AGENDA REPORTS PACK

Health & Wellbeing Board

Meeting of the Health and Wellbeing Board.

The Committee Rooms, Hackney Town Hall, London, E8 1EA

Thursday, 25 January 2024 at 3.00 pm.

The Live Steam link can be view here:

Main: https://youtube.com/live/rfwHpIHWpfw
Backup: https://youtube.com/live/mjvpBTVIgnU

Contact: Mark Agnew
Governance Services Officer
Tel: 020 8356 3326
Email: governance@hackney.gov.uk

Dawn Carter-McDonald
Interim Chief Executive
17 January 2024

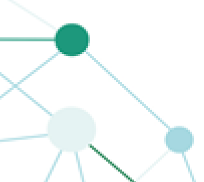
The press and public are welcome to attend this meeting

Health & Wellbeing Board

Board Membership and Additional Attendees

Board Members	
Dr Stephanie Coughlin (Co-Chair) Clinical Director, City & Hackney Place Based Partnership	**Cllr Christopher Kennedy (Co-Chair)** Cabinet Member for Health, Adult Social Care, Voluntary and Leisure
Cllr Anntoinette Bramble Deputy Mayor and Cabinet Member for Education, Young People and Children's Social Care	**Jacquie Burke** Group Director, Children and Education, Hackney Council
Dr Sandra Husbands Director of Public Health, City & Hackney	**Helen Woodland** Group Director, Adults, Health and Integration, Hackney Council
Sally Bevan Chief Executive, 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 Service	**Mary Clarke** Director of Nursing and Corporate Development, GP Confederation
Nina Griffith Director of Delivery, City & Hackney Place Based Partnership	**Frances Haste** VCS Leadership Group, Hackney CVS
Stephen Haynes Strategic Director Inclusive Economy, Corporate Policy and New Homes, Hackney Council	**Rosemary Jawara** VCS Leadership Group
Dalveer Johal Pharmacy Support Manager, City & Hackney Local Pharmaceutical Committee	**Andreas Lambrianou** Chief Executive Officer, City & Hackney GP Confederation
Chris Lovitt Deputy Director of Public Health, City & Hackney	**Jessica Lubin** Director of Health Transformation, Hackney Council for Voluntary Service
James O'Neill Borough Commander, London Fire Brigade	**Paul Senior** Interim Director of Education, Hackney Council
Shilpa Shah Chief Officer, City and Hackney Local Pharmaceutical Committee	**Dr Kathleen Wenaden** Clinical Director for Primary Care Network, NHS Primary Care Networks

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



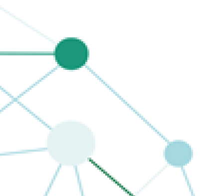
Health & Wellbeing Board

AGENDA

Thursday, 25 January 2024

ORDER OF BUSINESS

Item No	Title	Page No
1	**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 - 18
5	**Questions from the Public**	
6	**City & Hackney Safeguarding Children Partnership Annual Report 2022/23, including Child Q Update**	19 - 184
7	**Annual Director of Public Health Report 2023/24, including Confirmation of Themes for 2024/25**	185 - 246
8	**Community Voice: NEL Big Conversation - Hackney Findings**	247 - 306
9	**Sexual and Reproductive Health Strategy**	307 - 430
10	**Combating Drugs Partnership and Substance Use Support Update**	431 - 436
11	**NEL Joint Forward Plan**	437 - 486
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.

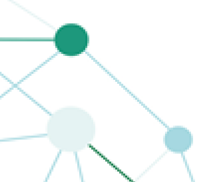
iii. If you have, however, obtained dispensation from the Monitoring Officer or Standards Committee you may remain in the meeting and participate in the meeting. If dispensation has been granted it will stipulate the extent of your involvement, such as whether you can only be present to make representations, 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.

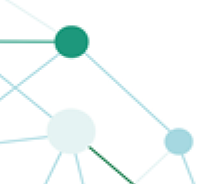
ii. You may remain in the meeting, participate in any discussion or vote provided that contractual, financial, consent, permission or licence matters are not under consideration relating to the item in which you have an interest.

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



Appendix 3 - Terms of Reference of Council Committees etc
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);

DRAFT

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
        - Sexual and Reproductive Health Strategy

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.

DRAFT

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

7. To receive regular Community Voice presentations from Healthwatch Hackney, in order to ensure the experience of service users and residents is considered by the Board.

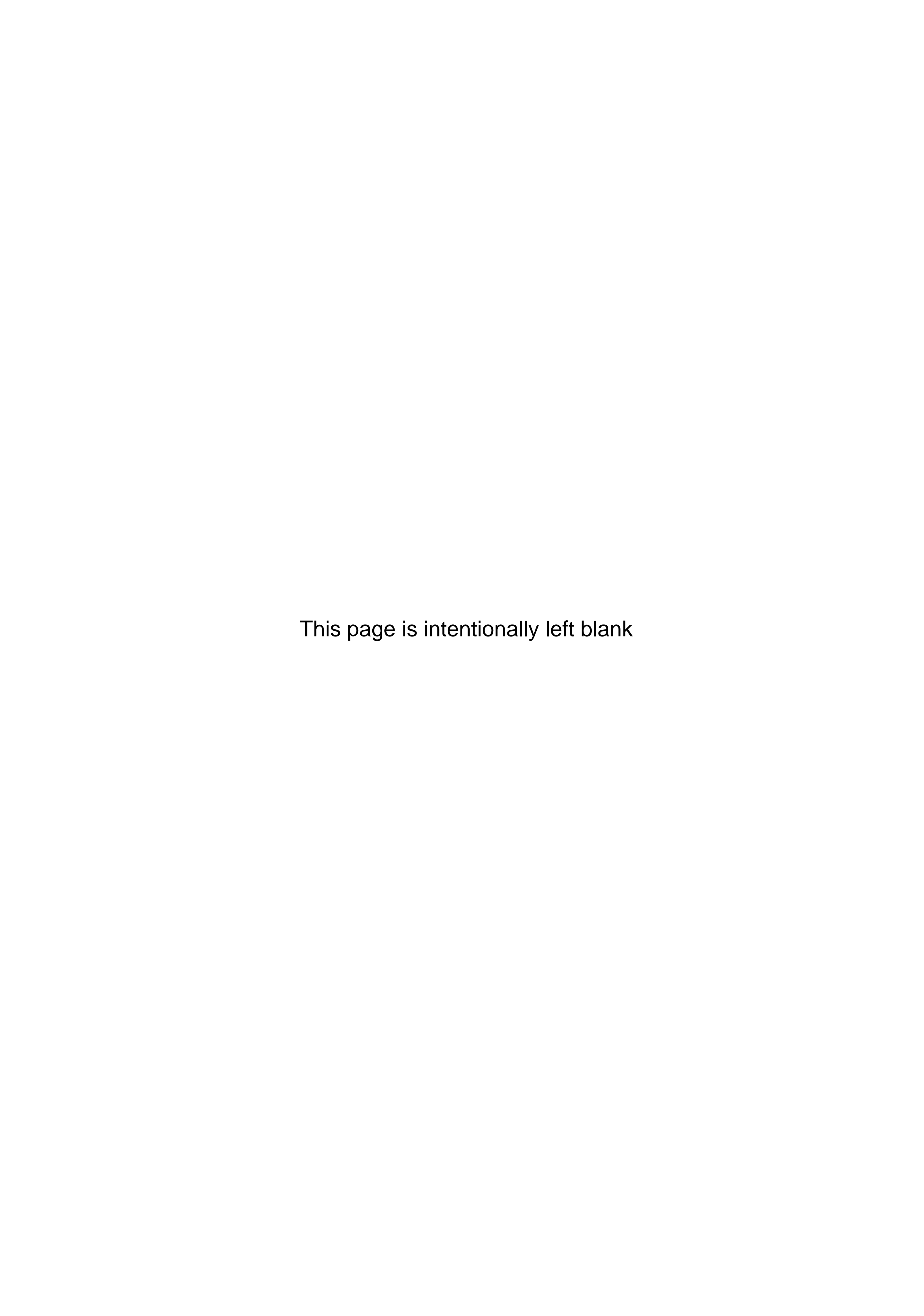
8. Communicate the work of the Board to all Hackney residents and other stakeholders, through its website and publications.

9. 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 6C of the Constitution.

DRAFT


This page is intentionally left blank

DRAFT MINUTES OF THE HEALTH AND WELLBEING BOARD THURSDAY, 21 SEPTEMBER 2023 AT 3.00PM

THE COUNCIL CHAMBER, HACKNEY TOWN HALL,
MARE STREET, LONDON, E8 1EA

In Person:	**Cllr Christopher Kennedy (Co-Chair), Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture (Hackney Council)** **Dr Stephanie Coughlin (Co-Chair), ICP Clinical Lead (City and Hackney)** **Sally Bevan, Chief Executive (Healthwatch Hackney)** **Cllr Susan Fajana-Thomas, Cabinet Member for Community Safety and Regulatory Services (Hackney Council)** **Cllr Carole Williams, Cabinet Member for Employment, Human Resources and Equalities (Hackney Council)**
Officers in Attendance:	**Mark Agnew, Governance Officer (Hackney Council)** **Emmanuel Ross, Programme and Projects Officer (City and Hackney)** **Dr Julia Simon, Director of Strategic Implementation & Partnerships, (Homerton Hospital)** **Kanariya Yuseinov, Enter and View and Volunteer Manager (Healthwatch Hackney)**
Virtually:	**Shohel Ahmed, Safeguarding Adults Board Manager (Hackney Council)** **Georgina Diba, Director Adult Social Care Operations (Hackney Council)** **Rosemary Jawara, VCS Leadership Group (Hackney VCS)** **Anna Garner, Head of Performance and Population Health (NHS North East London)** **Frances Haste, VCS Leadership Group (Hackney VCS)** **Mario Kahraman, Senior ICT Support Analyst (Hackney Council)** **DCI Yasmin Lalani (Metropolitan Police Service)** **Chris Lovitt, Deputy Director of Public Health (City and Hackney)** **Jennifer Millmore, Senior Public Health Specialist, (Hackney Council)** **Joia De Sa, Consultant in Public Health Population Health (Hackney Council)** **Andrew Trathen, Consultant in Public Health (Hackney Council)** **Mark Watson, Programme Lead (Hackney Council)**

Draft

1. Changes to the Board Chair and Membership

1.1 Cllr Christopher Kennedy, as Co-Chair, confirmed that following Raj Radia stepping down from the Health and Wellbeing Board (HWB), the representatives from the City and Hackney Local Pharmaceutical Committee would now be Shilpa Shah, Chief Officer, and Dalveer Johal, Pharmacy Support Manager.

2. Apologies for Absence

2.1 Apologies for absence were received from Cllr Anntoinette Bramble, Jacquie Burke, Mary Clarke, Dr Adi Cooper, Jim Gamble, Nina Griffith, Stephen Haynes, Dr Sandra Husbands, Dalveer Johal, Jessica Lubin, Shilpa Shah, Paul Senior, Dr Kathleen Wenaden, and Helen Woodland.

2.2 In addition, apologies for absence were also received from Det Chief Superintendent James Conway, who was represented by Det Chief Inspector Yasmin Lalani, and it was confirmed that Dr Stephanie Coughlin would join late.

3. Declarations of Interest - Members to declare as appropriate

3.1 There were no declarations of interest.

4. Minutes of the Previous Meeting

RESOLVED: That the minutes of the meeting held on 29 June 2023 be agreed as a true and accurate record of proceedings.

5. Action Tracker

5.1 The tracker was noted.

RESOLVED: To note the Action Tracker.

6. Questions from the Public

6.1 There were no questions from members of the public, but Cllr Kennedy confirmed that he had taken receipt of postcards from the 'Keep our NHS Public' campaign before the start of the meeting, and would reply, treating them as a petition.

7. Annual Report: City & Hackney Safeguarding Adults Board

7.1 Shohel Ahmed, Safeguarding Adults Board Manager, introduced the report and highlighted the achievements of the City & Hackney Safeguarding Adults

Draft

Board (CHSAB), which included the publishing of two Safeguarding Adults Reviews (SAR) and the commissioning of one further SAR; the ongoing action plan which identified learning from SARs; work on raising awareness and engagement, and learning and development; and, the distribution of grant monies allowing community organisations to hold Safeguarding Adults Awareness events throughout Hackney.

7.2 The report also highlighted priorities for 2023/2024, which included the inclusion of new aims related to self-neglect, and continuing to raise SAR awareness. The report also provided a breakdown of the data sets that had helped to drive the work of the CHSAB and their priorities.

7.3 Questions and comments relating to the report were raised by Frances Haste, Cllr Fajana-Thomas, Chris Lovitt, and Rosemary Jawara who asked;

- about the consultation planned on the findings of the report, particularly amongst partners providing services to vulnerable adults;
- about the housing repairs issues highlighted by case study 1;
- what trends were being seen in relation to domestic abuse;
- was there further opportunity to include safeguarding clauses in non-public health contracts;
- and, what links there might be between increased instances of domestic abuse and the cost of living crisis.

7.4 In response Cllr Kennedy, the Safeguarding Adults Board Manager, Georgina Diba, Director Adult Social Care Operations, and DCI Yasmin Lalani, Metropolitan Police Service, confirmed that;

- CHSAB partners, including HCVS, had been consulted with during preparation of the annual report, but further feedback would be gratefully received;
- the case studies omitted some detail to preserve anonymity, but in case study 1 the referral to Safeguarding came from the Council's Housing department;
- representatives of the Council's Housing department attended safeguarding learning events;
- the increase in domestic abuse was likely due to changes in recording of abuse instances, but a possible increase in adult children on parents cases was noted;
- the Police were reassured that reporting of domestic abuse had improved, in part because confidence amongst victims had increased;
- the Citizens Advice Bureau reported positive interactions and support from Safeguarding partners, when reporting instances of domestic abuse;
- the suggestion relating to contract clauses would be raised with CHSAB;
- and, the cost of living crisis was not an excuse for domestic abuse, but CHSAB and partners had taken an interest in this issue, and the wider support available was discussed.

Action: **1. CHSAB to consider inclusion of safeguarding considerations and concerns in future contracts**

Draft

8. Better Care Fund Plan

8.1 After discussion, Mark Watson, Programme Lead, and Chris Lovitt, Deputy Director of Public Health, confirmed that the request to the HWB was to agree that the report should still be presented to the Board annually, but that the HWB delegate approval of the Better Care Fund plans to the relevant Group Director and Cabinet Member.

8.2 Following a question from Cllr Williams, Cllr Kennedy, as the relevant Cabinet Member, advised that he would want the HWB to see an annual report for information, but was happy to take the decision on the plans with relevant Senior Officers on behalf of the Board.

RESOLVED: The HWB agreed to delegate approval of the Better Care Fund plans, and receive an annual report for information.

9. Mystery Shopper: Emergency Hormonal Contraception

9.1 Sally Bevan, Healthwatch Hackney Chief Executive, introduced the report and highlighted that every year the Local Authority encouraged community pharmacies to enter into a contract to deliver free emergency hormonal contraception, and Healthwatch Hackney wanted to see how that contract was being delivered by the 38 pharmacies who had agreed to provide that service.

9.2 Via a telephone mystery shop in 2022, 23 pharmacies offered the service for free and 15 charged. This was then followed by an in-person mystery shop of 16 pharmacies, which discovered that 9 had charged for the service, at c£25. As a result, recommendations were made to both Public Health and City and Hackney Local Pharmaceutical Committee, along with a commitment to continue to monitor the situation.

9.3 In 2023, when following up, 7 of the 9 pharmacies were still charging and some of the reasons given for charging included a pharmacy needing to refurbish consultation rooms and staff being on leave or having a lack of knowledge. This raised concerns for Healthwatch Hackney that other contracts might have been prepared without due consideration given to how they can be practically delivered. The HWB were invited to consider how they commissioned and managed services. Kanariya Yuseinov, Enter and View and Volunteer Manager, who led the mystery shop programme, also highlighted issues related to poor sign posting to accessing what is a free service.

9.4 In response, Cllr Kennedy provided confirmation from Dalveer Johal, Pharmacy Support Manager, that they would consider all the feedback from the report and the discussion. In addition the Deputy Director of Public Health welcomed the report, confirming that it accurately diagnosed the problem and also provided an opportunity to look at solutions, and also confirmed that the updated strategy was in the consultation phase and access to good sexual health would be a key aspect. The Deputy Director of Public Health also highlighted some of the services that were available at the local level and

Draft

being proposed at the national level. A detailed action plan would be presented to the HWB at a future meeting.

9.5 Questions and comments relating to the report were raised by Frances Haste, Rosemary Jawara, and Cllr Williams, who;
- asked why this was not a case of fraud;
- were concerned about the extent that Public Health should be encouraging people to take more responsibility for their sexual health, and increases in gonorrhoea rates;
- highlighted the competing demands on community pharmacies, which were also small businesses.

9.6 In response, the Deputy Director of Public Health confirmed that;
- an analysis of the contract had shown that none of the pharmacies that had charged had submitted invoices, indicating a lack of full awareness of the scheme and the processes required to deliver the programme;
- we do benefit from the number of community pharmacies in Hackney, as they are often a resident's most local NHS representative;
- at the Neighbourhood level Public Health is investigating the needs of local communities in relation to what community pharmacies can and should offer;
- And, that pharmacies are often private businesses, but there are minimum standards that they have to provide and there may be examples of where they are getting the balance between competing pressures wrong.

Action: 2. A report to be presented to the HWB on what is happening in the North East London sub-regional area.

10. Healthwatch: Follow-up to Community Pharmacy Accessibility Audit

10.1 The Healthwatch Hackney Chief Executive and the Enter and View and Volunteer Manager provided the background to the accessibility audit, which included visiting every community pharmacy in-person to examine physical access to the premises, the accessibility services within the premises, and signage and communications materials.

10.2 Key findings from the audit included;
- 26 pharmacies were recommended to build or repair the concrete ramp outside the premises;
- two pharmacies were recommended to repair the pavement outside the premises, and four were recommended to repair the potholes in front of their entrance;
- 36 pharmacies were recommended to install an accessible bell or entry phone system outside the premises;
- feedback from the investigation indicated that pharmacies had issues with landlords and the Council's Planning department;
- and, that pharmacies were businesses and a significant number had cash flow concerns, meaning no spare money to invest in necessary improvement works.

Draft

10.3 The Deputy Director of Public Health responded by thanking Healthwatch Hackney for their work and confirmed that Officers would liaise with relevant Council departments to address issues with pavements and potholes; in relation to bills and invoicing, whilst there was an important requirement to validate services, Public Health was mandated to pay as quickly as possible; and, the financial sustainability of community pharmacies is an issue that is being raised in a number of places. Cllr Williams recognised the importance of access, and highlighted the findings from dementia training, which should also be considered.

Action: **3. Public Health Programme and Projects Officer to discuss the streetscene issues raised with the Council's Highways department.**
4. The City and Hackney Local Pharmaceutical Committee Chief Executive to report back to HWB on progress.

11. Introduction to the Population Health Hub

11.1 Joia De Sa, Consultant in Public Health Population Health, and Anna Garner, Head of Performance and Population Health, spoke to the published presentation, providing details on the Population Health Hub (PHH), which would be a shared system resource, that aimed to support the City & Hackney Place Based Partnership, and wilder system partners, to reduce health inequalities and improve the health of the population. The six main focus areas were confirmed as;

- Capacity building
- Prevention and equity
- Evaluation of impact
- Codesign and partnerships
- Intelligence
- Evidence

11.2 After the presentation, questions and comments were raised by France Haste, Chris Lovitt, who;

- asked about the timeframe for partners to engage with issues relating to health inequalities;
- highlighted the findings of the Health in Hackney Scrutiny Commission's investigation into issues impacting Hackney's Trans community, that also focused on the need for better ways of collecting and reporting data;
- and, who asked for an update in relation to the LGBTQIA+ work around equalities.

11.3 In response, the Head of Performance and Population Health, Cllr Kennedy, and the Consultant in Public Health Population Health, confirmed that;

- partners had as long as they required to provide feedback and data as it was expected that the need for data and feedback would be an ongoing one, and that the PHH would always be grateful to receive what could be provided;

Draft

- an equalities data strategy was being scoped and some of the work would be around supporting those collecting data and explaining why it was being collected, as there was a recognition that there have previously been issues related to trust in this area;
- in relation to the use of data, there is an ambition to improve the collection of information about experiences and outcomes and the embedding of the data that is already collected;
- a needs assessment of the Youth Justice System had recently concluded and was hindered by the lack of access to data;
- and, Public Health Intelligence team leaders were providing a lot of training around data literacy to explain the importance of collecting data.

12 Suicide Prevention Update

12.1 Cllr Kennedy noted that 11 days before this meeting of the HWB had been World Suicide Prevention Day and, as per guidance from The Samaritans, we shouldn't report the locations or methods of suicide.

12.2 Jennifer Millmore, Senior Public Health Specialist, added that in relation to language, "commit" was a word not to employ, as it can imply a crime, nor should the words "successful" or "unsuccessful" be employed. It was noted that the data being provided in the report was numerical and summarising, but that it had not been forgotten that behind the information were real people and tragic circumstances.

12.3 Suicide prevention rests with Public Health and this would be the first in a series of annual reports. This first report indicated that suicide rates are not high in comparison to national rates and the data has provided some insights to help develop proposals to increase prevention.

12.4 Andrew Trathen, Consultant in Public Health, discussed the differences between incidents in Hackney and incidents in the City of London, which require a diverse set of responses; summarised the newly updated national strategy, including the aim to reduce the suicide rate over the next 5 years, as the rate had remained static since 2012; and, highlighted the work of the Zero Suicide Alliance.

12.5 Cllr Kennedy welcomed the report, thanked Officers for their work, and agreed that updates should return to the HWB annually.

Action: 5. Suicide Prevention Update to come back to the HWB annually.

13 Matters Arising

12.1 There were no matters arising for consideration.

14 Dates of Future Meetings

14.1 The next meeting of the Health and Wellbeing Board would be 25 January 2024 at 3.00pm.

Duration of Meeting: 3.00pm - 4.41pm

Chair: Cllr Christopher Kennedy

Title of Report	**The City & Hackney Safeguarding Children Partnership Annual Report 2022/23, including Child Q Update**
For Consideration By	Health and Wellbeing Board
Meeting Date	25 January 2024
Classification	Public
Ward(s) Affected	All Wards
Report Author	The CHSCP Team

Is this report for:

●	Information
●	Discussion

Why is the report being brought to the board?

In line with the CHSCP's written arrangements, the annual report of the CHSCP is presented to Hackney's Health & Wellbeing Board for information and discussion.

The Child Q Update report – *Why was it me*? is also presented for information and discussion. A summary of the progress made against the review's original 14 recommendations is summarised in the annual report (pages 108-118). The lessons arising from the Child Q review and this subsequent update have relevance to all strategic partnerships in Hackney.

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

The annual report was considered by Hackney CYP Scrutiny on 15 January 2024

1. **Background**

CHSCP Annual Report 2022/23

The City & Hackney Safeguarding Children Partnership annual report for 2022/23 sets out examples of the evidence, impact, assurance and learning of the statutory

safeguarding arrangements in the City of London and the London Borough of Hackney. It reports on the following activity:

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

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

Child Q

On publication of the initial Child Q review in March 2022, and at the request of Hackney's Mayor, the ISCC committed to providing an independent update on the progress made in response to the review's original 14 recommendations.

Co-authored by Jim Gamble QPM and Rory McCallum, Senior Professional Advisor, the Child Q Update report, 'Why was it me?' was released in June 2023. This report was the culmination of a substantial range of activity undertaken over 2022/23.

Setting out 13 new recommendations, it sets out what people have said, provides an independent perspective on the actions of key agencies and evaluates the impact that could be evidenced at the time.

The Child Q update report and accompanying video can be found HERE.

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
●	Supporting greater financial security
●	All of the above

Please detail which, if any, of the Health & Wellbeing Strategy '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 leve
●	Making the best of community resources
●	**All of the above**

1.2. **Equality Impact Assessment (EIA)**

Has an EIA been conducted for this work?

No

1.3. **Consultation**

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

Yes

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

Yes

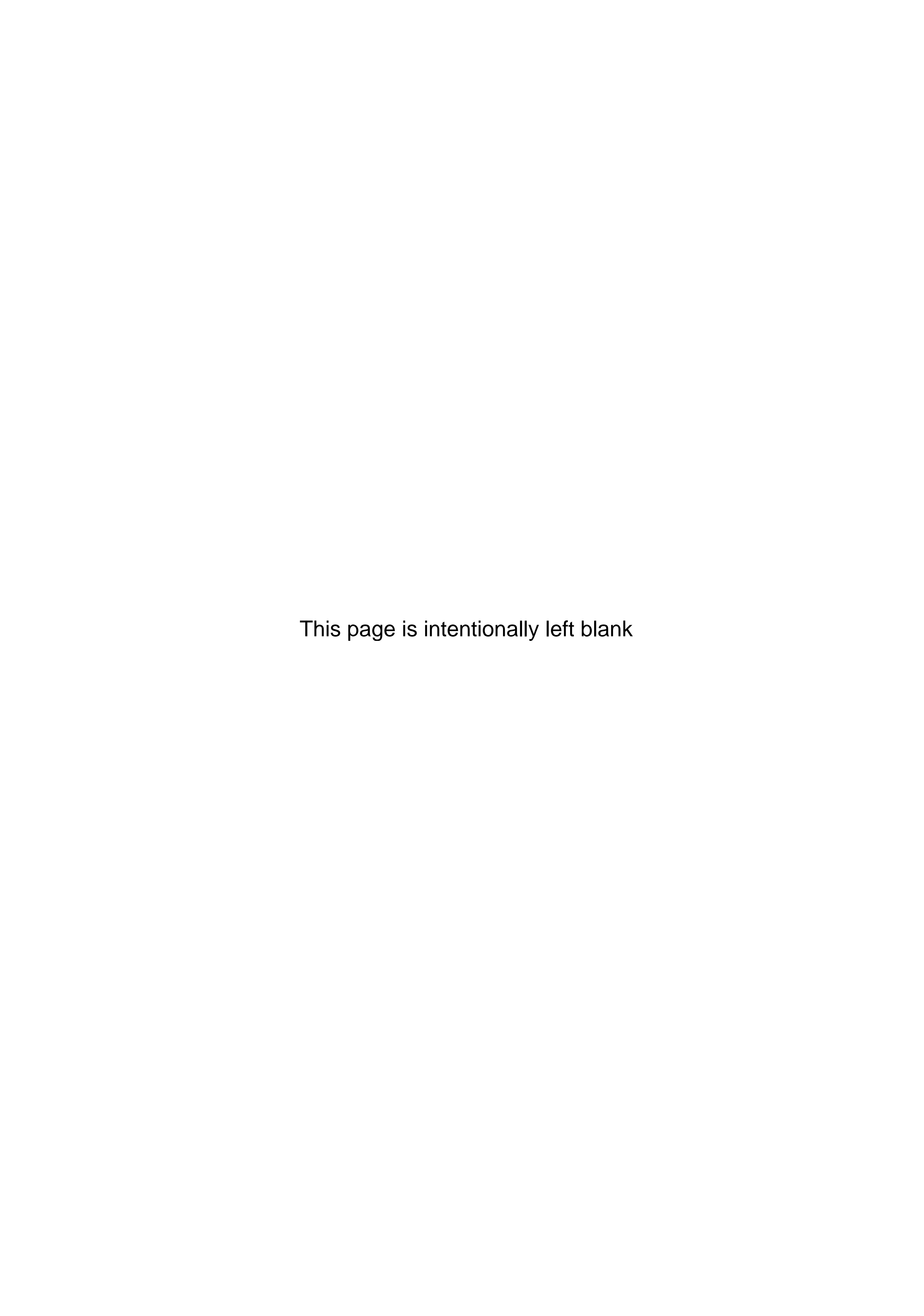
1.4. **Risk Assessment**

N/A

1.5. **Sustainability**

N/A

Report Author	Rory McCallum, Senior Professional Advisor, CHSCP
Contact details	rory.mccallum@hackney.gov.uk
Appendices	See links in the document above



This page is intentionally left blank

city & hackney
safeguarding
children
partnership
2022/23
ANNUAL REPORT
HACKNEY
Stoke
Newington
Dalston
Clapton
Homerton

Foreword

Without a healthy workforce across our partnership, we will be unable to provide the collective support that our community requires. That is why we continued to focus on their health, wellbeing, and stability over the reporting period of this annual report. Practitioners from all agencies are operating in difficult times defined by increases in the cost of living, greater need, complex cases, growing workloads and shrinking budgets. Whilst this has resulted in pressure, our staff survey indicates that many staff still feel supported within their organisations. We welcome this but recognise there are limits, alongside the need for ongoing oversight in this area.

Whilst many organisations had already begun work to address racism, the activity of the partnership following the Child Q case has been more firmly focused and we are determined to drive change. Developing anti-racist strategies cannot, in my opinion, be limited to policy papers and grand statements. All our young people must see and feel a change. Anyone can say they are anti-racist, but it is actions that make the difference. Going forward, we need policies informing practice, actual challenge and clear outcomes that are measurable. Whilst we have seen some promising initiatives, it is too early to say there has been substantial impact. In this regard, I look to the statutory partners to lead by example. Their leadership is key and agency leads must both recognise and contribute to the work that will drive change.

Whether as part of helping develop strategy, understanding performance, or improving practice, the partnership has demonstrated its commitment to hearing the voices of children, young people, their families and the community. Whilst there are a variety of ways we do this, we have learnt that reaching out and listening to authentic voices in places and spaces where people feel safe and able to share, is key. On that note, I'd like to put on record my gratitude to all those young people and community members who spoke with me as part of the Child Q review and update report. I want to reassure them all that this was the beginning of a process not the end. I will re-engage them in the coming months to ensure that they remain involved in the work that guarantees our commitments are delivered.

Whilst this annual report covers a range of issues reflecting the good work done by many of our partners in health, social care, the voluntary and criminal justice sectors, we recognise that there is room for improvement. We therefore remain committed to a continued focus on getting the basics right and getting them right in the context of the City of London and Hackney. This has been reflected through the themes overseen by the CHSCP Executive, the Boards, and the various subgroups in place across our partnership. The report sets out the detail of the activity undertaken in these areas, including our self-assessment programme, staff survey, auditing, and training delivery.

We are fundamentally committed to a safeguarding first approach and to this end our appetite to learn remains strong. Representatives from each partnership agency and organisation continue to support our core sub groups. We are also supported by a determined partnership team, and I want to thank the Senior Professional Advisor, the CHSCP's Business & Performance Manager, Training Coordinator and Partnership Coordinator for all the work they have done and continue to do.

Finally, at the time of writing, the government has just released the revised statutory guidance, Working Together 2023. We will do everything we can to ensure that our response to this strengthens safeguarding wherever possible, whilst retaining the critical level of independent insight and oversight that ensures we are all doing what is right and what is best for our children.

Jim Gamble QPM
Independent Child Safeguarding Commissioner
The City & Hackney Safeguarding Children Partnership

CONTENTS

About the Annual Report 5

The CHSCP 7
- Summary 8
- Purpose 8
- Vision 8
- Principles 9
- Key Roles & Relationships 11
- CHSCP Structure 17
- Attendance 18
- Financial Arrangements 21

Communication 22

Overview of Progress 2022/23 27

City Safeguarding Snapshot 35

Safeguarding in The City of London 37
- City of London Demographics 37
- Early Help 38
- Children in Need of Help and Protection 41
- Contacts, Referrals and Assessments 42
- Children on Child Protection Plans 43
- Children in Care 41
- Care Leavers 42
- Violence Against Women and Girls 43
- MARAC 43
- Safeguarding Adolescents 44
- Child Sexual Exploitation 47
- Children Missing from Home, Care and Education 48
- Gangs, Criminal Exploitation and Serious Youth Violence 49
- Radicalisation 49
- Private Fostering 50
- Children with Disabilities 51
- MAPPA 52
- Afghan Families Resettlement Programme 54
- Safer Workforce 56

Hackney Safeguarding Snapshot 59

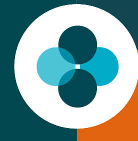
Safeguarding in Hackney 61
- Hackney Demographics 62
- Early Help 63
- Children in Need of Help and Protection 65
- Children in Care 68
- Care Leavers 70
- Violence Against Women and Girls 71
- MARAC 73
- Safeguarding Adolescents 74
- Private Fostering 84
- Children with Disabilities 85
- Children's Mental Health 86
- MAPPA 87
- Safer Workforce 103

Learning & Improvement 93
- Key Messages for Practice 94
- Safeguarding First 94
- SAFER - The Golden Rules of Safeguarding 99
- Auditing 129
- The Voice of the Child, Family & Community 138
- Reviews of Practice 100
- Rapid Reviews 101
- The Child Q Update Report 108
- Auditing 119
- The Voice of the Child, Family & Community 128
- Performance Data 135
- Front-Line Intelligence 136
- External Learning 141

Training & Development 142

Priorities & Pledge 149

What You Need to Know 154



About the Annual Report

Page 27

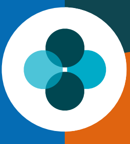
About the Annual Report

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

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

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

IMPACT EVIDENCE ASSURANCE LEARNING



The CHSCP

Page 29

Summary

The City of London and Hackney Safeguarding Children Partnership (CHSCP) is established in accordance with the Children Act 2004 (as amended by the Children and Social Work Act 2017) and the statutory guidance issued within Working Together to Safeguard Children 2018. The CHSCP's safeguarding arrangements define how safeguarding partners, relevant agencies and other organisations work together to coordinate their safeguarding services. These arrangements meet the requirements of statutory guidance and include details about how safeguarding partners will identify and respond to the needs of children, commission and publish local child safeguarding practice reviews and provide for independent leadership and scrutiny. The published arrangements are available HERE.

Purpose

The CHSCP's safeguarding arrangements support and enable local organisations and agencies to work together in a system where:

- Children are safeguarded and their welfare is promoted.
- Partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable children.
- Organisations and agencies challenge appropriately and hold one another to account effectively.
- There is early identification and analysis of new safeguarding issues and emerging threats.
- Learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice.
- Information is shared effectively to facilitate accurate and timely decision making for children and families.

Vision

That all children in the City of London and Hackney are seen, heard and helped; they are effectively safeguarded, properly supported and their lives improved by everyone working together.

Principles

As leaders across a range of organisations, the commitment of the CHSCP is to work together to make the lives of children safer by protecting them from harm; preventing impairment to their health and development, ensuring they receive safe and effective care; and ensuring a safe and nurturing environment for them to live in. The CHSCP wants to make sure that everyone who works with children across the City of London and Hackney has the protection of vulnerable children and young people at the heart of what they do. In practice, this means that children are seen, heard and helped:

- **Seen;** *in the context of their lives at home, friendship circles, health, education and public spaces (both offline and online).*
- **Heard;** *by professionals taking time to listen to what children and young people are saying - putting themselves in their shoes and thinking about what their lives might truly be like.*
- **Helped;** *by professionals remaining curious and by implementing timely, effective and imaginative solutions that help make children and young people safer.*

The CHSCP's aim is to ensure that safeguarding practice and outcomes for children are at least good, and that staff and volunteers in every agency, at every level, know what they need to do to keep children protected, and communicate effectively to ensure this happens. All of our activity is underpinned by the following principles:

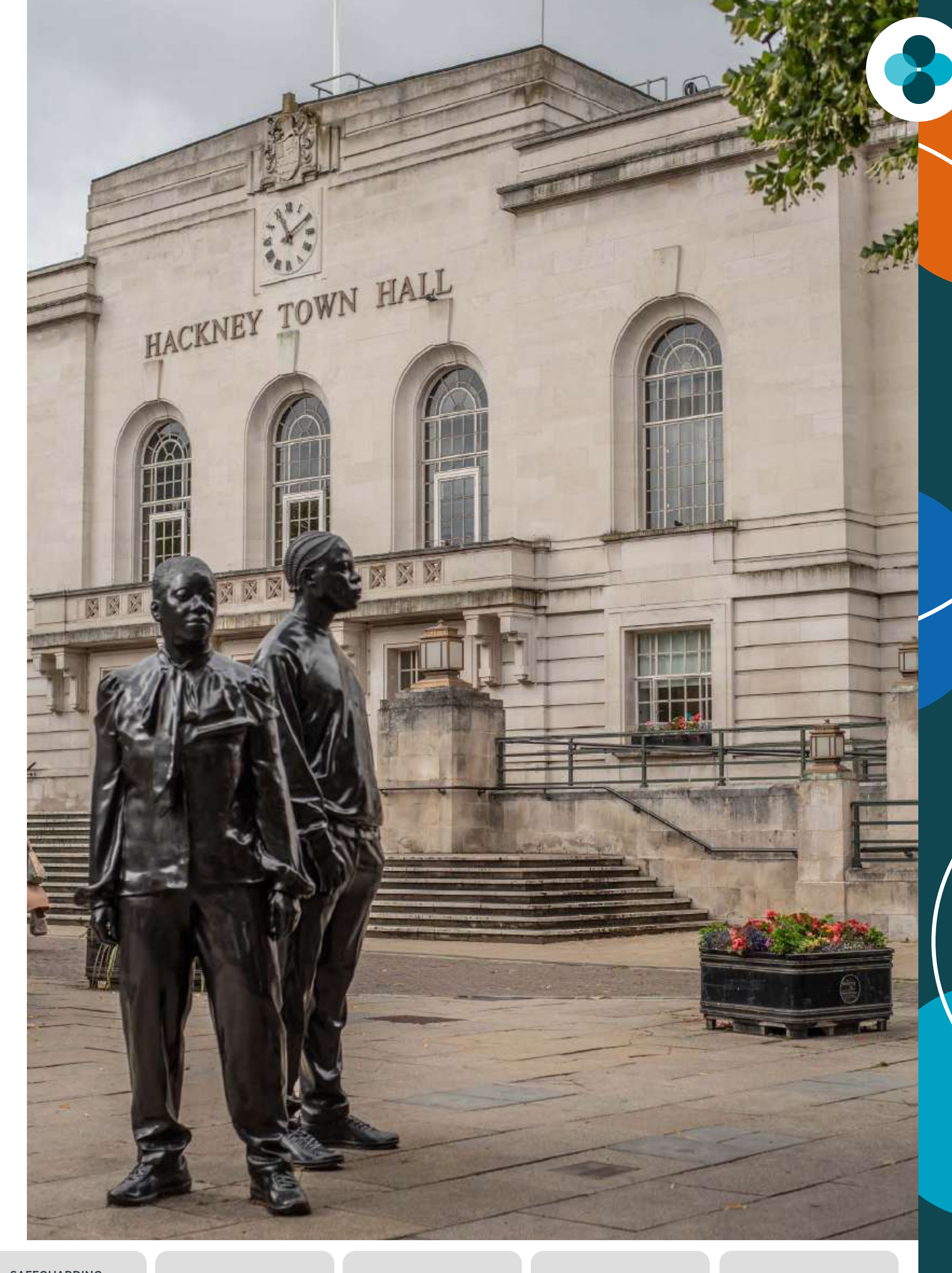
- **Safeguarding is everyone's responsibility.** As a partnership, we will champion the most vulnerable and maintain a single child-centred culture.
- **Context is key.** Capitalising on the unique opportunities presented by a dual-borough partnership, we will have an unswerving focus on both intra-familial and extra-familial safeguarding contexts across the City of London and the London Borough of Hackney.
- **Anti-Racist practice is key.** The CHSCP's safeguarding arrangements are proactively anti-racist. Our focus in this context moves beyond the rhetoric and is evident in our leadership, our practice and in the outcomes of the children, young people, and families we engage.
- **The voice of children and young people.** We will collaborate with children and young people and use their lived experience to inform the way we work. We will regularly engage with them as part of our core business and ensure their voices help both design and improve our local multi-agency safeguarding arrangements.
- **The voice of communities.** Improving our understanding of the diverse communities across the CHSCP's footprint, we will regularly communicate with, listen to, and engage local communities in the work of the CHSCP. We will harness their experience to both inform and improve the way we safeguard and promote the welfare of children and young people.
- **Enabling high quality safeguarding practice.** We will promote awareness, improve knowledge and work in a way that is characterised by an attitude of constructive professional challenge.
- **Fostering a culture of transparency.** We will enable the CHSCP to learn from individual experience and continuously improve the quality of multi-agency practice.

Key Roles and Relationships

SAFEGUARDING PARTNERS

The safeguarding partners agree on ways to coordinate safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning. All safeguarding partners retain an equal and joint responsibility for local safeguarding arrangements. In situations that require a single point of leadership, safeguarding partners will decide which partner will take the lead on relevant issues that arise. The safeguarding partners in the City of London and the London Borough of Hackney are Hackney Council, The City of London Corporation, NHS North East London (NHS NEL), The Metropolitan Police Service (MPS) and The City of London Police. The lead representatives of the safeguarding partners during 2022/23 were:

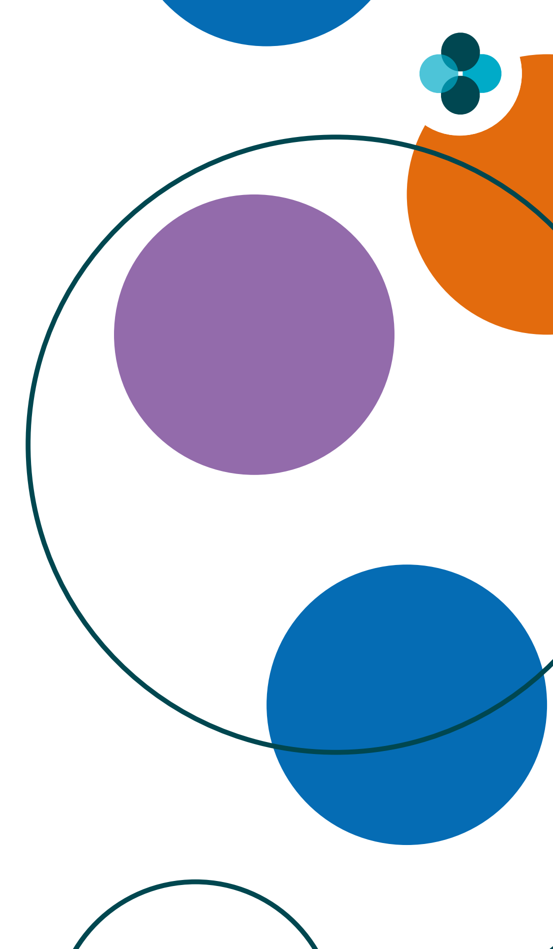
- **Mark Carroll**, Chief Executive of Hackney Council
- **John Barradell**, Town Clerk of the City of London Corporation (to December 2022) / **Ian Thomas CBE**, Town Clerk of the City of London Corporation (from February 2023)
- **Zina Etheridge**, Accountable Officer of the City & Hackney CCG
- **Marcus Barnett**, Commander of the MPS Central East BCU (to July 2022) / **Mike Hamer**, Interim Commander (from August to December 2022) / **James Conway**, Commander of the MPS Central East BCU (from January 2023)
- **Angela Mclaren**, Commissioner, City of London Police

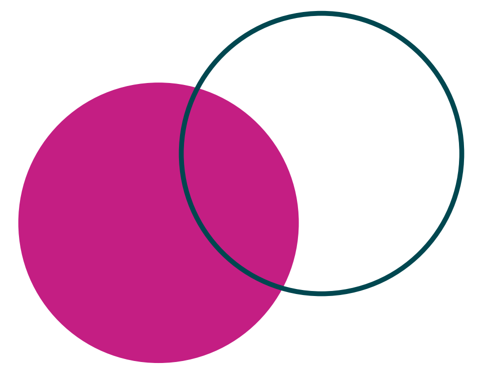


RELEVANT AGENCIES

Safeguarding partners are obliged to set out which agencies are required to work as part of the CHSCP's arrangements to safeguard and promote the welfare of local children. These agencies are referred to as relevant agencies and have a statutory duty to cooperate with the CHSCP's published arrangements. A defined number of relevant agencies will meet regularly with safeguarding partners through the City of London Safeguarding Children Partnership Board and the Hackney Safeguarding Children Partnership Board. Others are invited when deemed necessary and/or included in various sub-groups / thematic groups. The relevant agencies to which the CHSCP's safeguarding arrangements apply includes all those agencies defined in part 4 of the Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018. They include:

- Homerton Healthcare NHS Foundation Trust
- East London NHS Foundation Trust (ELFT)
- All schools (including independent schools, academies, and free schools), colleges and other educational providers
- The Probation Service (London Division)
- Children and Family Court Advisory and Support Service (CAFCASS)
- Hackney Council for Voluntary Services (HCVS)
- London Ambulance Service (LAS)
- London Fire Brigade (LFB)
- NHS England
- All registered charities within the geographic area of the CHSCP whose staff / volunteers work with or come into contact with children and their families



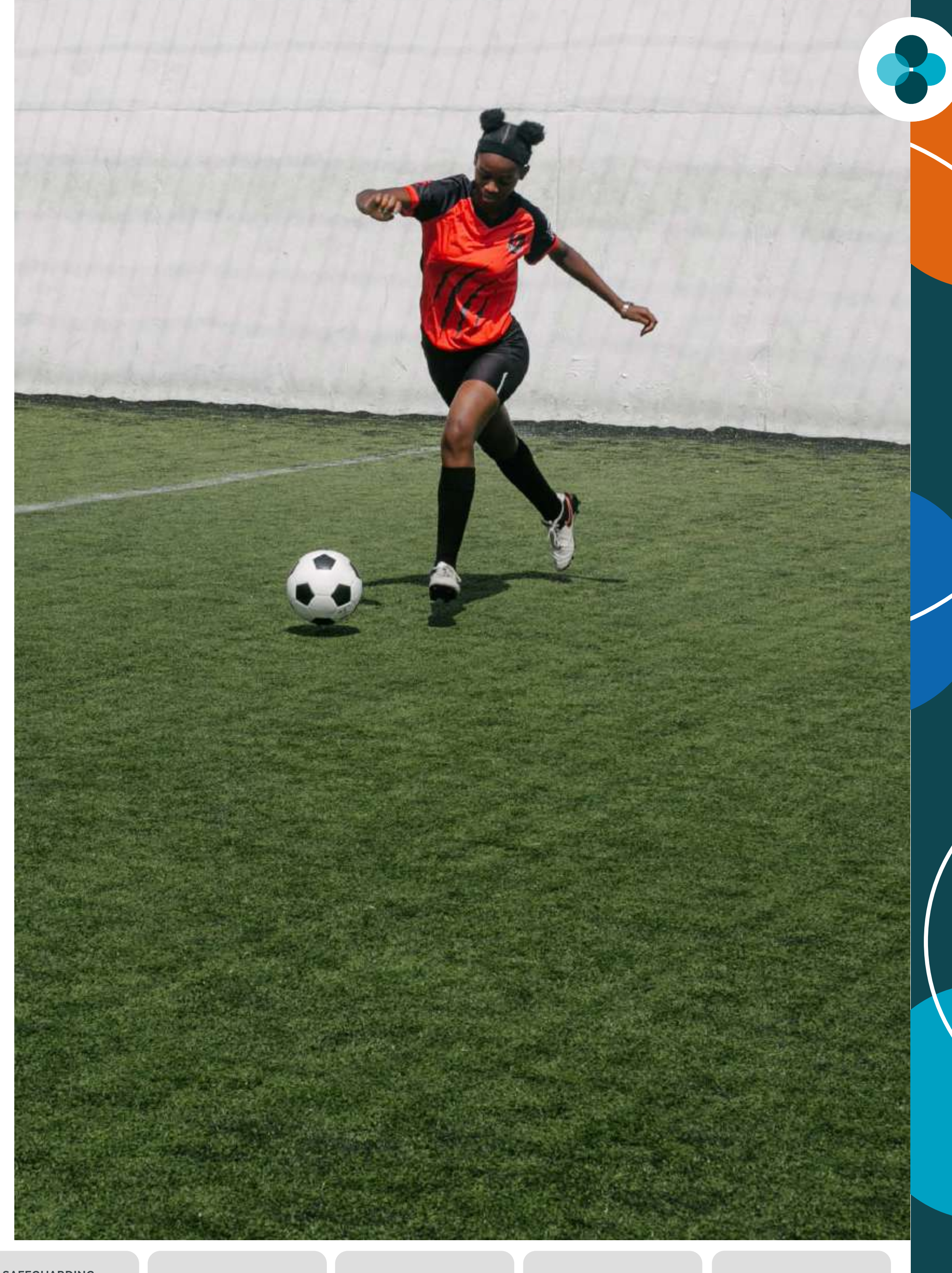


NAMED ORGANISATIONS

Safeguarding partners can also include any local or national organisation or agency in their arrangements regardless of whether they are named relevant agencies. Whilst not under the same statutory duty, there remains an expectation of compliance, with legal powers existing to ensure this in defined areas. For example, Section 16H of the Children Act 2004 contains a wider power exercisable by the safeguarding partners to request a 'person or body' to provide information to them. There is no limitation or definition of 'person or body' therefore the request can be made to anyone. Local organisations named by the CHSCP include all 'Out of School Settings' (providing tuition, training, instruction or activities without the supervision of parents or carers) and Social Housing providers.

