Health & Wellbeing Board

Meeting of the Health and Wellbeing Board

The Council Chamber, Hackney Town Hall, London, E8 1EA.

Thursday, 29 June 2023, at 3.00 pm.

The Live Steam link can be view here:

Main: https://youtube.com/live/cECAj8V1vec
Backup: https://youtube.com/live/FS1Uj0VyrvQ

Contact: Mark Agnew
Governance Services Officer
Tel: 020 8356 2398
Email: governance@hackney.gov.uk

Ian Williams
Acting Chief Executive
22 June 2023

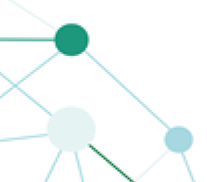
The press and public are welcome to attend this meeting

Health & Wellbeing Board

Board Membership and Additional Attendees

Board Members and Co-optees	
Dr Stephanie Coughlin (Co-Chair) Clinical Director, City & Hackney Place Based Partnership	**Cllr Christopher Kennedy** Cabinet Member for health, adult social care, voluntary sector and culture
Mayor Philip Glanville Hackney Council	**Cllr Anntoinette Bramble** Deputy Mayor and Cabinet Member for education, young people and children's social care
Jacquie Burke Group Director of Children and Education, Hackney Council	**Dr Sandra Husbands** Director of Public Health, City and Hackney
Helen Woodland Group Director Adults, Health and Integration, Hackney Council	**Vacancy** Healthwatch Hackney
Cllr Susan Fajana-Thomas Cabinet Member for community safety and regulatory services	**Cllr Carole Williams** Cabinet Member for employment, human resources and equalities
Louise Ashley Chief Executive, Homerton Healthcare NHS Foundation Trust	**DCS James Conway** BCU Commander, Hackney and Tower Hamlets, Metropolitan Police
Mary Clarke Director of Nursing and Corporate Development, General Practitioners Confederation	**Nina Griffith** Director of Delivery, City and Hackney Place Based Partnership
Frances Haste VCS Leadership Group	**Stephen Haynes** Strategic Director Inclusive Economy, Corporate Policy and New Homes, Hackney Council
Rosemary Jawara VCS Leadership Group	**Andreas Lambrianou** Chief Executive Officer, City and Hackney GP Confederation
Chris Lovitt Deputy Director of Public Health, City of London	**Jessica Lubin** Director of Health Transformation, Hackney Council for Voluntary Service
James O'Neill Borough Commander, London Fire Brigade	**Raj Radia** Chair, Local Pharmaceutical Committee
Paul Senior Interim Director of Education, Hackney Council	**Dr Kathleen Wenaden** Clinical Director for Primary Care Network

Independent Advisers	
Jim Gamble Chair, City and Hackney Safeguarding Children Board	**Adi Cooper** Chair, City and Hackney Safeguarding Adult Board

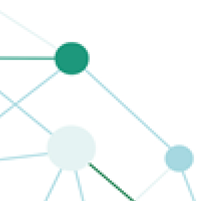


Health & Wellbeing Board

AGENDA
Thursday 29 June 2023

ORDER OF BUSINESS

Item No	Title	Page No
1	**Changes to Board Chair and Membership, and Updated Terms of Reference**	7 - 10
2	**Apologies for Absence**	
3	**Declarations of Interest - Members to Declare as Appropriate**	
4	**Minutes of the Previous Meeting**	11 - 22
5	**Action Tracker**	23 - 24
6	**Questions from the Public**	
7	**NEL Joint Forward Plan**	25 - 98
8	**Director of Public Health Annual Report "Healthy Sexually"**	99 - 150
9	**Sexual and Reproductive Health Strategy/Framework**	151 - 156
10	**Neighbourhoods Programme Response to the HCVS Connect Hackney Recommendations**	157 - 174
11	**The Future of the Health and Wellbeing Board**	
12	**Matters Arising**	
13	**Dates of Future Meetings**	



Public Attendance

Following the lifting of all Covid-19 restrictions by the Government and the Council updating its assessment of access to its buildings, the Town Hall is now open to the public and members of the public may attend meetings of the Council. We recognise, however, that you may find it more convenient to observe the meeting via the live-stream facility, the link for which appears on the agenda front sheet. We would ask that if you have either tested positive for Covid-19 or have any symptoms that you do not attend the meeting, but rather use the Livestream facility. If this applies and you are attending the meeting to ask a question, make a deputation or present a petition then you may contact the Officer named at the beginning of the Agenda and they will be able to make arrangements for the Chair of the meeting to ask the question, make the deputation or present the petition on your behalf.

The Council will continue to ensure that access to our meetings is in line with any Covid-19 restrictions that may be in force from time to time and also in line with public health advice. The latest general advice can be found here - https://hackney.gov.uk/coronavirus-support

RIGHTS OF PRESS AND PUBLIC TO REPORT ON MEETINGS

Where a meeting of the Council and its committees are open to the public, the press and public are welcome to report on meetings of the Council and its committees, through any audio, visual or written methods and may use digital and social media providing they do not disturb the conduct of the meeting and providing that the person reporting or providing the commentary is present at the meeting.

Those wishing to film, photograph or audio record a meeting are asked to notify the Council's Monitoring Officer by noon on the day of the meeting, if possible, or any time prior to the start of the meeting or notify the Chair at the start of the meeting.

The Monitoring Officer, or the Chair of the meeting, may designate a set area from which all recording must take place at a meeting.

The Council will endeavour to provide reasonable space and seating to view, hear and record the meeting. If those intending to record a meeting require any other reasonable facilities, notice should be given to the Monitoring Officer in advance of the meeting and will only be provided if practicable to do so.

The Chair shall have discretion to regulate the behaviour of all those present recording a meeting in the interests of the efficient conduct of the meeting. Anyone acting in a disruptive manner may be required by the Chair to cease recording or may be excluded from the meeting.

Disruptive behaviour may include: moving from any designated recording area; causing excessive noise; intrusive lighting; interrupting the meeting; or filming members of the public who have asked not to be filmed.

All those visually recording a meeting are requested to only focus on recording Councillors, officers and the public who are directly involved in the conduct of the meeting. The Chair of the meeting will ask any members of the public present if they have objections to being visually recorded. Those visually recording a meeting are asked to respect the wishes of those who do not wish to be filmed or photographed. Failure by someone recording a meeting to respect the wishes of those who do not wish to be filmed and photographed may result in the Chair instructing them to cease recording or in their exclusion from the meeting.

If a meeting passes a motion to exclude the press and public then in order to consider confidential or exempt information, all recording must cease and all recording equipment must be removed from the meeting. The press and public are not permitted to use any means which might enable them to see or hear the proceedings whilst they are excluded from a meeting and confidential or exempt information is under consideration.

Providing oral commentary during a meeting is not permitted.

ADVICE TO MEMBERS ON DECLARING INTERESTS

Hackney Council's Code of Conduct applies to all Members of the Council, the Mayor and co-opted Members. This note is intended to provide general guidance for Members on declaring interests. However, you may need to obtain specific advice on whether you have an interest in a particular matter. If you need advice, you can contact:

- Director of Legal, Democratic and Electoral Services
- the Legal Adviser to the Committee; or
- Governance Services.

If at all possible, you should try to identify any potential interest you may have before the meeting so that you and the person you ask for advice can fully consider all the circumstances before reaching a conclusion on what action you should take.

You will have a disclosable pecuniary interest in a matter if it:

i. relates to an interest that you have already registered in Parts A and C of the Register of Pecuniary Interests of you or your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner;

ii. relates to an interest that should be registered in Parts A and C of the Register of Pecuniary Interests of your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner, but you have not yet done so; or

iii. affects your well-being or financial position or that of your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner.

If you have a disclosable pecuniary interest in an item on the agenda you must:

i. Declare the existence and nature of the interest (in relation to the relevant agenda item) as soon as it becomes apparent to you (subject to the rules regarding sensitive interests).

ii. You must leave the meeting when the item in which you have an interest is being discussed. You cannot stay in the meeting whilst discussion of the item takes place and you cannot vote on the matter. In addition, you must not seek to improperly influence the decision.

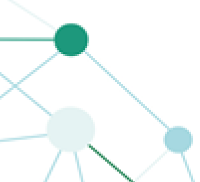
iii. If you have, however, obtained dispensation from the Monitoring Officer or Standards Committee you may remain in the meeting and participate in the meeting. If dispensation has been granted it will stipulate the extent of your involvement, such as whether you can only be present to make representations, provide evidence or whether you are able to fully participate and vote on the matter in which you have a pecuniary interest.

Do you have any other non-pecuniary interest on any matter on the agenda which is being considered at the meeting?

You will have 'other non-pecuniary interest' in a matter if:

i. It relates to an external body that you have been appointed to as a Member or in another capacity; or

ii. It relates to an organisation or individual which you have actively engaged in supporting.



If you have other non-pecuniary interest in an item on the agenda you must:

i.Declare the existence and nature of the interest (in relation to the relevant agenda item) as soon as it becomes apparent to you.

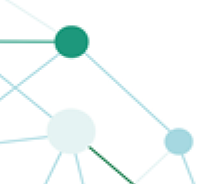
ii. You may remain in the meeting, participate in any discussion or vote provided that contractual, financial, consent, permission or licence matters are not under consideration relating to the item in which you have an interest.

iii. If you have an interest in a contractual, financial, consent, permission or licence matter under consideration, you must leave the meeting unless you have obtained a dispensation from the Monitoring Officer or Standards Committee. You cannot stay in the meeting whilst discussion of the item takes place and you cannot vote on the matter. In addition, you must not seek to improperly influence the decision. Where members of the public are allowed to make representations, or to give evidence or answer questions about the matter you may, with the permission of the meeting, speak on a matter then leave the meeting. Once you have finished making your representation, you must leave the meeting whilst the matter is being discussed.

iv. If you have been granted dispensation, in accordance with the Council's dispensation procedure you may remain in the meeting. If dispensation has been granted it will stipulate the extent of your involvement, such as whether you can only be present to make representations, provide evidence or whether you are able to fully participate and vote on the matter in which you have a non-pecuniary interest.

Further Information

Advice can be obtained from Dawn Carter-McDonald, Director of Legal, Democratic and Electoral Services via email dawn.carter-mcdonald@hackney.gov.uk



Terms of Reference - Health and Wellbeing Board

The Hackney Health and Wellbeing Board is a strategic, multi agency partnership board, carrying out duties conferred by the Health and Care Act (2022) and the National Health Service Act (2006). It brings together the Local Authority, the Integrated Commissioning Board, with local Healthwatch and other partners, in order to improve the commissioning of health and social care services and improve the health of the local population. Alongside its duty to improve commissioning of these, the Board also has responsibility for promoting integration between health and social care.

The Board brings together senior stakeholders and local representatives to strategically plan the commissioning of the right health and social care services for adults and children in Hackney, highlighting the most cost-effective ways to enable Hackney residents to live longer, healthier, safer, happier lives. The Board promotes the integration of services where this will promote more accessible, efficient and cost effective solutions to the challenges that the residents of Hackney face.

To carry out the duties and responsibilities of a Health and Wellbeing Board, in particular:

1. to encourage integrated working between commissioners of NHS, public health and social care services for the advancement of the health and wellbeing of the local population;

2. to provide advice, assistance or other support in order to encourage partnership arrangements such as the development of pool budgets or make lead commissioning arrangements;

3. to, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of health or social care services in its area to work in an integrated manner;

4. to provide advice, assistance or other support as it thinks appropriate for the purpose of encouraging arrangements. These are arrangements under which, for example, NHS Bodies and local authorities agree to exercise specified functions of each other or pool funds;

5. to discharge the functions of the Integrated Commissioning Board and the Local Authority in preparing joint strategic needs assessments (JSNA) and joint health wellbeing strategies (JHWS);

6. to, where appropriate, recommend Full Council to extend its functions relating to wider determinants of health, such as housing, that affect the health and

wellbeing of the population. To inform the Local Authority of its views on whether the authority is discharging its duty to have regard to the JSNA and JHWS in discharging its functions;

7. to discharge any non-executive function to enable it to carry out its statutory duties as Full Council may from time to time choose to delegate.

8. To prepare and publish a pharmaceutical needs assessment.

9. A duty to exercise functions with regard to the need to reduce inequalities between patients in outcomes and access to services.

Additional, non-statutory functions of the HWB include:

1. Lead and have oversight of system action to improve the health of the local population (beyond patients and service users) and reduce health inequities, through

    - tackling the wider determinants of health by promoting and embedding Health in All Policies across system partners
    - oversight of the following strategies and plans that include key aims to improve health and/or reduce inequalities, including
        - Community Strategy
        - Public health strategy
        - Hackney Autism Strategy
        - Alcohol Strategy
        - Mental health Priorities
        - Dementia strategy
        - Tobacco Strategy
        - Ageing Well Strategy
        - Serious Violence Action Plan.

2. Ensure a Health and Wellbeing Board work plan is implemented, reviewed and updated.

3. Establish relevant sub-groups or sub committees, determine their work programmes and ensure these are kept on track.

4. Ensure that Cabinet, the Integrated Commissioning Board and other members' boards are kept informed of progress and work of the board.

5. To receive the annual public health report/public health issues.

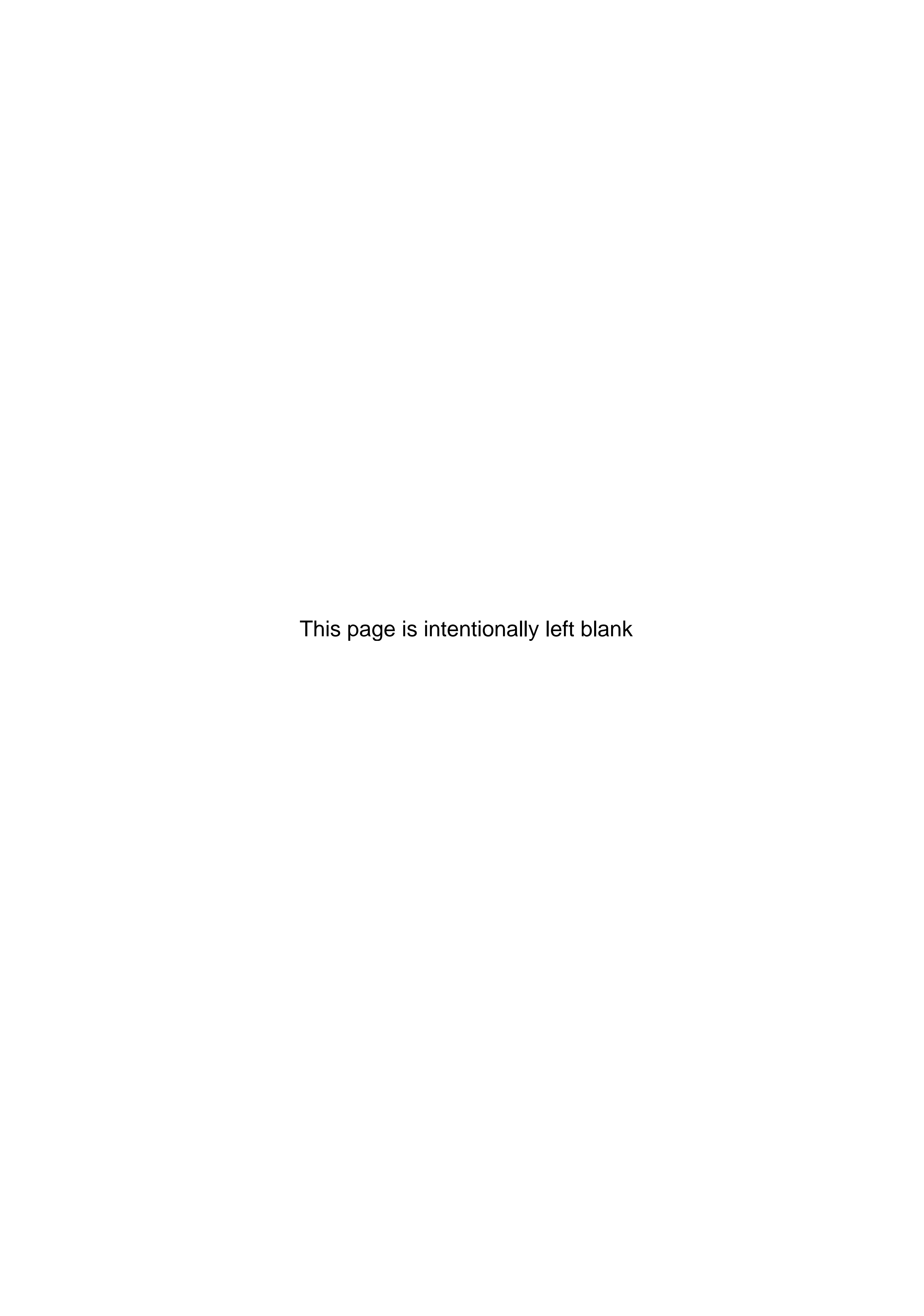
6. Have oversight of Hackney HealthWatch Plans and receive its Annual Report.

7. Communicate the work of the Board to all Hackney residents and other stakeholders, through its website and publications.

8. Agree and maintain a procedure for questions from members of the public.

The quorum for the Board will be at least 4 members, to include at least one Co-Chair and a Councillor.

The Board will act in accordance with the Access to Information procedure rules set out in Part 4 of the Constitution.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Health and Wellbeing Board
8 March 2023

DRAFT MINUTES OF THE HEALTH AND WELLBEING BOARD HELD ON WEDNESDAY 8 MARCH 2023 AT 2PM

THE COUNCIL CHAMBER
HACKNEY TOWN HALL, HACKNEY E8

THIS MEETING WAS LIVE STREAMED AND CAN BE VIEWED HERE
https://youtu.be/EefI92a7S34

In Person

Mayor Philip Glanville (Co-Chair - Hackney Council)
Councillor Christopher Kennedy (Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture - Hackney Council)
Susan Masters (Hackney Community and Voluntary Sector)
Councillor Carole Williams (Cabinet Member for Employment, Human Resources and Equalities - Hackney Council)

Virtually

Jacquie Burke (Group Director - Children and Education)
Mary Clarke (Director of Nursing and Corporate Development, GP Confederation)
Stephanie Coughlin (Co-Chair) (ICP Clinical Lead - City and Hackney)
Nina Griffith (Workstream Director - Unplanned Care - Homerton Hospital Foundation Trust)
Councillor Susan Fajana-Thomas (Cabinet Member for Community Safety and Regulatory Services - Hackney Council)
Dr Sandra Husbands (Director of Public Health, City and Hackney)
Rosemary Jawara (Hackney Community and Voluntary Sector)
Raj Radia (Community Pharmacies)
Helen Woodland (Group Director, Adults, Health and Integration - Hackney Council)

<u>Officers in Attendance:</u>
Mark Agnew (Governance Officer - Hackney Council)
Mark Carroll (Chief Executive - Hackney Council)
Diana Divajeva (Principal Public Health Analyst - Hackney Council)
Anna Garner (City and Hackney Integrated Care Partnership)
Peter Gray (Governance Officer - Hackney Council)
Donna Doherty Kelly (Principal Public Health Specialist - Hackney Council)
Sonia Khan (Head of Policy and Strategic Delivery - Hackney Council)
Cathal Ryan (Service Manager, Domestic Abuse Intervention Service - Hackney Council)
Chris Lovitt (Deputy Director of Public Health - City and Hackney)
Andrew Trathen (Consultant in Public Health - Hackney Council)

Also in Attendance:

Sally Bevan (Healthwatch Hackney)
Andreas Lambrianou (Chief Executive - City and Hackney GP Confederation
Lorraine Sunduza (Director of Nursing - East London Foundation Trust)

1. Apologies for Absence

1.1 Apologies for absence/lateness were from and/or on behalf of Deputy Mayor Bramble, James Conway, Frances Haste, Stephen Haynes, James O’Neill.

2. Appointment of James Conway (BCU Commander, Central East BCU (Hackney and Tower Hamlets)), Metropolitan Police, to the Health and Wellbeing Board

RESOLVED:

To appoint James Conway (BCU Commander, Central East BCU (Hackney and Tower Hamlets)), Metropolitan Police, to the Health and Wellbeing Board.

3. Declarations of Interest - Members to declare as appropriate

3.1 There were no declarations of interest.

4. Minutes of the previous meeting held on 27 January 2022

4.1 **RESOLVED:**

That the minutes of the meeting held on 27 January 2023 be agreed as a true and accurate record of proceedings.

5. Action Log - Review

5.1 The Principal Public Health Specialist updated the Board in regard to the Action Log.

RESOLVED:

To note the Action Log.

6. Hackney Council's Eliminating Violence Against Women and Girls Strategy

6.1 The Service Manager (Domestic Abuse Intervention Service) introduced the report. The Strategy provided a framework and impetus for the Council, partners, and residents, to make Hackney safer for all residents at risk from gender-based violence and domestic abuse, and women and girls in particular. The four priority areas of the Hackney strategy mirror those of the London MOPAC Violence Against Women and Girls (VAWG) strategy and the national VAWG strategy; preventing and reducing VAWG; supporting all victims and survivors; holding perpetrators to account; building trust and confidence.

