number of countries)
Medium	Herbs & spices	*Pesticide residues*	Tea leaves (especially from India); ginger, coriander roots & leaves, paprika, chilli powder; herbs (from Israel and Cambodia)
Low	Herbs & spices	*Benzo(a)pyrene (BaP)*	Ginger, oregano

Fruit & vegetables

Priority Ranking	Product Category	Hazard	Specific sampling guidance
High	Fruit & vegetables	*Salmonella, Shiga toxin producing E. coli (STEC), Listeria monocytogenes*	Potentially **ready-to-eat** commodities: e.g. peppers (sweet or bell), salad leaves, prepared fresh vegetables, enoki mushrooms (especially from China)
High	Fruit & vegetables	*Aflatoxins*	Dried figs, chilli peppers (fresh or dried)
Medium	Fruit & vegetables	*Pesticide residues*	Dried beans (from any non-EU country), beans (fresh), yardlong beans, okra, peppers (sweet or bell), chilli peppers (fresh or dried), spinach, vine leaves (from Egypt). Vine fruits/raisins, pomegranates, citrus fruits, mangoes (fresh or dried), prepared fresh fruit, dried dates, bananas (from Ecuador), apples (from India)
Medium	Fruit & vegetables	*Norovirus / Hepatitis A*	Frozen sweetcorn, frozen raspberries, other small fruit & berries
Low	Fruit & vegetables	*Ochratoxin A*	Vine fruits/raisins, dried figs

Low	Fruit & vegetables	*Cadmium*	Avocados & asparagus (from Peru)
Low	Fruit & vegetables	*Undeclared sulphites*	Dried apricots, dried dates, other dried or candied/mixed fruits
Low	Fruit & vegetables	*Iodine*	Seaweed and kelp (from China, Japan & Korea)

Other FNAO products

Priority Ranking	Product Category	Hazard	Specific sampling guidance
High	Edible oils	*Sudan dyes*	Palm oil (from Ivory Coast)
High	Grain products	*Sudan dyes*	Couscous (from Lebanon), fruit bars (from USA)
Medium	Edible oils	*3-MPCD & Pyrrolizidine alkaloids (PAHs)*	Palm oil
Medium	Grain products	*Pesticide residues*	Rice (from India)
Low	Grain products	*Ethylene oxide*	Noodles (from Vietnam)
Low	Food supplements	*Ethylene oxide*	Various food supplements (from India)

Annex B:

Imported POAO NMP 23/24

BCP	Type	Sample	Samples
London Gateway	Honey	LPHA - Honey - Antibacterials and Pesticides	4
London Gateway	Honey	LPHA - Honey - Authenticity	2
London Gateway	Casings	LPHA - Meat & Products for Anthelmintics	1
London Gateway	Casings	LPHA - Animal Casings - Antibacterials	1
London Gateway	Casings	LPHA - Meat for Residues	1
London Gateway	Dairy	LPHA - Milk Products - Fungal moulds and yeasts	1
London Gateway	Dairy	LPHA - Milk Products - lead and cadmium	1
London Gateway	Dairy	LPHA - Milk products - Microbiological	3
London Gateway	Bovine	LPHA - Fresh and Poultry Meats - dioxin and PCB	1
London Gateway	Bovine	LPHA - Fresh and Poultry Meats - lead and cadmium	1
London Gateway	Bovine	LPHA - Hormonal growth promoters	2
London Gateway	Bovine	LPHA - Meat & Products for Anthelmintics	11
London Gateway	Bovine	LPHA - Meat for E. Coli STEC	3
London Gateway	Bovine	LPHA - Canned products - tin	4
London Gateway	Bovine	LPHA - Flame Grilled Products - PAH	1
London Gateway	Ovine	LPHA - Fresh and Poultry Meats - dioxin and PCB	1
London Gateway	Ovine	LPHA - Fresh and Poultry Meats - lead and cadmium	1
London Gateway	Ovine	LPHA - Meat and Preparations - Salmonella and E. coli	3
London Gateway	Ovine	LPHA - Meat for Residues	4
London Gateway	Porcine	LPHA - Fresh and Poultry Meats - dioxin and PCB	1
London Gateway	Porcine	LPHA - Fresh and Poultry Meats - lead and cadmium	1
London Gateway	Porcine	LPHA - Meat for Residues	2
London Gateway	Porcine	LPHA - Flame Grilled Products - PAH	1
London Gateway	Poultry	LPHA - Fresh and Poultry Meats - dioxin and PCB	1
London Gateway	Poultry	LPHA - Fresh and Poultry Meats - lead and cadmium	2
London Gateway	Poultry	LPHA - Poultry for Residues	20
London Gateway	Poultry	LPHA - Raw Poultry - Carbapenemase, AmpC, ESBL	8
London Gateway	Poultry	LPHA - Raw Poultry AMR	8
London Gateway	Poultry	LPHA - Meat and Preparations - Micro	8
London Gateway	Poultry	LPHA - Cooked Poultry AMR	8
London Gateway	Poultry	LPHA - Meat Products - Micro	4
London Gateway	Gelatine/Collagen	LPHA - Gelatine / Collagen - Residues 853/2004	4
London Gateway	Gelatine/Collagen	LPHA - Gelatine / Collagen - Salmonella	1

London Gateway	Petfood/Dog Chews	LPHA - Dog chews / petfood - microbiological	6
London Gateway	Petfood/Dog Chews	LPHA - Dog chews / petfood - Veterinary Residues	1
London Gateway	Ready to Eat	LPHA - POAO Ready to Eat	2
Tilbury	Honey	LPHA - Honey - Antibacterials and Pesticides	2
Tilbury	Honey	LPHA - Honey - Authenticity	1
Tilbury	Dairy	LPHA - Milk Products - Fungal moulds and yeasts	1
Tilbury	Dairy	LPHA - Milk Products - lead and cadmium	1
Tilbury	Dairy	LPHA - Milk products - Microbiological	4
Tilbury	Bovine	LPHA - Fresh and Poultry Meats - dioxin and PCB	1
Tilbury	Bovine	LPHA - Fresh and Poultry Meats - lead and cadmium	1
Tilbury	Bovine	LPHA - Meat & Products for Anthelmintics	1
Tilbury	Bovine	LPHA - Meat for E. Coli STEC	2
Tilbury	Ovine	LPHA - Fresh and Poultry Meats - dioxin and PCB	1
Tilbury	Ovine	LPHA - Fresh and Poultry Meats - lead and cadmium	1
Tilbury	Ovine	LPHA - Meat and Preparations - Salmonella -E coli	2
Tilbury	Ovine	LPHA - Meat for Residues	2
Tilbury	Poultry	LPHA - Meat and Preparations - Micro	1
Tilbury	Petfood/Dog Chews	LPHA - Dog chews / petfood - microbiological	2
Tilbury	Petfood/Dog Chews	LPHA - Dog chews / petfood - Veterinary Residues	1

Total Samples: 148

Fishery Products Monitoring Plan 23/24

Port	Total Samples	Product	Test
London Gateway	1	Cooked molluscs	Salmonella/Vibrio
London Gateway	7	Cooked crustacean	Salmonella/Vibrio
London Gateway	26	Farmed fishery products	Residues/antimicrobials/dyes
Tilbury	2	Farmed fishery products	Residues/antimicrobials/dyes
London Gateway	9	Fishery products – fish/molluscs/cephalopods/crustaceans	Cadmium/Lead/Mercury
Tilbury	1	Fishery products – fish/molluscs/cephalopods/crustaceans	Cadmium/Lead/Mercury
London Gateway	7	Fishery products associated with high amounts of histidine	Histamine
Tilbury	1	Fishery products associated with high amounts of histidine	Histamine
London Gateway	1	Dried fish	Irradiation
London Gateway	1	Imitation crab claws from India	E. coli/Staphylococcus Aureus
London Gateway	2	Oily fish	Dioxins/PCBs

Total Samples:58

Committee(s): Department of Community and Children's Services Grand Committee – For Information Health and Social Care Scrutiny Committee – For Information Health and Wellbeing Board – For Information	**Dated:** 12/04/2023
Subject: Adult Social Care Inspection Framework - Care Quality Commission (CQC)	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	**1,2,3**
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: Clare Chamberlain, Director of Community and Children's Services	**For Information**
Report author: Emma Masters, Transformation Programme Manager, Adult Social Care	

Summary

The Health and Care Act 2022 gives new powers to the Care Quality Commission (CQC) to provide a meaningful and independent assessment of care at a local authority and integrated care system level, starting in April 2023.

In response to the requirement, Adult Social Care is undertaking a self-evaluation against the Assessment framework for local authority assurance and its four quality themes.

Below, we outline CQC's launch plan and an update on our progress and ongoing approach to local authority and integrated care system assessments.

Recommendation

Members are asked to:

- Note the report.

Main Report

Background

1. The Health and Care Act received Royal Assent in April 2022 and introduced significant reforms to the organisation and delivery of health and care services in England, including the return of CQC assessment of local authority Adult Social Care services.

2. From 1 April 2023, CQC will have new powers to assess local authorities in England and will be looking at how we meet our duties under the Care Act (2014). CQC have published an implementation plan, with a view to start full inspection activity from September 2023.

3. From 1 April 2023 through to September 2023, CQC will start to review data and published documentary evidence across all local authorities. The data and evidence from this activity will be published at an overall national level as a collection of evidence, for example, in CQC's annual statutory State of Care report to Parliament. This national review will be the first element towards full assessment of two quality statements. It will constitute CQC's first steps in developing judgements for individual authorities. It will also provide valuable context and an opportunity to benchmark national data.

4. During the same period, CQC will commence pilot assessment activity for up to five local authorities, on a voluntarily basis. Publication of findings from these pilots are subject to further determination between the CQC and local authorities involved. City of London Adult Social Care have not requested to participate at this time.

5. From September to December 2023, CQC will start the roll out of formal inspection activity for all local authorities, with an aim to conduct up to 20 assessments during this period. City of London may be chosen as one of the local authorities in this tranche. We would have around four weeks' notice to plan and start activity.

6. From early 2024 onwards, CQC will continue to conduct further formal assessments and report on their findings. The Government has requested that CQC publish individual ratings of local authorities following the pilots and assessments. CQC plan to work with local authorities and Department of Health and Social Care during this time to inform how findings are published and rated.

Current Position

7. We are finalising our self-assessment against the four quality themes and collating the required supporting data and evidence. Our aim is to have a final draft completed by early June 2023.

8. On 13 and 14 June 2023, a peer review via the Local Government Association to provide additional input into and scrutiny of our Adult Social Care self-assessment and inspection readiness. This activity is expected to provide further opportunity for insight and reflection to enhance our final self-assessment, and strengthen our improvement plans to ensure compliance.

9. Alongside the self-assessment we have a draft Adult Social Care Improvement Plan, which is required as supporting evidence. Our aim is to know ourselves and know ourselves well, ensuring that any identified plans for improvement are well documented, governed and have delivery plans. The Adult Social Care Transformation Programme is currently documenting and providing the governance for this.

10. The initial data requirement to accompany the self-assessment is the Client Level Data (CLD) return. From April 2023, the Government has introduced person-level data collection to provide better insights into care journeys and outcomes to show which interventions work best and how we can improve how people move between health and social care. This is a new nationally, and a significant piece of work, with the first return due in July 2023. We currently have this project in delivery and will assess outputs in early May 2023.

11. On completion of the peer review activity, we will share the outcomes. The findings, expected to be both positive and self-reflecting, will inform the production of our final Self-Assessment document.

12. In addition to the completion of documentation and evidence, we are producing a practical plan, similar to our Ofsted inspection approach, which outlines clear responsibilities, roles and resources required to manage the inspection activity.

13. This is the start of how things will change for Adult Social Care with a continuous rolling plan.

14. **Financial implications**: The cost of the peer review is £5,000.00 plus expenses and is met via Adult Social Care grant funding.

    We anticipate that additional resources may be required to support improvement delivery. Adult Social Care grant funding has been identified to meet the current pressures.

15. **Resource implications**: The extent that the Adult Social Care statutory inspections will impact on Adult Social Care resources will be determined by the ongoing pressures of inspection activity. While we are seeking synergies across Children's and SEND inspections, the additional governance and resourcing requirement are expected to have impact in the longer term.

16. **Legal implications:** This is a legislative change for Adult Social Care service delivery. The City of London will need to ensure that there is legislative compliance.

17. **Risk implications:** The CQC's assessment of local authority Adult Social Care services represents a reputational risk on a par with the Ofsted assessment of Children's Services.

18. **Equalities implications**: The Government has conducted Equalities Impact Assessments on all reform initiatives.

19. **Climate implications**: N/A

20. **Security implications:** N/A

Conclusion

21. The implementation of the new Adult Social Care Inspection Framework carries with it a level of reputational, legal, and financial risk over the next few years. The City of London has put in place a programme structure to effectively plan for and deliver the

requirements of inspection outlined in CQC's launch plans. There remains a level of uncertainty across the Adult Social Care sector regarding the future funding of this additional responsibility.

Appendices

- **Background Papers**

  - Health and Care Act (2022)
  - Assessment framework for local authority assurance

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Committee(s): City of London Health and Wellbeing Board - For information	**Dated:** 29-06-2023
Subject: Children and young people commissioning update	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	1, 2, 3, 4, 8
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?	**Y/N**
Report of: Dr Sandra Husbands, Director of Public Health; Judith Finlay, Executive Director, Community and Children's Services	**For Information**
Report author: Carolyn Sharpe, Consultant in Public Health (children, young people and health protection), Hackney Council Amy Wilkinson, Workstream Director Integrated Commissioning: Children, Young People, Maternity and Families, NHS North East London	

Summary

This paper provides the board with an overview and update on commissioning activities for children and young people in the City of London by Public Health and to highlight key strands of work within the Children, Young People, Maternity and Families Integrated Commissioning Workstream.

Recommendation(s)

Members are asked to:

- Note the report.

Main Report

Background

1. This paper details updates on the commissioning arrangements and activities for children and young people in the City of London by Public Health and the Children, Young People, Maternity and Families (CYPMF) Integrated Commissioning Workstream. The CYPMF workstream team is an integrated team comprising North East London (NEL) Integrated Care Board (ICB) and London Borough of Hackney (LBH) staff, with commissioning responsibility for a range of services on behalf of NHS North East London Integrated Care Board. The City and Hackney part of this is referred to as the 'Place Based Partnership'. The joint commissioning portfolio includes a breadth of services, both universal and targeted, that aim to provide the best start in life for children and young people in Hackney and the City of London.

2. The majority of the services included in this briefing are commissioned by Hackney Council on behalf of the City of London Corporation (CoL) and covered by a Service Level Agreement with the CoL. Services that are the commissioning responsibility of NHS ICB are also commissioned for both Hackney and the City of London.

Public Health commissioning update

3. Appendix 1 provides a summary table of all services for children and young people in the CIty of London commissioned by the City and Hackney Public Health Team including the service name, current provider, a brief description of the service provided and contract dates.

4. A narrative update with regards to high spend and/or high priority commissioning activity is provided below.

5. Health visiting services

    a. We are currently in the mobilisation phase for a new Enhanced Health Visiting (EHV) Service. The contract has been awarded to Homerton Healthcare NHS Foundation Trust and will commence on 1 September 2023.

    b. The EHV Service will be 'universal in reach – personalised in response' and meets the 2021 Healthy Child Programme guidelines. The new service model includes an additional fifth service level, over and above the four levels of service currently provided. This intensive fifth level (replacing the Family Nurse Partnership Service, see section 6 below) will support vulnerable, complex families and will have a broader eligibility criteria so that families that require support are not restricted access due to the parent's age or if they have more than one child.

c. In addition to the five mandated visits, the EHV Service also comprises three targeted visits (1 specifically to act as a safety net for School Readiness); additional speech, language, and communication reviews at the 9-12 month visit, 2-2.5 year visit and at the 3-3.5 year visit to address the impact of COVID-19 on early years development.

d. The EHV service includes 11 high impact lead roles which will focus on key aspects of child health, wellbeing and development. The service will also include an 18 month desktop review of child health records to ensure any outstanding remedial action is identified and addressed before development is impaired.

6. Family Nurse Partnership (FNP)

   a. FNP is a licensed nurse-led home visiting service for first time young mums aged under 19 or up to the age of 25 with known vulnerabilities. The service is in the process of being decommissioned and will come to a close at the end of August 2023. From September 2023, all families that would have been eligible for the FNP service will be supported through the Intensive Home Visiting element of the new Enhanced Health Visiting Service (see section 5 above).

   b. The FNP programme model has a number of limitations:

      i. It only works with first-time young mothers under 25 years old. This is not in line with the needs of the City & Hackney population, which has a reduced number of teenage parents, and an increasing number of older first-time parents.

      ii. The programme only works with one child - the first child up to 2 years. This excludes families with more than one child and communities in the borough where the birth rate is high.

      iii. The programme does not support concealed pregnancies, as you cannot access the programme if you are more than 28 weeks pregnant.

      iv. FNP is a licensed model and is not flexible to suit the needs of our local population.

   c. A multi-stakeholder FNP transition working group has been established and has been meeting on a regular basis to support the safe transition of clients from the FNP to the EHV caseload. Guidelines provided by the FNP national team are being used to steer the process.

7. Community peer mentoring, advice and signposting service

   a. A new integrated community based peer mentoring, advice and signposting service is being commissioned for socially vulnerable pregnant women and new mothers and will start on 1 September 2023. The new service will have a greater focus on peer mentoring.

   b. The Service aims to increase awareness of and reduce access barriers to perinatal and postnatal local support services as well as provide social, emotional and informational support to socially vulnerable pregnant women and new mothers within the first 1001 days, in Hackney and the City of London.

c. Evidence shows that community peer support programmes can enable and empower women to make informed choices about their pregnancy and early parenthood. Providing sustained peer mentoring support aims to help and encourage women to engage with local maternity and other support services and build social capital within the local community.

8. Clinical health and wellbeing service (CHYPS Plus)

a. The Young People's Clinical Health and Wellbeing Service (CHYPS Plus) contract is due to expire on 31 August 2023. Although Hackney Cabinet Procurement and Insourcing Committee approved a one-year contract extension (until 31 August 2024), a decision has been taken not to grant this full extension. Rather a three-month extension (until 30 November 2023) will be granted to facilitate a smooth termination of the service.

b. The CHYPS Plus service has been underperforming for many years. Pre-COVID the service was not meeting performance targets, with performance being even further impacted by the COVID-19 pandemic. Trends indicate that service performance is unlikely to recover.

c. Alternative provision for all elements of the CHYPS Plus service is either already available locally or will be commissioned through enhancing an existing service.

d. It is clear from the service activity data that the CHYPS Plus service model does not meet the needs of young people locally. Public Health therefore intends to carry out work to explore new service models, taking into account what is working well in other London boroughs and, essentially, drawing on insights from engagement work that is happening currently with young people through the Super Youth Hub Project (see section below).

Children, young people, maternity and families (CYPMF) integrated workstream programmes and services update

9. Overview

a. We are working closely with (and as part of) NHS NEL ICB to shape the future NEL Babies, Children and Young People programme. It has been agreed that Children and Young People's work should sit and be led by Place based Partnerships, with a high level NEL programme plan agreed where shared work adds value. NEL Directors of Children's services are part of these discussions. This CYPMF delivery plan and our local CYPMF governance is feeding into NEL thinking on this. Delivery of our NHS City and Hackney place based work is outlined in our Integrated delivery plan.
b. Following the central NEL safeguarding re-structure, both children and adults safeguarding health functions are line managed by NEL ICB. There is work to do to agree how this will continue to function effectively at place.
c. A number of transformation schemes were approved across the City and Hackney CYPMF agenda, supported by non recurrent transformation

funding to move forward key priorities with our partners. This includes supporting development of family hubs, addressing wait lists in community services, re-working the youth justice health offer, increasing immunisations and inequalities in maternity work. A small amount of NEL health inequalities funding was recently secured for specific work on emotional wellbeing and immunisations.

d. We continue to work jointly across Public Health, the NEL NHS ICB, City and Hackney and with education, social care and provider partners in the development of a CYP Integrated health and wellbeing framework, with an agreed local vision, priorities, shared set of indicators and action plan and supporting the recommissioning of the 0-25 Public Health services. We are developing the health offer in family hubs, and working on the re-alignment of clusters to the neighbourhoods footprint. Key priority areas are outlined below:

10. Improving Children and Young People's Emotional Health and Wellbeing / CAMHs

a. We are continuing to manage the surge in demand for CAMHs, including progressing the integration of services through launching the new Single Point of access and working closely with partners on discharge and pathways planning. We are delivering on our new Eating Disorder action plan, through close work with parents and community providers and will host a crisis summit in October.
b. Trauma informed work is rolling out, with training sessions delivered for LBH Link Workers, Homes for Ukraine Support Team, and Hackney Youth Justice colleagues. This training will also be available for City of London practitioners. Emotional wellbeing and CAMHS will form a key part of the new ways of working embedded through transformation of the LBH C&E transformation programme, including pushing forward anti-racism plans, and the WAMHS programme will be delivered in all Hackney schools from Autumn 2022.
c. The Joint 0-25 Emotional Health and Wellbeing Strategy was published in January 2021. The purpose of the Strategy is to ensure that we are working together as an integrated system to support the emotional health and wellbeing of all children and young people in the City of London and Hackney. Since then, the Emotional Health & Wellbeing Partnership has worked together to identify priorities for the system and deliver on the action plan which was outlined at the end of the Strategy. We are now half way through the life of the strategy and we would like to take stock and review progress, as well as refreshing our priorities for the remainder of the Strategy.
d. A stakeholder workshop will take place in mid July to review progress against actions and agree future actions. This will be presented at the Emotional Health and Wellbeing Partnership (EHWP) July- September 2023..

11. Super Youth Hub

e. The Super Youth Hub is a place-based partnership project aiming to improve independent access to a range of integrated services for young

people aged between 11-18 (24 with SEND). The project is in the early stages of development, with possible services in scope to be integrated for delivery in one place include; early mental health and wellbeing support, sexual and reproductive health, substance misuse, primary care (GP), training, employment and social prescribing.

f. This work is currently in the design phase, and locations will be shaped and developed by the views of young residents in Hackney and The City. Young residents aged 16-19 (including one individual from the City of London) have been recruited and trained in participatory action research (PAR) techniques to learn methods of engagement. This is enabling them to gather data and insights from other young people to understand how services should be designed and delivered in a way that ensures that young people are able to find and access support in the right place (for them) at the right time with the right person.

g. As part of this project the team have also been visiting other boroughs to learn from existing examples of holistic, integrated health services for children and young people.

h. It is envisaged a new service model will be designed for winter 2023. Discussions are beginning around sustainable funding routes.

12. Improving Outcomes for Black Children and Young People (BCYP): Mental Health Workstream

a. Key work areas over May and June 2023 include moving forward a data review across the workstreams, with an increased focus on measuring impact, and the strategic relaunch of the BCYP improving outcomes event in the community in October. We are Identifying opportunities for engagement with BCYP in community settings, and continuing to align strategically with the Children's and Education Anti-Racist Practice Joint Action Plan. Learning from this will inform mental health provision for City children and young people, and we are keen to work with City of London colleagues to explore this.
b. Planning for the next quarterly BCYP Group Sessions has started. The next session will be in July 2023, and aims to ensure there is transparency and accountability in sharing progress on the agreed BCYP MH Workstream priorities
c. We will be aligning City and Hackney Anti-racism actions plans and work relating to tackling disproportionality with the BCYP MH workstream, and building a strong network, which amplifies good practice in culturally specific interventions, young people lead initiatives, and awareness in key areas of practice
d. The Growing Minds (CAMHS Alliance) mental health targeted programme to children, young people and families from African, Caribbean and mixed heritage backgrounds is continuing. Key updates include:
    i. In April-May two new rounds of community based parenting programmes started using non-violent resistance approaches
    ii. Increased numbers of young males are engaging with counselling and the art therapy offer delivered through Off Centre following the appointment of a black male therapist

iii. Growing Minds are continuing to deliver Tree of Life in secondary schools using peer-to-peer models with young leaders in the community and MHSTs. A series of groups have been booked for the summer term and autumn term next academic year.

13. Embedding Anti-Racist Practice Across the System

a. CYPMF Integrated health teams' collaboration continues in developing LBH Anti-Racist practice. The workstream is a key partner of the newly formed Children and Education Anti-Racism Staff Reference Group (ARP SRG). This has included contributing to the development of the ARP SRG principles, as well as the development of LBH Anti-racist practice resources and content - bringing a cross system approach to this work.
b. The CYPMF Integrated Health team has input from a Health perspective into the LBH Children and Education Joint Anti Racist Action Plan, with a particular focus on Mental Health and Maternity. This work is also applicable to the City of London, in terms of work with specific communities and we would welcome some thinking together around how we might use this approach and learning in a transferable way.

14. Children and Young People with Complex Needs and Special Educational Needs

a. Health colleagues continue to prepare with partners for the anticipated SEND inspection. We are expecting a SEND inspection imminently for both the City of London and for Hackney. We are working closely with City of London SEND colleagues.
b. The ICB funded Partnership Lead for Preparing for Adulthood has started in post. This 12 month role is hosted by Hackney and will work across the local system, initially focusing on health transition pathways.
c. The multi-agency Dynamic Support Register monthly meeting reviews all children and young people who (with consent) are rag-rated for risk of placement breakdown in the community and / or at risk of Tier 4 admission. These are children and young people with Autism and / or LD, and with challenging behaviour. Where there is a significant risk, a Care Education Treatment Review (CETR) meeting is convened with NHSE-sourced independent Panel members who meet with the CYP, family and practitioners to critically assess what support should be provided in the community / whether admission is recommended

15. Neighbourhoods

i. There has been system wide consultation on new geographical alignment of health services to a neighbourhood footprint as part of family hub work and we are exploring the potential for re-alignment of provider services, ie. maternity and health visiting. A health funded Family hub health coordinator is in place and there is a business case in development for continued CYP neighbourhoods resource to 2024.
j. Renaisi has been appointed as an external evaluator and has worked with the team to develop a Theory of Change for the Children, Young People

and Maternity workstream of the Neighbourhoods programme informing the evaluation and contribution analysis of the work.

k. Neighbourhood forums continue to take place quarterly attended by local voluntary sector organisations and residents, facilitated by facilitators from local organisations. The forums are being used to gather intelligence about the opportunities, barriers and perceived gaps to health and wellbeing locally and focus on health inequalities
l. The synergies and opportunities arising from the development of Children and Family Hubs and the Neighbourhoods programme continue to be worked through.

Corporate & Strategic Implications

This paper is not a proposal for change, rather it is to provide an update on key integration projects and programmes as well as commissioned services for children and young people in the City of London.

Strategic implications – The proposals set out in this report directly support achievement of a range of outcomes as set out in the City Corporation's Corporate Plan 2018-23. In particular, two core objectives lie at the heart of the proposals: that 'people enjoy good health and wellbeing' and 'people have equal opportunities to enrich their lives and reach their full potential' (*Contribute to a flourishing society*).

Financial implications - none

Resource implications - none

Legal implications - none

Risk implications - none

Equalities implications – The report provides an overview of a number of projects and services that have a central focus on reducing inequalities, including on the basis of protected characteristics.

Climate implications - none

Security implications - none

Conclusion

9. Public Health and the Children, Young People, Maternity and Families (CYPMF) Integrated Commissioning Workstream are working in partnership to ensure every child in the City of London has the best start in life. This is being mobilised through a wide range of universal and targeted commissioned services (Appendix 1) as well as through key work programmes. These programmes are focusing on achieving greater integration across the CYPMF portfolio that will lead to services that are more efficient, effective and provide a better experience for children and families. Programmes are also focused on reducing health inequalities for the most vulnerable children and young people, including those with special educational needs and disabilities, those with poor mental health, and those from global majority communities.