DESIGNATED PROFESSIONALS

The Designated Doctor and Nurses for Safeguarding Children take a strategic and professional lead on all aspects of the health service contribution to safeguarding children. Designated professionals are a vital source of professional expertise. The Designated Doctors and Nurses have continued to demonstrate their value by offering challenge and support to partners.



THE INDEPENDENT SAFEGUARDING CHILDREN COMMISSIONER

Jim Gamble QPM is the Independent Safeguarding Children Commissioner (ISCC) of the CHSCP. This role is appointed by safeguarding partners and given authority to coordinate independent scrutiny of the local child safeguarding arrangements. The ISCC is fundamentally independent and has delegated authority from safeguarding partners to instigate Local Child Safeguarding Practice Reviews. The ISCC has significant experience of operating at a senior level in the strategic coordination of multi-agency services to safeguard and promote the welfare of children.

ASSURANCE

Through engagement, commentary, and lobbying, the ISCC provides independent leadership in respect of local matters relevant to the safeguarding of children and young people. The ICSC holds both safeguarding partners and relevant agencies to account for their effectiveness in safeguarding children and young people. The ISCC chairs the CHSCP's Executive and the CHSCP Boards to ensure fundamental independence is built into the oversight of statutory safeguarding partners and relevant agencies. The ISCC also chairs the Case Review sub-group to ensure independent decision making in respect of the commissioning and progress of reviews. The ISCC continues to be engaged with elected officials to brief on specific issues, raise concerns and to provide an independent overview of practice. This takes place via 1:1 meetings and other forums (such as 'joint chairs' meetings) and those that engage elected members and other local boards. The ISCC is also engaged by the Local Authority scrutiny functions in both the City of London and Hackney.

ASSURANCE

The outcome of an internal audit conducted by Hackney Council in June 2022 found that the Independent Safeguarding Children Commissioner, with the focused support of the CHSCP's Senior Professional Advisor and the partnership team, enhanced the effectiveness of risk management controls and governance arrangements which were pivotal in the CHSCP's operational success.

THE CHSCP EXECUTIVE

CHSCP Executive members are senior officers that can speak with authority for the safeguarding partner they represent. They can hold their organisation to account, take decisions and commit them on policy, resourcing and practice matters. The Executive is chaired by the ISCC and during 2022/23, comprised the following:

- **Jacquie Burke**, The Group Director of Children & Education
- **Andrew Carter**, The Director of Children and Community Services (The City of London Corporation) - to July 2022 / Clare Chamberlain, Interim Director of Children and Community Services (to March 2023)
- **Amy Wilkinson**, Integrated Commissioning Director NHS NEL ICB (to October 2022) / Diane Jones, Chief Nursing Officer NHS North East London ICB (from January 2023)
- **Marcus Barnett**, The Commander of the MPS Central East BCU (to July 2022) / Mike Hamer, Interim Commander of the MPS Central East BCU (from August - to December 2022) / James Conway, The Commander of the MPS Central East BCU (from January 2023)
- **Umer Khan**, T/Commander, City of London Police
- **Annie Gammon**, Director of Hackney Education (Hackney Council) to August 2022 / Paul Senior Director of Hackney Education (from September 2022)

Page 37

IMPACT

The CHSCP Executive had already extended its membership to include Hackney Council's Director of Education. To further strengthen its engagement with the education sector, Mark Emmerson, the Chief Executive Officer of the City of London Academies Trust, is also now a formal member of the group.

CHALLENGE

As part of a recent consultation on the statutory guidance, Working Together, the CHSCP Executive submitted a collective response to the Department for Education. This confirmed our local position that 'Education' should be made the fourth statutory safeguarding partner. The view of the Executive is that this sends a clear message about the leadership role that schools and colleges have in safeguarding and promoting the welfare of children and the need for them to be part of the leadership arrangements in local areas. This needs to be beyond their status as a 'relevant agency'. That said, the Executive recognised the challenges in how this might be practically discharged in terms of governance given the number of school / college leaders. However, this is not insurmountable. It requires further thinking about what the LSP status means in terms of accountability and how this can be discharged.

THE CHSCP BOARDS

In mid-2021, the former CHSCP Executive group split to become two separate forums – The City of London Safeguarding Children Partnership Board and the Hackney Safeguarding Children Partnership Board. These groups comprise representatives from safeguarding partners and several relevant agencies. They include named and designated professionals. Both are independently chaired by the ISCC and are responsible for delivering the CHSCP business plan. The core membership of the CHSCP Boards can be found HERE.

ASSURANCE

The Boards in the City of London and Hackney met quarterly during 2022/23, with an additional combined meeting held in July 2022. For each meeting, Board members are expected to submit partner agency updates that focus on key issues within their respective agencies alongside a specific theme identified for deeper scrutiny. Over the reporting period, these themes included the Child Q review, the lessons arising from the national review into Arthur Labinjo Hughes and Star Hobson and multi-agency working, workforce health and stability and general progress. An extraordinary meeting focused on the cost-of-living crisis.

THE CHSCP TEAM

The CHSCP continues to be supported by a dedicated group of staff. The core team includes a Senior Professional Advisor, a Business and Performance Manager, a Training Coordinator and a Partnership Coordinator.

RELATIONSHIPS WITH OTHER BOARDS / FORUMS

There was ongoing engagement with other strategic partnerships in the City of London and Hackney during 2022/23. This included the Health & Wellbeing Boards in the City of London and Hackney, Hackney's Community Safety Partnership, the Safer City Partnership and the City & Hackney Safeguarding Adults Board. The work of the CHSCP continued to feature as items for oversight by the political scrutiny functions in both areas.

EVIDENCE

During 2022/23, a joint piece of work involving partners from the CHSAB and CHSCP was initiated to refresh the local 'Think Family' guidance. Arising from local learning identified in several reviews, this work is scheduled for completion in 2023/24.

CHSCP Structure 2022/23

Independent Safeguarding Children Commissioner

Statutory Safeguarding Partners

The Executive

Hackney Safeguarding Children Partnership Board

City of London Safeguarding Children Partnership Board

Case Review

Quality Assurance

Training Learning & Development

Thematic Sub-Groups / Task & Finish Groups

Strategic Links to:

Hackney Health & Wellbeing Board

Hackney Community Safety Partnership

Hackney CYP Scrutiny

Safer City Partnership

City of London Health & Wellbeing Board

City of London Safeguarding Commission

Attendance

HACKNEY EXECUTIVE

Organisation	May 2022	July 2022	Oct 2022	Jan 2023	Agency Specific Attendance (%)
City of London Corporation	Yes	Yes	Yes	Yes	100
Hackney Council	Yes	Yes	Yes	Yes	100
Hackney Education	Yes	No	Yes	No	50
City & Hackney NHS North East London	Yes	Yes	Yes	Yes	100
Metropolitan Police Service	Yes	No	Yes	Yes	75
City of London Police	No	No	Yes	Yes	50

HACKNEY BOARD

Organisation	May 2022	Sept 2022	Nov 2022	Feb 2023	Agency Specific Attendance (%)
CAFCASS - Children & Families Court Advisory & Support Service	Yes	No	Yes	Yes	75
Hackney Education	No	Yes	Yes	No	50
London Fire Brigade	No	Yes	No	No	25
Hackney Children & Families Service	Yes	Yes	Yes	Yes	100
Hackney Community & Voluntary Services	Yes	Yes	Yes	No	75
Homerton Healthcare NHS Foundation	Yes	Yes	Yes	Yes	100
NHS North East London (City and Hackney)	Yes	Yes	Yes	Yes	100
East London NHS Foundation Trust	No	No	Yes	Yes	50
Hackney Housing Services	Yes	Yes	No	Yes	75
Metropolitan Police Service	Yes	No	Yes	Yes	75
Probation Service	No	Yes	Yes	Yes	75
Public Health	No	Yes	Yes	Yes	75

CITY OF LONDON BOARD

Organisation	May 2022	Sept 2022	Nov 2022	Feb 2023	Agency Specific Attendance (%)
CAFCASS - Children & Families Court Advisory & Support Service	No	No	Yes	No	25
City of London Corporation	Yes	Yes	Yes	Yes	100
London Fire Brigade	No	Yes	No	No	25
Homerton Healthcare NHS Foundation	Yes	Yes	Yes	Yes	100
City & Hackney NHS North East London (City and Hackney)	Yes	Yes	Yes	Yes	100
East London NHS Foundation Trust	No	No	Yes	No	25
City of London Police	Yes	Yes	No	Yes	75
Probation Service	No	Yes	Yes	Yes	75
Public Health	No	No	Yes	Yes	50

Financial Arrangements

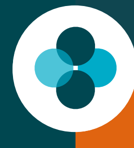
IMPACT

As part of its Corporate Social Responsibility (CSR) programme, INEQE Safeguarding Group continues to support the local partnership in the production of its annual report.

EXPENDITURE	£
Reviews	24,700
External Auditing	2,750
Staffing and Travel	355,104
Training, Learning & Development	19,038
Printing, Supplies & Equipment	14,236
Venues & Miscellaneous	2,893
Total Expenditure	**418,722**

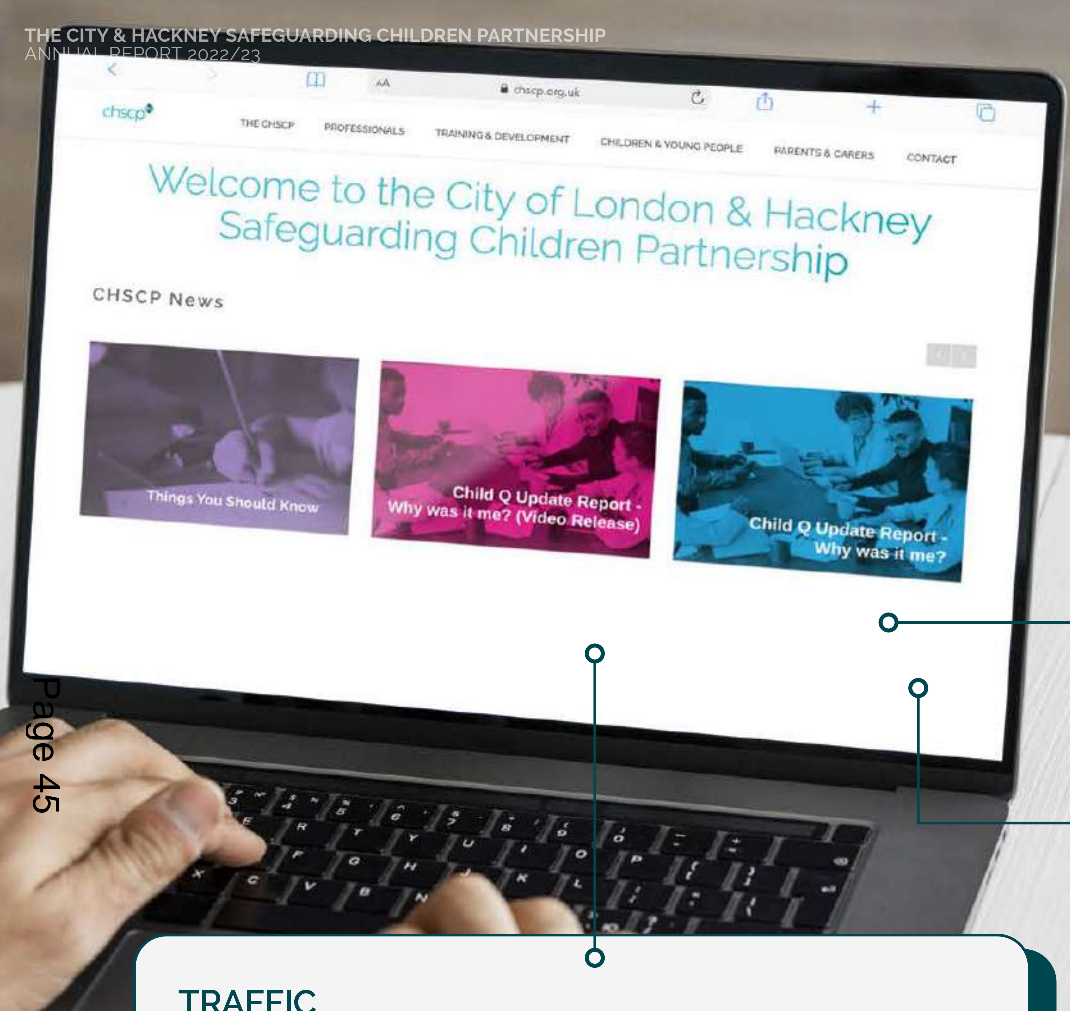
Page 43

INCOME	£
Hackney Council (not including overheads)	238,193
City of London Corporation	29,480
Hackney Education	24,480
East London NHS Foundation Trust	24,480
North East London ICB247	12,000
Homerton Healthcare NHS Foundation Trust	12,000
Metropolitan Police Service	5,000
Probation Service (London Division)	2,000
DFE Project funding (use of funding received in 2021/22)	40,000
Total Income	**363,153**



Communication

Page 44



Page 45

CHSCP WEBSITE

www.chscp.org.uk

21,136 visitors to the CHSCP website.

1,761 monthly average visitors.

13,656 (81%) UK based visitors. **7,480 (19%) Global** visitors.

43 unique languages accessed the site.

Following the **publication of the Second Child Q Update** Report review, the website received **1,424 page views**. (Thursday 21 July 2022)

INTERACTION

Total Page views	44,418 times
Home Page views	10,167 times
Case Reviews Page views	3,953 times
Child Q Review views	3,785 times
Training Calendar views	1,122 times
Membership Page views	1,634 times
Practice Guidance views	932 times

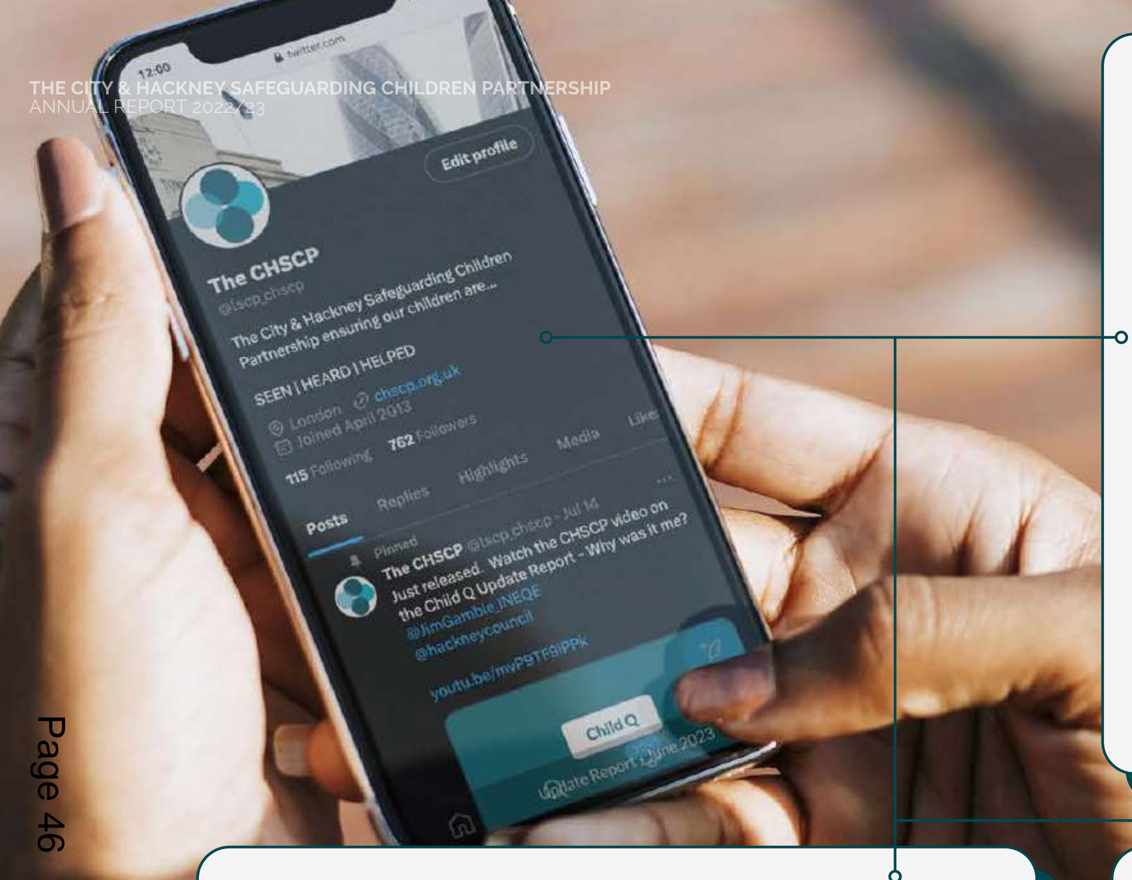
TRAFFIC

9154 (49%) of visitors used an **organic search** (search engine)

6203 (33%) of visitors used a **direct search** (url bar)

3202 (17%) were referred via **another website**

128 (1%) via a **social media** link. **X (Formerly Twitter)** was the most used with **73 (40%)** of referrals.



Page 46

X (FORMERLY TWITTER)

Within the time frame of 1st April 2022 - 31st March 2023, the posts promoting our TUSK (Things You Should Know) Briefings received 487 impressions.

CHILD Q UPDATE REPORT

The Child Q Update Report was released in June 2023 and the post promoting the release has received **9,995 views** to date.

CHILD Q UPDATE REPORT - VIDEO

The Child Q Update Report Video was released in July 2023 and the post promoting the release has received **4,421 views** to date.

Child Q

Update Report - June 2023

PRIVATE FOSTERING APP

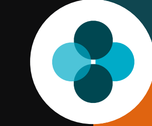
The CHSCP continues to promote its Private Fostering App. Alongside providing information about private fostering, the App includes a training module and other important advice for safeguarding professionals.

TUSK BRIEFINGS

The CHSCP produces e-briefings called Things You Should Know, more commonly referred to as 'TUSK' briefings. These are circulated to subscribers and cascaded by safeguarding partners, relevant agencies and named organisations. The number of subscribers to the TUSK remained broadly static over 2022/23 with 1478 subscribers.

chscp
Things You Should Know

Page 47



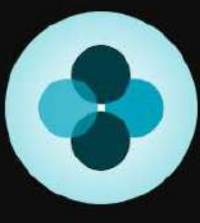
Home
Shorts
Subscriptions

You >

Your channel
History
Your videos
Watch Later
Show more

Explore

Trending
Music
Movies & TV
Live
Gaming
News
Sport
Learning
Fashion & beauty



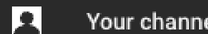
CHSCP

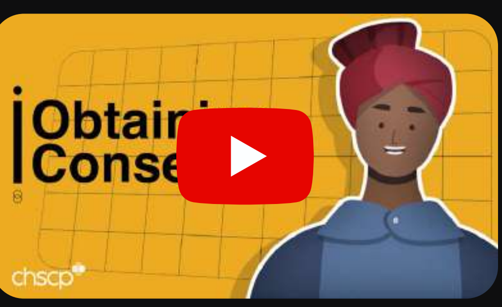
@chscp4170 · 25 subscribers · 12 videos

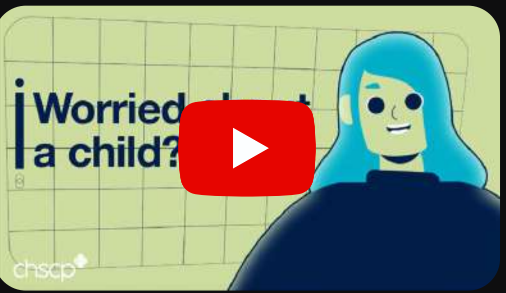
The City & Hackney Safeguarding Children Partnership aims to ensure that all children and ...

chscp.org.uk and 1 more link

Customise channel | Manage videos

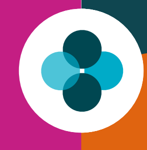






YOUTUBE

The CHSCP has produced several video guides covering a range of safeguarding topics. These can be viewed HERE. These have attracted just over **4,362 views** to date.



Overview of Progress 2022/23

PRIORITY 1

The Health & Stability of the Safeguarding Workforce

Progress: During 2022/23, the CHSCP maintained its focus on the health and stability of the workforce as a key priority. There were three main ways in which this was undertaken. Firstly, through the development and launch of the CHSCP's Safeguarding Self-Assessment tool in February 2023. This tool is issued to all safeguarding partners, relevant agencies and named organisations and includes key questions about workforce sufficiency. An overview is included later in this report. Secondly, through the staff survey; establishing from practitioners themselves their views on issues such as management support, workloads and other potential workforce pressures. This too is covered later in this report under the Learning & Improvement section. Lastly, through the CHSCP's efforts in supporting the development of the safeguarding workforce through the provision of high-quality training, learning and development opportunities (see Training & Development).

In addition to these areas of activity, the CHSCP Executive and both Boards maintained clear oversight of these issues by way of the CHSCP risk register, where the health and stability of the workforce is a standing risk. Key areas of focus included the ongoing workforce pressures within CAMHS and the impact of the cost-of-living crisis. The cost-of-living crisis was considered at an extraordinary meeting of the CHSCP in July 2022, where reassurance was sought about the sufficiency of the arrangements in place to help mitigate the impact on children, their families and the safeguarding workforce. The health and stability of the workforce was a specific theme considered by the February 2023 Boards.

PRIORITY 2

Active Anti-Racist Practice

Progress: Much of the activity generated against this priority links with the CHSCP's work on the initial Child Q review and the Child Q update report published in June 2023. Details in this context are included under the Learning & Improvement section of this report. For individual organisations, section 8 of the Child Q update report provided an evaluation of the steps taken. These can be read HERE. Other actions taken include partners being much sharper on exploring issues of disproportionality. Most recently, this has been seen with HCFS identifying a potential practice issue relating to the triggering of child protection enquiries with Black African children where there are concerns about physical abuse. Whilst work is ongoing, this has led to some early conversations with a relevant charity seeking to develop improved preventative measures and awareness raising with children, families and practitioners.

PRIORITY 3

The Voice of Children and Young People

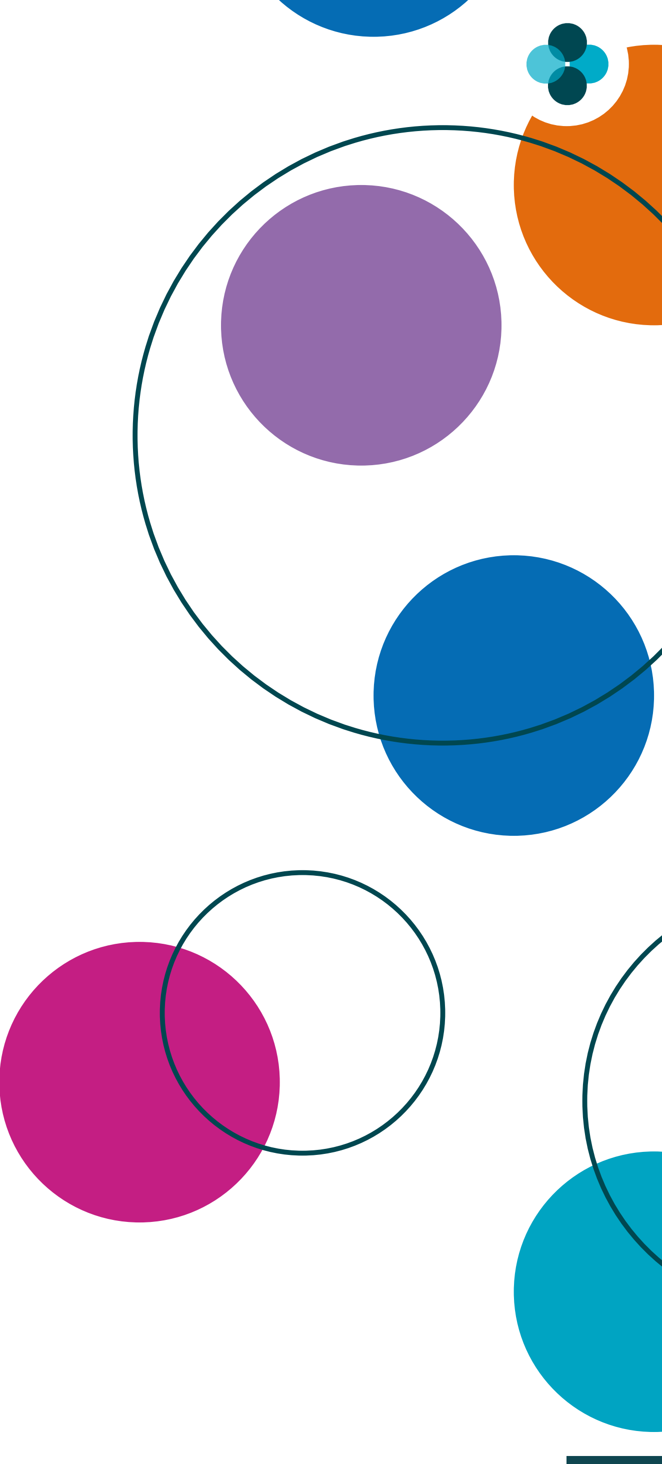
Progress: Again, the specific progress on how the voice of children, young people and families is included in the Learning & Improvement section of this report. There is good evidence that this has remained a central theme at both a strategic level and as part of direct practice. From the CHSCP's perspective, the engagement with nearly 100 children by the ISCC as part of the Child Q Update report demonstrated the priority placed on this aspect. The views captured have led to direct recommendations about wider engagement with children and young people, alongside developing mechanisms through which they can contribute to the independent scrutiny of our local arrangements.

Page 52

PRIORITY 4

Getting the Basics Right

Progress: Work in Hackney has mainly focused on strengthening the way in which local early help arrangements operate - recognised as being key to effective help and protection. Work in the City of London has focused on maintaining these - with the local framework here being effective and established for several years. In addition, the CHSCP has maintained its priority on keeping its local policies and guidance up to date, routinely promoting these via its TUSK briefings. One key area that was explored during 2022/23 was Neglect. Building on its existing guidance and toolkit, the CHSCP commissioned the NSPCC's Graded Care Profile 2 tool with a view to implementing this across the partnership. However, after a significant amount of work developing our local infrastructure, on release of the tool itself, practitioners raised several concerns about its applicability in the context of local safeguarding practice. In summary, these concerns related to the scoring mechanism of the tool and the fact it was considered to be too Eurocentric in its foundations. After carefully considering the pros and cons of implementation, the partnership decided not to endorse its use. The City of London Corporation agreed to test the tool for a defined period and further decisions will be made at this stage.



Page 53

PRIORITY 5

The Appetite to Learn

Progress: Progress against this priority remains strong. Whether through reviews, auditing or one of several mechanisms in operation, the CHSCP's Learning & Improvement framework continues to drive activity and identify lessons for practice improvement. Furthermore, our local focus on independent leadership and scrutiny via the ISCC remains a key component to our drive for improvement. With that in mind, it is of concern that the recent consultation by the Department for Education on the statutory guidance for safeguarding children, Working Together, appears to be diluting this. Whilst awaiting the outcome of the consultation, our local position on retaining independence in both partnership's chairing functions remains clear. For transparency, the collective response of the CHSCP's safeguarding partners on the DfE's proposal to remove independent chairs from local safeguarding arrangements was as follows:

We are fundamentally opposed to this proposal. If implemented, this will significantly weaken how local arrangements operate in many areas, the significant majority of which retain an independent chair role. The requirement to mandate a partnership chair should be withdrawn from WT 2023.

The proposal to remove independent chairs and replace them with chairs from one of the three statutory safeguarding partners is defaulting back to a pre-Laming era and is therefore a step backwards.

The dilution of independence by removing independent chairs presents a risk. Lord Laming said partnership is about challenge. Healthy tension and grit are needed in the system for it to be truly independent and for it to work. There is a need to give Chairs and/or scrutineers teeth, not remove them.

Agencies have different priorities and will do what is right for them as individual agencies. Where agencies cannot agree, independence is needed. Chairs ask the questions that partners will not ask of each other.

It is important that partners do not mark their own homework or worse, decide not to do it at all. It is critical that one partner does not dominate the partnership. This proposal is a consensus model and therefore cannot work.

Independent Chairs do a lot more than turn up to meetings to chair them. For example, chairs hold escalation panels to resolve disputes. Locally, our independent commissioner decides whether the threshold has been met for a LCSPR. They have a role in independently advocating for and on behalf of children and families. These are functions beyond that of a 'scrutineer'. We believe strongly that there needs to be someone independent to make these decisions and deliver these functions. As an example, the Child Q Review would never have gone ahead if it had been left to the safeguarding partners.

The proposal is disconnected with what is happening on the ground and fails to recognise how the independent chairing of key partnership meetings is also a dedicated function of independent scrutiny, challenge and holding to account. Removing the independent chairing role would, for us, remove a key mechanism for independent scrutiny.

The Wood Review left choice for partnerships. Partnerships have chosen what works for them which includes retaining an independent chair – someone with insight and oversight.

Safeguarding children can be one priority amongst many for senior leaders of organisations. For independent chairs, it is their priority, and this helps drive an unswerving focus on children.
Based on the DfE sessions some of us have attended, this seems to be a fait accompli, but there is no substantive evidence that those areas who have adopted an approach without independent chairs are doing any better.

The DfE has been unable to provide specific exemplars to demonstrate which partnerships are working well under this type of arrangement.
It has not approached the City of London or Hackney, despite the fact that Ofsted highlighted good partnership arrangements in these areas.
One of the points of the Wood Review was about the quality of independent chairs. There has been an assumption made about the quality of individuals and we believe this has acted as a key catalyst for the proposals. This needs to be about system over personalities.
It is highly likely that in most areas, the DCS will be made the Partnership Chair. However, many will not have the capacity – some have broad spans of control, and some remain 'twin-hatters' and have responsibility for Adults Services and/or other functions such as Housing, Public Health etc.

In Sir Alan's initial report he highlighted "Despite the post of independent chair of the LSCB reporting to the local authority Chief Executive and statutory guidance on the role of the Director of Children's Services and the Lead Member, the situation is unsatisfactory and leadership expectations are focused on the local authority.

This does not have sufficient impact in relation to senior leaders in the police and the range of health services.' In all likelihood, the Partnership Chair role will once again place leadership expectations on the local authority.

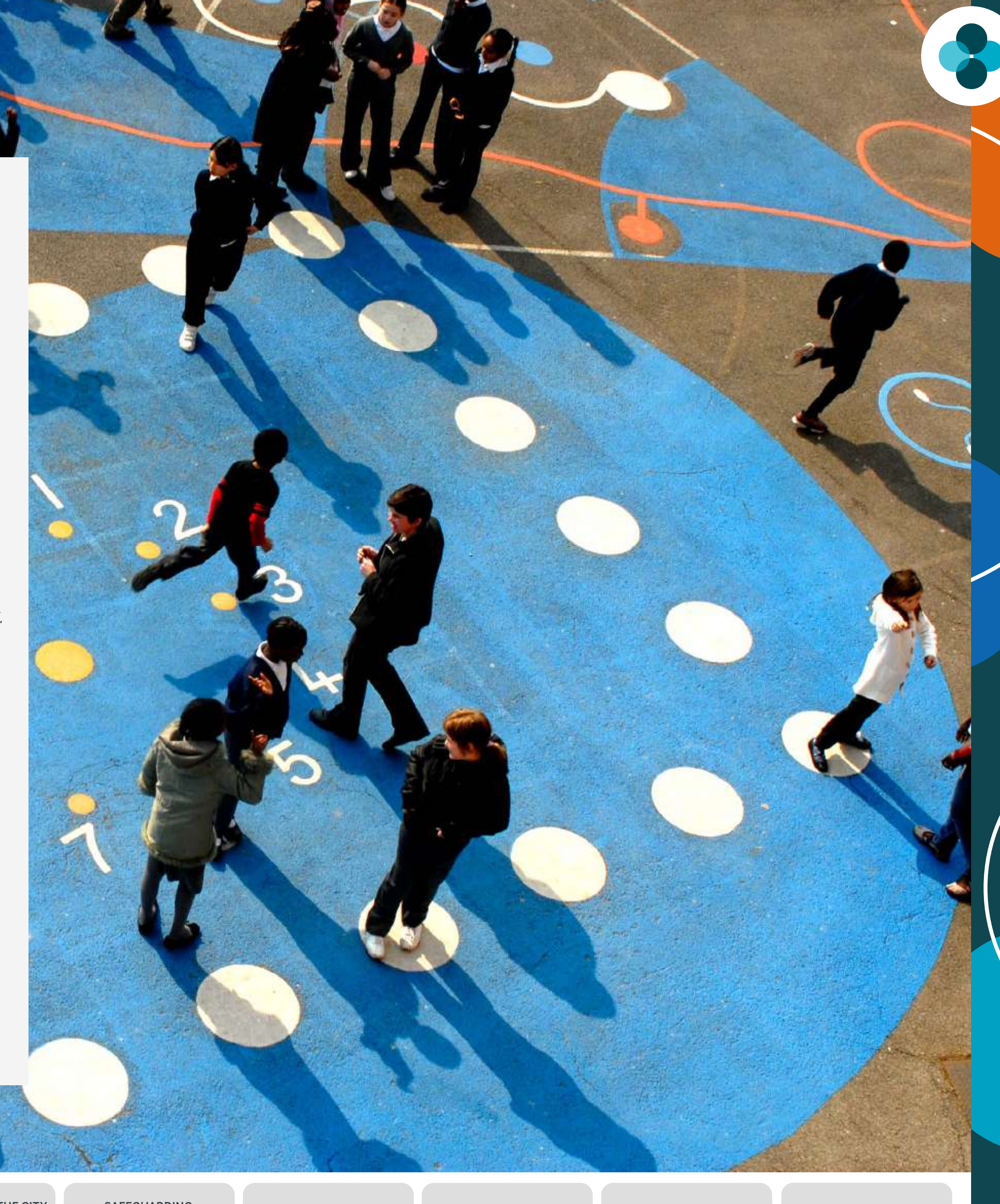
There is a need to professionalise the role of Independent Chair, with local areas retaining the ability to bring in a scrutineer where there is a specific issue to look at.

80% of areas still have an Independent Chair/Scrutineer and both roles appear to be rolled into one.

An Independent Chair brings continuity and corporate memory.

This is a top-down approach. There should be an acknowledgement and respect for how local areas have chosen to do things.

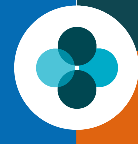
Page 55



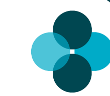
PRIORITY 6

Making the Invisible Visible

Progress: Progress has disappointingly but not surprisingly been absent in terms of the Unregistered Educational Settings (UES) agenda and its links to this priority area of the CHSCP. Notwithstanding the significant efforts by many of our local professionals, children who attend UES in Hackney continue to be outside the line of sight of safeguarding professionals. There is no direct mechanism to ensure that the premises within which they congregate are safe; that the infrastructure is sound; environment appropriate; or that contemporary safer recruitment practices are being applied to those working frequently and routinely with children. The comprehensive package of safeguarding support that was previously developed and shared with community leaders has received no uptake and based on the conditions seen at some UES (via the UES protocol meetings), this remains a significant concern. Equally concerning is the ongoing legislative vacuum that facilitates the operation of UES as they are. The redaction of the Schools Bill, alongside the absence of any meaningful cooperation from those responsible for UES, is not making children who attend UES safer.



City Safeguarding Snapshot 2022/23



765 children and young people under 19

5.4% of total population

14.5% of children in primary schools in receipt of free school meals

58 cases referred / stepped-down to the City's Early Help Team

29 Team around the Child (TAC) meetings held

3 young people going missing from care (12 incidents)

2 incidents of children & young people missing from home

707 contacts to the City Children & Families Team Hub

63 referrals

30% re-referrals

41 statutory social work assessments completed by The City Children & Families Team

89% of assessments completed within 45 days

11 child protection investigations

2 children on a Child Protection Plan as of March 2023

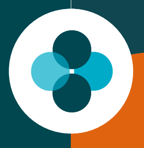
131 Children in Need episodes as of March 2023

9 children & young people looked after as of March 2023

1 MARAC meeting involving children

13 referrals to the LADO

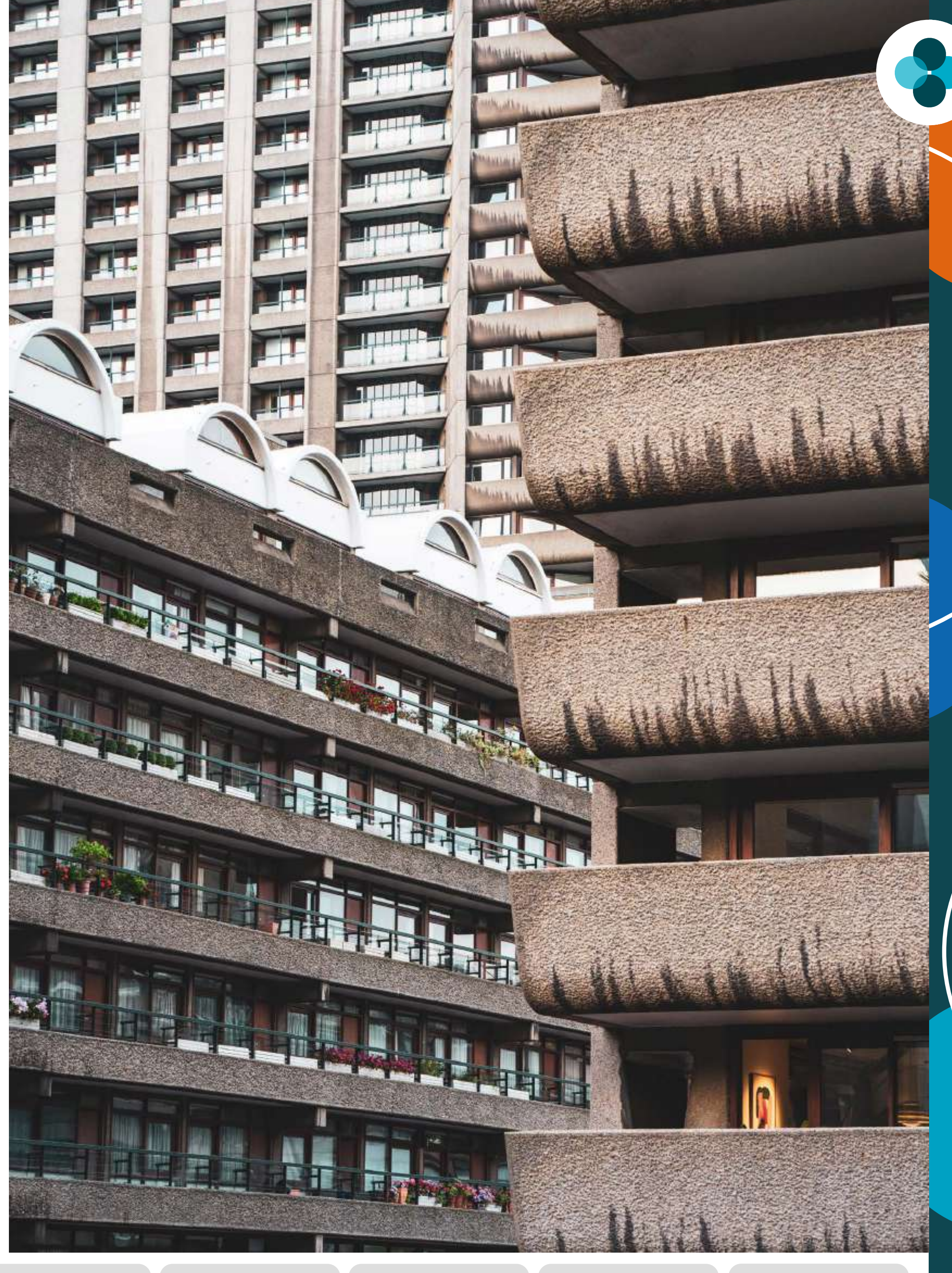
0 Private Fostering arrangements as of March 2022



Safeguarding in The City of London

City of London Demographics

The City of London has an estimated resident population of about 10,847 people (ONS, November 2023) and approximately 587,000 workers. City jobs have grown over 15% between 2017 and 2021, with nearly 75,000 more jobs than in 2017. Of the resident population, 2468 children and young people (0-25) live in the City of London with 765 under the age of 19 and 580 under the age of 15. The City of London is an economically diverse area, with its population characterised by areas of affluence and poverty. Within the Square Mile, there are large disparities. The Barbican West and East residential areas are among the most affluent areas in England. Portsoken Ward, however, is among the most deprived. The Bangladeshi community makes up 3.3% of the total population. Poverty and overcrowding in housing were identified as significant issues in children's wellbeing as well as the Covid 19 pandemic. The pandemic increased the demand for mental health and speech and language services, and had a detrimental impact on children's personal, social, and emotional development. Within the City, there is one maintained primary school (with a Children's Centre attached), four independent schools and several higher educational establishments. It has no maintained secondary schools. Most children attending these schools come from other boroughs and most of the local authority's secondary school age children go to school outside of the City.



Early Help

Early help services across the City of London are delivered by People's Services and a range of partners, including schools, children's centres, one GP surgery and health colleagues as well as other local service providers, including the community and voluntary sector. They are effective, and some are particularly strong. The range of services available to children, young people and their families in the City continue to adapt and evolve based on the needs of the local population. The early help arrangements in the City have been in place now for several years and are embedded with agencies. All children needing an early help service in the City receive a well-resourced, dedicated service, which is provided by trained staff. Over 2022/23, the Early Help Strategy for the City of London continued to drive partnership improvements. With a focus on ensuring the right help is provided at the right time and in the right place, the strategy is focussed on key strategic objectives and is coordinated by the CHSCP City Early Help Sub-Group. Through critical reflection, consultation and co-production with children and families, partners from the Multi-Agency Practitioners Forum and the City's Parent Carer Forum for children with SEND, the following progress has been made:

Page 61

EVIDENCE

In 2022/23, the total number of cases referred or stepped down to early help services was 58, an increase on the 40 in 2021/22. There were no re-referrals to early help within 12 months of closure. This has been a consistent pattern and reflects the effectiveness of the multi-agency intervention in the City to improve outcomes for children and young people, preventing problems getting worse.

ASSURANCE

'The City of London Corporation provides effective front door arrangements through a multi-agency safeguarding hub (MASH). Although professionals are not all physically co-located, the service ensures that children receive timely and responsive social work and early help services. Thresholds are clearly understood by professionals. Partners have good access to social work consultation. This helps to ensure that children are referred for the appropriate level of service, and that intervention is timely.'

Ofsted, December 2022

ASSURANCE

'When decisions are made to step children's cases down to early help services, children receive high-quality assessments that identify their needs well. This leads to skilful early intervention that improves children's circumstances and prevents concerns escalating.'

Ofsted, December 2022

ASSURANCE

The City of London has a clear Thresholds of Need document that has been agreed with partner agencies. This is used to provide services at an appropriate stage and as early as possible to prevent higher levels of need in the future.

There is a single point of contact for referrals to Early Help services and Children's Social Care, enabling timely and appropriate decision making and allocation.

The Early Help Assessment is co-created with the family, including discussions with the child/ young person as well as with practitioners from involved agencies.