6.2 The Service Manager, Domestic Abuse Interventions Service, presented to the Board, highlighting the following:

- Eliminating Violence Against Women and Young Girls Strategy agreed by Cabinet on 12 September 2022;
- Policy context, including improving mental health and supporting greater financial security;
- The use of screening and intervention tools;
- Building capacity into the system to ensure that young people can obtain the necessary assistance;
- Intervention at the early stages to mitigate the negative impacts on children;
- Prioritisation of the housing needs of victims/ survivors of domestic abuse;
- Employers to support victims/ survivors of domestic abuse;
- Aim to ensure that all employers in Hackney are equipped to support victims/ survivors of domestic abuse;
- Ways of working, including collaborations and partnerships, and making the best of community resources;

- All agencies across the Hackney Partnership to understand and work to an agreed casework pathway when addressing all forms of domestic abuse;
- Work ongoing with the Hackney Community and Voluntary Sector, and faith and community groups to promote awareness and collaboration;

6.1 Councillor Fajana-Thomas stressed that domestic violence was a major public health problem and that it was important for the Health and Wellbeing Board to review how it was being addressed. Domestic violence could affect women's mental health, physical health, and reproduction. In regard to the Night Time Economy, work was ongoing to make this safer for visitors and residents. Work was ongoing with Tower Hamlets on training on skills and knowledge for those working in licensed premises.

6.2 The Deputy Director of Public Health highlighted that the Homerton Hospital had carried out a great deal of work in regard to identifying domestic violence and referral pathways. Covid 19 had disrupted much of this work, and he asked for an update on any renewed progress in this area.

6.3 Mayor Glanville stressed the good work being carried out, including the multi-generational work, work with young men on breaking the cycle and the recent event on eliminating violence. He asked for clarification on the relationship with the Money Hub to support individuals at the point of crisis and the Hackney Business Network.

6.4 Raj Radia told the Board of the initiative launched in 2021 during the pandemic encouraging those who had been the subject of domestic violence to attend community pharmacies as a safe setting. He emphasised that Community Pharmacies could always assist in this area.

6.5 The Chief Executive stressed the importance of the link between the domestic violence work and the Health and Wellbeing Board. He asked that if the strategy was successful, what metrics would be in place to measure impact.

6.6 The Service Manager, Domestic Abuse Intervention Service, highlighted that:

- That work was ongoing with the Night Time Economy Manager to provide training related to domestic abuse;
- Contact will be made with the Money Hub and Money Matters to consider ways to support individuals at the point of crisis;
- Targets and Indicators were currently in place but there was scope for more health related matrices to be put in place.

6.7 Public Health and the former Clinical Commissioning Group had funded the service to deliver partnership training and to expand the capacity to respond to domestic abuse across Hackney and the City of London.

ACTION:
- The Service Manager, Domestic Abuse Intervention Service, to contact the Money Hub to link into work to support individuals at the point of crisis
- The Service Manager, Domestic Abuse Intervention Service, to make contact with Raj Radia to discuss the role of community pharmacies in domestic violence

RESOLVED:

To note the report.

7. Community Voice - Ageing Well

7.1 Sally Beaven introduced the report. Healthwatch Hackney were asked to contribute a Community Voice item at the Hackney Health and Wellbeing Board around the Ageing Well Strategy. A focus group with 8 older people, who were residents in Hackney, had been convened. Sally Beaven highlighted the following:

- Older peoples' continued involvement;
- The need for joined-up working;
- Older people wanted more detail on all the various organisations involved in the strategy;
- The need for appropriate communication and information flows;
- Concerns around excessive jargon.

Recommendations were as follows:
- Bite sized sessions on the roles of the various organisations was required;
- A newsletter designed to keep older people informed was needed;
- More careful planning of events to ensure that they are accessible;
- Organisations should use the City and Hackney Co-production Charter;
- Ensure communications are jargon free and multilingual;

7.2 Mayor Glanvile asked if all partners were signed up to the City and Hackney Co-production Charter Health and Social Care, stressed the need to use 'Love Hackney' in communicating with Older People, and the importance of ensuring that communication was bilingual and appropriate. He agreed that the recommendations should be embedded in service delivery.

7.3 Councillor Kennedy also highlighted the importance of the productive use of 'Love Hackney' and the need to understand more clearly the roles of other organisations in this area. He informed the Board that all partners had signed up to the co-production charter.

7.4 Susan Masters told the Board:

- that the publication 'Hackney Senior' was written by older people for older people;

- Inappropriate presentation and jargon were common issues of concern in this area;
- Discussions were underway on training for statutory partners on effective presentation;
- The matter had been discussed at the Hackney Downs Forum with recommendations around more targeted communication around such issues as sheltered housing;
- That many over 55s were still in work, were not being reached by activities at present, and whether there needed to be more activity in the early evening to target that cohort.

RESOLVED:

To note the report.

8. **Ageing Well Strategy - Update**

8.1 Anna Garner introduced the report, providing a progress update and identifying some current cross cutting issues of particular relevance to the Health and Wellbeing Strategy priorities and to the Health and Wellbeing Board.

8.2 The Head of Policy and Strategic Delivery highlighted the following:

- Understand and respond to localised need and the interests of older people;
- Ensure Council Services and policies and priorities are age friendly;
- Create a culture shift in how how older people are perceived and supported;
- Influence partners and the Community and Voluntary Sector to support the shared vision;
- How to encourage ageing as a lifelong process;
- Work to highlight the specific support needs of people over 50, and the importance of more targeted support that also supports financial security and wellbeing;
- Emerging solutions from recent scoping sessions;
- The importance of social connection;
- The need to consider the intersection between age, ethnicity, and disability.

RESOLVED:

To note the report.

9. Discussion - Ageing Well Strategy

9.1 Mayor Glanville highlighted the lived experience of ageing in Hackney in areas such as:

- Financial insecurity and health;

- Living in the private rented sector;
- Life limiting conditions;
- Isolation;
- The importance of not stigmatising older people.
- Difficulties around multi-generational households, exacerbated by the housing crisis;
- The need to extend the reach of services and consultation to other groups to influence policy development;
- That the level of pensioner's credit take-up remained low and required to be monitored;
- The need for engagement on the strategy.

9.2 Councillor Fajana-Thomas stressed the importance of seeing ageing as a lifelong process. She commended the work of, and services provided by, 'Hackney Circle'.

9.3 Dr Sandra Husbands highlighted:

- The role of the Board in embedding health inequalities as an outcome;
- Taking into account those areas where dimensions of inequality or discrimination interact;
- The importance of understanding the intersection between age, ethnicity, and disability in driving the work forward;
- That older people do not wish to be marginalised and want to be heard;
- Helping people to age well assists in the achievement of other outcomes for the population.

9.4 Councillor Kennedy highlighted:

- The need to consult on services in a way that does not stigmatise;
- The need to consider how to destigmatise areas such as the reception of credit;
- Thall all partners had signed up to the same co-production charter and were signed up to the idea that all individuals do not interact in the same way, the need to be discreet and looking at how people respond best;
- There were 7,000 unpaid carers in City and Hackney and presently partners had the ability to contact approximately 2,500 in part because many people did not view themselves as carers. Work would soon to start on the Carers Strategy, including looking at ways to better identify that community;

9.5 The Head of Policy and Strategic Delivery confirmed that there would be ongoing systematic engagement on the strategy with partners, with a sense check in six months on progress. She stressed that there was a need to consider how the experience of those over 50 is improved, Recognising intersectionality and tackling key health inequalities will assist in this aim.

10. Health and Wellbeing Board Strategy - Update (Joia De Sa/Anna Garner) (10 Minutes)

10.1. The Consultant in Public Health, Population Health, introduced the report. The Health and the Wellbeing Board had previously agreed the overall aim of this strategy was to reduce health inequalities, focusing on three priorities; improving mental health; increasing social connections; and supporting greater financial security. The Strategy was signed off at the March 2022 Board meeting, and work had started to develop the action plan in July 2022. Since November 2022 this work had been led by the Population Health Hub.

10.2. The Consultant in Public Health highlighted:

- The Population Health Hub had been tasked with coordinating the implementation of the strategy with a report on this work to be submitted to the next meeting of the Board;
- The role of the system wide resource was to support people in looking at how to improve population health;
- The aim was to ensure that the work leverages opportunities to add value to systems and structures that are already in place;
- It had been agreed to convene a social connection actions group with nominated champions to take forward the draft action plan that emerged from the workshop. The aim was to build on the good work carried out, and identify the existing gaps and opportunities;
- Work was ongoing around the system wide cost of living group, with the Population Hub attending to ensure that the perspective around increasing financial security was considered.

10.3. The Consultant in Public Health, highlighted:

- Much good work was being carried out on mental health in North East London, with the Integrated Care Strategy reflecting both mental health and place-based priorities;
- The approach was to design something that was complimentary to all systems currently in place, and the priorities that had already emerged;
- The proposal was to develop a strategic action plan to be rooted in a strong evidence base. Work had started on scoping what the needs assessment is going to accomplish, with time frames dependent on the chosen questions;
- The Population Health Hub attends the Mental Health Integration Committee, to ensure that health and wellbeing priorities are fed in.

10.4. Dr Stephanie Coughlin stressed that the interface between mental health and physical health was recurring as a theme, and suggested this area should be considered as part of this ongoing work.

10.5. The Consultant in Public Health confirmed that this area was forming part of the need assessment.

10.6. Councillor Williams raised the question of trauma amongst the Turkish community following the recent earthquakes. The Chair stressed that work had been carried out in this area, with concerns around long term impacts.

There was a need to look at a long term approach to the impacts of issues such as inequalities and external events.

10.7. The Chair asked if there were any barriers to the implementation of the Health and Wellbeing Strategy that the Board could assist with.

10.8. The Consultant in Public Health confirmed positive reaction to the wide engagement on the strategy, but highlighted that there was no specific funding attached to this work despite it being a big priority. There was a need to think more creatively around socal connection and consider other levers such as how services are commissioned. The Chair welcomed any business case for investment. He stressed the need to connect with the broader themes on mental health, aligning with the Mayor's initiatives and the work of the Integrated Care Board, and giving access to external expertise and resources.

10.9. The Head of Policy and Strategic Delivery highlighted:

- There was was a need to developing a long term approach when considering how inequalities and external events impact on mental health;
- The need to consider how the Council works with the Community and Voluntary Sector to inform the current thinking around investment, and also consider how organisations are funded, valuing social connection and outcomes.

9.10 The Director of Public Health highlighted;

- The need for increased funding in the area of social connection;
- The need to value the work of community groups in relation to social connection;
- The need to consider doing things differently by bringing people together;
- Measuring impacts in different ways.

11. Update on the Joint Strategic Needs Assessment Work Programme

11.1 The Chair agreed that the report be considered as an urgent item so that work on the JSNA can progress.

11.2 The Principal Public Health Analyst introduced the update report, highlighting the following:

- Homelessness and substance abuse are to be moved to the new financial year, though some of the work on substance abuse was already underway;
- Mental health had been added to the work plan for the next year;
- The final draft on sexual health was ending its review;
- Work on tobacco and cancer were slightly delayed but work was ongoing.

11.3 Partners should contact the Principal Public Health Analyst if they wish to add to the work programme.

11.4 Councillor Williams asked if rare and less common cancers will be considered.

11.5 Councillor Kennedy asked that the relevant lead officer attend the Board to report on key findings when a review of an area of work is complete.

11.6 The Chair highlighted:

- That data from scoping out homelessness would be useful in informing the Housing Strategy and the Housing Needs Strategy;
- The need to capture national policy change in the JSNA;
- The need for data on Project ADDER and its impact
- There was a waiting list around the treatment of cancer. Did condition, inequality, and geography impact this. There was a need to look for opportunities to collaborate on this across North East London.

11.7 Councillor Fajana-Thomas referred to the Late Night Levy and Substance Abuse Board and asked whether there was linkage on substance abuse.

11.8 The Principal Health Analyst responded as follows:

- That analysis could be carried out on rare cancers but as this would be on a small group this would not be as meaningful as if this analysis was carried out on a larger number.
- Colleagues had been engaging with the Cancer Network and the Community and Voluntary Sector to get insights from the patient's perspective;

11.9 The Director of Public Health highlighted;

- That efforts were made to ensure that comprehensive information on conditions was produced, but that in the case of rare cancers there would only be a small cohort making it difficult to draw inferences from the data, with the added difficulty that it could be possible to identify individuals from the data;

11.10 The Consultant in Public Health told the Board that there was priority to establish a Combating Drugs Partnership, with representatives from Community Safety and those working on the Night Time Economy in City and Hackney, which was in the process of setting strategic objectives, to coincide with grant funding coming on line in the next financial year.

12. Health Based Promotions

12.1 The Chair referred to the fact that a lot of health based promotions had been passed by full Council, such as rare and uncommon cancers and menopause which most be built into the work programmes of partners and asked that these are circulated to the Board.

ACTION: Governance Services to circulate details of health based promotions as passed by Full Council Council to members of the Board.

End of meeting

Duration of Meeting: 4 - 6pm

Chair: Mayor Glanville

Contact:
Peter Gray
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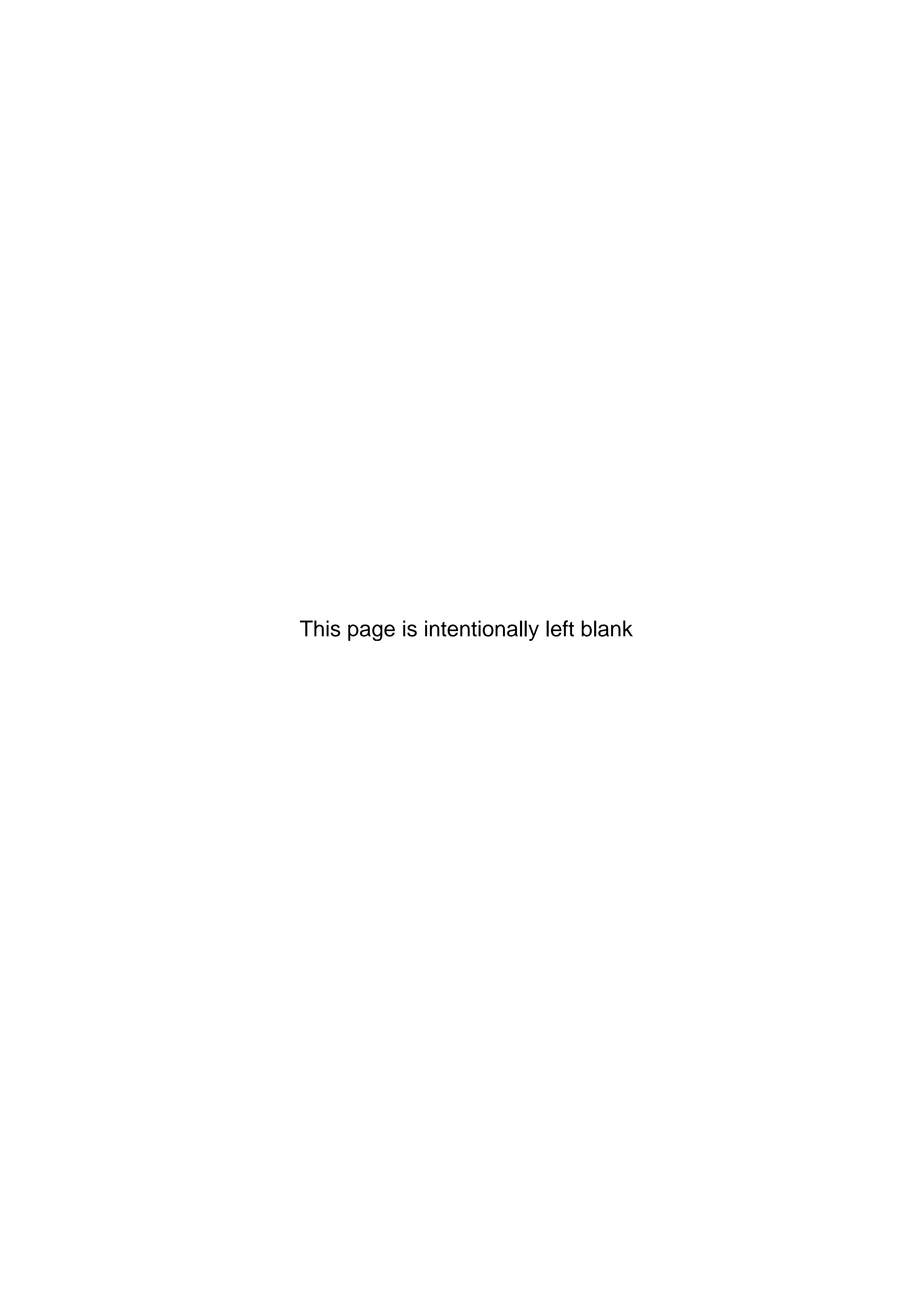
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Meeting Date	Agenda Item	Ref	Action	Responsible Officer	Action to be completed by	Notes	Status
08.03.2023	6: Hackney Council's Eliminating Violence Against Women and Girls Strategy	1	The Service Manager, Domestic Abuse Intervention Service, to contact the Money Hub to link into work to support individuals at the point of crisis	Cathal Ryan	ASAP	Cathal followed up with Money Hub on 9th March. Cathal presented to the 'Poverty reduction: Tools for work with residents who are struggling' forum on 20th April about recognising and responding to domestic abuse and the offer of training available to the partnership and community from the Council's Domestic Abuse Intervention Service. Cathal organised for the Money Hub to present to staff across local domestic abuse agencies in Hackney on 19th April and has disseminated Money Hub training slides to the Hackney domestic abuse partnership. This action is complete	Complete
		2	The Service Manager, Domestic Abuse Intervention Service, to make contact with Raj Radia to discuss the role of community pharmacies in domestic violence	Cathal Ryan	ASAP	Cathal followed up with Raj on 8th March and has followed up again since then. Cathal has also followed up with Public Health colleagues regarding pharmacies and has asked Raj and Public Health to help map recognition and response to domestic abuse. This strand of work is ongoing	Ongoing

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Title of Report	**NEL Joint Forward Plan**
For Consideration By	Health and Wellbeing Board
Meeting Date	29 June 2023
Classification	Open
Ward(s) Affected	All
Report Author	Jubada Akhtar-Arif, *Transformation Programme Manager, NHS North East London* Hilary Ross, *Director of Strategy, North East London ICS*

Is this report for:

- ☐ Information
- ☑ ~~Discussion~~
- ☐ Decision

Why is the report being brought to the board?

This report is being brought to the board as part of an engagement session. We are engaging with all HWBB.

Has the report been considered at any other committee meeting of the Council or other stakeholders?

This has been considered at all other HWBB and Place based Partnership meetings.

1. Background

1.1. 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.

1.2. 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.

1.3. 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.

1.4. 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.

1.5. 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.

2. Recommendation(s)

The Health and Wellbeing Board is recommended to:

2.1. Consider and comment on the NEL JFP and how it aligns with Tower Hamlets local priorities

2.2. Identifying any potential gaps

3. Main Report

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

4. Policy Context:

Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?

- ☐ Improving mental health
- ☐ Increasing social connection and
- ☐ Supporting greater financial security
- ☑ ~~All of the above~~

Please detail which, if any, of the Health & Wellbeing Ways of Working this report relates to?

- ☐ Strengthening our communities
- ☐ Creating, supporting and working with volunteer and peer roles

☐ Collaborations and partnerships: including at a neighbourhood level
☐ Making the best of community resources
☑ ~~All of the above~~

5. **Equality Impact Assessment**

Has an EIA been conducted for this work?

☐ Yes
☑ ~~No~~

6. **Consultation**

Has public, service user, patient feedback/consultation informed the recommendations of this report?