Appendices

Appendix 1 – Summary of children and young people's services commissioned by the City and Hackney Public Health Team

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Appendix 1: Summary of children and young people's services commissioned by the City and Hackney Public Health Team

Service name	Provider	Service description	Contract start - end date
SERVICES FOR THOSE AGED 0-5			
Health Visiting	Homerton Healthcare NHS Foundation Trust	Health visiting is a statutory nurse-led service for 0-5s which is both universal and targeted. It is a four tier offer with five mandatory universal reviews for all children. Families with additional needs can also receive a visit at one month and four months in addition to the five mandated visits. The Health Visiting service is to be replaced by a new Enhanced Health visiting Service from 1 September 2023 (see section 5 of the main report).	01/07/2016-31/08/2023
Family Nurse Partnership	The Whittington Healthcare Trust	Family Nurse Partnership (FNP) is a licensed nurse-led home visiting service for first time young mums aged under 19 or up to the age of 25 with known vulnerabilities. The FNP service ends August 2023 and will be replaced by the Enhanced Health Visiting Service from 1 September 2023 (see section 5 of the main report).	01/09/2018 - 31/08/2023

Service name	Provider	Service description	Contract start - end date
Bump Buddies	Shoreditch Trust	Shoreditch Trust currently delivers the Bump Buddies service which provides community support to vulnerable pregnant women and new mothers who are affected by complex social issues including poverty, homelessness, social isolation, domestic violence, insecure immigration status, trauma and poor mental and/or physical health. Services provided include information and signposting, crisis support and peer mentoring. The Bump Buddies services is being replaced by a new community peer mentoring, advice and signposting service - which places a greater emphasis on peer mentoring. The new service will commence on 1 September 2023 (see section 7 of the main report).	01/04/2018 - 31/08/2023
0-5 Healthy Lifestyle Service	HENRY	A universal and targeted healthy weight service for children aged 0-5 years and their families. There are four key components to the service: 1) Healthy Start Vitamin promotion and delivery 2) Healthy eating education workshops for families 3) Health promotion of a healthy weight 4) Training and development	1/04/2023 - 31/3/2025
Alexander Rose	Alexander Rose Charity	The Alexander Rose Vouchers for Fruit & Vegetables service helps families with children aged 0-4 years old and pregnant women on low incomes to buy fresh fruit and vegetables and supports them to give their children the healthiest possible start in life.	01/03/2023 - 31/04/2027

Service name	Provider	Service description	Contract start - end date
		A family receives £4 of Alexander Rose Vouchers for each child every week, or £6 if the child is under one year old. The Service will be provided to families with young children (under 5), and pregnant women. Families can either be: ● on low income ● eligible for Healthy Start vouchers ● with No Recourse to Public Funds	
Oral Health[1] Prevention and Promotion Service	Kent Community Health	The Oral Health Prevention and Promotion Service aims to deliver a high quality, effective, efficient, accessible and innovative service to improve oral health and reduce oral health inequalities in the population of the London Borough of Hackney and the City of London. The service includes: ● universal provision of toothbrushes and fluoride toothpaste amongst children and young people in early years nurseries, childrens centres, special schools, care and nursing homes. ● oral health training of children and adult service staff. ● targeted interventions including: a) targeted supervised tooth-brushing programme in SEND Schools, Pupil Referral Units and nurseries including Orthodox Jewish nurseries and childminding day nurseries	01/01/2023 - 31/12/2027

[1] Service is also for older adults in care homes

Service name	Provider	Service description	Contract start - end date
		b) Fluoride Varnish Programme in state and independent primary schools c) support implementation of CQC oral health standards in nursing and supported living settings.	
SERVICES FOR THOSE AGED 5-25			
School-based health service	Homerton Healthcare NHS Foundation Trust	A nurse-led service for school age children which includes the National Weight Measurement Programme (NCMP) and school entry health check, Safeguarding (all schools) Individual Care Plans for children with health conditions. The service includes dedicated nursing support for children attending special schools.	01/09/2018 - 31/08/2024
City & Hackney Young People's Clinical Health and Wellbeing Service CHYPS +	Homerton Healthcare NHS Foundation Trust	An advice and clinical treatment service for children and young people (CYP) which includes: ● Sex and reproductive health advice and clinical interventions (including STI testing and contraception) ● Emotional health and wellbeing brief interventions and referral ● Smoking cessation advice and support ● Identification of CYP with a high body mass index (BMI) and onward referral to weight management services	01/11/2016 - 31/08/2024
Young People's	Young Hackney	The Service aims to deliver a holistic young person centred, health and wellbeing education service that is focused on improving the health and	01/11/2016 - 31/08/2024

Service name	Provider	Service description	Contract start - end date
Education and Outreach Service		wellbeing outcomes of all children and young people in City and Hackney. The service is focused on prevention, building young people's knowledge, self-esteem and resilience, while enabling them to manage their own health and wellbeing either independently or with support. The service works with all children and young people in City and Hackney aged 5-19 years, and up to 25 years. It provides a universal and targeted service, delivering advice and information, signposting, health promotion, awareness-raising and health education including the facilitation of PSHE and RSE delivery in schools and youth settings.	
5-19 interim Healthy Weight Service[2]	Homerton Healthcare NHS Foundation Trust	Responsible for delivering and creating a behaviour change programme for children, young people and families in City and Hackney, helping them improve their weight and create long term healthy habits related to diet and physical activity	01/02/2023 - 31/08/2024
Young People's Substance Misuse Service[3]	Young Hackney	A non-prescribing service for children and young people which includes harm reduction interventions, working with children in contact with youth justice, prevention, education and outreach working in partnership with Hackney Health and Wellbeing service.	01/04/2015 - 30/09/2023

[2] contract not directly managed by the children and YP /HP team
[3] contract not directly managed by the children and YP /HP team

Service name	Provider	Service description	Contract start - end date
DOMESTIC VIOLENCE SERVICES FOR THOSE AGED 16+			
Identification & Referral to Improve Safety (IRIS) in Primary Care	Nia	Nia delivers the Primary Care Domestic Violence Identification and Referral Service (IRIS service - Identification and Referral to Improve Safety). The IRIS service is a specialist domestic violence and abuse (DVA) training, support and referral programme for general practices. The service aims to increase the confidence of competence of GP practice staff to recognise the signs of domestic abuse and provide a consistent response by taking the appropriate safeguarding actions.	01/10/2016 - 30/03/2023 New contract started from 03/04/2023
Domestic Violence Training service	Hackney's Domestic Abuse Intervention Service (DAIS)	Public Health and NEL ICB are jointly funding Hackney's Domestic Abuse Intervention Service (DAIS) to deliver a domestic abuse training and case consultation service (consisting of 2 domestic abuse trainers) for a wide range of front facing practitioners. There is a focus on those working within NHS and local authority services (including Hackney council and City of London Corporation) but may also include staff in the voluntary and charity sector (VCS) and external agencies such as the Metropolitan and City of London Police and the London Fire Brigade. The aim of the service is to increase early identification, prevention, action and appropriate referral of individuals experiencing domestic abuse across a range of front facing practitioners in City and Hackney.	30/01/2023 - 29/07/2024

Committee(s): City of London Health & Wellbeing Board	**Dated:** 29 June 2023
Subject: NEL Joint Forward Plan	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	Contributing to a flourishing society
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: NHS NEL ICB	For Information
Report author: Hilary Ross, Director of Strategy, NHS NEL ICB	

City's Corporate Plan
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.*
4. *Communities are cohesive and have the facilities they need.*

Support a thriving economy

5. *Businesses are trusted and socially and environmentally responsible.*
6. *We have the world's best legal and regulatory framework and access to global markets.*
7. *We are a global hub for innovation in finance and professional services, commerce and culture.*
8. *We have access to the skills and talent we need.*

Shape outstanding environments

9. *We are digitally and physically well-connected and responsive.*
10. *We inspire enterprise, excellence, creativity and collaboration.*
11. *We have clean air, land and water and a thriving and sustainable natural environment.*
12. *Our spaces are secure, resilient and well-maintained*

Summary

Background

1. The NEL Joint Forward Plan (NEL JFP) is a complete draft of our system's five-year plan describing how we will, as a system, deliver our Integrated Care Partnership Strategy as well as core NHS services – and a supporting reference document providing further detail on the transformation programmes described in the main plan.

2. As a partnership, we have more work to do to develop a cohesive and complete action plan for meeting all the challenges we face. We will work with local people, partners and stakeholders to iterate and improve the plan as we develop our partnership, including annual refreshes, to ensure it stays relevant and useful to partners across the system.
3. This Joint Forward Plan is north east London's first five-year plan since the establishment of NHS NEL. In the plan, we 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.
4. 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 we describe the substantial portfolio of transformation programmes that are seeking to do just that.
5. 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.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

- Consider and comment on the NEL JFP and how it aligns with Tower Hamlets local priorities
- Identifying any potential gaps

Main Report

The Joint Forward Plan is included with the agenda and papers for this meeting.

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North East London Health & Care Partnership

NHS
North East London

DRAFT

North East London (NEL) Joint Forward Plan

March 2023

1. Introduction

Introduction

- This Joint Forward Plan is north east London's first five-year plan since the establishment of NHS NEL. In this plan, we 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.
- 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 we describe the substantial portfolio of transformation programmes that are seeking to do just that.
- 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.
- This is the first draft of our Joint Forward Plan and reflects that, as a partnership, we have more work to do to develop a cohesive and complete action plan for meeting all the challenges we face. We will work with local people, partners and stakeholders to iterate and improve the plan as we develop our partnership, including annual refreshes, 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 increasing, 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

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 and 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 & 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**

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

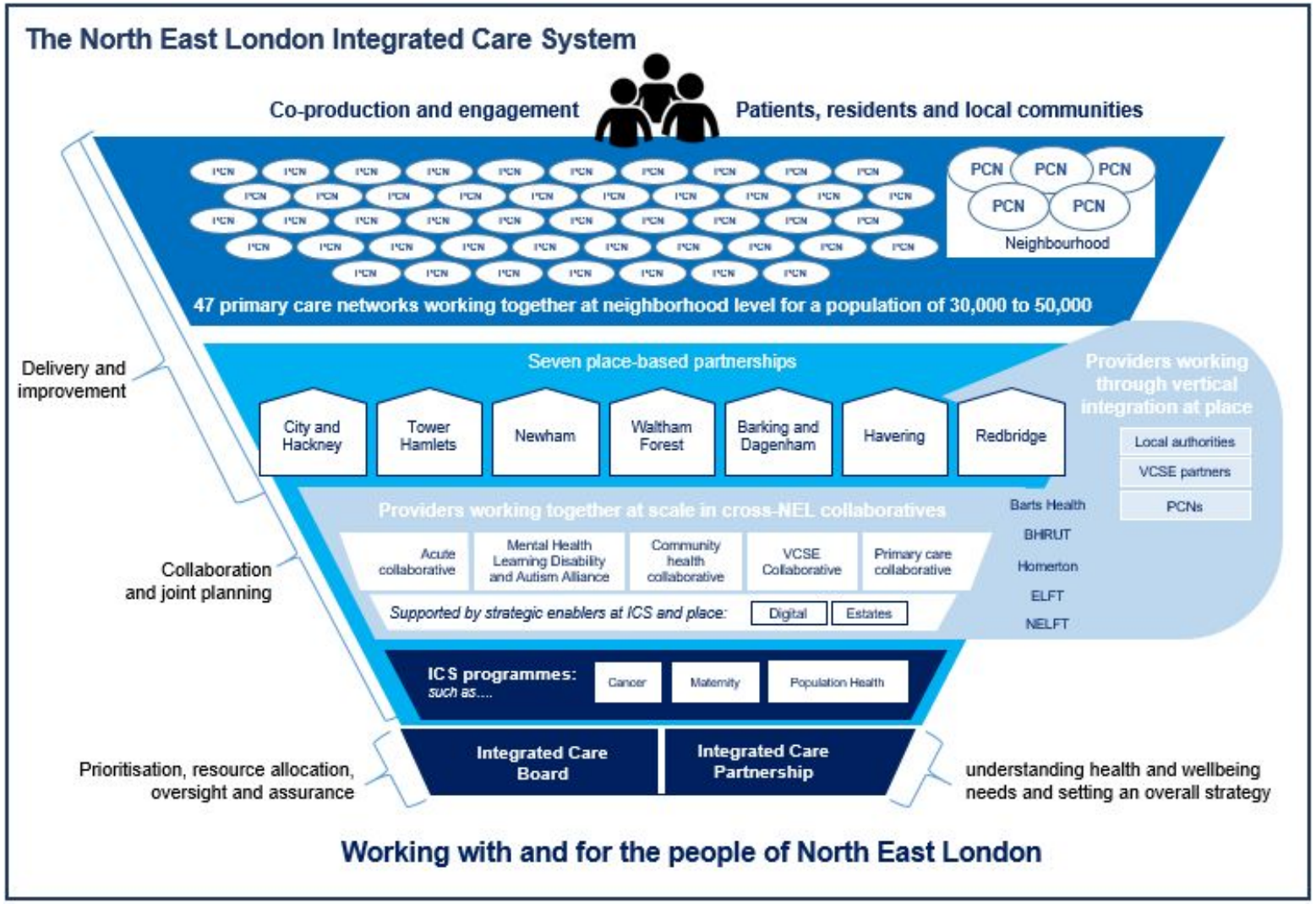
We are a broad partnership, brought together by a single purpose: to improve health and wellbeing outcomes for the people of north east London.

Each of our partners has an impact 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.

Our partnership between local people and communities, the NHS, local authorities and the voluntary 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.



2. Our unique population

Understanding our unique population is key to addressing our challenges and capitalising 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.

Rich diversity

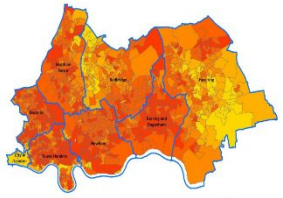
NEL is made up of many different communities and cultures. Just over half (53%) of our population are from ethnic minority backgrounds.

Our diversity means a 'one size fits all' approach will not work for local people and communities, but there is 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

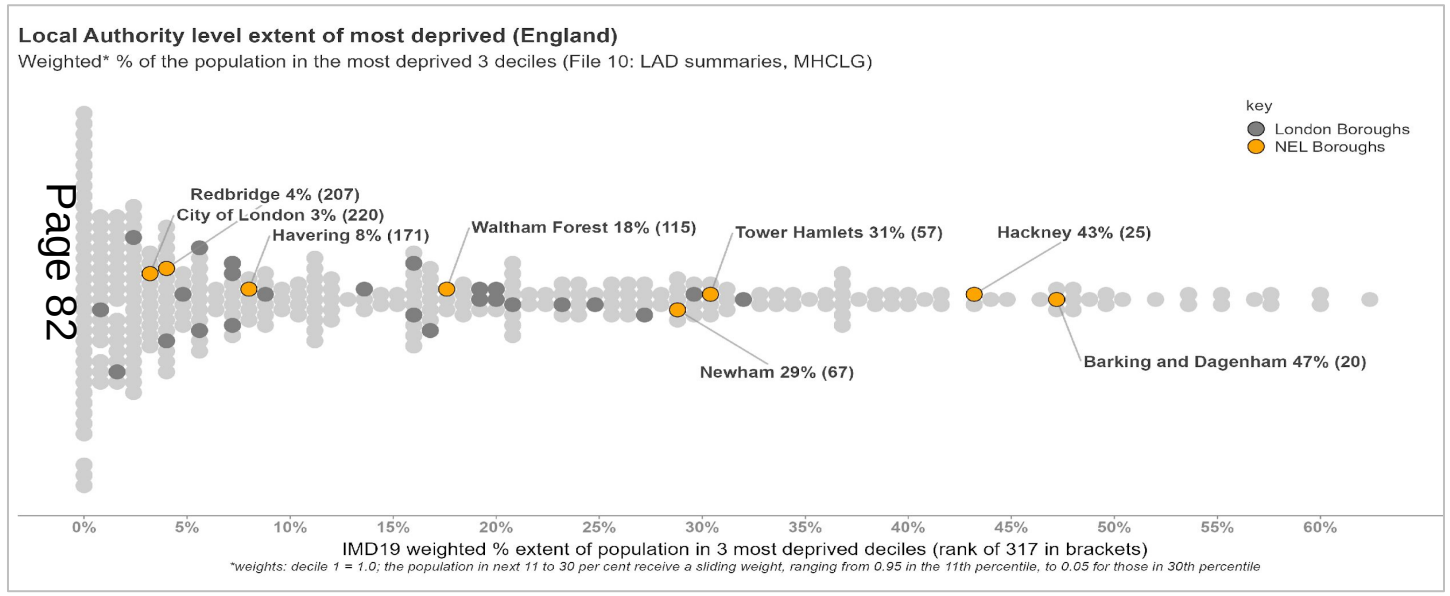
There are significant inequalities within and between our communities in NEL, and our population has worse health outcomes than the rest of the country across many key indicators. Health inequalities are linked to wider social and economic inequalities including poverty and ethnicity.

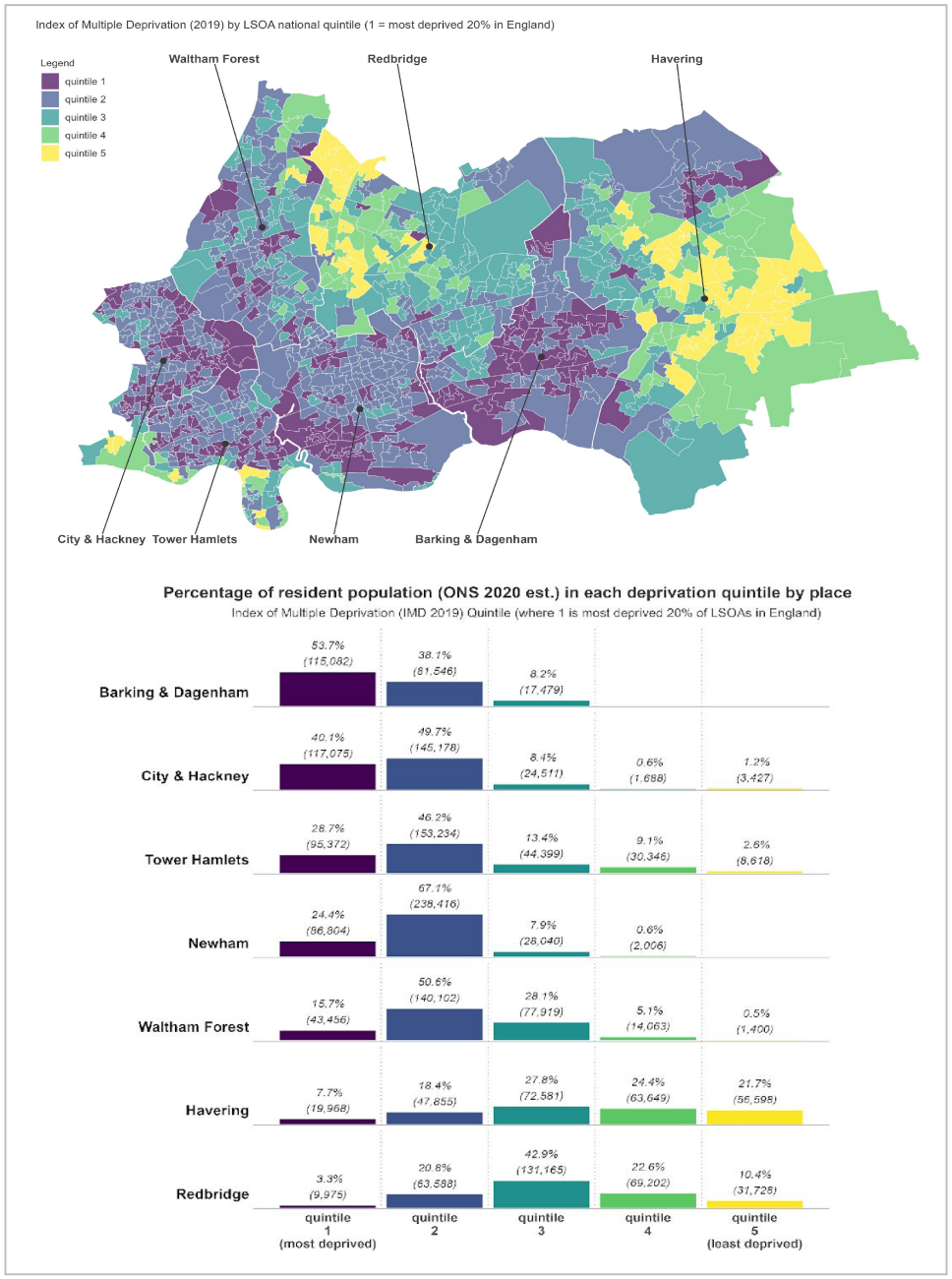
Our population has been disproportionately impacted by the pandemic and recent cost of living increase.

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 & Dagenham (54%), City & 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).





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 and 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.

The health of our population is worsening and 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

1 in 20 pregnant women smoke 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 high numbers of vulnerably housed and homeless people 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 estimate that there were 42,399 homeless individuals in NEL in 2022 including those in all kinds of temporary accommodation, hostels, rough sleeping and in social services accommodation: 1 in 47 people, compared to 1 in 208 people across England and 1 in 58 in London.

Childhood Poverty

5 NEL boroughs have highest proportion of children living low income families in London. In 2020/21 98,332 of NEL young people equate to 32% of the London living in low-income families. Since the 2014 the proportion of children living in low income families is increasing faster than the England average.

Childhood Vaccinations

The NEL average rate of uptake for ALL infant and early years vaccinations are 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. This suggests that there is 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 that these are more common among particular groups, for example at Whipps Cross Hospital DNAs are highest among people living in deprived areas and 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.

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

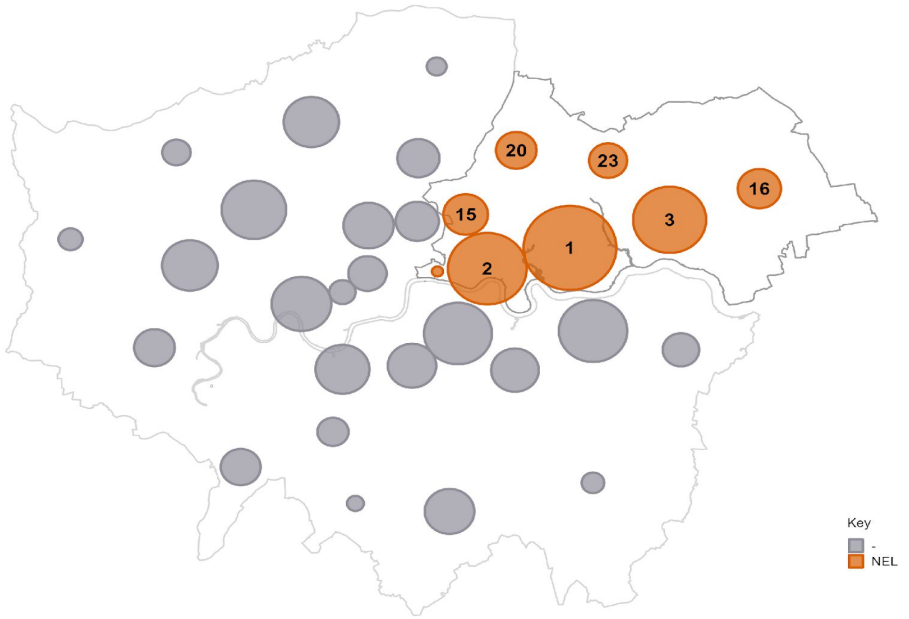
The population of north east London (currently just over 2 million) is projected to increase by almost 15% (or 300k people) between 2023 and 2040, the equivalent to adding a whole new borough to the ICS, and by far the largest population increase in London.

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

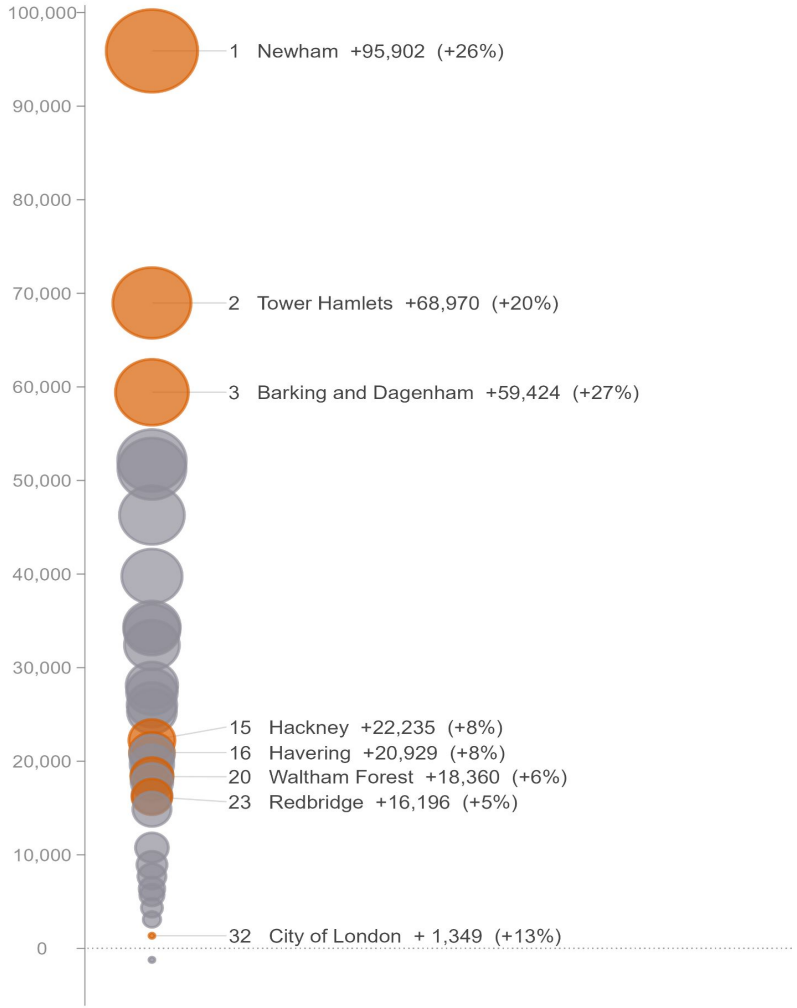
In addition, the age profile of our population is set to change over the coming years. Our population now is relatively young, however, some of our boroughs will see high increases in the number of older people in the coming years as well as increasing complexity in overall health and care needs.

London borough all age population increase 2023-2040
Labelled circles = NEL Boroughs rank out of 33 in London



GLA Identified Capacity Scenario, published September 2021, 2020 based

London borough all age population increase 2023-2040
Labellled circles = NEL Boroughs rank out of 33 in London



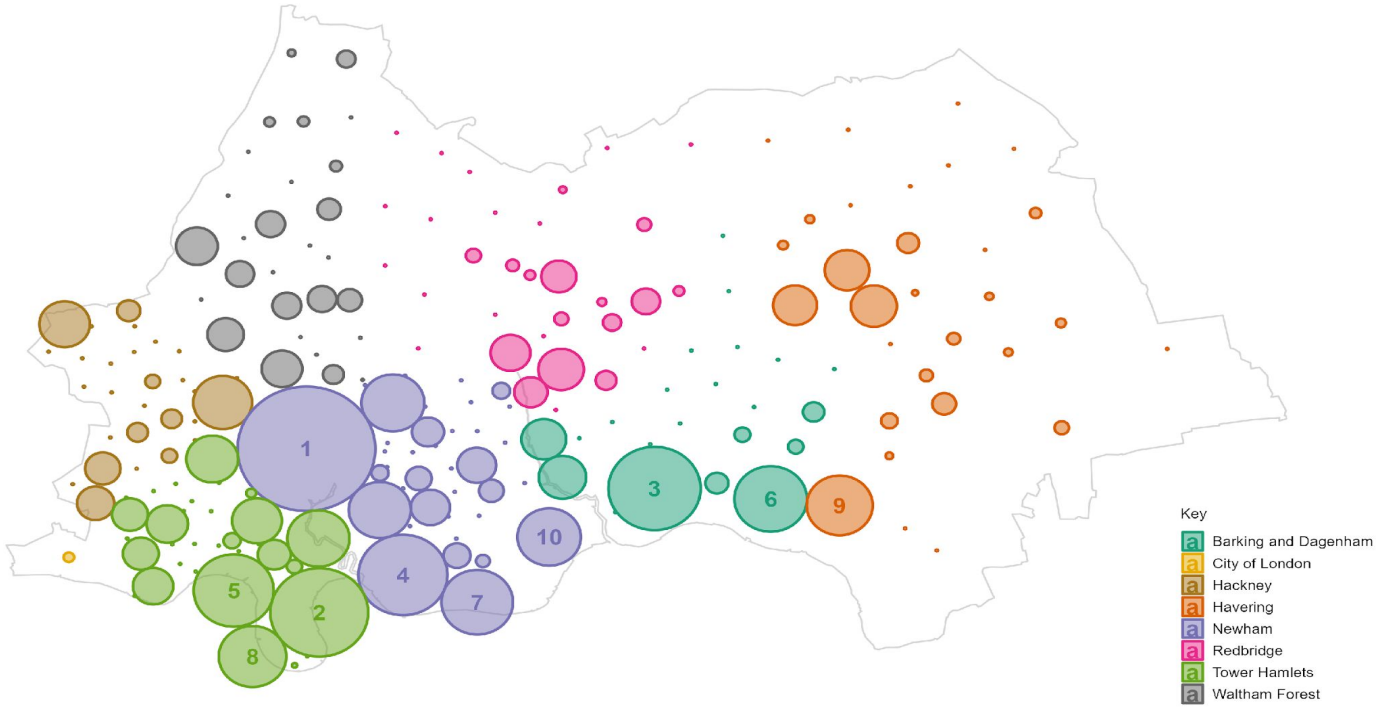
GLA Identified Capacity Scenario, published September 2021, 2020 based

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 & Dagenham.