Early help practice in the City of London is **Empowered**: evidenced through insightful assessments by highly skilled staff, that lead to robust offers of help. **Child-centred**: evidenced by children and young people routinely being present at meetings or represented through direct work. **Integrated**: evidenced through a strong 'Think Family Focus', and a 'top-three' (cases of concern) collaboration across children's, health, adult, housing and homeless service.

Children in Need of Help and Protection

Good practice with children and young people who need help and protection can be seen when help is provided early in the emergence of a problem and there is a well-coordinated multi-agency response. Thresholds between early help and statutory child protection work are appropriate, understood and operate effectively. Risk is effectively mitigated, and outcomes improved through good assessment, authoritative practice, planning and review.

ASSURANCE

'Children who require statutory services receive a timely assessment of need. Assessments are child-centred, of high quality and clearly identify and analyse risk, need and strengths. This supports effective care planning.'

Ofsted, December 2022

ASSURANCE

'Children at risk of harm are identified promptly. Strategy discussions are timely and are well attended by multi-agency professionals. This ensures that effective information is shared in order to inform risk assessments, so that prompt decisions and actions can be made to safeguard children.'

Ofsted, December 2022

ASSURANCE

'MASH health contributes to the City of London (CoL) virtual MASH through participating in strategy discussions, representing health, gathering health information for MASH checks, and identifying / facilitating appropriate health professionals to participate in strategy meetings. Working with the Homerton informatics team the data has now been disaggregated to show CoL strategy meeting requests and CoL MASH information/health checks for data gathering in 2022/23. The working arrangements for the CoL virtual MASH and MASH health have been further embedded in CoL practice, which resulted in 14 health requests for MASH checks (+4 from 2021/22) and seven strategy discussions participation.

Contacts, Referrals and Assessments

The Children and Families Team Hub provides responsive screening activities and ensures all contacts are immediately progressed as a referral if the threshold for a statutory social work assessment is met. Signposting activity requires staff to have a continually updated knowledge of local services alongside a comprehensive understanding of the City of London Thresholds of Need. The Children and Families Team Hub aims to ensure that only those children meeting thresholds for statutory assessments are progressed as referrals. Local Authorities undertake these assessments to determine what services to provide and what action to take. The full set of statutory assessments under the Children Act 1989 can be found HERE.

EVIDENCE

The 707 contacts made to the Children and Families Hub reflects a further increase in activity (551 in 2021/22 and 259 in 2020/21). Referrals decreased to 63 from 139 in 2021/22. The re-referral rate in the City of London increased from 15% to 30%. Notwithstanding the increased demand during 2021/22, the performance data in the City continues to be indicative of a good social work response and timely access to appropriate support that helps children and their families. The Children and Families Team completed 59 assessments during 2021/22, compared to 38 in 2020/21. 71% of assessments were completed within 45 days or less. Child protection activity increased significantly. There were 23 child protection (Section 47) enquiries in 2010/22, compared to just five in 2020/21.

ASSURANCE

Despite the clear challenges arising from identification of need and risk, children continued to receive a swift service during 2022/23 when safeguarding concerns became apparent. All Section 47 enquiries undertaken in the City are led by a suitably qualified and experienced registered social worker.

Children on Child Protection Plans

Following a child protection enquiry, where concerns of significant harm are substantiated and the child is judged to be suffering, or likely to suffer, significant harm, social workers and their managers should convene an Initial Child Protection Conference (ICPC). An ICPC brings together family members (and children / young people where appropriate) with supporters, advocates and professionals to analyse information and plan how best to safeguard and promote the welfare of the child / young person. If the ICPC considers that the child / young person is at a continuing risk of significant harm, they will be made the subject of a Child Protection Plan (CPP). Children who have a CPP are considered to be in need of protection from either neglect, physical, sexual or emotional abuse; or a combination of one or more of these. The CPP details the main areas of concern, what action will be taken to reduce those concerns and by whom, and how professionals, the family and the child or young person (where appropriate) will know when progress is being made. Two children were subject to a CPP in the City at the end of 2022/23.

Children in Care

A child or young person who is 'looked after' is in the care of the local authority. They can be placed in care voluntarily by parents struggling to cope, they can be unaccompanied asylum-seeking children; or in other circumstances, The City of London Corporation and partners will intervene because the child or young person is at risk of significant harm. As of 31 March 2023, the City of London Corporation was responsible for looking after nine children and young people, a reduction from 11 in the previous year. There were 21 looked after children throughout 2022/23 - a reduction of 30% from the 30 in 2021/22. The City of London's rate for looked after children is well above statistical neighbours and proportionately, this reflects a high volume of work for the City of London social workers.

Page 66

PLACEMENT STABILITY, TYPE AND LOCATION

Of the nine children in care at the end of the reporting year, three were in foster placements, four children were in semi-independent provision, one child was in a residential school for children with disabilities and one child was in a mother and child placement.

In 2022/23, no looked after child had three or more changes of placement and for those in placement for over 2.5 years, all had been in the same placement for two years or more. This continues to reflect good performance and means that children looked after by the City tend to enjoy good stability and placements that meet their needs well. The local authority does not have its own fostering service due to the size of the looked after children population, but spot purchases from the Pan-London consortium. Ofsted rates all independent fostering agencies used by the City either Good or Outstanding. There are sufficient suitable placements available to meet the needs of the City's looked after children and young people. All placements are outside of the local authority.

ASSURANCE

A positive development in the last reporting year was the introduction of a new 'Home Panel'. The purpose of the panel is to have a service wide discussion about the implications of moving a young person if their placement is presenting as unstable. This may be due to the placement expressing concerns or the young person expressing a wish to move. Included in the panel is the Head of the Virtual School so they can have an input into the impact on a child's education if they were to move. Also present are members of the commissioning team so they can advise on placement availability. The panel can be called to meet at short notice if there is an unexpected placement disruption. This has strengthened the multi-agency planning around care placements, taking into account the child's hoslitic needs. It has created greater senior management oversight of placements moves, and increased consistency in relation to care planning decision making for all children.

City of London IRO Annual Report 2022/23

Care Leavers

There is a strong range of support for care leavers in the City of London. They are well supported, workers remain in touch with them, there is availability of suitable accommodation, and they are provided with health support. At year end, there were 59 care leavers. 52 out of 59 care leavers were in education, training or employment, 88% had an up-to-date pathway plan and 55/59 were considered to be in suitable accommodation.

Violence Against Women and Girls

Children and young people who are exposed to domestic violence and abuse can grow up in a vacuum of what is expected in terms of a positive and healthy relationship. This can create additional vulnerabilities and/or harmful behaviours. Responding proactively and in collaboration with the Safer City Partnership (SCP), violence against women and girls remains a key priority for the CHSCP, recognising both the short and long-term impact on the safety and welfare of children and young people. During 2022/23, the SCP continued its focus on implementing the City of London Violence Against Women and Girls Strategy.

MARAC

Operational arrangements for MARAC (multi-agency risk assessment case conference) processes are clearly defined in the City. The City MARAC operates a lower threshold than in other local authorities and takes cases where a preventative approach would be helpful. This is good practice and enables children with these families to have a better co-ordinated multi agency service.

EVIDENCE

In 2022/23, seven cases were considered at City's MARAC, with one case involving children.

Safeguarding Adolescents

Understanding the context in which children and young people live their lives is an essential feature of effective multi-agency intervention. For the CHSCP, this issue remains central to our overall approach in making children and young people safer. Context is key. During 2019/20, the CHSCP refreshed its defined strategy for safeguarding adolescents. This strategy builds on the progress made by the partnership in safeguarding children and young people at risk of child sexual exploitation (CSE) and those missing from home, care and education. It was developed in parallel to our improved understanding of the issues facing young people; established through focused problem profiles, national and local learning and intelligence pictures involving vulnerable adolescents.

The strategy continually draws on evidence about effective practice from contemporary research. It is a focussed document that sets the parameters for developing our understanding of the complexities of young people's vulnerabilities and finding more effective multi-agency responses to these issues. The strategy maintains a focus on making sure that professionals are getting the basics right whilst striving to develop best practice in terms of the following priorities:

- Knowing our Problem, Knowing our Response
- Strong Leadership
- Prevention and Early Intervention
- Protection and Support
- Disruption and Prosecution

ASSURANCE

'Leaders use intelligence and data from partners well to inform a multi-agency response to risk of extra-familial harm. For example, the work in Multi-Agency Child Exploitation meetings is used effectively in order to track emerging themes that happen in the City of London. The co-chairing of this meeting by the police and children's services, with good attendance from other agencies, has allowed partners to develop creative ways of identifying and dealing with a range of issues, and to tackle complexity as early as possible in order to better protect the most vulnerable children. This includes responding to low-level gang activity in order to prevent concerns escalating and identifying children who are vulnerable to trafficking.'

Ofsted, December 2022

ASSURANCE

A forensic CAMHS worker has been added to the team, funded through the London health offer to work once a month as of August 2022. This service is open to all children and young people in the service, but with a particular focus on vulnerable children and young people presenting with complex mental health needs and high-risk behaviours to support them to understand and reduce any risks they may face or pose and prevent escalation into criminality.

Page 68

Child Sexual Exploitation

Understanding the nature and prevalence of child sexual exploitation (CSE) and harmful sexual behaviour (HSB) and ensuring that partner agencies provide appropriate safeguarding responses and interventions remains a priority. In February 2017, a revised definition of CSE was issued by the Department for Education (DfE).

'Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.'

DfE 2017

The City of London continued to experience a low number of cases relating to Child Sexual Exploitation (CSE), with most contacts being about non-residents. Over the last five years, the crimes relating to CSE that have been recorded by the City Police include rape, sexual activity and possession of indecent images. Cases have also included grooming by offenders via the internet / social media. Partner agencies engaged in the City continue to share intelligence that may influence the knowledge of the profile. Of significance is the City's location as a major transport hub. A quarterly data set of over twenty indicators produced for the MACE Group supplements the information provided by the City Police. This informs understanding, and the identification of risk indicators. In recognition of the overlapping vulnerabilities adolescents face, the City Multi-Agency Sexual Exploitation panel was changed to the Multi-Agency Child Exploitation panel to include all forms of abuse and exploitation that adolescents are at increased risk of. Although few in number and type and relatively lower-level risk in comparison to neighbouring LAs, the City is not complacent and maintains an 'it could happen here' stance.

Children Missing from Home, Care and Education

The City Police lead on all children who go missing from home or care and a coordinated response takes place with the City Children and Families team, working closely with the child's parents or carers. Numbers of children who go missing in the City of London are very low. A specific part of the Safeguarding Adolescent Strategy focuses on the effective management of children who are missing. The City of London has reviewed its Missing from Care Procedures and the arrangements for Return Home Interviews. There remains senior leadership oversight through the missing period with robust partnership arrangements in place. All strategy meetings have health, social care and police engagement as a minimum. This has helped with the timely response to missing episodes and alerting relevant authorities to missing episodes.

Page 70

ASSURANCE

NCH Action for Children is commissioned by the City of London Corporation to give missing children a return home interview within 72 hours. These interviews are followed up with therapeutic support depending on the outcome to address risk-taking behaviour. This is in line with statutory guidance published by the Department of Education in 2014. Return home interviews are reviewed and used by the partnership to understand the reasons why children go missing and inform strategy and service delivery.

ASSURANCE

Since 2015, the City of London Corporation has implemented a rigorous system to identify all children of statutory school age and where they attend school. The City of London maintains this record of where children are placed through the primary and secondary transitions process. A school tracker is updated and reviewed regularly.

ASSURANCE

There is senior leadership oversight through the missing period with robust partnership arrangements in place. All strategy meetings have health, social care and police engagement as a minimum. This has helped with the timely response to missing episodes and alerting relevant authorities to missing episodes.

A Vulnerable Children's list includes missing episodesand includes oversight by social care and education. This is currently reviewed monthly and throughout Covid-19 was reviewed weekly.

Gangs, Criminal Exploitation and Serious Youth Violence

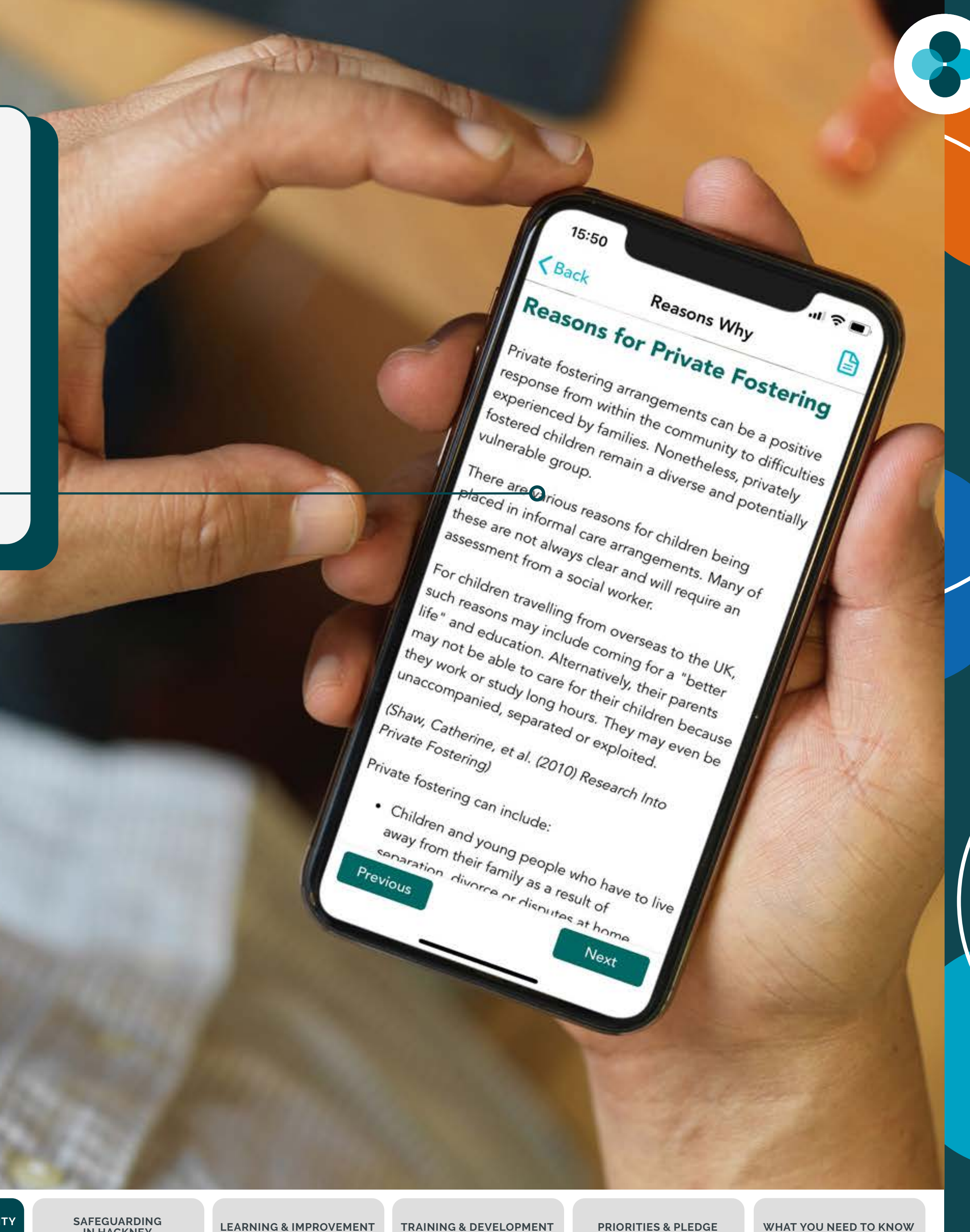
There are several ways in which young people can be put at risk by gang activity, both through participation in and as victims of gang violence which can be in relation to their peers or to a gang-involved adult in their household. The City of London Drugs Profile found that the largest area of drug misuse was among affluent City workers with the supply of drugs controlled by organised criminal groups involving male 'runners' in their 20s who often deal pre-ordered drugs out of their cars. While drug related crime involving resident CYPs is low, a case involving a trafficked young person highlights this as an emerging theme that requires close attention and partnership working between Police, Adult and Children's Social Care, and businesses in the City. There is concern in the north that young adults known to be associated with Islington gangs have started to hang around Golden Lane Estate. Community safety partners are monitoring this closely and report 'no hard issues' other than gang related graffiti to date. Work with the estate and Islington is needed to understand this emerging pattern and mitigate associated risks for CYP.

Radicalisation

The Counter Terrorism and Security Act received Royal Assent on 12th February 2015. Prevent was placed on a statutory footing in July 2015 to ensure all specified authorities in local areas, as a minimum, understand the local threat and take action to address it, assess if local frontline staff need training to recognise radicalisation, and to ensure that all of those who need to work together to deliver the programme do so in the most effective way. The City of London has not been identified as a Priority Area and as such, receives no additional Home Office funding to deliver its Prevent programme. The Safer City Partnership (SCP) retains overall governance of this agenda, which includes a focus on ensuring there are sufficient arrangements in place to safeguard children and young people. The City of London Police delivers Prevent training to schools, youth providers and businesses.

Private Fostering

A child under the age of 16 (under 18, if disabled) who is cared for and provided with accommodation by someone other than a parent, person with parental responsibility or a close relative for 28 days or more is privately fostered. The arrangements for managing private fostering in the City accord with statutory requirements. No notifications were received in The City of London during 2022/23. Private Fostering continues to be promoted via the CHSCP Private Fostering App.



ASSURANCE

A Private Fostering App originally launched in the City of London (and subsequently developed by the CHSCP) to support awareness raising across the partnership.

ASSURANCE

'The local authority and the safeguarding partnership are exploring innovative ways to raise awareness of private fostering in the area, given the very low number of referrals. This work is ongoing and subject to monitoring and review through the partnership board.'

Ofsted, December 2022

Children with Disabilities

Since the introduction of the special educational needs and disability (SEND) reforms in September 2014, the City of London Corporation has made good progress in implementing these. All former Statements of Special Educational Needs were transferred to Education, Health and Care (EHC) plans well in advance of the national deadline of 1 April 2018. All statutory assessments are completed within 20 weeks (the statutory timeframe). There remains a very high level of satisfaction rate amongst families accessing the City of London's services and their view of multi-agency working is good. The SEND Joint Strategy and self-evaluation form (SEF) is being developed with both partners and families to set out the City's priorities and to highlight the areas where the most progress is being made.

EVIDENCE

The City of London provided short breaks to 11 children supported by Early Help and there were 22 children with EHC plans over 2022/23. There is a disability lead in the social work team who has specialist knowledge and supports the service when needing to progress assessment work with disabled children. Partners have continued to offer close support to children with EHC Plans and their families through a strong integrated offer between Special Educational Needs and Children's Social Care.

MAPPA

Multi-Agency Public Protection Arrangements (MAPPA) are the statutory measures for managing sexual and violent offenders. The Police, Prison and Probation Services (Responsible Authority) have the duty and responsibility to ensure MAPPA are established in their area and for the assessment and management of risk of all identified MAPPA offenders. The purpose of MAPPA is to help reduce the re-offending behaviour of sexual and violent offenders in order to protect the public from serious harm, by ensuring all agencies work together effectively.

EVIDENCE

Across London on 31 March 2023, there were 6901 Category 1 'Registered Sex Offenders' (RSOs) (6700 in 2021/22, 6549 in 2020/21, 6581 in 2019/20 and 6452 in 2018/19), 3669 Category 2 'Violent Offenders' (3660 in 2021/22, 3521 in 2020/21, 3735 in 2019/20 and 4128 in 2018/19) and 51 Category 3 'Other Dangerous Offenders' (55 in 2021/22, 61 in 2020/21, 31 in 2019/20 and 27 in 2018/19). 158 RSOs were cautioned or convicted for breach of notification requirements. (153 in 2021/22)

LEARNING

Whilst scheduled for publication in early 2024, the following extract from the report into Case A (a Hackney case) provides an insight into the challenges being faced in this area of safeguarding.

For individuals known to have committed child sex offences, they will always present a risk to children. What this looks like will vary from offender to offender and can change over time, but there will never be no risk at all. Accepting this fact must be the starting point for everyone working with children, their families and offenders themselves. It reflects an unambiguous safeguarding first approach and there should be no practice within our system that dilutes this position. Time served in prison, sex offender courses, dynamic assessment and monitoring can all have the potential to reduce recidivism. However, what they can't do is change the fantasies of those with a deviant sexual interest in children or predict with absolute certainty who will go on to re-offend. It is factors such as these that make the management of child sex offenders so complex and why the paramountcy of child protection must always steer the decision making and actions of practitioners.

Beyond this complexity, we also know there continues to be a growth in activity and that resource pressures on public services remain. Combined, these circumstances have created somewhat of a 'perfect storm' that is placing immense strain on those agencies responsible for this work, particularly the police. As highlighted in the independent review by Mick Creedon QPM, because of this environment the system needs to work differently. We agree.

However, whilst accepting there are no easy answers, we don't believe that system change should correlate with a system doing less. Many would see this as counter-intuitive, and yet solutions continue to be promoted that focus on a reduction in activity to cope with demand. This has largely, but not exclusively, focused on those perceived as being 'low risk offenders' and/or 'viewers' of indecent images.

As far back as 2017, the former child protection lead for the National Police Chief's Council (NPCC) raised concerns about the volume of offending and that the police had reached 'saturation point' in terms of its capacity to respond. He argued there was a need to look at alternatives to custodial sentences, including prevention and rehabilitation, although the monitoring of offenders would continue. More recently, the report by Mick Creedon QPM recommended changing the monitoring regime itself by introducing discretion, reducing timescales and allowing for more flexibility in decision making.

All these points can be seen as an understandable response to the demand / resource conundrum that the police are facing. That said, it is hard to see how any of them will make children safer. Tweaking the system will weaken the system and doing less won't address the fundamental challenges in this space. What is perhaps more likely is that additional fault-lines will appear in the form of harm. Based on the lessons from this review, we believe there are opportunities to do more. More by way of harnessing the insights of others to help improve the monitoring of offenders, mitigate risk and increase protection. This can only happen with improved partnership arrangements and information sharing.

Jim Gamble QPM & Rory McCallum, SPA

Afghan Families Resettlement Project

The Afghan Resettlement Programme was established in the City of London in August 2021 in response to the placement of around 500 Afghan people in 2 bridging hotels in the City of London. This included around 250 children. The Afghan Families have been supported by the Children and Families service working in partnership with other teams and organisations to access education and school places, register for healthcare services, including Covid vaccination services and access to community groups and services.

Responses to the conflict in Ukraine, including the Homes for Ukraine programme and Family Visa Scheme have also arisen within this reporting period. The service has helped families when needed, including those who have children with a Special Educational Need or Disability. Examples of the support provided include sourcing suitable school placements, employment and housing.

IMPACT

The Health Visiting team from Homerton Healthcare NHS Foundation Trust, working alongside key stakeholders including Aldgate Children's Centre and the Multi Agency Safeguarding Hub (MASH) in the City of London were instrumental to the joined-up approach to support the Afghan families who were in temporary housing. Key challenges for the families included the constraints of living in temporary hotel accommodation; uprooted from strong family and social ties, illiteracy amongst the women and access to GP and dental appointments. Working together resulted in a family with a child with complex special needs rehoused in the City.

IMPACT

'Good political and corporate support for children's services has helped children's leaders deliver a remarkable service to Afghan children and families through their resettlement programme. The co-location of the early help lead, adviser for early years and social work managers supports timely and effective communication, and consultation between services. This strength of joint working underpins effective support being provided for the children and families. For example, leaders liaised extensively with partners to quickly coordinate and mobilise services, including deploying a dedicated early help practitioner to support the Afghan children. The creative and innovative partnership also created a bespoke learning centre and a play centre for over 320 children within one week of the children arriving in London. The council and its partners worked collaboratively to secure education provision for all school-aged children, in time for them to start the new school term alongside their peers.'

Ofsted, December 2022

EVIDENCE

Recognising the new environment in which families would be living, the CHSCP partnered with the Royal Society for the Prevention of Accidents to issue translated material for families in both Pashto and Dari.

RoSPA
ایمن در خانه
تکنیک هایی برای اطفال زیر سن 5 سال
The Royal Society for the Prevention of Accidents

RoSPA
په کور خوندي پاتي شئ
The Royal Society for the Prevention of Accidents

Page 77

Safer Workforce

Despite all efforts to recruit safely there will be occasions when allegations are made against staff or volunteers working with children. Organisations should have clear procedures in place that explain what should happen when such allegations are raised. These should include the requirement to appoint a Designated Safeguarding Lead (DSL) to whom these allegations are reported. It is ordinarily the responsibility of the DSL to report allegations to, and otherwise liaise with, the Designated Officer in the local authority (referred to as the LADO). The LADO has the responsibility to manage and have oversight of allegations against people who work with children. Reporting to the Assistant Director of People Services, the LADO role in the City is held by the Safeguarding and Quality Assurance Service Manager. The LADO should always be contacted when there is an allegation that any person who works with children has:

- Behaved in a way that has harmed a child or may have harmed a child.
- Possibly committed a criminal offence against or related to a child.
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.
- Behaved or may have behaved in a way that indicates they may not be suitable to work with children.

IMPACT

'The local authority designated officer provides a robust service, taking a forensic approach to analysing current and historical information, and making timely and effective decisions. The designated officer also provides skilled professional challenge to organisations when necessary.'

Ofsted, December 2022

EVIDENCE

Activity - There were 13 referrals made to the LADO during 2022/2023, slightly lower than the 15 in 2021/22. Sources of referrals were varied, with the highest proportion coming from other Local Authorities. There was also a further increase in referrals from employment agencies based in the City of London (covering health, social care and education). Concerns from this sector involved allegations that occurred outside of the City of London (where the professionals worked). Whilst the City of London LADO provided support and advice, all these allegations were managed by the LADO in the area they occurred. Positively, there have been two referrals from the City of London Police (and one from the MPS).

EVIDENCE

Of the 13 referrals received, only one referral required an Allegation Against Staff and Volunteers (ASV). Of the 12 remaining referrals, two did not meet the threshold for LADO involvement, and the remaining 10 required advice and support from the LADO in managing the concerns. In most of these cases the allegation is dealt with by the LADO in the area where the incident occurred. However, if the agency of the professional is based in the City of London, then the LADO would support that agency in managing the potential risks regarding the individual and advise on any safer recruitment concerns.

EVIDENCE

Themes - Of the 13 referrals received, four fell under the category of sexual, three were physical, four related to the individual's behaviour and two involved concerns in relation to the individual's personal life.

IMPACT

The role of the City of London LADO often involves supporting agencies in getting information about the allegations, as it can be difficult getting hold of individuals working in other Local Authorities or Police Forces. The support from the City of London LADO in obtaining this information assists in the management of risk and disciplinary processes as required.

IMPACT

Training on the LADO role was offered in March 2023, by the City of London and Hackney LADO, via the CHSCP, take up of this training was limited from both City and Hackney, this may have been due to the training being face to face. New staff in the City of London from the Peoples Directorate meet with the LADO as part of their induction process, and going forward there will be face to face induction days for staff, where training on the role of the LADO will be covered.

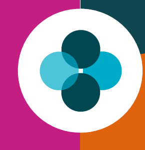
ASSURANCE

The responsibility of the LADO is set out in Working Together to Safeguard Children 2018 and Chapter 7 of the London Child Protection Procedures (7th edition). All allegations made against staff, including volunteers, that call into question their suitability to work with or be in a position of trust with children, whether made about events in their private or professional life, need to be formally reported to the LADO. Chapter 7 of the London Child Protection Procedures has recently been amended to provide consistency in respect of the response to low level concerns and to include the wider definition of people in 'Positions of Trust' (The Police, Crime, Sentencing and Courts Act 2022 has extended the definition of Position of Trust within the Sexual Offences Act 2003 section 22A to include anyone who coaches, teaches, trains, supervises or instructs a child under 18, on a regular basis, in a sport or a religion).

ASSURANCE

In January 2022, the CHSCP Executive discussed the interface between the police and the Local Authority Designated Officer (LADO). This related to the absence of routine contact from the police concerning conduct matters that meet the threshold for the LADO to be notified. This has been an ongoing issue for some time and is not unique to the City of London or Hackney. A Pan-London group looked at solutions, although work was placed on hold due to COVID-19 and subsequently stalled. With the agreement of the Executive, a small group was scheduled to meet to discuss the possibility of a local protocol, although for a variety of reasons, this did not go ahead.

Given there remained no consistent mechanism allowing for oversight on possible LADO issues concerning the police, the ISCC wrote to Commanders in both the City of London and Hackney seeking their cooperation in this regard. The request has been relatively simple in that the City Police and CE BCU should include a trigger point within their processes to notify the LADO of any case that meets the criteria. This will not interfere with conduct procedures and will create immediate alignment with other safeguarding partners and relevant agencies. At present, the police remain an outlier to working within our defined safeguarding arrangements and procedures, although it is positive to note the three police contacts to the City LADO in 2022/23.



Hackney Safeguarding Snapshot 2022/23

Page 81

Approximately **55,059** children and young people under 18

21% of total population

24.7% of under 16s live in a low income family

37.9% of primary pupils eligible for free school meals

42.6% of secondary school pupils eligible for free school meals

580 families with children under 5 received Early Help MAT intervenion

394 new early help cases identified and supported through the MAT process

14,248 contacts to Hackney CFS

4,148 referrals

20% re-referrals

3,998 assessments completed by Hackney CFS

69% of assessments were completed within 45 days

1,326 child protection investigations

181 Children on a Child Protection Plan as of March 2023

392 children & young people looked after as of March 2023

327 MARAC meetings involving children and young people living in families with domestic violence

355 contacts to the LADO

10 Private Fostering arrangements as of March 2023

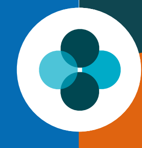
16,811 young people accessed universal services offered through Young Hackney

1,410 young people received targeted support through Young Hackney

185 children entered care during 2022/23

409 care leavers aged between 17 and 21 were being supported by the Leaving Care Service

291 children allocated for direct work with the Clinical Service in 2022/23



Safeguarding in Hackney

Hackney Demographics

The London Borough of Hackney is an inner-city London borough. The ONS estimates there were **261,491** people living in Hackney in November 2023 with **21.1%** of its population aged under 18 (**55,059** children). Hackney is a culturally diverse area, with significant 'Other White', Black and Turkish/Kurdish communities. A large Charedi Jewish community is concentrated in the North East of the borough and is growing. Hackney was the 22nd most deprived local authority in England in the 2019 Index of Multiple Deprivation, in 2015, it was ranked 11th, and in 2010 it was ranked second. It is relatively more deprived in relation to barriers to housing and services, income and living environment than its overall rank suggests, but generally less deprived than its overall ranking for crime, employment and health and significantly less deprived for education. At GCSE the average Attainment 8-point score per pupil in Hackney was **54** points, this was higher than the London average of **50.6** points. The borough experienced a slight decline in the incidents of crime. The average number of open cases in 2020-21 was 648. In 2021/22 this reduced to 620. However Hackney's crime rate is 22% higher compared to the rest of London and 38% higher compared to the national average.

For additional context, reference should be made to the Hackney CFS Annual Report for 2022/23. This includes more detailed information covering data, progress and the quality assurance activity covering key safeguarding and child protection processes.

Page 84

Early Help

Children and young people in Hackney continue to have access to and benefit from an extremely wide range of early help services that are sharply focused on meeting the diverse needs of local communities. These services are delivered by the Hackney Children and Families Service, Hackney Education and a range of partners, including schools and a network of children centres delivering a range of services and working closely with schools, GPs and health colleagues as well as other local service providers, including the community and voluntary sector.

ASSURANCE

Between 2019-2022, Hackney Council undertook a review of its Early Help Model in consultation with parents and young people, schools, partner agencies and staff. Over the reporting year, the Council produced a refreshed vision for Early Help in Hackney and began implementing a series of operational changes that were required.

IMPACT

The introduction of a shared set of Early Help Practice Standards.

One 'Request for support' form which will all be screened by the Early Help Hub.

A consistent step-up/ step-down protocol between Children's Social Care and targeted Early Help.

The Hackney Wellbeing Framework will continue to be embedded across Early Help services.

One case-management system for all Early Help services, with the ability for improved information-sharing with partners, in-line with GDPR and consent. (HCFS Annual report 2022/23)

IMPACT

The maternity safeguarding team at Homerton Healthcare NHS Foundation Trust have been involved in several projects this year; **Removal at Birth, Hope box project** – Homerton are a pilot site for this project which is a joint initiative from The Centre for Child and Family Justice Research at Lancaster University, Birth Companions, and the PAUSE project. HOPE boxes (Hold on Pain Eases) have been put together by women with lived experience with the support of these organisations to enable women at risk of care proceedings to have the opportunity to create connections and build support. The boxes enable midwives and families to have discussions around care planning and aim to support women during this difficult time. This feeds into a larger QI project at Homerton around Separation at Birth. A Trauma Informed Care Plan and Guideline have been developed to support this work and we have now given out 4 sets of boxes which have been very well received by women and midwives.

CHILDREN'S CENTRE FAMILY SUPPORT AND MULTI-AGENCY TEAM (MAT) MEETINGS

Family support in children's centres seeks to improve parenting capacity, protect children from harm and neglect and improve outcomes for young children. Family support is part of the early help Universal Partnership Plus offer to families with children predominantly but not exclusively, under 6 years and is coordinated by the MAT (Multi-Agency Team meetings), underpinned by the Common Assessment Framework (CAF) early help assessment. MAT meetings have continued to occur fortnightly in each of the six strategic children's centres in Hackney. Chaired by a qualified social worker employed by Hackney Learning Trust, MAT meetings are attended by a range of professionals including midwives, health visitors, Children's Centre family support teams, speech and language therapists and First Steps. Early help interventions delivered include parenting programmes; individual and small group work to address family relationships and dynamics; support with housing; finance; child behaviour; sleeping; toilet training; routines; and the transition to nursery and school.

YOUNG HACKNEY

Young Hackney provides early help, prevention and diversion service for children and young people aged 6-19 years old and up to 25 years if the young person has a special education need or disability. The service works with young people to support their development and transition to adulthood by intervening early to address adolescent risk, develop pro-social behaviours and build resilience. The service offers outcome-focused, time-limited interventions through universal plus and targeted services designed to reduce or prevent problems from escalating or becoming entrenched and then requiring intervention by Children's Social Care.

IMPACT

An estimated total of 16,811 young people accessed universal services offered through Young Hackney during 2022/23, based on 154,030 named and anonymous attendances. This is in line with 16,676 accessing Young Hackney Universal services during 2021/22. Young Hackney delivered targeted support to 1,410 young people in 2022-23, which is in line with the previous year (1,471 in 2021/22). (HCFS Annual Report 2022/23)

Children in Need of Help and Protection

Good practice with children and young people who need help and protection can be seen when help is provided early in the emergence of a problem and there is a well-coordinated multi-agency response. Thresholds between early help and statutory child protection work are appropriate, understood and operate effectively. Risk is effectively mitigated, and outcomes improved through good assessment, authoritative practice, planning and review.

Page 87

CONTACTS, REFERRALS AND ASSESSMENTS

During 2021/22, Hackney redesigned its First Access & Screening Team to a Multi-Agency Safeguarding Hub (MASH) model. This now acts as the single point of contact for referrals to Children's Social Care in Hackney and provides responsive screening activities. The move to a MASH aligns Hackney with most other LA areas. Alongside integrating an Early Help Hub within the MASH and revisions to the Hackney Child Wellbeing Framework, a MASH consultation line was also introduced to help practitioners navigate issues such as consent and thresholds for intervention.

EVIDENCE

The Hackney MASH received 14,248 contacts from a range of sources of which 29% were accepted as a referral to CFS (29% in 2021/22). This remains less than the number of contacts and referrals pre-pandemic (2019/20), but an increase from the last reporting year (12,313). Referrals also increased by 16% (from 3559 to 4148). The percentage of cases which were re-referrals (which had been open in the last 12 months) was 20%. This is in line with the national average and slightly above statistical neighbours (18%)

ASSURANCE

Purposeful work has been undertaken through the revision of the Hackney Child Wellbeing Framework, the shift to a Multi-Agency Safeguarding Hub, an Early Help Hub, changes to the way contacts are recorded and the introduction of a consultation line. The positive impact of the consultation line means that requests for support not meeting statutory intervention are not processed as contacts. However, there is still some 'oversharing' from some agencies, mainly the Police, which is being addressed.

(HCFS Annual Report 22/23)

Following contact, the MASH aims to ensure that only those children meeting thresholds for statutory assessments are progressed as referrals to CFS. Local Authorities undertake these assessments to determine what services to provide and what action to take. The full set of statutory assessments under the Children Act 1989 can be found HERE.

EVIDENCE

3998 assessments (718 per 10k) were completed in 2022/23, an increase of 23% compared to 3858 and 3244 assessments in 2020/21, 2021/22 respectively. Hackney's current rate of assessment is above the average for statistical neighbour authorities (589 per 10k).

EVIDENCE

Last year, performance in relation to the timescale for the completion of assessments within 45 working days was on a trajectory of improvement. 93% of assessments during the first quarter of 2021/22 were completed within 45 working days. At the end of 2021/22, this was 82% compared with 78% for 2020-21. However, in early 2022/23, there has been a notable decline. The end of year percentage for 2022/23 was 69%. Reasons for this as set out by Hackney Children & Families Services included the reintroduction of the Mosaic recording system, some notable staff challenges as a result of staff sickness (including due to COVID-19), staff changes and some performance management concerns. Management oversight and accountability has improved, and assessment timeliness has steadily improved: it is currently at 82% for April to September 2023.

EVIDENCE

1326 Section 47 investigations (child protection investigations) began in 2022/23, an increase on 825 the previous year. This represents a rate of 238 Section 47 investigations per 10k, which is more than statistical neighbours (203 in 2021/22) and the England average (180 in 2021/22). 23% of Section 47 investigations progressed to an Initial Child Protection Conference in 2022/23, a decrease from 32% in 2021/22. This is lower than statistical neighbours (31% in 2021/22) and lower than the England average (34% in 2021/22).

EVIDENCE

In 2022/23, 67% of assessments completed resulted in no further statutory social work action, a slight decrease compared to 70% in 2021-22. As at the end of September 2023, this rate remained the same at 67%.

STRATEGY DISCUSSIONS

Ofsted's inspection of Hackney's children's social care services in 2019 identified that in some strategy discussions, they do not involve all relevant partners sharing agency information until the initial child protection conference stage. In response, the CHSCP has developed this protocol as a practical guide for Hackney professionals involved in a child protection enquiry. It covers details about when strategy discussions should be convened, who needs to be involved and what factors need to be considered. The protocol includes an agenda template that will help practitioners follow the process and understand the decisions that need to be made. This material has been further enhanced through the CHSCP launching an animated video guide on strategy discussions. Watch it HERE.

Page 89

ASSURANCE

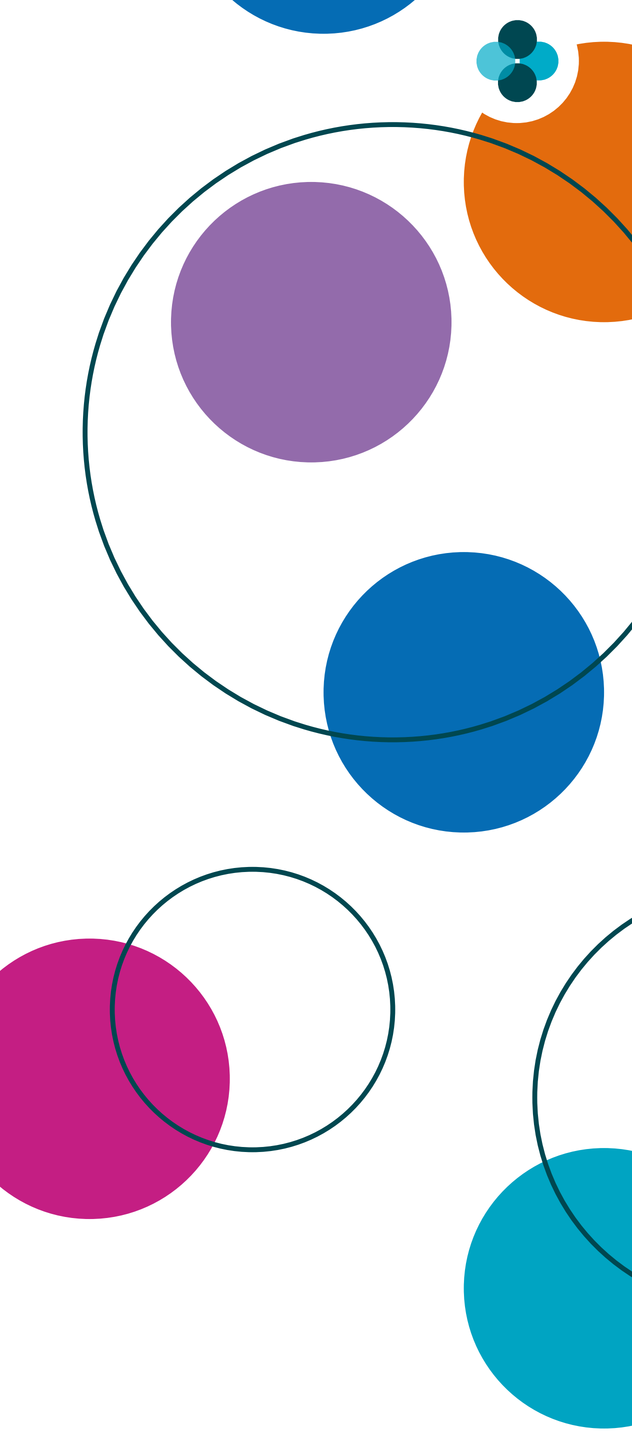
The CHSCP Quality Assurance Sub-Group maintains oversight of the quality of strategy discussions via audit and tracks the progress of multi-agency improvement actions. The most recent audit was commissioned using external auditors in March 2022. Broad findings in audit rounds demonstrated good timeliness, with evidence of sufficient information sharing, understanding the child's needs, decision making and planning. No cases were escalated as a concern.

CHILDREN ON CHILD PROTECTION PLANS

Following a child protection enquiry, where concerns of significant harm are substantiated and the child is judged to be suffering, or likely to suffer, significant harm, social workers and their managers should convene an Initial Child Protection Conference (ICPC). An ICPC brings together family members (and children / young people where appropriate) with supporters, advocates and professionals to analyse information and plan how best to safeguard and promote the welfare of the child / young person. If the ICPC considers that the child / young person is at a continuing risk of significant harm, they will be made the subject of a Child Protection Plan (CPP).

EVIDENCE

At the end of March 2023, 181 children were on a CP Plan, a reduction of 211 from 2021/22. This reducing rate continues the trend seen over previous years and at 33 per 10k is well below statistical neighbours (42) and the England average (42). Hackney Children & Families Services accounts for this as follows: Our rate per 10,000 last year was also lower than our rate the previous year. This decrease in the rate is despite a 13% increase in Initial Child Protection Conferences, with 301 held in 2022/23 compared to 267 in 2021/22. There was a 5% increase in children ceasing a Child Protection Plan over the last year, from 267 up to 281. Through the course of the pandemic we saw an increase in some of our longer Child Protection Plans where children were subjects of Care Proceedings and living at home. As these proceedings have concluded, we have seen a decrease in the number of Child Protection Plans. London neighbouring boroughs are reporting a similar reduction in Child Protection numbers, as families are also moving out of London due to cost of housing and cost of living crisis, evidenced through the closure/merging of schools across London due to falling pupil numbers. (HCFS Annual Report 2022/23)



Children in Care

A child or young person who is in care is in the care of the local authority. They can be placed in care voluntarily by parents struggling to cope, they can be unaccompanied asylum-seeking children; or in other circumstances, Hackney CFS and partners will intervene because the child or young person is at risk of significant harm.

EVIDENCE

As of 31st March 2023, Hackney was responsible for looking after 392 children and young people. There has been a significant decrease in the number of children who are in care from a peak of 477 children (75 per 10k) in November 2020 (Hackney CFS believe the high numbers were a direct result of family stressors arising because of Covid-19 lockdowns). The March 2023 rate (65 per 10k) is below the statistical neighbour average (71 per 10k).

EVIDENCE

30% of our looked after children are aged 16 and 17; we continue to have a high proportion of adolescents coming into care. Analysis indicates that these children have a family history of trauma, educational exclusion, extra-familial risk and have significant risk factors for adolescents on the edge of care (with Black Caribbean and African backgrounds strongly over-represented). This analysis is informing the development of our Edge of Care strategy. Levels of children accommodated under Section 20 continue to fall. More work is required through the Edge of Care strategy to try and support children to safely return home to parents or family from care, whether they are in care short or long-term.

(HCFS Annual Report 2022/23)

PLACEMENT STABILITY, TYPE & LOCATION

Overall, stability is associated with better outcomes for children. Proper assessment of a child's needs and a sufficient choice of placements to meet the varied and specific needs of different children are essential if appropriate stable placements are to be achieved. Inappropriate placements tend to break down and lead to frequent moves. Data capture on these indicators was affected by the pandemic. Similar to earlier years, most children who are in care are in foster placements.

IMPACT

There are some indications that a renewed commitment to a foster-first approach is achieving good outcomes for our looked after children and care leavers with 74% of looked after children in foster care arrangements as at the end of March 2023, which is in line with 75% at the end of March 2022. 28 children (7%) were living in residential homes as at the end of March 2023, a significant decrease from 34 (17%) at the end of March 2022 and down from a high point of 40 children at the end of March 2020.

(HCFS Annual Report 2022/23)

EVIDENCE

The number of children experiencing three or more care arrangements over the course of a year for 2022/23 was 14% which is higher than the statistical neighbour and national averages in 2022/23 of 9% and 10% respectively. As at 30 September 2023, 12% of looked after children had experienced three or more care arrangements in one year. The proportion of children aged under 16 who have been looked after for more than 2.5 years, who have lived in the same home for over 2 years was 64% in 2022/23 compared to 71% in 2021/22. As at 30 September 2023, 69% of looked after children aged under 16 who had been looked after for more than 2.5 years had lived in the same home for over 2 years.