☐ Yes
☑ ~~No~~

Have the relevant members/ organisations and officers been consulted on the recommendations in this report

☐ Yes
☑ ~~No~~

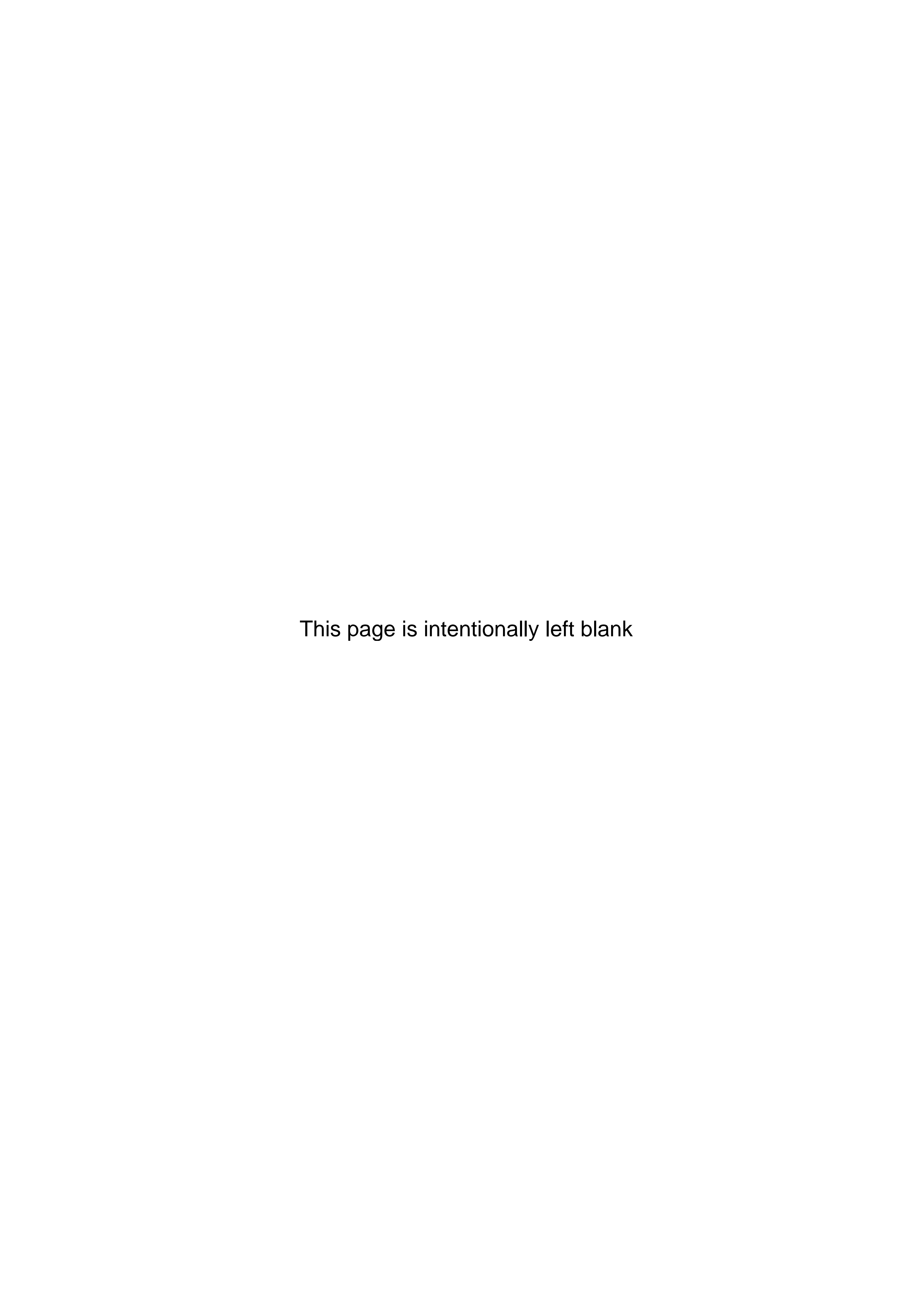
7. **Risk Assessment**

N/A

8. **Sustainability**

N/A

Report Author	Jubada Akhtar-Arif, *Transformation Programme Manager, NHS North East London* Hilary Ross, *Director of Strategy, North East London ICS*
Contact details	j.akhtar-arif@nhs.net hilary.ross1@nhs.net
Appendices	NEL Joint Forward Plan March 2023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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

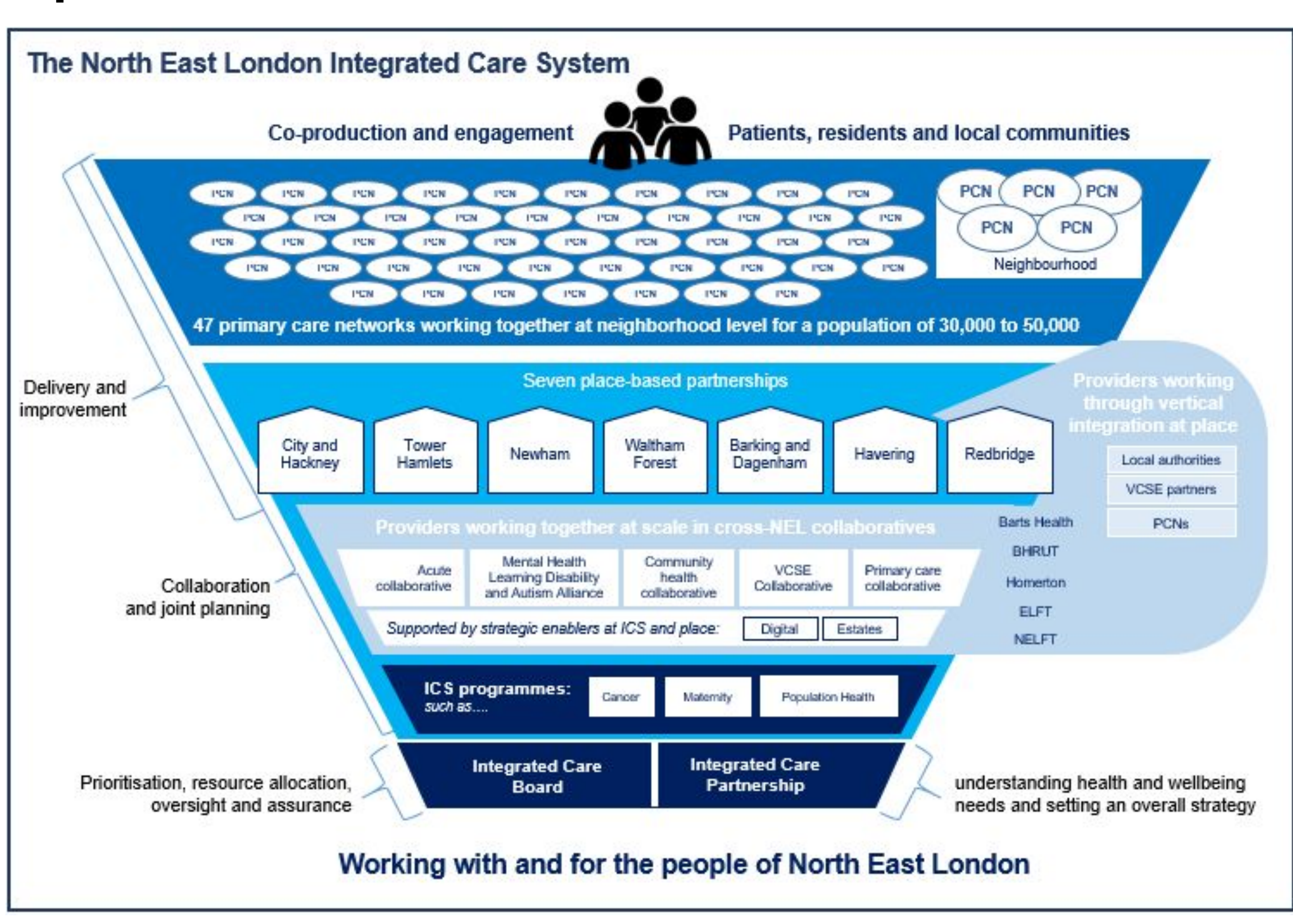
We are a broad partnership, brought together by a single purpose: to improve health and wellbeing outcomes for the people of north east London.

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

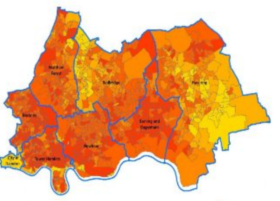
NEL is made up of many different communities and cultures. Just over half (53%) of our population are from ethnic minority backgrounds.

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

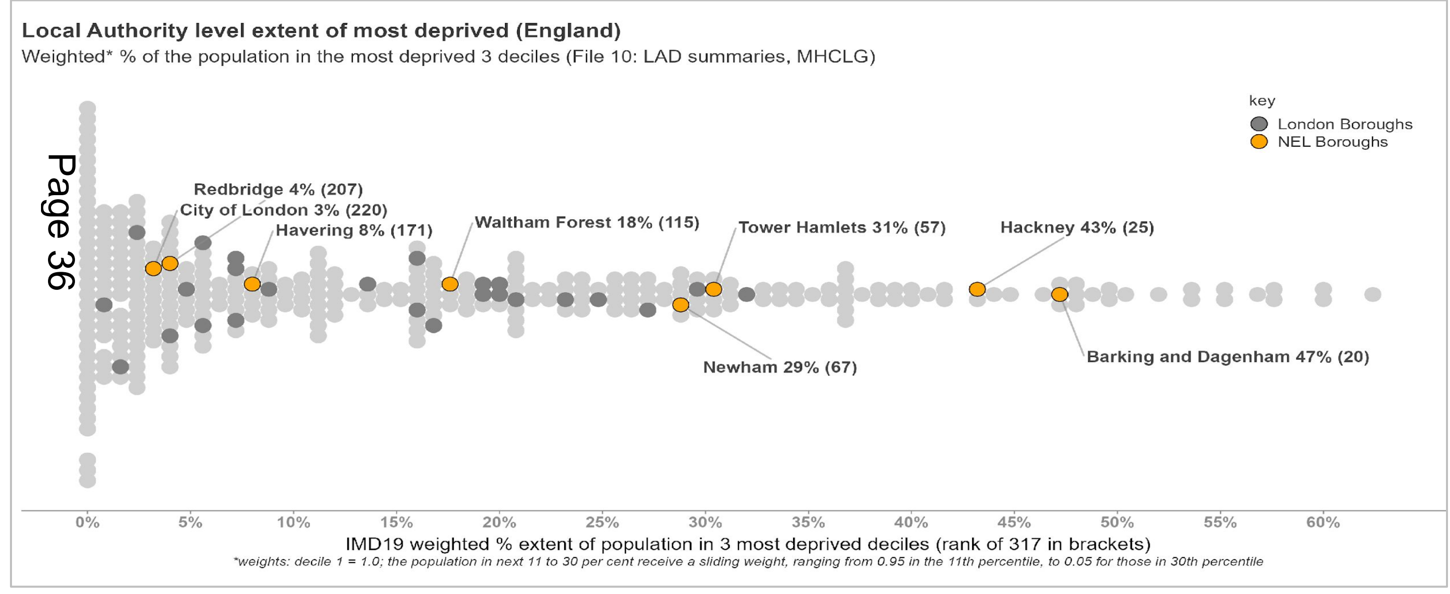
There are significant inequalities within and between our communities in NEL, and our population has worse health outcomes than the rest of the country across many key indicators. Health inequalities are linked to wider social and economic inequalities including poverty and ethnicity.

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.

Index of Multiple Deprivation (2019) by LSOA national quintile (1 = most deprived 20% in England)

Legend: quintile 1, quintile 2, quintile 3, quintile 4, quintile 5

Waltham Forest, Redbridge, Havering, City & Hackney, Tower Hamlets, Newham, Barking & Dagenham

Percentage of resident population (ONS 2020 est.) in each deprivation quintile by place

Index of Multiple Deprivation (IMD 2019) Quintile (where 1 is most deprived 20% of LSOAs in England)

	quintile 1 (most deprived)	quintile 2	quintile 3	quintile 4	quintile 5 (least deprived)
Barking & Dagenham	53.7% (115,082)	38.1% (81,546)	8.2% (17,479)		
City & Hackney	40.1% (117,075)	49.7% (145,178)	8.4% (24,511)	0.6% (1,688)	1.2% (3,427)
Tower Hamlets	28.7% (95,372)	46.2% (153,234)	13.4% (44,399)	9.1% (30,346)	2.6% (8,618)
Newham	24.4% (86,804)	67.1% (238,416)	7.9% (28,040)	0.6% (2,006)	
Waltham Forest	15.7% (43,456)	50.6% (140,102)	28.1% (77,919)	5.1% (14,063)	0.5% (1,400)
Havering	7.7% (19,968)	18.4% (47,855)	27.8% (72,581)	24.4% (63,649)	21.7% (56,598)
Redbridge	3.3% (9,975)	20.8% (63,588)	42.9% (131,165)	22.6% (69,202)	10.4% (31,728)

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.

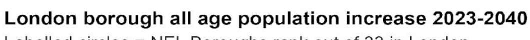
Our population is not static – we expect it to grow by over 300,000 in the coming years, significantly increasing demand for local health and care services

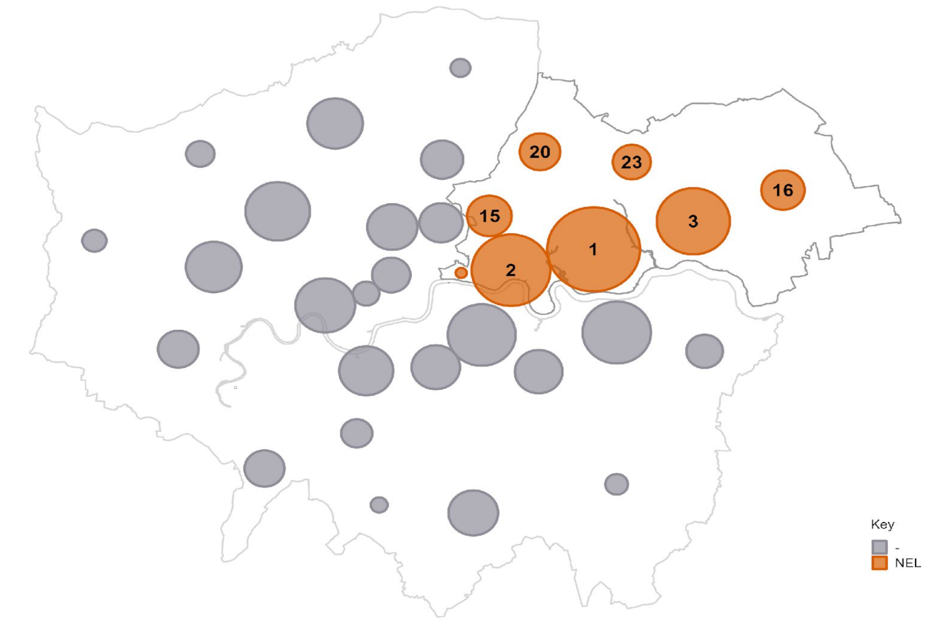
The population of north east London (currently just over 2 million) is projected to increase by almost 15% (or 300k people) between 2023 and 2040, the equivalent to adding a whole new borough to the ICS, and by far the largest population increase in London.

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.

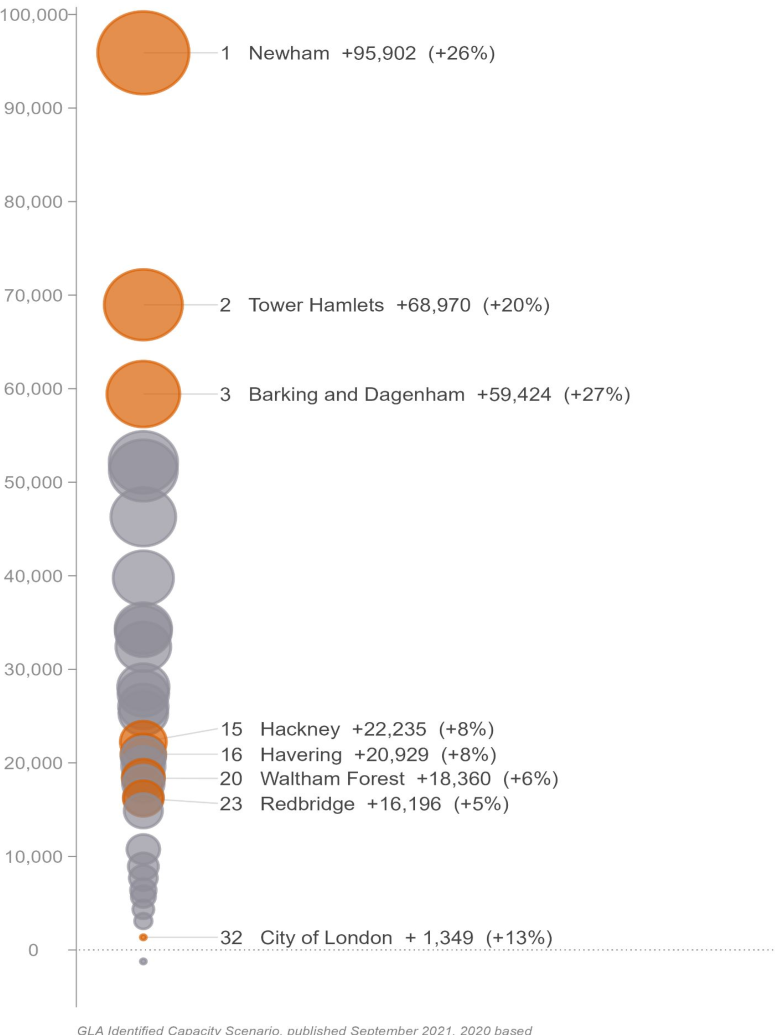
ICS	Increase in population 2023-2040
NEL	+303,365
SEL	+175,292
NWL	+169,344
NCL	+115,801
SWL	+90,220

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.





GLA Identified Capacity Scenario, published September 2021, 2020 based

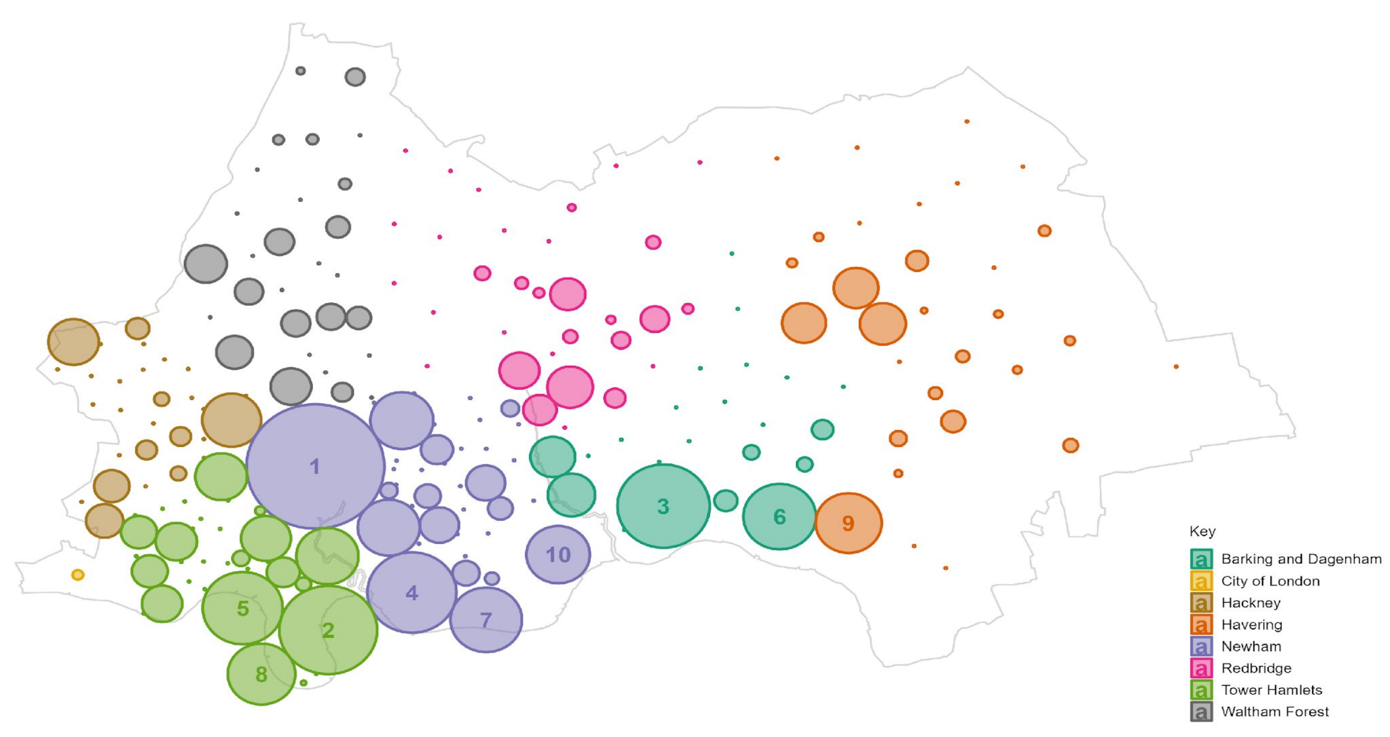


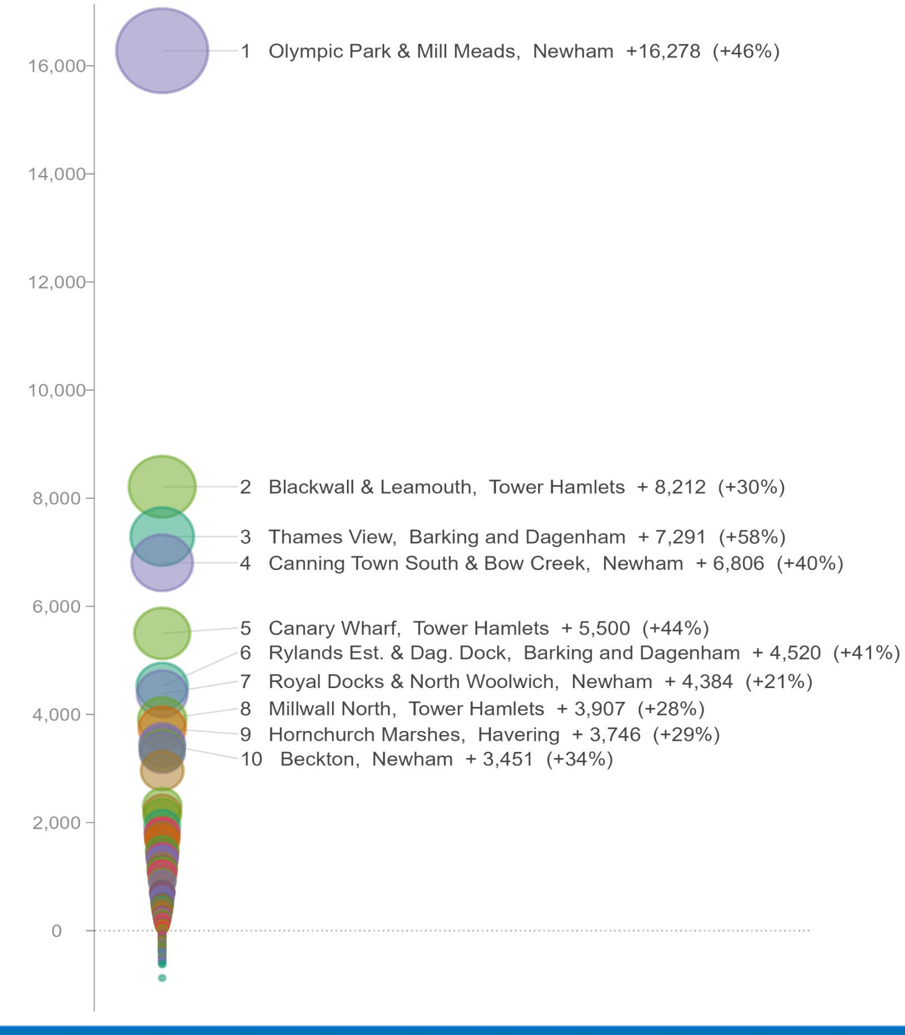
GLA Identified Capacity Scenario, published September 2021, 2020 based

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.