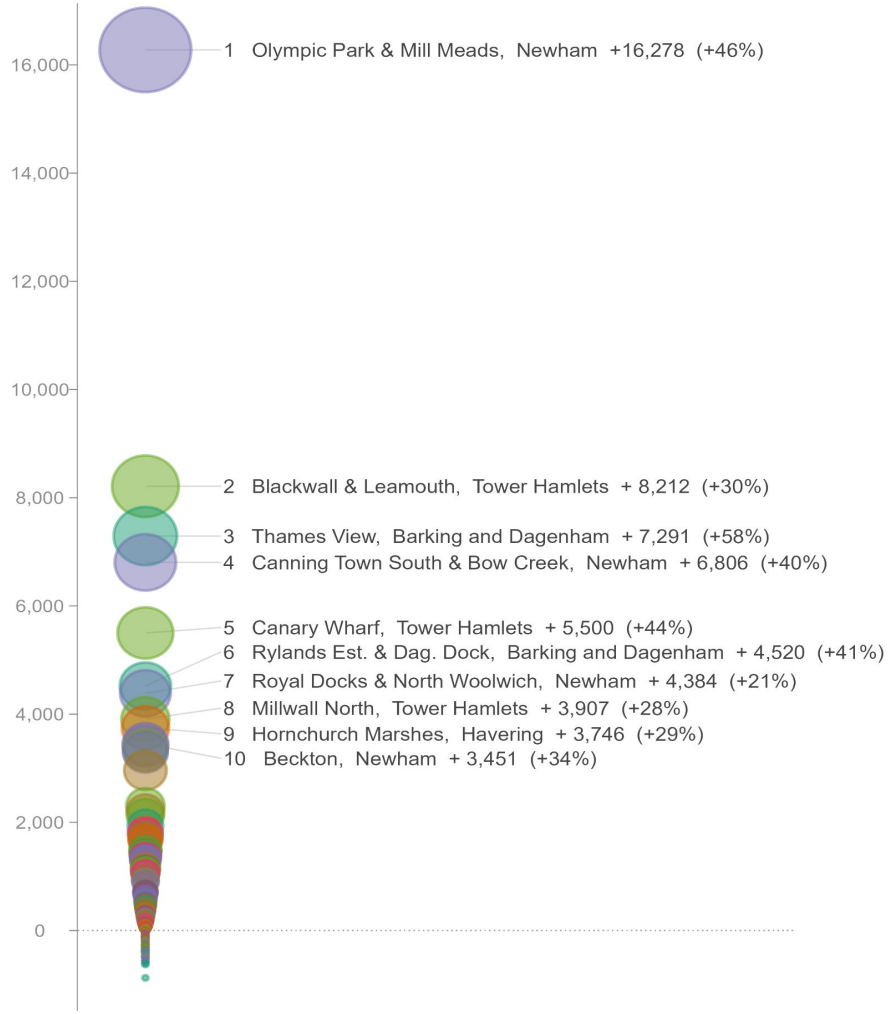
Sustaining core services for our rapidly growing population will require a systematic focus on prevention and innovation as well as increased longer term investment in our health and care infrastructure.

NEL neighbourhood (MSOA) all age population increase 2023-2028
Smallest circles = MSOAs with zero increase or marginal decrease, labelled circles = top 10 NEL neighbourhoods by population increase (1=highest)



GLA Identified Capacity Scenario, published September 2021, 2020 based

NEL neighbourhood (MSOA) all age population increase 2023-2028
Labelled circles = top 10 NEL neighbourhoods by population increase



3. Our assets

We have significant assets to draw from

North east London (NEL) has a growing population of over 2 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 and confirmed funding for the Whipp's Cross Hospital redevelopment. There are also plans 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** – who 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 to evidence what works for our diverse communities/groups. We want to build on our 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, innovate and use data and evidence in order to continually improve. Strong clinical leadership is essential to lead communities, 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 residents 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, and across our public sector partners in north east London, including local authorities, schools and the police, there are 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 with improve outcomes and reduce inequality in 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 residents.

Our health and care workforce is our greatest asset

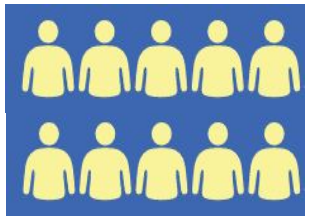
To be updated during April-June in line with People Strategy currently under development

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 them 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, working in multi-disciplinary teams so that the needs of residents, not the way organisations work, are central and where necessary stepping 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 representative of our local communities at all levels of 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, the skills to adapt to new ways of working, and potentially new roles.

Our ICS People Strategy will ensure there is a system wide plan underpinning the delivery of our new Integrated Care Strategy and Joint Forward Plan focused on increasing support for our current workforce, strengthening the behaviours and values that support greater integration, and collaboration across teams, organisations and sectors and contributing to the social and economic development of our local population through upskilling and employing more local people.



There are almost one hundred thousand staff working in health and care in NEL; and our employed workforce has grown by 1,840 in the last year.

Our workforce includes -

- Over 4,000 people working in general practice with 3.7% growth in our workforce over the last year
- 46,000 people working in social care
- 49,000 people working in our trusts

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 supporting a greater shift towards prevention and self-care. They work closely with local communities and are key system transformation, innovation and integration partners.

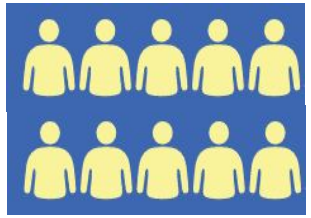
In NEL we are supporting the development of a VCSE Collaborative to create the enabling infrastructure and support sustainability of our rich and diverse VCSE in NEL, also ensuring that the contribution of the VCSE is valued equally.

Social care also 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 involves 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 or 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, which as described above are significant challenges in north east London, is critical in 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.

4. Our challenges and opportunities

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 are facing 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 our 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 themselves have knock-on impacts.

The wider determinants of health are also key challenges that contribute to challenges, across most of our places we have seen unemployment rise during the pandemic, although this number is dropping, we still have populations who are still 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, which will be 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, but 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.

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 four hour A&E target) • Growing demand for unplanned care within acute settings risks undermining efforts to reduce backlogs 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 (around 4,500 are expected to have 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 from 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

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 is 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

We need to expand and improve primary and community care, including improving care and support for those with long term conditions

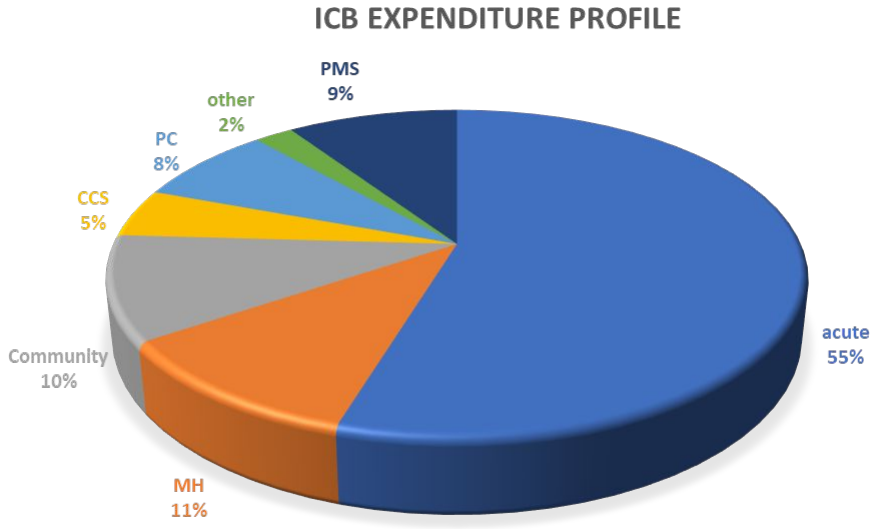
- North east London currently has relatively few GP appointments per 100,000 weighted population (39,244 vs a median for all ICSs of 42,360 – i.e. the national median is around 8% greater than in NEL), suggesting part of the cause of pressure on other parts of the system, including greater than expected non-elective admissions at the acute providers, may be due to insufficient primary care capacity.
- The variation of clinical care encounters per week (all appointment types) varies from 79.85 per '1000 patients in Waltham Forest to 58.43 per '1000 patients in Barking and Dagenham, with the NEL average being 69.43 per '1000 patients.
- Without substantial increases in primary care staffing the GP:patient ratio will worsen as demand for primary care encounters (a broader measure of patient interaction with clinical primary care staff than GP encounters alone) are set to increase by 15% across north east London over the next 5 years, with growth in Newham as high as 19%.
- There are pockets of workforce shortages with significant variation in approaches to training, education, recruitment and retention.
- 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

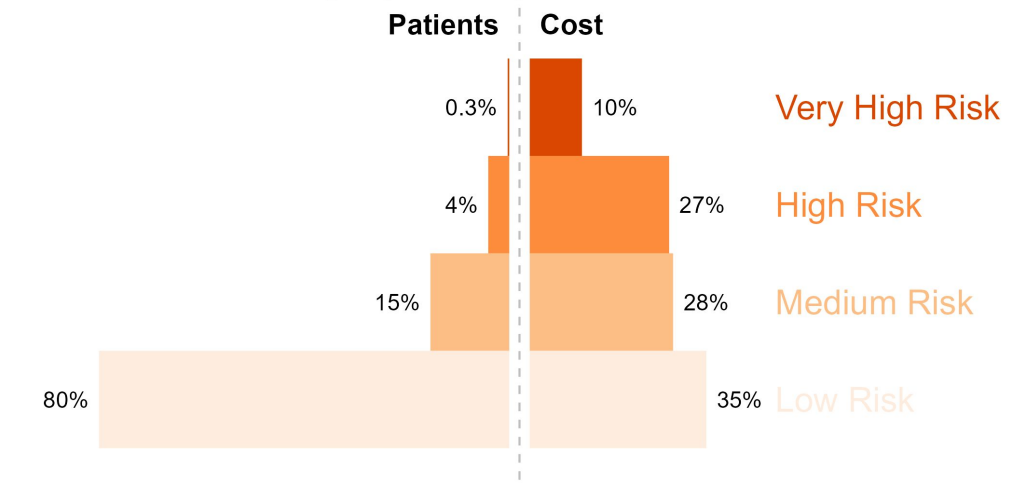
- Across north east London one in four (over 600 thousand people) have at least one long term condition, with significant variation between our places (in Havering the figure is 33%, vs 23% in Newham and Tower Hamlets).
- Age and deprivation are strong predictors of long term conditions, so while north 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.

We need to move away from the current blend of care provision as this 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.
- 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 – in NEL agency spend is 7% of total spend vs 4% median for London ICSs.
- In addition to a financial gap for the system overall, there are also 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 (of around £90m), 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.
- There is huge variation in the public health grant received by each of NEL's local authorities from central government – ranging from £114 per person in City and Hackney to £43 per person in Redbridge. 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. Barking and Dagenham has the highest SMR<75 of any borough in London, yet receives only £71 per person. Havering has the same SMR<75 as Tower Hamlets (97) yet Havering receives £45 per person, whereas Tower Hamlets receives £104 per person. This significantly 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 particular populations (0.3% of the population account for 10% of costs associated with emergency admissions; just under 20% account for 65%).



Risk stratified cost of emergency admissions



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

5. How we are transforming the way we work

Current plans are a first step towards building a sustainable, high quality health and care system, but we know there is more to do

We recognise that existing programmes will not be sufficient to meet all the challenges we face as a system, we therefore intend to use this plan to identify the gaps and to engage system partners and our local people on how best to redirect limited resources to have greatest impact

1	A description of the major transformation programmes underway across north east London, setting out the benefits for residents, how the work addresses inequalities, key features and milestones, and what transformation in the area will need to include over the longer term	Covered in this Joint Forward Plan (March submission)
2	Analysis of where our current transformation portfolio aligns with our integrated care partnership's strategy, our operating plan, and the challenges set out in earlier sections of this joint forward plan;	
3	Identification of the gaps in the coverage of the transformation portfolio and also where any current transformation work does not fully align with current system challenges and ambitions	To be developed through engagement with system partners and local people — April-June
4	How our system transformation portfolio should evolve and re-prioritise – in terms of the deployment of financial and people resources – to ensure that it delivers greatest benefits for local people	To be developed through engagement with system partners and local people — June onwards
5	Develop and evolve our plans and how we work together as a system – in particular partners responsible areas that impact our population's health, but sit outside the health and care system, such as Housing – to better align partners in the best interests of local people	Plan continues to be developed and iterated, with annual refreshes

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 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 four 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. Local priorities within NEL

A quick snapshot of NEL's transformation work

- The next part of this plan contains summary information about existing transformation programmes, with full detail of all programmes contained in the reference pack accompanying this plan.
- Some highlights of the portfolio that will deliver during 2023/24 include:

By April 2024

- equitable access to cardiac rehabilitation services for all eligible local people
- new community diagnostic centres open in Barking and Mile End
- a seven-day-a-week transient ischemic attack (mini-stroke) service
- two home-from-home haemodialysis (kidney dialysis) stations in the East London Mosque
- almost one thousand local people supported by urgent community response services
- mobilisation of a digital framework for community and social care providers to enable greater interoperability and so joined up care
- consistent medicines reviews and oral checks for all residents in care homes
- three family hubs in Barking and Dagenham
- equal access to palliative end-of-life care services for all local people
- access to specialist post-covid services in less than four weeks from GP referral
- wellbeing and mental health support in all City and Hackney schools
- the new St George's health and wellbeing hub open in Hornchurch
- an infrastructure plan for Newham to meet the challenge of population growth over twenty years
- new services supporting thousands of inpatients to stop smoking
- a concerted drive to improve performance and quality in general practices with CQC ratings of 'inadequate' or 'requires improvement'
- all general practices incentivised to deliver enhanced care to local people with long-term conditions
- 300 additional personal health budgets for people with serious mental illness
- 1,000 active users of the Patient Knows Best patient-held record
- the new Ilford Exchange Health and Care Centre open to local people

Urgent and emergency care

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Reduced ambulance conveyances to EDs
  - No ambulance handovers over 60 mins
  - Increased access to Same Day Emergency Care (SDEC) across Acute sites
  - Constituently meeting 70% + UCR target NEL target is 90% meet trajectory count of 9995 residents supported 23/24
  - Implementation of virtual ward interfaces and more digital interoperability
- April 2026:
  - Increased and new community medicine pathways to support out of hospital arrangements where appropriate
  - Increased access via digital to support access to services ie bookable urgent appointments
  - Pipeline of U&EC workforce with clear career/ skills development opportunities across NEL
  - Expansion of UCR service offer more support for identified residents as high intensity users
  - More mobilisation of digital enabled technology for delivery of UCR

How this transformation programme reduces inequalities between north east London's residents and communities:

- Increasing equality of access across the geography (front door streaming, SDEC access, optimising pathway 0)
- Through the ambulance flow workstream, working with ambulance Providers, to support Frailty pathways
- Support to patients with Learning Difficulties and Autism accessing U&EC services
- Collaborative working with the Mental Health Collaborative on U&EC pathways for patients

Key programme features and milestones:

- U&EC Programme aim to improve equality of access to non-elective care for the population of NEL
- Workstream focus on:
  - REACH and PRU sustainability and development
  - Ambulance flow
  - 'front door' working with UTCs
  - SDEC
  - U&EC workforce - newer roles and CESR training programme
  - Urgent diagnostic access
  - Optimising pathway 0.
- 9995 residents supported by the end of 23/24 in accordance with trajectory for the service
- Electronic Single Point of access pull Pilot to increase count of residents accessing the service via 111/999 triage

Further transformation to be planned in this area:

Over the next two years

- Keeping people safe and well at home: virtual wards, effective falls response, anticipatory care, etc
- Access to real-time information across the system to support forecast/ demand management
- Join up pathways including access to UCR virtual wards with existing pathways to maximise

Over years three to five

- Further development of virtual consultations for U&EC

Programme funding:

- See reference pack for details
- SDF funding
- NHSE funding

Leadership and governance arrangements:

- APC U&EC monthly Programme Board
- Community Based Care
- Task & Finish Groups for Delivery Oversight with providers
- Operations Working Group – Trajectory, Capacity and Delivery Monitoring

Key delivery risks currently being mitigated:

- Funding requests not yet approved, impacting on the ability tot delivery the full programme of work, ICB prioritisation may be required
- Variation of the way service is configured across NEL provision
- Comms and engagement to promote the service - need additional support so care homes, primary care and other parts of system think UCR first
- Digital connectivity with LAS / UCR – this will be explored in Pilot

Alignment to the integrated care strategy:									
Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Community health services

The benefits that north east London residents will experience by April 2024 and April 2026:

- April 2024:
  - greater digital interoperability and one shared record to include universal care plans, which enables more joined up care across providers
  - standardisation of access to palliative care services across north east London
  - access to post-covid rehabilitation within four to ten weeks of persistent ongoing symptoms and access to specialist services within four weeks of GP referral
  - proactive care assessments for residents with two or more long-term health conditions
  - at least 551 virtual ward beds with an integrated acute and community provision model
- April 2026:
  - a shared care record for health and special care, leading to better feedback loops for residents
  - two thousand generalist staff trained on a range of palliate care delivery areas
  - standardisation of quality of and access to palliative care services across north east London
  - post-covid care is part of a business as usual offer within community provision
  - an equitable offer of proactive care across north east London

How this transformation programme reduces inequalities between north east London's residents and communities:

- By reducing barriers to care for local people through further roll-out of the shared care record across care homes and social care providers
- By equalising the digital offer to local people across north east London
- By co-designing digital tools with local people from across north east London's communities
- By ensuring a representative sample of local people's voices participate in service design
- By increasing patient choice, with personalised care through digital tools where applicable

Key programme features and milestones:

- Building equitable care offers for all local people Patient empowerment through improved access to data
- Better care through improved data sharing and digital operability across health and social care providers
- Deep and continuous resident engagement and co-production
- Ongoing dialogue and strengthening of relationships with Healthwatch and the voluntary, community and social enterprise sector

Further transformation to be planned in this area:

- Over the next two years
  - rollout of universal care plan and shared care records
  - for proactive care, establishing the local population health cohort of at-risk residents
  - bereavement service accessible by all local people
- Over years three to five
  - integrating proactive care with hospital discharge processes to reduce avoidable readmissions
  - integrated workforce tools across health and care

Programme funding:

- See reference pack for details: System Development fund, National Ageing Well funding, Virtual ward funding, NHS England funding for shared care records and EPR

Leadership and governance arrangements:

- Community collaborative and individual programme governance – under development
- interfaces with relevant provider collaborative governance and NHS NEL

Key delivery risks currently being mitigated:

- Uncertainty of some medium-term funding
- Information governance issues around care records
- Workforce availability and capacity
- Current inequities of funding across places

Alignment to the integrated care strategy:									
Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Primary care

The benefits that north east London residents will experience by April 2024, April 2026, and April 2028:

- April 2024:
  - improved digital access, including through remote consultations, the NHS app, improved website quality, and e-Hubs
  - all practices offering core and enhanced care for people with long-term conditions to a minimum NEL-wide standard
  - additional services from community pharmacies
- April 2026:
  - all practices will be CQC rated as GOOD or have action plans to achieve this
  - further equalisation of enhanced services
- 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

How this transformation programme reduces inequalities between north east London's residents and communities:

- By tackling the digital divide between local people – and resulting inequalities – through the recruitment of Digital Champions across north east London
- By equalising the use of – and therefore local people's access through – digital tools by all practices and primary care networks
- By providing the same access to primary care for all local people, irrespective of where they live in north east London
- By levelling up the overall quality of primary care in north east London, as shown through CQC ratings
- By better understanding local population need and inequalities through improved practice coding

Key programme features and milestones:

- LIS and LES equalisation programme
- EQUIP's *Understanding demand* programme
- Local primary care teams working with practices on local variation
- Promoting use of online and video consultation through engagement sessions with local people
- The same-day access programme is in its design phase, based on the key principles of: a clearly defined service offer, intuitive access points, the availability of self-care approaches, self-referral to community services, and innovative services in the community
- The scope of the same-day access programme covers primary care same-day access, 111 services, and urgent treatment centres

Further transformation to be planned in this area:

- Over the next two years
  - Further digital enabling of social prescribing, community pharmacy, care homes, and UEC
  - Improved understanding of demand and capacity through digital tools
  - Further improvement of same-day services
  - Better understanding of inequalities at place and PCN level

Programme funding:

- For Digital First: £1.9m for 2022/23; TBC for 2023/24
- For same-day access, from core ICB service funding

Leadership and governance arrangements:

- interfaces with relevant provider collaborative governance, the ICB UEC board and the Fuller Oversight Board
- Digital First Board

Key delivery risks currently being mitigated:

- Uncertainty of ongoing funding for Digital First, including national online consultation licence
- Availability of funding to deliver equalisation of the long-term condition enhanced care offer
- Workforce capacity to deliver new services
- Teams' capacity to deliver change
- Digital operability
- Variation of stakeholder participation across NEL

Alignment to the integrated care strategy:									
Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Planned care and diagnostics

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Waiting times for elective care are reduced so that no one is waiting more than 52 weeks
  - Improved equality of access to diagnostic and elective care through creation of Community Diagnostic Centres in Mile End & Barking, surgical capacity at KGH and NUH and ophthalmology in Stratford
  - Reduced unwarranted variation in access to 'out of hospital' services
- April 2026:
  - Waiting times for elective care are reduced in line with national requirements moving towards a return to 18-week referral to treatment standard.

How this transformation programme reduces inequalities between north east London's residents and communities:

- By April 2024, we will have reduced the variation in waiting times that exists between acute providers for elective care
- By April 2024 we will have increased the availability of 'Advice & Refer' services via GPs to residents
- By April 2024 we will have reduced the variation in community/out of hospital service access across NEL specifically in ENT, MSK, dermatology, gynaecology & ophthalmology
- By April 2024 residents and communities able to access community diagnostic services in Barking and Mile End.

Key programme features and milestones:

The Planned Care Recovery & Transformation portfolio is designed to meet national requirements for recovering & transformation elective care services. In NEL, this will mean delivering reduction in waiting times and importantly reducing the variation in access that exists. The portfolio of work covers the elective care pathway from referral to treatment

Key milestones include:

- Development of single NEL community/out of hospital pathways
- CDCs in Barking & Mile End
- Ophthalmic outpatient/diagnostic/surgical centre-Stratford
- Additional theatre capacity in Newham, Ilford & Hackney.

Further transformation to be planned in this area:

- Over the next two years
  - Development of referral optimisation tools across NEL
  - Review for all contracts for out of hospital services
  - Increasing use of Advice & Guidance/Refer, Patient Initiated Follow-up (PIFU)
- Over years three to five
  - On-going development/implementation of transformation programmes to reduce the variation in inequalities in access

Programme funding:

- The programme is resourced from the ICB & acute trusts
- Theatre expansion from Targeted Investment Fund
- CDC national capital & revenue funds

Leadership and governance arrangements:

- Planned Care Recovery & Transformation Board & associated sub-committees
- APC Executive & Board
- Clinical Leadership Group in high volume surgical specialities

Key delivery risks currently being mitigated:

- Workforce –ability to recruit required workforce to fill exist -ing vacancies, creation of CDCs & expansion of theatres.
- Digital – Digital transformation linked to service transformation
- Access to transformation funding to test new care models
- Inflationary pressures on building costs

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities	X	Personalised care		High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention		Co-production		Learning system	

Cancer

The benefits that north east London residents will experience by April 2024 and April 2026:

- April 2024:
  - Access to Targeted Lung Health Check service for 40% of the eligible population
  - Access to prostate health check clinic for those with a high risk
  - Implementation of Lynch Syndrome pathways and Liver surveillance
- April 2026:
  - Earlier detection of cancer
  - Improved uptake of cancer screening
  - Every person in NEL receives personalised care and support from cancer diagnosis

How this transformation programme reduces inequalities between north east London's residents and communities:

- By March 2024 The programme will reduce health inequalities in accessing cancer screening and early diagnosis by tailoring interventions to specific audiences
- By March 2024 The programme will undertake innovative research such as the Colon Flag programme to identify patients patients who may have cancer earlier
- By March 2024 Early diagnosis work on Eastern European and Turkish populations as well as engaging with Roma and Traveller communities.
- By March 2024 Health and wellbeing information provided in various formats / languages, support for patients who do not use digital and support for people with pre-existing mental health problems

Key programme features and milestones:

The programme consists of projects to improve diagnosis, treatment and personalised care.

Key milestones to be delivered by March 2024 include:

BPTP milestones in suspected prostate, lower GI, skin and breast cancer pathways delivered

- National cancer audit implementation
- TLHCs provided in 3 boroughs with an agreed plan for expansion in 2024/25
- Cancer Alliances' psychosocial support development plan delivered
- Develop and deliver coproduced quality improvement action plans to improve experience of care.

Further transformation to be planned in this area:

- Over the next two years
  - Support the extension of the GRAIL interim implementation pilot into NEL.
  - Implement pancreatic cancer surveillance for those with inherited high risk.
  - Evaluate impact that rehabilitation interventions has on patient outcomes and efficiencies i.e. reducing length of stay and emergency admissions.
- Please note that Cancer Alliance Programme is currently funded nationally until March 2025.

Programme funding:

- *Overall sum and source: Cancer alliance funded by NHSE*

Leadership and governance arrangements:

- Programme Director Archna Mathur; Lead Femi Odewale
- Cancer board – internal assurance
- Programme Executive Board – NEL operational delivery
- APC Board and National / Regional Cancer Board

Key delivery risks currently being mitigated:

- Imaging delays in scanning and reporting (affecting backlog)
- Histopathology reporting turnaround time
- Recruitment of targeted lung health staff at Barts Health
- implementing a stratified pathway into primary care
- RMS delays at Homerton/ BHRUT are due to workforce capacity and PCC leads vacancy

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production	X	Learning system	

Maternity

The benefits that north east London residents will experience by April 2024 and April 2026:

- April 2024:
  - Improved access to postnatal physiotherapy for women experiencing urinary incontinence
  - Reduced unwanted variation in the delivery of care (through the regional service specification)
  - Increased breastfeeding rates, especially amongst babies born to women living in the most deprived areas
- April 2026:
  - The majority of women are offered Midwifery Continuity Care
  - A single digital system across NEL for maternity care records
  - Improved post-natal care to support areas such as reduction in smoking, obesity, and other public health concerns
  - Better integrated maternity and neonatal services and improved interface with primary care

How this transformation programme reduces inequalities between north east London's residents and communities:

- By reducing stillbirth, maternal mortality, neonatal mortality, and serious brain injury in women and babies from BME background and women from deprived areas.
- By closely aligning maternity and neonatal care to deliver the best outcomes for women and their babies who need specialised care
- By improving personalised care for women with heightened risk of pre-term birth, including for younger mothers and those from deprived backgrounds
- By ensuring that all providers have full baby-friendly accreditation and that support is available to those living in deprived areas who wish to breastfeed their baby

Key programme features and milestones:

- Delivering key maternity safety actions
- Achieving the Ockenden Essential Actions in collaboration with the Neonatal Operational Delivery Network
- Supporting the recommendations of the Neonatal Critical Care Review
- Facilitating and supporting leadership cultural development
- Supporting the recruitment, retention and well-being of maternity workforce
- Supporting the training and education of maternity staff, in partnership with Health Education England

Further transformation to be planned in this area:

- Over the next two years
  - Implementation of safety improvements set out in the Single Delivery Plan published in March 2023
  - Implementation of Midwifery Continuity Care
- Over years three to five
  - Development of the single digital system across NEL for maternity care records

Programme funding:

- Multiple external sources, including regional maternity transformation programme funding, neonatal ODN transformation funding, plus various streams of NHS NEL funding

Leadership and governance arrangements:

- Programme leads and SROs
- Internal NHS NEL reporting
- APC governance, including APC executive and relevant oversight group

Key delivery risks currently being mitigated:

- Recruitment and retention of maternity workforce
- Stability and sustainability of programme delivery teams
- Funding to support acute demand and capacity analysis

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health		Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions		Employment and workforce		Prevention	X	Co-production	X	Learning system	

Babies, children, and young people

The benefits that north east London residents will experience by April 2024 and April 2026:

- April 2024:
  - Enhanced access to, and experience of, mental health services for children and young people
  - Setting up acute paediatric care to a range of patients and families in the community and Hosptial@Home (H@H)
  - Social prescribing and key worker offers to support early help and system navigation
  - Children aged 5 to 11 that are an unhealthy weight will have access to childrens weight management services.
- April 2026:
  - Reduction in waiting times for community-based care CYP services (less than 52 weeks)
  - Integrated family support services from pre birth through to early adulthood in their locality
  - Community-based care services are high quality and personalised (Outcomes framework)

How this transformation programme reduces inequalities between north east London's residents and communities:

- By ensuring services meet their specific needs far more closely through a whole family, personalised approach.
- By addressing inequalities of access to services by working with our seldom heard communities to improve the offer and make services more accessible, acceptable and effective.
- CYP with emotional health and wellbeing needs receive early help to maintain school engagement, pre- diagnosis support based on need, with fewer CYP requiring unplanned admissions.
- Embedding of SEND joint commissioning across education, health and care means there is equal access to high quality provision. Robust needs assessment, demand and capacity planning, workforce innovation, co-production with CYP and families, our offer will respond to the needs of our communities; with a focus on access for specific groups such as those attending independent schools. Safeguarding at Place supports our focus on reducing inequalities for our Looked After Children
- By addressing inequalities that are causing higher obesity levels in children and young people from certain backgrounds more than others, using a targeted approach where required

Key programme features and milestones:

- Improved SEND provision focuses on: leading SEND, early identification and assessment, commissioning effective services, good quality education provision & supporting successful transitions.
- Tackling childhood obesity has 3 focus areas: healthy places, healthy settings, healthy services.
- More integrated services plans to start with the ambition of creating an effective Early Help Eco system with a common practice approach
- Levelling up H@H ensuring equality of access and services
- Build upon and increase existing community capacity, aligning to family hubs and strengthening adolescent healthcare. Through social prescribing and multi-disciplinary teams we will enable links to community assets including the community and voluntary sector and put health inequalities at the heart of our work
- Developing integrated care models and pathways for children across primary secondary and community care
- Give patients and (with patient consent) carers and clinicians involved in their care, better access to their care record

Further transformation to be planned in this area:

Over the next two years to five years

- MDTs in primary care for CYP
- Expand the childrens weight management service to be located across broader footprints
- Increasing MDT working and integrated service configuration at neighbourhood level
- Further needs assessment and targeting of 0-5 services to ensure vulnerable groups access effective services earlier and don't escalate.
- Identify further collaboration opportunities between education, health and social care to ensure school readiness for all children and to meet the needs of children with SEND, autism and complex medical issues

Programme funding:

- See reference pack for details
- SDF funding
- Pooled resources
- Health inequality funding
- NHSE funding

Leadership and governance arrangements:

- NEL BCYP Executive Board & CBC
- NEL BCYP Delivery Group
- NEL ICB BCYP Delivery Leads
- NEL ICS Place based partnership boards and local governance arrangements

Key delivery risks currently being mitigated:

- Staff recruitment challenges across specific services and recognition of urgent risks across NEL
- LA pressures including SEND system and high cost packages of care (SEND estates strategy and developing joint funding arrangements in train)
- BCYP weight management service - Lack of engagement from families with children that are an unhealthy weight
- Ability to invest long term in areas that will reduce inequality whilst still trying to meet acute demand

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	X	High-trust environment	
Long-term conditions		Employment and workforce	x	Prevention		Co-production	x	Learning system	

Long-term conditions

The benefits that north east London residents will experience by April 2024 and April 2026:

April 2024:

- By 2024 all eligible residents across NEL will have equitable access to Cardiac Rehabilitation services and a plan to further improve access to heart failure services
- Prevention of Type 2 (T2) diabetes through an increased number of people referred and starting the National Diabetes Prevention Programme (45% of eligible populations) and increase the numbers of residents who achieve T2 diabetes remission,
- Increased personalised care plans through population Health Management and coproduction
- 90% of people presenting 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
- All residents who experience a neurological condition will have equitable access to rehabilitation across the pathway of care (acute, bedded and community)
- Improved access to specialist Chronic Kidney Disease (CKD) intervention clinics for all NEL residents. By **2024 virtual CKD Clinics** will be available across NEL
- Early & Accurate Diagnosis of Respiratory Conditions through Primary Care Hublets (available in all 7 Places).