2020/21 stability figures were particularly good, believed to be influenced by the context of lockdown in the pandemic. However, further analysis has taken place on the cohort of children with 3+ care arrangements and those who have left long term homes to think about what we need to do to strengthen placements; we are working to strengthen our oversight of Independent Fostering Agencies support and training for their carers, we reviewed all connected care arrangements in July 2023 to consider opportunities to strengthen them.

We have also taken steps to improve the process of oversight for planning for children once they enter a legal framework and beyond the conclusion of any legal proceedings, again to help ensure that the right decisions are made for children, at the right time. For example through our Permanency Planning Meetings, which are overseen by senior managers, we ensure parallel planning is in place to consider alternative routes to permanency for long-term looked after children.

(HCFS Annual Report 2022/23)

Care Leavers

The Leaving Care Service ensures that young people are supported to develop independent living skills. They are offered career advice, training and educational opportunities, and are supported to reach their full potential in all aspects of their life.

EVIDENCE

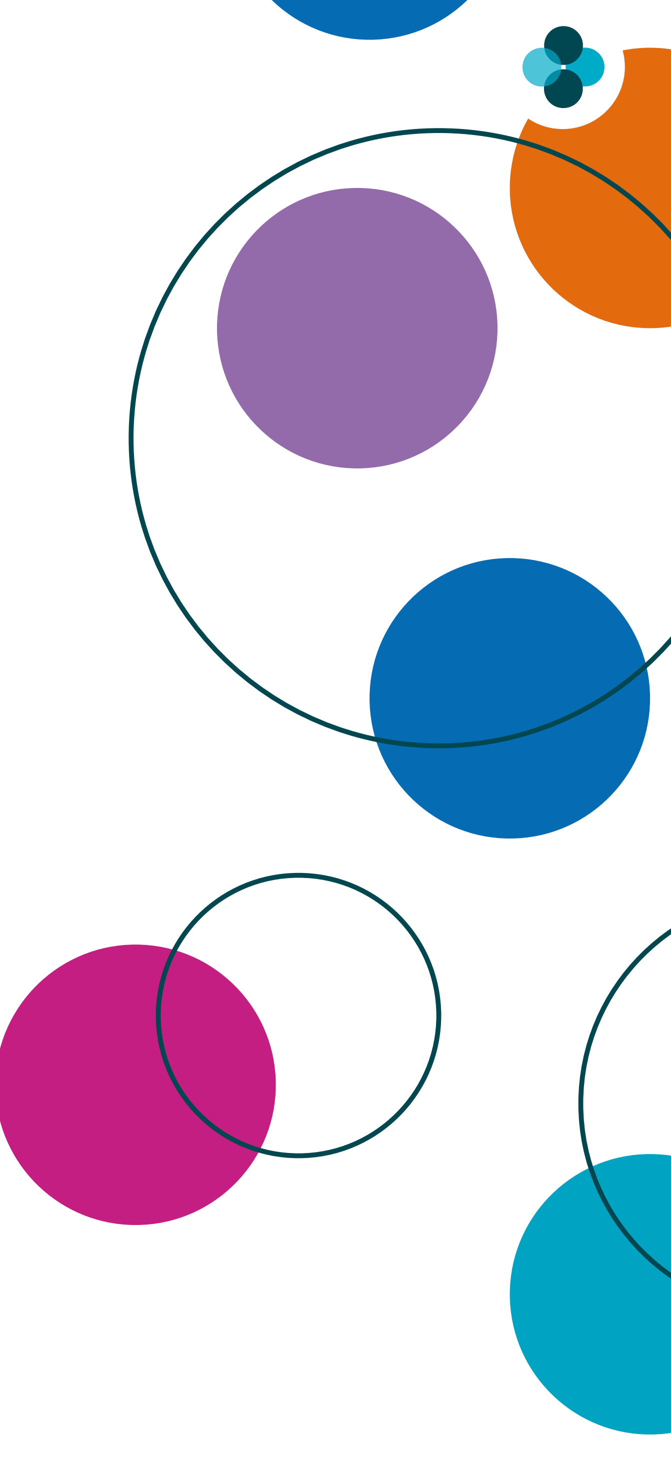
409 care leavers aged between 17 and 21 years were being supported by the Leaving Care service at 31 March 2023, an increase of 20 (5%) from 391 at the same point in 2022. As at 30th September 2023, 378 care leavers aged 17-21 were being supported. There were 296 care leavers aged 22 and older being supported as at 31st March 2023. This has decreased to 102 being supported as at 30th September 2023

(HCFS Annual Report 2022/23)

Violence against Women & Girls

It is estimated that 3 in 10 women (aged 16+) will have experienced domestic abuse at some point in their lives and that 1 in 5 children have been exposed to domestic abuse in the home. Responding proactively and in collaboration with the Community Safety Partnership remains a key priority for the CHSCP, recognising both the short and long-term impact on the safety and welfare of children and young people. The CHSCP is represented on Violence Against Women and Girls operational and strategic panels, which is comprised of statutory and voluntary sector organisations. The partnership in Hackney progressed its ambition to move from a strategy based on tackling DV to one that aims at a wider approach responding to all forms of VAWG. This development follows national and regional policy and aims to embrace all forms of violence that are committed against women and girls as they have several commonalities and therefore suggest a linked approach. Operationally, the Domestic Abuse Intervention Service (DAIS) in Hackney encompasses the following areas:

- **Intervention Officers.** The Intervention Officer posts allow for the recruitment of social workers, former police officers, probation officers as well as qualified domestic abuse advocates. This will build a service with a mix of skills and backgrounds who are experienced in assessing and managing risk.
- **Perpetrator interventions.** This model integrates allows for the flexibility for staff to engage with perpetrators directly as needed to deliver a responsive, holistic and victim-focused risk management service.
- **Operational and strategic management.** Managers are responsible for operational case work and for strategic / partnership working. This differs from the usual model whereby a 'VAWG co-ordinator' role sits separately from the delivery of risk management services working with clients.



From April 2017, the Domestic Abuse Intervention Service (DAIS) joined the Children and Families Service as part of the Early Help and Prevention Service. DAIS works with anyone experiencing domestic abuse who is living in Hackney, aged 16 or over, of any sex and gender, and of any sexual orientation. The service assesses need, provides information and support on legal and housing rights, supports service users with court attendance, supports service users to obtain legal protection, and works with service users and other professionals to address their needs. The service also works with perpetrators of domestic abuse to try to reduce risk.

EVIDENCE

The average weekly number of referrals into DAIS across 2022/23 was 29 - an increase on 23 in 2021/22. At year end, there were 583 allocated cases in DAIS, with 212 having children.

IMPACT

During 2022/23 and in 2023/24 DAIS has increased its offer of training to the Hackney partnership and it is believed this, along with campaign work, increase in awareness has led to greater confidence in the public and professionals accessing help for domestic abuse.

EVIDENCE

With a focus on perpetrator interventions, the Domestic Abuse Prevention Programme, working with those who harm others through their behaviour is a 26-session programme that continues to operate on a rolling basis. During 2022/23, there were 23 participants in the programme. 13 left prior to completion and 7 completed the sessions in full.

MARAC

The MARAC (Multi Agency Risk Assessment Conference) is a fortnightly multi-agency meeting to discuss and take action on cases of domestic abuse where there is a 'high risk' of death or serious injury. Numbers have continued to rise, and the partnership continues to reflect a robust response to providing multi-agency support to victims and children at risk.

EVIDENCE

691 cases were heard at MARAC in 2022/23, consistent with the numbers heard the previous year (694) Around half of all MARAC cases (327) have children living in the household; this has remained consistent over recent years. 166 were repeat cases heard at MARAC. Domestic Violence and Abuse remains one of the key issues impacting upon the safety and welfare of Hackney's children.

Safeguarding Adolescents

Understanding the context in which children and young people live their lives is an essential feature of effective multi-agency intervention. For the CHSCP, this issue remains central to our overall approach in making children and young people safer. Context is key. During 2019/20, the CHSCP refreshed its defined strategy for safeguarding adolescents. This strategy builds on the progress made by the partnership in safeguarding children and young people at risk of child sexual exploitation (CSE) and those missing from home, care and education. It was developed in parallel to our improved understanding of the issues facing young people; established through focused problem profiles, national and local learning and intelligence pictures involving vulnerable adolescents.

Page 96

The strategy draws on evidence about effective practice from contemporary research. It is a focussed document that sets the parameters for developing our understanding of the complexities of young people's vulnerabilities and finding more effective multi-agency responses to these issues. The strategy maintains an unswerving focus on making sure that professionals are getting the basics right whilst striving to develop best practice in terms of the following priorities:

- Knowing our Problem, Knowing our Response
- Strong Leadership
- Prevention and Early Intervention
- Protection and Support
- Disruption and Prosecution

The partnership has continued to develop its understanding of exploitation and extra-familial harm including criminal exploitation, county lines and trafficking. The Extra-Familial Risk Panel, a key operational component, continued to be held fortnightly to ensure consistent oversight and planning for cases where young people are at risk of experiencing, or are involved in, harmful behaviours outside the home. There is strong multi-agency attendance from Police, Education, Health, Youth Offending Team, Young Hackney and the Integrated Gangs Unit. The Panel develops operational actions which looks to reduce harm and disrupt exploitation of children. Themes and strategic issues from the Extra-Familial Risk Panel are shared with the Multi-Agency Child Exploitation (MACE) group for wider consideration and agency action. Both forums also report back any significant issues via the CHSCP Safeguarding Adolescents Group.

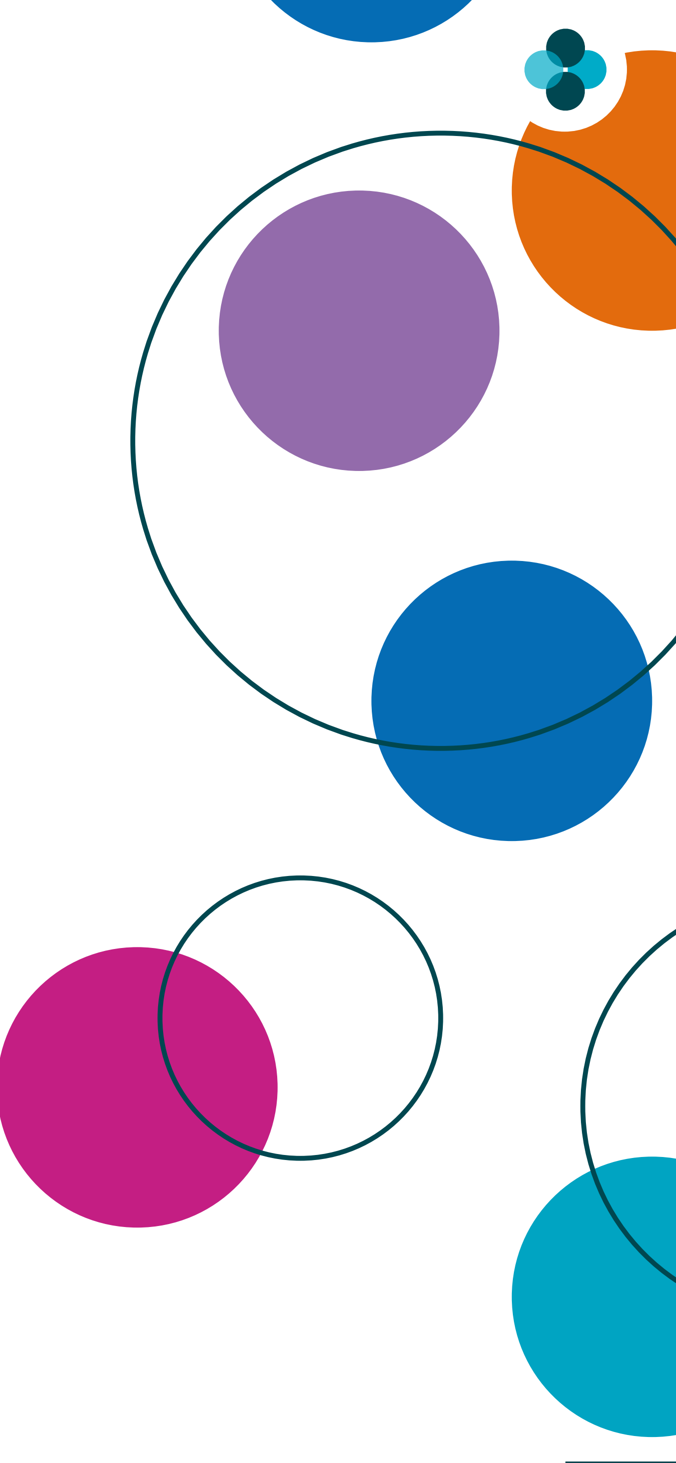
ASSURANCE

In March 2023, in response to a locally commissioned report on serious youth violence, 'Living in Fear', we introduced the process of convening Initial Child Protection Conferences where the risk of significant harm is identified as being solely outside of the family home. Previously these children would be supported primarily through a Child in Need Plan and Initial Child Protection Conferences were held where the risk was identified inside of the family home, or both inside and outside of the family home. These Child Protection Plans are monitored by the Head of Service, and we will be reviewing and monitoring the impact of these plans on children's outcomes.

(HCFS Annual Report 2022/23)

LEARNING

The CHSCP undertook a Rapid Review following the fatal stabbing of a young person, Child J. Learning identified from this process is feeding into a refresh of the CHSCP's safeguarding adolescent strategy and action plan. Further details about Child J are included in the Learning & Improvement section of this report.



CHILD SEXUAL EXPLOITATION

Understanding the nature and prevalence of child sexual exploitation (CSE) and harmful sexual behaviour (HSB) and ensuring that partner agencies provide appropriate safeguarding responses and interventions remains a priority. In February 2017, a revised definition of CSE was issued by the Department for Education (DfE).

'Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.'

DfE 2017

EVIDENCE

Analytical research has been undertaken to interrogate data relating to CSE and HSB and to identify emerging themes and trends which inform service development. The research has highlighted three broad CSE profiles in Hackney:

- CSE risk resulting from peer-on-peer abuse (sexual offences/ exploitation against one or more victims and usually perpetrated in a group setting)
- CSE risk from an adult perpetrator (typically a young person believing themselves to be in a 'relationship' with an adult after being introduced to them by a normally vulnerable friend, or through online contact)
- Exploitation via social media (inciting or encouraging a victim to take and send explicit images of his/herself)

EVIDENCE

Contacts for 37 children were received where Child Sexual Exploitation had been identified as a potential concern. This represents 0.4% of all children who had contacts received in the year.

75 children had a statutory social work assessment that took place where Child Sexual Exploitation was listed as an Assessment Factor. This represents 1.7% of all children with Child and Family Assessments received in the year.

On 31/03/2023, there were 10 open children to Children and Family Services who had a contact with Child Sexual Exploitation flagged as a concern.

Referrals for CSE are more heavily weighted towards females than with other forms of extra-familial harm.

ASSURANCE

Redthread is a charity that works alongside young people who have been affected by, or are at risk of, violence and/or exploitation and has been based in ED at Homerton Hospital since July 2018. *Youth workers are embedded within the Emergency Department supporting young people at the bedside and then follow them into the community, for 6 - 12 weeks of work, to ensure they have the wrap-around and long-term support in place. Our Young Women's Service (YWS) at Homerton, which is our only local hospital to have this service in place, launched in July 2021. The YWS is similar to YVIP in that we support young women aged 11 - 24 who have experienced or are at risk of violence, sexual violence and exploitation (both criminal and sexual) and young people who have been impacted or self- identify as 'gang' affected. The key difference is that the service offers a longer-term support of up to a year for young women and self-identifying young women.*

Homerton Healthcare NHS Foundation Trust Annual Report 2022/23

IMPACT

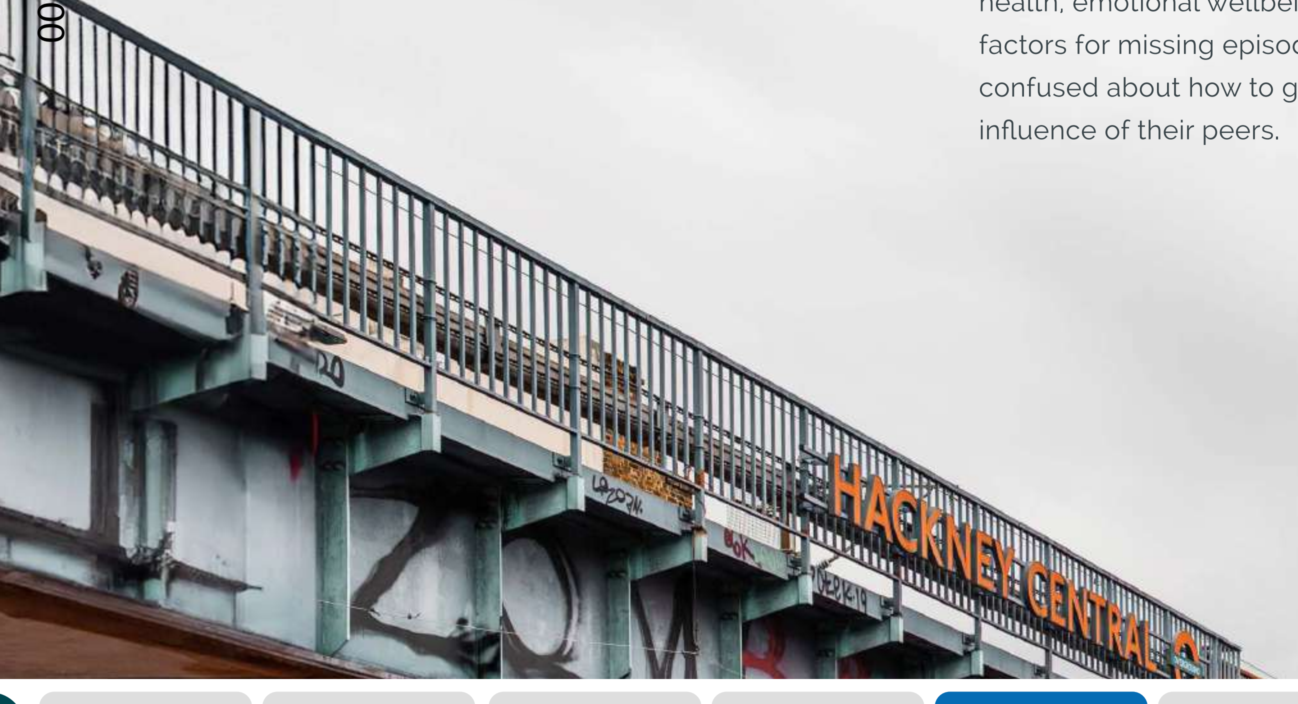
Redthread intervention has demonstrated to be especially beneficial to the young people who engaged with the service. This has been possible thanks to the strong multi-agency collaboration between ED, the SCT and CAMHS.

- 166 total eligible referrals to Redthread
- 111 of eligible young people referred were supported in some capacity by Redthread.
- 103 eligible referrals received for under 18s (66% of eligible referrals)
- 100% of young people felt as safe (64%) or safer (36%) after working with Redthread.

CHILDREN MISSING FROM HOME, CARE AND EDUCATION

The Police lead on all children who go missing from home or care and a coordinated response takes place with Hackney CFS working closely with the child's parents or carers. For those young people who repeatedly go missing this coordinated response often involves a lead professional from education, Young Hackney, Youth Justice Service and the Integrated Gangs Unit. Hackney CFS has led on strengthening the partnership's understanding of and response to children and young people who go missing from home and care. Missing episodes are considered as part of a broader spectrum of vulnerabilities affecting adolescents which include CSE, harmful sexual behaviour (ASB), radicalisation and gang and youth violence.

When a young person returns from an episode of going missing, they are offered an independent return home (IRH) interview by the Children's Rights Service. The use of Independent Return Home Interviews continues to be effective in supporting young people to share information about push and pull factors, what happens when they go missing and what support they need to reduce further episodes. The implementation of a daily meeting with Missing Police has supported better working relationships, information sharing and development of robust risk assessments and timely plans to locate children and offer the appropriate support. The most prominent reason why children and young people go missing is 'difficulties at home or school', with overcrowding also being highlighted in a number of cases. Mental health, emotional wellbeing and learning needs were also precipitating factors for missing episodes. For some young people, they became confused about how to get home or made poor decisions due to the influence of their peers.



EVIDENCE

There were 1,301 missing episodes which took place between 01/04/2022 and 31/03/2023.

A total of 265 children were reported missing (an average of 4.9 missing episodes per person)

69% of children reported missing were reported missing from home, and accounted for 28.4% of all missing episodes (an average of 2 missing episodes per person)

37% of children reported missing were looked after at the time of the missing episode and accounted for 71.6% of all missing episodes (an average of 9.5 episodes per person).

In relation to missing children there is less discrepancy in relation to gender, and both males and females are evenly split in being reported as missing. 57% male, 43% female.

IMPACT

Hackney CFS and the police have agreed that any child identified as high risk with a pattern of missing episodes will have a Missing Child Meeting within 24 hours of them going missing rather than 72 hours, with the aim to respond to these children in line with other concerns, such as domestic abuse.

In respect of children missing education, The Children Missing Education (CME) Team continues to identify, monitor and track children missing or not receiving a suitable education. This includes liaison with MASH when there are safeguarding concerns. The work of the CME team fits closely with other strands of work to support vulnerable pupils including supporting schools and families to prevent poor school attendance, truancy, exclusions and supporting schools and families to get children back to school once absence has occurred. The team liaises closely with the Education Attendance and Admissions services.

EVIDENCE

As of September 2023, there were 356 children electively home educated (EHE) by their parents. A new EHE policy and assessment framework was introduced in June 2020 and is now embedded into practice. New referrals receive a suitability assessment within 12 weeks of referral and an annual assessment. 84% of this current cohort were seen within 12 weeks (a drop from 95% the previous year).

Locally, the majority of children missing education (CME) are from the Orthodox Jewish community, with these children attending unregistered education settings (UES) on a full-time basis, where we are unable to assess the suitability of their education. As of September 2023, there are 1173 registered children missing education (up 365 on 21/22), with 1051 (up 297 on 21/22) from the Orthodox Jewish community. Processes are in place for tracking CME in and out of the borough and steps are taken to visit the known Orthodox Jewish families to check on children's wellbeing, though impact here is more limited.

GANGS, CRIMINAL EXPLOITATION AND SERIOUS YOUTH VIOLENCE

The approach of safeguarding partners to violence treats it as a preventable public health issue; using data and analysis to identify causes, to examine what works and to co-produce solutions. Incidents of serious violence have a significant and lasting impact on the wider community as well as for the young people and families involved. Safeguarding partners remain conscious of the impact and effect of trauma and as a partnership, we are committed to increasing resilience and developing trauma informed practice.

EVIDENCE

Contacts for 167 children were received by HCFS where Criminal Exploitation had been identified as a potential concern. This represents 1.7% of all children who had contacts received in the year.

145 children had a statutory social work assessment where Criminal Exploitation was listed as an Assessment Factor. This represents 3.2% of all children who had Child and Family Assessments received in the year.

On 31/03/2023, there were 74 children open to HCFS where Child Criminal Exploitation had been flagged as a concern.

Most referrals in relation to Criminal Exploitation relating to either drugs or gangs were in relation to male children from Black and Global Majority backgrounds.

EVIDENCE

Contacts for 185 children were received by HCFS where Serious Youth Violence and Weapons had been identified as a potential concern. This represents 1.9% of all children with contacts received in the year.

13 children had a statutory social work assessment that took place that had Serious Youth Violence and Weapons related assessment factors. This represents 0.3% of all children with Child and Family Assessments received in the year.

On 31/03/2023, there were 70 open children to Children and Family Services who had a contact with Serious Youth Violence and Weapons flagged as a concern.

EVIDENCE

Local police continue to conduct serious violence threat assessments daily, weekly and monthly to support the tasking process. The tasking process ensures that partnership resources are allocated to undertake interventions in an integrated way. Health services and third sector charities are also playing a key part in the approach to tackling SYV. Red Thread and St. Giles Trust staff are embedded at Homerton University Hospital NHS Foundation Trust (HUHFT) and the Royal London Hospital trauma unit respectively and use 'teachable moments' to divert young people away from offending and violence.

Hackney's Context Intervention Unit and Integrated Gangs Unit are developing closer working relationships with both teams to ensure the partnership is fully sighted on emerging trends and peer groups and locations of harm. Within the Safer Schools Partnership, information is exchanged on a case by case or school by school basis to inform daily and weekly deployments of police, schools and partnership staff. A monthly Gangs Partnership Tasking Meeting is held to present the latest intelligence and analysis on gang youth related violence and exploitation. This meeting identifies priority areas and individuals who require immediate and longer-term partnership interventions.

IMPACT

As part of a week-long intensification of Operation Sceptre, the MPS ramped up its activity between 14-20 November 2022. A vast range of activity was carried out by officers across London, with officers increasing patrols in violence hotspots, executing warrants to target those known to carry knives and conducting weapons sweeps in areas known for discarded knives. Working closely with the British Transport Police, knife arches were used at transport hubs to deter people from carrying weapons and drugs on trains and the tube. MPS Special Constables and Police Cadets volunteered in their own time to assist regular officers in the operation.

The operation yielded 514 arrests, 995 weapon sweeps, 130 knives recovered and 17 warrants. Furthermore, there were 104 community meetings and educational events, engaging with 949 people; 88 school presentations and engagements, involving 2,466 young people; and 140 retailer visits.

YOUTH JUSTICE

The Youth Justice Service works with all young people in Hackney who are arrested or convicted of crimes and undertakes youth justice work including bail and remand supervision and supervising young people who have been given community or custodial sentences. Young people are supported by a multi-agency team including a Forensic Psychologist, the Virtual School, Speech and Language Therapists, the Police, a Nurse, Probation Services, a Substance Misuse Worker and a Dealing Officer.

EVIDENCE

The overall number of young people entering the youth justice system for the first time in Hackney in 2022/23 was 54, a 19% decrease from 67 young people in 2021/22. This remains below national and statistical neighbour averages. 91% of the young people referred to the Youth Justice Prevention and Diversion Team via Triage in 2021/22 were successfully diverted from becoming first time entrants to the youth justice system in the 12 months that followed (the 2022/23 cohort outcomes will be reported by November 2023). However, early help for young people at risk of becoming involved in crime is still not effective enough at preventing the most serious youth crime: the small number of young people referred to the Prevention and Diversion Team from Triage who have gone on to enter the youth justice system have in some cases faced extremely serious charges against them.

(HCFS Annual Report 2022/23)

ASSURANCE

Following a joint inspection in 2022/23 by His Majesty's Inspectorate of Probation, and colleagues from HM Inspectorate of Constabulary, Fire and Rescue, the Care Quality Commission, Ofsted Education and Ofsted Social Care, Hackney Youth Justice was judged to be 'GOOD'. Chief Inspector of Probation Justin Russell said: *"Hackney Youth Justice Service is a strong and passionate team who are determined to do all they can to improve the lives of the children they supervise. This is a service unafraid to tackle the issues children face, not least racism and disproportionate representation, and make positive changes. I look forward to watching them develop further."*

Read the report HERE.

RADICALISATION

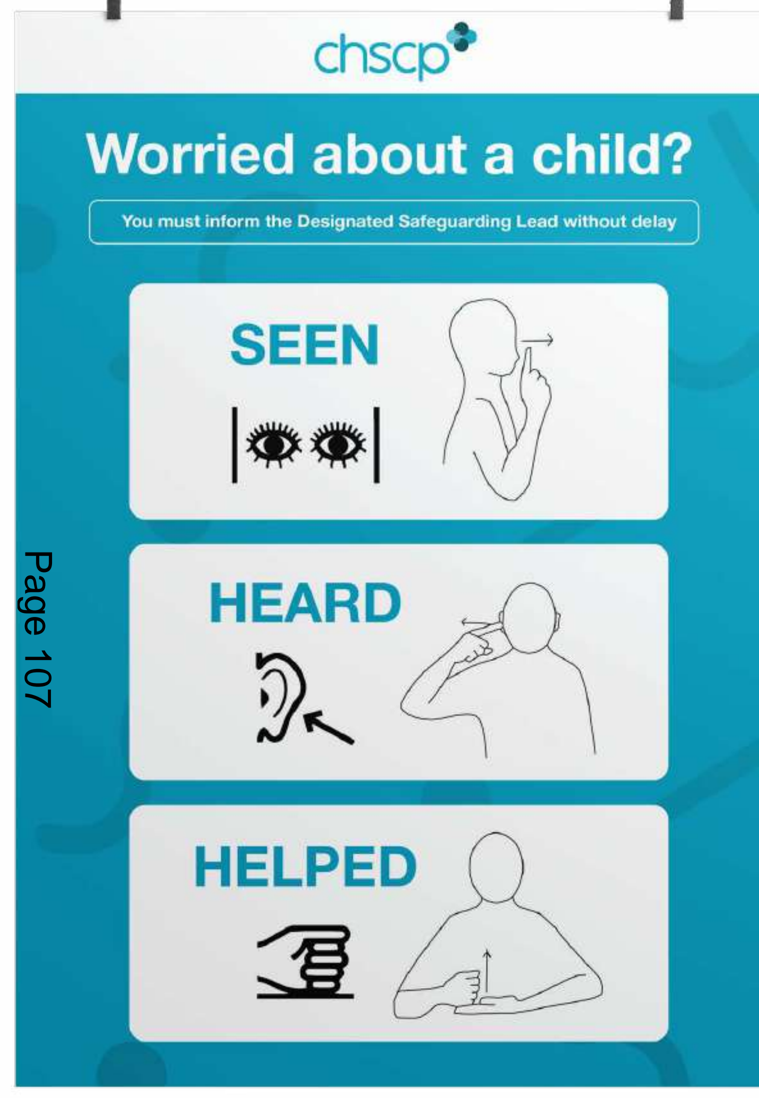
Statutory guidance expects Local Authorities to assess the threat of radicalisation in their areas and to take appropriate action. The Community Safety Partnership (CSP) retains overall governance of this agenda, which includes a focus on ensuring there are sufficient arrangements in place to safeguard children and young people. The Prevent Strategy is a key part of the Government's counter-terrorism CONTEST strategy. It aims to stop people becoming terrorists or supporting terrorism and has three objectives - challenging ideology, supporting vulnerable individuals and working with sectors and institutions. A strategic priority for Hackney's Prevent work is to ensure the safeguarding of children and young people to prevent them becoming drawn into supporting terrorism. In Hackney a multi-agency Channel Panel, chaired by the Head of Safer Communities, works at the pre-criminal stage to support vulnerable individuals where a risk of radicalisation is assessed, and a plan of action devised.

EVIDENCE

During 2022/23, there were 35 referrals made to the Prevent Mailbox, an increase from the 26 made in 2021/22. Out of these, 26 referrals were male subjects, and six were female. The largest number of referrals originated from the MPS. 14 involved young people under the age of 18.

Private Fostering

A child under the age of 16 (under 18, if disabled) who is cared for and provided with accommodation by someone other than a parent, person with parental responsibility or a close relative for 28 days or more is privately fostered. Comparison with national and statistical neighbours has not been undertaken following the DfE ceasing to publish statistics on notifications and closing the private fostering data collection for local authorities. At the end of October 2023, 9 private fostering arrangements were open to Hackney.



Page 107

Children with Disabilities

EVIDENCE

As at the 31 of March 2023, Hackney's Disabled Children's Service was working with 416 children and young people. Of these 143 were female and 273 were male. This is a 5% increase compared to 2021/22, when the service was working with 395 children and young people.

ASSURANCE

Since April 2021, children receiving care packages who are also on Child in Need Plans in relation to safeguarding concerns have transferred to the Disabled Children's Service. This provides greater consistency and ensures that processes are clearer for families. As at the end of March 2023, there were 14 children on Child in Need Plans, 4 children on Child Protection Plans and 4 looked after children receiving support from the Disabled Children's Service.

Children's Mental Health

The Child and Adolescent Mental Health Services (CAMHS) in City and Hackney are provide by Homerton Healthcare NHS Foundation Trust (First Steps and the CAMHS disability team, a joint service with the ELFT CAMHS); Clinicians employed by London Borough of Hackney's children's social care and the Specialist Service is provided by the East London NHS Foundation Trust (ELFT). ELFT CAMHS provides the specialist (tier 3) community-based service, the CAMHS provision within the Young Hackney Service and a service for adolescents with more complex mental health needs, for example, first onset psychosis and complex eating disorders. East London NHS Foundation Trust also provides the inpatient service (tier 4) and the out-of-hours service for City and Hackney.

EVIDENCE

For the early intervention part of our services, we have initiated a number of wait-list initiatives over the past year and waiting times across First Steps have decreased from the peak of 18 months to 6 months on average across pathways, however this is still higher the pre-COVID wait time of 3 months and this work will continue over the next phase. Our initiatives have included an increased number of workshops available, a trial of face-to-face initial consultations and online guided self-help programmes. We have also increased our uptake of training places for clinical psychologists and CAMHS clinicians to strengthen the capacity of our workforce. Homerton Healthcare.

NHS Foundation Trust Annual Report 2022/23

EVIDENCE

Mental health is a flagship priority for the ICS, with a strong provider collaborative established to work with communities and partners in all of our seven places to improve experience, access and outcomes for local people. There has been a sustained focus on expanding and improving mental health services, and services for people with a learning disability and/or autism. We know that Covid-19 has not only affected the delivery of services but has also caused in increase in demand, particularly for talking therapies, children and young people's services, severe mental health and perinatal health. NHS NEL Annual Report 22/23. These challenges as they relate to services for children, young people and families remain subject to scrutiny by the CHSCP through its risk register.

Page 109

MAPPA

Multi-Agency Public Protection Arrangements (MAPPA) are the statutory measures for managing sexual and violent offenders. The Police, Prison and Probation Services (Responsible Authority) have the duty and responsibility to ensure MAPPA are established in their area and for the assessment and management of risk of all identified MAPPA offenders. The purpose of MAPPA is to help reduce the re-offending behaviour of sexual and violent offenders to protect the public from serious harm, by ensuring all agencies work together effectively.

EVIDENCE

Across London on 31 March 2023, there were 6901 Category 1 'Registered Sex Offenders' (RSOs) (6700 in 2021/22, 6549 in 2020/21, 6581 in 2019/20 and 6452 in 2018/19), 3669 Category 2 'Violent Offenders' (3660 in 2021/22, 3521 in 2020/21, 3735 in 2019/20 and 4128 in 2018/19) and 51 Category 3 'Other Dangerous Offenders' (55 in 2021/22, 61 in 2020/21, 31 in 2019/20 and 27 in 2018/19). 158 RSOs were cautioned or convicted for breach of notification requirements. (153 in 2021/22)

LEARNING

Whilst scheduled for publication in early 2024, the following extract from the report into Case A provides an insight into the challenges being faced in this area of safeguarding.

For individuals known to have committed child sex offences, they will always present a risk to children. What this looks like will vary from offender to offender and can change over time, but there will never be no risk at all. Accepting this fact must be the starting point for everyone working with children, their families and offenders themselves. It reflects an unambiguous safeguarding first approach and there should be no practice within our system that dilutes this position. Time served in prison, sex offender courses, dynamic assessment and monitoring can all have the potential to reduce recidivism. However, what they can't do is change the fantasies of those with a deviant sexual interest in children or predict with absolute certainty who will go on to re-offend. It is factors such as these that make the management of child sex offenders so complex and why the paramountcy of child protection must always steer the decision making and actions of practitioners.

Beyond this complexity, we also know there continues to be a growth in activity and that resource pressures on public services remain. Combined, these circumstances have created somewhat of a 'perfect storm' that is placing immense strain on those agencies responsible for this work, particularly the police. As highlighted in the independent review by Mick Creedon QPM, because of this environment the system needs to work differently. We agree.

However, whilst accepting there are no easy answers, we don't believe that system change should correlate with a system doing less. Many would see this as counter-intuitive, and yet solutions continue to be promoted that focus on a reduction in activity to cope with demand. This has largely, but not exclusively, focused on those perceived as being 'low risk offenders' and/or 'viewers' of indecent images.

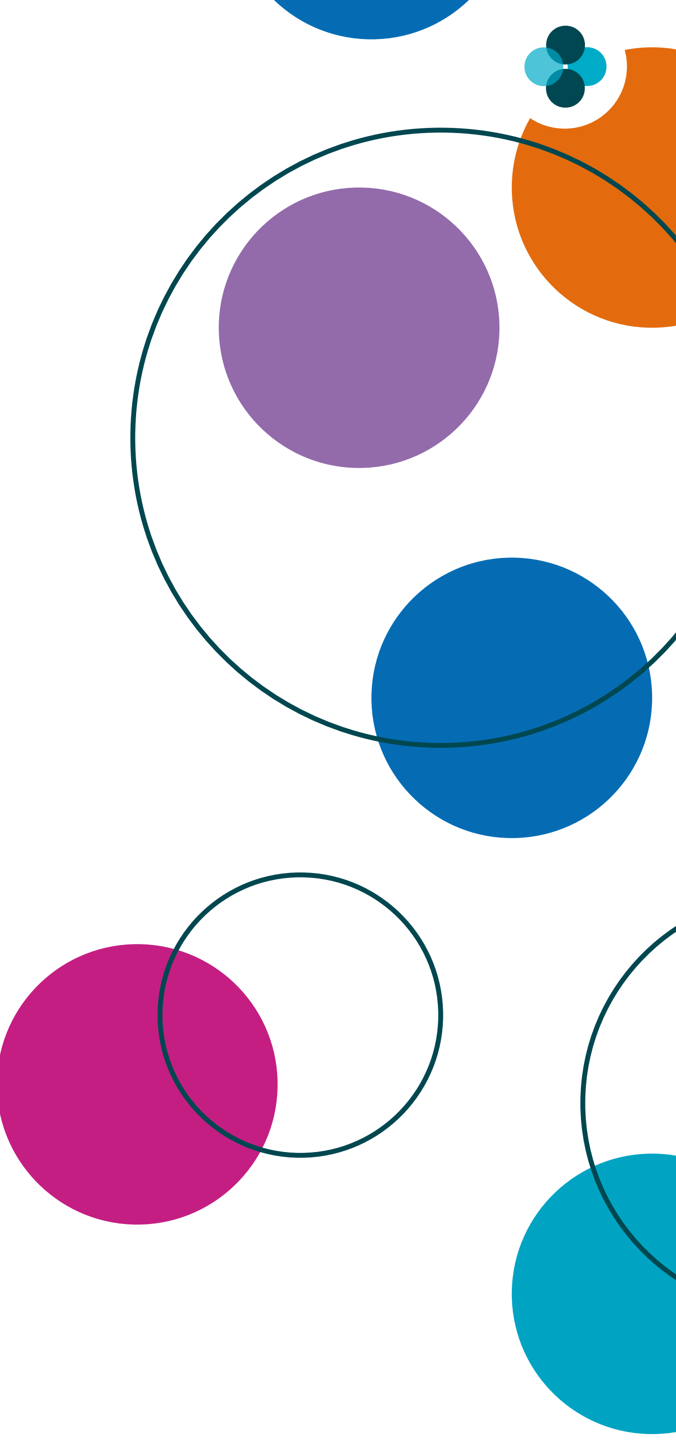
As far back as 2017, the former child protection lead for the National Police Chief's Council (NPCC) raised concerns about the volume of offending and that the police had reached 'saturation point' in terms of its capacity to respond. He argued there was a need to look at alternatives to custodial

Page 110

sentences, including prevention and rehabilitation, although the monitoring of offenders would continue. More recently, the report by Mick Creedon QPM recommended changing the monitoring regime itself by introducing discretion, reducing timescales and allowing for more flexibility in decision making.

All these points can be seen as an understandable response to the demand / resource conundrum that the police are facing. That said, it is hard to see how any of them will make children safer. Tweaking the system will weaken the system and doing less won't address the fundamental challenges in this space. What is perhaps more likely is that additional fault-lines will appear in the form of harm. Based on the lessons from this review, we believe there are opportunities to do more. More by way of harnessing the insights of others to help improve the monitoring of offenders, mitigate risk and increase protection. This can only happen with improved partnership arrangements and information sharing.

Jim Gamble QPM & Rory McCallum, SPA



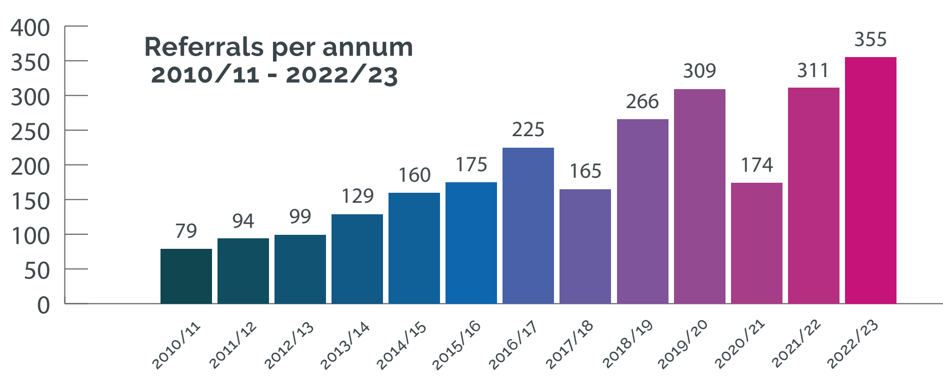
Safer Workforce

Despite all efforts to recruit safely there will be occasions when allegations are made against staff or volunteers working with children. Organisations should have clear procedures in place that explain what should happen when such allegations are raised. These should include the requirement to appoint a designated safeguarding lead (DSL) to whom these allegations are reported. It is ordinarily the responsibility of the DSL to report allegations to, and otherwise liaise with, the designated officer in the local authority (referred to as the LADO). The LADO has the responsibility to manage and have oversight of allegations against people who work with children. The LADO should always be contacted when there is an allegation that any person who works with children has:

- Behaved in a way that has harmed a child or may have harmed a child.
- Possibly committed a criminal offence against or related to a child.
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.
- Behaved or may have behaved in a way that indicates they may not be suitable to work with children.

EVIDENCE

There were 355 contacts to the LADO in 2022/23, a 12% increase from the 311 contacts in 2021/22. Other than during 2020/21, there remains a year-on-year increase in activity.

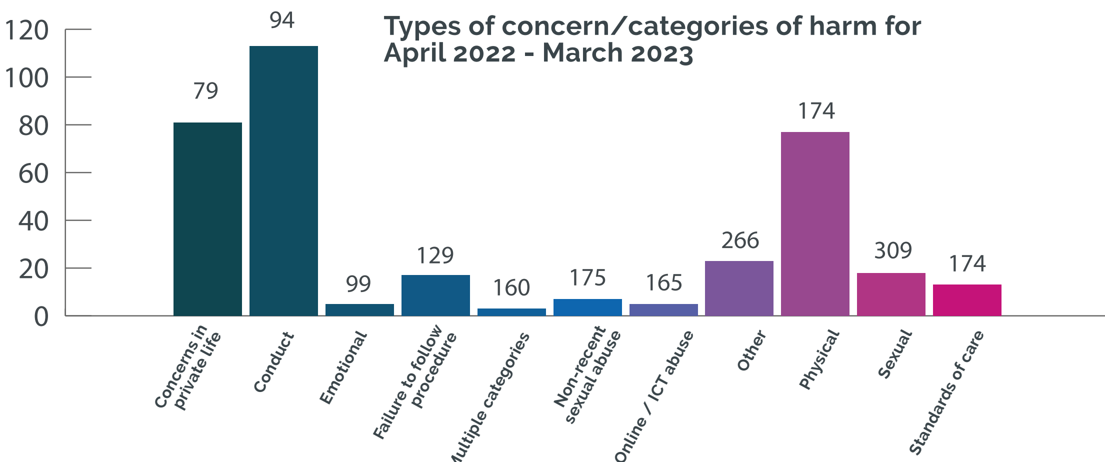


EVIDENCE

The occupations with the highest number of contacts were school support staff (26%), teachers (26%) and nursery workers (12%). An increase was noted for both school support staff (by 3%) and nursery workers (by 5%) with teachers showing a decrease (by 3%) compared to 2021/22. The three occupation groups with the highest number of contacts remain unchanged.

EVIDENCE

The highest number of contacts related to concerns about conduct (32%), concerns in private life (23%) and concerns about physical harm (22%). These, as the top three categories, remain unchanged from the previous period, although for the first time, conduct matters were highest.



Once contact has been made with the LADO service, it will result in one of the five following actions being taken:

Page 113

- The contact/referral is managed by a LADO in ***another local authority***.
- A ***consultation*** takes place where the matter is discussed between the referrer and the LADO to decide on what action to take next.
- An ***evaluation meeting*** is held when the contact provides information that would suggest there is potential risk in the person's employment but would require further information before the decision is made that LADO oversight or an investigation is required.
- ***Guidance and oversight*** are offered by the LADO when an employer is completing an internal investigation.
- An ***Allegations against Staff and Volunteers (ASV)*** meeting will be convened when it has been decided by the LADO that the threshold of harm/risk has been met.

EVIDENCE

Consultations were the highest demand for the LADO service in 2022/23 accounting for 77% of contacts, which is in line with the percentage for the previous period (75%). Less ASV meetings took place in 2022/23 (5.9% compared with 10.6% in 2021/22).

EVIDENCE

'The majority of cases during 2022/2023 resulted in an 'unsubstantiated' outcome. The fact that the concern/allegation had not been substantiated for the majority of cases does not suggest that these matters did not need consideration under the LADO procedures. It only indicated that evidence was lacking to support the allegation/concern or could not disprove it. Uncommonly, two cases resulted in a 'false' outcome. The cases that are 'ongoing' refer to awaited outcomes of Police investigations related to suspicion of possession/distribution of indecent images of children which involves long waiting times due to the forensic analysis of electronic devices required and delays owing to the volume of such cases.'

Hackney LADO Annual Report 2022/23

LEARNING

LADO Training & Awareness Raising - The Hackney Education (HE) Safeguarding in Education Team runs an extensive training programme throughout the year including Safeguarding and Child Protection training for Hackney Education staff, Designated Safeguarding Leads for schools, colleges and early years, school and college staff, governors, early years and childminders. Their training covers safe practice and the procedures for dealing with allegations against adults who work with children and young people. They continue to run specific training dealing with managing allegations for managers in the early years and school sector, once every academic year for schools and twice for early years managers. CHSCP training at Level 1 and 3 also covers the management of allegations against staff and volunteers. The LADO services for Hackney and the City of London are now offering joint training on allegations against staff and volunteers. The first training session was held on 24/03/2023 and will be offered bi-annually (spring and autumn).