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

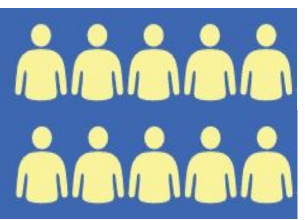
To be updated during April-June in line with People Strategy currently under development

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.

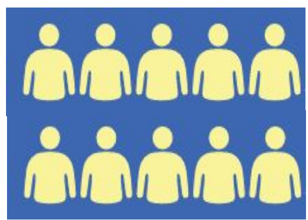
In NEL we are supporting the development of a VCSE Collaborative to create the enabling infrastructure and support sustainability of our rich and diverse VCSE in NEL, also ensuring that the contribution of the VCSE is valued equally.

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

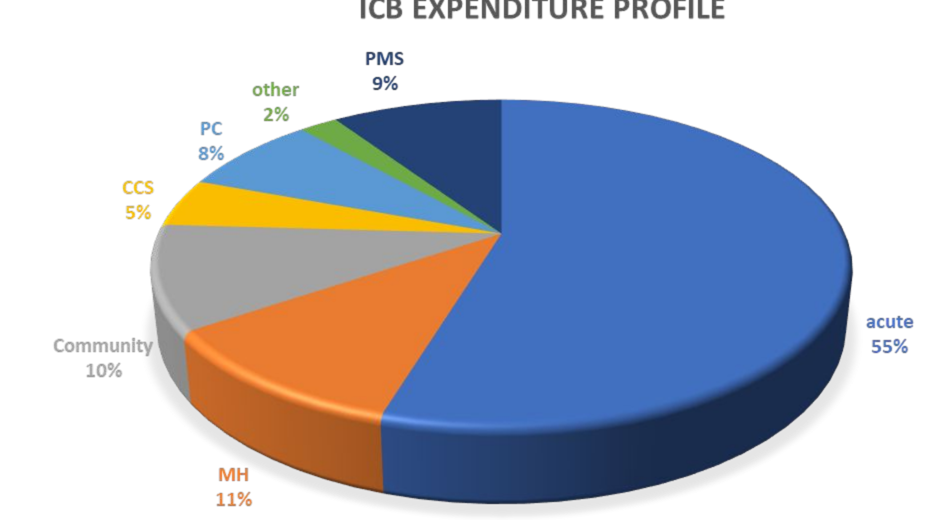
- North east London currently has relatively few GP appointments per 100,000 weighted population (39,244 vs a median for all ICSs of 42,360 – i.e. the national median is around 8% greater than in NEL), suggesting part of the cause of pressure on other parts of the system, including greater than expected 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

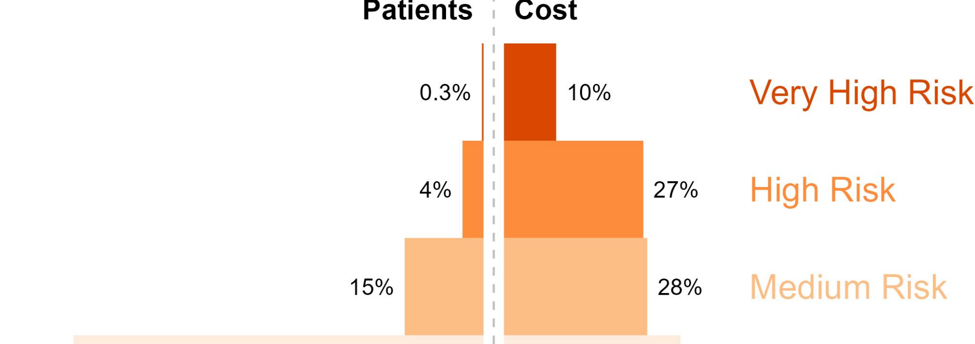
- Across north east London one in four (over 600 thousand people) have at least one long term condition, with significant variation between our places (in Havering the figure is 33%, vs 23% in Newham and Tower Hamlets).
- Age and deprivation are strong predictors of long term conditions, so while north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



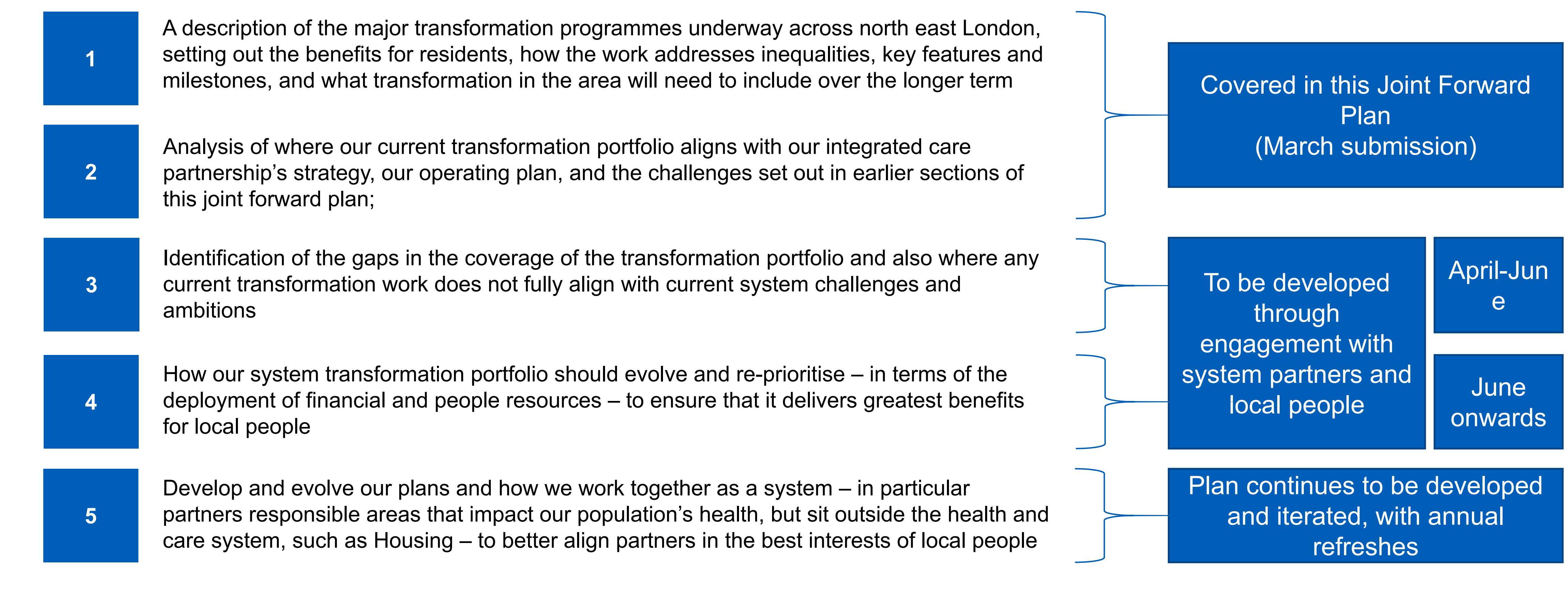
Percentage of emergency admission cost and patients attributable to risk bands for expected risk of admission for patients registered with a NEL GP in February 2023. Combined Predictive Model run on NEL SUS data estimates risk of admission. Cost of all emergency admissions to patients in each risk band 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



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** (by 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.

Led by	Programme	Page*
Acute provider collaborative	Critical care	85
	Research and clinical trials	86
	Specialist services	87
Mental health, learning disabilities, and autism collaborative	Lived experience leadership programme	88
	Learning disabilities and autism improvement programme	89
Barking and Dagenham place partnership	Ageing well	90
	Healthier weight	91
	Stop smoking	92
	Estates	93
City and Hackney place partnership	Supporting with the cost of living	94
	Population health	95
	Neighbourhoods programme	96
Havering place partnership	Infrastructure and enablers	97
	Building community resilience	98
	St George's health and wellbeing hub	99
	Living well	100
	Ageing well	101
Newham	Frailty model	102
	Neighbourhood model	103
	Population growth	104

Led by	Programme	Page*
Newham place partnership	Learning disabilities and autism	105
	Ageing well	106
	Primary care	107
Redbridge place partnership	Health inequalities	108
	Accelerator priorities	109
	Development of the Ilford Exchange	110
Tower Hamlets place partnership	Living well	111
	Promoting independence	112
Waltham Forest place partnership	Centre of excellence	113
	Care closer to home	114
	Home first	115
	Learning disabilities and autism	116
	Wellbeing	117
NHS North East London	Tobacco dependence programme	118
	NEL homelessness programme	119
	Anchors programme	120
	Net zero (ICS Green Plan)	121
	Refugees and asylum seekers	122
	Discharge pathways programme	123
	Pharmacy and Medicine Optimisation/ NEL	124

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 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
Recovering our core services and improving productivity	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

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 occuring 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 infastrcutrue	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 disabilities and autism 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 smoking		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 disabilities and autism																					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.

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.

April

May

June

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

April / May
- 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

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

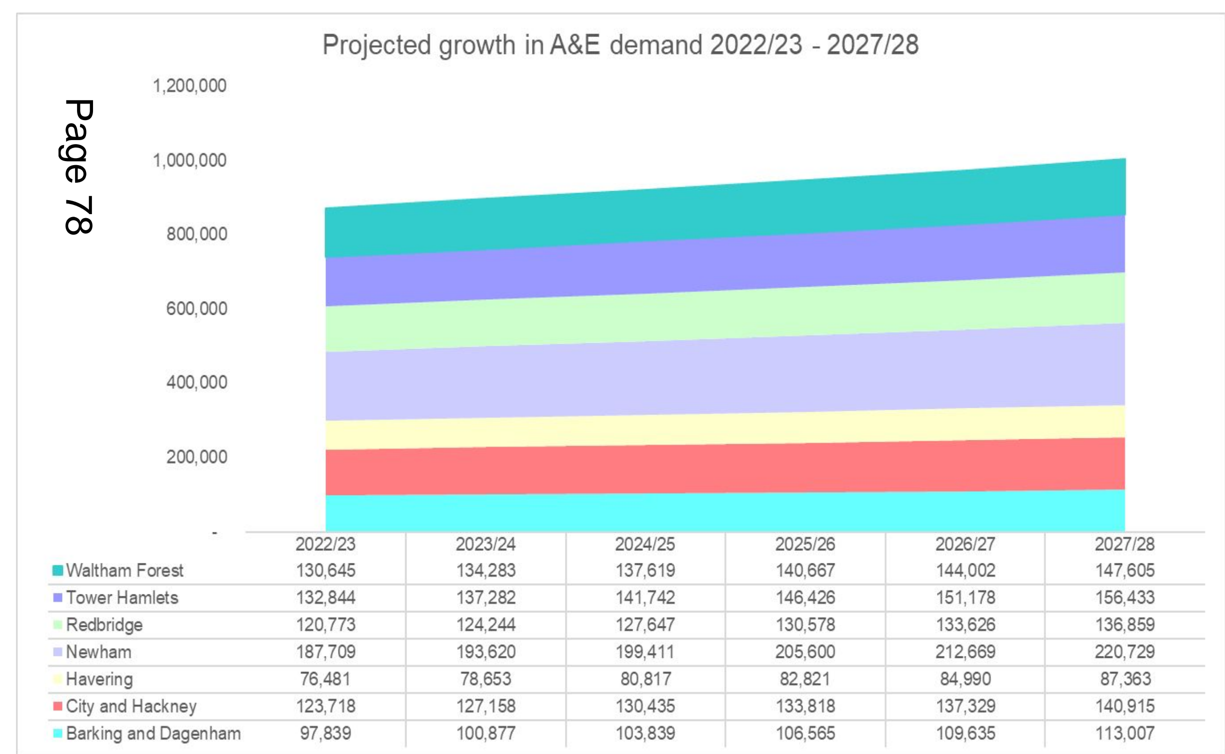
Annex 9A - demand projections

Demand projections for UEC

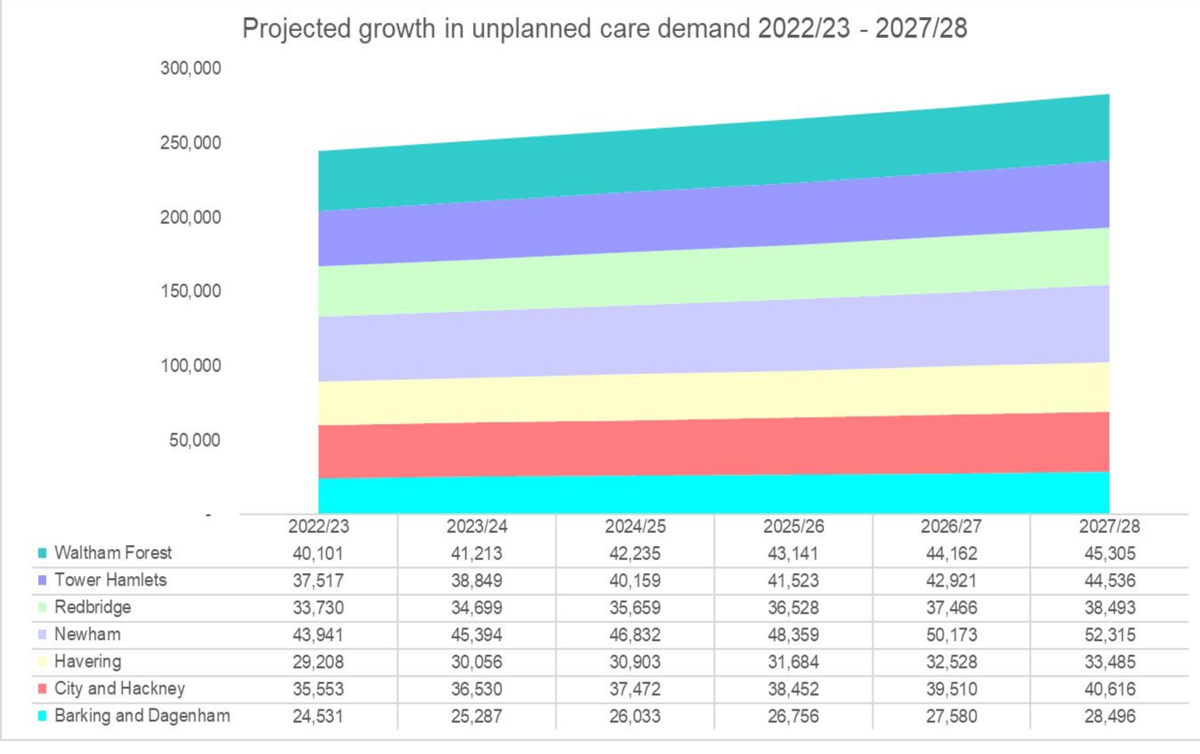
A&E demand is expected to grow – as a result of demographic and non-demographic growth – by 15.3% during the five-year period. That would equate to around 133,000 extra A&E attendances.

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.



	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

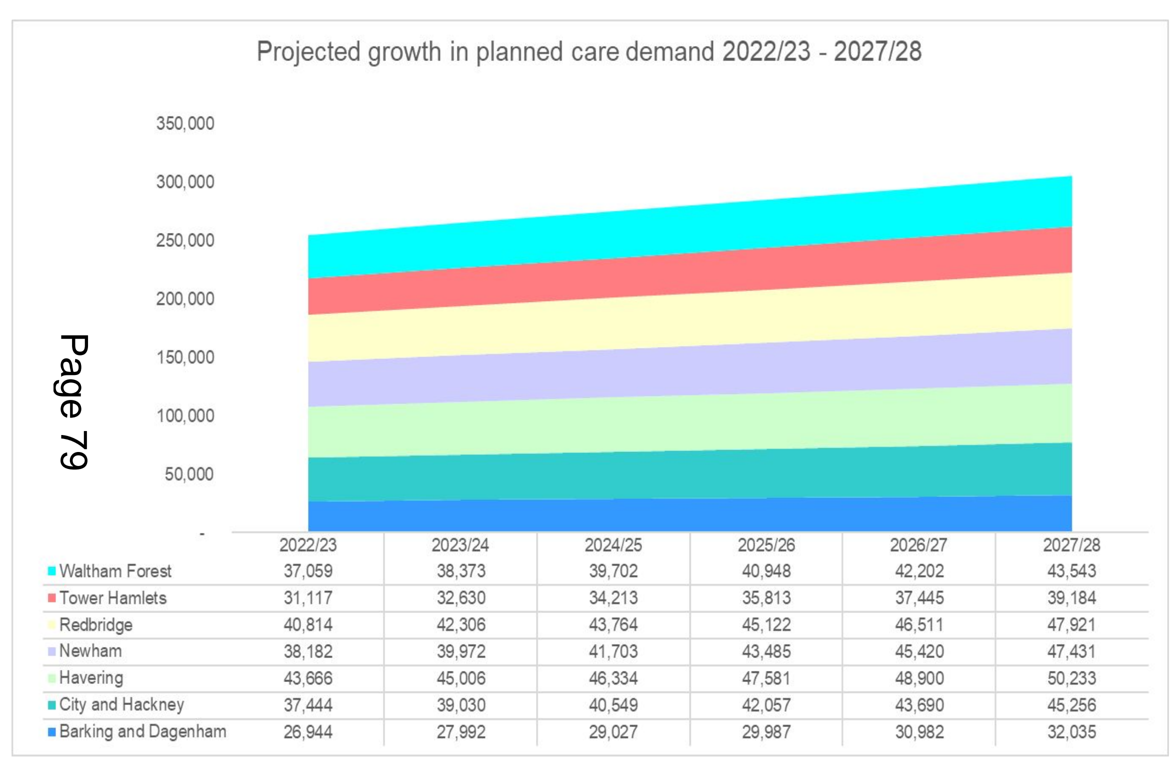


	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Waltham Forest	40,101	41,213	42,235	43,141	44,162	45,305
Tower Hamlets	37,517	38,849	40,159	41,523	42,921	44,536
Redbridge	33,730	34,699	35,659	36,528	37,466	38,493
Newham	43,941	45,394	46,832	48,359	50,173	52,315
Havering	29,208	30,056	30,903	31,684	32,528	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