April 2026:

- Improve detection of **atrial fibrillation (b**y 2029 85% of expected numbers with AF are detected, and 90% of patients with AF and high risk of a stroke on anticoagulation) AND **hypertension** (by 2029 80% of expected numbers with hypertension are detected and 80% of people with high blood pressure are treated to target)
- Robust transition pathways for children living with diabetes across NEL
- Maximise patient dialysing at home AND patients being transplanted
- Pulmonary Rehab available to patients with all chronic lung conditions and all local languages

How this transformation programme reduces inequalities between north east London's residents and communities:

- By taking a population health approach and using insights and data to inform priorities, target inequalities and variation
- By utilising deep dive data analysis into local participation rates to support target local campaigns to improve equitable access to diabetes treatment by sex
- By reducing unwarranted variation in access to specialist assessment and treatment for Neurosciences within 24 hours of symptom onset for NEL residents with TIA which currently ranges between 40% for BHR residents to 92% for City and Hackney residents
- By April 2024 all Places will have accredited providers (Hublets) of Diagnostic Spirometry and FeNO to reduce inequalities across NEL (currently available in 3 Places with none-to-little provision in remaining 4 Places) to be followed by educational videos in all local languages to explain the why & how of respiratory diagnostic testing.

Key programme features and milestones:

- Roll out of the LTC outcomes framework (Q2 23/24) (led contractually by primary care) – impacting on benefits
- Co-produce 7 day TIA service with residents so that 90% of people with TIA
- New Digital PR DHI with shared-working between places (co-production start. March 2023 with potential capacity for c.250 extra participants a year).
- Acute Respiratory Infection (ARI) Virtual Wards (with plan for provision in each Place before Winter 23/24).

Further transformation to be planned in this area:

Over the next two years

- Improve acute stroke standards and flow across the stroke pathway

Over years three to five

- Diabetes education platform
- Rehabilitation facilities for people with complex cognitive and behavioural challenges and disorders of consciousness

Programme funding:

- See reference pack for details
- SDF funding
- IHIP funding
- Pooled resources
- Health inequality funding
- NHSE funding

Leadership and governance arrangements:

- Pan London Networks
- NEL LTC Clinical Networks / Boards
- NEL ICB LTC Delivery Leads
- NEL ICS Place based partnership boards and local governance arrangements

Key delivery risks currently being mitigated:

- Failure to formalise joint working agreements between partners, teams and functions effecting delivery affecting delivery of NEL wide plans to address regional, national and local ambitions.
- Financial reduction in NHS SDF funding in 23.24 effecting sustainability of programmes across LTCs
- Workforce availability to staff new clinical teams and staff programme team

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	X	High-trust environment	x
Long-term conditions	x	Employment and workforce	x	Prevention	x	Co-production	x	Learning system	x

Mental health

The benefits that north east London residents will experience by April 2024 and April 2026:

April 2024:

- Increased provision of group therapies 29% of people with common mental health conditions accessing talking therapies
- 1000 patients with SMIs accessing Patient Knows Best across NEL
- 300 additional personal health budgets for people with SMI
- Roll-out of Intensive Community CAMHS Services (ICCS) across INEL
- 95% of referrals to eating disorder services seen within 1 week (urgent) or 4 weeks (routine)
- 2000 co-produced digital personalised mental health care plans
- More paid employment opportunities for people with mental health needs, including people participation as a route into paid employment

April 2026:

- 30% of people with common mental health conditions accessing talking therapies
- 2000 patients with SMIs accessing Patient Knows Best across NEL
- NHS 111 press 2 for mental health available across all places in North East London
- Talking therapies for anxiety and depression expanded to include 16 and 17 year olds
- 3000 co-produced digital personalised mental health care plans

How this transformation programme reduces inequalities between north east London's residents and communities:

- Increased availability of peer support workers, promoting access for underserved communities, and expanding our workforce so that is more representative of the communities we serve
- Through our improvement network approach, we are harnessing clinical and service user leadership, and using quality improvement and population health management tools to understand and address inequities in outcomes and experience for people with intersecting protected characteristics
- Our IAPT Improvement Network will also have a specific lens on health inequalities, and will be hosting a Population Health Fellow to help us to systematically understand which groups (e.g. people with LTCs, older adults, black men) are underserved by talking therapy services, and using QI tools and techniques to improve access, experience and outcomes for those groups
- The emphasis on targeting high-risk service users (people with SMI who are infrequent users of primary care and/or have never received a health check) through new culturally sensitive community outreach services will address health inequities driven through structural inequalities, particularly for minoritised communities across NEL
- Working to address the over-representation of black men being detained for mental health treatment through better join-up with the voluntary & community sector, and focusing on prevention

Key programme features and milestones:

- Operate a coproduction of place between partner and residents with lived experience to develop and deliver resident centred services
- Additional crises bed capacity brought online and operational by October 2023 (in preparation for winter)
- First roll-out of NHS 111 press 2 for mental health by end of March 2024 (may be staggered by geography)
- Coproduction event planned for April 2023 to support the development of Lived Experience Leaders in CYP
- Expansion of talking therapies to 16/17s by March 2025

Further transformation to be planned in this area:

Over the next two years

- Review and potential expansion of MH joint response cars
- Social prescribing plan for CYPs developed in line with iThrive principles with service users

Over years three to five

- Comprehensive digital offer underpinning NEL mental health and emotional wellbeing approach
- Lived Experience-Led crisis service developed

Programme funding:

- See reference pack for details
- SDF and MHIS funding
- Investment and innovation fund
- Pooled resources
- NHSE funding

Leadership and governance arrangements:

- MHLDA Collaborative Committee
- Programme Boards
- IAPT Improvement, crisis Improvement, CYP Mental Health Improvement Networks
- NEL ICS Place-based partnership boards and local governance arrangements

Key delivery risks currently being mitigated:

- In some boroughs reduced access has been caused by high numbers of staff vacancies. Through focused efforts to increase recruitment and retention, and work across the Improvement Network to harness mutual support, these are largely mitigated for 2023/24
- There are issues with the integration engine to enable bi-directional data flows between trust records and Patient Knows Best. However, work is currently underway with digital leads to resolve this.
- Programmes sits in multiple portfolios (e.g. primary care, frailty, mental health, end of life, planned care, social care) which means that there is a lack of clarity across places and the system on leadership and improvement goals. This risk could be mitigated through the resourcing and establishment of a NEL wide-programme, led by the MHLDA Collaborative, with strong links into place-based partnerships and other provider collaboratives and ICS workstreams
- There is currently a full-time programme manager supporting this work, funded by the ICB non-recurrently. There is no clarity on longer term resource available.

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Employment and workforce

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - We will deliver by April 2025 900 jobs in health and care to residents in NEL
  - All providers to agree to work towards gaining accreditation for London Living Wage
  - We will work with partners to develop roles and services that provide services out of hospital
- April 2026: To be confirmed
  - Establish a permanent hub for local population to access job opportunities in health and care (To be confirmed)
  - Methodology for planning and introducing new roles building on the learning from collaboratives and development of new services and approaches (St Georges)

How this transformation programme reduces inequalities between north east London's residents and communities:

- By providing employment opportunities to our local residents in our health and care organisations providing employment to ensure social mobility.
- By ensuring opportunity and development to our residents to reduce deprivation and health opportunities
- By providing career pathways for our staff to develop skills that deliver effective health and care to our
- By ensuring that all employers agree to commit and start accreditation to be a london Living Wage employer

Key programme features and milestones:

- June 2023 Recruitment Health Hub and Social Care Hub to be operational
  April 2024 900 starts in London Living Wage posts across employers in Health and Care
- April 2024 – Learning from Bank and agency and good practice examples highlighted, shared and adopted
- April 2024 - System-wide integrated high-level co-designed Workforce Strategy focusing on enabling system-wide workforce transformation at System, Place and Neighbourhood, to be signed off.
- April 2024 – Workforce Productivity activities to contribute to deliver of activity and finance requirements 2from 2022-23 operational plan

Further transformation to be planned in this area:

- Over the next two years
  - Develop five-year co-designed NEL ICS workforce strategy action plan to deliver objectives, priorities and programmes
  - Shared workforce across health, technology starting with acute collaboratives, Care using collaboratives
  - Increase substantive posts within providers to reduce reliance on bank and agency and productivity
  - Build on Health and Care hubs to explore feasibility of training academies to support pipeline
- Over years three to five: TBC

Programme funding:

- Non recurrent, Funding from NHSE/Health Education England and GLA where fit against NEL priorities
- Funding redistribution as we move to new models of community care

Leadership and governance arrangements:

- To be confirmed SRO for specific areas of transformation
- NEL People Board, EMT and the ICB Executive

Key delivery risks currently being mitigated:

- No confirmed and recurrent funding to support workforce transformation and innovation
- No funding clarity for ARRs roles for in Primary Care
- Turnover rate increases due to ageing work population
- Burnout of health and care staff caused by increased workload and pandemic
- Mitigations Turnover and Burnout: Creation of a single NEL workforce offer including health and wellbeing, development and mobility

Alignment to the integrated care strategy:									
Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce	X	Prevention		Co-production		Learning system	X

Physical infrastructure

The benefits that north east London residents 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 site at St Georges
- Formal opening of new St Georges Hospital Site – **Spring 2024**

How this transformation programme reduces inequalities between north east London's residents 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

Alignment to the integrated care strategy:										
	Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care		High-trust environment	
	Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production		Learning system	

Digital infrastructure

The benefits that north east London residents will experience by April 2024 and April 2026:

- Improve accuracy of record keeping and recall within the trust, enabling patients to 'tell their story once', enable efficient handovers and staff communication
- Online registration for GP patients
- Rollout of the call/recall Active Patient Link tools for Childhood Immunisation and Atrial Fibrillation
- Delivery of the patient held record programme to improve communication channels with patients and reduce unnecessary visits to hospital (Patient Initiated Follow Up)

How this transformation programme reduces inequalities between north east London's residents and communities:

- Developing a linked dataset to support the identification of specific populations (utilising CORE25 plus 5 methodology) to target and organise health and care interventions to improve outcomes, drive self care and reduce inequalities
- Improve the availability, timeliness and quality of clinical data
- Support clinical decision making by reducing the need to check other systems for information

Key programme features and milestones:

- Single provider for acute EPRs (replacing BHRUT's)
- Single provider for General Practice patient record systems
- East London Patient Record (eLPR) Shared care record across all providers – to be expanded to include social care, pharmacists, care homes, community providers and independent providers
- Promotion of the NHSApp as the 'front door' to NHS services, including Patient Knows Best (PKB), primary care record, Online Consultations and ordering of repeat prescriptions
- Maternity service digitisation Expanding the Electronic Prescription Service to outpatient services

Further transformation to be planned in this area:

- move to cloud based telephony across primary care to facilitate collaboration across practices and PCNs
- Implementation of shared digital image capture and real-time sharing to reduce unnecessary procedures after transfers
- Network, cyber and end user device improvements (using VDI where practical) to improve staff experience and ease of access to information

Programme funding:

- £220m capital, £270m revenue over 5 years; including £43m for EPR replacement for BHRUT and £2.7m investment in care home EPRs.

Leadership and governance arrangements:

- Programmes have their own Boards reflecting footprint of decision-making (OneLondon is London wide; Digital; First is NEL). All report through IG Steering Group, Data Access Group and Clinical Advisory Group

Key delivery risks currently being mitigated:

- Risk that insufficient capital is available to fund all programmes. Options for staggering programmes being developed

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production		Learning system	X

Further programmes

Across our partnership there are many further programmes, beyond those described in the previous section, that are focused on specific populations or responding to specific local priorities. More detail on these programmes can be found in the reference pack accompanying this plan. Below is a snapshot of those programmes, along with where ownership for them sits within the system.

6. Implications and next steps

Early lessons from work to develop this plan

- The previous section is a significant step towards the collaborative and co-ordinated management of north east London's transformation portfolio.
- The portfolio demonstrates the **ambition**, **energy**, and **creativity** of north east London's health and care partners.
- At this stage, however, it is a relatively raw write-up of current transformation by teams across north east London leading the programmes, with further work needed during the engagement phase on articulating the full detail for each programme and further understanding of the overlaps between programmes and gaps within them
- Initial **learning** from the work to bring together these currently disparate programmes is that we need to:
    - better understand and explain the specific beneficial impact of each programme for residents by key dates, as the basis for ongoing investment in the programmes;
    - reframe our programmes around the needs of our local people rather than the services we provide;
    - understand the affordability of these programme plans as they are predicated on current finance and people resources, which are coming under increasing pressure;
    - ensure full alignment between multiple programmes across a common theme to ensure that delivery is integrated and efficient;
    - progress in some areas from restating strategy to setting out plans with clear timelines and deliverables; and
    - develop a medium-term view of how individual programmes progress, or whether they should be assumed to finish and close after current plans have been delivered.
- These areas will all be worked as we iterate the plans and programmes described between now and June 2023.

Analysing our transformation portfolio - i

- The table below shows, at a headline level, how the programmes within the current system portfolio align to:
  - the integrated care strategy – both flagship priorities and cross-cutting themes; and
  - the requirements of the operating plan.
- Alignment with the integrated care strategy has been identified by the programme teams and alignment to the operating plan has been added by the portfolio management office.
- This is a currently retrofitted view, given that the portfolio has developed organically rather than in response to strategy or the broad areas in this year's operating plan requirements.

Area	Programme	Lead system partner	Babies, children, and young people	Long-term conditions	Mental health	Employment and workforce	Tackling health inequalities	Prevention	Personalisation	Co-production	High-trust environment	A learning system	Urgent and emergency care	Community health services	Primary care	Elective care	Cancer	Diagnostics	Maternity	Use of resources	Workforce	Mental health	People with a learning disability and autistic people	Prevention and health inequalities	**How are does the programme have a five-year forward view?** (R: absence; A: broad intentions; G: full set of milestones) As set out in the benefits and further planned transformation boxes
Urgent and emergency care	Urgent and emergency care	Acute provider collaborative				X				X			X	X											Red
	Enhanced health in care homes	Community collaborative	X	X		X	X		X	X	X	X	X		X										Amber
	Ageing Well (focus on urgent community response)		X	X	X	X	X	X	X	X	X	X	X								X				Amber
Community helath services	Digital community services	Community collaborative	X	X	X	X	X	X	X	X	X	X	X	X	X	X					X			X	Amber
	End-of-life care		X	X		X	X	X	X	X	X	X													Amber
	Post-covid care		X	X	X	X	X			X	X	X	X	X	X			X			X				Amber
	Proactive care / Anticipatory care			X		X	X	X	X	X	X														Amber
	Virtual wards			X		X	X		X	X	X	X	X	X											Amber
Primary Care	Digital First	Primary care collaborative	X			X	X	X	X	X	X	X			X						X			X	Amber
	Same-day access		X	X	X	X	X	X		X	X		X		X					X	X				Red
	Tackling unwarranted variation, levelling up, and addressing inequalities														X					X	X			X	Amber
Planned care and diagnositcs	Planned care	Acute provider collaborative		X			X							X	X	X		X							Red
Cancer	Cancer	Acute provider collaborative		X													X								Red
Materity	Maternity	Acute provider collaborative	X				X			X															Red
	Maternity	NHS NEL												X					X		X	X		X	Amber
	Maternity safety and quality assurance programme	NHS NEL												X					X		X	X		X	Red

Recovering our core services and improving productivity

Analysing our transformation portfolio - ii

	Area	Programme	Lead system partner	Babies, children, and young people	Long-term conditions	Mental health	Employment and workforce	Tackling heath inequalities	Prevention	Personalisation	Co-production	High-trust environment	A learning system	Urgent and emergency care	Community health services	Primary care	Elective care	Cancer	Diagnostics	Maternity	Use of resources	Workforce	Mental health	People with a learning disability and autistic people	Prevention and health inequalities	How are does the programme have a five-year forward view? (R: absence; A: broad intentions; G: full set of milestones) As set out in the benefits and further planned transformation boxes
ICS flagship priorities	Babies, children and young people – to make north east London the best place to grow up, through early support when it is needed and the delivery of accessible and responsive services	Developing clearly defined prevention priorities for BCYP	NHS NEL	X		X		X	X		X	X			X	X										Red
		Community-based care	NHS NEL											X	X	X										Amber
		Vulnerable babies, children and young people	NHS NEL											X	X								X	X	X	Amber
		Babies, children and young people	Acute provider collaborative	X							X															Red
		Babies, children and young people	Community collaborative	X	X	X	X	X	X	X	X	X	X	X	X										X	Amber
		Best chance for babies, children, and young people	Barking and Dagenham place partnership	X	X	X		X	X	X	X		X		X	X				X					X	Amber
		Children, young people, maternity, and families	City and Hackney place partnership	X	X	X	X	X	X	X	X	X	X		X									X		Amber
		Childhood immunisations	City and Hackney place partnership	X				X	X	X	X														X	Amber
		Starting well	Havering place partnership	X	X			X	X																X	Amber
		Born well, grow well	Tower Hamlet place partnership	X	X	X		X	X	X	X	X	X										X		X	Red
		Babies, children, and young people	Waltham Forest place partnership	X	X	X	X	X	X		X		X	X		X									X	Amber
	Long-term conditions – 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	CVD	NHS NEL	X	X	X	X	X	X	X	X	X	X		X	X			X			X				Amber
		Diabetes	NHS NEL	X		X	X	X	X	X	X			X	X	X							X			Amber
		Neurosciences	NHS NEL		X			X	X	X	X			X											X	Amber
		Renal	NHS NEL	X	X	X	X	X	X	X	X	X	X	X	X	X					X				X	Red
		Respiratory	NHS NEL		X	X	X	X	X	X	X	X		X	X	X			X			X			X	Amber
		Prevention / Prohab	Barking and Dagenham, Havering and Redbridge Places	X	X	X	X	X	X	X	X	X	X	X	X	X			X		X	X			X	Amber
		Cardiology	Barking and Dagenham, Havering and Redbridge Places		X	X	X	X	X	X	X	X	X	X	X	X			X			X			X	Amber
		Diabetes	Barking and Dagenham, Havering and Redbridge Places	X	X	X	X	X	X		X		X	X	X	X						X			X	Amber
		Improving outcomes for people with long-term health and care needs	City and Hackney place partnership		X			X	X	X	X								X							Amber
		Enhanced community response	City and Hackney place partnership		X	X	X	X	X		X			X	X							X	X		X	Amber
		Cardiovascular Disease Prevention	Redbridge place partnership	X	X	X	X	X	X	X	X	X	X	X	X	X			X		X	X	X		X	Amber
	Mental health – to transform accessibility to, experience of and outcomes from mental health services and well-being support for the people of north east London	Perinatal mental health improvement network	Mental health, learning disabilities, and autism collaborative	X		X		X	X		X	X	X		X					X		X	X		X	Amber
		IAPT improvement network			X	X		X	X		X	X	X										X		X	Red
		Improving health outcomes and choice for people with severe mental illness			X	X		X	X	X	X	X	X	X									X		X	Amber
		Improving outcomes and experience for people with dementia and their carers			X	X		X	X	X	X	X	X										X		X	Amber
		Crisis improvement network		X		X		X	X		X	X	X	X	X	X						X			X	Amber
		Children and young people's mental health improvement network		X		X	X	X	X	X	X	X	X		X	X						X	X		X	Amber
		Mental Health	City and Hackney place partnership		X	X		X	X	X	X												X	X	X	Amber
		Mental Health	Havering place partnership			X	X	X	X					X	X	X			X				X		X	Amber
		Mental health	Tower Hamlets place partnership	X	X	X	X	X	X	X	X	X	X									X	X	X		Red
		Mental Health	Waltham Forest place partnership			X	X	X	X					X		X							X			Red
	Employment and workforce – to work together to create meaningful work opportunities and employment for people in north east London now and in the future	Workforce transformation	NHS NEL	X	X	X		X	X	X	X	X		X	X	X						X				Amber
	Infastructure	Digital Infastrucutre	NHS NEL																							
		Physical infastrcuture	NHS NEL																							

Analysing our transformation portfolio - iii

	Area	Programme	Lead system partner	Babies, children, and young people	Long-term conditions	Mental health	Employment and workforce	Tackling health inequalities	Prevention	Personalisation	Co-production	High-trust environment	A learning system	Urgent and emergency care	Community health services	Primary care	Elective care	Cancer	Diagnostics	Maternity	Use of resources	Workforce	Mental health	People with a learning disability and autistic people	Prevention and health inequalities	How are does the programme have a five-year forward view? (R: absence; A: broad intentions; G: full set of milestones) As set out in the benefits and further planned transformation boxes
Additional work led by provider collaboratives	Acute provoider collaborative	Critical care	Acute provider collaborative								X			X												Red
		Research and clinical trials	Acute provider collaborative								X		X													Red
		Specialist services	Acute provider collaborative		X				X		X			X	X											Red
	Mental health, learning disabilities, and autism collaborative	Learning dis abilities and autis m improvement programme	Mental health, learning disabilities, and autism collaborative	X	X	X		X		X	X	X	X	X	X	X								X		Amber
		Lived experience leadership programme		X		X	X	X			X	X	X		X								X		X	Amber
Additional work led by place partnerships	Barking and Dagenham	Ageing well	Barking and Dagenham place partnership		X	X		X	X	X		X	X	X	X	X							X			Amber
		Healthier weight		X	X			X	X						X	X										Amber
		Stop s moking		X	X	X		X	X	X					X	X									X	Amber
		Estates		X	X	X	X	X	X	X	X					X			X						X	Amber
	City and Hackney	Supporting residents with cost of living pressures	City and Hackney place partnership	X	X	X	X	X	X					X		X									X	Amber
		Population health		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Red
		Neighbourhoods programme			X	X	X	X	X		X	X	X		X	X									X	Amber
	Havering	Infrastructure and enablers	Havering place partnership	X	X	X		X	X	X	X	X											X	X		Amber
		Building community resilience		X	X	X	X	X	X	X	X	X	X												X	Amber
		St George's health and wellbeing hub		X	X	X	X	X	X	X	X	X	X		X	X			X		X	X	X	X	X	Amber
		Living well		X	X	X	X	X	X	X	X				X	X							X		X	Amber
		Ageing Well			X				X	X				X	X	X									X	Amber
	Newham	Frailty model	Newham place partnership		X	X		X	X	X				X		X							X		X	Amber
		Neighbourhood model		X	X	X	X	X	X	X	X	X	X		X	X										Amber
		Population growth		X	X	X	X	X	X	X	X	X	X		X	X						X				Red
	Redbridge	Health inequalities	Redbridge place partnership	X	X	X	X	X	X	X	X	X	X	X	X	X			X		X	X		X	X	Red
		Accelerator priorities		X	X	X	X	X	X	X	X	X	X	X	X	X			X		X	X	X		X	Amber
		Development of Ilford Exchange Health and Care Centre		X	X	X	X	X	X	X	X	X	X		X	X					X	X			X	Amber
	Tower Hamlets	Living well	Tower Hamlets place partnership		X			X	X		X	X	X			X			X						X	Red
		Promoting independence			X	X		X	X	X	X	X	X		X											Red
	Waltham Forest	Centre of Excellence	Waltham Forest place partnership		X	X	X	X	X	X	X	X	X	X	X	X					X	X			X	Red
		Care closer to home			X	X	X	X	X	X	X	X	X	X	X	X							X			Amber
		Home first			X	X	X	X	X	X	X	X	X	X	X	X						X				Amber
		Learning dis abilities and autis m																					X	X	X	Red
		Wellbeing					X	X	X	X	X	X	X	X	X							X			X	Red
Additional work led by NHS NEL on behalf of the system	Prevention and health inequalities	Tobacco dependence treatment programme	NHS NEL	X	X	X		X	X	X	X	X	X	X			X	X		X					X	Amber
		NEL homelessness programme			X	X	X	X	X	X	X	X	X	X	X	X							X		X	Amber
		Anchors programme				X	X	X	X	X	X	X	X													Amber
		Net zero (ICS Green Plan)		X	X	X	X	X	X	X	X	X	X													Amber
		NEL refugees and asylum seeker working group		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Amber
	Unplanned care	Discharge pathways programme												X		X										Amber

Next steps

- 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 the more specific challenges called out in the first half of this plan is more variable.
- Our shared task is now 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 local people.

Technical work

Tightening descriptions of the current programmes of work as the basis to inform prioritisation, especially:

- the **quantifiable beneficial impact** on residents, 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, 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.