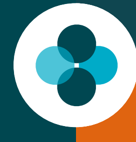
Page 114

ASSURANCE

The responsibility of the LADO is set out in Working Together to Safeguard Children 2018 and Chapter 7 of the London Child Protection Procedures (7th edition). All allegations made against staff, including volunteers, that call into question their suitability to work with or be in a position of trust with children, whether made about events in their private or professional life, need to be formally reported to the LADO. Chapter 7 of the London Child Protection Procedures has recently been amended to provide consistency in respect of the response to low level concerns and to include the wider definition of people in '*Positions of Trust*' (The Police, Crime, Sentencing and Courts Act 2022 has extended the definition of Position of Trust within the Sexual Offences Act 2003 section 22A to include anyone who coaches, teaches, trains, supervises or instructs a child under 18, on a regular basis, in a sport or a religion)

ASSURANCE

In January 2022, the CHSCP Executive discussed the interface between the police and the Local Authority Designated Officer (LADO). This related to the absence of routine contact from the police concerning conduct matters that meet the threshold for the LADO to be notified. This has been an ongoing issue for some time and is not unique to the City of London or Hackney. A Pan-London group looked at solutions, although work was placed on hold due to COVID-19 and subsequently stalled. Given there remained no consistent mechanism allowing for oversight on possible LADO issues concerning the police, the ISCC wrote to Commanders in both the City of London and Hackney seeking their cooperation in this regard. Agreement was reached that the City Police and CE BCU would include a trigger point within their processes to notify the LADO of any case that meets the criteria. However, during the reporting period, only three police referrals had been received by the Hackney LADO.



Learning & Improvement

Page 115

Key Messages for Practice

Over the past few years, the CHSCP has undertaken a substantial range of activity seeking to identify lessons for practice improvement. Through its learning and improvement framework, many have been captured. That said, from all this work, we have seen a range of common themes that should remain as priorities for our front-line practitioners.

Page 116

Safeguarding First

The need for practitioners to adopt a 'Safeguarding First' approach to their practice has been a key theme for the partnership since the publication of its review into **Chadrack Mbala-Mulo**, and that involving **Child Q**. This is not a particularly complicated message, but one that needs to be routinely reinforced, along with the CHSCP's principles of children being seen, heard and helped. Put simply, whatever your role or whatever policy or procedure you might be following, you should always be considering the safeguarding needs of a child. Their safety and welfare should always be your first priorities and whilst 'safeguarding is everyone's responsibility', that doesn't mean you can rely on someone else to act. You need to.

Applying this approach to practice is less about reading pages and pages of guidance, but more about the culture of how you and your agencies operate. Developing a culture that places the safety of children at the heart of our system is the first step we all need to take. It's also something that our leaders need to promote rigorously. If they aren't talking about safeguarding as a priority, those on the front-line won't be either. The next step is acknowledging that whilst safeguarding might be one priority amongst many for you, you need to make a concentrated effort to always base your decisions and actions on the best interests of the child. Develop your skills and confidence, engage other practitioners and access the support from your supervisors. Listen to what children and young people have said they need from those who work with them (Working Together 2018).

CHILDREN HAVE SAID THEY NEED

VIGILANCE: to have adults notice when things are troubling them.

UNDERSTANDING AND ACTION: to understand what is happening; to be heard and understood; and to have that understanding acted upon.

STABILITY: to be able to develop an ongoing stable relationship of trust with those helping them.

RESPECT: to be treated with the expectation that they are competent rather than not.

INFORMATION AND ENGAGEMENT: to be informed about and involved in procedures, decisions, concerns and plans.

EXPLANATION: to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response.

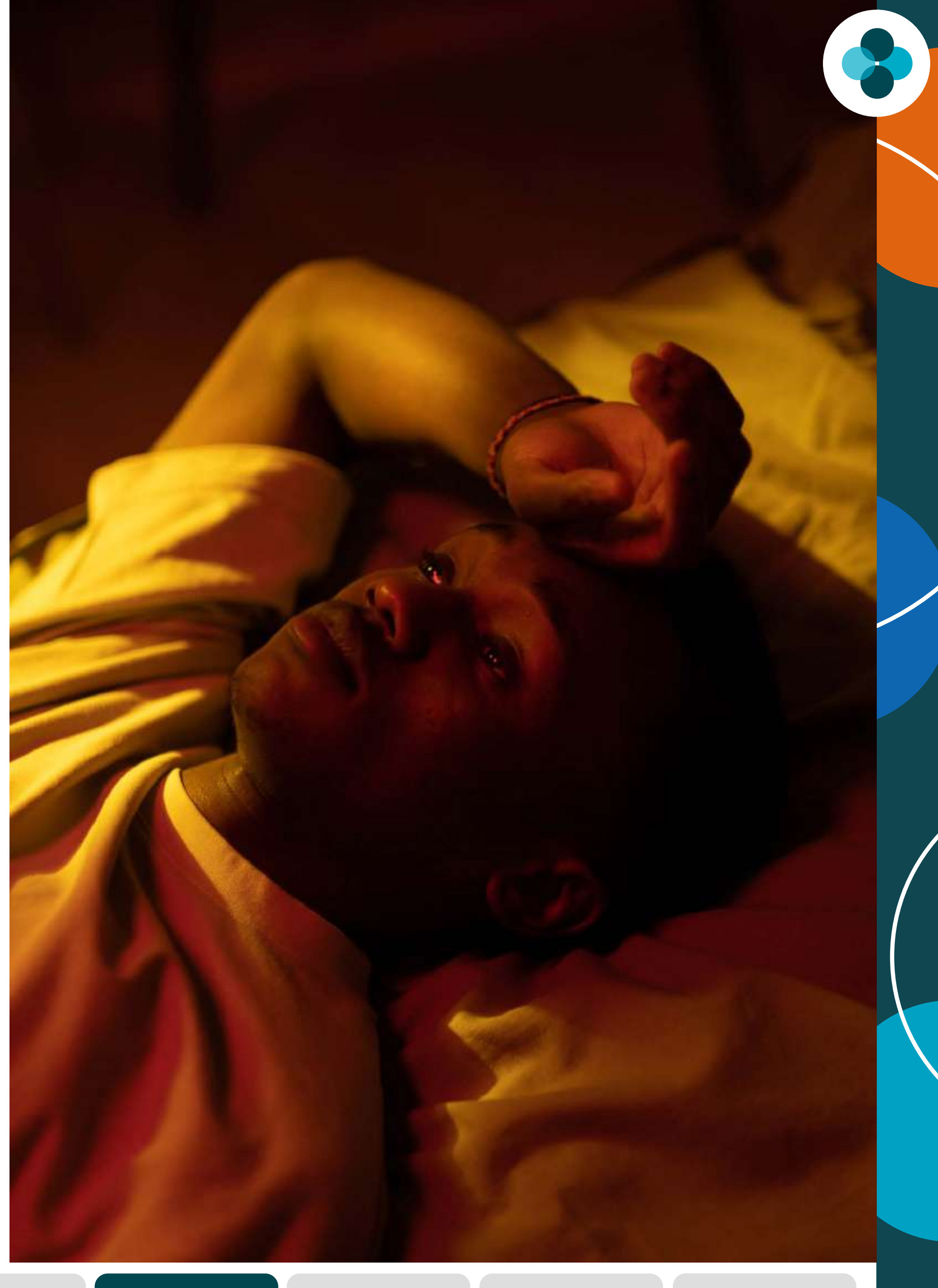
SUPPORT: to be provided with support in their own right as well as a member of their family.

ADVOCACY: to be provided with advocacy to assist them in putting forward their views.

PROTECTION: to be protected against all forms of abuse and discrimination and the right to special protection and help if a refugee.

CONTEXT

Context is key and understanding the context of a child's life is essential for effective safeguarding. In terms of practice, this is about how the partnership works together to better understand the lived experience of children at home, in education and in health, alongside those aspects that are typically outside of the family environment, such as peer groups, places and spaces, and the virtual world that children occupy through their use of technology and social media. Knowing about these contexts will help us determine whether they reflect pathways to harm or pathways to protection. However, it is usual that no one individual has oversight on the detail of everything. In this respect, a first and important step is to make sure that professionals are confident in sharing information and talking with each other. If you are worried about a child or young person, you are allowed to talk with other professionals without fearing you are doing something wrong. You aren't. Talking to each other and sharing information when trying to protect people from actual or likely harm or to prevent a crime is lawful and in the substantial public interest.



CURIOSITY

Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. This has been described at the need for practitioners to practice 'respectful uncertainty' – applying critical evaluation to any information they receive and maintaining an open mind. In safeguarding the term 'safe uncertainty' is used to describe an approach which is focused on safety but that takes into account changing information, different perspectives and acknowledges that certainty may not be achievable. Professional curiosity can require practitioners to think 'outside the box', beyond their usual professional role, and consider families' circumstances holistically. Professional curiosity and a real willingness to engage with children, adults and their families or carers are vital to promoting safety and stability for everyone.

Much has been written about the importance of curiosity during home visits and the need for authentic, close relationships of the kind where we see, hear and touch the truth of their experience of 'daily life' and are able to act on it and to achieve similar closeness with parents or carers. Practitioners will often come into contact with a child, young person, adult or their family when they are in crisis or vulnerable to harm. These interactions present crucial opportunities for protection. Responding to these opportunities requires the ability to recognise (or see the signs of) vulnerabilities and potential or actual risks of harm, maintaining an open stance of professional curiosity (or enquiring deeper), and understanding one's own responsibility and knowing how to take action. Children in particular, but also some adults, rarely disclose abuse and neglect directly to practitioners and, if they do, it will often be through unusual behaviour or comments. This makes identifying abuse and neglect difficult for professionals across agencies. We know that it is better to help as early as possible, before issues get worse. That means that all agencies and practitioners need to work together – the first step is to be professionally curious.

Curious professionals will spend time engaging with families on visits. They will know that talk, play and touch can all be important to observe and consider. Do not presume you know what is happening in the family home – ask questions and seek clarity if you are not certain. Do not be afraid to ask questions (and difficult questions) of families and do so in an open way so they know that you are asking to keep the child or young person safe, not to judge or criticise. Be open to the unexpected and incorporate information that does not support your initial assumptions into your assessment of what life is like for the child or young person in the family.

CHALLENGE

Differences in professional opinion, concerns and issues can arise for practitioners at work and it is important they are resolved as effectively and swiftly as possible. Having different professional perspectives within safeguarding practice is a sign of a healthy and well-functioning partnership. These differences of opinion are usually resolved by discussion and negotiation between the practitioners concerned. It is essential that where differences of opinion arise, they do not adversely affect the outcomes for children, young people or adults and are resolved in a constructive and timely manner. Differences could arise in several areas of multi-agency working as well as within single agency working. Differences are most likely to arise in relation to the criteria for referrals, outcomes of assessments, roles and responsibilities of workers, service provision, timeliness of interventions, information sharing and communication. Safeguarding is everyone's responsibility and front-line staff need to be both professionally curious and confident in challenging the decisions and actions of others. Where disagreement remains, concerns should always be escalated for resolution. To help, the CHSCP has issued a simple Escalation Policy.

SAFER - The Golden Rules of Safeguarding

We expect all safeguarding practitioners to be confident and competent in their ability to identify, assess, analyse and manage risk confidently. We want them to have an unswerving focus on the basics. We must get this right - every time. As a minimum, this means all safeguarding practitioners operating to the CHSCP's Golden Rules of Safeguarding

Sharing Information	Good information sharing is vital when professionals are worried about people and want to help them. Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. Learning from Serious Case Reviews reinforces the fact that both children and adults can suffer significant harm or death when professionals fail to share information or fail to share it in a timely way. Good communication and appropriate information sharing between professionals is therefore a critical element of effective safeguarding practice.
Assessing (& Managing) Risk	When safeguarding children, practitioners working in the City of London and Hackney need to know what to look for and what to do if they think they've seen it. This means practitioners having a good understanding of the signs and symptoms of abuse and neglect and a working knowledge of the local threshold tool. It also means practitioners knowing where to seek help (for example, from their DSL) and how to report any concerns. Importantly, practitioners from both children and adult services need to engage in our multi-agency arrangements, and when needed, contribute to any multi-agency meetings or processes tasked with helping and protecting children.
Focus on the Child	Maintaining a focus on the child and hearing their voice is paramount to our local arrangements. In all our work, we need to listen and think carefully about what children are saying and what meaning this has for them. We need to try and understand their lived experience and what life is like through their eyes.
Escalation	Differences of opinion, concerns and issues can arise for practitioners at work, and it is important they are resolved as effectively and swiftly as possible. Having different professional perspectives within safeguarding practice is a sign of a healthy and well-functioning partnership. Don't be afraid to voice them. These differences of opinion are usually resolved by discussion and negotiation between the practitioners concerned. It is essential that where differences of opinion arise, they do not adversely affect the outcomes for children, young people or adults and are resolved in a constructive and timely manner.
Recording	We should all recognise the importance of good recording. The ability to maintain records that are focused, accurate and evidence professional judgement is a key skill we expect all practitioners to have. Good recording can help us spot themes, patterns and trends in a child's care (such a neglect). They are a record for the child and an audit trail of your practice.

Reviews of Practice

Local Child Safeguarding Practice Reviews are undertaken on *'serious child safeguarding cases'* to learn lessons and improve the way in which local professionals and organisations work together to safeguard and promote the welfare of children. These reviews were previously known as Serious Case Reviews (SCRs) and were transitioned to this alternative model in July 2019. As set out in Working Together 2018: *'Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose, including through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings.'*

Page 122

ASSURANCE

Since its inception, the National Child Safeguarding Practice Review Panel (the Panel) has emphasised the responsibility of safeguarding partners to decide upon whether a review is needed or not. However, the risks in this approach have been recognised, with safeguarding partners of the CHSCP agreeing to maintain fundamental independence within our reviewing arrangements. This is the right thing to do in terms of transparency and to ensure that safeguarding partners avoid being in a position of either marking their own homework or deciding not to do their homework at all. Locally, the decision-making function for instigating a review is delegated to the Independent Safeguarding Children Commissioner. Safeguarding partners ratify any decisions made, with a resolution process existing to deal with any differences of opinion.

EVIDENCE

During 2022/23, three serious incident notifications were made by Hackney Council to the Panel, all of which were subject to a Rapid Review by the CHSCP. No serious incident notifications were made by the City of London Corporation.

From the notified cases, two Local Child Safeguarding Practice Reviews were subsequently commissioned.

Three other cases (not meeting the criteria for notification) were also considered by the Case Review Sub-Group during 2022/23. One of these resulted in a Rapid Review, although no reviews were triggered.

Whilst no reviews were published during the period, substantial activity was undertaken in preparing for the Child Q update report.

Full details of all the reviews published by the CHSCP are available HERE.

Rapid Reviews

Following notification of a serious incident to the Panel, the CHSCP will always initiate a Rapid Review. The aim of a Rapid Review is to:

- Gather the facts about the case, as far as they can be readily established at the time.
- Discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately.
- Consider the potential for identifying improvements to safeguard and promote the welfare of children.
- Decide what steps they should take next, including whether or not to undertake a child safeguarding practice review.

Once complete, the outcome of a Rapid Review and the CHSCP's decision about whether a review is appropriate is shared with the Panel. The CHSCP's analysis will include whether it thinks the case raises issues which are complex or of national importance such that a national review may be appropriate. Where an incident has not been notified and does not meet the criteria for notification, there is no requirement to send a Rapid Review to the Panel.

Four Rapid Reviews were undertaken in 2022-23.

RAPID REVIEW - YOUNG PERSON J

Fifteen-year-old J was attacked and fatally injured in a park in August 2022. He approached police officers in the area, telling them he had been stabbed. Soon afterwards he collapsed, and officers identified a large wound to the right side of his chest. Assistance from the London Ambulance Service (LAS) was immediately requested with the officers performing CPR at the scene. On arrival, LAS medics took over the care of J and he was treated at the scene. J was taken to hospital by ambulance where sadly, he died a short time later.

LEARNING

- The help and protection nature of early help support should be explained as such to parents/carers when seeking consent.
- Offers of early help support should be timely and where risks escalate, timely request for statutory support is also vital.
- Exclusion from mainstream school can potentially heighten the likelihood of greater risk.
- In addressing extra-familial risk it is essential to consider the needs and challenges encountered by young people across various situations, and a collaborative effort involving multiple agencies is crucial for ensuring effective safeguarding.
- Think Family professionals should identify risk from wider family network and significant others connected to a child in particular in multi-generational households.

ASSURANCE

Following careful consideration, and reference to the relevant guidance set out in Chapter 4 para 15-19 of Working Together to Safeguard Children 2018, the ISCC made the decision not to instigate a review of this case. Safeguarding partners and the Panel fully ratified this decision. By way of rationale, there was no evidence that either the actions or inactions of practitioners resulted in missed opportunities to protect J. The details of this case pointed clearly towards committed practitioners from a range of services who were trying hard to help and protect this young person and there were many examples of good practice. Additionally issues of concern relating to extra-familial harm, exploitation, violence and gangs have previously been subject to considerable scrutiny at both a national and local level. Whilst the circumstances in this case highlighted areas for improvement, the immediate learning and recommendations were responded to via the existing structures of the CHSCP and individual agencies.

LEARNING

GP Leads from the NEL ICB undertook to provide reassurance around the de-registering process for children from a GP (when and how it takes place) and the process for transferring records.

IMPACT

There was focused awareness raising with GP safeguarding leads in the City of London and Hackney about not deregistering vulnerable children (even if there is non-engagement). Where this is being considered, cases should be discussed at the UPP meeting (meeting between primary care and HV services) to facilitate handover. If registering elsewhere, children would be automatically deregistered from their previous GP.

The circumstances of this case have fed into the ongoing work and refresh of the Safeguarding Adolescents Strategy.

The London Safeguarding Adolescent Oversight Board, which is part of the London Innovation and Improvement Alliance undertook a project aimed at distilling the learning from rapid reviews over the last 18 months (for young people aged 12-18 where significant harm suffered came from outside their immediate family) into a Lessons for London work programme. This Rapid Review report was submitted to feed into this work programme.

RAPID REVIEW - CASE A

In 2023, Mr A pleaded guilty to over 30 sexual offences involving both children and adults. He was given a custodial sentence, made subject to notification requirements and issued with a court-imposed Sexual Harm Prevention Order (SHPO). His crimes included sexual assault, engaging in sexual activity in the presence of a child, making indecent photographs of a child, voyeurism, exposure and up-skirting.

Without question, the nature and scale of Mr A's offences are both shocking and deeply disturbing. However, they weren't his first. In 2014, Mr A was found guilty of possessing indecent images of children and given a suspended sentence. At the time, notification requirements were similarly put into place alongside a five-year Sexual Offences Prevention Order (SOPO). Mr A participated in an internet sex offender programme, unpaid work and was monitored by a local Jigsaw team from the Metropolitan Police Service. Whilst subject to this supervision, Mr A became the father of two children. However, there was no record of him telling the police or the probation service about their births. Furthermore, despite ongoing monitoring and there being intelligence that Mr A had a child, it was not until late 2018 that a referral was made to children's social care. By this time, the eldest child was two and a half years old, and the youngest, five months. A statutory social work assessment was subsequently triggered by children's social care, although this resulted in no further action and the case was closed. Supervision of Mr A remained with the police until the ending of his notification requirements in 2021.

Page 126

ASSURANCE

This case was presented to the Case Review Sub Group of the CHSCP in September 2022. Having considered the circumstances, actions were agreed for the Hackney Council to formally notify this case to the Panel and for there to be a Rapid Review. This was undertaken in October 2022. A decision was subsequently made by the ISCC to trigger a review. Due to a delay in the submission of documentation and capacity issues, the review was not completed within six months and at the time of writing, remains ongoing. It is scheduled for publication in early 2024. The Panel has been alerted to this delay. The review will examine how local agencies managed and mitigated the risks posed by Mr A to his children, other family members and the wider public.

CHALLENGE

Further to the ISCC's decision, not all safeguarding partners agreed that the case met the criteria for review. Consistent with the CHSCP's written arrangements, this was subsequently resolved by the ISCC engaging directly with Executive members and further explaining the rationale behind his decision.

RAPID REVIEW - CHILD V

Child V, a White female child, died in January 2023 at the age of seven. She had a range of complex health needs and multiple diagnoses. In the years preceding Child V's death, there had been significant contact with health and social care practitioners due to long-standing concerns about neglect and Child V's health and wellbeing.

ASSURANCE

Hackney Council notified the Panel of Child V's death in January 2023. Following a Rapid Review, the ISCC decided to instigate a review. This decision was ratified by safeguarding partners and agreed by the Panel. The review remains ongoing and is due to be published in early 2024. It will seek to answer the following questions:

- Was multi-agency practice sufficient and timely in responding to the risks that Child V faced?
- What factors inhibited engagement with and from this family and how did these influence perceptions of risk?
- What role might Child V's complex health needs and disabilities have played in relation to what appears to be a greater tolerance of the parents' actions?
- Was the judicial process sufficient and timely in meeting the needs of Child V and mitigating the ongoing risks that she faced?

RAPID REVIEW - YOUNG PERSON G

This case relates to a young person with complex needs and autism and the challenges identified in meeting her needs and securing her safety and that of her family. The Police had been called out to the family's address nearly 100 times since March 2021 and there had been numerous hospital admissions.

ASSURANCE

The MPS identified this as a case for potential learning and submitted a CHSCP 'case for consideration form' to the Case Review Sub-Group in September 2022. An update on the operational issues was also provided in November 2022 and, given the issues of national relevance, an action was agreed to develop and submit a Rapid Review report to the Panel. This was done in January 2023.

LEARNING

Based on the circumstances facing practitioners, the potential for improvements identified in the Rapid Review were largely outside of the local sphere of influence. All had a nexus with the actions / decisions of central government. For example:

- The impact upon the effectiveness of practice to safeguard children because of the limited placement availability for children.
- The impact upon the effectiveness of practice to safeguard children because of CAMHS resourcing pressures.
- The impact upon the effectiveness of practice to safeguard children because of the parameters governing unregulated / unregistered care provision.

Page 129

IMPACT

Correspondence from the Panel in February 2023 noted recognition of these issues at a national level. The Panel acknowledged it would continue to use its influence to raise the profile of these factors with government officials and senior officers. As a follow up locally, an extraordinary meeting of key agencies met in June 2023. This meeting acknowledged that since the original escalation of this case, regular and specialist placements were increasingly difficult to arrange due to a national shortage. Locally, partners acknowledged the usefulness of regular meetings across agencies to discuss available places, to iron out challenges and hold difficult discussions. Autism guidance had also been circulated to the Police and advice provided that discussions on similar cases could be held in the monthly conversations between the Police and HCFS.

Feedback in July 2023 from CAMHS highlighted local factors including depleted staffing (difficulties in recruiting and retaining psychologists). There was also a noted increase in Autism diagnoses that has impacted on capacity to respond - the waiting list for assessment at the time was approaching 18 months. Prior to diagnosis, mental health needs are managed in the wider City and Hackney CAMHS services. An update on the operational issues was also provided in November 2022 and given the issues of national relevance, it was agreed to submit a Rapid Review report to the Panel. This was done in January 2023.

The Child Q Update Report - Why was it me?

On publication of the initial Child Q review in March 2022, and at the request of Hackney's Mayor, the ISCC committed to providing an independent update on the progress made in response to the review's original 14 recommendations. Co-authored by Jim Gamble QPM and Rory McCallum, Senior Professional Advisor, the Child Q Update report, 'Why was it me?' was released in June 2023.

This report was the culmination of a substantial range of activity undertaken over 2022/23. Setting out 13 new recommendations, it sets out what people have said, provides an independent perspective on the actions of key agencies and evaluates the impact that could be evidenced at the time. The update report can be read HERE.

Page 130

ASSURANCE

Recommendation 1: The Child Safeguarding Practice Review Panel should engage the IOPC with a view to developing national guidance on the IOPC's interface with the Local Child Safeguarding Practice Review process. As a minimum, this should set out the arrangements for securing cooperation, accessing key staff for interview and the requirements for the timely sharing of information.

Activity in response to this recommendation involved the Panel drafting a new protocol (and information sharing template) and seeking to broker a national agreement on behalf of all safeguarding partners with the IOPC. In addition, the Panel also started to keep track of other serious child safeguarding incidents where joint investigations were taking place, so wider experiences of joint working with the IOPC could inform the work underway. By April 2023, discussions were ongoing about precisely what guidance and supporting documents were needed. At the end of May 2023, the Panel confirmed that agreement had been reached to move forward with the protocol with the aim of having it published later in the summer. The first draft of the protocol was shared with the CHSCP in July 2023.

Page 131

CHALLENGE

Recommendation 1: Whilst positive steps have been taken to develop this protocol, the ISCC remains concerned about its proposals to allow for the sharing of interview records of those engaged in a review with the IOPC. This was set out in a letter to the Chair of the Panel in July 2023 and again, in October 2023. Disappointingly, the Panel has decided against making any changes based on the ISCC suggestions. These are detailed below:

"In the Child Q case, the key issue was that those who engaged with us, did so on the understanding that they were participating in a learning exercise. We clearly emphasised this position and the difference between our approach and that of any misconduct or criminal processes at the beginning of each interview. It was on this basis that people ultimately agreed to speak with us.

In my opinion, sharing LCSPR interview notes with the IOPC would be inconsistent with Working Together 2018 that sets out the clear distinction between the various processes that can arise from a serious child safeguarding case. I would be concerned that having this as a defined requirement runs the risk of practitioners being less than open during a LCSPR (if they know that whatever they say will be passed onto those investigating matters of misconduct). Whilst noting the protocol includes the need to explain the sharing of notes, I am concerned that in future reviews, we may find that practitioners are less likely to engage with us at all. This would ultimately impact on the ability of safeguarding partners to fulfil their statutory functions.

Furthermore, interviewing individuals under different circumstances for different purposes could be found to be an abuse of process. Interviews regarding culpability are usually focused on conduct and accountability and generally take place under 'caution', those carried out to reflect, learn and improve practice (sometimes in groups and generally more discursive) are very different. Other than if there was an admission of a criminal offence or identified safeguarding issue, there should be no expectation that notes/statements gathered for the LCSPR should be used for any other purpose.

During our engagement with the IOPC (as part of the Child Q review), the key problem we faced was having access to the officers involved. We were told at the outset that the likelihood of these officers meeting with us was remote, and that the Police Federation would likely advise the officers not to do so. This was understandable given the conduct investigation they were facing and the risk of prejudicing their position if interviewed by ourselves.

In response, the IOPC made the CHSCP an 'interested party' – this facilitated the sharing of the IOPC's interview notes with ourselves. Whilst speaking to them would have been ideal, this was the best option available and allowed the review to be completed.

At the time, we were clear with the IOPC that we wouldn't reciprocate and share our own interview notes. The IOPC could simply approach those who they needed to speak to as part of its investigation into conduct. We have made the same point to the Teaching Regulation Agency. Whilst acknowledging this may appear to be a 'one-way' agreement, the benefits for LSCPs is the ability to gain an account from police officers who are unlikely to be interviewed. For the IOPC, this ultimately saves a degree of time.

I don't dispute the complexity involved here, but my strong advice would be to reword this section to describe the sharing of interview notes being agreed where LSCPs have been unable to access the police officers under investigation and for this to be achieved through the designation of the LSCP as an interested party. I think it would be reasonable for LSCPs to share the details of those interviewed with the IOPC so it can make a determination as to who it might want to approach."

- Jim Gamble QPM

ASSURANCE

Recommendation 2: The MPS should review and revise its recording system for stop and search to ensure it clearly identifies and allows for retrieval of the full range of activity under stop and search powers (including the ability to differentiate between the different types of strip searches undertaken).

Having acknowledged that the need to publish this data should have been understood much earlier, significant efforts have been made by the MPS over the last year to improve the accuracy of data recording and how this is shared for wider consumption. A thorough review of records indicated double recording of some MTIP searches on the police custody record system and the search record system. Briefings were subsequently provided to all officers, supervisors and the Senior Leadership Team to ensure that data was being captured correctly. Awareness raising, training and regular refreshers about the importance of correct recording continued for all officers, with a particular focus on new joiners and 'street duties' officers. The MPS also released two new dashboards (the Custody Dashboard and the Stops and Search - More Thorough Searches Dashboard) which provide greater granularity, are more user friendly and contain relevant additional data on stop and searches, such as that involving Appropriate Adults. They are a significant improvement on what was available before in the MPS Stop and Search Dashboard. The ability to review data with greater confidence provides more opportunities to identify practice issues, including those that might be linked to disproportionality.

ASSURANCE

Recommendation 3: The Department for Education should review and revise its guidance on Searching, Screening and Confiscation (2018) to include more explicit reference to safeguarding and to amend its use of inappropriate language.

In response to this recommendation, the Department for Education (DfE) worked at pace, recognising the critical importance of incorporating lessons from the Child Q report into its guidance as quickly as possible. An updated version of the DfE's Searching, Screening and Confiscation (2022) guidance was published in July 2022 and implemented in September 2022.

ASSURANCE

Recommendation 4: The MPS should update its guidance note and local policy to better emphasise the requirements for engaging an Appropriate Adult under the revised Code C, PACE,1984.

Update guidance was swiftly issued by the CE BCU prior to publication of the Child Q review. MPS-wide Operational Notices (including relevant practice resources for officers) were created and released on 25 May 2022. This included an immediate policy change requiring an Inspector to authorise any MTIP on a child under 18. 4.33 The MPS stop and search policy was also updated to better reflect PACE Code C, Annexe A, paragraph 11, emphasising the requirement for having an Appropriate Adult present, who would constitute an Appropriate Adult, their role and the recording requirements should one be refused by the child. Reminders continue to be sent locally within the CE BCU and guidance has been made available on the home page of the MPS Intranet.

IMPACT

Recommendation 4: Updating and improving the guidance needed to happen and is reported by the MPS as having been welcomed by officers. Previous guidance was insufficiently detailed to mitigate incorrect and poor practice. By way of potential impact, it is important to emphasise that no MTIPS involving children have taken place in Hackney since March 2022.

London-wide, there has been a 45% reduction from 2021 to 2022.

Furthermore, no MTIP has taken place on a child without the authority of an Inspector. Whilst this would have made no difference for Child Q (given no authorisation was sought), this has been a sensible response from the MPS in terms of strengthening senior management oversight and decision-making. This approach has since been adopted nationally and features as recommended guidance issued by the College of Policing. More recently, the CE BCU has further reinforced these arrangements. MTIPs involving children now require Superintendent authorisation and those undertaken 'out of hours', must be approved by the CE BCU Commander.

Part of the explicit orders given by Inspectors are that the age of the person being searched is verified and if required, an Appropriate Adult is present. The MPS report that this has resulted in more Appropriate Adults being part of the process and children receiving the protection they are entitled to. In 2020, 29% of MTIPs involving children across London did not have an Appropriate Adult present. In 2021, this had increased to 32%. From April 2022 to March 2023, this figure had reduced to 20%.

Page 135

ASSURANCE

Recommendation 5: The CHSCP should review and revise its awareness raising and training content to ensure the Child Q case is referenced, with a specific focus on reinforcing the responsibilities of practitioners to advocate for and on behalf of the children they are working with / who are in their care.

The CHSCP and its partner agencies have all been engaged in significant awareness raising and training activity during 2022/23. The core safeguarding training programme delivered by the CHSCP routinely reinforces the lessons from Child Q. Furthermore, there is ongoing communication through the CHSCP's monthly briefings and external trainers have been directly appraised of the Child Q findings for inclusion in any courses as necessary. The CHSCP's Basic Safeguarding Awareness and Training for Designated Safeguarding Leads routinely promotes the need for professionals to apply the principles of Safeguarding First, Context, Curiosity and

ASSURANCE

Recommendation 6: Relevant police guidance (both local and national) governing the policy on strip searching children should clearly define a need to focus on the safeguarding needs of children and follow up actions that need to be considered by way of helping and protecting children at potential risk.

MPS policy was reviewed and updated to align with best practice and to ensure that the impact upon children is routinely considered whenever they are searched. As part of these revisions, the MPS introduced a mandatory process that involves the completion of a Merlin and safeguarding referral for each child subject to an MTIP. Systems have been put in place to monitor and measure outcomes, so that the difference made to children and their families can be monitored and reported upon.

ASSURANCE

Recommendation 7: The Central East BCU should engage the local stop and search monitoring group, ACCOUNT, and other representative bodies to consider the lessons from this review and how the effectiveness of safeguarding (as part of stop and search practice) can be overseen through their respective activities.

Progress has been variable. In some areas, working relationships have been established between the local police and other organisations such as Hackney CVS and the Crib Youth Project. Both are part of the current Community Monitoring Group (CMG) (whilst awaiting a new pilot for this forum). The Wickers is another organisation that has engaged in dialogue with the police and has shown an active interest in joining the CMG. In respect of this specific recommendation, working relationships between the police and ACCOUNT have been harder to establish. The reasons for this are both acknowledged and understood. At a meeting with ACCOUNT members (following the publication of the Child Q report), many expressed continuing distrust with the police, frustration that they were 'meeting but not engaging' and that there was a general lack of transparency and respect given ACCOUNT's lack of access to senior leaders. Views were also expressed that different community groups were being 'played off' against each other by the police. In the context of Child Q's experiences, there was also understandable anger and a belief that the police simply didn't understand the issues, or the effects that the actions of its officers were having on communities in the long run. At a local level, it is this inherent lack of trust that the CE BCU need to prioritise if meaningful engagement is ever to be achieved. There are no quick fixes to this. On a positive note, green shoots are emerging. With new leadership at the CE BCU, its Commander and senior staff are making efforts to connect with key stakeholders with an interest in how the police operate locally.

ASSURANCE

Recommendation 8: Where any suspicion of harm arises by way of concerns for potential or actual substance misuse, a safeguarding response is paramount. Practitioners should always contact Children's Social Care to make a referral or seek further advice in such circumstances.

The CHSCP continues to routinely promote the Young Hackney Substance Misuse Service and the Hackney Child Wellbeing Framework which is a key tool to help professionals understand the safeguarding action needed when there is a concern for potential or actual substance misuse. Hackney Education has issued supplementary guidance to reinforce advice on this issue. A pilot has also been developed between Hackney Children's Social Care and the police aiming for all children who come to the notice of the police for substance misuse concerns (as part of a stop and search) to be referred to Hackney's Multi-Agency Safeguarding Hub (MASH).

ASSURANCE

Recommendation 9: The MPS should engage The College of Policing to explore potential improvements to the guidance concerning reasonable grounds involving stop and search activity with children.

The NPCC and College of Policing have worked together to revise and strengthen the available guidance for police officers to help them make good and consistent judgements about what might constitute reasonable grounds to search a child. Whilst determining what is reasonable or not will always attract a degree of subjectivity, mitigations by way of increasing the minimum authority levels for MTIPs should help improve the consistency of decision making. The CHSCP has further recommended that where, in the exceptional circumstances, police officers have reasonable grounds to undertake an MTIP search of a child, they should consider arresting the child and conducting the search in a police station. This will ensure supervision takes place, authorisation is confirmed, an appropriate adult or parent / carer is present and monitoring of the process is strictly applied.

ASSURANCE

Recommendation 10: Alongside Recommendation 3, the Department for Education should review and revise its guidance on Searching, Screening and Confiscation (2018) to include much stronger reference to the importance of keeping records and engaging parents as part of best safeguarding practice.

Specific guidance on record keeping is contained on page 14 of the updated guidance. This sets out a list of what a school should include in their records, such as the reason for the search, who conducted the search and the outcome. Significantly, the DfE has also emphasised the importance of analysing any data collected to help establish whether 'searching is falling disproportionately on any group or groups [and] they should consider whether any actions should be taken to prevent this'. Guidance on informing parents has also been enhanced and is set out on page 15 of the updated guidance. This was absent from the previous version.

ASSURANCE

Recommendation 11 The Home Office and the National Police Chiefs Council should seek to strengthen the Revised Code C, PACE 1984 to better define the engagement of parents / carers / guardians when strip searches that involve the exposure of intimate parts of the body are undertaken on children.

The aim of this recommendation was simply to strengthen the safeguards available to children by way of their parents, carers or guardians being appropriately informed and engaged by the police. This did not happen with Child Q. Disappointingly, at the time of writing the update report, there had been no progress on this matter, with the government choosing to await the outcome of the IOPC's conduct investigation to consider its next steps.

ASSURANCE

Recommendation 12 The CHSCP should engage ACCOUNT, Safer Schools Police Officers and other community organisations to develop an awareness raising programme across schools and colleges about stop and search activity by the police.

The aim of this recommendation was to help educate and empower children to better understand their rights in respect of stop and search activity by the police. Activity included Hackney Education circulating MOPAC's Stop and Search 'Need to Know' guidance to all schools and colleges. Many local schools also include awareness raising around searches as part of their PHSE lessons and a QR code has been developed in partnership between the CE BCU and Hackney Council, which directs children to a range of non-police advice (collated by Young Hackney) that is focused on staying safe, rights awareness and signposting to support.

ASSURANCE

Recommendation 13 The CHSCP should continue with its rolling programme of multi-agency adultification training. Participation should be actively focused on practitioners from the police and schools, with the Training, Learning & Development Sub group developing a process to specifically evaluate impact across these sectors.

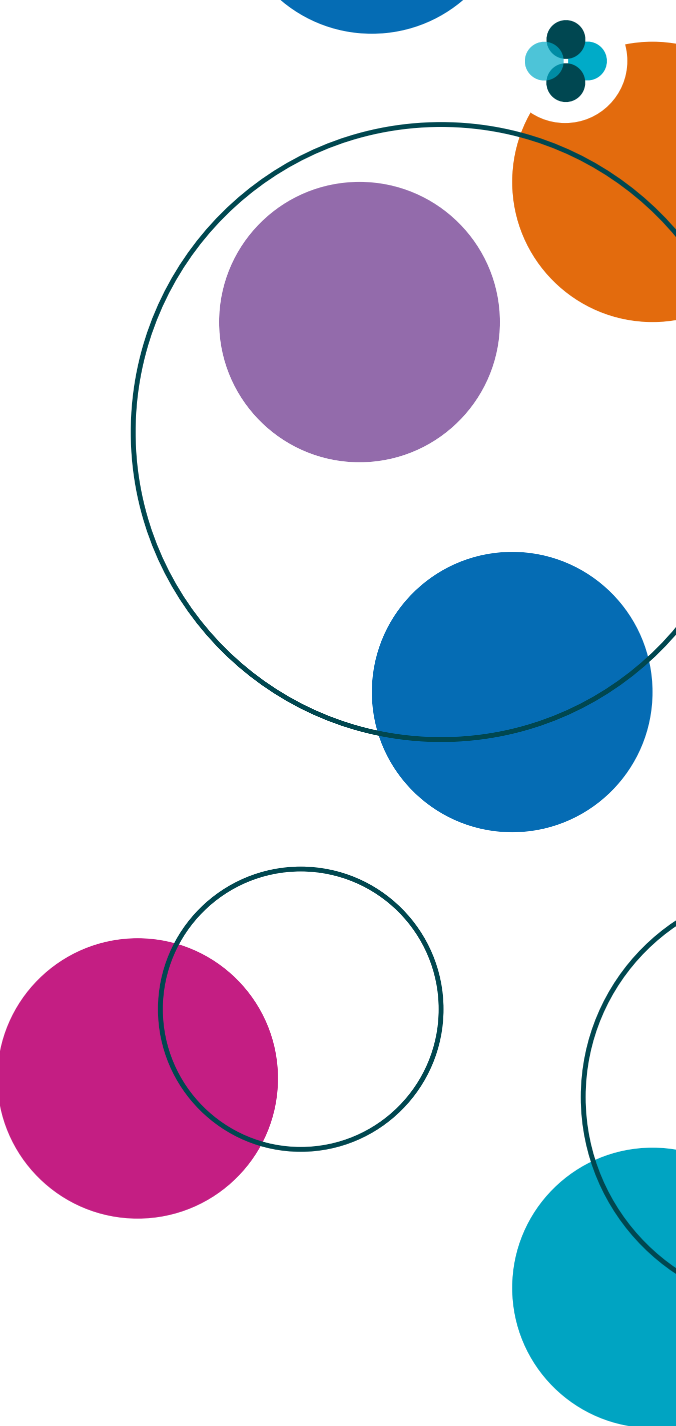
Building on the sessions that had already commenced in 2021, the CHSCP commissioned twice the number of sessions over 2022/23. These continued to explore the concept of 'adultification' from both a research and practice perspective, using case studies, small group discussions and serious case review findings to explore how adultification manifests in practice and its potentially life-long impact. Further details can be found in the training section of the Annual Report.

Page 140

ASSURANCE

Recommendation 14 The CHSCP should expedite its work on developing an anti-racist charter and practical guides that support the eradicating of racism, discrimination and injustice across its local safeguarding arrangements.

Whilst a draft charter was developed, it has yet to be formally agreed. This has not only been caused by some practical issues, but the significant challenges in trying to align a collective position for the numerous agencies for whom the Charter is intended. Many remain in different places in terms of their understanding of racism and acceptance of certain definitions. This is no more evident than through the debate that has arisen following the publication of the Casey's review, and the MPS Commissioner's unwillingness to accept the use of the term 'institutional'. This was used by Baroness Casey to describe the MPS's problems with racism, homophobia and misogyny. It is also linked to feedback on the use of other terminology such as 'Black and Global Majority'. Other agencies, their staff and some of the children we have spoken with do not agree with this as being either an accurate or appropriate definition. These issues require further dialogue to resolve. Whilst this has not prevented the significant activity of many organisations in respect of anti-racist practice, the progress towards agreeing this Charter remains challenging.



Auditing

THE CHSCP'S SELF-ASSESSMENT FRAMEWORK

During 2020/21, the CHSCP launched its new Safeguarding Self-Assessment Framework to help organisations make children safer. It replaced the Section 11 audits and Section 157 / 175 audits with the aim of making the process easier to access and update. Whether an organisation is a safeguarding partner, a relevant agency or named within our local arrangements, there is an expectation that the self-assessment is completed. The Self-Assessment programme engaged Social Housing Providers and Out of School Settings (OOSS) for the first time and demonstrated increased engagement by VCS organisations.

Activity across 2022/23 involved preparation and the re-launch of the Self-Assessment Tool across agencies in the City of London and Hackney. This included a review of current standards and inclusion of updated/new standards including the unacceptability of racism, discrimination and inappropriate behaviour.

ASSURANCE

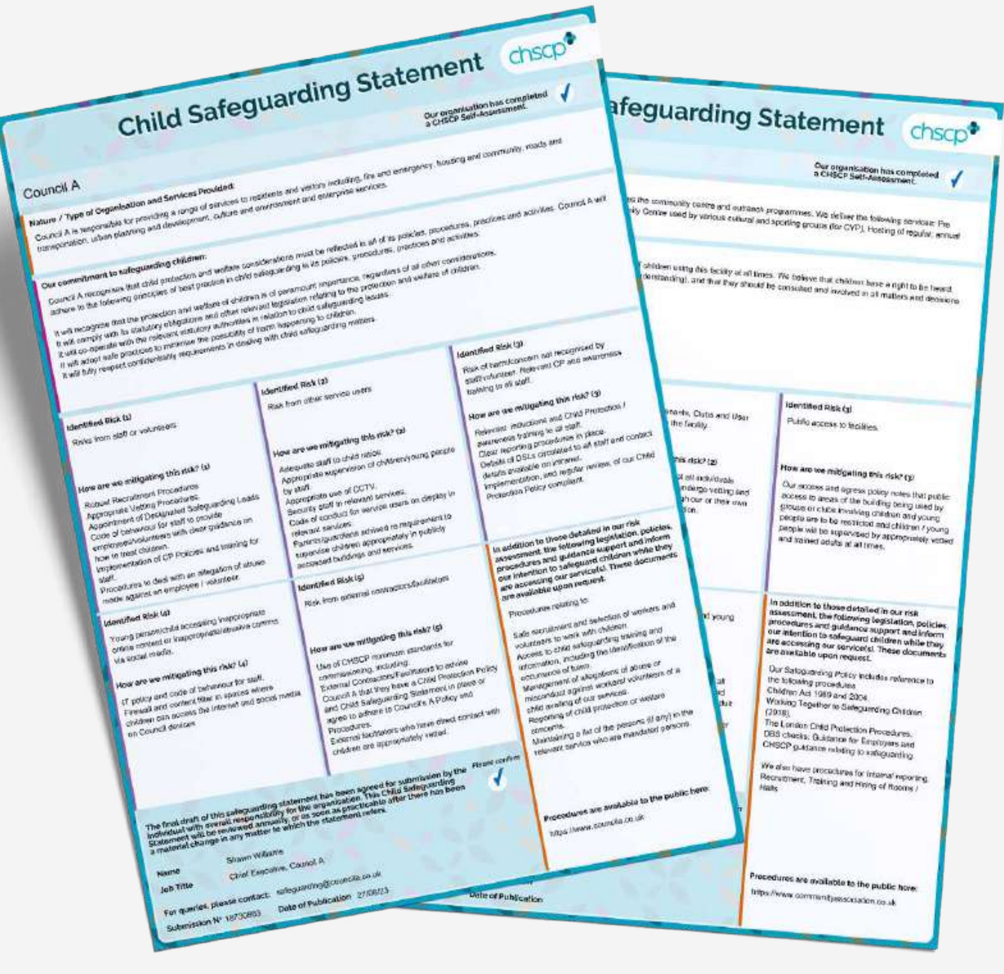
Evaluation of self-assessment returns from the City of London and Hackney provided reassurance about the sufficiency and focus on safeguarding children. There was a generally high response rate of organisations self-assessing as meeting local safeguarding standards. Positively, most standards show either the same (or an increase) in the numbers being fully met. This indicates an awareness of, and the embedding of local standards in organisational practice.