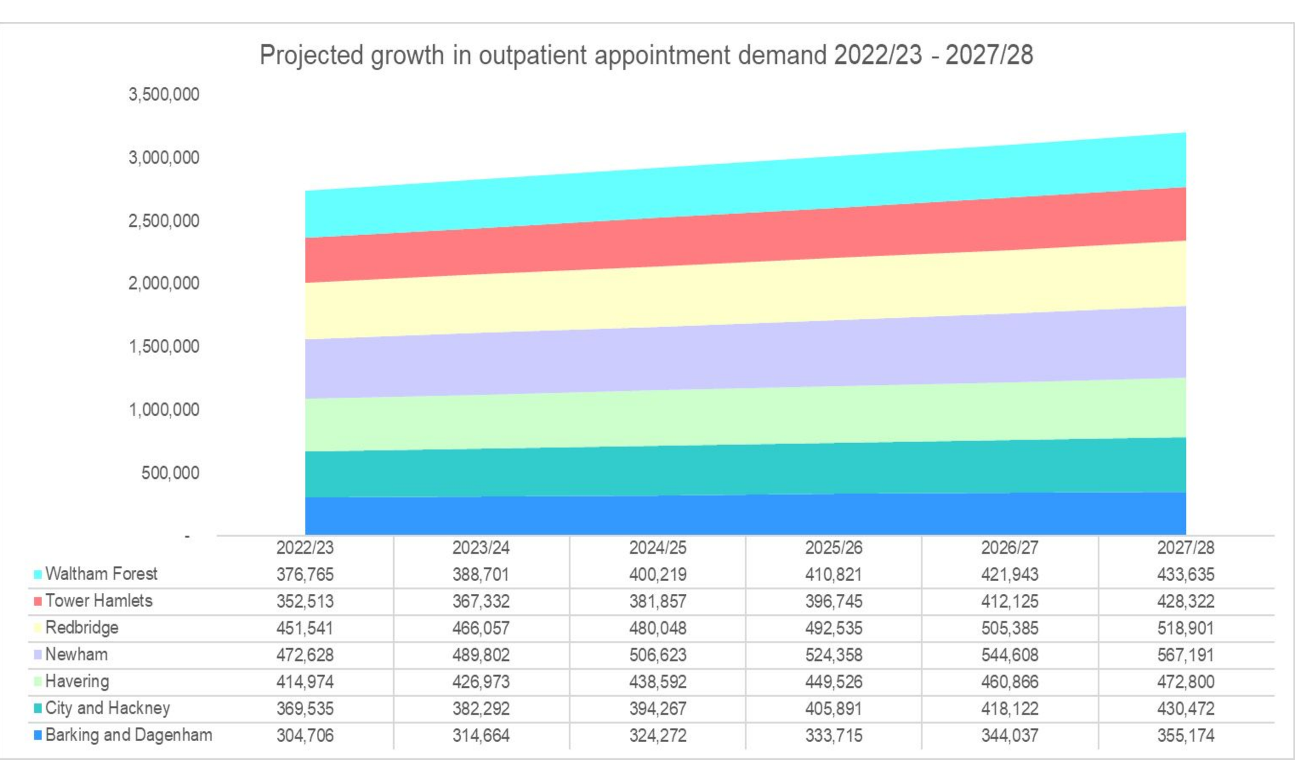
Figures are based on modelling by the NEL Insights Team which uses GLA population growth projections

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

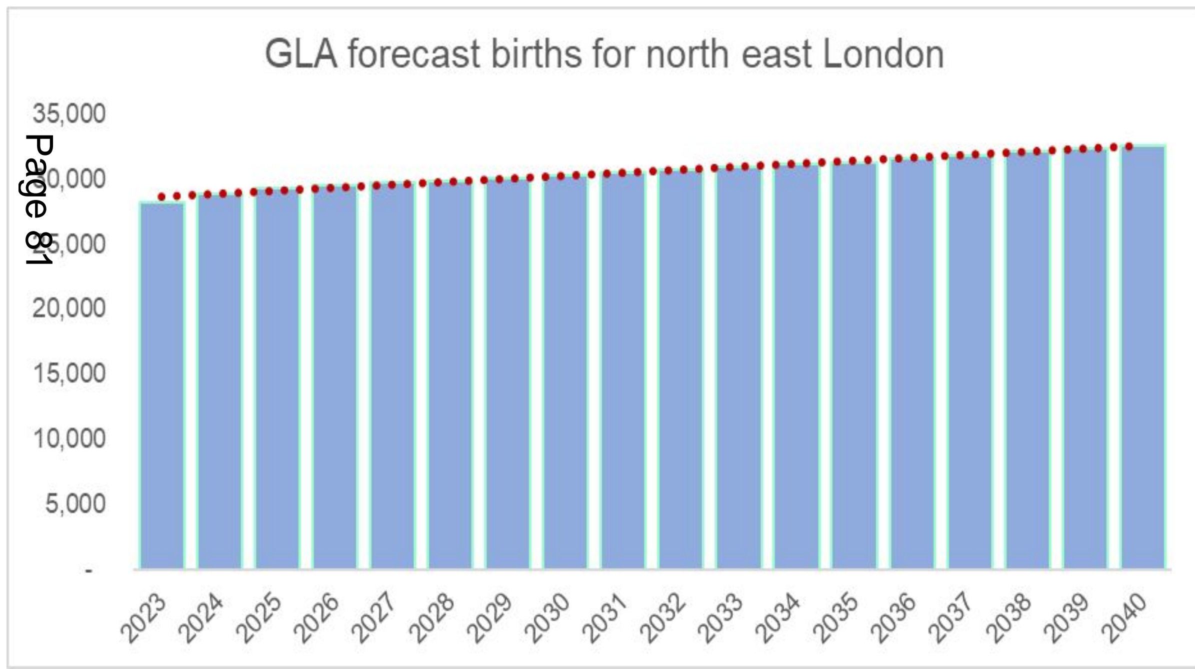
Imaging diagnostics projected demand growth 2022/23 - 2027/28								
	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	Growth	5 year trend
Cone Beam CT	1,515	1,557	1,599	1,643	1,690	1,738	14.7%	
CT Scan	214,182	223,675	233,001	242,000	251,320	261,346	22.0%	
Endoscopy	1,668	1,744	1,818	1,888	1,962	2,041	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%**	

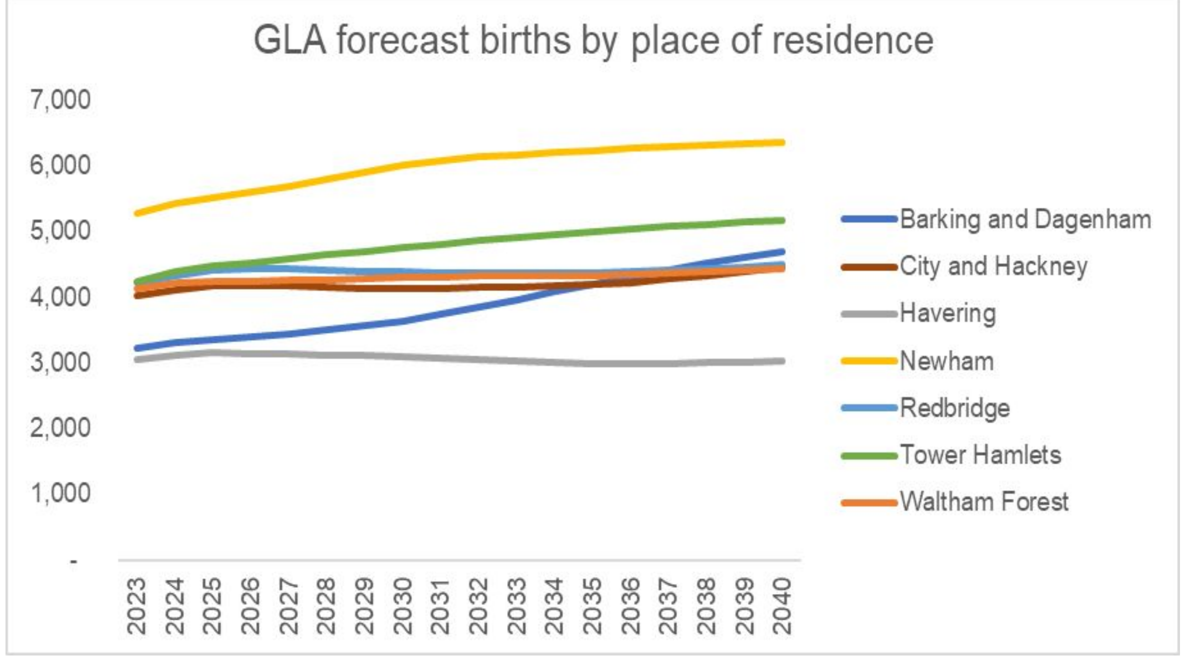
Demand projections for maternity

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.

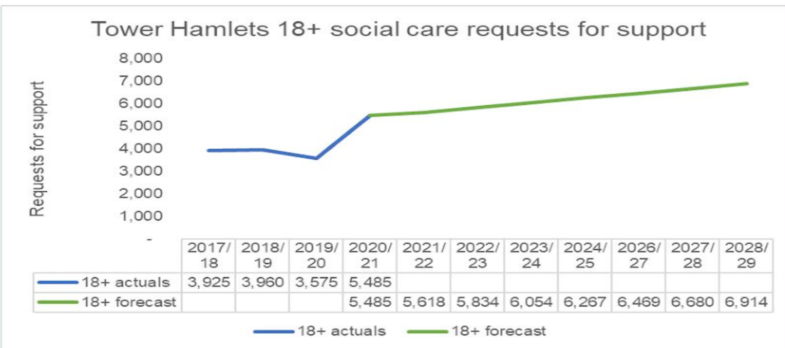
Havering forecast a reducing number of births between 2026 and 2036.



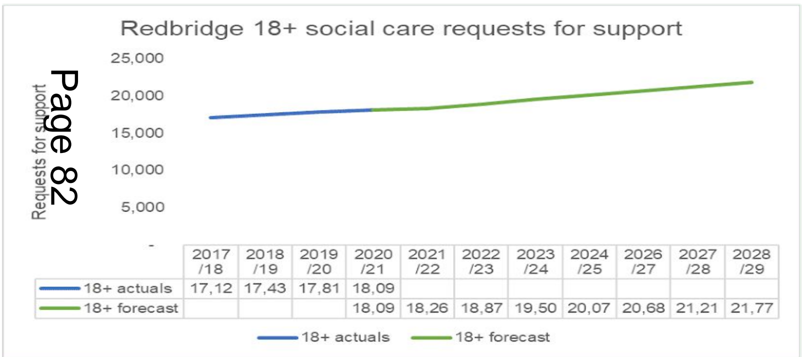


Demand projections for social care

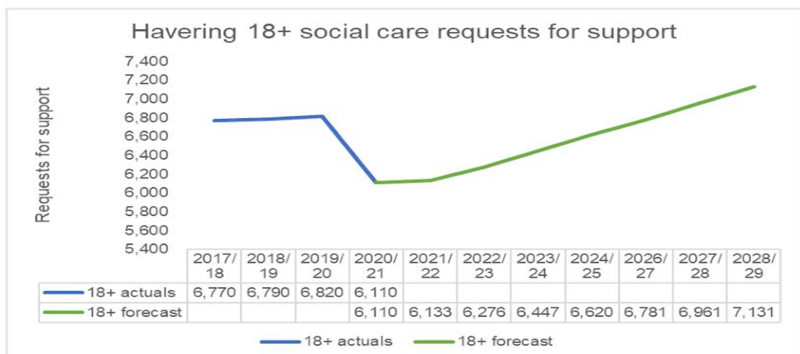
- This forecast is based on social care social care data showing number of requests for support received from new clients aged 18+.
- Approach to high level model:
  - Demographic growth assumption based on GLA housing led population projection (2021-based identified capacity scenario)
  - Non-demographic 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.



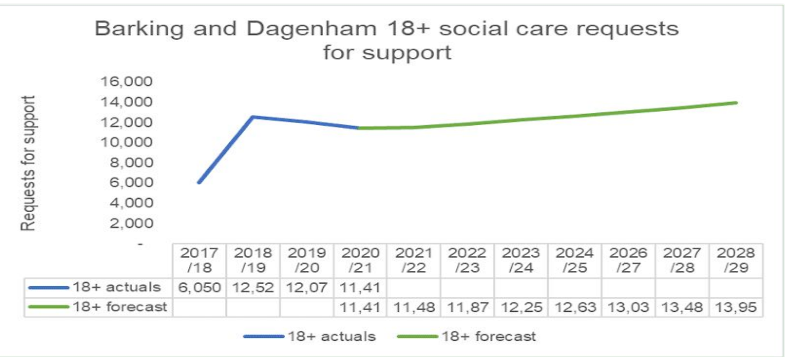
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	3,925	3,960	3,575	5,485							
18+ forecast				5,485	5,618	5,834	6,054	6,267	6,469	6,680	6,914



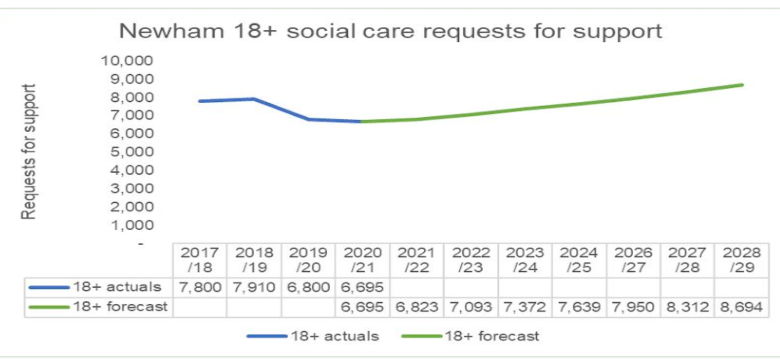
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	17,12	17,43	17,81	18,09							
18+ forecast				18,09	18,26	18,87	19,50	20,07	20,68	21,21	21,77



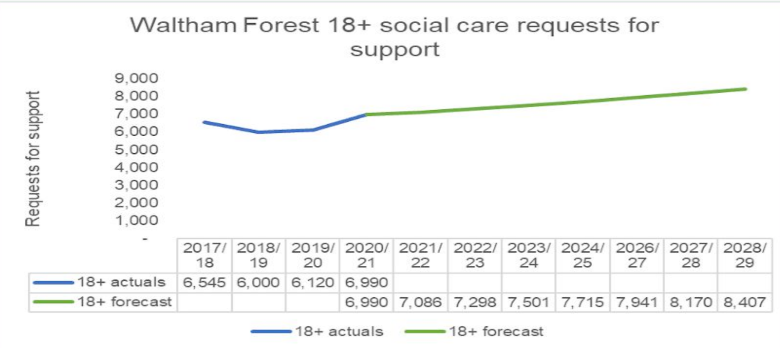
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	6,770	6,790	6,820	6,110							
18+ forecast				6,110	6,133	6,276	6,447	6,620	6,781	6,961	7,131



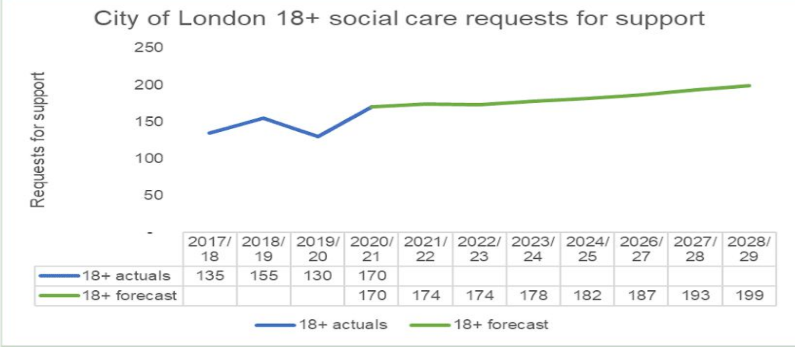
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	6,050	12,52	12,07	11,41							
18+ forecast				11,41	11,48	11,87	12,25	12,63	13,03	13,48	13,95



	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



	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



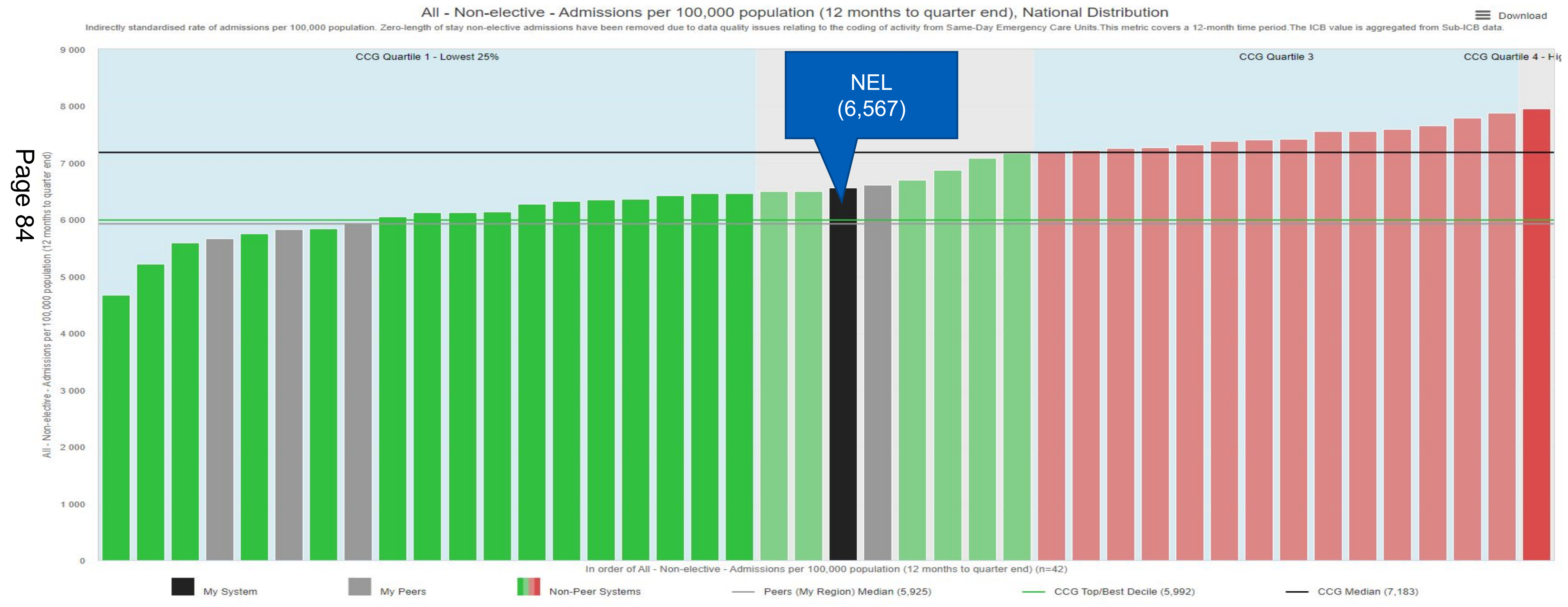
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	135	155	130	170							
18+ forecast				170	174	174	178	182	187	193	199

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%

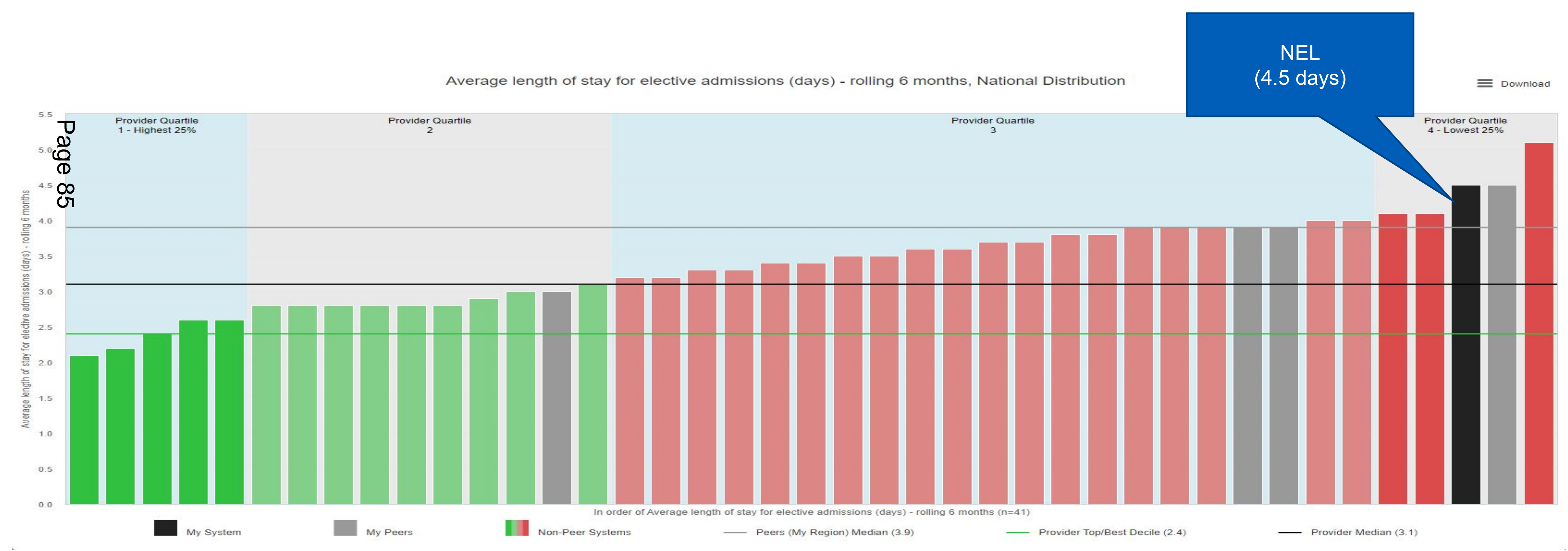


Data is from 'Model Health System' and covers a 12-month period, ending Q2 2022/23.