7. National planning requirements lookup tables

Links to other plans and strategies

NHSE guidance described a number of areas Joint Forward Plans should cover, many of which are covered within existing plans and strategies (held and/or developed by various partners across the system) or those under development. Rather than duplicate those plans within the JFP we have referenced them below

Additional plan requirements	
Requirement	**Strategies and plans already developed**
Describing the health services for which the ICB proposes to make arrangements	Integrated care strategy; all delivery plans set out in the reference document; operating plan
Duty to promote integration	Integrated care strategy; Mutual accountability framework for place partnerships and provider collaboratives; ICB governance review
Duty to have regard to wider effect of decisions	Integrated care strategy; NEL Quality Approach Framework; NEL ICS Green Plan
Financial duties	NEL Financial Strategy
Implementing any JLHWS	Integrated care strategy; place-based transformation plans (see reference document)
Duty to improve quality of services	NEL Quality Approach Framework
Duty to reduce inequalities	Integrated care strategy; all transformation plans set out in the accompanying document
Duty to promote involvement of each patient	Integrated care strategy; and references to personalisation in transformation plans set out in the reference document)
Duty to involve the public	NEL Working with People and Communities Strategy
Duty to promote patient choice	ICB Governance Handbook

Additional plan requirements	
Requirement	**Strategies and plans already developed**
Duty to obtain appropriate advice	NHS NEL governance handbook
Duty to promote research and innovation	Barts Life Sciences; Research Engagement Network partnering with UCLP and North Thames Clinical Research Network
Duty to promote education and training	Integrated care strategy; employment and workforce transformation plan; ICS People Plan under development
Duty as to climate change, etc.	NEL ICS Green Plan
Addressing the particular needs of children and young persons	Integrated care strategy; BCYP transformation plans (see reference document)
Addressing the particular needs of victims of abuse	Place-based plans and Multi Agency Risk Assessment Conference
Procurement and supply chain	NEL Procurement Group; ‘Evaluating and embedding social values in procurement’ (ELFT); NEL Anchor Charter
Population health management	NEL PHM Roadmap
System development	Mutual accountability framework for place partnerships and provider collaboratives; ICB governance review
Supporting wider social and economic development	NEL Anchor Charter

Annex 8. Engagement plan

How we engage with our partners on the Joint Forward Plan

- We have involved an extensive range of people in the development of our Joint Forward Plan and have been guided by our ICS Strategy Task & Finish Group to ensure partnership co-design.
- We now embark on a wider engagement with all our partners across the health and care landscape in north east London. This will involve all our Place-based Partnerships, our Provider Collaboratives and the Health and Well-being Boards. Furthermore, we will also engage with other key stakeholders such as our voluntary and community sector, our care providers as well as local residents through our Big Conversation. This will then be approved through the formal governance within our ICS: the ICP Steering Group, the ICB Board and the ICP Full Meeting.
- Part of the conversation will be focussed on this year's Joint Forward Plan to ensure it represent our whole system plan. In addition, we want to explore how we learn from this year's process to enable our joint planning to evolve over the year and informs how we develop the next year's Joint Forward Plan. This will be the start of a continuous dialogue and process across our partnership towards operating fully as a learning system.
- A high-level timeline has been included below.

•ICS Strategy T&F Group
•ICP Steering Group
•ICB Board
•EMT
•Exec Committee to the ICB Board
•ICP Full Meeting

- Place-based Partnerships x 7
- Health and Well-being Boards x 8
- Voluntary and community sector engagement
- Care providers engagement
- Big Conversation with the local residents

•ICS Strategy T&F Group
•ICP Steering Group
•ICB Board
•EMT
•Exec Committee to the ICB Board
•ICP Full Meeting

Annex 9A - demand projections

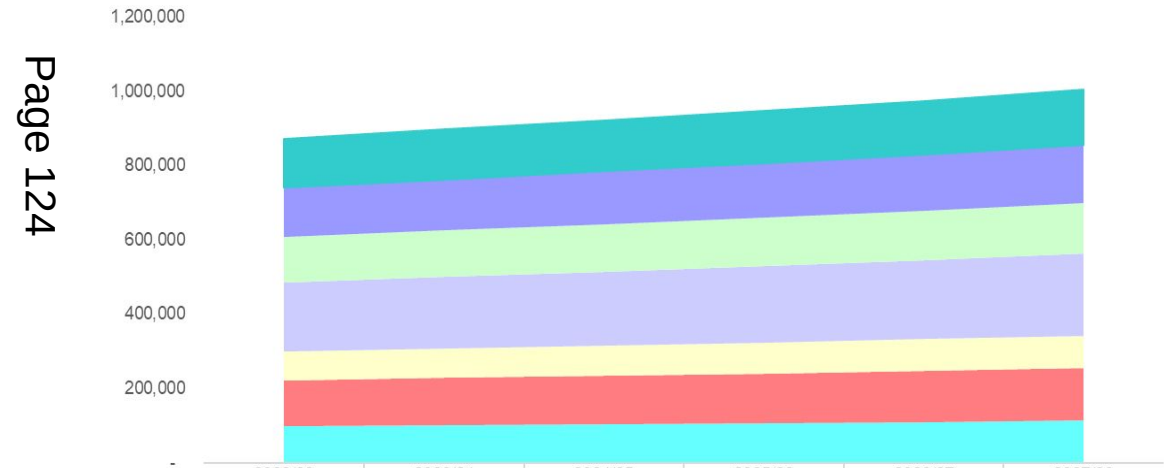
Demand projections for UEC

A&E demand is expected to grow – as a result of demographic and non-demographic growth – by 15.3% during the five-year period. That would equate to around 133,000 extra A&E attendances.

Unplanned care is also expected to grow – as a result of demographic and non-demographic growth – by 15.8% during the five-year period, which would equate to an extra 38,500 non-elective admissions.

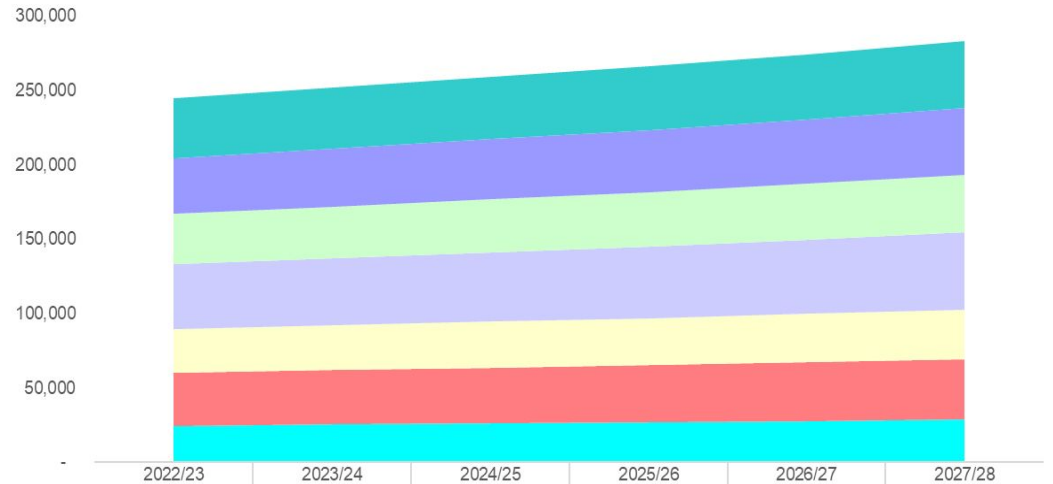
Newham (19.1%) and Tower Hamlets (18.7%) are projected to see the largest increases.

Projected growth in A&E demand 2022/23 - 2027/28



	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Waltham Forest	130,645	134,283	137,619	140,667	144,002	147,605
Tower Hamlets	132,844	137,282	141,742	146,426	151,178	156,433
Redbridge	120,773	124,244	127,647	130,578	133,626	136,859
Newham	187,709	193,620	199,411	205,600	212,669	220,729
Havering	76,481	78,653	80,817	82,821	84,990	87,363
City and Hackney	123,718	127,158	130,435	133,818	137,329	140,915
Barking and Dagenham	97,839	100,877	103,839	106,565	109,635	113,007

Projected growth in unplanned care demand 2022/23 - 2027/28

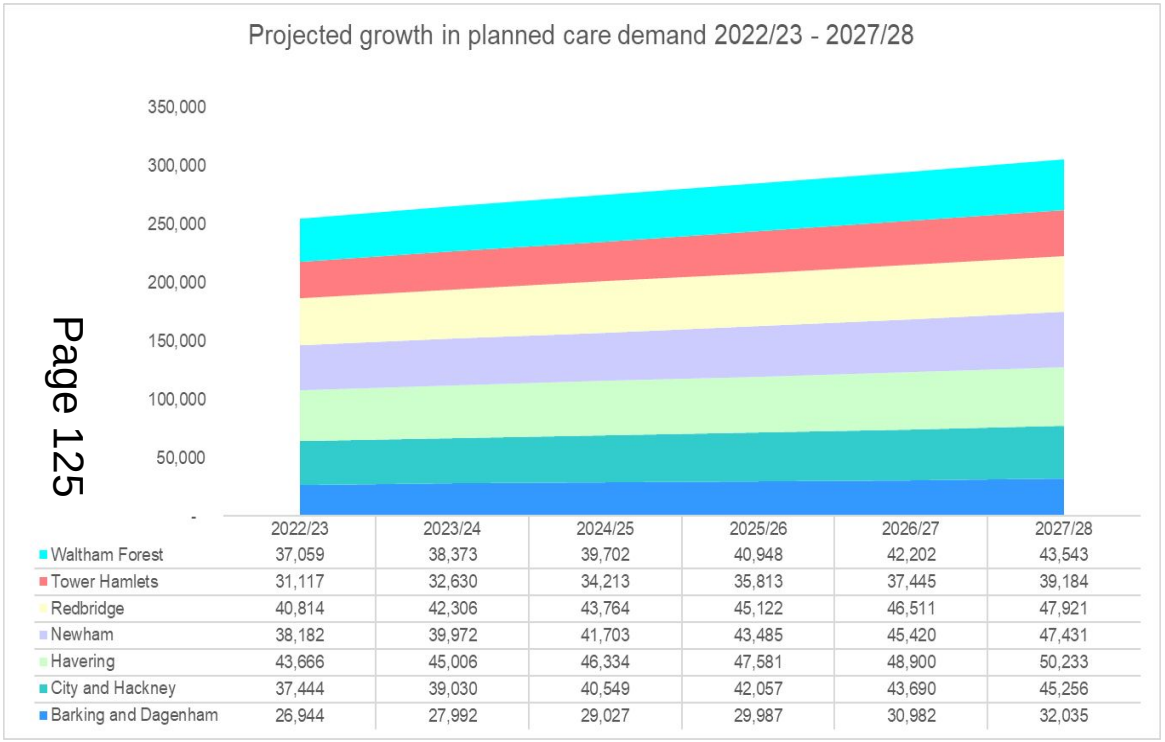


	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Waltham Forest	40,101	41,213	42,235	43,141	44,162	45,305
Tower Hamlets	37,517	38,849	40,159	41,523	42,921	44,536
Redbridge	33,730	34,699	35,659	36,528	37,466	38,493
Newham	43,941	45,394	46,832	48,359	50,173	52,315
Havering	29,208	30,056	30,903	31,684	32,528	33,485
City and Hackney	35,553	36,530	37,472	38,452	39,510	40,616
Barking and Dagenham	24,531	25,287	26,033	26,756	27,580	28,496

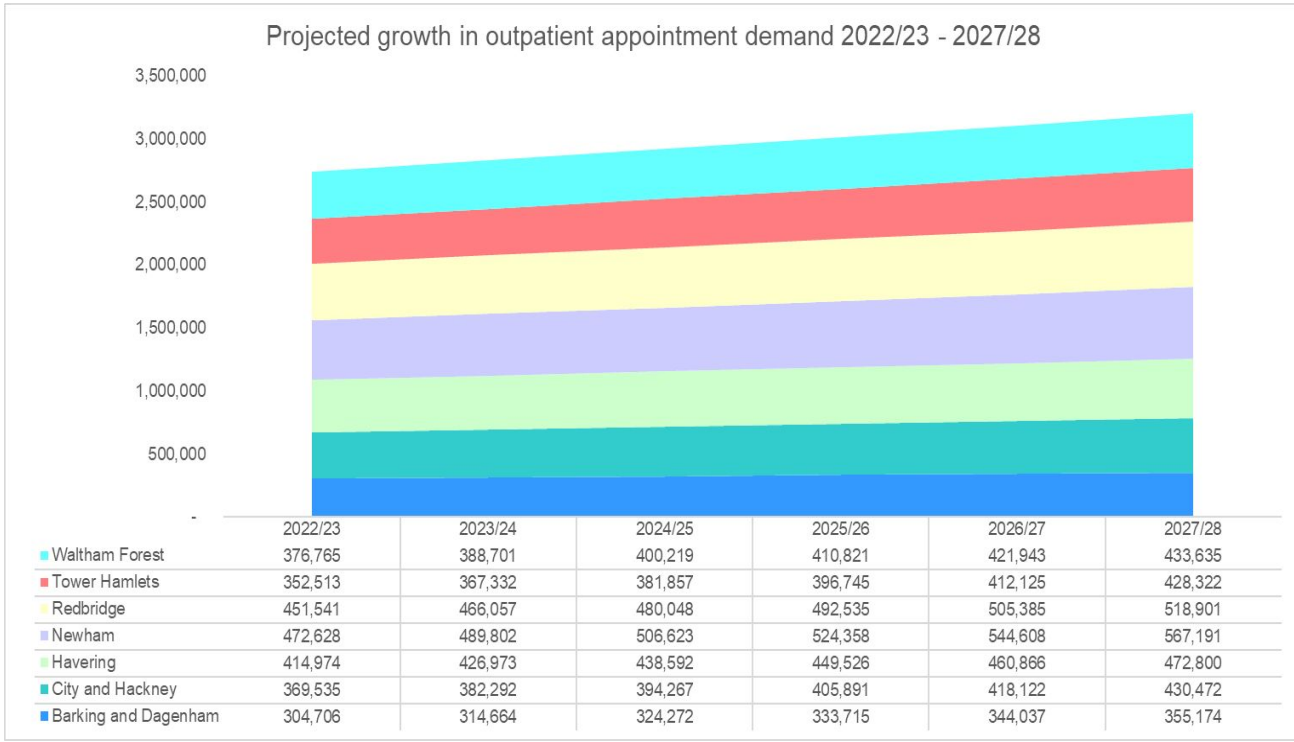
Figures are based on modelling by the NEL Insights Team which uses GLA population growth projections

Demand projections for planned care

Across north east London, demand for planned care is expected to grow by 19.7% between 2022/23 and 2027/28, or by around 4% per year.



	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Waltham Forest	37,059	38,373	39,702	40,948	42,202	43,543
Tower Hamlets	31,117	32,630	34,213	35,813	37,445	39,184
Redbridge	40,814	42,306	43,764	45,122	46,511	47,921
Newham	38,182	39,972	41,703	43,485	45,420	47,431
Havering	43,666	45,006	46,334	47,581	48,900	50,233
City and Hackney	37,444	39,030	40,549	42,057	43,690	45,256
Barking and Dagenham	26,944	27,992	29,027	29,987	30,982	32,035



	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Waltham Forest	376,765	388,701	400,219	410,821	421,943	433,635
Tower Hamlets	352,513	367,332	381,857	396,745	412,125	428,322
Redbridge	451,541	466,057	480,048	492,535	505,385	518,901
Newham	472,628	489,802	506,623	524,358	544,608	567,191
Havering	414,974	426,973	438,592	449,526	460,866	472,800
City and Hackney	369,535	382,292	394,267	405,891	418,122	430,472
Barking and Dagenham	304,706	314,664	324,272	333,715	344,037	355,174

Demand projections for diagnostics

Across north east London demand for imaging diagnostics is expected to grow by around 18%, or 3.6% per year

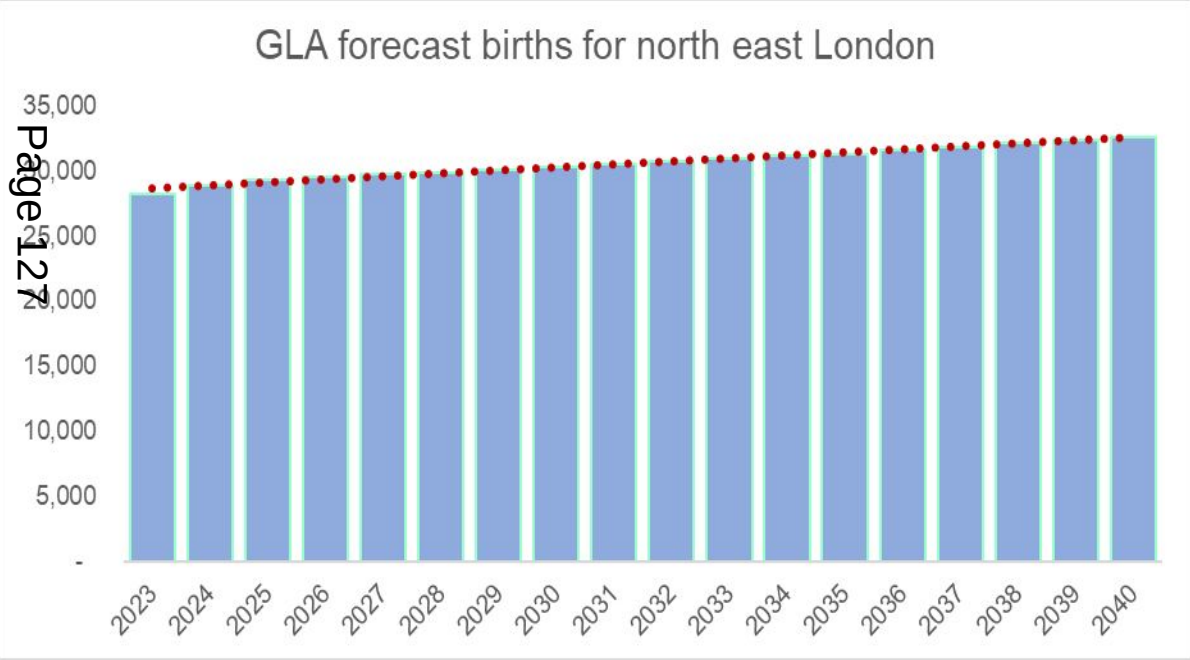
Imaging diagnostics projected demand growth 2022/23 - 2027/28								
	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	Growth	5 year trend
Cone Beam CT	1,515	1,557	1,599	1,643	1,690	1,738	14.7%	
CT Scan	214,182	223,675	233,001	242,000	251,320	261,346	22.0%	
Endoscopy	1,668	1,744	1,818	1,888	1,962	2,041	22.4%	
Fluoroscopy	29,532	30,780	31,998	33,160	34,398	35,674	20.8%	
Medical photography	14	14	15	16	16	18	28.6%	
MRI	199,421	206,903	214,152	221,127	228,537	236,128	18.4%	
Nuclear Medicine	17,546	18,281	18,984	19,665	20,389	21,148	20.5%	
PET-CT Scan	6,098	6,388	6,682	6,955	7,247	7,539	23.6%	
SPECT Scan	1,253	1,302	1,344	1,385	1,424	1,463	16.8%	
Ultrasound	565,530	583,749	601,181	617,962	635,933	655,186	15.9%	
X-ray	884,831	918,064	950,447	981,507	1,014,316	1,048,943	18.5%	
All imaging	**1,921,590**	**1,992,457**	**2,061,221**	**2,127,308**	**2,197,232**	**2,271,224**	**18.2%**	

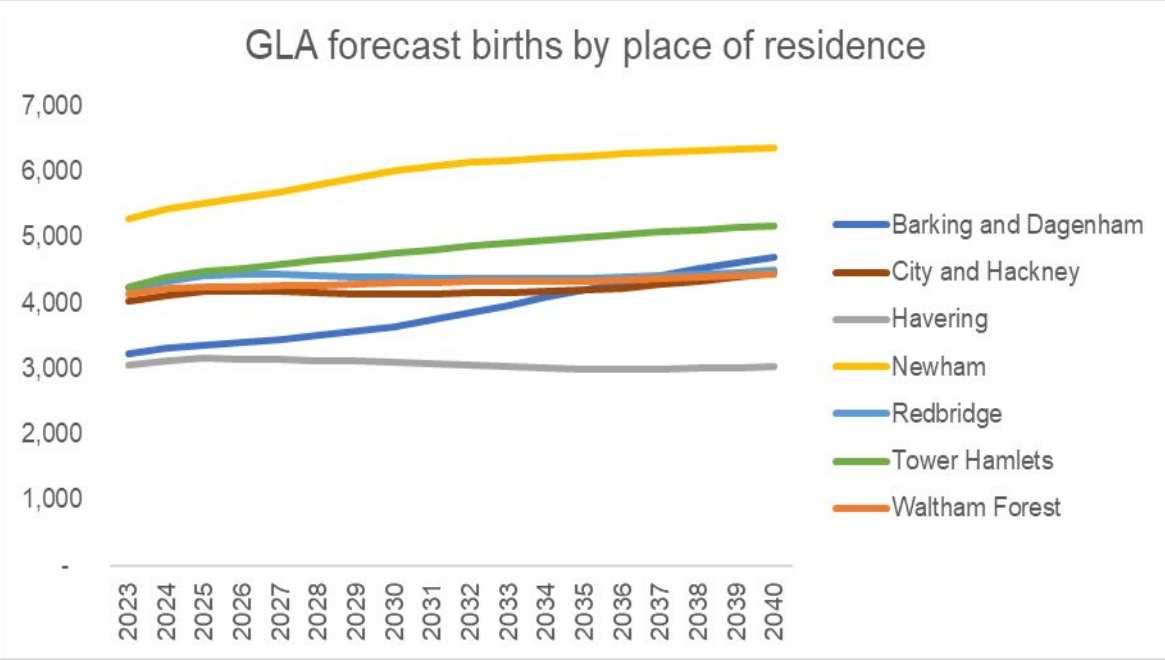
Demand projections for maternity

Total births in north east London is projected to grow by almost 16% between 2023 and 2040, or 0.9% per year

In Barking and Dagenham growth is projected to be 47% over the same period, or 2.8% per year.

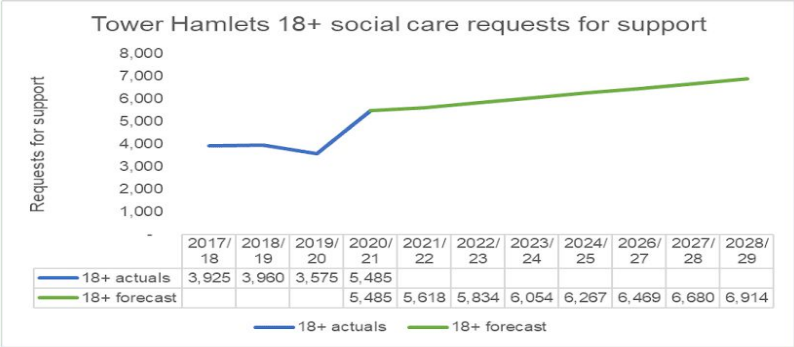
Havering forecast a reducing number of births between 2026 and 2036.





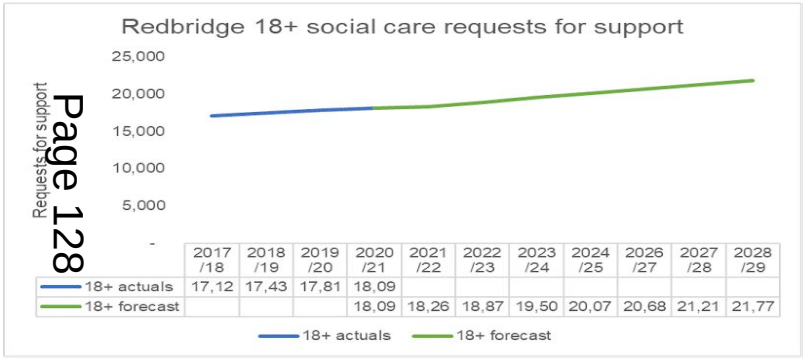
Demand projections for social care

- This forecast is based on social care social care data showing number of requests for support received from new clients aged 18+.
- Approach to high level model:
  - Demographic growth assumption based on GLA housing led population projection (2021-based identified capacity scenario)
  - Non-demographic growth assumption of 1% p.a. agreed with client
  - Trend-based forecast uses an ordinary least squares linear regression model
- We will work with our local authority partners to develop this model further.



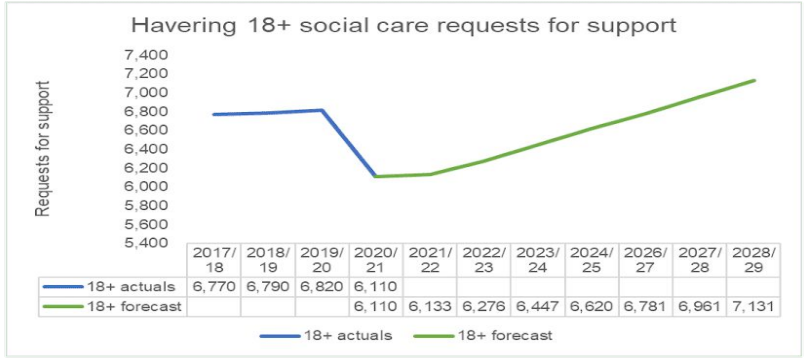
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	3,925	3,960	3,575	5,485							
18+ forecast				5,485	5,618	5,834	6,054	6,267	6,469	6,680	6,914

18+ actuals 18+ forecast



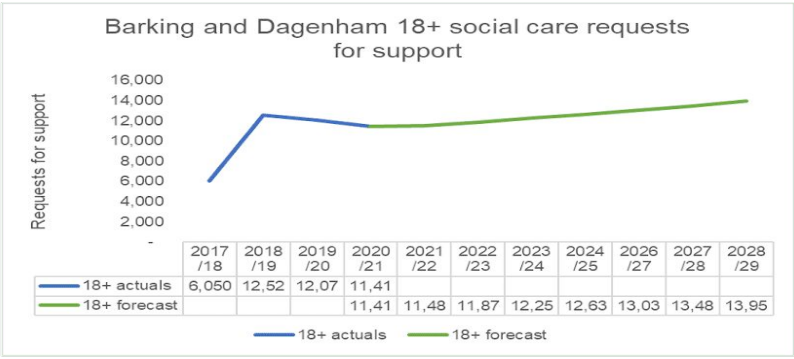
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	17,12	17,43	17,81	18,09							
18+ forecast				18,09	18,26	18,87	19,50	20,07	20,68	21,21	21,77

18+ actuals 18+ forecast



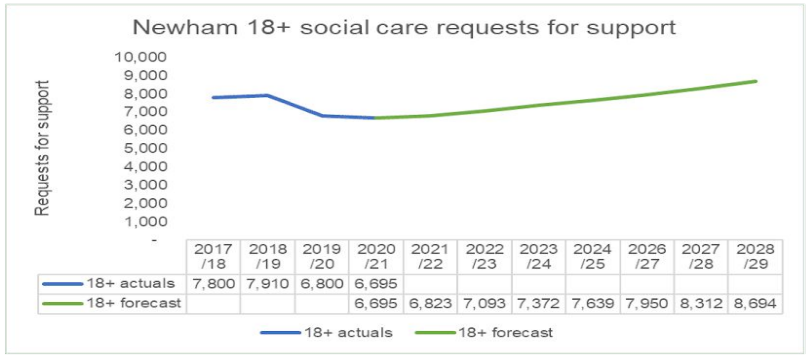
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	6,770	6,790	6,820	6,110							
18+ forecast				6,110	6,133	6,276	6,447	6,620	6,781	6,961	7,131

18+ actuals 18+ forecast



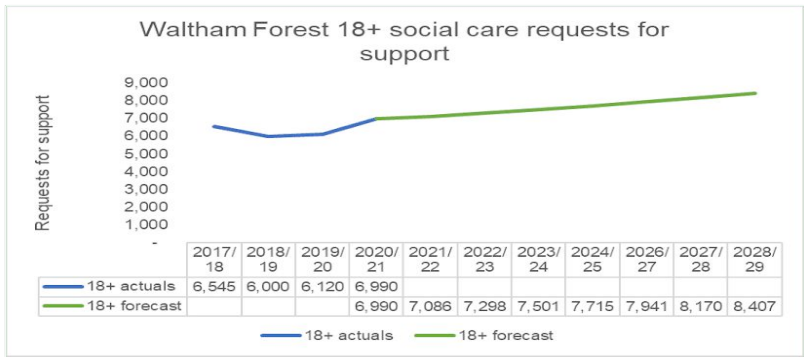
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	6,050	12,52	12,07	11,41							
18+ forecast				11,41	11,48	11,87	12,25	12,63	13,03	13,48	13,95

18+ actuals 18+ forecast



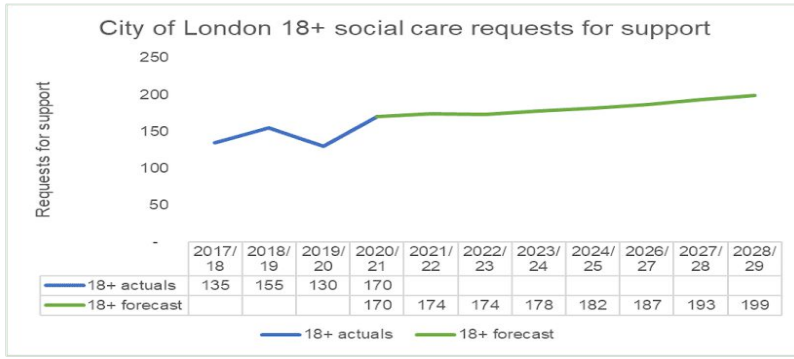
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	7,800	7,910	6,800	6,695							
18+ forecast				6,695	6,823	7,093	7,372	7,639	7,950	8,312	8,694

18+ actuals 18+ forecast



	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	6,545	6,000	6,120	6,990							
18+ forecast				6,990	7,086	7,298	7,501	7,715	7,941	8,170	8,407

18+ actuals 18+ forecast



	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	135	155	130	170							
18+ forecast				170	174	174	178	182	187	193	199