Areas for focus included considering how to consistently engage Out of School Settings and Voluntary & Community Sector Settings about CHSCP training and safeguarding updates and also how to increase engagement by Housing Services (Local Authority and Social Housing Providers). Activity in 2023-24 will include the introduction of Child Safeguarding Statements to support the existing Self-Assessment Framework.

ASSURANCE

Child Safeguarding Statements - In 2022/23, the CHSCP prepared the launch of Child Safeguarding Statements as an additional process to help strengthen leadership and accountability. Developed from a model in operation in Ireland, Child Safeguarding Statements are intended to enhance an organisation's ability to identify potential risks, develop policies and procedures and review whether adequate precautions have been taken to eliminate or reduce these risks. More information can be found HERE.

A pilot has been undertaken with CHSCP member agencies of the City of London / Hackney Safeguarding Children Partnership Boards. Following feedback, it is proposed that the pilot will engage wider Relevant Agencies and Named Organisations in City and Hackney in 2024/25. A live index of organisations and their completed Child Safeguarding Statements will be hosted on the CHSCP website. Whilst not an official accreditation, this will provide a public directory of agencies that have cooperated with the CHSCP's written safeguarding arrangements.


Child Safeguarding Statement
chscp
Council A

MULTI-AGENCY CASE AUDITS

The Multi-Agency Case Auditing programme was further developed to focus on specific areas of the safeguarding system. This has allowed multi-agency partners to increase the number of auditing rounds and the breadth of scrutiny whilst adapting rapidly to local or national intelligence. This auditing methodology has received excellent feedback from partners and lessons identified have led to tangible improvements. All audits result in an outcome focused action plan that the CHSCP uses to track and evidence improvements in front-line practice. Learning is also disseminated to front line staff via the Things You Should Know (TUSK) monthly briefings.

In 2022/23, the CHSCP utilised the in-house expertise of the partnership as well as an externally commissioned service (to provide another level of independent scrutiny). Early in the year, a short delay in the programme occurred due to refocusing the audit theme on the national review into the murders of Arthur Labinjo-Hughes and Star Hobson - Child Protection in England. On publication (in May 2022), it was agreed to evaluate the sufficiency of multi-agency meetings, specifically CIN meetings and Core Groups.

An external audit of CSA was undertaken in Spring 2023, with the findings feeding into a Live Learning Event hosted by HCFS. CSA will be a focus of a multi-agency case audit and full findings will be shared in next year's annual report.

ASSURANCE

Focusing on the CHSCP's priority to be actively anti-racist, the QA Sub-Group ensured that audited cases were sufficiently reflective of the local demographics and ethnicities of local children and families. The audit tool was also strengthened to evaluate anti-racist practice as a specific theme. This focus will continue in future rounds. In 2022/23, it was agreed to disseminate learning and seek to capture evidence of impact of each audit undertaken in both Hackney and the City of London (regardless of which area the audit cases originated from). This will help build up an evidence bank of shared learning across the partnership.

ASSURANCE

In June 2023, the ISCC wrote an open letter to all staff emphasising the importance of multi-agency engagement and strong teamwork - Together Everyone Achieves More (TEAM). Acknowledging the lessons arising from the Child Protection in England report by the national panel and the CHSCP's local audits, this letter set out a range of minimum expectations based on established procedure and both national and local learning. Read the letter HERE.

EVIDENCE & LEARNING

The audit of multi-agency meetings demonstrated that:

- Whilst attendance at multi-agency meetings was generally good, some agencies were not being routinely engaged. Identified areas for improvement related to the scheduling of meetings, where invitations were being sent and how opportunities to facilitate attendance could be enhanced. The audits also identified the need for all practitioners to have access to available support following their attendance at these often-challenging meetings.
- Professionals are proactively sharing information and updates during and between multi-agency meetings. Identified areas for improvement related to the sharing of reports with families, the sharing of minutes and ensuring that information requests made by Children's Social Care to other agencies were clear in explaining the reasons why such a request was being made.
- There was inconsistency in how meetings were being recorded. In examples of good practice, some minutes had woven narratives around the plan into the minutes whilst in other cases, minutes were brief, and it was not possible to discern exactly what information was shared and whether the plan had been discussed in detail at the meeting. Issues were also identified around capacity and skill sets for organising, chairing and minutes of the meetings, which were often undertaken by Local Authority staff. The audits identified the need to review sharing the resourcing for these meetings within the wider partnership.
- Plans were clear and supported good practice. In general they were multi-agency in focus, and it was clear who tasks were allocated to. Areas for improvement were identified around plans being more focused on the outcomes trying to be achieved, ensuring there was a sufficient focus on all children in a family and ensuring actions were explicit for all parents / carers - as opposed to these being heavily weighted towards mothers.
- In Hackney, practitioners were exploring issues around diversity. In the City of London the external audit provided evidence of exploration around issues arising from diversity and this was also evidenced as happening within 1:1 and group supervision sessions. In both local areas, there was good use of interpreters where necessary. The audits identified that support is needed to help professionals explore the impact of racism with the families with whom they work. The CHSCP's Active Anti-Racist Charter is intended to help in this regard and will be released shortly.

- In both Hackney and in the City of London professionals were actively engaging children, young people and family members. Contributions from parents (mostly mothers) were included in the minutes and they were allocated tasks in the plan, along with other members of the network. The audits also demonstrated that the lived experiences of children (where age appropriate) were being explored with children and young people and that the voice of the family was being recorded in meetings. Where appropriate interpreters were used to engage families. A focus on fathers was demonstrated, in particular in Hackney where work with male perpetrators of domestic abuse was featured in plans. Overall, the audits demonstrated that despite some parental non-engagement, practitioners continued to work together and to build bridges with families. The audits identified that children could be better engaged to attend meetings or for advocacy arrangements to be used.

IMPACT

The audits identified that the correct pathways were being used to invite health professionals to multi-agency meetings.

There had been updates to the City of London Mosaic system to consistently record meeting attendees and recipients of meeting minutes. Internal practice standards have also been set which require the sending of all CIN and Core Group meetings to GP Practices. Administrative resources now facilitate the process of minute taking and distribution to aid consistency.

A City of London Early Help practitioner now attends the multidisciplinary team meeting at the GP Practice.

Findings from the audit have been shared with the Safeguarding Adults Board to support the engagement of adult services, with the audit findings supporting the development of new Think Family guidance.

The audits established reassurance that information requests are sharing the details about why information is being requested and the nature of the concern involving the children.

SINGLE AGENCY AUDITING

Partner agencies of the CHSCB have continued to operate a variety of single agency quality assurance frameworks to maintain oversight on safeguarding and promoting the welfare of children and young people. Examples of audits undertaken are below:

LEARNING

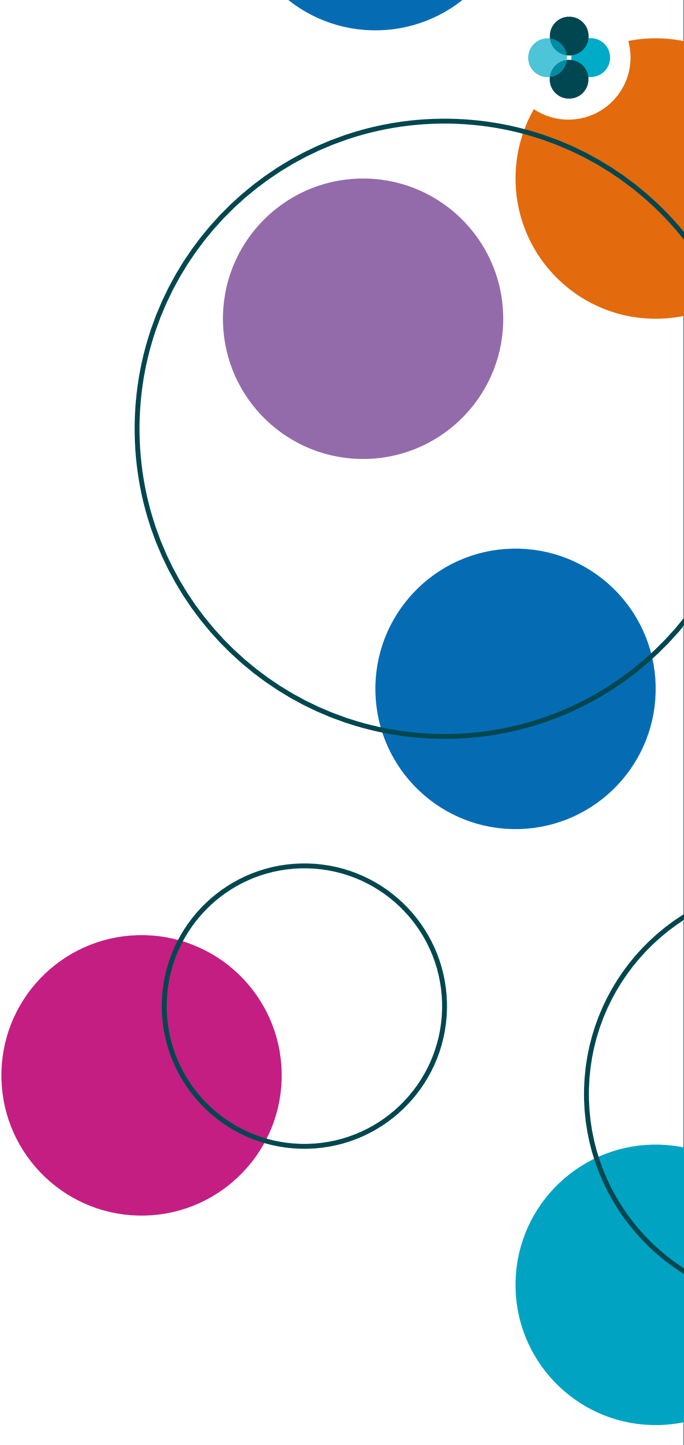
NEL ICB - An audit by NEL ICB looking at the quality of GP submissions found that GPs who did not use the templates were more likely to not include medical information about parents. Information was disseminated to GPs about how to locate information sharing proformas and the importance of sharing parental medical information.

LEARNING

Metropolitan Police Service - An MPS audit recognised the need to implement best practice of creating prompt Computer Aided Dispatch Briefings for all unborn children at risk. Controller Inspectors were briefed and up skilled on their significance to ensure an appropriate response to any triggered call for assistance by social workers. Social workers are individually briefed by the Police Conference Liaison Officers to ensure the CAD reference is to hand should they need to trigger any requirement for urgent assistance.

LEARNING

Homerton Healthcare NHS Foundation Trust - Homerton undertook a follow-up audit (first undertaken in 2015) to review the outcome when referrals were made to CSC. Findings indicated a decrease in cases assigned as no further action by CSC. In addition, all cases that were selected were discussed at the weekly paediatric psychosocial meeting demonstrating that when safeguarding concerns are identified by Homerton staff that the children and young people are discussed in a multi-professional meeting to ensure that all follow up is completed. There was also improvement noted by all services completing referrals by the health professional who identified the safeguarding concern. Staff on the acute site have been able to complete referrals on Electronic Patient Record since 2018 which has improved the timeliness of the referrals being made.



EVIDENCE

Hackney Children and Families Services (HCFS) - As part of its Quality Assurance Framework, HCFS undertakes regular thematic auditing of cases. In 2022-23, outcomes were as follows:

- Care leaver parents (June 2022): 40% of audits were rated as good and 52% rated as requires improvement.
- Domestic abuse (December 2022): 55% of audits were rated as good and 39% rated as requires improvement.
- Sexual harm (March 2023): 67% of audits were rated as good or outstanding and 26% rated as requires improvement.
- Life story audit - November 2022: 67% of these audits rated good or better for overall practice.
- Disabled Children's Service looking at children's assessments and plans: 64% rated as good or outstanding.

HCFS also monitors the impact of auditing; three months after an audit has been completed that was scored 'Requires Improvement' or 'Inadequate', a review of the work completed by the auditor is undertaken by Practice Development Managers across HCFS and the findings from the audits are shared with leaders. As a consequence of this monitoring, there has been an increase in the percentage of files improving in ratings of good practice (59% of dip sampled cases showed improvement in April 2023 compared with 65% in June 2023).

IMPACT

The City of London Corporation - As part of its Quality Assurance Framework, the City of London undertakes a quarterly independent audit of cases open to the Children's Social Care team. One of the audits focussed on the impact of social work practice on the children and families they worked with. The findings included that:

"...the quality of relationships between practitioners, children, young people and families continues to be of a high quality with pieces of excellent practice identified in many of the cases".

"Assessment and planning were found to be thorough, regularly reviewed and child centred. Plans would be strengthened by ensuring that outcomes are specific to the child and not a service, by being specific about who is responsible for delivering actions in the plan and particularly where a parent is required to complete an action, so they are clear about the local authority's expectations."

An area for development was identified as being that *"Social workers shared that they felt supported by their managers, however this was not evident on files where supervision records had not been uploaded for some time."* The issues identified in the audit were progressed and signed off at a meeting chaired by the Assistant Director of People Directorate.

Out of the 10 cases, one was identified as excellent, eight were good and one case required improvement. Recommendations from these audits were completed within a 6-week timeframe from the completion of the audit.

EVIDENCE

Following publication of the Serious Case Review for Child A in 2021, it was recommended that health providers undertake an audit of paediatric community and inpatient records to ensure that children accessing health care have been involved in an age-appropriate way at each stage of their care planning, and had their views listened to and considered. A summary of the audit report by Homerton Healthcare is detailed below.

An audit of children's notes randomly selected from specific outpatient clinics was undertaken (chosen based on the assumed complexity of the medical needs of children attending). Reviewers objectively reviewed notes to ascertain if attempts were made to see the child alone, and to determine if the voice of the child had been documented. 81 children's notes were reviewed, with 271 appointments attended. In the hospital setting the voice of the child was well documented in 15% of the notes reviewed compared to 37% of those attending community-based appointments. The cohort of children selected had known communication difficulties, 12% of patients seen at the hospital and 75% in the community, which will have impacted on the ability of practitioners to document their voice. This audit highlighted that there is no consistent method of capturing a child's voice in health care settings. Despite education regarding the importance of capturing the child's views about their health care, this continues to be poorly documented in health records. The nature of medical records however means that it is extremely difficult to determine the extent of the child's input into conversations held when reviewing notes at a later date. Changing the way the consultation is documented may help with this. Capturing the voice of the child is significantly harder for non-verbal children and further education and support needs to be given to all health practitioners working with children to ensure that every child's voice is heard.

Audit recommendations include:

- Training on how to capture the voice of the child for all health practitioners, focusing especially on non-verbal children. This could be provided in a variety of formats to make it accessible.
- Changes to documentation standardly used in the emergency department, paediatric wards and outpatients if required to clearly identify the adults accompanying the child, whether the child is seen alone, and if not the reasons for this, and to clearly document the child's participation in the consultation.
- Paediatric consultants and trainees to be encouraged to attend the RCPCH training on fabricated illness.

Results of the audit were also shared with paediatric staff to encourage better documentation of the voice of the child.

Page 150

The Voice of the Child, Family & Community

EVIDENCE

As part of the engagement activity feeding into the Child Q Update Report, the Independent Child Safeguarding Commissioner engaged with over 100 children and young people and parents, carers and members of the community. Their authentic voices were invaluable in helping to develop the report's additional findings and recommendations.

EVIDENCE

Homerton University Hospital NHS Foundation Trust uses a range of mechanisms to capture the feedback of service users which includes, but is not limited to, electronic surveys, the Friends and Family Test and complaints. Information is collected through hand held devices or electronic survey links are sent to the parents. The impact of the pandemic and the reduction in face-to-face contact with children and families impacted on collecting service user

Page 151

EVIDENCE

ELFT CAMHS has strong People Participation work and they run a group with young people, families and carers several times a year. ELFT has a dedicated people participation lead for East London and as part of its recruitment processes, service users are included on the recruitment panels for staff. Service users are encouraged to prepare their own questions for candidates, based on their own experiences of the care they have received from CAMHS. As part of the feedback, the young people recommended that the advert focus less on the processes involved in the job and more on the impact doing this job will have on young people. The feedback was used by the panel to improve the advert.

In one-to-one conversations, participation groups and online surveys, feedback was also sought about the service user experience of the assessment process.

Feedback indicated that service users were unclear about many aspects of CAMHS. Amongst a range of issues, this included how cases are assessed and prioritised, the expected length of waiting times, available support and how best to prepare for assessments.

To drive forward improvements in communications, a working group was formed involving young people and parents. Areas for improvement were identified as making videos (to explain what to expect at certain points), diagrams / maps / flow charts as visual aids, improved webpages, improved letters, text updates, pathway leaflets, new noticeboard displays, and waiting room TV displays.

EVIDENCE

The NEL ICB System Influencers Programme aims to:

- Increase the voice of young people to directly inform how services are designed and delivered
- Increase Health and Social Care professional understanding of the barriers faced by young people
- Help young people feel more valued and gain confidence, experience and qualifications, which lead to better outcomes.
- Create more opportunities for local young people to become part of the City and Hackney workforce.

System Projects which young people worked on included:

- Data analysis in Quality Improvement Programme, Homerton Hospital
- Marketing and Communications in Quality Improvement Programme, Homerton Hospital
- Physical Activity and Healthy Weight in CYP, Public Health, and
- CYP Community Navigation Project, Neighbourhoods

EVIDENCE

The City of London Corporation commissions Action for Children to complete an annual survey of all the children and young people open to the Children's Social Care Team and Early Help Service. This survey is completed by someone independent from the city, and the information is anonymous, so children and young people can speak freely. This survey is shared across the organisation, with partner agencies and Members, so that any learning from this survey can be acted on. The 7th annual survey was undertaken in 2022-23. A summary of feedback developed by City of London notes:

- Feedback in general remained positive: there were clear strengths identified by service users, particularly in Early Help and Children in Need, where overall satisfaction of families increased to 66% from 53% in the previous year; and 100% of these families feel included in the development of their Child in Need Plan and its review and believe that this has been explained to them adequately.
- The strength of relationships for children in care was notable: 100% of children in care spoken with said they were able to contact their social workers. Children in care also unanimously felt safe where they are living, and happy with the support they received from a range of professionals, including the Independent Reviewing Officer, participation worker and Virtual School.
- The largest cohort of survey participants were care leavers: 91% felt 'comfortable and easy' to contact their worker, 83% felt that they see their worker at an appropriate frequency, 81% of care leavers were happy with where they live, and 75% felt that the education they accessed was good or very good, an increase from 59% in the previous year.
- Common themes of concern in relation to accommodation issues were noted as: lack of space, awaiting permanent accommodation; location of available accommodation options, and social isolation due to this. Moving through services, and workers leaving were also areas that some respondents found difficult, particularly those who have been involved with services for many years. There was also feedback around lack of clarity in relation to some processes and how services worked together, specifically in relation to children with Special Educational Needs and the Education, Health and Care Plan process.
- Feedback will take the form of a 'You Said, We Did' response to the survey, which can be circulated in written format and via an online template.
- A longitudinal review by the Head of Safeguarding and Quality Assurance will also be undertaken to assess the impact of the surveys on service delivery over time and ascertain how this has changed the experiences and feedback of those working with Children's Social Care and Early Help.

EVIDENCE

Feedback received by Hackney Council from children and families has included:

Clinical Service Team - In 2022/23, a Liaison and Diversion participation group was run over 8 weeks with 10 young people. The young people gave feedback on their experiences with CAMHS and the Police:

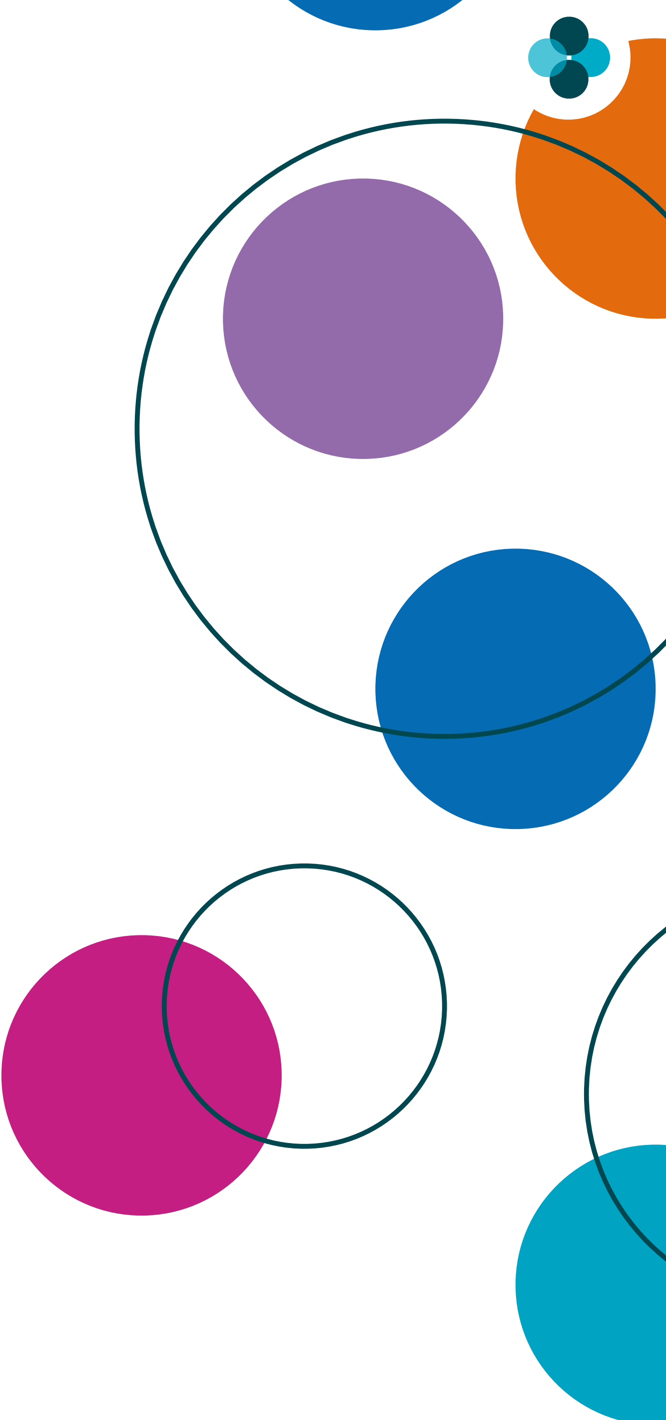
- They would like to re-name the clinical service to be called 'Mental health protection and prevention service'.
- They would like there to be more young black clinicians available, safe places to see meet where they feel welcome, and to have food provided. Young people also expressed they needed workers to give them time alone when needed and breaks between sessions.
- Feedback on the 'ideal police officer' was varied, with comments including: someone who is young, understanding and respectful of boundaries; someone that has time, is non-judgemental, and asks 'how do you want to be helped?'; and someone who is able to make a change is older and has experience.

An Open Letter to Hackney Council - In October 2022, Hackney of Tomorrow (the Children in Care Council) members wrote an open letter to Hackney's Corporate Parenting Service outlining their view of what it is to be a Corporate Parent and how Hackney Council can best live up to this role. The letter was sent to Service Managers within Hackney's Corporate Parenting Service, as well as Local Councillors and was discussed at Hackney's Corporate Parenting Board and incorporated into the Council's 2023/25 Corporate Parenting Strategy. This autumn, HCFS recruited two new Care Leavers Ambassador posts, to support the work of HoT and to become full-time members of the Corporate Parenting Board, to represent the voice of care leavers.

Support from Children's Rights Officers - There were three responses received between April 2022 and December 2022. Overall, children felt positive about the support they received from their Children's Rights Officer (CRO).

- In response to the question 'How did your CRO help you?', 1 person felt their CRO helped them to share their views, 1 person felt their CRO helped them by attending meetings with them, 1 person stated 'other'.
- All 3 felt that their CRO listened to their views, ensured they were involved in decisions that affected them, were treated equally and fairly, understood their situation better since working with their CRO and their CRO helped them to resolve the issues they were unhappy with.
- All 3 felt they knew how to make a complaint about Hackney Children and Families Service.

Domestic Abuse Intervention Service - 97% of clients (35) felt positive about the support received from the Domestic Abuse Intervention Service (DAIS). 94% would recommend the service to friends and family who needed help and 86% felt that DAIS took their cultural needs into consideration. 91% felt safer following involvement from DAIS.



Page 156

Young Hackney - A range of feedback has been provided by children, young people and families about the impact that Young Hackney Services have had upon their lives.

Feedback from a parent: 'Thank you for spending time with [child] over the last few weeks. [Child] has enjoyed talking to you and sharing her thoughts with you. Personally, I want to say thank you for showing up for her and coming when you said you would. It's the little things that mean a lot to her. Also your insight into how we can better communicate and navigate through our emotions were very helpful'.

Feedback from a child: 'Our conversations helped me a lot as I was able to understand things in a different perspective. Our little walks around the area were fun, thanks for seeing me for me'.

Feedback from a parent: 'I was blown away by the support we received from [Practitioner] from Young Hackney, it was beyond my expectations, and I will always be grateful for the guidance my son, and I received. Not only did [Practitioner] create a great space for the family to be open, but he was quick to grasp the intricacies of the post-separation abuse my family suffers, without judgement. In addition to doing a cracking job in helping [Child] manage his emotions, ([Child]'s mood visibly improved for days after each meeting, which accumulated as the sessions progressed), he provided solid guidance and support for me when dealing with Hackney Children Services. Furthermore, when [Child]'s frustrations flared up recently, [Practitioner] made an appointment to see [Child] without hesitation! [Child] and I wish to thank [Practitioner] and Young Hackney for helping my family through a tricky time. He is truly a 'man of the people'.

Performance Data

Activity during 2022/23 focused on the ongoing review of the CHSCP dataset and the development of new dashboards by the CHSCP's Business & Performance Manager. Introduced across Hackney and the City of London, these dashboards provide a much clearer overview of the themes, patterns and trends relating to the key safeguarding metrics. Plans to build on the CHSCP's initial strategic threat assessment have been paused, primarily due to the departure of the fixed-term role that was expected to cover this activity, and a lack of available capacity in the existing team. This will be revisited in 2023/24.

Page 157

Front-Line Intelligence

ASSURANCE

Staff Survey 2023

For all organisations involved with safeguarding children and young people, staff and volunteers are their most important asset. It is for this reason that the CHSCP has applied a focus upon the health of the workforce since 2017/18. The CHSCP Staff Survey was developed through 2022/23 and issued in February 2023 with several of the questions aimed at triangulating organisational responses from the submitted Self-Assessments and providing reassurance around the CHSCP safeguarding arrangements, the CHSCP's priorities (including Health & Stability of the Safeguarding Workforce) and key practice themes. Given the overall increase in activity across the partnership and the emotional complexity of many safeguarding cases, it is positive to note that in the 2022/23 survey, responses have remained overall positive.

- In total, there were 335 responses received from across the partnership.
- This is a 33% decline in overall response rates since the last Staff Survey in 2018/19.
- Early Years and Education Settings provided the highest number of responses in Hackney.
- Education Settings and Housing provided the highest number of responses in the City of London.

Overall, themes from the Staff Survey provide reassurance about organisations prioritising safeguarding children, access to induction and training, policy and procedures and confidence in practice. Whilst workload was deemed manageable, there were feelings of being at capacity and under pressure to deliver against workloads.

Understandably, concerns were noted around the impact of the cost-of-living crisis, especially the cost of commuting when asked to return to the office. Whilst respondents had been thinking about changing roles, there was an awareness that the cost-of-living impact was a national and not local issue which would not be addressed by moving roles. Respondents felt that organisations should continue raising awareness of support for staff; this could help organisations retain the workforce resulting in stability for service users. A breakdown of the response rates and some of the responses are provided below.

Page 159

THE CITY OF LONDON'S WORKFORCE

52 responses from the City of London. **32** working cross-borough.

27% decrease from the last staff survey in 2018/19.

57% of respondents from the City of London and **65%** of respondents working cross-borough **work directly with children and young people and families ('direct'). The remainder do not work directly with children and families but will have contact with them ('non-direct').**

96% of direct and **91%** of non-direct staff strongly agreed or agreed that their organisation prioritises the safeguarding of children.

98% of direct and **79%** of non-direct staff strongly agreed or agreed that they knew who the key safeguarding leads within their organisation were and how to contact them if there is a concern.

94% of direct and **49%** of non-direct staff indicated they received an induction that covered safeguarding children when joining their organisation.

76% of direct and **85%** of non-direct staff indicated they never or rarely had to cancel or rearrange previously agreed training or development activities due to case work demands.

92% of direct and **76%** of non-direct staff strongly agreed or agreed their organisation's child protection / safeguarding policies and procedures are detailed and provide them with step-by step guidance on what to do.

71% of direct and **39%** of non-direct staff knew how to access and use the relevant threshold tool (Hackney Child Wellbeing Framework and / or the City of London Thresholds of Need).

82% of direct and **79%** of non-direct staff strongly agreed or agreed that they felt confident knowing what to do if they disagreed with another professional about their actions or decisions.

94% of direct and **88%** of non-direct staff strongly agreed or agreed that they were confident they would know what to do if concerned about the behaviour of a professional working with or having access to children and young people.

94% of direct and **100%** of non-direct staff strongly agreed or agreed that they had a clear understanding of what anti-racism means and what it is to be anti-racist in practice.

92% of direct and **97%** of non-direct staff strongly agreed or agreed that they had sufficient understanding and confidence to be able to challenge racism or microaggressions in practice.

82% of direct and **94%** of non-direct staff felt their workload was

manageable.

82% of direct and **76%** of non-direct staff strongly agreed or agreed that they could raise concerns if their workload was too high, and that action would be taken to support them.

94% of direct and **88%** of non-direct staff have access to good quality supervision.

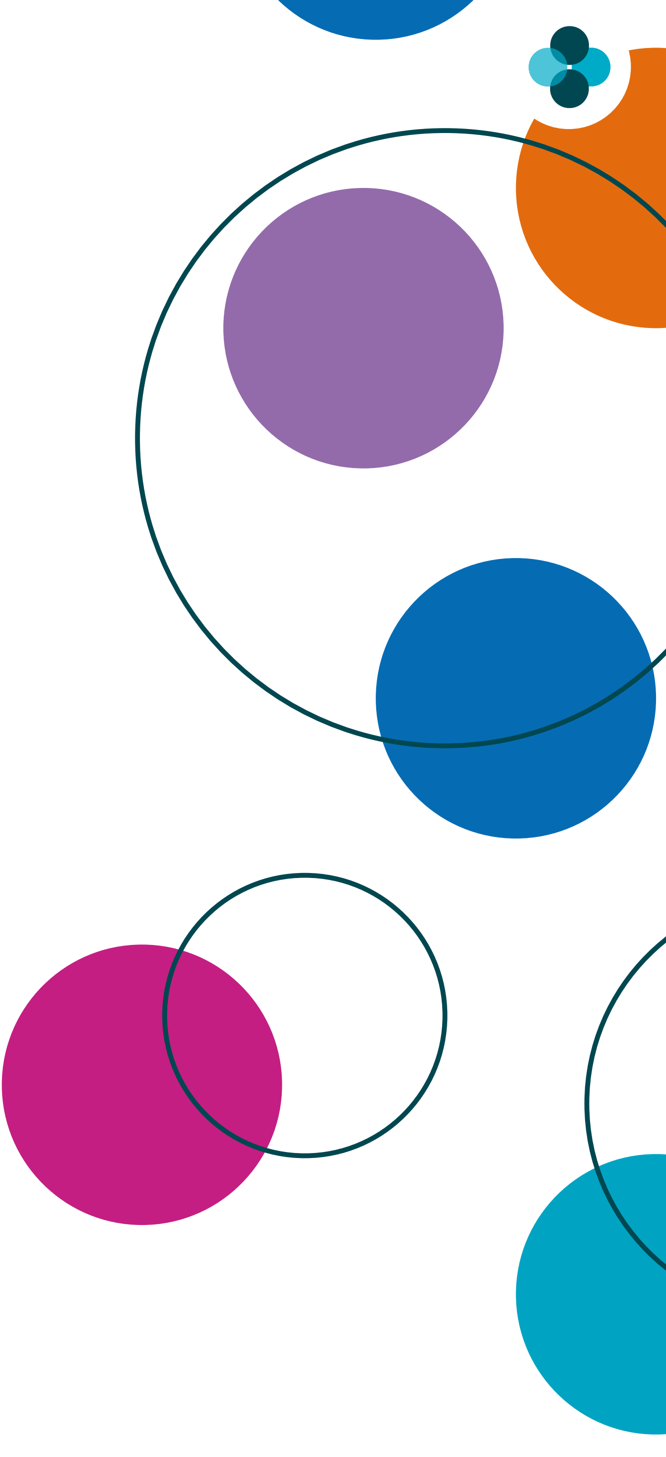
77% of direct and **70%** of non-direct staff strongly agreed or agreed that their supervision routinely focuses on helping them to 'think family' and consider the needs of all individuals that they work with directly or with whom they have contact.

73% of direct and **82%** of non-direct staff strongly agreed or agreed that their supervision routinely covered whether the children they are working with have been seen and spoken to and agreed actions where this hasn't happened.

90% of direct and **58%** of non-direct staff indicated they were alerted to the publication of a CHSCP review by their organisation and made sure they were aware of relevant learning.

43% of direct and **18%** of non-direct staff strongly agreed or agreed that the cost-of-Living crisis is negatively impacting upon their effectiveness at work.

37% of direct and **30%** of non-direct staff strongly agreed or agreed that they were thinking about changing their job due to the cost-of-living crisis.



Page 161

HACKNEY'S WORKFORCE

251 responses from Hackney. **32** working cross-borough.

34% decrease from the last staff survey in 2018/19.

80% of respondents from Hackney and **65%** of respondents working cross-borough **work directly with children and young people and families ('direct'). The remainder do not work directly with children and families but will have contact with them ('non-direct').**

98% of direct and **98%** of non-direct staff strongly agreed or agreed that their organisation prioritises the safeguarding of children.

96% of direct and **94%** of non-direct staff strongly agreed that they knew who the key safeguarding leads within their organisation were and how to contact them if there is a concern.

97% of direct and **81%** of non-direct staff indicated they received an induction that covered safeguarding children when joining their organisation.

72% of direct and **77%** of non-direct staff indicated they never or rarely had to cancel or re-arrange previously agreed training or development activities due to case work demands.

96% of direct and **90%** of non-direct staff strongly agreed or agreed their organisation's child protection / safeguarding policies and procedures are detailed and provide them with step-by step guidance on what to do.

62% of direct and **62%** of non-direct staff knew how to access and use the relevant threshold tool (Hackney Child Wellbeing Framework and / or the City of London Thresholds of Need).

89% of direct and **89%** of non-direct staff strongly agreed or agreed that they felt confident knowing what to do if they disagreed with another professional about their actions or decisions.

98% of direct and **94%** of non-direct staff strongly agreed or agreed that they were confident they would know what to do if concerned about the behaviour of a professional working with or having access to children and young people.

90% of direct and **94%** of non-direct staff strongly agreed or agreed that they had a clear understanding of what anti-racism means and what it is to be anti-racist in practice.

73% of direct and **87%** of non-direct staff felt their workload was manageable.

73% of direct and **81%** of non-direct staff strongly agreed or agreed

that they could raise concerns if their workload was too high, and that action would be taken to support them.

85% of direct and **87%** of non-direct staff have access to good quality supervision.

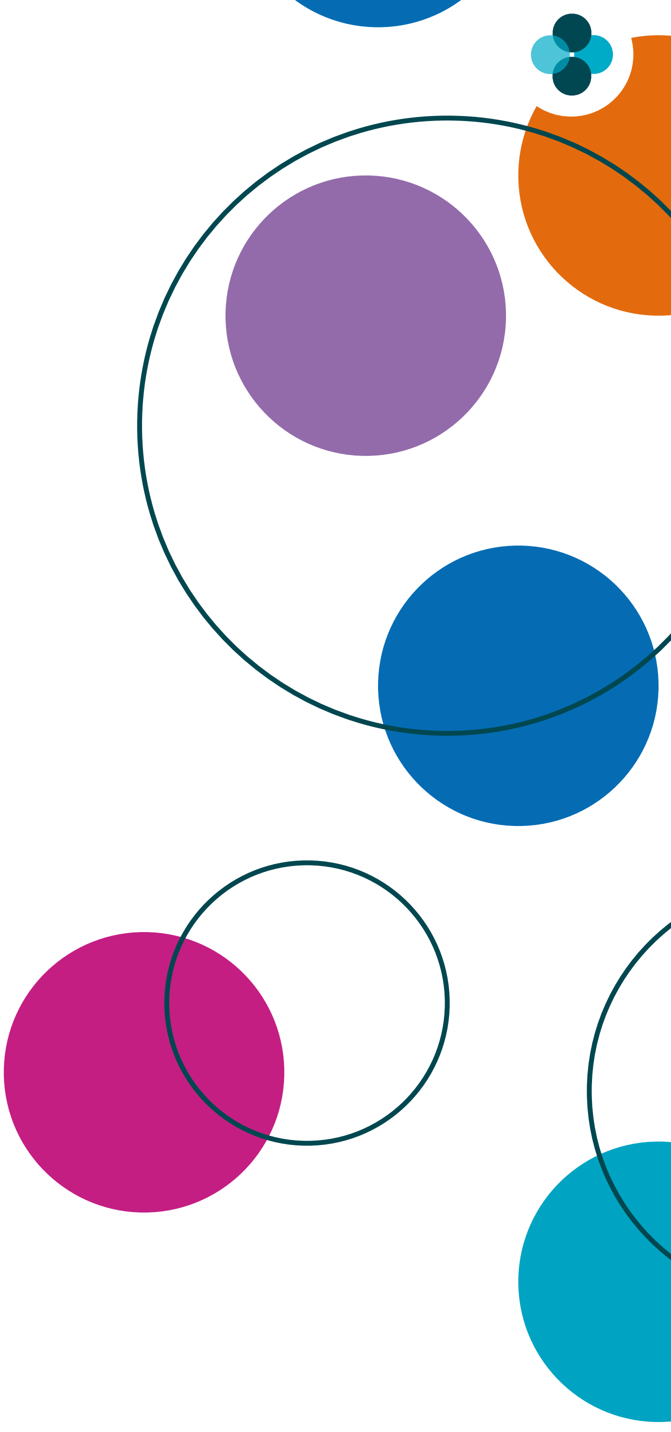
68% of direct and **68%** of non-direct staff strongly agreed or agreed that their supervision routinely focuses on helping them to 'think family' and consider the needs of all individuals that they work with directly or with whom they have contact.

64% of direct and **11%** of non-direct staff strongly agreed or agreed that their supervision routinely covered whether the children they are working with have been seen and spoken to and agreed actions where this hasn't happened.

78% of direct and **79%** of non-direct staff indicated they were alerted to the publication of a CHSCP review by their organisation and made sure they were aware of relevant learning.

43% of direct and **39%** of non-direct staff strongly agreed or agreed that the cost-of-living crisis is negatively impacting upon their effectiveness at work.

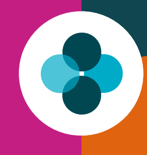
40% of direct and **42%** of non-direct staff strongly agreed or agreed that they were thinking about changing their job due to the cost-of-living crisis.



External Learning

As a learning organisation, the CHSCP is constantly looking outwards to identify learning that can help improve practice across the City of London and Hackney. Where relevant, national reviews and inspection reports are considered by the CHSCP. Links to NSPCC thematic briefings and wider learning from other local areas continue to be disseminated to front-line staff via CHSCP training and TUSK briefings.

Page 163



Training & Development

Training Summary 2021/22

The training opportunities offered by the CHSCP are designed to meet the diverse needs of staff at different levels within the wide range of organisations that work with children, young people, or adult family members. Sessions range from those that raise awareness about safeguarding and child protection to specialist topics aimed at more experienced staff. The training programme focuses on areas of practice prioritised by the CHSCP, with learning from local and national case reviews integrated into the training material. As a result of the pandemic, the CHSCP's training programme rapidly pivoted to virtual delivery and currently remains as such. The CHSCP team and trainers were swift to adapt and overall, attendance figures continue to increase from 2019/20 to present day. Feedback also remains positive with the programme continuing to improve the knowledge and skills of the safeguarding workforce.

Page 165

EVIDENCE

- **56 training sessions** were held in 2022/23 (47 in 2021/22 and 70 in 2019/20).
- **21 safeguarding topics** were covered.
- **52 of 56 courses were delivered virtually** over a 12-month period.
- **2217 available training places**, 1121 attended.
- Of the **1718 booked places**, 1121 delegates attended, 252 (14.7%) either cancelled or 345 (20.1%) did not attend the course (an increase from a combined total of 29% in 2021/22).
- **70.4%** of attended bookings are attributed to practitioners working in **Hackney**, **11.2%** in the **City of London**, and **18.4%** working across **both Boroughs**.

EVIDENCE

The following list highlights the number of each course held with the number of delegates and the trend from 2021-22 indicated in brackets:

- **18*** An Introduction to Adultification courses **(363↗)**.
- **2*** Child Criminal Exploitation and County Lines **(33↗)**.
- **2*** Child Sexual Abuse Education **(26↗)**.
- **2*** Children's Wellbeing and Mental Health courses **(45↗)**.
- **3*** Designated Safeguarding Lead (Level 3) courses **(109↘)**.
- **2*** Early Help and Hackney Child Wellbeing Framework courses **(53↗)**.
- **1*** Early Help Pathway, Request for Support Form, and Assessment course **(19↗)**.
- **1*** FGM and Breast Flattening course **(31↗)**.
- **3*** Impact of Neglect and Emotional Abuse on the Development of Children and Young People courses **(56↗)**.
- **2*** Improving Professional Participation in Child Protection Conferences courses **(23↗)**.
- **1*** Incel Ideology & Extreme Misogyny Training course **(3↗)**.
- **1*** Intra-Familial Child Sexual Abuse course **(17↗)**.
- **1*** LADO: Allegations Against Staff and Volunteers course **(8↗)**.
- **1*** Non-Recent Child Sexual Abuse course **(14↗)**.
- **2*** Police Procedures courses **(18↗)**.
- **1*** Protecting Children and Vulnerable Adults from Abuse Linked to Faith or Belief course **(13↘)**.
- **4*** Safeguarding Children Basic Awareness (Level 1) courses **(158↘)**.
- **1*** Safeguarding Children with Disabilities course **(11↗)**.
- **3*** Safeguarding in a Digital World courses **(45↗)**.
- **3*** Safer Sleep courses **(60↗)**.
- **1*** Working with Cultural & Economic Diversity course **(15↘)**.

Page 166

EVIDENCE

Over the course of 2022/23, 18 Adultification sessions were delivered to the partnership (representing a 100% increase on 2021/22). A total of 268 practitioners attended, with 66 others booking, but cancelling. As of March 2023, 438 practitioners had received this training.

ASSURANCE

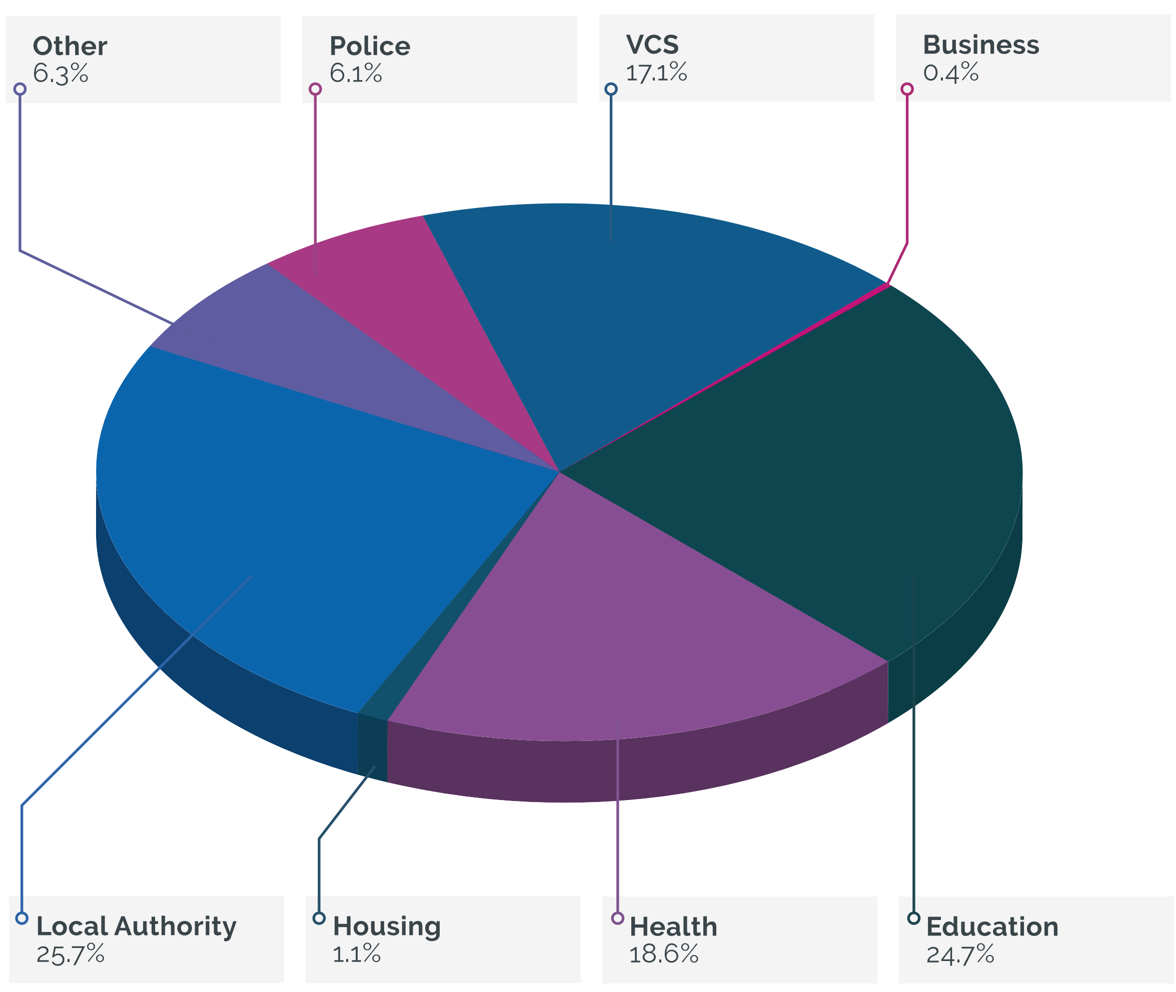
The PHEW learning management system has been a great addition to the training element of the CHSCP. It has helped to reduce admin time in terms of not having to download registration and evaluation data from multiple sources and the training coordinator not having to produce individual certificates for delegates. In addition, the system sends calendar invites for each course, booking confirmations and reminder emails to delegates. Delegates are now able to download pre-course materials up to one week prior to their training session, and post course materials following their attendance being recorded online. Delegates are also able to print their own certificates after completion of the evaluation form for the relevant course.