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

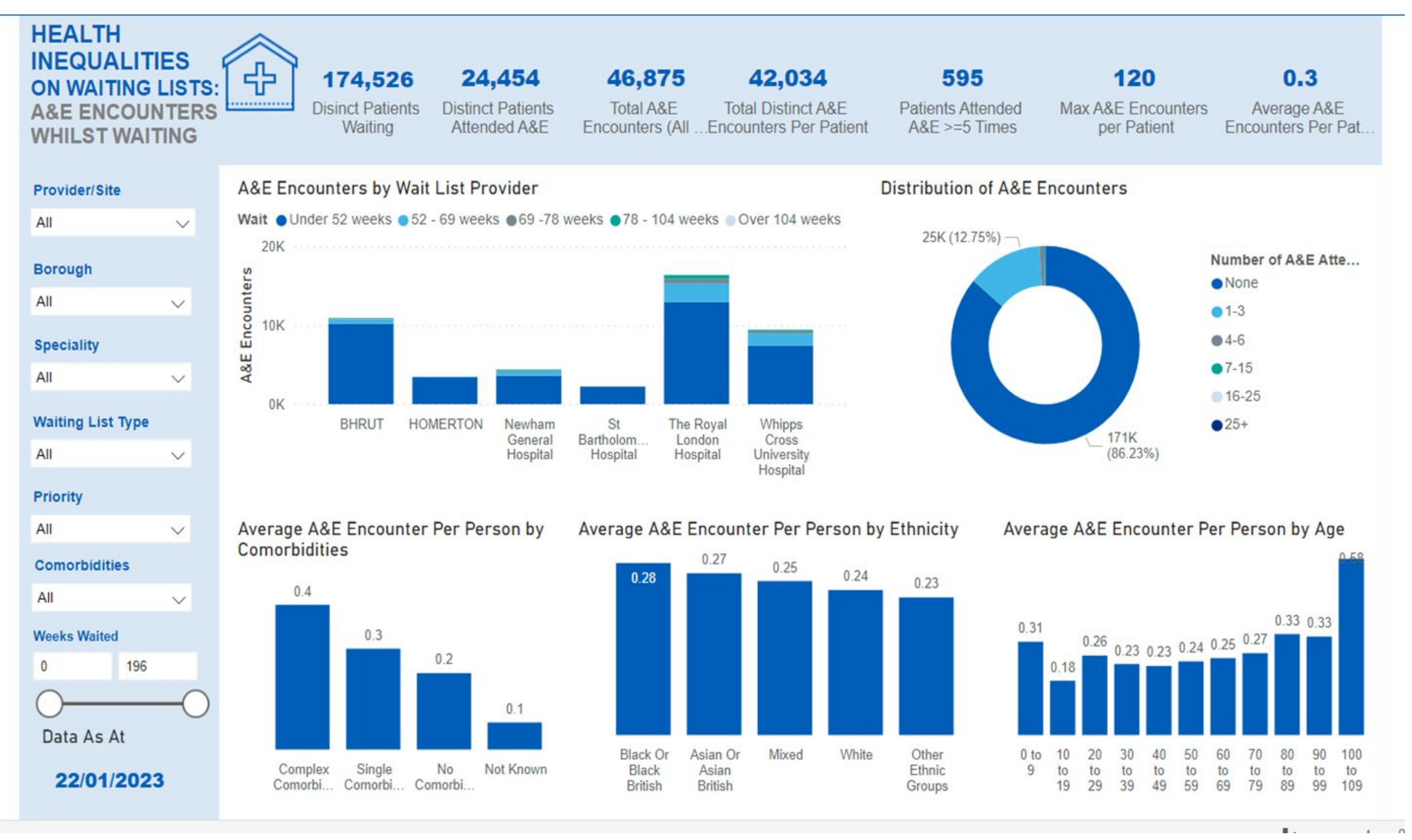
UEC – opportunities for improvement

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

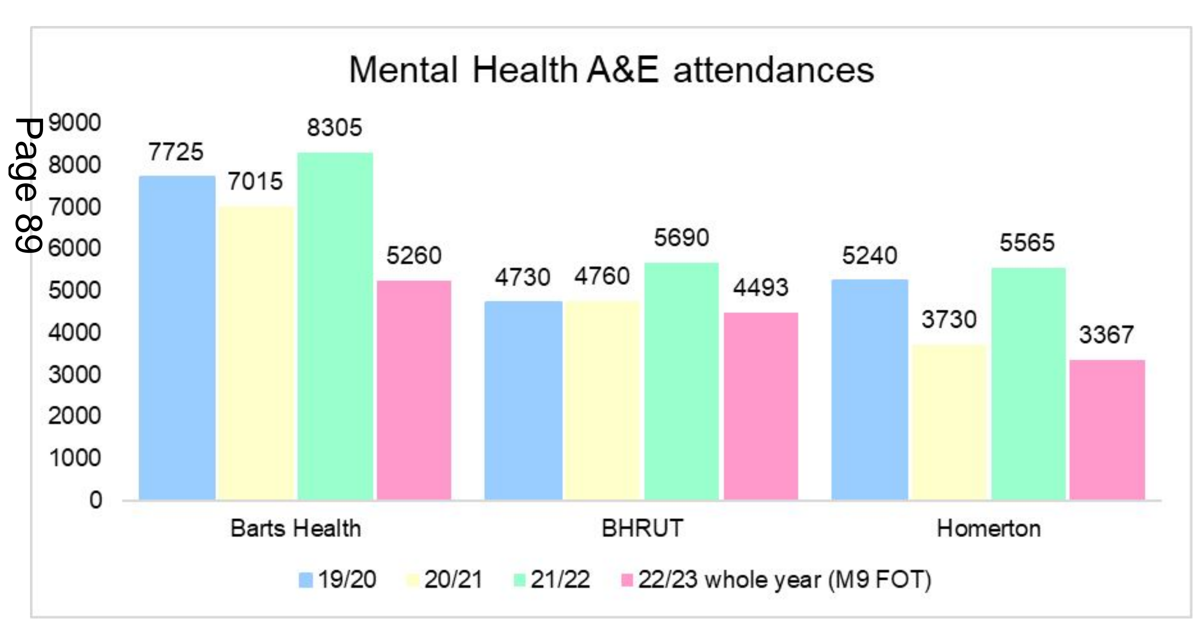
Information based on analysis by the NEL Insights Team

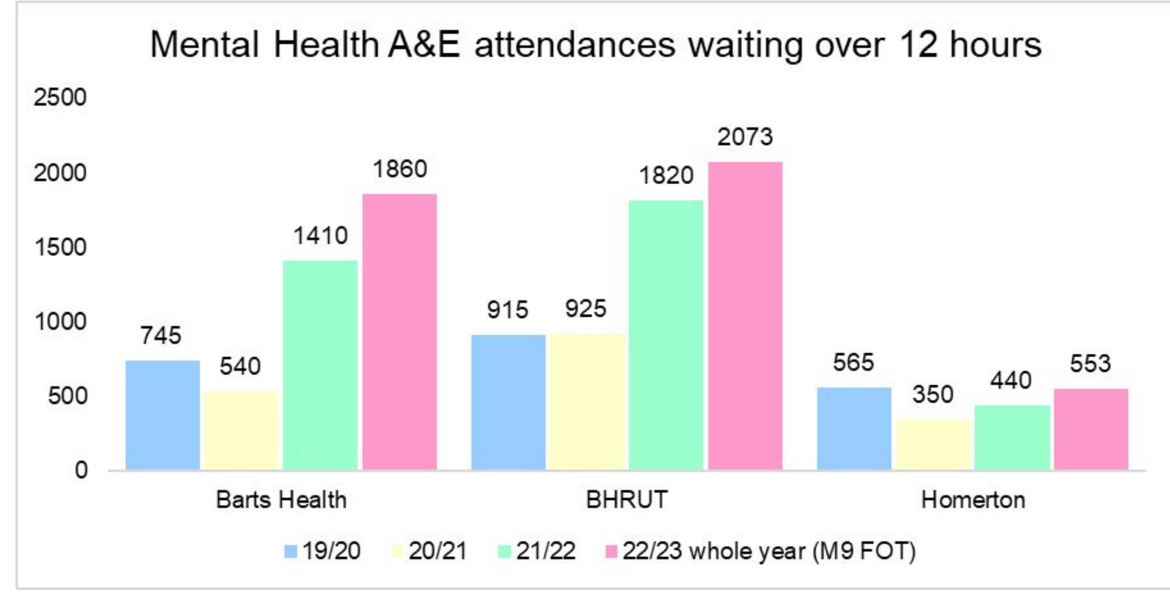
UEC – opportunities for improvement

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

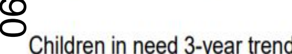
The size of children's social care in East London

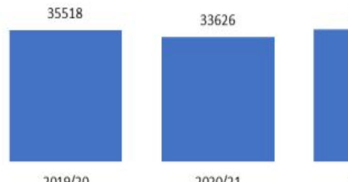
Children social care numbers

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

Page 91

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
Nutrion & 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 Clinic	Communitas Clinics
community dermatology	DMC HEALTHCARE LTD	Homerton	MC HEALTHCARE LT	ot first social enterprise	DMC HEALTHCARE LTD	x	ESS Primary Care Solutions Ltd
Community Gynae	x	Homerton	x	ot 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	ot 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
Domiciliary 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 fed	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

Title of Report	DPH 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*
For Consideration By	Health and Wellbeing Board
Meeting Date	29/06/2023
Classification	Open
Ward(s) Affected	All
Report Author	Sandra Husbands, Director of Public Health; Chris Lovitt, Deputy Director of Public Health; Danny Turton, Public Health Registrar

This report is for information and discussion.

Why is the report being brought to the Board?

The report is being brought 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.

Has the report been considered at any other committee meeting of the Council or other stakeholders

The recommendations made in the Annual Report were discussed at the LBH Adults, Health and Integration Directorate Leadership Team (AH&I DLT) meeting on 1 March 2023.

1. **Background**

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. The DPH is responsible for its content and structure while the local authority has a corresponding statutory duty to publish it. The report 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 Director of Public Health 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 focuses on young people's Sexual and Reproductive Health (SRH).

Hackney has a young, ethnically and sexually diverse population. It has a proud history of providing a wide range of sexual and reproductive health (SRH) services to its residents. The DPH report provides an overview of these services, but focuses in particular on younger people (those under 30) and on testing for sexually transmitted infections (STIs). This is because young people access sexual health services more frequently than other sections of the population and, when they do access services, they are more likely to be diagnosed with 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.

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.

The report makes five broad recommendations, aimed at both service providers and commissioners. These are:

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.

1.1. **Policy Context:**

Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?

Enhancing the sexual and reproductive health of our community through collaborative working and building people's confidence to access services will benefit mental health, social connection and help mitigate financial insecurity.

- ☐ Improving mental health
- ☐ Increasing social connection and
- ☐ Supporting greater financial security
- ☐ **X All of the above**

Please detail which, if any, of the Health & Wellbeing Ways of Working this report relates to?

The report advocates a community-centred public health approach[1] with collaboration at the centre of all new initiatives. The first recommendation made in the report is for health providers and commissioners to reconfirm their commitment

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[1] 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).

to working with communities to co-produce new initiatives and when developing existing services.

- ☐ Strengthening our communities
- ☐ Creating, supporting and working with volunteer and peer roles
- ☐ Collaborations and partnerships: including at a neighbourhood level
- ☐ Making the best of community resources
- ☐ **X All of the above**

1.2. Equality Impact Assessment

Has an EIA been conducted for this work?

- ☐ Yes
- ☐ **X No**

1.3. Consultation

Has public, service user, patient feedback/consultation informed the recommendations of this report?

Yes. The recommendations were informed by the results of two separate mystery shopper reviews conducted by Future Insight Partnership Projects and by Healthwatch Hackney as well as other recent consultations with young people across the borough.

Have the relevant members/ organisations and officers been consulted on the recommendations in this report?

Yes. Consultations were held widely with stakeholders across the SRH field, within the LBH Council, local and regional NHS partners and with voluntary sector organisations. Stakeholders were also sent an early draft of the report for their comments and feedback.

1.4. Risk Assessment

Formal risk assessment has not been undertaken.

1.5. Sustainability

Sustainability is not addressed in the report as it offers broad recommendations to be implemented as considered most appropriate by stakeholders and commissioners.

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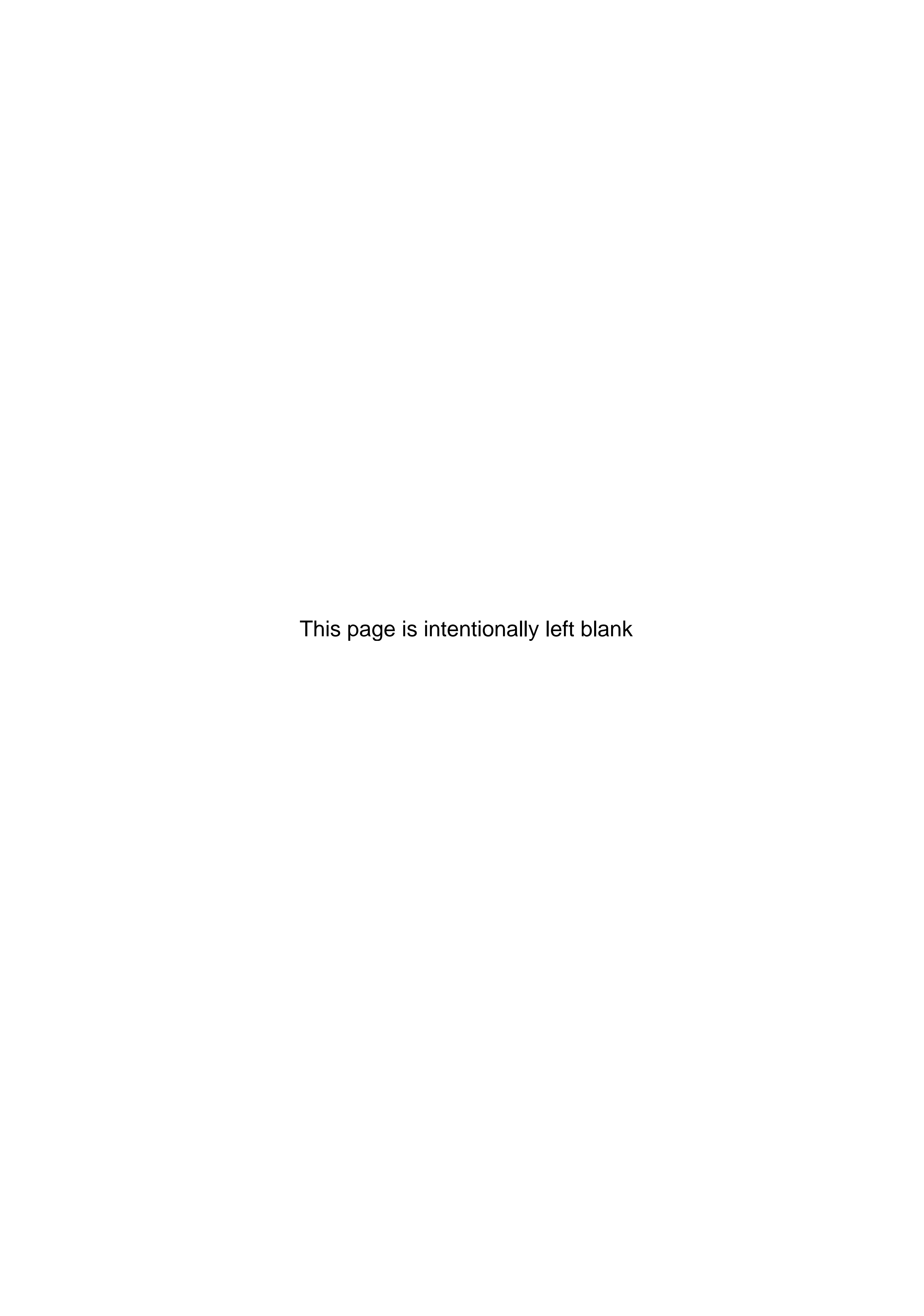
Appendices	Appendix 1: Update on recommendations made in last year's Director of Public Health Annual Report (2022) Appendix 2: A model of Sexual and Reproductive Health services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+DPH Annual Report draft

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

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[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*).

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.

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[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.

Contents

Introduction & Recommendations
Key Messages
Background - where are we now?
How do we improve access?
Recommendation 1
Recommendation 2
Recommendation 3
Recommendation 4
Recommendation 5
Conclusion

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]

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[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).

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.

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[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.

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

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[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.

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

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[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).

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.

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[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*).

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

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[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.

- 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:

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[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".

- 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.

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[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.

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

[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.

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

[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).

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

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[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).

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

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[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

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.

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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).

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

[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.

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.

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[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.

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

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[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).

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

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[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.

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

[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.

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

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[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.

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

[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.

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

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[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

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.

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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).

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

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[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.

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

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[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.

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

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[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.

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

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[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.

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

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[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.

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

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[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.

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:

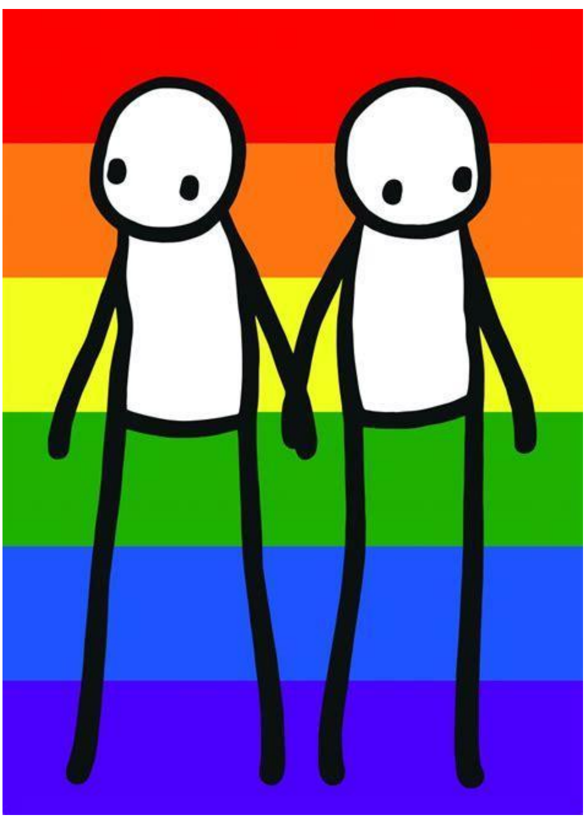
> *"[f]ocusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage"* (*Fair Society, Healthy Lives (The 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]

[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).

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]

[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.

Endnotes

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.

On ensuring access to Mental Health Support for Children and Young People:

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.