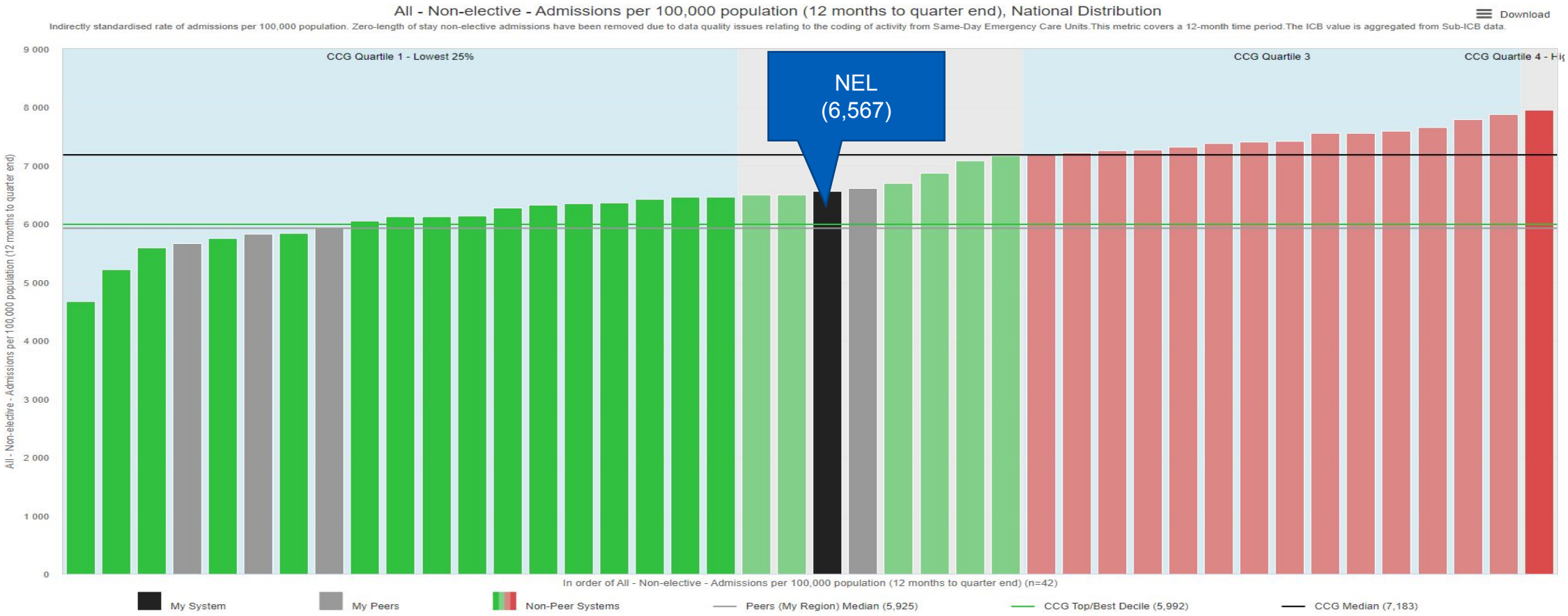
18+ actuals 18+ forecast

Annex 9B - Benchmarking

Urgent and Emergency care benchmarking

Non-elective admission rates

Improving non-elective admission rates to the London median would mean 642 fewer admissions per 100,000 population, or an improvement of just under 10%

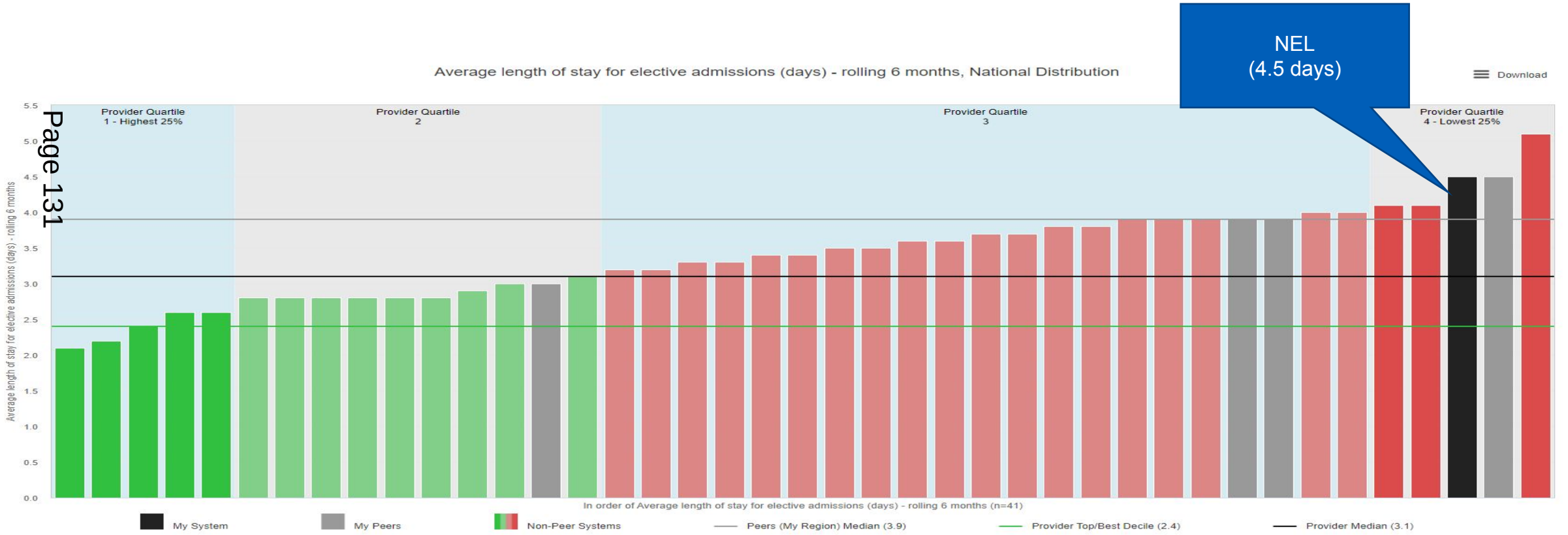


Data is from 'Model Health System' and covers a 12-month period, ending Q2 2022/23.

Elective care benchmarking

LOS for elective admissions

Improving length of stay to London median (3.9 days) would mean 13% fewer bed days. Moving to the England median would mean 31% fewer beds days.



Data is from 'Model Health System' and looks at average LOS for elective admissions, excluding day cases. It covers a 6-month period, ending Q3 2022/23.

Annex 9C - improvement opportunities data

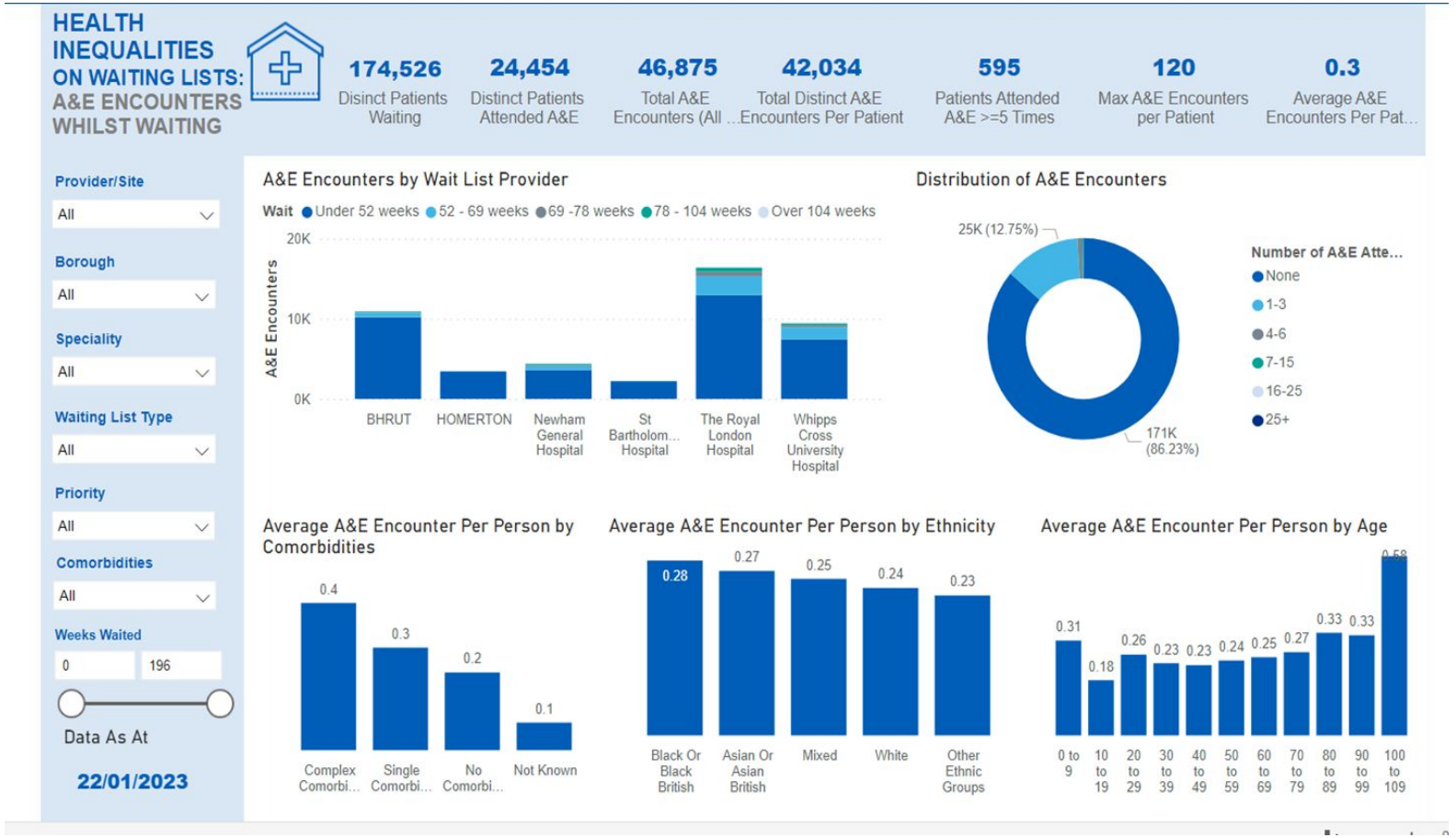
UEC – opportunities for improvement

Waiting list management

There are currently ~174,000 people waiting for elective care. Of that group around 600 have attended A&E 5 times or more while waiting.

The majority of people waiting (86%) have not attended A&E while waiting, however the remaining 14% have attended A&E almost 47,000 times while waiting.

One person waiting (for non-admitted care) has attended A&E 120 times whilst on the waiting list (they have no recorded comorbidity).



UEC – opportunities for improvement

Avoidable admissions

Emergency admissions for conditions not usually requiring hospital treatment

The indicator measures the number of emergency admissions to hospital in England for acute conditions such as ear/nose/throat infections, kidney/urinary tract infections and angina, among others, that could potentially have been avoided if the patient had been better managed in primary care.

The NEL average rate of admissions for conditions not usually requiring hospital treatment is 8.8 admissions per 1,000 patient population. The rate among ten practices with highest rates is between 19.9 and 13.6.

Six of the top ten rates are from GP Practices within the Barking and Dagenham, three from Havering practices and one from City and Hackney.

Among the 273 NEL practices included as operational during the period of this analysis, 37 practices have a rate that is identified as a (statistically significant) high outlier compared to rates at all NEL practices and accounting for the underlying practice populations

Unplanned hospitalisations for chronic ambulatory care sensitive conditions

This indicator measures how many people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. These conditions include, for example, diabetes, epilepsy and high blood pressure.

This outcome is concerned with how successfully NHS health services manages to reduce emergency admissions for all long-term conditions where optimum management can be achieved in the community.

The NEL average rate of unplanned hospitalisations for chronic ambulatory care sensitive conditions is admissions is 8.2 admissions per 1,000 patient population. The rate among ten practices with highest rates is between 16.4 and 13.3.

Nine of the top ten rates are from GP Practices within the Barking & Dagenham, one is from a Waltham Forest Practice.

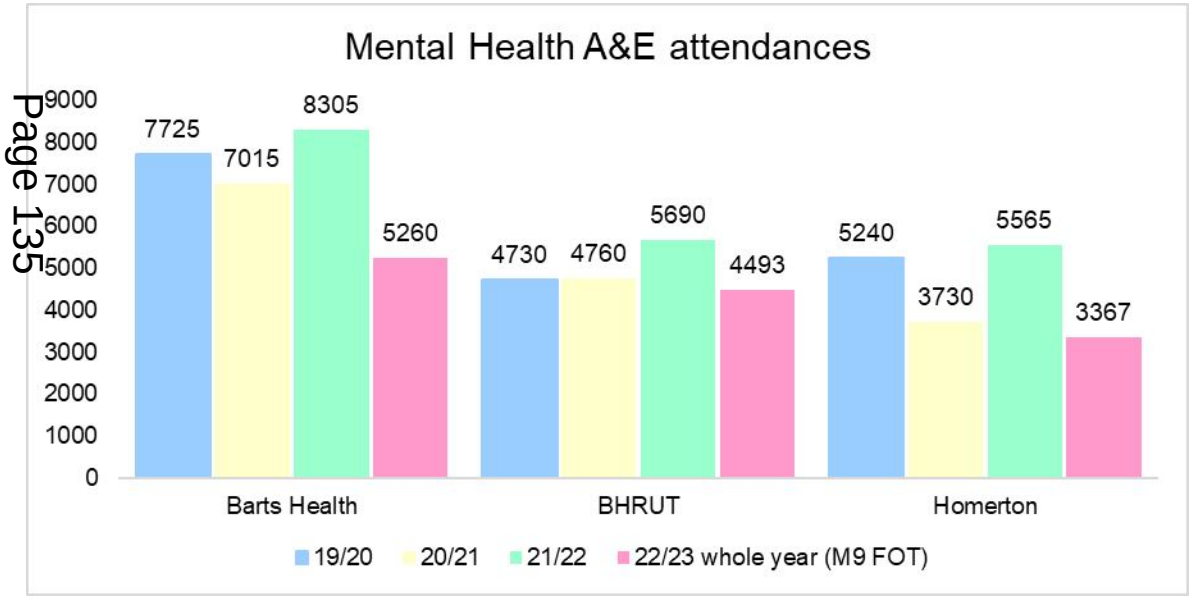
Among the 273 NEL practices included as operational during the period of this analysis, 46 practices have a rate that is identified as a (statistically significant) high outlier compared to rates at all NEL practices and accounting for the underlying practice populations

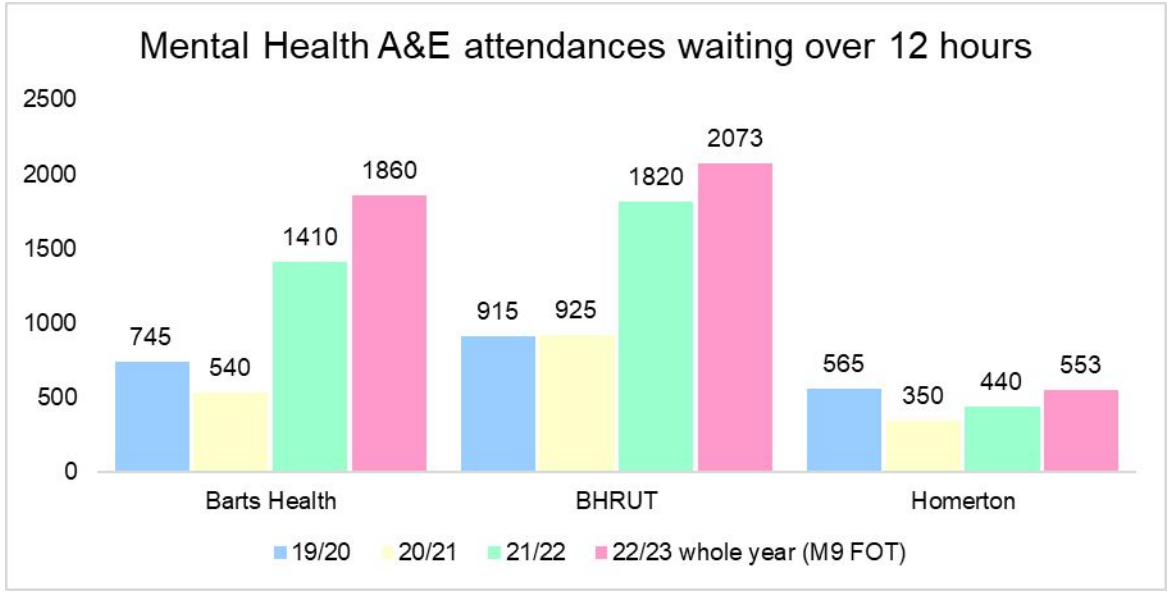
UEC – opportunities for improvement

Mental health patients in A&E

There appears to be a reduction in the number of mental health patients attending A&E across NEL, while the number waiting over 12 hours has been increasing.

During 22/23 (July-Sept) ELFT and NELFT averaged 90.9% and 89.9% overnight bed occupancy respectively.





The north east London health and care system – children's and adult social care services

The size of children's social care in East London

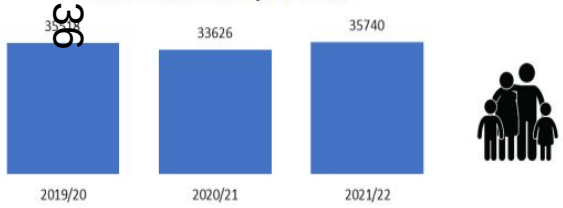
Children social care numbers

1st April 2021-31st March 2022

Children *during the year* — Children *at 31st March 2022*

Referrals	Assessments	s47 investigations	Child Protection	Children looked after	Care experienced
*35,505** (Hackney figures based on 2019/20)	33,243* (Hackney figures based on 2019/20)	9,822* (Hackney figures based on 2019/20)	*2,743** (Hackney figures based on 2019/20)	2,471	2,213* (aged 17)

Children in need 3-year trend



The total number of children in need at any point in the last three years has increased to 35,740 children, this figure includes children looked after and care experienced young people aged 17 to 21 years of age. Responsibility for care experienced young people can extend to their 25th birthday.

(Hackney numbers have been based on 2019/20 figures)

	Gross Current Expenditure (£'000s)	Number of requests for support received from new clients		New clients with an episode of ST-Max care and a known sequel		Long Term Support during the year		Support provided to carers during the year
		18 to 64	65 and over	18 to 64	65 and over	18 to 64	65 and over	
City and Hackney (figures from 19/20	£94,902	3,925	2,795	40	230	1,350	2,110	1,595
Tower Hamlets	£109,262	2,965	2,170	105	295	1,735	2,015	1,900
Barking and Dagenham	£65,615	5,770	5,055	190	790	1,195	1,650	1,000
Havering	£76,617	1,290	5,055	120	1,510	1,070	2,610	2,525
Newham	£122,066	3,555	3,845	220	260	2,240	2,620	3,690
Redbridge	£96,884	2,945	6,500	90	665	1,620	2,630	3,695
Waltham Forest	£97,153	2,545	5,460	200	980	1,605	2,160	755
NEL Total	**£662,499**	**22,995**	**30,880**	**965**	**4,730**	**10,815**	**15,795**	**15,160**

The north east London health and care system – community care services

Community service mapping – Unplanned / planned

Community Service	Barking & Dagenham	City & Hackney	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest
Unplanned Care services							
2 hour crisis response (Urgent Community Response/Rapid Response)	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Support to nursing homes	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Walk-in centre / UTC /	PELC	Homerton	PELC	BARTS	PELC	BARTS	NELFT
Planned Care Services							
Audiology	Communitas / In Health	InHealth, Scrivens Outside Clinic, Specsavers, RNID	Communitas/In Health	BARTS	Communitas/In Health	BARTS	Scrivens, Outside Clinics, Specsavers
Neurorehabilitation (multi-disciplinary) stroke, head injury and neurological conditions	NELFT/ BHRUT	Homerton	NELFT/BHRUT	ELFT /BARTS	NELFT/BHRUT	BARTS	BARTS
Bedded rehabilitation	NELFT	ELFT	NELFT	ELFT	NELFT	ELFT	NELFT
Community stroke rehab services	NELFT	Homerton	NELFT	ELFT	NELFT	BARTS	BARTS
Community rehab	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Discharge to assess	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
District Nursing	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Early supported Stroke discharge	NELFT	Homerton	NELFT	ELFT	NELFT	BARTS	BARTS
Falls Services	NELFT	MRS independent living	NELFT	ELFT	NELFT	ELFT	NELFT
Integrated discharge	NELFT	Homerton	NELFT	ELFT	NELFT		NELFT
Pall care & EOL - home based	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Pall care & EOL - bed based	Marie Curie / St Francis	St Joseph's	St Joseph's / St Francis	St Joseph's	St Joseph's / St Francis	St Joseph's	St Joseph's

Community service mapping – Adult therapies, equipment & coordination

Community Service	Barking & Dagenham	City & Hackney	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest
Adult therapies							
MSK	NELFT	Homerton	NELFT	BARTS	NELFT	BARTS	BARTS
Nutrution & dietetics	NELFT	Homerton	NELFT	x	NELFT	BARTS	NELFT
Orthotics	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Podiartic surgery	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Podiatry	NELFT	Hoxton Health / Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
SLT	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Equipment and technology							
Assistive teleheath	x	x	x	ELFT	x	x	x
Community equipment	NELFT	Homerton / LA	NELFT	x	NELFT	ELFT	x
Wheelchair services	AJM Wheelchairs	Homerton	AJM Wheelchairs	Enabled living	AJM Wheelchairs	Whizz Mobility	AJM Wheelchairs
specilaist seating	NELFT	x	NELFT	x	NELFT	x	x
Care Coordination							
Care coordination	NELFT	Primary care	NELFT	Coordinated GP fed	NELFT		NELFT
CHC - continuing care packages	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT

Community Service Mapping – specialist services

Community Service	Barking & Dagenham	City & Hackney	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest
Specialist nurses - out side of hospital							
Cardiac rehab	BHRUT	Homerton	BHRUT	ELFT	BHRUT	BARTS	BARTS
Community ENT	Communitas Clinics	Communitas	Communitas Clinics	Communitas	Communitas Clinics	Communitas Clinics	Communitas Clinics
community dermatology	DMC HEALTHCARE LTD	Homerton	MC HEALTHCARE LT	t first social enterprise	DMC HEALTHCARE LTD	x	ESS Primary Care Solutions Ltd
Community Gynae	x	Homerton	x	t first social enterprise	x	x	ESS Primary Care Solutions Ltd
Contienence	AQP WF adults	Homerton	NELFT	x	NELFT	ELFT	NELFT
Community Urology	x	x	x	t first social enterprise	x	x	x
Diabetes	NELFT	Homerton	NELFT	ELFT	NELFT	BARTS	NELFT
Maintaining Health and Wellbeing including managing long term conditions	NELFT	x	NELFT	x	NELFT	Primary care	x
diabetes education	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Heart Failure	NELFT	Homerton	NELFT	x	NELFT	BARTS	x
Lymphodema	Accelerate	Accelerate	Accelerate	Accelerate	Accelerate	Accelerate	Acclerate
Pain management	x	Homerton / MSK	x	x	x	BARTS	x
Parkinsons servive	NELFT	Homerton	NELFT	x	NELFT	x	x
Phlebotomy	NELFT /PCNs	Homerton / GP Confed	NELFT /PCNs	ELFT /PCNs	NELFT /PCNs	PCNS	NELFT
Home oxygen assessment services	NELFT	Homerton	NELFT	BARTS	NELFT	BARTS	BARTS
Domicilary Phlebotomy	NELFT	GP Confed?	NELFT	ELFT	NELFT	PCNS	NELFT
Pulmonary rehab	NELFT	Homerton	NELFT	ELFT	NELFT	BARTS	NELFT
Respiratory Asthma / COPD / other	NELFT	Homerton	NELFT	x	NELFT	BARTS	NELFT
Sickle servie and Thalassaemia	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Spirometry	GP federation	Homerton / GP red	GP federation	Primary care	GP federation	primary care	NELFT
Tissue Viability	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT

Annex 9D - transformation portfolio

The transformation portfolio:

core elements of high-quality care and a sustainable system

Core elements of high-quality care and a sustainable system (taken from the 'Recovering our core services and improving productivity' section of NHS operating guidance)			
Service area	Programme	Lead system partner	Page*
Urgent and emergency care	Urgent and emergency care	Acute provider collaborative	8
	Enhanced health in care homes	Community collaborative	9
	Ageing well (focussed on urgent community response)		10
	Urgent & emergency care	B&D, Havering, and Redbridge place partnerships	11
	Improving outcomes for people with long term health and care needs - Enhanced community response	City and Hackney place partnership	12
	Out of hospital - Unplanned Care, Admission Avoidance	Newham place partnership	13
		Tower Hamlets place partnership	14
		Waltham Forest place partnership	15
	Out of hospital - Unplanned Care (Demand & Capacity)	Newham place partnership	16
		Tower Hamlets place partnership	17
		Waltham Forest place partnership	18
Community health services	Digital community services	Community collaborative	19
	End-of-life care		20
	Post-covid care		21
	Proactive care / Anticipatory care		22
	Virtual wards		23
	Community Health Services Transformation		24
	Out of Hospital Unplanned Care Specialist Pathway Programme (Stroke, Neuro and EOLC)	Newham place partnership	25
		Tower Hamlets place partnership	26
		Waltham Forest place partnership	27

The transformation portfolio:

core elements of high-quality care and a sustainable system

Core elements of high-quality care and a sustainable system (taken from the 'Recovering our core services and improving productivity' section of NHS operating guidance)			
Service area	Programme	Lead system partner	Page*
Primary care	Digital First	Primary care collaborative	28
	Same-day access		29
	Tackling unwarranted variation, levelling up and addressing inequalities		30
Planned care and diagnostics	Planned care	Acute provider collaborative	31
Cancer	Cancer alliance		32
Maternity	Maternity		33
	Maternity	NHS NEL	34
	Maternity safety and quality assurance programme	NHS NEL	35

The transformation portfolio:

additional local strategic priorities

Additional local strategic priorities			
Priority	Programme	Lead system partner	Page*
Babies, children and young people – to make north east London the best place to grow up, through early support when it is needed and the delivery of accessible and responsive services	Developing clearly defined prevention priorities for BCYP	NHS NEL	36
	Community based care	NHS NEL	37
	Vulnerable babies, children and young people	NHS NEL	38
	Babies, children, and young people	Community collaborative	39
	Best chance for babies, children, and young people	Barking and Dagenham place partnership	40
	Children, young people, maternity, and families	City and Hackney place partnership	41
	Childhood immunisations	City and Hackney place partnership	42
	Starting well	Havering place partnership	43
	Autism (ASD) Programme	B&D, Havering, and Redbridge place partnerships	44
	Paediatric Integrated Nursing Service (PINS)		45
	Tier 3 NICE compliant Paediatric Obesity		46
	SEND Therapy Provision		47
	Babies, Children and Young People	Newham place partnership	48
	Born well, grow well	Tower Hamlets place partnership	49
	Babies, children, and young people	Waltham Forest place partnership	50

The transformation portfolio:

additional local strategic priorities

Additional local strategic priorities			
Priority	Programme	Lead system partner	Page*
Long-term conditions (NEL LTC programmes delivered as part of the LTC and specialised services clinical networks)	CVD	NHS NEL	51
	Diabetes	NHS NEL	52
	Neurosciences	NHS NEL for LTC and APC for specialised services	53
	Renal	NHS NEL for LTC and APC for specialised services	54
	Respiratory	NHS NEL for LTC and APC for specialised services	55
	HIV	NHS NEL for LTC and APC for specialised services	56
	Hepatitis and liver	NHS NEL for LTC and APC for specialised services	57
	Haemoglobinopathy	NHS NEL for LTC and APC for specialised services	58
	Prevention / Prohab	B&D, Havering, and Redbridge place partnerships	59
	Diabetes		60
	Cardiology		61
	Diabetes	Tower Hamlets, Newham and Waltham Forest place partnerships	62
	Cardiology		63
	Respiratory		64
	Improving outcomes for people with long-term health and care needs	City and Hackney place partnership	65
	Enhanced community response	City and Hackney place partnership	66
	Cardiovascular disease prevention	Redbridge place partnership	67

The transformation portfolio:

additional local strategic priorities

Additional local strategic priorities			
Priority	Programme	Lead system partner	Page*
Mental health – to transform accessibility to, experience of and outcomes from mental health services and well-being support for the people of north east London	Perinatal mental health improvement network	Mental health, learning disabilities, and autism collaborative	68
	IAPT improvement network		69
	Improving health outcomes and choice for people with severe mental illness		70
	Improving outcomes and experience for people with dementia		71
	Crisis improvement network		72
	CYP mental health improvement network		73
	Mental Health	City and Hackney place partnership	74
	Mental health	Havering place partnership	75
	Adult Mental Health	Newham place partnership	76
	Mental Health	Tower Hamlets place partnership	77
	Mental Health	Waltham Forest place partnership	78
Employment and workforce – to work together to create meaningful work opportunities and employment for people in north east London now and in the future	Workforce transformation	NHS NEL	79
	BHR Health and Care Workforce Academy	B&D, Havering, and Redbridge place partnerships	80
Infrastructure	Digital infrastructure	NHS NEL	81
	Physical infrastructure		85

The transformation portfolio:

further local priorities

Further local priorities		
Led by	Programme	Page*
Acute provider collaborative	Critical care	86
	Research and clinical trials	87
	Specialist services (also see p53 to 58)	88
Mental health, learning disabilities, and autism collaborative	Lived experience leadership programme	89
	Learning disabilities and autism improvement programme	90
Barking and Dagenham place partnership	Ageing well	91
	Healthier weight	92
	Stop smoking	93
	Estates	94
City and Hackney place partnership	Supporting with the cost of living	95
	Population health	96
	Neighbourhoods programme	97
Havering place partnership	Infrastructure and enablers	98
	Building community resilience	99
	St George's health and wellbeing hub	100
	Living well	101
	Ageing well	102
Newham	Frailty model	103
	Neighbourhood model	104
	Population growth	105

Further local priorities		
Led by	Programme	Page*
Newham	Learning disabilities and autism	106
	Ageing well	107
	Primary care	108
Redbridge place partnership	Health inequalities	109
	Accelerator priorities	110
	Development of the Ilford Exchange	111
Tower Hamlets place partnership	Living well	112
	Promoting independence	113
Waltham Forest place partnership	Centre of excellence	114
	Care closer to home	115
	Home first	116
	Learning disabilities and autism	117
	Wellbeing	118
NHS North East London	Tobacco dependence programme	119
	NEL homelessness programme	120
	Anchors programme	121
	Net zero (ICS Green Plan)	122
	Refugees and asylum seekers	123
	Discharge pathways programme	124
	Pharmacy and Medicine Optimisation/ NEL	125

Committee(s): Health and Wellbeing Board – For Information	**Dated:** 29/06/2023
Subject: 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*	**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?	
What is the source of Funding?	**NA**
Has this Funding Source been agreed with the Chamberlain's Department?	**NA**
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.	