Page 167

DELEGATE BREAKDOWN

Sector	Number	Percentage
Business	4	0.4%
Education	277	24.7%
Health	209	18.6%
Housing	12	1.1%
Local Authority	288	25.7%
Other	71	6.3%
Police	68	6.1%
Voluntary and Community Services	192	17.1%
Grand Total	**1121**	**100%**

Page 168



EVALUATION

Supported by its Training Evaluation and Analysis Framework, the CHSCP continues to monitor and evaluate the effectiveness of its core training programme. Work undertaken to review the quality of training in 2022/23 has enabled the CHSCP to gain important insight into the difference it is making towards improved outcomes for children and young people. The CHSCP is now able to provide trainers with one 'pre-level' and three 'post levels' of evaluation that include the voices of delegates and line managers.

EVIDENCE

98.1% of delegates stated that the trainers' facilitation skills, teaching style and knowledge were GOOD (11.1%) VERY GOOD (33.6%) or EXCELLENT (53.4%). This is excellent feedback and a testament to the skill and expertise of our internal & commissioned trainers.

IMPACT

BEFORE training 50.9% of delegates believed their knowledge was GOOD (35.4%), VERY GOOD (13%) or EXCELLENT (2.5%).

AFTER training 90.4% stated their knowledge was GOOD (20.4%), VERY GOOD (46.7%) or EXCELLENT (23.3%).

IMPACT

98.5% stated what they had learned would help them safeguard children & young people more effectively.

96.4% said the course met their expectations.

IMPACT

"I think all aspects of the course were useful as even when I knew about some topic and issues beforehand, it is useful to mention it in case someone did not come around them yet and also for me to put everything into context and remind myself of what I know".

Safeguarding Children Basic Awareness, Post Evaluation.

"The trainer - Tony Bravo - had so much real experience of working with CYP affected by CCE and County Lines - it was helpful to get strong knowledge of what it looks like to practitioners when a YP is involved in county lines".

Child Criminal Exploitation and County Lines, Post Evaluation.

"I found the explanation on how adultification and intersectionality are linked and how they influence each other to be very insightful. Also, I was very appreciative of how the facilitator made sure to speak about how adultification works for black girls because their struggles are often overlooked".

An Introduction to Adultification, Post Evaluation.

"The team delivering the course were incredibly knowledgeable and gave lots of helpful examples to apply 'theory' to 'real life'. The case study was helpful, and it was particularly beneficial to have the process of the professionals' reports explained".

Improving Professionals Participation in Child Protection (CP) Conferences, Post Evaluation.

"I thought all aspects of the training were useful. I liked the opening activity where it helped me to reflect on my opinions".

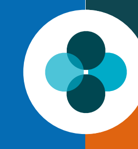
Safeguarding Children Basic Awareness, Post Evaluation.

"[I am] more aware of ways young people can be subject to adultification by organisations and individuals, including myself."

An Introduction to Adultification, Level 2 Evaluation.

"[I have] a greater understanding of roles and responsibilities".

Improving Professionals Participation in Child Protection (CP) Conferences, Level 2 Evaluation.



Priorities & Pledge

CHSCP Priorities 2021/22

Priority 1: The Health & Stability of the Safeguarding Workforce

Outcome: Safeguarding partners, relevant agencies and named organisations attract, retain, develop, and support their workforce. A healthy and stable workforce contributes to high quality safeguarding practice that improves outcomes for children and young people.

Priority 2: *Active* Anti-Racist Practice

Outcome: The partnership's approach to safeguarding children and young people in a 'racialised society' is characterised by active anti-racism. This is reflected in the people employed, the policies developed, and the practice undertaken. Practice that disproportionately and negatively impacts on Black and Global Majority children (and their outcomes) is identified and reduced. Children and their families are confident in challenging their experiences of racism and have mechanisms in place to escalate their concerns, practitioners are confident in challenging racism and there is evidence this is being done. Children and families tell us that they can see change.

Page 172

Priority 3: The Voice of Children and Young People

Outcome: Multi-agency safeguarding practice reflects the lived experience of children and young people. The voices of children and young people are central to all aspects of practice across the child's journey in the safeguarding system. These influence action and improve outcomes.

Priority 4: Getting the Basics Right

Outcome: Safeguarding practice in the City of London and Hackney is at least good. Children and young people are effectively protected from harm by early, robust, timely and coordinated multi-agency intervention and support.

Priority 5: The Appetite to Learn

Outcome: Children and young people are effectively safeguarded by professionals being actively engaged with the CHSCP's learning & improvement framework. Leaders encourage independent scrutiny, challenge performance, and embed lessons for practice improvement across their respective organisations.

Priority 6: Making the Invisible Visible

Outcome: The activity of safeguarding partners, relevant agencies and named organisations makes children and young people who live in groups and communities that are less visible and less engaged with public services safer. Of specific relevance to our local context, legislation in respect of Unregistered Educational Settings (UES) is amended by the government and the CHSCP obtains reassurance that the safeguarding arrangements of all settings are sufficiently robust.

Our Pledge

The Health & Stability of the Safeguarding Workforce - Without a healthy and engaged workforce, no agency can fully participate in and support the work of the partnership. The CHSCP will therefore seek to develop a better understanding of the pressures that staff and volunteers face and the steps that can be taken to mitigate them. This work will be undertaken in the context of what we know about the current conditions – Covid-19, organisational change, and restructure, reduced resourcing levels and increased demand. It will include evaluation of workforce stability, its capacity, and the support available to help deliver high-quality practice.

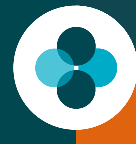
Active Anti-Racist Practice – Through our collective leadership, we will model our values and promote a way of working that puts active anti-racism front and centre. This will be seen in the strategies we develop, the decisions we take and the people we employ. Critically, active anti-racist practice will be evidenced in the behaviours of our staff and volunteers. Through a relentless focus on improvement and challenge, children and families will see, hear and feel the difference when engaged by those responsible for their help and protection.

The Voice of Children and Young People - We will support and enable a culture of working that routinely seeks out and reflects the voices of children and young people. The lived experience of local children and young people and their voices will be evident in the policies we create, the practice we review and the communication channels that our wider partnership creates. Importantly, it will be evident in our casework and our intervention to improve outcomes for children and young people.

Getting the Basics Right - Whilst welcoming innovation, the CHSCP is aware that good practice begins with getting the basics right. We will maintain focus on ensuring these aspects are embedded in our work covering the journey of the child through the safeguarding system. This includes our approach to early help, children in need (including those with SEND), child protection, looked after children and care leavers. We will also concentrate on those areas that require strengthening as identified by our Learning & Improvement Framework, local intelligence and the CHSCP strategic data analyst.

The Appetite to Learn - We are committed to maintaining our improvement journey and to that end, we will actively seek out and embrace opportunities to learn. Our quality assurance activity remains structured on our learning and improvement framework. We will routinely revisit the action plans to ensure that identified improvements are reflected in contemporary practice. Critically, we will respect the independent scrutiny role of the Independent Child Safeguarding Commissioner, the right to 'roam', the right to ask difficult questions and the right respectfully challenge. Whenever required, safeguarding partners, relevant agencies and named organisations will provide whatever information they can to address a relevant enquiry or concern.

Making the Invisible Visible - The CHSCP will seek to better understand the vulnerabilities that can negatively impact on the outcomes for children and young people, particularly with those for whom oversight, and engagement is limited. We will seek to develop a more complete understanding of existing and emerging harms and work with communities to mitigate and prevent them. We will seek to understand vulnerability based on age, location, need and the context of young people's lives, at home, in care and in the public spaces and places (including the internet) they frequent.



What You Need to Know

Children and Young People

- Nothing is more important than making sure you are safe and well cared for.
- As adults, sometimes we think we always know best. We don't, and that's why your voice is so important.
- This is about you, and we want to know more about how you think children and young people can be better protected.
- We want to talk to you more often and we want you to help us find the best way to do this.
- If you are worried about your own safety or that of a friend, speak to a professional you trust or speak to Childline on 0800 1111

childline

ONLINE, ON THE PHONE, ANYTIME
childline.org.uk | 0800 1111

Page 177

Parents and Carers

- Public agencies are there to support you and prevent any problems you are having from getting worse. Don't be afraid to ask for help.
- It's important to tell us what works for you and what doesn't so that professionals can help you in the best way possible.
- Make sure you know about the best way to protect your child and take time to understand some of the risks they can face.
- You'll never get ahead of your child when it comes to understanding social media and IT – but make yourself aware of the risks that children and young people can face.

The Community

- You are in the best place to look out for children and young people and to raise the alarm if something is going wrong for them.
- We all share responsibility for protecting children. Don't turn a blind eye. If you see something, say something.
- If you live in Hackney, call the **Multi-Agency Safeguarding Hub (MASH) on 0208 356 5500.**
- If you live in the City, call the **Children & Families Team on 0207332 3621.**
- You can also call the **NSPCC Child Protection helpline on 0808 800 5000.**

Front-line Staff and Volunteers working with Children or Adults

- Make children and young people are seen, heard and helped. **SAFEGUARDING FIRST, CONTEXT, CURIOSITY & CHALLENGE**
- Your **professional judgement** is what ultimately makes a difference, and you must invest in developing the knowledge, skills and experiences needed to effectively safeguard children and young people. Attend all training required for your role.
- Be familiar with, and use, when necessary, the **Hackney Child Wellbeing Framework and/or The City of London Thresholds of Need tool** to ensure an appropriate response to safeguarding children and young people.
- Understand the importance of **talking with colleagues and don't be afraid to share information**. If in doubt, speak to your manager.
- **Escalate your concerns** if you do not believe a child or young person is being safeguarded. This is non-negotiable.
- Use your representative on the CHSCP to make sure that your voice and that of the children and young people you work with are heard.
- If your work is mainly with adults, make sure you consider the needs of any children if those adults are parents.

Local Politicians

- You are leaders in your local area. Do not underestimate the importance of your role in advocating for the most vulnerable children and making sure everyone takes their safeguarding responsibilities seriously.
- Deputy Mayor Anntoinette Bramble (Hackney) and Ruby Sayed (The City of London) are the lead members for Children's Services and have a key role in children's safeguarding – so does every other councillor.
- You can be the eyes and ears of vulnerable children and families... Keep the protection of children at the front of your mind.

Page 180

Chief Executives and Directors

- You set the tone for the culture of your organisation. When you talk, people listen. Talk about children and young people. Talk about **SAFEGUARDING FIRST**.
- Your leadership is vital if children and young people are to be safeguarded.
- Understand the capability and capacity of your front-line services to protect children and young people - make sure both are robust.
- Ensure your workforce attend relevant CHSCP training courses and learning events.
- Ensure your agency contributes to the work of CHSCP and give this the highest priority. Be compliant with minimum standards for safeguarding.
- Advise the CHSCP of any organisational restructures and how these might affect your capacity to safeguard children and young people.

The Police

- Robustly pursue offenders and disrupt their attempts to abuse children.
- Ensure officers and police staff have the opportunity to train with their colleagues in partner agencies.
- Ensure that the voices of all child victims are heard, particularly in relation to listening to evidence where children disclose abuse.
- Ensure a strong focus on MAPPA and MARAC arrangements.

Page 181

Head Teachers and Governors of Schools

- Ensure that your school / academy/ educational establishment is compliant with statutory guidance KCSIE.
- Remember that you see children more than any other profession and will naturally develop some of the most meaningful and important relationships with them.
- Keep engaged with the safeguarding process and continue to identify children who need early help and protection.

Integrated Commissioning Boards

- The ICB has a key role in scrutinising the governance and planning across a range of health organisations.
- Discharge your safeguarding duties effectively and ensure that services are commissioned for the most vulnerable children.

The Local Media

- Safeguarding children and young people is a tough job.
- Communicating the message that safeguarding is everyone's responsibility is crucial - you can help do this positively.
- **Hundreds of children and young people are effectively safeguarded every year across the City and Hackney.**
- **This is news.**

© CHSCP 2024

Address: 4th Floor Hackney Learning Trust
1 Reading Lane, Hackney EH 1GQ

Website: www.chscp.org.uk
Email: chscp@hackney.gov.uk
Tel: 0208 356 4183
Twitter: @lscp_chscp
p. 05.02.24 v.1.0.2

An INEQE Safeguarding Group Ltd CSR Publication 2024

chscp
Seen | Heard | Helped
www.chscp.org.uk

Title of Report	**Director of Public Health Annual Report (2023). "Sexually Healthy" & announcing the Director of Public Health Annual Reports (2024 & 2025) on Social Capital.**
For Consideration By	Health and Wellbeing Board
Meeting Date	25/01/24
Classification	Public
Ward(s) Affected	All
Report Author	Sandra Husbands, Director of Public Health; Chris Lovitt, Deputy Director of Public Health; Danny Turton, Public Health Registrar.

Is this report for:

☑	Information
☐	Discussion
☐	Decision

Why is the report being brought to the board?

Members of the Hackney Health and Wellbeing Board are asked to:

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

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

Adults and Children, Young People Health Scrutiny

1. **Background**

1.1. Overview

The 2023 report looked at sexual and reproductive health (SRH) with a particular focus on young people under 30 and on testing for sexually transmitted infections (STIs). The report was developed in liaison with stakeholders across the City of London and Hackney, including local and regional NHS partners and voluntary sector organisations. The report benefited from the SRH Needs Assessment 2023 and the development of a five year SRH Strategy for 2023-2028.

1.2. Current Position

The Sexually Healthy DPH Report recommendations are as follows:

- 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.
- 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.
- 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.
- 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.
- 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.

1.3. Proposal

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

- In the first year, the work will be focused on the evidence base of how to build social capital at the community level and the role that the public health team and the wider system can play in doing so.
- The second year will then look at working with the City of London and Hackney community to turn that evidence into an action plan that can have a practical impact on the health and wellbeing of our population.

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

1.4. Conclusion

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

2. Policy Context:

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

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

Please detail which, if any, of the Health & Wellbeing Strategy ‘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

3. Equality Impact Assessment (EIA)

Has an EIA been conducted for this work?

☐	Yes
☑	No

4. 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

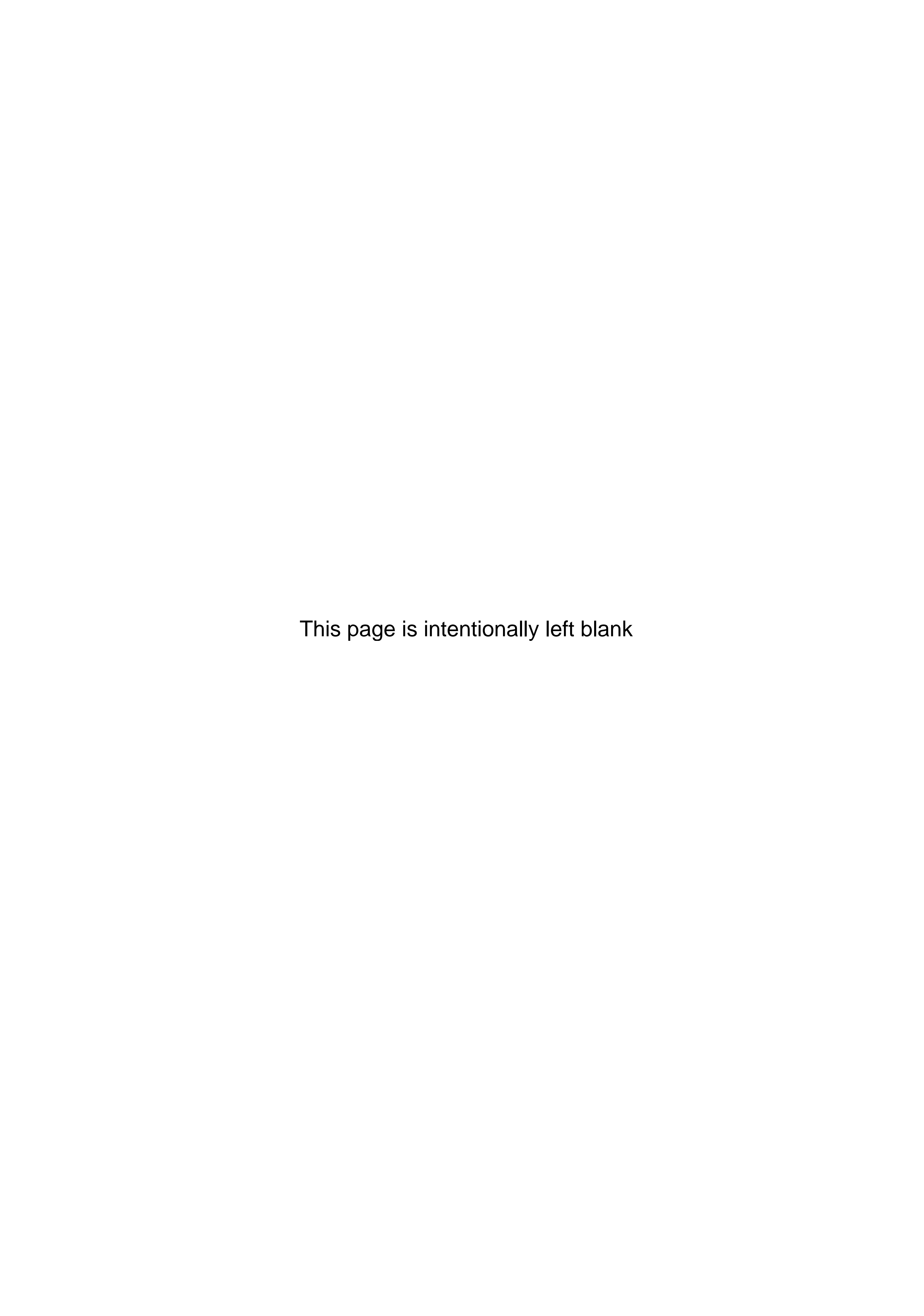
5. Risk Assessment

This will be considered in the Sexual and Reproductive Health Strategy

6. Sustainability

This will be considered in the Sexual and Reproductive Health Strategy

Report Author	Sandra Husbands, Director of Public Health; Chris Lovitt, Deputy Director of Public Health; Danny Turton, Public Health Registrar.
Contact details	City & Hackney Public Health Team
Appendices	Sexually Healthy - Full Report Sexually Healthy - Executive Summary



This page is intentionally left blank

Holding Hands, Hoxton Square, STIK 2020

Sexually Healthy

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

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

Summary 2023/24

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

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

Sexually Healthy

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

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

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

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

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

Berlin Wall with NOIR, STIK 2019

Sexually transmitted infections

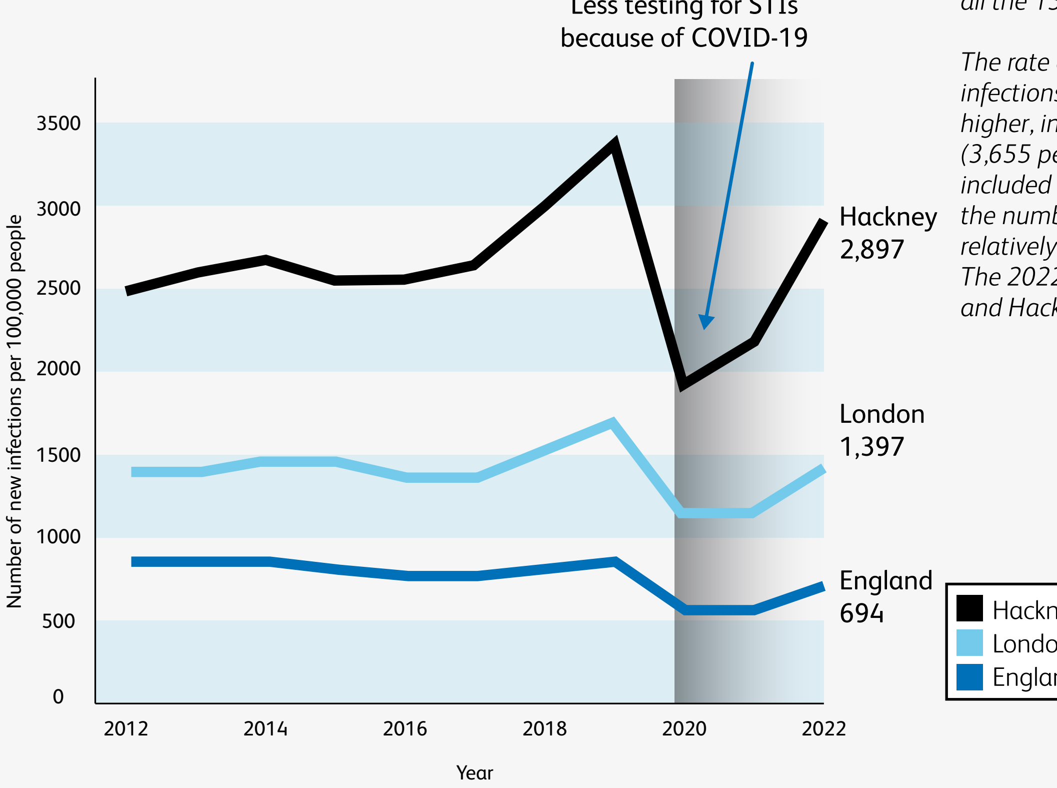
The number of sexually transmitted infections diagnosed in Hackney and the City each year is extremely high (see Figure 1). These infections can be treated and managed but the earlier they are diagnosed the better.

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

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

New diagnoses of sexually transmitted infections

Figure 1: Sexually transmitted infections by area of residence



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

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

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

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

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

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

Broome and Lafayette, LA2 and STIK 2016

Keith's Garage, Bentley Road, 2008

Recommendations

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

Work hand in hand with communities…

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

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

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

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

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

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

never forgetting to identify and combat inequalities.

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

Key messages

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

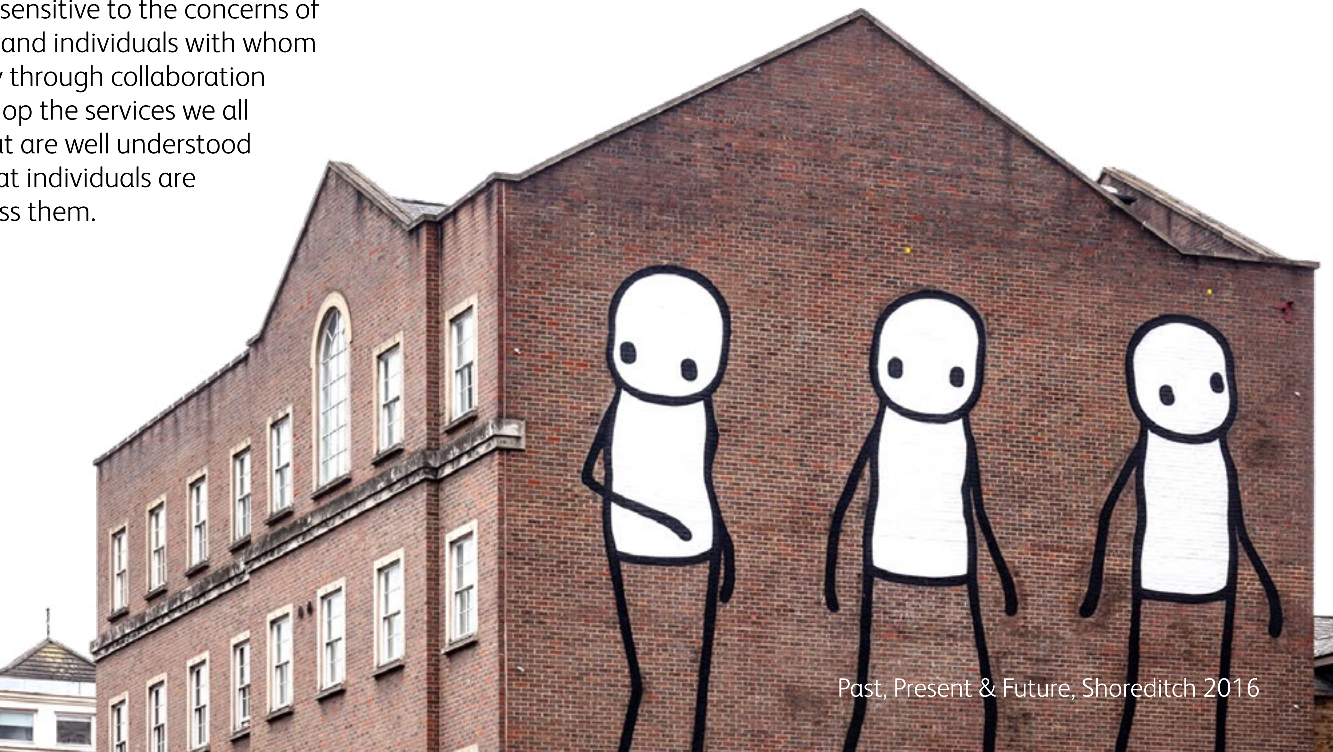
We need to recognise how important sexual and reproductive health is to our entire population. Sexual and reproductive health goes beyond the presence or absence of an infection. It involves choice, consent, pleasure, and good relationships. The World Health Organisation describes sexual health as "fundamental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

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

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

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

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



Past, Present & Future, Shoreditch 2016

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

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

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

HDS17072

This page is intentionally left blank

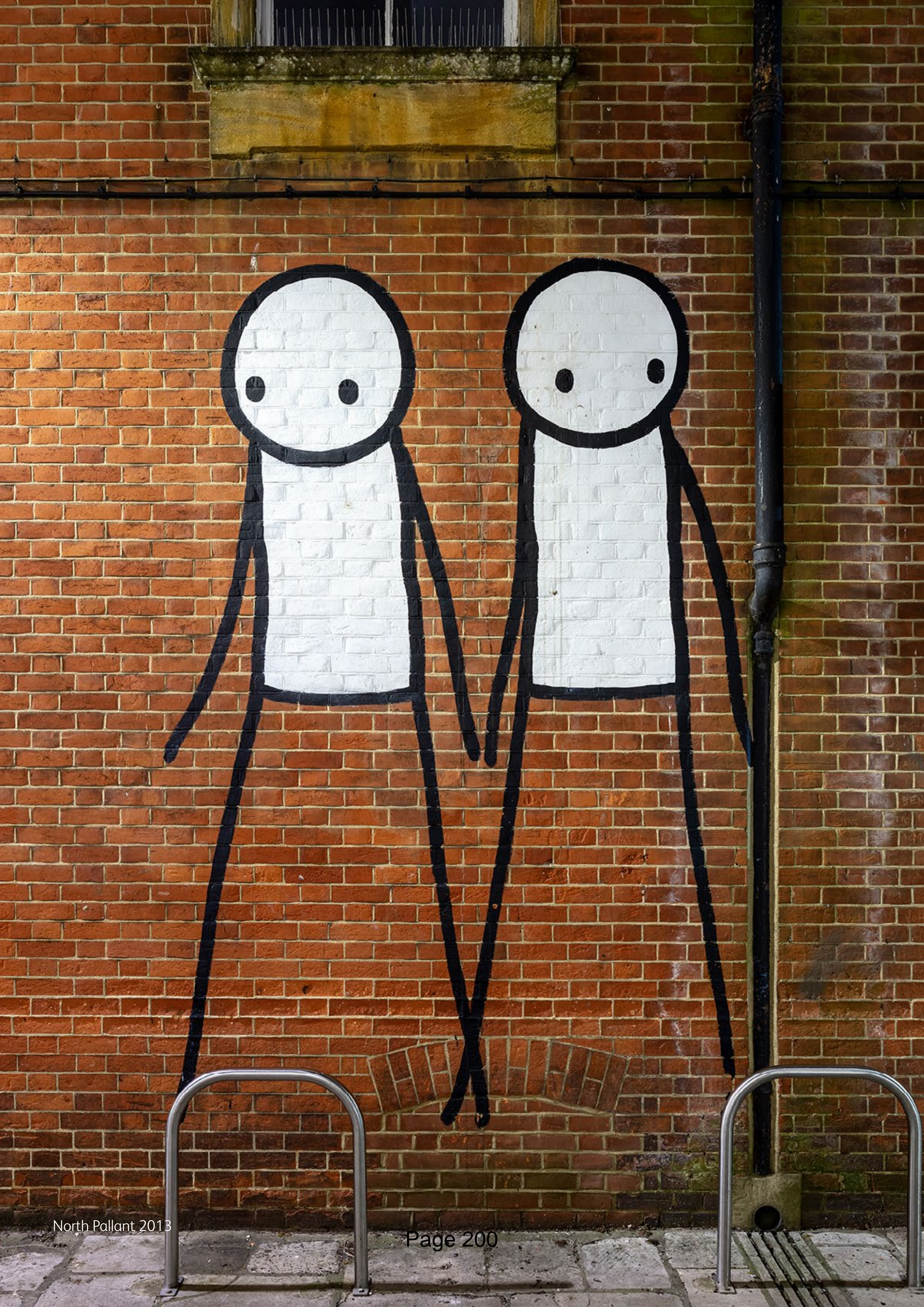
Holding Hands, Hoxton Square, STIK 2020

Sexually Healthy

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

2023/24

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



North Pallant 2013

Introduction

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

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

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

The City of London and Hackney have recorded higher rates of newly diagnosed STIs than the London or England averages for the past eleven years of available data. The rate in 2022 was almost five times the average for England and more than double the average for London.[1] At the same time, we have seen a large reduction in the number of STI tests being performed. Over ten thousand fewer tests were undertaken in 2021/22 compared to before the pandemic.[2]

Ensuring prompt diagnosis, partner notification and treatment of STIs is the mainstay of SRH services and an area where improvements can, and must, be made. Furthermore, initiatives taken to promote SRH among young people can provide wider benefits to our communities. By examining current challenges facing young people and considering how to address them, we throw light on other aspects of SRH and propose general principles to guide future work.

There are five areas in which recommendations are proposed to address the high levels of local need and reduce health inequalities. The first relates to embedding collaboration and co-production principles and is the cornerstone for implementation of the other recommendations. While these recommendations focus on young people, the principles are applicable across SRH and should be applied to work with other specific groups and communities.

Dr Sandra Husbands
Director of Public Health
for City and Hackney

Recommendations

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

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

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

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

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

Key Messages

Public health is concerned with health creation - our approach must be community based and participatory.

We need to find a shared purpose with the communities we serve and be guided by meaningful collaboration and a desire for true co-production of services.

We need to recognise how important sexual and reproductive health (SRH) is to our entire population.

SRH goes beyond the presence or absence of an infection. It involves choice, consent, pleasure, and good relationships. The World Health Organisation describes sexual health as "fundamental to the overall health and well-being of individuals, couples and families".[3]

We must support every individual's right to enjoy a fulfilling sexual life and loving relationships.

We need to empower people and foster their sense of control. People engage in sexual activity for different reasons, but they should be able to choose whether or not to have sex, free from coercion or violence, choose whether or not to get pregnant, and know what to do and where to go if they have problems. We must adopt a "sex-positive" approach that is "open, frank and positive about sex, that challenges negative societal attitudes to sex and that emphasises sexual diversity at the same time as emphasising the importance of consent".[4]

Issues related to sexual and reproductive health are deeply linked to our individual identities and cultures; and remembering this underlines the importance of working with communities.

It is only through collaboration that we can develop the services we all need. Services that not only prevent ill health but can also address problems when they arise or refer people to other services that can help. SRH services need to be trusted so that individuals are confident and comfortable accessing testing and treatment. As one person interviewed during the preparation of this report observed, *"we are good at commissioning services but there is something beyond creating services, it's about talking to people and communities, it's about how to engage"*. Without ongoing engagement with individuals and communities, SRH services cannot flourish.

We need to normalise conversations about sex while at the same time being sensitive to the concerns of the communities and individuals with whom we work.

Our aim should be to reduce embarrassment and by doing so help communities and individuals feel comfortable accessing the services they need. Services that reduce inequalities and promote the enjoyment of rich and fulfilling lives.

Contents

Introduction 1

Recommendations 2

Key messages 3

Background - where are we now? 5

How do we improve access? 8

Recommendation 1 15

Recommendation 2 16

Recommendation 3 21

Recommendation 4 23

Recommendation 5 24

Conclusion 25

Appendix 1 26

Appendix 2 30

Endnotes 34

Appendix endnotes 43

Background - where are we now?

What is special about the City of London and Hackney? What characterises this area of London and the people who live here? We will consider how the City of London and Hackney differs from other areas of London, and the nation, in terms of sexual and reproductive health (SRH).

The City of London and Hackney is young; ethnically, linguistically and sexually diverse; and proud

Approximately 260,000 people live in Hackney and around 9,000 people live in the City of London.[5] In addition to these residents, it is thought that over 400,000 people commute into the square mile to work on many weekdays.

The City of London and Hackney has a young population, with almost two thirds of the population 40 years old or less.[6] According to the 2021 census, 54% of the population are white but only 34% are white British.[7] There are large black African and black Caribbean communities, and the Charedi, or Orthodox Jewish, community makes up approximately 7% of Hackney's total population.[8] The Turkish and Kurdish communities are also large, with around 6% of Hackney's residents born in Turkey. In the City, which has a less diverse, albeit much smaller, population there is a large Bangladeshi community. Across the City of London and Hackney, there are a range of other distinct communities, including Chinese, Somali and Vietnamese. In short, there is a rich cultural mix as demonstrated by the 100 different languages that are estimated to be spoken across the City of London and Hackney.[9]

According to the 2021 Census, 7% of the population in the City of London and Hackney was lesbian, gay or bisexual (LGB). A further 0.9% responded as having an "other sexual orientation" and 12.5% chose not to answer.[10] Taking the 2021 census data for England and Wales as a whole, 2.8% of the population was LGB, 0.3% responded as "other" and 7.5% chose not to answer. The proportion of the local population that is LBG is, therefore, much higher than the national average. Furthermore, according to the 2021 Census data, the percentage of men in the City of London and Hackney who are gay or bisexual was 8.23% compared to the average over England and Wales of 2.74%.[11]

Notwithstanding the vibrance and wealth of communities living in the City of London and Hackney, there is considerable socio-economic deprivation present across the local authorities. Hackney as a whole had, in 2019, an Index of Multiple Deprivation (IMD) score[12] of 32.5 which was the 18th worst in England (out of 152 areas) and the second worst in London (out of 33 local authorities).[13] The City of London, however, had a score of 14.7 which was the 26th best in England and the sixth best in London.[14] Recognising the level of deprivation affecting the local population is important when considering sexual health because deprivation is associated with a range of poor health outcomes, including sexual health problems.[15]

People who live and work in the City of London and Hackney are proud of their communities and their colleagues. There is a strong sense of place and of history. There is a civic pride that stems from these roots and an earnest belief in the important role public, private and community organisations play in fostering change and improving conditions for the community as a whole. Many of the people interviewed while preparing this report talked with pride about the services that have been provided in the context of sexual health and the initiatives being taken. There is a recognition of the challenges but also hope and determination. Without forgetting that optimism, let us turn now to look at some of the challenges.

How does the City of London and Hackney compare with other parts of London?

In this section we consider areas in which the

data from the City of London and Hackney differ from other areas of London and England. We are interested in where we are an outlier, understanding why this may be the case, and where we need to focus our attention.

The City of London and Hackney have been relative outliers compared to other London local authorities in two key areas of SRH, namely the provision of long-acting reversible contraception (LARC) and the prevalence of sexually transmitted infections (STIs).

While it is true that the most recent data available suggests that rates of LARC prescription are coming back in line with London averages, Hackney remains with above average rates of abortions in certain demographics and ensuring good access to contraception options, including LARC, is a key requirement. Here we outline some of the key data relating to LARC provision and STIs, as well as key data on teenage pregnancies and abortions.

Long-Acting Reversible Contraception (LARC)

LARC is considered the most effective method of contraception.[16] It can help people to plan pregnancies as they wish, resulting in better outcomes for mother, child and the wider family.[17] In 2020, the total rate of LARC prescribed in Hackney was 19.3 per 1,000 women, and 13.6 per 1,000 women for the City of London.[18] These figures were considerably lower than the rate in England as a whole which was 34.6 per 1,000 women, and lower than the London average of 27 per 1,000 women.

New data made available in February 2023 shows, however, that in 2021, rates of LARC prescriptions rose in both the City of London and Hackney to 20.8 and 37.5 respectively. Hackney was, therefore, once more above the London average of 30.4 for the same period, although still lower than the England average of 41.8 per 1,000 women.[19] While the provision of LARC has started to recover, and Hackney at least is no longer below the London average, it has not yet returned to pre-pandemic levels when, in 2019, the rate of prescription was 45.9 per 1,000 in Hackney and 24.3 per 1,000 in the City of London.

The data on LARC prescriptions highlight two areas that warrant further research. First, that there is a large, and longstanding, discrepancy between the rate of LARC prescriptions made in primary care in Hackney (8.3 per 1,000 in 2021) compared to the rate of prescriptions made in primary care in England as a whole (25.7 per 1,000).[20] Second, that the City of London has relatively low rates of LARC prescription: in 2021 it had the third lowest rate in London and the 12th lowest in England.[21] These areas are worth investigating because increasing access to and, where appropriate, uptake of LARC can help people to plan their pregnancies. The recommendations made in this report are relevant to those efforts to increase access.[22]

Teenage pregnancies and repeat abortions in women under 25 years of age

Teenage pregnancy is associated with significantly poorer outcomes for both young parents and their children.[23] The City of London and Hackney have been effective at reducing the rate of teenage pregnancies over the last ten years of available data and has, since 2018, seen a rate consistently below the average for England.[24] At the same time, figures show that the percentage of teenage conceptions ending in abortion is higher than London and national averages (70.5% in Hackney and the City compared to 63.2% in London and 53% in England). While it would be desirable to help people prevent unwanted pregnancies, the relatively high proportion of teenage conceptions ending in abortion is an indication of good access to abortion services.

The available data on the rate of teenage pregnancies is encouraging but only goes up to 2020. More recent data is available for the under 18s abortion rate in Hackney, which rose in 2021 for the first time since 2016. From 2020 to 2021, Hackney saw a 29.7% increase in the number of women under 18 years old needing an abortion, with a rate of 8.3 per 1,000 women[25] compared to a London average of 5.5 and an average in England of 6.5.[26] It is possible, therefore, that the number of conceptions in women under 18 will also be seen to have risen when 2021 data becomes available.

Another area of concern is the data relating to abortions in women under 25 years old where the women have had one or more previous abortions. This is a key indicator of a lack of access to good quality contraception services and advice for a group of women who have, by definition, previously been in contact with SRH services. In 2021, 34.1% of abortions involving women

under 25 in Hackney were repeat abortions. Hackney had the third highest rate compared to its 15 statistically nearest neighbours.[27] In the City of London, however, the 2021 figure for repeat abortions under 25 was 28.6%, lower than both the London and England averages (31.6% and 29.7% respectively).

Notwithstanding relatively high rates in Hackney for abortions in under 18s, and repeat abortions in under 25s, the absolute abortion rate in Hackney was similar to that in its closest comparable neighbours and lower than the London average, although higher than the England average. This suggests that interventions should be targeted to support women under 18, and those under 25 who have already had an abortion, in order to redress this difference between them and the rest of the population.

Sexually Transmitted Infections (STIs)

The detection and treatment of STIs is a fundamental component of Sexual and Reproductive Health services. Even when treated, STIs can cause long-term complications affecting health and some require ongoing management. Detection is necessary to ensure effective treatment and timely partner notification to prevent onward transmission.[28] Prompt detection can also reduce the significant costs of treatment and management.

The City of London and Hackney have recorded a significantly higher rate of newly diagnosed STIs than the London or England averages for the past eleven years of available data (see Figure 1). In 2022, Hackney ranked fourth highest out of the 150 local authorities across England for new STI diagnoses and the City ranked top, although care must be taken with the City data because of the relatively small number of residents. The rate in Hackney was more than four times the England average: 2,897 per 100,000 residents compared with a rate of 694 per 100,000 for England as a whole.[29] Furthermore, both the City of London and Hackney are areas of high prevalence of HIV.[30]

Access to testing for STIs is key for treatment of individuals and their partners and to prevent further infections. The COVID-19 pandemic has seen a large reduction in the overall number of tests being performed with fewer than half the number of tests being performed in 2021 compared to 2019.[31] This is notwithstanding the welcome increase in the numbers of people self-testing through the Sexual Health London digital service (SHL).[32] The shift away from face-to-face appointments that occurred in both primary and secondary care as a result of the pandemic seems to be a major factor explaining the reduction in the level of testing for STIs across the City of London and Hackney. While it is true that the number of new STIs diagnosed has also dropped between 2019 and 2021, and this might appear to be encouraging, it is in the context of a much larger drop in the amount of testing being performed.[33] This means that the fall in the number of new STIs diagnosed in 2021 was most likely a reflection of the reduction in testing rather than due to a reduction of disease in the community. This is borne out by the fact that when testing increased in 2022, so too did the number of new STI diagnoses. Recently released data shows an increase of 34% in the number of new STI diagnoses in Hackney and the City of London between 2021 and 2022.[34]

In the following chapter, we focus on the successes and challenges relating to providing services in these areas and how we can encourage and promote appropriate access, with a particular focus on young people.

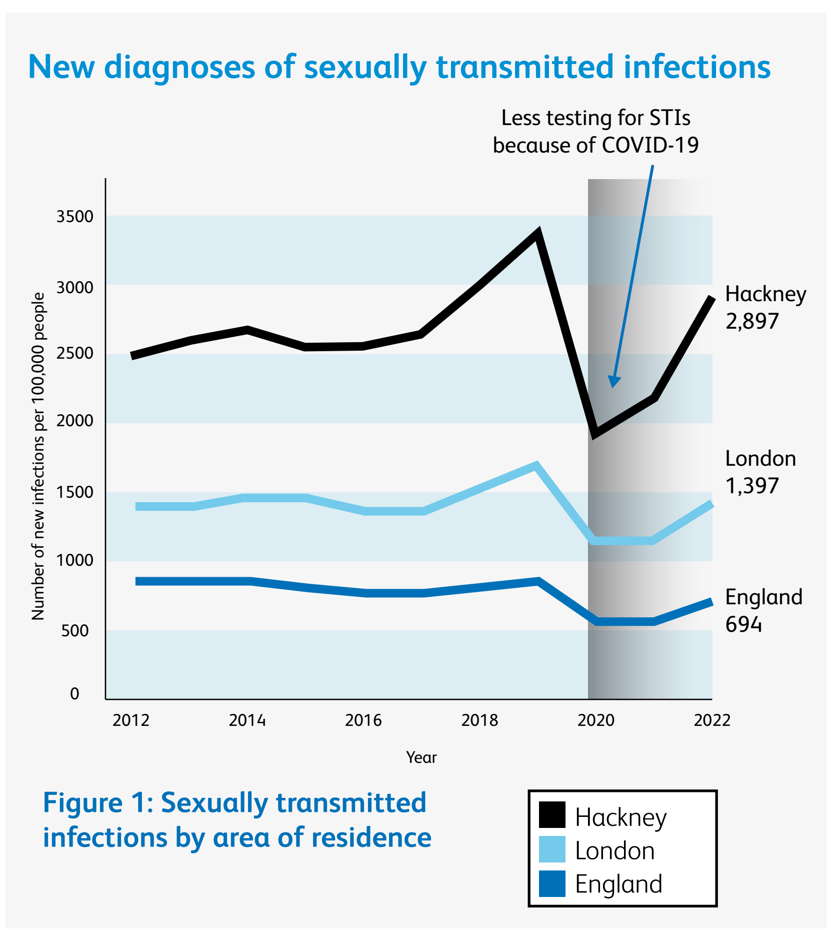


Figure 1: Sexually transmitted infections by area of residence

Scriven Street, Hackney 2012

How do we improve access?

"Every report talks about improving access" (stakeholder)

While it is true that there is frequently a call to improve access to services, in this section we will discuss why this is central to SRH services and what barriers exist. We will consider what impact the COVID-19 pandemic has had, both on the services themselves and how people access them. We will then briefly explore which groups or communities have higher needs before explaining why, for the rest of the report, we will focus predominantly on the experiences of younger people.

What are the services we're talking about?

We should consider services as activities that promote the wellbeing of communities rather than using the medical model where we focus on treating the ill health of individuals. As such, SRH services include initiatives to raise awareness and knowledge - steps taken to empower people so that they are more in control of their sexual health and wellbeing.

There are many services across the range of SRH but they all require people to choose to access them. Access can be in a variety of ways. They can be through self-referral or attendance at a drop-in clinic, or may require referral by a professional. Some services proactively seek engagement from individuals and communities.[35]

Services are provided in many different settings including GP surgeries, pharmacies, specialist clinics, in schools and the community, and online through platforms such as **Sexual Health London**. Services may be funded through local authorities and regional NHS bodies working within the integrated care system, by national NHS bodies, or by individual grants provided to voluntary, community and social enterprise organisations.

Often, the same organisation is commissioned by different bodies to run multiple services. The SRH field is, therefore, complex.[36] Services cover a wide range of activities including:

- testing, treatment and management of infections, including contact tracing and partner notification[37]
- provision of routine and emergency contraception
- **maternity** and **gynaecology** care, including support for menopause symptoms and abortion services
- psychology services, including psychosexual services, and services focusing on high-risk behaviours including the use of drugs, domestic violence, and sexual assault
- social support services including mentoring and health advice
- health promotion, such as Relationships and Sex Education (RSE) in schools; and awareness campaigns such as **"Can't Pass It On"**
- disease prevention, such as pre-exposure prophylaxis[38] for HIV (PrEP), and immunisations that can prevent infections that may be spread through sexual contact, such as HPV,[39] Mpox, and Hepatitis A and B.