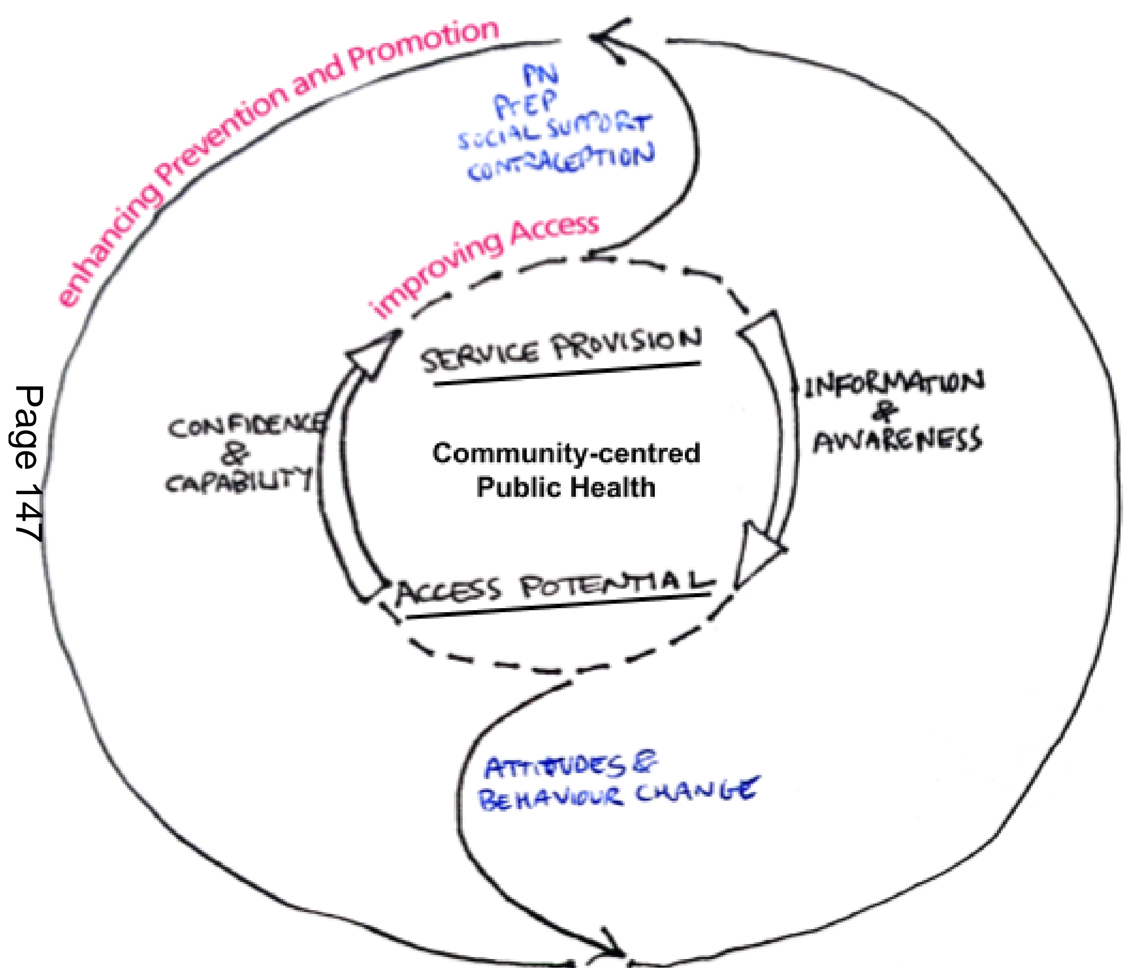
Many public health models look at the determinants of health, either from the perspective of the individual or the public, or they examine how best to implement and provide services to a population.[8] This model, however, aims to draw attention to the linked nature of service provision on the one hand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

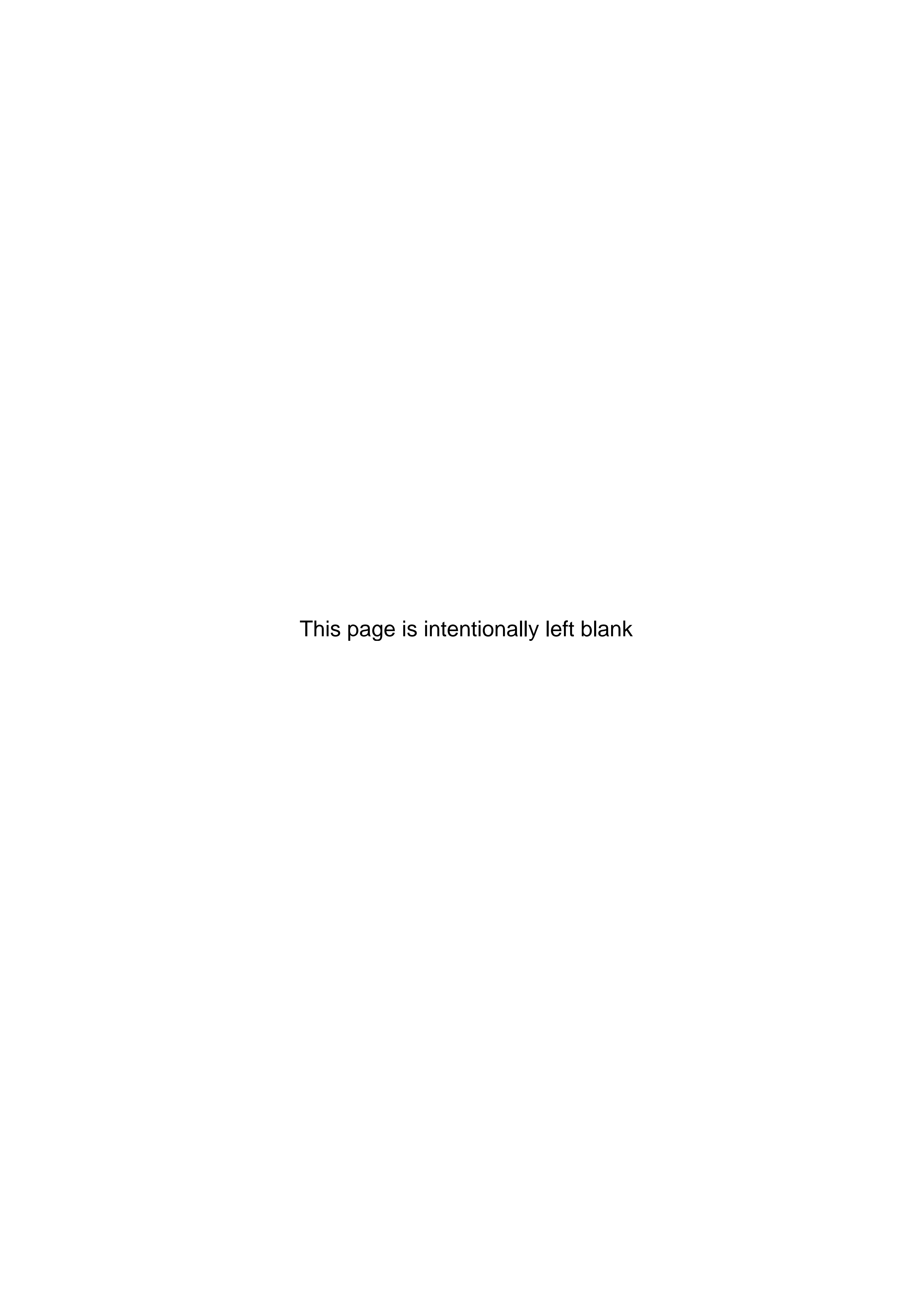
This circle represents the wider community - the population level - and the role of public health to promote wellbeing and prevent illness. The reach of this circle is increased by work to improve both “service provision” and “access potential”.

“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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Title of Report	Consultation on the proposed City and Hackney Sexual and Reproductive Health Strategy (2023-2028)
For Consideration By	Health and Wellbeing Board
Meeting Date	29 June 2023
Classification	Open
Ward(s) Affected	All (population wide)
Report Author	Froeks Kamminga, *Senior Public Health Specialist*

Is this report for:

- ☐ Information
- ☐ Discussion
- ☑ ~~Decision~~

Why is the report being brought to the board?

This report is being brought to the Board to ask for approval of 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.

Has the report been considered at any other committee meeting of the Council or other stakeholders

The draft strategy and a high-level summary have previously been shared for initial feedback with commissioned services, Public Health colleagues, Cllr Kennedy, and place-based partnerships, as well as City of London based colleagues/stakeholders.

1. **Background**

The London Borough of Hackney and the City of London 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.

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.

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

The strategy is organised around five key thematic areas of which four also inform the NEL Sexual and Reproductive Health (SRH) strategy, ensuring alignment with the priorities of other local authority areas in North East London that have similar types and levels of SRH need within their populations.

The five overarching themes are:

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

Implementation

The intention is for the strategy to be accompanied by an annual action plan to ensure implementation and delivery on key priorities.

It is suggested the first action plan will be developed in tandem with the consultation process and be presented at the September HWBs for City and Hackney. That action plan would then 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 stakeholders from within the ICS and local resident bodies and representation, including young people.

To monitor implementation of the strategy, a sexual health dashboard will be developed 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.

Include any asks/recommendation for HWB

The Health and Wellbeing Board is requested to endorse the development of this strategy and is asked to approve a formal 12-week consultation on the strategy to be held, starting 1 July 2023.
As part of resident engagement during the consultation process, the Public Health team would liaise with a range of partners and stakeholders, including Healthwatch City and Hackney, Hackney CVS, Community Champions and other specific groups.

A North East London wide sexual and reproductive health strategy is being developed concurrently. As the four main themes in the NEL strategy are the same as in the City & Hackney strategy, the period of consultation would also inform the NEL strategy.

The Board is further asked to endorse a process of action planning during the 12-week consultation period, to result in an action plan for implementation of the strategy for the financial year 2023/24 and 2024/25. For the years after, an action planning process would be held annually.

If approved, the consultation and action planning process will be reported on to the September Board meeting.

1.1. **Policy Context:**

Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?

- ☐ Improving mental health
- ☐ Increasing social connection and
- ☐ Supporting greater financial security
- ☐ All of the above

Please detail which, if any, of the Health & Wellbeing Ways of Working this report relates to?

- ☐ Strengthening our communities
- ☐ Creating, supporting and working with volunteer and peer roles
- ☑ ~~Collaborations and partnerships: including at a neighbourhood level~~
- ☐ Making the best of community resources
- ☐ All of the above

1.2. **Equality Impact Assessment**

Has an EIA been conducted for this work?

- ☐ Yes
- ☑ ~~No~~

1.3. **Consultation**

Has public, service user, patient feedback/consultation informed the recommendations of this report?

- ☐ Yes
- ☑ ~~No~~

Have the relevant members/ organisations and officers been consulted on the recommendations in this report

- ☑ ~~Yes~~
- ☐ No

1.4. **Risk Assessment**

Sexual and reproductive health are often highly sensitive, personal and emotive subjects, where culture and religion can play an important role.

Whilst the consultation process will aim to be mindful of this and respectful of all opinions, the local authority has a legal obligation to provide services that allow each resident to have the best possible sexual and reproductive health and wellbeing, and open access to the services that support this from a clinical care and wellbeing perspective.

1.5. **Sustainability**

Having a five year strategy will help us to work in closer partnership with other organisations with legal duties to commission SRH services, such as the North East

London Integrated Care Board (NEL ICB), NHS partners, neighbouring local authorities, and other place-based partners within the Integrated Care System (ICS).

With a reduction in resources available for public health (the PH grant for 23/24 was not increased and considering inflation a reduction in real terms), collaboration and partnership working are important to ensure continued delivery of high quality services that contribute to better sexual health and wellbeing outcomes of all residents.

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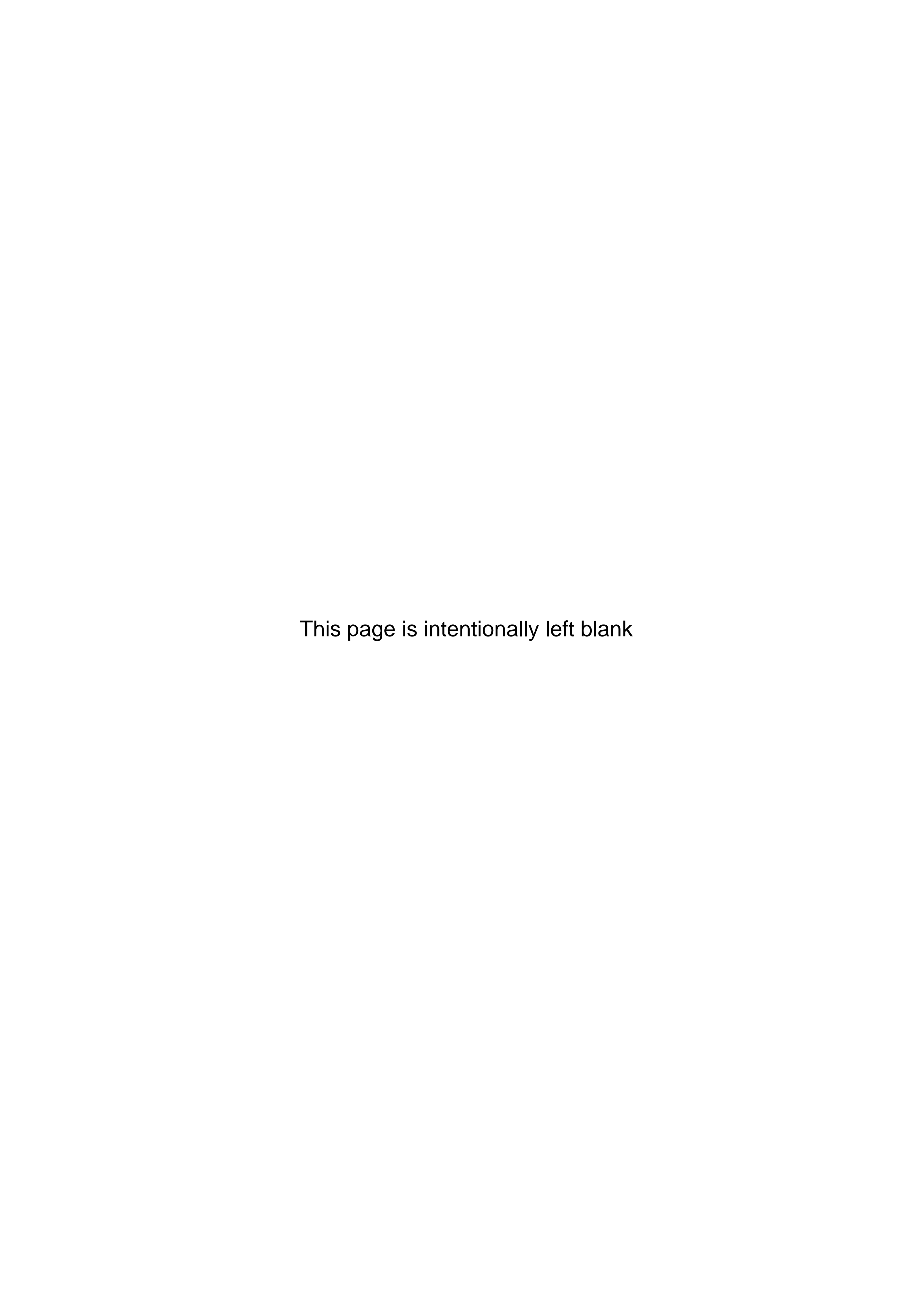
Appendices	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Agenda Item 10

Title of Report	Neighbourhoods Programme Response to Connect Hackney Recommendations
For Consideration By	Health and Wellbeing Board
Meeting Date	29 June 2023
Classification	Open
Ward(s) Affected	All
Report Author	Dr Sadie King, *Neighbourhoods Programme Lead City and Hackney, Homerton*

Is this report for:

- ☐ Information
- ☑ ~~Discussion~~
- ☐ Decision

Why is the report being brought to the board?

At the Health and Wellbeing Board 16 June 2022 Sonia Khan, Head of Policy and Strategic Delivery presented a paper in response to Connect Hackney recommendations that were agreed by the board in January 2022 to take forward.

A number of the recommendations were appropriate to take forward through the Neighbourhoods Programme. The Programme delivers transformation across the Place Based Partnership to address health inequalities through integrating health and care, embedding personalisation and strong resident and voluntary sector engagement in Neighbourhood level services and pathways.

This report responds to the relevant recommendations to the Neighbourhoods programme of work. These are:

4. Include home visits in the design of system navigation services
5. Commission service navigation schemes that include provision for people who do not speak English in order to reach communities known to be at high risk of social isolation.
7. Identify, and find ways to overcome, barriers between LBH social prescribing services and voluntary and community sector activities.
14. Embed Connect Hackney learning on how to maximise opportunities for social connections into the design of all commissioned community activities.

Has the report been considered at any other committee meeting of the Council or other stakeholders?

The report has not been considered at any other committee meeting of the Council. This report is based on wide ranging stakeholder engagement across the partnership.

1. Background

The Neighbourhoods Programme has been underway for 4 years, the achievements are explored in detail here.

The key aim of the programme is to support change that results in improved outcomes for residents through:

- Focus on small **Neighbourhoods**, populations of 30,000 to 50,000, bringing together groups of practices (PCNs) and other providers of healthcare, social care and community support around a natural geography
- Integrating **community based** services around people's needs, supporting collaborative **multi-agency** working to deliver joined up, local and holistic care for people

More recently the programme has worked to support reducing **health inequalities** and thinking more about **population health management** and **prevention**.

The Neighbourhood and PCN geographies align and there are plans in place for further partnership development. There are several services shaped around or delivering on the footprint including community nursing, mental health, pharmacy, adult social care and community navigation and therapies. Some are not complete transformations but are developing and working on further change and continuous improvement.

Monthly Neighbourhood multi-disciplinary meetings (MDMs), Neighbourhood Forums and community navigation networks are also working on the footprint. The Programme is being independently evaluated, including 'deep dives' into the Organisational Development Pilot, and the Proactive care pathway (2023-2024). This will build on the existing theory of change and outcomes framework.

The board is asked to consider the way in which the Neighbourhoods Programme is delivering change that addresses the relevant recommendations coming from the Connect Hackney work and how this is monitored through the evaluation of the programme.

1.1. **Policy Context:**

Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?

- ☐ Improving mental health
- ☐ Increasing social connection and
- ☐ Supporting greater financial security
- ☑ ~~All of the above~~

Please detail which, if any, of the Health & Wellbeing Ways of Working this report relates to?

- ☐ Strengthening our communities
- ☐ Creating, supporting and working with volunteer and peer roles
- ☐ Collaborations and partnerships: including at a neighbourhood level
- ☐ Making the best of community resources
- ☑ ~~All of the above~~

1.2. **Equality Impact Assessment**

Has an EIA been conducted for this work?

- ☐ Yes
- ☑ ~~No*~~

* This paper describes different strands of work that relate to the recommendations. Whilst there is no overarching EIA for the response, Equality assessment is embedded in the work described. For example, the barriers to prevention research aimed at residents over 50 is a recommendation from an EIA on anticipatory care.

Another example of Equality informed work is targeted navigation to address health inequalities in long term conditions (Neighbourhood pilots in women's health and CVD), this is being developed with a population health equity and anti racist service design approach.

The evaluation of the Neighbourhoods Programme includes assessment of impact on Health Inequalities.

1.3. **Consultation**

Has public, service user, patient feedback/consultation informed the recommendations of this report?

☑ ~~Yes~~

☐ No

Have the relevant members/ organisations and officers been consulted on the recommendations in this report

☐ Yes

☐ No

N/A This paper does not make recommendations.

1.4. Risk Assessment

N/A

1.5. Sustainability

The City and Hackney Place Based Partnership is committed to developing the Neighbourhoods model to improve outcomes for all residents.

2. Neighbourhood Programme Response to Connect Hackney Recommendations

Recommendation 4. Include home visits in the design of system navigation services

The development of the City and Hackney community navigation system is set out in a new coproduced strategy Community Navigation Strategy.

One of the themes of the strategy is 'Maximising the impact of Community Navigation on addressing health inequalities in local communities and supporting City & Hackney residents who experience health inequalities'.

This includes Organisational Development work to build stronger connections between navigator roles and the statutory sector.

As part of this work, the Central Neighbourhoods team are conducting research/consultation with partners on home visiting (either navigators conducting home visits and/or the development of navigation skills and resources in services that already carry out home visits, e.g. community nurses). This includes a review of all current service specifications and formal and informal policies on home visiting.

In general Community Navigation services meet people in the community by default, whether this is at their GP surgery or in another location of their preference. Different

services have different policies for meeting people at homes when they are not able to meet in the community. The Community Navigation Strategy sets out to develop a centralised system to understand better referrals and process across the sector. Home visiting will be explored under this strand of work.

Currently we are aware that although the following requirement was included in the specification for the commissioning of the Social Prescribing and Outreach service, (October 2022) - *The SP&CN service will be expected to offer at least one home visit to those who are unable to easily access the service in other locations. Eligibility and the level of activity that can be met through home visits will need to be agreed with the commissioner, and will be capped to ensure sufficient service capacity.'* , that there has been low take up/ request for this.

We are currently exploring broadening referrals from other services e.g. Homecare, Community Nursing through the closer working of navigators to the wider Neighbourhood team (beyond G.P. referral). This is being monitored by the service and is expected to improve through the role of the Community Engagement Coordinator.

The research will be taken forward through the Community Navigation System Design Group. Home visiting will be monitored through the outcome:

' Improve our understanding of Community Navigation

● *Residents know where to go for help when they need it*

● *Health and care staff better understand the role of non-medical/statutory*

community-based interventions'

Part of Community Navigation strategy around health inequalities is to collect and share insights around people accessing Community Navigation services, identifying communities or groups of people not using Community Navigation. This will feed into the Neighbourhoods organisational development pilots that includes the aim of developing smaller organisations who support people experiencing health inequalities.

A piece of work is currently underway by our learning partners Renaisi is a resident survey, staff interviews, and neighbourhood focus groups exploring barriers to taking up preventative interventions. The results of this research will be available September 2023. This work will make recommendations to develop the new Proactive Care pathway and is likely to contain insights for the Home visits project.

Recommendation 5. Commission service navigation schemes that include provision for people who do not speak English in order to reach communities known to be at high risk of social isolation.

The Community Navigation Strategy 2023-25 includes a priority '*Maximising the impact of Community Navigation on addressing health inequalities in local communities and supporting City & Hackney residents who experience health inequalities*', this includes developing a better understanding of the communities that are not using Community Navigation services. This is part of the work plan monitored through the Community Navigation Design Group.

Currently we know that there are various types of provision for people who do not speak English. These include services often having staff who speak languages other than English and the use of Language Line. Intentional recruitment of staff with language skills has been an important element of the development of the sector for example the recent Inclusive Recruitment pilot in Neighbourhoods that recruited the new care coordinators for the Proactive Care pathway. We believe that the community navigator sector is a diverse workforce speaking many languages and this is a strength. Service users have reported that they really appreciated the support sessions in their own language and this enables trust and leads to appropriate solutions for the individual.

Case study: *Cem is 31 years old Turkish man with a mild learning disability. Cem was referred to the Social Prescribing and Outreach service because he was not eligible for a course the local Community College. Cem was feeling low and expressed feeling worthless. He also felt pressure from his family to marry and start a family. He reported that he was bullied a lot when he was a child. He also reported that he often lost his temper because other people were impatient with him. He felts he had no place where he belonged. The suggestion of attending a local Turkish support centre did not appeal to him. He wanted an alternative where he did not have to face cultural pressures.*

Cem was introduced to local community centre and he was welcomed immediately by everyone. He engaged well with others. He engaged in their activities, went for walks with them and expressed wanting to be more involved in the centre. They found him to be an incredibly nice and giving person. This is a contrast to the input he had received from other people in his life.