City's Corporate Plan

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.*
4. *Communities are cohesive and have the facilities they need.*

Support a thriving economy

5. *Businesses are trusted and socially and environmentally responsible.*
6. *We have the world's best legal and regulatory framework and access to global markets.*
7. *We are a global hub for innovation in finance and professional services, commerce and culture.*
8. *We have access to the skills and talent we need.*

Shape outstanding environments

9. *We are digitally and physically well-connected and responsive.*
10. *We inspire enterprise, excellence, creativity and collaboration.*
11. *We have clean air, land and water and a thriving and sustainable natural environment.*
12. *Our spaces are secure, resilient and well-maintained*

Summary

The Director of Public Health annual report is presented to the Health and Wellbeing Board prior to publication and as part of launching the report. The Board is asked to take note of the recommendations made in the report and to make any observations or suggestions, as appropriate, relating to their implementation. Members of the Board are asked to 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.

Last year's DPH annual report (available here) 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. This year's report, which is presented here to the Health and Wellbeing Board, focuses on young people's sexual and reproductive health (SRH).

Recommendations

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 implementation of the recommendations
- Recommend initiatives to enhance the SRH of young people living in the City of London and Hackney
- Suggest additional partners or stakeholders that should be sent the report directly or approached to collaborate on new initiatives

Main Report

Background

1. The DPH annual report provides an opportunity to assess an aspect of the local population's health and make recommendations as appropriate to address identified needs. This year's report looks at sexual and reproductive health (SRH) with a particular focus on young people under 30 and on testing for sexually transmitted infections (STIs). This is because young people access sexual health services relatively more frequently than other sections of the population and, when they do access services, they are more likely to have an STI. Furthermore, the City of London and Hackney have recorded significantly higher rates of newly diagnosed STIs than the London or England averages for the past ten years of available data.

2. The recommendations contained in the 2023 DPH annual report have been discussed at the City of London's Community and Children Services Directorate Leadership Team (CCS DLT) meeting on 1 March 2023.

3. The report was developed in liaison with stakeholders across the City of London and Hackney, and informed by desk research. Stakeholders were interviewed from local authorities as well as local and regional NHS partners and voluntary sector organisations. An early draft of the report was shared with stakeholders for their comment and feedback.

4. The report benefited from recent work by the City of London and Hackney Public Health team on an SRH Needs Assessment and the development of a five year SRH Strategy for 2023-2028.

5. The report makes five broad recommendations:

    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.

6. The DPH annual report will be published online in July 2023 and shared directly with stakeholders.

Current Position & Key Data

7. In 2021, the City of London ranked third highest, and Hackney fifth highest, for new STI diagnoses (excluding chlamydia in the under 25s) out of the 152 local authorities across England.[1] The rate in Hackney was over double the London average and over four times the England average.[2] The rate in the City of London was even higher (2,033 per 100,00), although caution is needed because the absolute numbers in the City of London are comparatively low. It should also be borne in mind that, as well as having high rates of new STI diagnoses, both the City of London and Hackney have extremely high prevalence rates of HIV.[3]

[1] Data available from the Office for Health Improvement and Disparities (OHID) here. The indicator 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 STIs, the rate in the City of London and Hackney in 2021 was still around four times higher than the England average, at 2,130 for the City of London and 1,998 for Hackney compared to the England average of 551 per 100,000.

[2] Hackney recorded 1,687 new STI diagnoses per 100,000 residents in 2021 (excluding chlamydia in the under 25s) compared to a rate of 935 acoss London and 394 per 100,000 for England as a whole (see OHID data here).

[3] The City of London was, in 2021, the local authority with the third highest prevalence of HIV in England, while Hackney had the twelfth highest prevalence. This is most recent data available from OHID (see here).

8. Notwithstanding relatively high levels of STIs in the community, there has been a marked reduction in the number of STI tests being performed since the COVID pandemic. The overall number of STI tests across the sector fell by 57% from 2019/20 to 2021/22 (HSHS Sexual Health Equality Audit 2022). This takes into account both primary and secondary care as well as online services provided by Sexual Health London. The DPH report aims, therefore, to encourage stakeholders to continue working together, and with the communities they serve, to bring STI testing back up to pre-pandemic levels and to continue working to enhance access to SRH services across the board.

Conclusion

9. The members of the Health and Wellbeing Board are asked to note the DPH annual report and support, as appropriate, the recommendations made within it.

Appendices

Appendix 1. Update on recommendations made in last year's Director of Public Health Annual Report (2022)

Appendix 2. A model of Sexual and Reproductive Health services

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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. There are five areas where last year's report made recommendations. Listed below are each of these recommendations with a brief update regarding ongoing activities that relate to them.

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 public health worked with NHS North East London, 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 head teachers) 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 1st and 2nd dose of COVID-19 and the Spring booster for those that 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 communications campaigns and targeted events. A new Children and Young Persons Immunisation Coordinator has been recruited to lead further work with communities. Beyond routine vaccinations, significant work has been undertaken to maximise uptake of the polio booster, including working with specific communities 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 the maternal and childhood vaccines.

However, routine vaccination coverage has declined across London. Vaccination fatigue, reduction in trust with 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%.[1] 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 2 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 the City of London and Hackney children who are at risk of vaccine preventable diseases. These diseases can cause life long 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.*

The Government funding to support schools to help pupils make up for missed learning due to the pandemic finished in the summer of 2021. It was replaced with a time-limited recovery premium grant providing over £300m of additional funding for state-funded schools in the 2021 to 2022; and £1bn across 2022 to 2023 and 2023 to 2024. Schools are targeting pupils on the basis of assessment of need, focusing the recovery premium grant where needs are greatest.[2] 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[3] for pupils at both key stages 2 and 4 has widened in 2022 to the highest levels since 2012.[4] 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 in order to achieve, and surpass, pre-pandemic levels.

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[1] See data provided here by the Office for Health Improvement and Disparities. The same trend is seen with routine vaccinations at 5 years old. The data from primary and secondary school aged children does not show such marked reductions.

[2] Schools are following the approach outlined in the Education Endowment Foundation's Guide to the Pupil Premium.

[3] 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.

[4] For further information see reports on Key stage 2 attainment (2021-22) and Key stage 4 performance (2021-22).

Within the Early Years setting, among other activities, support has been given to providers to register with the DfE Covid Recovery funded "Early Years Professional Development Programme". 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 who 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 the least 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,[5] to establish healthier practices in food businesses,[6] and to ensure sufficient outdoor play areas in new developments.[7]

[5] Hackney's Sustainability Team has been working with ProVeg International to promote use of plant-based, nutritious food in schools.
[6] 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.
[7] 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.

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 6, 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.

5. *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. Whilst 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 next page) 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.

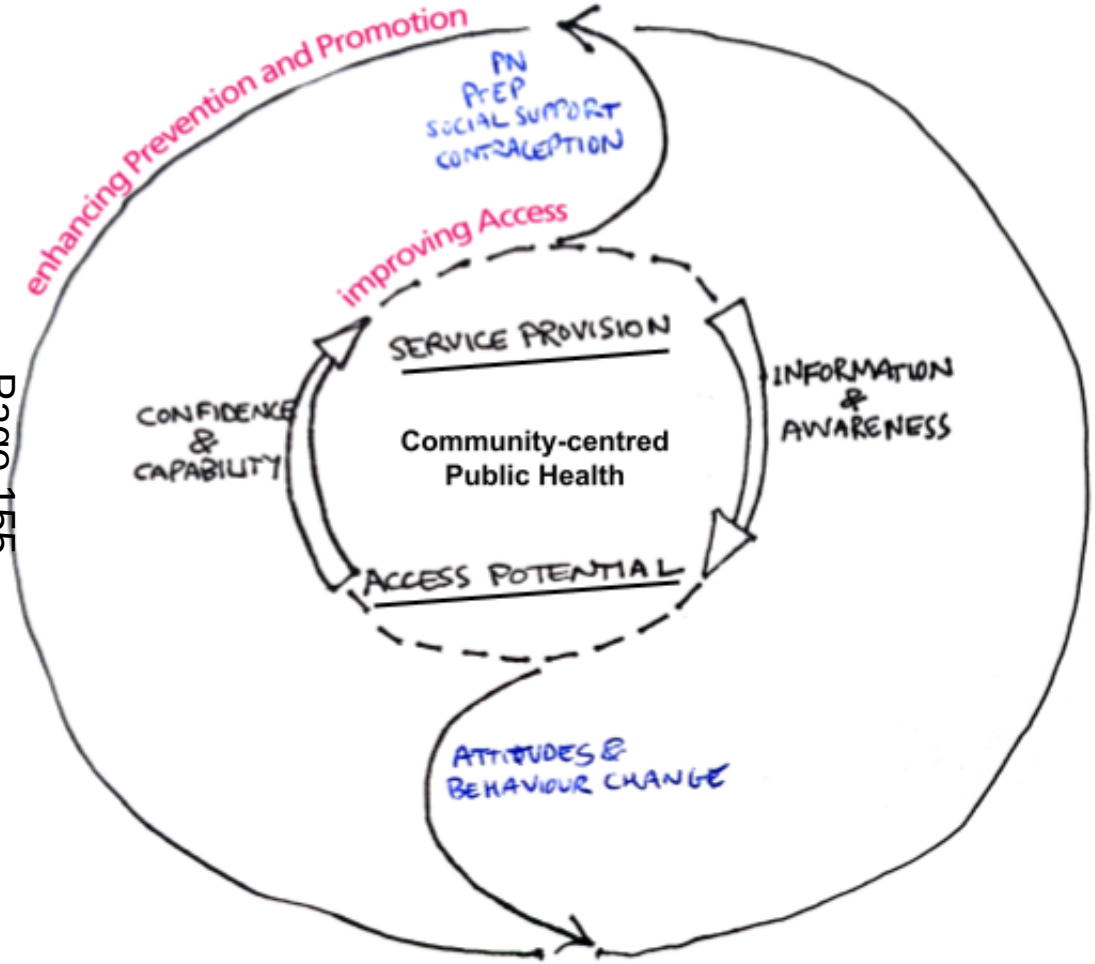
Many public health models look at the determinants of health, either from the perspective of the individual or the public, or they examine how best to implement and provide services to a population.[8] This model, however, aims to draw attention to the linked nature of service provision on the one hand 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.

[8] 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).

Sexual Health Services Model



Virtuous cycles

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, embarrassment 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[9]). 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 is a virtuous cycle, with positive self-reinforcement maximised by addressing as many aspects of the model as possible.

The outer circle - enhancing Prevention and Promotion

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[9] 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.

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*)[10]; 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 *service 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.

[10] 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.

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DPH Annual Report draft

Short Version

Healthy Sexually

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

"Holding Hands" in Hoxton Square, sculpture by STIK

Introduction & Recommendations

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 five year SRH 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 will focus on young people, meaning those people 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 very 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 5 year strategy.

The City and Hackney have recorded a higher rate of newly diagnosed STIs than the London or England averages for the past nine years of available data. The rate in 2021 was over four times the average for England.[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, effective 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.

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 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 must not only prevent ill health but also be able to address problems when they do occur or be able to refer effectively to services that can. Services need to be trusted so that individuals are confident and comfortable in 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.

Contents

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, sexually and linguistically 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] The total rate of LARC prescribed in Hackney in 2020 was 19.3 per 1,000 women, and 13.6 per 1,000 women for the City of London.[18] These figures are 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. This difference is particularly high between the rate of LARC prescriptions in primary care in Hackney (7.2 per 1,000 women) compared to the rate of prescriptions in primary care in England as a whole (21.1 per 1,000 women).[19]

New data made available in February 2023 show, however, that in 2021, rates of LARC prescriptions rose in both The City of London and Hackney to 37.5 and 20.8 respectively. Hackney was, therefore, once more above the London average of 30.4 for the same period, but still lower than the England average of 41.8 per 1,000 women.[20] 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 and in the City of London it was 24.3 per 1,000. The City of London has the third lowest rate of LARC in London and the 12th lowest in England.[21] Ensuring appropriate access to LARC, together with other forms of contraception, is one element of helping people achieve planned pregnancies. Whilst many of the recommendations in this report equally apply to increase access to and uptake of LARC this will be fully considered in the sexual health strategy.

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.[22] 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.[23] 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 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[24] compared to a London average of 5.5 and an average in England of 6.5.[25] 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.[26] 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. [27] 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 ten years of available data. In 2021, Hackney ranked fourth highest out of 150 local authorities[28] for new STI diagnoses.[29] The rate in Hackney was over four times the England average: 1,687 per 100,000 residents compared with a rate of 394 per 100,000 for England as whole.[30]

Furthermore, both the City of London and Hackney are areas of very high prevalence of HIV.[31]

Access to testing for STIs is key for treatment of individuals and their partners and to prevent further infections. The COVID 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.[32] This is notwithstanding the welcome increase in the numbers of people self-testing through the Sexual Health London digital service (SHL).[33] 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.[34] This means that the fall in the number of new STIs being diagnosed is more likely to reflect the reduction in testing rather than a reduction in the burden of disease in the community.

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.

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 to exist. We will consider what impact the COVID 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 on-line 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 Sector Organisations (VSOs). 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 care 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 through provision of pre-exposure prophylaxis[38] (PrEP) for HIV, and immunisations that can prevent infections that may be spread through sexual contact, such as HPV[39], Mpox, 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 SRH field. We use the term "sexual and reproductive health"

(SRH) 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 those services and who can benefit from them. These concerns have become particularly pronounced since the COVID 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 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 relating 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.[40] 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.[41] 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[42]
- booking process: where appointments are required, booking systems must be in place that are easy to navigate, support different languages and meet accessibility standards[43]
- capacity: services must have the capacity to provide support to the numbers of people trying to access them in a time-appropriate manner[44]

Increasing collaboration between the many actors working in the SRH field - service providers and commissioners - and with the communities they serve, will help mitigate many of these potential barriers.[45] 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.[46]

Barriers relating 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 East London noted difficulties with accessing accurate information on websites and by telephone.[47]

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?

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 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.[48] 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,[49] 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 2019/20 to 2021/22.[50] This is despite the number of STI screens distributed by SHL more than doubling during the same period.[51]

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.[52] 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.[53] 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.[54] 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 stakeholder observed, "some communities would be horrified if GP surgeries sent a text message to 16 year olds inviting them for a chlamydia screen" (primary care stakeholder). 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 which whilst overall are reducing will still remain a significant issue for some. 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 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, then 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.[55] Indeed,

they argue that there were already problems around staffing even before the pandemic[56] and so the impact of COVID 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.[57] 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 and the pandemic 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.[58] For more discussion of the impact of COVID 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, then, 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.[59] 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.[60] 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.[61] For example, 2021 data show 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.[62] Poverty, then, is associated with poor SRH outcomes[63] but the relationship is two-way.[64] 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 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,[65] and there are suggestions that Turkish-speaking communities may not be accessing menopause services through primary care.[66]

Even in areas where local performance is good, inequalities between groups may exist that need to be addressed. For example, late diagnosis[67] 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 2019-21 was 30.7%[68] 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.[69] 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 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 IAPS[70] services 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.[71]

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.[72] 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 less, over 34% aged 30 or less, and over 32% aged 25 or less.[73] It is young people that access SRH services the most.[74] The highest proportion of both men and women attending Homerton Sexual Health Services (HSHS) fell within the 25-29 year old age group and 54% of all women accessing HSHS were under 30 years old.[75] Not only are young people disproportionately accessing services, they are also more likely to be diagnosed with an STI when they are seen.[76] Furthermore, stakeholders report specific challenges for young people to access services, particularly since the COVID 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,[77] who make up over a third of the estimated population of the City of London and Hackney.[78] 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.

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 that 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 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. This guideline recommends that interventions aimed at

reducing STIs should be planned, designed, implemented and evaluated "in consultation with the groups that they are for".[79] 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".[80]

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[81] 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[82] to ensure new initiatives are culturally appropriate, well targeted and effective. Specific activities, such as peer-led participatory action research,[83] 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.[84]

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 these data are outlined in the section above: "How does the City of London and Hackney compare with other parts of London". Without repeating the information already given, 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, including specific services for young people such as the City and Hackney Young People's Service (CHYPS Plus).

Young people have the highest rates of access of services and are most likely to have a positive test result for an STI.[85] Furthermore, data available for the City of London shows

that reinfection rates for young people are much higher than the national average.[86] In the five year period from 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.[87] 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 pandemic has caused a large reduction in the number of STI tests being performed. In the financial year 2021-22, the number of STI screens performed in the City of London and Hackney was less than half than in the year before the pandemic.[88] 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 Homerton Sexual Health Services (HSHS). Since the pandemic, the majority of screening tests have been provided through the online service, Sexual Health London.[89] 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.[90] 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[91] 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.[92]

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.[93] 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.[94]

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.[95] 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;[96] 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.[97]

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[98] do 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.[99]

Two specific elements of STI testing in primary care have been highlighted as areas of concern by stakeholders. They are Partner Notification and the communication of test results.

Partner Notification (PN) 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.[100] 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.[101]

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".[102] 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[103] 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[104] 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).[105]

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 a LARC service in 2021, over 70% of the fittings were carried out in just five practices.[106] 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.[107] 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.[108] There are, nevertheless, positive initiatives in this area include 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.[109]

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.[110]

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.[111] 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[112] and 40% said that they would charge for the service. These findings were largely confirmed by in-person visits to 16 of the pharmacies,[113] 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,[114] 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 aged 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).[115]

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.[116] 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%).[117] This again highlights the central importance of pharmacies.[118] 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 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;[119] the location of hubs and outreach services;[120] and ways of improving appointment availability and booking systems.[121]

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).[122] 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;[123] exploring how to strengthen systems for partner notification[124] and STI test result notification[125]

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[126] 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.

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.[127] 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;[128] (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.[129]

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,[130] levels of STIs in the community, recommendations on frequency of STI testing, the importance of sexual self-efficacy[131] and the impact of stigma.

    ii. Review the implementation and quality of Relationships and Sex Education (RSE) provision in our 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.[132] Some stakeholders suggest that the amount and quality of RSE provided may vary between different schools.[133]

    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.[134]

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.[135] Consider the use of text and chat methods for accessing information about available services.[136]

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;[137] and better understand how and where different people like to access services.[138]

    ii. Explore interventions, in collaboration with young people and their specific communities, to normalise discussions around SRH and to tackle stigma;[139]

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",[140] 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)".[141] 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,[142] 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.[143]

Collaboration should be promoted at the level of service provision without significant structural change, for example to facilitate co-location of services,[144] 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.

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.[145]

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.[146] 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[147] should be adopted.

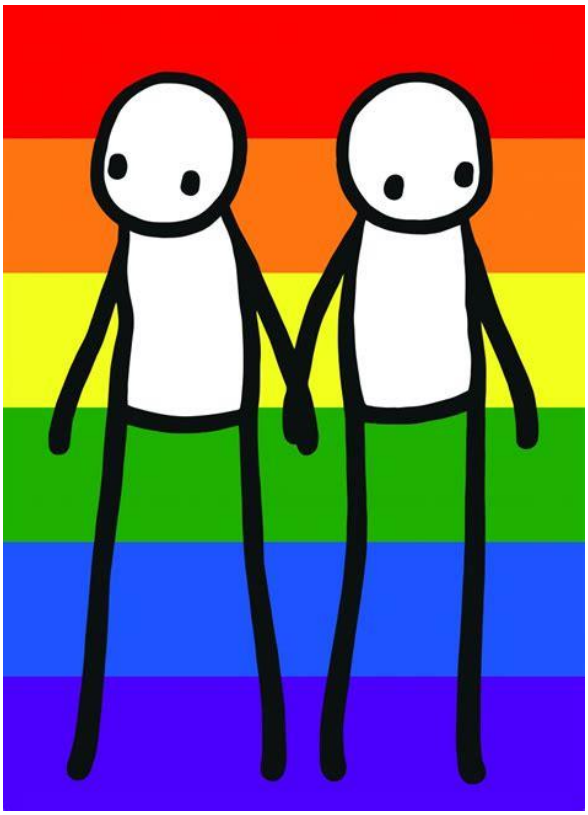
The concept of proportionate universalism states that:

> *"[f]ocusing 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 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.[148]

Conclusion

We must remember that “high-quality sexual health services are the cornerstone of ensuring good population health”.[149] 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 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.[150]

Endnotes

[1] UKHSA Summary profile of local authority sexual health Hackney, Feb 2023. Note that the UKHSA data refers to either Hackney alone or both Hackney and City of London combined but this is not specified for each item. The rate of "new STI diagnoses" excludes diagnoses of chlamydia in the under 25s because those numbers are so high it makes comparison between authorities more difficult. However, even including all STIs, the rate in the City of London and Hackney in 2021 was almost four times higher than the England average, at 1,998 compared to 551 per 100,000.

[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 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] UKHSA Summary profile of local authority sexual health Hackney, 1st Feb 2023. N.B. "The data in this report either refers to Hackney or both Hackney and City of London combined" but the report does not specify what is the case for each data item.

[20] From 2014 to 2021, Hackney was only below the London average in 2020.

[21] This is according to the most recent data available from the Office of Health Improvement and Disparities, available here.

[22] 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).

[23] 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.

[24] Data for the City of London is not available.

[25] 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).

[26] UKHSA Summary profile of local authority sexual health Hackney, 1st Feb 2023.

[27] 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.

[28] This figure of 150 includes upper tier local authorities (UTLAs) and unitary authorities (UAs).

[29] The rate of "new STI diagnoses" excludes diagnoses of chlamydia in the under 25s because those numbers are so high it makes comparison between authorities more difficult. However, even including all STIs, the rate in The City of London and Hackney in 2021 was almost four times higher than the England average, at 1,998 compared to 551 per 100,000.

[30] UKHSA Summary profile of local authority sexual health Hackney, Feb 2023. N.B. "The data in this report either refers to Hackney or both Hackney and City of London combined" but the report does not specify what is the case for each data item.

[31] The City of London is the local authority with the third highest prevalence of HIV in England, while Hackney has the twelfth highest prevalence. This is according to the most recent available data (see here) which is for 2021.

[32] 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*).

[33] 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.

[34] 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 tests to positive results has increased slightly from 1:3.5 to 1:3.1 (HSHS, *Sexual Health Equity Audit 2021*).

[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 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 0222).
[40] Note that people can choose to access sexual health services outside of Hackney or the City of London.
[41] Stakeholders are nevertheless concerned about potential gaps and these are discussed below in the section "groups requiring particular attention".
[42] 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.
[43] 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).
[44] 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.
[45] See Recommendation 4 below.
[46] See Recommendation 1 below.
[47] Future Insight Partnership Projects report, East London Mystery Shopping, Dec 2022.
[48] 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.
[49] 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.
[50] HSHS Sexual Health Equality Audit 2022.
[51] 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.
[52] 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).
[53] 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.
[54] 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 (data available here).
[55] 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.
[56] Some stakeholders felt that the impact of Brexit locally was to exacerbate staffing difficulties within healthcare.
[57] "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.
[58] 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).

[59] For example, the proportion of 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).

[60] 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).

[61] DoH & PHE (2018) *Integrated Sexual Health Services: A suggested national service specification*.

[62] 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.

[63] 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.

[64] As one local expert commented, "Hackney still has a deprived population and good sexual health goes hand in hand with addressing that deprivation".

[65] 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).

[66] 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.

[67] Late diagnosis is defined here as having a CD4 count <350 cells/mm^3 within 91 days of first HIV diagnosis in the UK.

[68] 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.

[69] In Hackney, 2019-21, 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).

[70] The Improving Access to Psychological Therapies (IAPT) programme was developed as a systematic way to organise and improve the delivery of, and access to, evidence-based psychological therapies within the NHS. It is now called the NHS Talking Therapies programme.

[71] 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".

[72] 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.

[73] 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).

[74] 2021-22 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*).

[75] 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.

[76] People aged 20-24 attending the service were more likely to have an STI diagnosis than any other age group.

[77] Different organisations adopt different cut-offs. The Homerton Sexual Health Service, for example, defines young people as those aged 25 and below.

[78] ONS 2021 mid-year population estimates, available here.

[79] See 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.

[80] NICE guideline [NG221] *Reducing sexually transmitted infections* Published: 15 June 2022, p.11.

[81] The final version of the charter was published in 2022 with the cooperation of LBH, CoL, 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).

[82] 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).

[83] 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.

[84] The issue of young people's awareness of services and their willingness to access them is dealt with under recommendation 3.

[85] 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 data on STI tests, diagnoses and services from all commissioned sexual health services in England.

[86] Reinfection rates refer to the likelihood of someone testing positive for an STI within one year of previously testing positive. It

[87] 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).

[88] 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).

[89] 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.

[90] 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).

[91] 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, has unfortunately struggled to maintain its level of service post-pandemic due to staffing issues.

[92] 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.

[93] This is from CCG GP data quoted in the Hackney and City Sexual Health Needs Assessment 2023.

[94] 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.

[95] 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).

[96] 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.

[97] 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.

[98] 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.

[99] 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.

[100] See Society of Sexual Health Advisers *Guidance on Partner Notification*, Aug 2015 available here.

[101] 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).

[102] British Association for Sexual Health and HIV *Standards for the management of sexually transmitted infections (STIs),* (April 2019).See p.36, available here.

[103] 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".

[104] 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.

[105] HSHS Equity Audit 2022 and HSHS Activity Report, January 2023.

[106] City & Hackney GP Confederation data, 1 April 2021 to 1 January 2022.

[107] Stakeholders also noted that GP surgeries pay a higher price for the coils themselves than the price offered to sexual health clinics.

[108] 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.

[109] 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.

[110] Data from Pharmoutcomes, Pathway analytics, and Preventx.

[111] Healthwatch Hackney, *Mystery Shopping exercise of Access to Emergency Hormonal Contraception in Hackney,* February 2023.

[112] 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.
[113] One pharmacy that had offered free services on the phone, requested payment for the service during the visit.
[114] Pharmacy data shows that EHC usage is highest among 15-24 year olds (Pharmoutcomes).
[115] 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.
[116] 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.
[117] 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%.
[118] 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.
[119] 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.
[120] 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.
[121] Issues regarding booking systems and appointment availability were highlighted by the NEL Mystery Shopping exercise.
[122] See here for the type of RSE support provided by Young Hackney's Health and Wellbeing Team.
[123] 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.
[124] 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.
[125] 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.
[126] For example, HIV testing may be increased in primary care as part of new patient checks, where these are ongoing, or NHS health checks.
[127] 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."
[128] "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.
[129] 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.
[130] 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.

[131] 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).

[132] 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 practice safe sex; make it more likely that 'first sex' is concensual; improve online literacy; and, increase gender-equitable and inclusive attitudes.

[133] 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.

[134] This may, for example, follow the model of Making Every Contact Count brief interventions to affect behaviour change.

[135] 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.

[136] 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.

[137] 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.

[138] Different groups may have preferences for accessing services in GP practices, pharmacies, specialised clinics or online; and this should be taken into account.

[139] 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.

[140] 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.

[141] NICE guideline [NG221] *Reducing sexually transmitted infections* Published: 15 June 2022.

[142] 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.

[143] 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.

[144] 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.

[145] 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.

[146] 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.

[147] 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).
[148] A Public Health Scotland 2014 briefing gives the following description: "[p]roportionate 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).
[149] BASHH Standards for the Management of STIs 2019, at p.4.
[150] 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.

Committee(s): Health and Wellbeing Board	**Dated:** 14-06-2023
Subject: Consultation on the proposed City and Hackney Sexual and Reproductive Health Strategy (2023-2028)	**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.*
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: Sandra Husbands	**For Decision**
Report author: Froeks Kamminga, Chris Lovitt	

Summary

This report is being brought to the Board to ask for the approval to commence a formal 12-week consultation to be held on the proposed five-year sexual and reproductive health strategy for City and Hackney, to commence on 1 July 2023.

Approval is also sought for an action planning process to run alongside and during this consultation period to inform the creation of an action plan for 2023-2024, to facilitate implementation of the strategy.

Recommendation(s)

Members are asked to:

- Note the strategy and proposed priorities
- Endorse a formal 12-week consultation to be held on the proposed five-year sexual and reproductive health strategy for City and Hackney, to commence on 1 July 2023.
- Endorse the process of action planning for the strategy to run alongside the consultation period.
- Recognise that the consultation process will also inform the proposed North East London Sexual and Reproductive Health strategy.

Main Report

Background

1. The City of London and the 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.

2. Although significant improvements have been achieved in improving sexual health, in partnership with the NHS and the voluntary sector, 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 other areas in London and across England.

3. 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 including provision of sex and relationship education, to address the most pressing issues and gaps in provision and uptake of care.

4. As such, this strategy will lay the foundation for the reimagining and (re)commissioning of sexual and reproductive health services that are comprehensive and inclusive, recognising synergies with other services and providers, and contributing to better sexual and reproductive health outcomes for all residents.

5. The strategy is organised around five key thematic areas of which four also feature within the proposed NEL Sexual and Reproductive Health (SRH) strategy. This will help ensure both a locally focused strategy but also enable priorities are aligned across areas in North East London that have similar types and levels of SRH need within their populations.

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) Getting to Zero new HIV transmissions
e) Vulnerable populations

Current Position

6. To ensure that key stakeholders, system partners and residents are involved in deciding the priorities and outcomes in the draft strategy, the intention is to have a formal 12-week consultation period which is planned to commence on the 1 July 2023. It is then the intention for the strategy to be presented at the

September HWB for City and Hackney, respectively, for formal adoption as a partnership strategy.

7. The intention is further for the strategy to be accompanied by an annual action plan to ensure implementation and delivery on key priorities. To facilitate this action planning the proposal is to run this during and alongside the 12-week consultation, involving the same partners, stakeholders and residents representation.

8. The first action plan will be developed in tandem with the consultation process and be presented for formal adoption at the September HWB for City and Hackney, respectively and cover the remainder of the financial year 2023/24, as well as 2024/25. During 2024/25 a new action plan will be developed for 2025/26. The intention is that currently commissioned providers will all be involved in this process, with active involvement by other place-based stakeholders from within the Integrated Care System, and local resident bodies and representation, including young people.

9. To monitor implementation of the strategy, a sexual health dashboard is in development by the Public Health Intelligence Team (PHIT). This will include and collate quarterly data from key sources and platforms such as Pathway Analytics, Preventx and Pharmoutcomes that are used to reflect activity by Homerton Sexual Health Services, SHL and pharmacies. It will also incorporate GUMCAD, SPLASH and Fingertips data and updates. Lastly, where relevant and possible, it will include performance data derived from KPI reports submitted by commissioned services.

Proposals

10. In order to involve key stakeholders, system partners and residents in deciding the priorities and outcomes in the draft strategy, the Board is requested to endorse a formal 12-week consultation to be held on the proposed five-year sexual and reproductive health strategy for City and Hackney, and for this consultation to commence on 2 July 2023.

11. To facilitate implementation of the strategy, the Board is asked to endorse the process of action planning for the strategy to run alongside the consultation period.

12. As a Sexual and Reproductive Health Strategy for North East London is being developed concurrently to the City and Hackney London Sexual and Reproductive Health strategy, for the Board to recognise that the consultation process will also inform the proposed North East London Sexual and Reproductive Health strategy.

Corporate & Strategic Implications

Following through on the proposed actions and the eventual adoption of a Sexual and Reproductive Health Strategy will contribute to the following strategic priorities:

Strategic implications

Contribute to a flourishing society

People enjoy good health and wellbeing.

People have equal opportunities to enrich their lives and reach their full potential.

Equalities implications

The strategy highlights that significant inequalities exist in access to services and health outcomes based on ethnicity, age and sexual orientation. The action plan will ensure that appropriate actions are taken to address and reduce inequalities.

Conclusion

13. A five-year strategy for Sexual and Reproductive Health for City and Hackney is being developed, concurrently with a NEL SRH strategy. The Board is requested to endorse a formal 12-week consultation on this proposed strategy in order to invite and reflect the views and inputs from system partners, stakeholders and resident representation on the suggested priorities and outcomes, and for this consultation to commence on 2 July 2023.

14. To facilitate implementation of the strategy, once finalised and adopted, the Board is asked to endorse the process of action planning for the strategy to run alongside the consultation period.

15. This consultation process will also inform the proposed North East London Sexual and Reproductive Health strategy.

Appendices

None

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Committee(s): Health and Wellbeing Board - For information	**Dated:** [Insert date as DD/MM/YYY}
Subject: Pan-London Online Sexual Health Service contract	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	2
Does this proposal require extra revenue and/or capital spending?	**N**
If so, how much?	**£**
What is the source of Funding?	Management fees that have already been paid to the City Corporation by 30 authorities (all London authorities except Croydon, Greenwich and Hillingdon)
Has this Funding Source been agreed with the Chamberlain's Department?	**Y/N**
Report of: Judith Finlay, Executive Director, C&CS	**For Information**
Report author: Adrian Kelly, Lead Commissioner, C&CS	

Summary

This report informs members of the Health and Wellbeing Board of a request made to the City Corporation, by the Local Authority representatives on the Strategic Board of the London Sexual Health Programme, to assess options for the re-procurement of a city-wide online sexual health service.

Any procurement and/or subsequent award would be intended to replace the current contract, which is managed by the City Corporation acting on behalf of 30 authorities (all London authorities save Croydon, Greenwich and Hillingdon) who pay management fees to the City Corporation which covers the costs of hosting a small programme team based at the Guildhall.

The programme has raised sufficient resources from the participating authorities thus far, ahead of any decision on whether (and/or what) to re-procure. These reserves are able to cover the additional costs of this initial phase, including internal recharges by colleagues in other departments and external expert capacity where necessary.

This report does not request authorisation for initiating a procurement exercise.

Recommendation(s)

Members are asked to:

- Note the report.

Main Report

1. Background

1.1. Local government acquired responsibility for commissioning many sexual health services in April 2013, as part of changes under the Health and Social Care Act 2012. This responsibility includes an obligation to pay open-access sexual health clinics anywhere in England and Wales, whenever their residents use those services.

1.2. An extensive range of clinic locations operate across London, with significant flow of residents to services in other areas of the capital. There has been substantial growth in sexual health service activity in recent years, for testing which has been accompanied by increases in the diagnosis and treatment of some sexually transmitted infections. This means collaborative commissioning arrangements In London are needed so authorities can manage the risk to their budgets accordingly.

1.3. Collaborative commissioning arrangements for sexual health clinics are facilitated by London Sexual Health Programme, in addition to the programme managing the contract for online sexual health services for residents of the participating authorities.

2. Current Position

2.1. The City Corporation currently manages a contract for the provision of London-wide online/remote sexual health testing services which it entered on August 15th, 2017, for a minimum term of 5 years with the option to extend the contract by up to 4 more years. This award followed a procurement process undertaken by Camden Council on behalf of 31 “named” authorities.

2.2. The authorities that participate in the programme pay management fees to the City Corporation; this pays for a small programme team that delivers a whole-system transformation programme by:

2.2.1. Providing system leadership by consensus-building across authorities.

2.2.2. Coordinating contracting and cross-charging arrangements for clinics.

2.2.3. Managing the supplier’s performance under the online contract.

2.2.4. Recharging authorities for use of the online service by their residents.

2.2.5. Providing a secretariat function for the programme’s governance.

2.3. The online service, mobilised on January 8th, 2018, had a goal of moving at least one third of testing for sexually transmitted infection from physical clinics to the online channel over a 3-year period. This objective had been broadly achieved by 2020, when a third of sexual health testing screens were delivered online.

2.4. The COVID19 pandemic was especially challenging for London's sexual health clinics, and the online service has played a key role in assuring the continuity and sustainability of access to public health services for residents. Consequently, the proportion of testing done online has increased further, with two-thirds now done online. Service lines for contraception were also introduced for authorities that choose to activate them for their residents, these additional service lines now cover half of London.

2.5. The 30 authorities that participate in the contract have subsequently agreed to extend it by three years beyond the minimum term, to August 14th, 2025. The option for a fourth and final one-year extension remains.

2.6. The programme is not authorised to pursue successor arrangements under its existing governance, this requires new authorisation: from the Corporation as the lead authority and from any authorities who wish to participate in any new procurement process and/or contract award.

3. Options

3.1. As this paper is for information, options are not presented at this point. An options paper will be presented in the autumn to relevant committees of City Corporation and to the other authorites involved in the programme.

4. Proposals

4.1. The representatives of the authorites that participate in the London Sexual Health Programme request that the Corporation of London supports them in exploring their options for successor arrangements for the online contract and the Programme.

4.2. Options for successor arrangements will need to be informed by the following products which the Programme Team intends to initiate at this time:

4.2.1. A market engagement exercise

4.2.2. Service user and stakeholder engagement

4.2.3. A Needs Assessment

4.2.4. An initial Equalities Impact Assessment

4.3. When the authorities' representatives have reached a consensus, in Autumn 2023, the Programme Team will prepare a report on their proposals for consideration by the participating authorites and the relevant committees of the Corporation of London. This is likely to request that one authority leads a procurement exercise on their behalf with the objective of awarding a successor contract by August 2025, and the consensus of the Programme's authorities indicates they are keen for the City of London Corporation to carry out this role. Proposals for new governance arrangements and resource requirements for hosting the contract/programme will also be set out ahead of any decisions.

4.4. Any new procurement proposals will build on the substantial work undertaken in the development of the current service and original contract model, combined with updated expectations and requirements.

4.5. If the Corporation decides not to take on the procurement role for a new online service, the participating authorities will need to identify an alternative authority to lead the procurement/programme.

5. Key Data

5.1. With a kit return rate of 78%, the online service has tested 1.7m returned kits since January 2018. All service users are invited to rate their experience out of 5 stars, approximately half respond, and 99% rate it positively.

5.2. Over £100m spend is forecasted across the 8 years that the current contract operates and if the same activity was delivered in clinics, we estimate that it would instead cost the authorities c£350m.

5.3. The value of a successor contract is expected to exceed £20m per annum – the equivalent activity is estimated to cost the authorities c£70m per annum if provided by physical clinics instead.

5.4. Successor arrangements for when the current contract ends in August 2025 will need to be in developed and delivered if the authorities wish to continue benefitting from the efficiencies generated by having online channels.

6. Corporate & Strategic Implications

- *Strategic implications*

The transformation of sexual health service delivery across London helps:

> *Contribute to a Flourishing Society where people have good health and wellbeing, equal opportunities to enrich their lives/reach their potential and feel safe in cohesive communities that have the facilities they need.*

The online service is an important source for HIV testing and supports the use of anti-HIV Pre-Exposure Prophylaxis (PrEP), which are important contributors to the Fast Track Cities goal of no new HIV infections in London by 2030.

The successful implementation of online services has increased the resilience of the wider sexual health system, enhanced the City's reputation for digital innovation around the world and supported economic regeneration in Sheffield where the laboratory of the current supplier is based.

Relevant regional and national strategies this work support include:

Fast-Track Cities London Roadmap to Zero new HIV infections, zero deaths and zero stigma

A Framework for Sexual Health Improvement in England

Commissioning sexual health, reproductive health and HIV services

- *Financial implications*

  No financial implications arise from this stage of the process, the cost of the proposed activities can be met by the budget reserves that the programme team holds. This reserve is formed of any budget surplus from the annual management fees that participating authorites have paid to the Corporation and would be returned to those authorities if not used for the proposed purpose.

  When the options have been assessed in detail they will be costed and any additional funding that participating authorities may need to pay the Corporation, will be set out.

- *Resource implications*

  Undertaking a procurement exercise is resource intensive and will need to be delivered in partnership with specialist colleagues in Chamberlain's and Comptroller's departments. Internal recharges against the Programme budget will ensure that the cost of providing additional support for this exercise is recovered by the department/s.

- *Legal implications*

  The Programme team has managed the risks associated with hosting the current arrangements through effective partnership working with colleagues in Chamberlain's and the Comptroller's departments.

  In the pre-procurement phase, the risk of legal challenge by a potential supplier is paramount and is mitigated by acting transparently and fairly, this includes:
    - Ensuring the incumbent receives no unfair advantage through our ongoing contract management relationship.
    - Complying with regulations and good practice for transparency in respect of the current contract and its performance.
    - Conducting early market engagement though approved processes.

  Developing and agreeing new governance arrangements, including the contract, will be undertaken by a specialist legal firm with oversight from colleagues in Chamberlains.

  This subsequent phase, of going to market, will require individual authorities to confirm their commitment and obligations for indemnification of the City Corporation ahead of going to market.

- *Risk implications*

  Any procurement exercise will be guided by a detailed risk assessment which is actively managed with colleagues in the Chamberlains and Comptrollers departments as outlined in the preceding section and overseen by the representatives of the participating authorities.

The Programme team will commission expert support for proactive stakeholder communications with senior leaders across London to manage reputational risk.

- *Equalities implications*

  Sexual health outcomes are closely aligned with social and economic inequalities. An Equality Impact Assessment will be completed over the summer to inform the appraisal of options before concrete proposals are brough to City Corporation Committees and the Cabinets of individual authorities.

- *Climate implications*

  The current supplier is fully engaged with the City Corporation's program to achieve net zero carbon emissions within its full value chain by 2040. Learning from this work will inform the options that are presented in the autumn.

- Security implications

  None

7. Conclusion

7.1. The City Corporation has successfully delivered on the undertaking it gave to London's authorities: to facilitate the transformation of the capital's sexual health system through hosting the London Sexual Health Programme and the online contract. This new request, to prepare options for successor arrangements, is a clear endorsement by our stakeholders that this phase has been satisfactorily delivered. Additionally, London's national and international reputation for innovation and ambition has been enhanced considerably with widespread interest in our achievements.

7.2. The forces driving the programme's inception, rising need coupled with pressure on public finances, are expected to continue for the foreseeable future and successor arrangements will therefore continue to be required. The programme has developed the expertise to prepare proposals for what comes next, and it has that built up cash reserves to ensure that this initial phase is adequately resourced and supported by expert advice from across the City Corporation.

7.3. The Board is asked to note the proposal to embark on the initial phases of delivery market engagement, needs assessment, stakeholder engagement and assessing impact on equalities so the programme team can work with London's authorities in preparing concrete proposals for proper consideration.

8. Appendices

None

Background Papers

Extension to the contract for the provision of E-Services relating to the Pan London Sexual Health Transformation Programme.

Adrian Kelly
Lead Commissioner, C&CS

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Committee(s): Health & Wellbeing Board - For information	**Dated:** 29062023
Subject: An introduction to the Population Health Hub and how we can support work in the City of London	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	2,3,4
Does this proposal require extra revenue and/or capital spending?	**N**
If so, how much?	**£**
What is the source of Funding?	**N/A**
Has this Funding Source been agreed with the Chamberlain's Department?	**N**
Report of: Dr Sandra Husbands, Director of Public Health; Judith Finlay, Executive Director, Community and Children's Services	**For Information**
Report author: Joia de Sa, Consultant in Public Health, City & Hackney Public Health Team Anna Garner, Head of Performance and Population Health	

City's Corporate Plan

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.*
4. *Communities are cohesive and have the facilities they need.*

Support a thriving economy

5. *Businesses are trusted and socially and environmentally responsible.*
6. *We have the world's best legal and regulatory framework and access to global markets.*
7. *We are a global hub for innovation in finance and professional services, commerce and culture.*
8. *We have access to the skills and talent we need.*

Shape outstanding environments

9. *We are digitally and physically well-connected and responsive.*
10. *We inspire enterprise, excellence, creativity and collaboration.*
11. *We have clean air, land and water and a thriving and sustainable natural environment.*
12. *Our spaces are secure, resilient and well-maintained*

Summary

This is an introduction to the Population Health Hub, a system wide resource to support teams across City & Hackney to realise their role in improving population health and reducing health inequalities.

The presentation includes information on the Population Health Hub, our ways of working, focus areas and examples of our work. We pose questions to members on how best we can work together to promote the Board's priorities.

Recommendation(s)

Members are asked to:

- Note the report, including the offer of system support from the Population Health Hub
- Consider ways the Population Health Hub can work to support the Board, including the Board's commitment to adopting a 'health in all policies' approach.
- Define the tools, resources and other support that would help the Board to (more) explicitly incorporate consideration of health inequalities in its work.
- Consider further actions that the Board can take to ensure it is using all levers at its disposal to influence wider Corporation strategies and plans to improve population health and reduce health inequalities.

Main Report

Background

1. The Population Health Hub is a shared, system resource which aims to support the City & Hackney Place Based Partnership (PbP) and wider system partners to reduce health inequalities and improve the health of our population.

2. We support the City and Hackney Place Based Partnership Vision: " Working together with our residents to improve health and care, address health inequalities and make City and Hackney thrive".

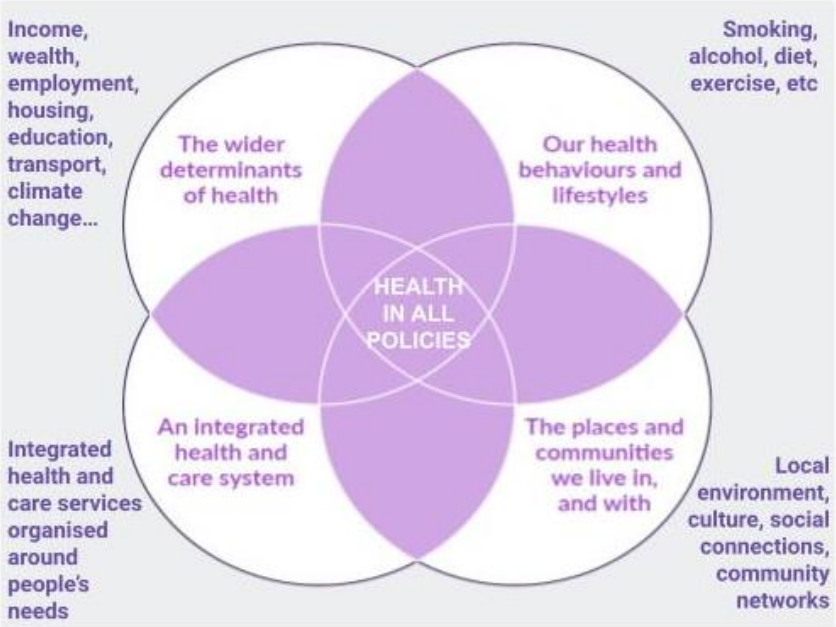
3. Health inequalities are avoidable and unjust differences in health outcomes between groups of people or communities and are defined according to a number of different dimensions (see Box 1 below). Taking action to reduce health inequalities is a matter of social justice.

Box 1: 'Dimensions' of health inequalities

Protected characteristics: age, disability, sex, gender reassignment, ethnicity/race, religion or belief, sexual orientation, marriage and civil partnership, pregnancy and maternity
Social inequalities: poverty, housing, education, unemployment, etc
Geographical inequalities: urban vs rural, local area deprivation, etc
Vulnerability: carers, rough sleepers, care leavers, people with no recourse to public funds (NRPF) etc

4. The unequal distribution of population health outcomes is driven by a complex interaction of individual, community and structural factors. Tackling health inequalities and improving population health requires action at multiple levels and across all sections of society. This means addressing all four 'pillars' of a population health system (see figure 1 below).

Figure 1: Population Health Pillars[1]



5. Taking a population health approach means rebalancing investment across the four pillars, while also focusing attention on the areas of overlap and intersection - where there are the greatest opportunities for impact. We also want to support system partners to take shared responsibility for improving population health. Effective system-wide action requires a common understanding of population health drivers, outcomes and effective interventions.

6. At the heart of this population health framework is a 'health in all policies' (HiaP) approach, which is based on the recognition that our greatest health challenges cannot be resolved through the health and care system alone, but are highly complex and most commonly driven by social, economic and environmental factors. A HiaP approach systematically and explicitly incorporates health improvement and health equality objectives into decision-making across sectors and policy areas, seeking to avoid harmful impacts of policies and practice and improve population health and reduce health inequalities. HiaP is built on the principles of co-benefits: a healthier population, and greater health equality, brings longer-term social and economic benefits for the local community.

[1] Adapted from, Buck et al (2018), *A vision for population health: towards a healthier future*, King's Fund

Current Position

6. The Population Health Hub has a small 'core team' reflecting the need to work in partnership with City & Hackney teams and system partners to achieve our aims. We work to proactively identify what the system needs, and also work in partnership on requests for support from stakeholders across the system.

7. We have six focus areas:

Evidence	Enabling the system to use evidence resources and expertise within the system, as well as supporting teams to develop skills in how to find evidence from literature.
Intelligence	Enabling the system to use existing data and intelligence (which contains qualitative and quantitative data) to generate useful analyses and insight.
Co-design & partnerships	Embedding codesign and partnership development of change ideas
Evaluating impact	Supporting system to evaluate what is working and what needs to change
Prevention & equity	Increasing focus and resources from the system on prevention and equity
Capacity building	Building capacity across the system in understanding drivers of population health and have the capacity and confidence to take action on this

8. Examples of how we support the system are:

- Leading on the delivery of key population health programmes and initiatives including Make Every Contact Count and establishing the Prevention Investment Standard (PInS)
- Working in partnership with the City and Hackney Health Inequalities Steering Group to support delivery of its priority action plans
- Involvement of residents, communities, frontline teams and other partners in developing population health priorities for City and Hackney
- Influencing departments and organisations across City of London, Hackney and beyond to take action on the social, economic determinants of health
- Supporting City and Hackney place-based partnership to take a population health approach in the design and delivery of health and care services for local people; enabling more efficient use of system resources and improving outcomes
- Supporting the development and implementation of Neighbourhood population health plans and both the City of London and Hackney's Joint Local Health and Wellbeing Strategies

9. Examples of our work include:

- a stocktake of equalities data across the health and care system (including a 'deep dive' of mental health and sexual health service data) and development of an equalities 'minimum dataset'
- co-development of an approach to embedding a culture of health equity in frontline teams including development of a resource pack to facilitate this (collaboration with the City Libraries Service has been instrumental in developing this resource pack)
- a series of workshops to co-develop a shared system framework for inclusive resident involvement to improve population health outcomes; plus completion of an equalities impact assessment of current resident engagement mechanisms
- a 1 year on report cataloguing our achievements over our first year and how we propose to work going forward

Proposals

10. In its leadership role to improve population health and reduce health inequalities across the Square Mile, there is an opportunity for the Board and member organisations to work more closely with the Population Health Hub.

11. We have included some suggestions on how the Board may want to consider working with the Population Health Hub:

Learning together	Building on the Board's commitment to addressing health inequalities and promoting a health in all policies approach: ● What data, tools and prompts might help Members assess the health impacts or inequalities implications of Corporation and HWB member organisation strategies and plans? ● Could the PHH provide training and support in the development and use of these tools?
Existing projects	● We are supporting the CoL strategy team with development of the JLHWBS ● We will continue to run our MATCH project (embedding a culture of health equity) and are keen to work with teams in the City of London ● We have introduced the EDI director to colleagues

	in Hackney working on anti-racism plans
New projects	• Are there other projects that would support CoL HWB aims and priorities? • What role might the Population Health Hub play in developing the City Plan?

Corporate & Strategic Implications

Strategic implications – The proposals set out in this report directly support achievement of a range of outcomes as set out in the City Corporation's Corporate Plan 2018-23. In particular, two core objectives lie at the heart of the proposals: that 'people enjoy good health and wellbeing' and 'people have equal opportunities to enrich their lives and reach their full potential' (*Contribute to a flourishing society*).

Financial implications - none

Resource implications - none

Legal implications - none

Risk implications - none

Equalities implications – The proposals contained within this report are focused on mobilising collective action to reduce health inequalities, including on the basis of protected characteristics.

Climate implications - none

Security implications - none

Conclusion

12. This report provides an introduction to and update on the work of the Population Health Hub, a shared, system wide resource which aims to support the City & Hackney Place Based Partnership (PbP) and wider system partners to reduce health inequalities and improve the health of our population.

13. Members are invited to consider how the Board's leadership role can be further strengthened to contribute to collective local action to improve population health, and the support that the Population Health Hub could provide to help do this most effectively.

Appendices

- None

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Committee(s): Health and Wellbeing Board – for approval	**Dated:** 29 June 2023
Subject: Better Care Fund End of Year Report 2022/23	**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: Judith Finlay, Executive Director, Community and Children's Services	**For Decision**
Report author: Ellie Ward, Head of Strategy and Performance, Community and Children's Services	

Summary

The Better Care Fund (BCF) programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.

The Fund is based on a pooled budget of funding from ICBs and local authorities. Each year local systems have to produce an End of Year Report detailing how BCF plans were met and funding spent.

This End of Year report has to be approved by the Health and Wellbeing Board. The report was submitted in May as per requirements but is now coming to the Board for formal approval.

Recommendation(s)

Members are asked to:

- Approve the Better Care Fund End of Year Report 2022/23

Main Report

Background

1. The Better Care Fund (BCF) was established in 2013 and encourages integration by requiring ICBs and local authorities to enter into pooled budget arrangements and agree an integrated spending plan.

2. Each organisation has designated funds they have to include in the pooled budget and it is at their discretion whether they add additional funding to the pot.

3. Every year, local systems agree how the money will be spent within criteria set out by the Department of Health and Social Care (DHSC) and produce plans in accordance with BCF policy and requirements. A key component of the requirements focus on supporting hospital discharge and out of hospital care.

4. The policy and guidance documents for plans are produced each year but are often published late in the financial year. All plans have to be approved by the local Health and Wellbeing Board (HWB) and plans for 2023 – 2025 will come to the next HWB in September.

5. Although the plans are submitted after the start of the financial year, local areas are allowed to continue with schemes from the previous year.

6. Local areas are also required to submit an End of Year Report giving detail of spend, impact and delivery of metrics.

Current Position

7. The BCF end of year report for 2022/23 was submitted in May 2023 and requires formal HWB sign off. This is attached at Appendix 1.

8. For 2022/23, the total pooled budget was £1,206,009, consisting of an ICB contribution of £845,259 and a City of London Corporation contribution of £360,750. In November 2022, significant funding for discharge was also added to the BCF pot – a total of £86,165 for the City of London Corporation, increasing the overall budget to £1,292,174.

9. The City of London Corporation schemes in the 2022-23 BCF remained broadly the same to previous years but with some bolstering of the hospital discharge scheme to reflect changing requirements, guidance and services.

10. Of the pooled budget, £328,977 was spent spent on City of London services (not including iBCF and DFG), above the £154,749 required. The £86,165 was also spent on hospital discharge – a breakdown of that can be seen in tab 7 of the spreadsheet in Appendix 1.

11. The designated four metrics and progress against these are recorded in Tab 4 of the spreadsheet. The first two are provided by health and the final two by adult social care. It is noted that we have excellent performance in relation to keeping people at home and independent for long periods of time and for supporting people when they are discharged from hospital. The metric on

avoidable admissions is difficult for health to produce accurately for the City of London and is therefore under discussion in terms of a target for the next BCF plan.

Corporate & Strategic Implications

The BCF aligns with our corporate priorities of

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.
4. Communities are cohesive and have the facilities they need.

It also sits within a wider strategic context of health and social care integration and policies driving hospital discharge work.

Financial implications

The City of London Corporation only contributes required funding to the pooled budget and does not contribute any additional funding.

In terms of expenditure on schemes within the plan, City Corporation schemes are funded above the minimum required from the pooled budget.

Resource implications

None

Legal implications

None

Risk implications

None

Equalities implications

All schemes which are funded through the BCF and commissioned or delivered by the City of London Corporation are subject to Equality Impact Assessments.

Climate implications

None

Security implications

None

Conclusion

12. The Health and Wellbeing Board is asked to approve the end of year report for the BCF 2022/23.

Appendices

- Appendix 1 – City of London BCF End of Year Report 2022/23

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