The following requirement was included in the specification for the commissioning of the Social Prescribing and Outreach service, the service began in October 2022 - '*The service must be accessible to people who use British Sign Language (BSL), who have a learning disability or do not speak English as a first language; ensuring that there is provision for people with the most commonly spoken languages in the City and Hackney, to ensure it meets the needs of the diverse communities living locally. This applies to support sessions and written materials that are produced to share with service users once they have been referred into the service.'*

The Neighbourhoods Programme will continue to support the Community Navigation providers to reach all communities through growing and supporting the diverse

workforce. In addition it will ensure smaller community organisations have access to development support that can improve their capacity to work in partnership statutory sector. Also the Neighbourhood Programme is piloting an anti-racist service design/improvement process with the aim at supporting all services to address institutional racism in our health and care pathways. This will produce resources and case studies as part of the induction pack to Neighbourhoods for staff across all sectors.

Recommendation 7. Identify, and find ways to overcome, barriers between LBH social prescribing services and voluntary and community sector activities.

Neighbourhood Navigation Networks bring people in Community Navigation roles together on a Neighbourhoods footprint to build relationships, understand roles and share resources. Through this network challenges and barriers between Community Navigation and VCS can be identified, and worked through to find solutions. The networks are linking into the new Neighbourhood Forums and have been attending the new Neighbourhoods staff meetings. Neighbourhood Forums are a place that brings together VCS organisations and people in Community Navigation roles, as well as people from the statutory sector and residents. Neighbourhood staff meetings bring together people working on a Neighbourhood footprint to develop relationships. This work aims to bring all community navigation roles into stronger relationships with local providers of activities and services.

We expect the Barriers to preventative interventions research (current: expected results September 2023) and the new Neighbourhood Forum insight reports being developed to identify specific barriers and create action plans for joint work through the PCNs and wider Neighbourhoods partners to support plans agreed at each Neighbourhood level to address barriers. This is the rationale for place based working, that solutions can be found at a smaller population level, through strong multidisciplinary working with resident views driving the solutions.

Recommendation 14. Embed Connect Hackney learning on how to maximise opportunities for social connections into the design of all commissioned community activities.

The Neighbourhoods Programme aims to develop and support a culture change towards prevention, personalisation, coproduction and a focus on the wider determinants of health. Improving social connections is a key part of this. These are the current key work strands that deliver on this recommendation:

A/ The Neighbourhoods Organisational Development Pilot is delivering:

- Staff meetings that include community navigators

- Neighbourhood Leadership groups that consider local health inequalities and how to improve social connections for individual cases through Multidisciplinary working and on a neighbourhood population level by identifying needs and coproducing solutions.
- Anti racist Service Design for Long term conditions pilots: Currently running in Women's Health and CVD pathways working with residents and small voluntary sector organisations.
- Inclusive Recruitment: Materials and case studies for a new recruitment policy that values lived experience (pilotted successfully in the Proactive Care pathway). To recruit more local people who are able to support City and Hackney communities appropriately and in a preventative way.
- Neighbourhood Resident Advisors: Creating a sustainable, supported community of residents experts in quality improvement to work with services on improvement projects.

B/ The Community Navigation Strategy has drawn attention to the need for the sector to understand local needs, identify barriers, work closer with the statutory sector, support and develop the workforce.

C/ The Neighbourhood Forums are mechanisms for resident involvement, strong voluntary sector leadership to collect insights and develop local solutions in partnership with services. Their work extends far beyond a meeting and discussion. For example, Well Street Common Neighbourhood Forum has been working on the need for wellbeing support for young people waiting for CAMHS services. Parents and practitioners worked together to provide a workshop for parents of children waiting for services of wellbeing practices and sharing of information on appropriate activities that can be accessed by young people. Similarly, the Forum has identified barriers and solutions to accessing services for older people who may have limited mobility and are experiencing social isolation. Follow link for agendas and minutes of the Neighbourhood Forums .

D/ The new Proactive care pathway aims to reach people with moderate frailty, ensure they have access to services they need, understand their desires and motivations and link them into non-medical care opportunities that increase social connections and enhance their wellbeing. This includes developing a 'frailty aware neighbourhood' training and resources to support work with frail residents and a personal budgets pilot that will also be used to identify barriers and address them through improvement projects.

E/ A current review of the Neighbourhoods model will include how to embed further the demedicalisation of care, prevention and personalisation. Improving social connection is a key component of this. In the presention to the Hackney Health and Wellbeing Board 27th January 2022 : Addressing social isolation and loneliness

amongst older people The impact and reach of the Connect Hackney programme. The following success factors were outlined:

•Sustained proactive strategies to reach the most isolated (referrals, outreach, word of mouth)

•Support for those not initially ready to connect

•Regular meaningful and shared activities

•Skills and qualities of project staff and project environment

•Projects as a bridge to other activities

Whilst many of these themes are enabled through the Neighbourhoods Programme through supporting community navigation, the development of more integration in Neighbourhoods, more resident insight and more Neighbourhood level leadership, it is the new Proactive care new pathway that really can build on these success factors.

The pathway will support a cohort of moderately frail individuals and sustain proactive communication with them even when they are not ready to connect, build culturally appropriate frailty awareness into Neighbourhoods through training and online resources. This pathway is being evaluated over the next 2 years. A baseline is currently being established.

3. Conclusion

The Neighbourhoods Programme is aligned and beginning to deliver on the recommendations of Connect Hackney to the Health and Wellbeing Board 2022. The Programme is evolving and key structures, resources and new pathways are still in development. We will ensure that the above responses to the recommendations from Connect Hackney are built into the outcomes framework and monitored going forward.

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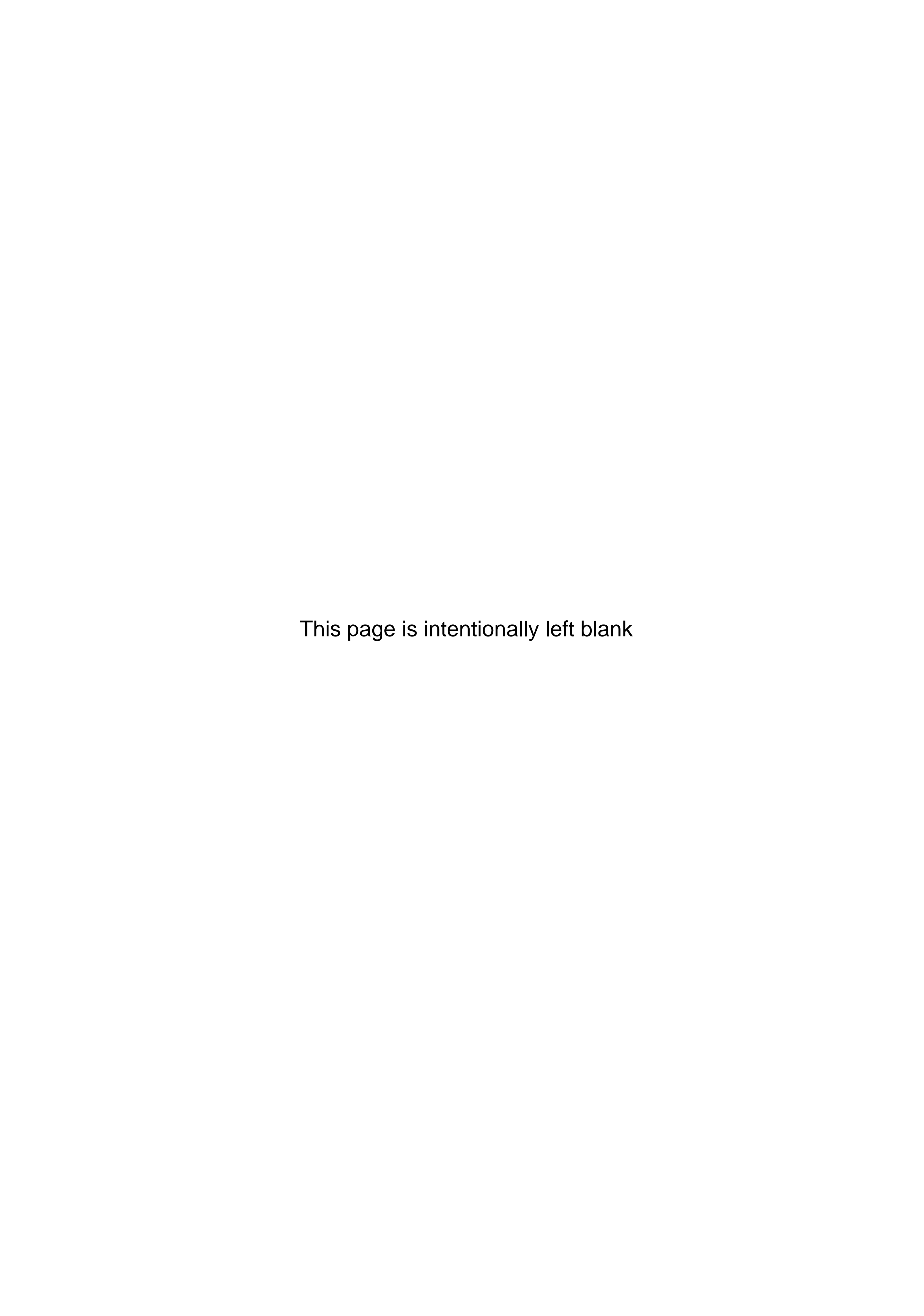
Appendices	The Community Navigation Strategy The Neighbourhood Programme Theory of Change The Neighbourhood Programme Outcome Framework



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AGENDA ITEM

TITLE OF REPORT Update on Connect Hackney findings	
HEALTH AND WELLBEING BOARD - 16 June 2022	**CLASSIFICATION:** **Open**
WARD(S) AFFECTED **All Wards**	
Head of Service Sonia Khan, Head of Policy and Strategic Delivery	

1. INTRODUCTION AND PURPOSE

This paper provides an update to the agenda item from January 2022 in which Connect Hackney presented their Phase 2 Reach and Impact report and the recommendations that they wanted the Health and Wellbeing Board to accept and take forward. The action from the meeting was that a response be provided to the paper within the next 6 months with discussions on monitoring and impact during this time.

2. RECOMMENDATIONS

The Board is asked to:

- consider and discuss other opportunities for these recommendations to be taken forward by partners sitting on the Board as these are cross-cutting asks.
- agree to embed the principles of these recommendations into broader work programmes undertaken by the system.
- note that an update on the Ageing Well strategy is on the forward plan for a future Health and Wellbeing Board meeting and that some of these

recommendations will fall into the broader delivery plan where updates will be provided.

3. BACKGROUND

In January 2022, Connect Hackney presented their Phase 2 Reach and Impact report and the recommendations that they wanted the Health and Wellbeing Board to accept and take forward. The 14 recommendations they made to the Board were:

1. Consider how local, low cost and accessible leisure activities for older people can be integrated into health and wellbeing commissioning plans/strategies
2. Consider how commissioning plans/strategies can support older people's digital inclusion.
3. Consider how commissioning plans/strategies can resource community organisations working with ethnically minoritised communities
4. Include home visits in the design of system navigation services
5. Commission service navigation schemes that include provision for people who do not speak English in order to reach communities known to be at high risk of social isolation.
6. Adopt a person-centred approach in the delivery of services working with isolated older people.
7. Identify, and find ways to overcome, barriers between LBH social prescribing services and voluntary and community sector activities.
8. Identify, and find ways to overcome, barriers to referrals between the LBH learning disabilities service and voluntary and community sector activities.
9. Ensure that social care packages include support for older people with learning disabilities to attend community activities.
10. Use Ageing Better Camden's outreach toolkit to train staff undertaking resident engagement work.
11. Use Ageing Better Camden's warm welcome toolkit to train staff working with older people.
12. Consider how libraries can be used as venues to promote voluntary and community sector projects
13. Include 'increased social connections' as a default outcome of all commissioned community activities.
14. Embed Connect Hackney learning on how to maximise opportunities for social connections into the design of all commissioned community activities.

4. UPDATE AND PROPOSED NEXT STEPS

The learning from the Connect Hackney programme around what works to support older people around reducing social isolation and loneliness is one that the Council and partners are keen to implement and embed as key principles. The learning from this work and the recommendations align strongly with the Council's Ageing Well strategy and it is important that the strategy delivery is agile enough to accommodate new recommendations that come out of learning and programme pilots in the borough. The implementation and delivery of these recommendations therefore will sit in the overall delivery plan for the Ageing Well strategy and will look at bringing in key partners that contribute to meeting these recommendations, recognising it is a system effort to consider and respond to older people's needs and interests. The updates below show where we have got to in meeting these recommendations, however recognise a full discussion with partners is needed that will look at how these recommendations can be more fully met.

1. **Consider how local, low cost and accessible leisure activities for older people can be integrated into health and wellbeing commissioning plans/strategies**

The Council already provides local, low cost and accessible leisure activities for older people:, for instance, 50+Club, Free Swimming, New Age Games, Walking Together, Concessionary Access to Leisure Centres. The council also funds a range of resident led over 50s clubs that is funded through the resident engagement team. The Council's Ageing Well Strategy looks at how we make the borough more age-friendly and how we work with partners to consider and respond to the needs and interests of older residents. Part of this wider approach is also encouraging co-production. Examples of other strategies and council programmes that are considering older people's wider wellbeing through leisure activities include:

- gym equipment being fitted in parks through our parks strategy and ensuring they are accessible to our residents,
- Plans to pilot a health-based programme of activity in Hackney Marshes that focuses on ageing well
- Kings Park moving Together is currently looking at a programme of activity that is specific to older people and linked to the pilot above.
- Relaunching Hackney Circle (*a Cultural Pathway for Hackney residents, with a view to supporting older residents to access the benefits of engaging in Hackney's vibrant cultural life).*

City and Hackney's Public Health team also commission The Sharp End to deliver low cost activities for over 55s in Hackney, and provide a number of physical activity classes each week. Public Health is currently reviewing the physical activity provision to ensure that physical activity commissioned is reaching those who experience inequalities related to physical activity.

2. **Consider how commissioning plans/strategies can support older people's digital inclusion.**

Digital buddies will continue to be rolled out across the borough; the Council currently have 7 sessions running. Digital Buddies is a volunteering programme offering face-to-face practical help supporting local residents providing help with online tasks ranging from paying bills, looking for jobs, creating formal documents, or filling in online forms. Residents are also supported with online tasks such as creating new emails, showing them how to block spam, or downloading or installing new software such as Zoom or WhatsApp.

The Council is also continuing to recruit volunteers to run the programme to cover additional sessions to start, including at Hoxton Hub and Hackney Central/Stamford Hill libraries. Currently the adult skills team are also working with the Resident Participation team to look at courses to be delivered at community settings and offer bespoke courses for the residents on site. The team are also currently in discussions around how staff can further support the Hackney Service Centre front of house team in dealing with resident queries and offering support to residents. There is also an active conversation with the library service to partner on delivering adult learning courses across more library sites to ensure further digital access to residents.

In terms of wider work around digital inclusion, the Council is working actively with all three broadband companies to ensure that broadband offers are made for all residents and there is free access if given to community centres in the borough.

3. Consider how commissioning plans/strategies can resource community organisations working with ethnically minoritised communities

All Grants in the VCS Grants Programme have a focus on key equalities aims which include supporting ethnically minoritised communities. Although grants are open to all eligible applicants, when scoring applications the assessors look at information on key inequalities provided by the council's corporate plan and use this to inform decision making. In addition to this, when grants panels make their final decisions on who to award funding to, they look at applications holistically to ensure that there is a spread across the borough and in key equalities groups. A recent example of this can be seen in the Equalities Impact Assessment written for the most recent round of open grants programmes in May 2022.

The council also have an inclusive economy strategy and anti-racism plan in which these factors are considered as key.

4. Include home visits in the design of system navigation services

This action will need to be followed up with discussion on what might be possible with partners, including the CCG and Neighbourhoods programme and ask that a lead for this recommendation is agreed at the Board meeting. The action can also be tracked through our Ageing Well oversight partnership group that has undergone a process of review and being stood up in the summer.

5. Commission service navigation schemes that include provision for people who do not speak English in order to reach communities known to be at high risk of social isolation.

This action will need to be followed up with discussion on what might be possible with partners, including the CCG and Neighbourhoods programme and ask that a lead for this recommendation is agreed at the Board meeting. There is a recommendation that tracking for this action happens through the Health Inequalities Steering Group.

6. Adopt a person-centred approach in the delivery of services working with isolated older people.

The Council have been focusing on preventative approaches with residents that are person- centred and strength based and this continues to be a strong aim. This example below highlights the principles the council is adopting in person-centred approaches:

A recent council pilot looked at early intervention in hoarding, by providing therapeutic decluttering and broader holistic support to low level hoarders. The project looked at a flexible process, for instance changing the eligibility criteria mid-way so that residents could self-refer themselves for support and looking at the holistic support required for someone who might have a hoarding disorder. Hoarding disorder has been a recognised mental health condition since 2013 and tends to affect older adults who experience at least one other mental health condition who live alone. We know that all the major triggers for hoarding disorder - loneliness, isolation, bereavement and other pressures on mental health - have been intensified by the pandemic.

There is an opportunity to also look at how wider learning can be cascaded, shared and discussed with Council services through our Ageing Well oversight partnership group that has undergone a process of review and being stood up in the summer.

7. Identify, and find ways to overcome, barriers between LBH social prescribing services and voluntary and community sector activities.

This action will need to be taken forward by the CCG and neighbourhood team that commission social prescribing and ask that a lead for this recommendation is agreed at the Board meeting. The action can also be tracked through our Ageing Well oversight partnership group that has undergone a process of review and being stood up in the summer.

In terms of future programmes of work relevant to this action, there are plans of the neighbourhood team working with the Council's Culture team on the relaunch of Hackney Circle (*a new Cultural Referral Pathway for Hackney, with a view to supporting isolated older residents to access the benefits of engaging in Hackney's vibrant cultural life)* representing community navigation and thinking about how to link Hackney Circle resources up with community navigation.

North East London are also currently working on a community chest to fund organisations/groups/activities that social prescribers refer to. This will be a pilot process and so roll out will be gradual across the borough.

8. Identify, and find ways to overcome, barriers to referrals between the LBH learning disabilities service and voluntary and community sector activities.

This is currently being discussed with colleagues in Adult Social Care about how this recommendation can be taken forward.

9. Ensure that social care packages include support for older people with learning disabilities to attend community activities.

The Council currently does this if there is an identified need under the care act, but only for people who are eligible for Adult Social Care. The council does aim to focus on a strengths-based approach, and look at what other provision the resident can access from non-statutory services.

10. Use Ageing Better Camden's outreach toolkit to train staff undertaking resident engagement work.

The Council's Resident Engagement team have reached out to Ageing Better Camden to understand how the toolkit can be used by the team and also commissioned providers who deliver resident engagement work to older people.

11. Use Ageing Better Camden's warm welcome toolkit to train staff working with older people.

The Council's Resident Engagement team have reached out to Ageing Better Camden to understand how the toolkit can be used by the team and also commissioned providers who deliver resident engagement work to older people.

12. Consider how libraries can be used as venues to promote voluntary and community sector projects

The Libraries strategy aims to provide inclusive, flexible and innovative physical and online spaces for residents and the voluntary and community sector. Fundamentally, there are opportunities to inspire, innovate and encourage more local people to take up a broader service offering as part of an overall more inclusive approach.

In July 2021 the Council launched an extensive Libraries conversation with our residents, including current users and those that don't use libraries, to hear what those that use the service and those that do not use the service have to say - what areas of the service they value and where we can make improvements. Over 8,500 respondents were engaged in our public engagement programme which included surveys, focus groups, schools workshops, community interviews and street engagement. This also included conversations with older people's groups, including the Council's ageing well group; Hackney Older People's Co-production Committee.

Top three reasons for all respondents to use Libraries were:
1. Reading and literacy
2. Creative and cultural enrichment
3. Digital access and study/workspace

Libraries as culture and community hubs
All stakeholders were keen to attend more interactive, cultural events and arts exhibitions for children, young people and adults. Cultural organisations want to offer a variety of experiences that celebrate the cultural heritage of local people and reduce barriers to creative education. Library users of all ages wanted to make Libraries community hubs and create more comfortable spaces to socialise and network. Community groups and businesses valued the Libraries and their role as a non-judgmental community venue, providing a wide-ranging offer and access to meeting rooms and digital resources.

Commitments for Libraries in the new strategy that are relevant to encouraging healthier and happier lives are:

- Promoting the preventative role of library activities - socialisation, maintaining routine, enrichment
- Providing self-help resources (physical and digital) and structured Health and Wellbeing Resources and referrals
- Creating an affordable space in trusted settings for community groups and community-led activities
- Deliver a vibrant Community Library Service - mobile distribution of bookstock

by library officers for housebound residents

13. Include 'increased social connections' as a default outcome of all commissioned community activities.

There is an opportunity to discuss this with Council services through our inclusive economy strategy and our Ageing Well oversight partnership group that has undergone a process of review and being stood up in the summer.

14. Embed Connect Hackney learning on how to maximise opportunities for social connections into the design of all commissioned community activities.

There is an opportunity to look at how this learning can be cascaded, shared and discussed with Council services through our Ageing Well oversight partnership group that has undergone a process of review and being stood up in the summer.

BACKGROUND PAPERS

In accordance with The Local Authorities (Executive Arrangements) (Meetings and Access to Information) England Regulations 2012 publication of Background Papers used in the preparation of reports is required

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