In this report, some services will necessarily be discussed in greater detail than others. It is important, nonetheless, to acknowledge the complexities and interconnected nature of activities undertaken in the sexual and reproductive health (SRH) field. We use the term "sexual and reproductive health" precisely because of its breadth. Initiatives taken to improve outcomes in one area of SRH will often have positive outcomes throughout the wider system.

What are the potential barriers to accessing services?

Staff working in the City of London and Hackney are rightly proud of the SRH services they provide and for the history of service innovation and development in this field. Both staff and users generally agree that services are good but there are issues about accessing these services and who can benefit from them. These concerns have become particularly pronounced since the COVID-19 pandemic. In this section we will briefly explore the nature of access before, in the next section, considering the impact of the pandemic.

Access to services is a two-way process. Services must be available and people must be able and willing to access them. Ensuring access, particularly to SRH services, therefore involves considering both (1) the services that are being provided; and (2) the willingness of people to access those services - their access potential.

Barriers to service provision

While people can only access services that are being provided, there is a wide range of services available in the City of London and Hackney and, furthermore, residents are able to use services across London. Gaps may exist because a specific service has not been created, or as a result of how services define their access criteria, but these concerns are relatively rare and affect small numbers of people.[40] Potential barriers to accessing those services that already exist may relate to any of the following issues:

- location: people must be able to access the service and feel comfortable doing so
- opening hours: the timing of services affects how accessible they are and will impact different patients to varying degrees[41]
- booking process: where appointments are required, booking systems must be in place that are easy to navigate, support different languages and meet accessibility standards[42]
- capacity: services must have the capacity to provide support to the numbers of people trying to access them in a time-appropriate manner[43]

Increasing collaboration between the many organisations working in the SRH field - service providers and commissioners - and with the communities they serve, will help mitigate many of these potential barriers (see **Recommendation 4**). Where new services need to be commissioned, configured or promoted then they should be designed in collaboration with the communities they aim to serve, not least in order to reduce the risk of creating any unintended barriers to access (see **Recommendation 1** below).

Barriers to access potential

Going beyond the design of the services, there are issues relating to people's awareness of services and their willingness to use them. We describe this as a service's "access potential".

Knowing about services, and where to find them, is often more complex in the SRH field than in other areas of healthcare. This is why public awareness and information is so important. A recent evaluation of SRH services in North East London noted difficulties with accessing accurate information on websites and by telephone.[44]

Furthermore, while all health issues are personal, SRH issues are often deeply related to identity and culture. This means that people can feel discouraged from accessing services for reasons related to their individual, or their community's, beliefs rather than because of the services themselves. Stakeholders report that social norms in some communities act as a barrier to individuals accessing services.

Addressing these issues around knowledge, attitudes and reducing stigma will provide benefits in terms of health promotion and prevention of ill-health that go beyond enhancing access to a specific service. These issues relate to **Recommendation 3** below.

What has changed because of COVID-19?

The COVID-19 pandemic and the lockdowns have had a huge impact on healthcare provision and on society in general. As one stakeholder in primary care explained when interviewed for this report, *"the impact of COVID is always the big issue in the room"*.

Direct impacts on healthcare provision

There was a reduction in the number of face-to-face appointments in both primary and secondary care due to the impact of the COVID-19 pandemic and the associated lockdowns. GPs have integrated online and text communication with their patients and in sexual health clinics there was a move away from "walk-in and wait" services to appointment-only systems and a greater use of STI testing ordered online.[45] Both of these factors led to a fall in the number of STI tests being carried out at face-to-face appointments.

While there has been a welcome increase in the number of STI tests being provided by digital services,[46] namely through **Sexual Health London** (SHL), this has not made up for the reduction seen in primary and secondary care. The overall number of STI tests across the sector, taking into account primary and secondary care as well as SHL, fell by 57% from 2019/2020 to 2021/2022.[47] This is despite the number of STI screens distributed by SHL more than doubling during the same period.[48]

The number of sexual health attendances in secondary care, at Homerton Sexual Health Services (**HSHS)**, dropped dramatically during the pandemic and is still only around 55% compared to pre-pandemic levels.[49] The number of sexual health attendances in primary care is more difficult to quantify due to difficulties with data capture. What all stakeholders report, however, is that face-to-face appointments have reduced.[50] This is partly as a result of changing practices in terms of using more telephone consultations. For example, while the number of HIV attendances at HSHS is 40% lower than before the pandemic, the number of HIV positive patients receiving care has nevertheless gone up by 6% due to the increased use of telephone consultations.

This change in practice does not appear to have affected all services equally. In particular, the level of LARC provision is returning towards pre-pandemic levels.[51] Nevertheless, stakeholders are concerned that this move to telephone and virtual consultations has an impact on important aspects of sexual and reproductive health provision. In primary care, for example, concerns around sexual health are often brought up incidentally during consultations for other issues.

While text messaging is an invaluable tool for communicating with patients, not everyone is comfortable receiving text messages to do with sexual health. As one primary care stakeholder observed, "some communities would be horrified if GP surgeries sent a text message to 16 year olds inviting them for a chlamydia screen" Furthermore, digital services may not always be effective at picking up safeguarding issues or instigating conversations around behaviour change and risk modification. There can also be barriers to accessing digital services for some people. While such barriers are reducing, they are likely to remain significant for some time. Although SHL has been highly successful and is effective at reducing the burden on other service providers, there is also recognition that it cannot replace the need for a wide range of services to ensure equitable access for all.

Some stakeholders in primary care report that more people are accessing SRH services through their GPs because access to specialist clinics has reduced since COVID-19 and it is difficult to get appointments. While they welcome this shift to primary care, they are also concerned because general demand for primary care services is "higher than ever before". At the same time, stakeholders in secondary care have a perception that less SRH care is being provided in GP practices because, again, it is more difficult to get face-to-face appointments and when patients are seen, they are less likely to have blood tests and STI swabs. These viewpoints are not entirely contradictory since data mentioned above does suggest that SRH activity has reduced in both GP practices, community pharmacies and secondary care, albeit more so in secondary compared to primary care. At the same time, primary care stakeholders suggest that many GPs do not view SRH as their primary responsibility and are perhaps not always as comfortable or skilled in this area. If this is a more recent trend it would explain the concerns voiced by clinicians in secondary care.

Notwithstanding these various perspectives, before the pandemic, there was more testing for STIs including HIV. Several experts suggest that the historic high rates of STIs in the City of London and Hackney were explained by having high levels of testing in a relatively deprived area of London with a young population and higher proportion of gay and bisexual men. Their concern is that now, with lower rates of testing, we will see lower rates of detection that do not reflect the true burden of disease in the community and that rates of infection will increase still further. Detection of STIs, along with highly effective partner notification, is vital for both treatment and prevention of onward transmission. Testing needs to increase not only to reach pre-pandemic levels once more but also ensure that the SRH activity in both primary and secondary care is fully reinstated.

Stakeholders interviewed for the preparation of this report point to staffing issues as the single most important factor explaining the reduction in SRH provision since the pandemic. This message was repeated by stakeholders in secondary care, general practice, outreach services and pharmacy, who all described staffing shortages as limiting services.[52] Indeed, they argue that there were already problems around staffing even before the pandemic[53] and so the impact of COVID-19 was to make a bad situation worse. As one stakeholder reported, "even if we did want to increase capacity [and had the funding to do so] we don't have the staff". They argue that a key strategy, therefore, must be further integration and better collaboration between partners.

Wider impacts on the population

As well as direct impacts on SRH provision, the pandemic has had a negative impact on people's wider mental health and wellbeing.[54] This pressure has continued with the cost of living crisis. Clinicians report that people are now more willing to discuss their wellbeing and mental health, and with growing awareness there is also more willingness among staff to proactively ask people about mental wellbeing. This means that there is more disclosure of trauma and mental health issues but there is not, however, an equivalent increase in the provision of mental health services. This is leading to significant waiting times for services. Stakeholders are concerned that higher levels of mental illness and financial stresses hamper people's ability to access and engage with services. It can also contribute to risk-taking behaviours and sexual exploitation or violence, thereby directly impacting people's health.

Of course, the pandemic has not only impacted the adult population. Many stakeholders also report the significant impact of school closures on children's development, particularly their emotional maturity. Furthermore, the pandemic seems to have disproportionately affected children from disadvantaged backgrounds, at least in terms of their academic learning.[55] For more discussion of the impact of COVID-19 on young people in the City of London and Hackney, see last year's Director of Public Health Annual Report, **"Children, young people and COVID-19 in the City of London and Hackney"**.

There is no doubt that the pandemic has had a major impact on SRH services - reductions in availability of appointments and provision of STI testing being just two examples, both of which due, at least in part, to staffing pressures. At the same time, the social and financial impact of the pandemic appears to have led to greater need in the population and, possibly, an adverse effect on health behaviours. Nevertheless, as one senior clinician told us during the preparation of this report, reflecting on the challenges of recent years, "we have a strong and proud tradition of supporting sexual health in the City of London and Hackney - let's regain it!"

Communities with high levels of unmet need

It is not surprising that some communities are over or under-represented in how they access specific SRH services compared to the population as a whole.[56] There can be many reasons for such disparities - some communities may have greater need, some may find it difficult to access services, and some may simply choose to access services in different ways, for example through a GP or pharmacist rather than a sexual health clinic. To try and understand these issues, and get beyond the bare data, we are indebted to the experts and stakeholders consulted during the preparation of this report.

People affected by poverty

One expert interviewed strongly believes that, within the City of London and Hackney, poverty is the major driving force behind inequalities relating to SRH rather than other attributes such as ethnicity.[57] While data is available for the ethnic background of people accessing services locally, there is no equivalent quantitative data for individual patients' financial situation. Nevertheless, we can see at a national level that deprivation is associated with worse SRH.[58] For example, 2021 data shows that the most affluent 40 % of local authorities in England all had lower rates of new STI diagnoses than the national average. More deprived local authorities, on the other hand, all had rates above the England average.[59] Poverty, then, is associated with poor SRH outcomes[60] but the relationship is two-way.[61] Improving SRH in the community can help tackle poverty by reducing morbidity, improving relationships, and reducing financial burdens.

Identifiable groups

The communities most often cited by stakeholders as currently requiring additional support include: young people, people with mental health difficulties, non-English speakers or people with communication difficulties, trans people, migrants, and for certain services specific ethnic groups. It is important to note that inequalities relating to accessing services vary according to the service in question.

For example, there is a concern that heterosexual people who may be at increased risk of acquiring HIV are not accessing PrEP as much as other groups in the population,[62] and there are suggestions that Turkish-speaking communities may not be accessing menopause services through primary care.[63]

Even in areas where local performance is good, inequalities between groups may exist that need to be addressed. For example, late diagnosis[64] of HIV is the most important predictor of HIV morbidity and short-term mortality. In Hackney, the percentage of HIV diagnoses made at a late stage of infection in the three-year period between 2019-2021 was 30.7 %[65] which is considerably better than the England average of 43.4 %. The discrepancy between the percentage of late diagnoses among men who have sex with men (MSM) as opposed to heterosexual people is, however, much greater than it is nationally. The percentage of late diagnoses among MSM in Hackney during this period was 16.7 %, much lower than the England average of 31.4 %, but among heterosexual people the diagnosis of HIV was made late more than half of the time.[66] This may indicate a relatively lack of awareness of HIV risk in the heterosexual community or difficulties in accessing services. The welcome fact that late diagnosis is relatively rare in the gay and bisexual community suggests that more can be done to raise awareness, or improve access to testing, among specific heterosexual communities at increased risk of acquiring HIV.

Potential gaps in services

During interviews conducted for this report, stakeholders have drawn attention to potential gaps in services which affect specific residents. For example, stakeholders highlight that the withdrawal of walk-in services at sexual health clinics is disproportionately affecting people who find it more challenging to arrange appointments. These may be people with low-level mental health issues or with other pressing health or financial concerns. One stakeholder suggested that the loss of walk-in services means that clinics are "increasingly serving the middle classes". Similarly, the reduction in out-of-hours clinics and outreach activities is likely to be impacting younger people's ability to access services, particularly those of school-age.

Another area of concern that has been highlighted relates to psychological support and psychosexual therapy. Since the COVID-19 pandemic, staffing issues coupled with funding restraints have left services finding it difficult to support those needing help. Stakeholders are concerned that the limited capacity of psychological services, and the different treatment criteria they adopt, are causing some patients to fall between gaps. For example, people with previous untreated trauma may be considered too complex for psychosexual therapy or the NHS Talking Therapies programme[67] but not urgent or complex enough to warrant secondary psychological care. This issue relates to the distinction drawn between "mental health" and "sexual mental health". Practitioners report that they aim to treat patients holistically but are hamstrung by complex commissioning arrangements.[68]

In some cases, the appropriate service may not exist. Clinicians in both primary and secondary care have raised concerns regarding the lack of available support to trans patients who are waiting for gender affirmation appointments. It is not clear to clinicians how to respond to this concern. Some have suggested a secondary care service should be established to provide support during the long waiting times, often several years, but others have expressed concern that without sufficient expertise it is not appropriate to assume the levels of risk involved. They argue it would be better for funds to be directed to the affirmation services to reduce waiting times.

Primary care stakeholders report that some patients with gender dysphoria are buying drugs on the internet, including hormones, but that GPs are not comfortable monitoring or supporting them.[69] Primary care practices do not have sufficient expertise but do not want to turn people away. Furthermore, it is not always clear to clinicians if the journey these patients, who are often young, are embarked upon is informed by sufficient clinical guidelines. There is sometimes concern around what is driving their decision making. As one stakeholder stated, "all services need to have better conversations with non-binary people but the gender dysphoria issue is a small subsection of those conversations and one that needs a specialist pathway - we need to establish that pathway".

One area that represents a lost opportunity rather than a gap in services is the health promotion and prevention work done within schools. According to stakeholders, shortages in school nursing are even more pronounced than in nursing in general. This means that school nurses, and other nurses working in the education field, have to focus on healthcare plans and safeguarding and do not have the time to do health promotion work. Stakeholders call for more information to identify schools needing particular support, and better alignment of the educational and clinical support provided to pupils. This is an area affecting large numbers of people and goes to the heart of public health objectives - promoting good health for the present and the future.

Why focus on young people?

The population of the City of London and Hackney is relatively young compared to other areas. Over 65% of residents are aged 40 or under, over 34% aged 30 or under, and over 32% aged 25 or under.[70] It is young people that access SRH services the most.[71] The highest proportion of both men and women attending HSHS fell within the 25-29 year old age group and 54% of all women accessing HSHS were under 30 years old.[72] Not only are young people disproportionately accessing services, they are also more likely to be diagnosed with an STI when they are seen.[73] Furthermore, stakeholders report specific challenges for young people to access services, particularly since the COVID-19 pandemic. Some of these issues will be discussed in the following chapter.

For the purposes of the report, "young people" is taken to mean all people up to the age of 30 years old,[74] who make up over a third of the estimated population of the City of London and Hackney.[75] This is not intended to negate the need for specific age-appropriate services designed for sub-groups within that demographic. Services appropriate for a 25 year old may not be appropriate for a 15 year old, and safeguarding considerations must always be at the forefront of service design. Proposing a focus on "young people" is not, therefore, meant to imply that this group is homogenous. On the contrary, the implication should be that we need to ensure there is a sufficient range of services and approaches to respond adequately to the

different needs of various sub-groups within the broad category of "young people", including those sharing particular cultures, genders or specific narrowly defined age-groups.

When considering SRH services, the provision available to young people is a central concern. They access services more than others and have the highest rates of disease. Working with young people to empower them to make their own choices, to protect their own health and exercise their rights, will provide benefits in both the short and the longer term. Not all young people are the same and we need to work with specific communities to ensure that services are as effective as possible. This echoes the first recommendation in this report: that co-producing services is central to improving the quality of SRH in our communities.

Broome and Lafayette, LA2 and STIK 2016

Recommendation 1.

Community involvement is key to providing high quality services

Health providers and commissioners should reconfirm, and put into action, their commitment to collaborate with young people in the co-production of services.

In this report, we use the term "young people" to refer to everyone under the age of 30. We realise this is a broad category and when talking about co-production, different approaches will be required for different groups. Nevertheless, the principles of co-production apply regardless of the age of service users.

The need to involve people in the design of the services is recognised in the 2022 NICE guidelines on reducing STIs. These recommend that interventions aimed at reducing STIs should be planned, designed, implemented and evaluated "in consultation with the groups that they are for".[76] The same guidelines note that commissioners and service providers should "regularly evaluate interventions, including the methods used to co-produce them, to determine their effectiveness and acceptability and identify gaps to make service improvements".[77]

Organisations in the City of London and Hackney recognise the importance of involving those they serve. In 2017, Healthwatch City of London and Healthwatch Hackney developed a co-production charter with the involvement of all stakeholders including the City of London Corporation and the London Borough of Hackney. The charter was reviewed in 2021 and presented to the health and social care partnership organisations.

This **co-production charter**[78] should form the basis of a renewed commitment to co-production with service users and the wider community as part of a community-centred public health approach[79] to ensure new initiatives are culturally appropriate, well targeted and effective. Specific activities, such as peer-led participatory action research,[80] should be undertaken to explore the concerns and needs of young people in relation to SRH services; and to ensure that co-production is integrated and sustained in both the commissioning and provision of services aimed at addressing these issues.

Recommendation 2.

Services must be accessible to young people

Refine existing SRH services and explore new initiatives in collaboration with young people to make accessing services as easy as possible.

This recommendation is about the design and provision of SRH services. It highlights the importance of working with young people to make sure that appropriate services exist and that they are as easy as possible to access.[81]

The common aim of all interventions should be to support young people, regardless of their background or situation, to establish good SRH behaviours in the short term and for later life. There are, however, specific areas of concern highlighted by the available data. These relate to two key aspects of SRH – STI testing and the provision of contraception. Some of this data is outlined in the section: "How does the City of London and Hackney compare with other parts of London". We will highlight here issues of concern relating specifically to the provision of services as they relate to STI testing services and availability of contraception.

Testing for sexually transmitted infections (STIs)

STI testing is available in primary and secondary care and using self-test kits available online for those over 16 years old and in pharmacies. There are also outreach services provided by both the NHS and the charitable sector.

Young people access SRH services more than other sections of the community and, when they do, are more likely to have a positive test result for an STI.[82] Furthermore, data available for the City of London shows that reinfection rates for young people are much higher than the national average.[83] In the five year period between 2016-2020, looking at data for 15-19 year olds an estimated 24.1% of women were reinfected within a year and an estimated 22% of men. This compares to England averages of 10.9% and 9.8% respectively. Data for Hackney has not been provided for 15-19 years olds specifically but general reinfection rates are approximately 50% higher than national averages.[84] Reinfection rates are an indicator that people are finding it difficult to protect their sexual health even after having been in contact with sexual health services.

As mentioned above, the COVID-19 pandemic has caused a large reduction in the number of STI tests being performed. In the financial year 2021-2022, the number of STI screens performed in the City of London and Hackney was less than half of the number carried out in the year before the pandemic.[85] Stakeholders interviewed for this report strongly believe that increasing the number of tests will increase the number of positive diagnoses and thus enable more timely treatment to limit medical complications and reduce the likelihood of onward transmission. They argue that increasing the levels of testing, at least getting back to pre-pandemic levels, is vital. Otherwise, the progress made in SRH in the years before the pandemic may be lost.

Before the pandemic, the vast majority of STI screens were conducted through the clinics run by **HSHS**. Since the pandemic, the majority of screening tests have been provided through the online service, **Sexual Health London**.[86] The largest fall in the number of STI screening tests has been at HSHS but there has also been a large reduction in general practice. While STI testing kits are available through pharmacies, they only account for a small proportion of the overall number of tests, although they do have some of the highest positivity rates.

The reduction in testing at HSHS and CHYPS Plus is because fewer people are attending the services. As noted above, the number of sexual health attendances at HSHS is still only around 55% of pre-pandemic levels.[87] Stakeholders believe that the reduction in attendance does not reflect a reduction in need but rather is due to the limited capacity of HSHS, largely caused by staffing issues. For example, walk-in clinics have stopped[88] and out-of-hours clinics reduced. Booking systems are under pressure and there are reports that both online and telephone booking can be difficult to navigate with a lack of appointments available.[89]

Beyond HSHS, testing must also be increased in primary care and pharmacies. Data from 2018-2021 show that STI testing in primary care and pharmacies varies across the City of London and Hackney. During this four-year period, almost 4,000 STI tests were undertaken through 37 GP practices in the City of London and Hackney but just three practices accounted for more than 50% of the tests completed.[90] Similarly, during the same period, STI self-test kits were available at 25 pharmacies in the City of London and Hackney but 50% of those STI kits were distributed via just five pharmacies.[91]

The reasons for why so few locations are responsible for so many of tests needs further research but the concern is that it may be more difficult to access tests at some practices and pharmacies than at others.[92] This means that if levels of testing were increased to match the most active GP practices and pharmacies, it would significantly contribute to increasing the number of tests overall. Stakeholders suggest encouraging more routine use of STI testing, including HIV, for new patients registering with GPs and at NHS Health Checks;[93] and providing additional support to pharmacies. They argue that additional training, for both GP and pharmacy staff, would be an important element of new initiatives.[94]

Other avenues for increasing the level of testing relate to outreach services that are provided by the NHS and the charitable sector, in particular to school-aged people. Stakeholders from both the NHS and the charitable sector have noted that there is duplication of effort in these areas. For example, not only do **CHYPS Plus** and **Young Hackney**[95] undertake outreach into schools and colleges, but **HSHS** also attend schools when asked. There are also other health professionals working in schools and colleges, such as school nurses and public health nurses, that might be involved with health promotion and testing if they had sufficient capacity. As one stakeholder explained, describing outreach services for younger people, "it's all a bit random". Indeed, the charity **Positive East**, which amongst other things is commissioned to provide outreach testing services for the general public, has made similar observations, noting that they and other providers are sometimes doubling up.[96]

Two specific elements of STI testing in primary care have been highlighted as areas of concern by stakeholders. They are partner notification (PN) and the communication of test results.

Partner notification has been used to help contain STIs since the early 1900s. It refers to informing the sexual contacts of people who test positive for an STI. Good PN helps to break the chain of infection and reduce re-infection rates as well as offering health education opportunities to encourage positive behaviour change.[97] There are reports, however, that PN is not working effectively in primary care, with several stakeholders reporting that PN is not routinely being provided. There is an online platform that GPs can use when patients are unable or unwilling to notify sexual contacts themselves but it is difficult to use and expensive. There is discussion regarding whether secondary care can provide support in this area but stakeholders agree that commissioners have responsibility for ensuring an effective system is in place. This is supported by standards published by the British Association for Sexual Health and HIV on the management of STIs (2019) which recommend that commissioners should ensure that PN is a core requirement for service providers.[98]

Communication of STI test results is also discussed in the British Association for Sexual Health and HIV standards. These stipulate that people should have access to their STI test results, "both positive and negative within eight working days".[99] Stakeholders in primary care, however, report that negative STI test results are not routinely provided to patients. While these patients may theoretically have access to their results, this represents a lost opportunity for promoting safe sexual practice and providing support to people who may be at risk. Communicating negative STI test results

might, for example, be an appropriate time to recommend when, and in what circumstances, to consider further testing. One senior stakeholder suggests that a “status neutral” approach[100] should be adopted with regards to all STIs. This would involve, for example, considering whether to use negative test results to start a conversation around behaviour change, risk adjustment or even the use of PrEP.

Provision of contraception services

Contraception is concerned with helping people plan when they want to become pregnant rather than simply helping them to avoid unwanted pregnancies. Planned pregnancies have fewer complications and better outcomes for mother and baby. Routine and emergency contraception is made available through GP surgeries, sexual health clinics, community pharmacies, the sexual health e-service SHL[101] and through outreach services. Local data relating specifically to long acting reversible contraception (LARC), teenage pregnancies and repeat abortions are discussed earlier in this report in the section **“How does the City of London and Hackney compare”**. In this section we draw attention to issues regarding how services are currently being provided for LARC, emergency contraception and condoms.

Services providing long acting reversible contraception (LARC)

LARC can be accessed through sexual health clinics and other secondary care settings, such as postnatal wards, with primary care complementing these services by providing fittings in uncomplicated cases. Although improving, LARC prescriptions have still not yet recovered to the levels seen before the pandemic. For example, attendances for LARC at HSHS were, in January 2023, only 70% of the number seen three years previously in January 2020 (297 as opposed to 425).[102]

In general practice, we see a similar pattern to the one described above regarding STI testing. While 22 of Hackney’s 39 GP surgeries provided

Triangle Road, Hackney 2011

a LARC service in 2021, over 70% of the fittings were carried out in just five practices.[103] This is not entirely unexpected given that the plan is for there to be one GP LARC hub within each of the eight primary care networks (PCNs) in the City of London and Hackney. These 'hubs' then take referrals from other practices within their PCN. Nevertheless, there is a recognition among stakeholders that LARC fitting in primary care could be increased. They explain that practices find it expensive to provide the service as it requires training for staff and backfilling of their roles while that training is completed. With high staff turnover, many practices are reluctant to make this investment.[104] Furthermore, each practice must offer sufficient fittings to maintain the skills of their staff who have a minimum number of fittings they must perform each year.[105] There are, nevertheless, positive initiatives in this area including an NHS England commissioned community gynae pilot project to establish a "Women's Health Hub" that is starting to deliver reproductive health services, including LARC clinics and LARC training to GPs.[106]

Provision of emergency hormonal contraception (EHC)

Emergency contraception can be in the form of pills or intrauterine devices (IUDs). While intrauterine devices are only available through primary care or sexual health clinics, emergency contraception in the form of pills is also available through pharmacies and, since January 2021, via the online platform, **Sexual Health London** (SHL). "Emergency Hormonal Contraception" (EHC) specifically refers to pills which, in the City of London and Hackney, are primarily accessed through pharmacies. In 2021, 70.0% of EHC was accessed via pharmacies, 16.4% through SHL, and 13.6% through HSHS.[107]

We can see a similar pattern emerging with regard to EHC as we have demonstrated in other areas of SRH provision, with a relatively small number of locations providing a disproportionate amount of the service. In the three years from 2019 to 2021, more than 33% of the EHC accessed through pharmacies were accessed through just five of the 34 pharmacies that distributed any EHC during that period.

Two recent reviews of EHC availability through pharmacies in Hackney and North East London have both reported problems with accessing the service. A mystery shopping exercise specifically looking at this issue was conducted by Healthwatch Hackney between May and September 2022.[108] The 38 community pharmacies in Hackney which had signed up to provide free access to EHC were included in the study. When contacted by phone, only 40% of these pharmacies were able to offer a free service on the day[109] and 40% said that they would charge for the service. These findings were largely confirmed by in-person visits to 16 of the pharmacies,[110] eight that had offered a free service on the phone and eight that had offered a paid service. Information about future options for contraception was only provided in four of the 16 visits. Recommendations stemming from this report include the need for further training of staff. The importance of ensuring a welcoming and confidential service for young people is underlined by the fact that it is young people that need to access EHC the most,[111] and they do so primarily through pharmacies.

Provision of free condoms

Condoms are an effective form of contraception that can also help prevent the transmission of STIs whether or not contraception is required. In the City of London and Hackney, young people under-25 are able to access free condoms and lubricant from a range of outlets, including pharmacies, sixth form colleges, youth hubs, GP practices and sexual health clinics through a scheme coordinated by Hackney Council (**Young Hackney**).[112]

It is striking that more than 50% of the distributions between 2019 and 2020 were recorded in just six out of more than 45 local outlets registered to offer condom distribution to under-25s.[113] Nevertheless, between 2019 and 2021, the majority of condom distribution for people under 25 in the City of London and Hackney were in pharmacies (51.3%).[114] This again highlights the central importance of pharmacies.[115] In particular, young men appear to prefer using pharmacies. While men represented a lower proportion of encounters for condoms at HSHS and Hackney Council's Children and Young People services compared to the population as a whole (19.2% and 17.2% respectively), they were overrepresented in terms of accessing condoms via pharmacies (60.2% of pharmacy condom distributions were to men). While pharmacy stakeholders report some confusion regarding the condom distribution scheme caused by changes in commissioning

over the last few years, which is being addressed through additional training and information provision, it is clear that pharmacies are already and must continue to be a vital resource for the provision of easily accessible walk-in SRH services.

Putting the recommendation into practice

Refine existing SRH services and explore new initiatives in collaboration with young people to make accessing services as easy as possible.

Priorities for how services should be changed or developed must be determined through co-production with young people. Nevertheless, we outline here three areas which warrant particular attention and may form the basis for future conversations and plans.

a. Reviewing the timing and location of services

Services are provided in a wide range of locations: clinics, GP surgeries, pharmacies, in youth hubs, online and through outreach activities, including in schools and colleges. Since the COVID-19 pandemic, there has been a general move away from face-to-face appointments. Furthermore, opening hours have changed and clinics have been rearranged. Working with young people, priorities may be identified regarding: the opening hours of clinics or restarting walk-in and wait options;[116] the location of hubs and outreach services;[117] and ways of improving appointment availability and booking systems.[118]

b. Enhancing coordination between providers so that interventions can be more effective

Together with young people, opportunities should be explored for how to better coordinate services and where appropriate, co-locate them. For example, Young Hackney's health and wellbeing team do outreach in schools and colleges to support the statutory requirements to provide Relationships and Sex Education (RSE).[119] These services might be better coordinated with outreach activities conducted by other services such as CHYPS Plus, HSHS or charitable organisations. Work in schools and colleges might further be enhanced through increased coordination with school nurses and public health nurses. Another area that might be explored could be coordinating charitable sector testing services with pharmacies and GP practices.

c. Investigating inconsistencies in SRH provision around contraception provision and STI testing;[120] exploring how to strengthen systems for partner notification[121] and STI test result notification[122]

By exploring the reasons for inconsistencies between GP practices and between different pharmacies, it may be possible, while working together with partners and young people, to identify opportunities for increasing STI testing[123] and improving access to contraception through sharing best practices and mutual support. Addressing both of these issues (contraception and STI testing) may involve further training and awareness sessions for staff. Similarly, working on improving partner notification and test result notification may involve collaboration between primary and secondary care, as well as working with specific communities to ensure that partner notification methods are acceptable and that health promotion messages that may be included with negative test results are culturally appropriate and effective.

Redchurch Street, Shoreditch, 2011

Recommendation 3.

Young people must be aware of when and how to access support

Improve young people's awareness of services and their willingness to access them.

This recommendation focuses on how to empower young people to have control of their sexual and reproductive health choices and to access the services they need.[124] This involves people knowing what services are available to them, or at least being able to easily find the necessary information, and knowing when it is appropriate to access those services. It recognises that barriers to accessing SRH can often arise from the individuals and communities themselves. Exploring these issues will necessarily involve collaborating with young people and their communities.

Initial consultation might explore three areas: (a) young people's existing attitudes to SRH and their knowledge of services;[125] (b) their preferred sources of information including the accuracy of the information that is currently available; and (c), the factors that may make young people unwilling to access services or uncomfortable doing so. Examples of possible activities, depending on the outcome of consultations, are provided below, grouped under these three areas.[126]

a. Increase awareness of available services and when to access them.

   i. Co-produce information campaigns with specific groups using appropriate media and involving community champions and leaders. Subjects may include what services are available, that services are free and confidential and how to access them,[127] levels of STIs in the community, recommendations on frequency of STI testing, the importance of sexual self-efficacy[128] and the impact of stigma.

   ii. Review the implementation and quality of Relationships and Sex Education (RSE) provision in schools. High quality RSE is a vital tool that has been shown to provide many benefits including encouraging young people to seek help when they need it.[129] Some stakeholders suggest that the amount and quality of RSE provided may vary between different schools.[130]

   iii. Explore initiatives to ensure people are proactively offered information on SRH by GPs, pharmacists and other staff working in healthcare and public organisations. Staff must be well-informed and confident to initiate conversations about SRH.[131]

b. Ensure information is clear and that signposting is accurate and streamlined.

   i. Depending on how young people are accessing information, consider establishing systems to monitor and improve the information on service provider websites as well as on national NHS websites.

   ii. Explore having a single telephone number for accessing information and booking appointments with SRH services. This could be at the Hackney and City level, North East London level, or even London-wide utilising the 111 system.[132] Consider the use of text and chat methods for accessing information about available services.[133]

c. Increase young people's confidence to access services.

   i. With the benefit of insights from young people, ensure that services are welcoming and inclusive;[134] and better understand how and where different people like to access services.[135]

   ii. Explore interventions, in collaboration with young people and their specific communities, to normalise discussions around SRH and to tackle stigma;[136] and to increase familiarity with services, for example through videos showing what a sexual health clinic is like and introducing their staff.

Recommendation 4.

Focus on enhancing collaboration and partnership working

Continue to develop collaborative working practices across SRH and beyond to mitigate pressures on services and improve user experiences.

Stakeholders report that problems with staffing coupled with increasing need in the population is a major issue currently affecting SRH service provision. These pressures make the integration of care, and "whole system commissioning",[137] all the more important. Working relationships must continue to be fostered between commissioning organisations, between primary and secondary care, and between sets of service providers, sometimes working in the same organisation but with different commissioning arrangements.

The 2022 NICE guideline on reducing STIs notes the importance of delivering interventions across a range of services "including within broader support interventions and community services (for example, in drug and alcohol services, abortion care services, HIV care and mental health services)".[138] This is an approach that requires ongoing effort from service providers and commissioners alike and the complexities should not be underestimated. Indeed, there are sobering reports from stakeholders that even in primary care sexual health is widely considered to be a "walled-off service". The consequent "silo mentality" is being tackled, for example in the management of perimenopause,[139] but there is room to improve collaboration across the range of SRH services, including in primary and secondary care, in children's services, in mental health services, in pharmacies and with the charitable sector. Much of this work may be led by commissioning organisations, recognising the support that service providers might need to enhance their levels of collaboration.[140]

Collaboration should be promoted at the level of service provision without significant structural change, for example to facilitate co-location of services,[141] but there needs to be recognition from all actors that coordinating services is a priority that requires time and commitment. Instigating new ways of working in a system already under stress is, of course, challenging. It is recommended that all stakeholders consider how they might enhance collaborative working with their key partners and across the sector, including with the communities they serve. One specific area where service providers have called for greater collaboration regards improving data sharing while maintaining confidentiality. This would enable interventions to be better targeted to reduce inequalities.

Berlin Wall with NOIR, STIK 2019

Recommendation 5.

Continue to identify and address inequalities in SRH

Ongoing research and audit, undertaken in collaboration with communities where possible, is recommended to identify inequalities and communicate findings to all concerned partners. Such research should be coupled with a funded commitment to address those inequalities that are identified.

Inequalities in the SRH field vary according to the particular service being considered. Individuals or communities may become disadvantaged because of attributes such as gender, sexual orientation, age, culture or ethnicity, or due to their specific circumstances. Furthermore, the individuals or communities that experience relative disadvantage will change over time. Ongoing research and evaluation, preferably participatory research, is therefore necessary to identify communities with higher levels of need.[142]

Once inequalities have been identified, it is necessary to take steps to address them. For example, it is not enough to note the low levels of PrEP update among black African communities, or women in general; we need to go further and engage communities and partners to try and build momentum for change.[143] Where research has been undertaken collaboratively with communities and stakeholders, being ready to act on the results of that research is vital to building trust and productive partnerships.

It should be noted that when seeking to address health inequalities, we should not focus exclusively on disadvantaged groups. Such an approach may offer advantages for monitoring and evaluation but can also have significant drawbacks, such as leading to stigmatisation and resentment. Furthermore, a narrow approach may act to shift relative disadvantage to other communities rather than mitigate inequalities in general.

This is particularly true in the field of SRH where relative needs can rapidly change. Instead, the principles of proportionate universalism[144] should be adopted.

The concept of proportionate universalism states that:

"Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage"

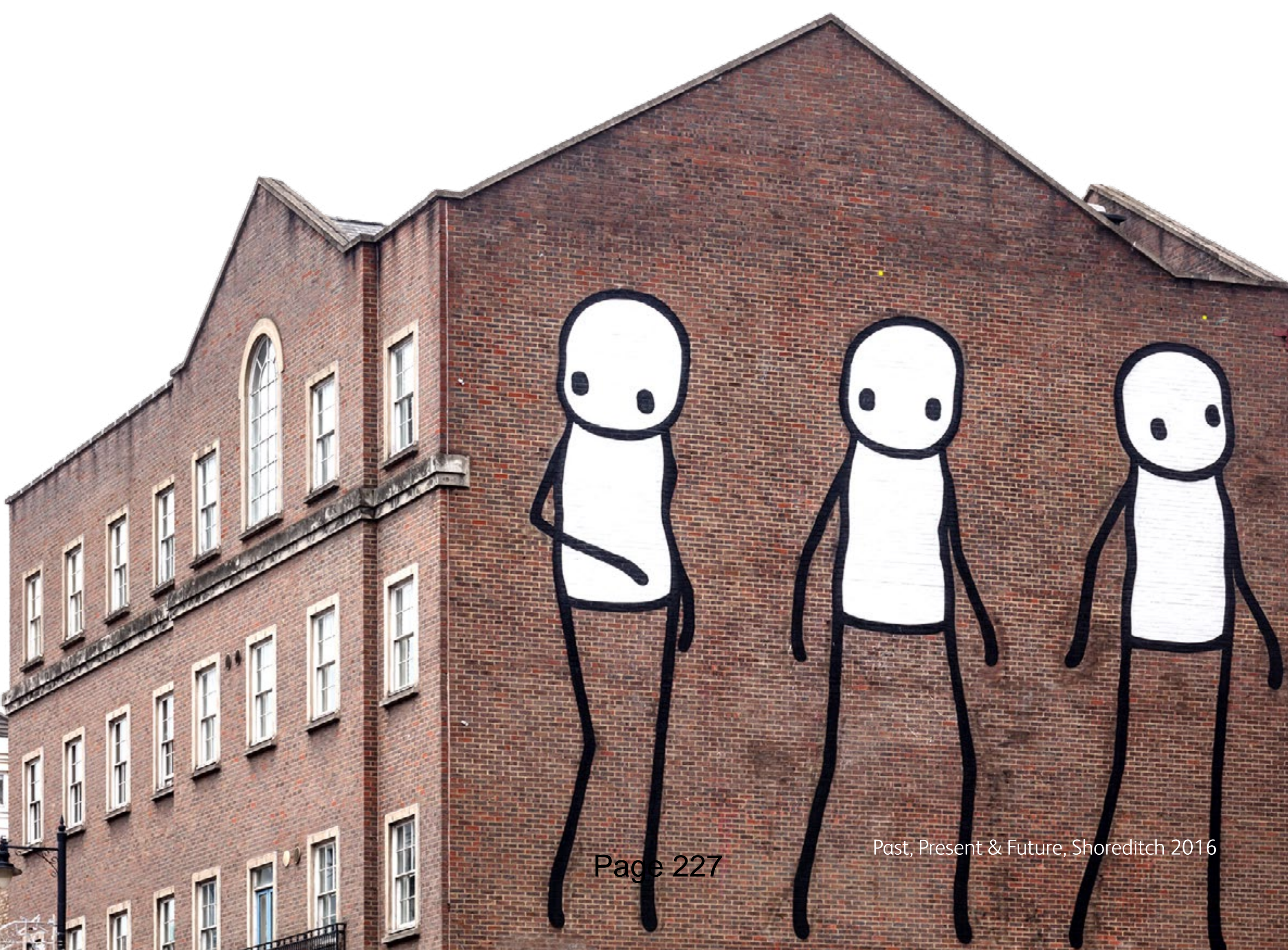
Fair Society, Healthy Lives (The Marmot Review), 2010, p.15.

Our aim must be, therefore, to optimise health and wellbeing through services that are both universally available yet also weighted in favour of those portions of society that have the greatest need.[145]

Conclusion

We must remember that "high-quality sexual health services are the cornerstone of ensuring good population health".[146] The City of London and Hackney have a strong history of promoting sexual and reproductive health throughout the population and stakeholders agree that there is a positive culture of encouraging and supporting innovation. The disrupting effects of the COVID-19 pandemic are, nevertheless, still being felt. Our response must be to redouble efforts to support people's rights to enjoy sexual and reproductive health through working collaboratively across the sector and hand in hand with the communities we serve.

The recommendations made in this report offer concrete suggestions for enhancing sexual and reproductive wellbeing through putting collaboration and a community-centred public health approach at the centre of our strategy.[147]



Past, Present & Future, Shoreditch 2016

DPH Annual Report (2023) Appendices

Appendix 1.

Update on recommendations made in last year's Director of Public Health annual report (2022)

Last year's Director of Public Health annual report (DPHAR) was published in April 2022 and looked at the impact of the COVID-19 pandemic on children and young people in the City of London and Hackney. It is available **here**. Last year's report made recommendations in five areas. These are listed below, with brief updates about ongoing related activities.

1. As the pandemic still has the potential to disrupt crucial services for children (such as education and healthcare) and affect children directly, it remains important to control COVID-19 and prevent illness through vaccination.

Over the winter months, the Public Health team worked with NHS North East London and colleagues in communications and primary care to increase access to and awareness of the COVID-19 vaccine for all residents, including children and young people. We provided regular updates to Education and Early Years colleagues (including headteachers) on local trends in COVID-19 infection rates and vaccination uptake. Direct support, advice and guidance for the prevention and management of acute respiratory infections, including COVID-19, was provided by Public Health's infection prevention and control capacity.

Targeted communication campaigns continue to maximise uptake of the first and second doses of COVID-19 and the Spring booster for those who are eligible. Since the DPHAR's publication in April 2022, there have been no full or partial school closures as a result of COVID-19.

2. This opportunity must be taken to strengthen and improve our vaccination uptake from all immunisations.

Stakeholders working in the field of immunisations from across the City of London and Hackney meet regularly to discuss operational challenges, as well as strategic opportunities to achieve a sustained increase in routine vaccination coverage. Activities undertaken include public webinars with local clinicians, specific communication campaigns and targeted events. A new Children and Young Persons Immunisation Coordinator has been recruited to lead further work with communities to increase uptake. Beyond routine vaccinations, significant work has been undertaken to maximise uptake of the polio booster, including with specific groups such as the Charedi community in Stamford Hill. Further, in response to a pertussis outbreak in the Charedi community, Public Health has worked with colleagues from UKHSA, NHS London, NHS North East London, local maternity services and primary care, as well as with Charedi community organisations and residents, to coordinate a system response to increasing uptake of maternal and childhood vaccines.

However, routine vaccination coverage has declined across London. Vaccination fatigue, reduction in trust of public services, impacts from COVID-19 and reduced access to care (e.g. high waiting times) are likely to have contributed to this. Concerningly, the reduction in vaccine uptake in the City of London and Hackney is more pronounced than in the rest of London. For example, comparing 2018/19 figures with 2021/22, the uptake of one dose of the MMR

vaccine in two-year-olds dropped by 8.9%, from 74.3% to 65.4%. This is much greater than the reduction across London of 3.1% and across England of just 1.1%.[148] As well as the reduction being greater, the overall proportion of vaccine uptake is also lower in the City of London and Hackney than in the rest of London. In 2021/22, 65.4% of two-year-olds received one dose of MMR vaccine in the City of London and Hackney, while across London the figure was 79.9%, and across England it was 89.2%.

The continued reduction in childhood vaccination coverage will undoubtedly increase the number of children in the City of London and Hackney who are at risk of contracting vaccine preventable diseases which can cause lifelong morbidity and even mortality. There remains an increased partnership focus on increasing vaccination coverage and further work and regular progress updates should be prioritised by the HWB, and NHS and Local Authority place-based partnerships.

3. To reduce inequalities that could have been widened by the pandemic, it is vital that catching up on what's been missed in education and healthcare should be approached in an equitable way. Getting education and healthcare services back on track will be key.

Government funding to support schools to help pupils make up for missed learning during the pandemic finished in the summer of 2021. It was replaced with a time-limited recovery premium grant providing over £300 million of additional funding for state-funded schools in 2021-2022; and £1bn across 2022-2023 and 2023-2024. Schools are targeting pupils on the basis of assessments of need, focusing the recovery premium grant where needs are greatest.[149] Work continues on developing curriculum implementation (recall, retrieval, live marking), tutoring, catch-up classes and the development of approaches, including use of additional resources and alternative provision.

Across England, the disadvantaged gap index[150] for pupils at both Key Stages 2 and 4 has widened in 2022 to the highest levels since 2012.[151] Locally, schools are reporting that performance gaps for disadvantaged and lower attaining pupils did not widen as expected, but that the attainment and progress of more able pupils was not as strong. Ongoing work is required, locally and nationally, to address inequalities to achieve - and surpass - pre-pandemic levels of educational progress.

Within the Early Years setting, among other activities, support has been given to providers to register with the Department for Education funded "Early Years Professional Development Programme" which aims to address the effects of the pandemic on young children. This online training focuses on communication and language; and personal, social and emotional development. Training is for Early Years settings that have children with SEND or have funded two-year-olds.

4. New needs have arisen as a result of the pandemic, and these should be recognised and addressed. These include:

a. Addressing obesity by supporting children and young people to eat healthily and move more. Interventions and system-wide efforts that can help children and young people (and their families) maintain a healthy weight will be vital.

b. Making sure children and young people can access mental health support is essential, especially in the context of those who may have been impacted by trauma.

On addressing obesity:

City and Hackney Public Health have commissioned a new Tier 2 family-based community intervention, starting in March 2023, to support families which have children above a healthy weight. This behaviour change programme is aimed at young people and families in the City of London and Hackney to help them create long-term, healthy habits relating to diet and physical activity. Public Health also launched a new Healthier Hackney physical activity community grants programme in February 2023. The programme aims to support less active residents in Hackney to become more active, building on what we have learned from residents and local organisations over the

past year. Children and families are one of the target groups for this new grants programme. The learning from this programme will provide opportunities for a similar approach to be considered for the City of London.

Ongoing activities have also been recommissioned. For example, the 0-5 healthy lifestyles service that provides lifestyle education to families and oversees the universal Healthy Start vitamin distribution scheme. Training is provided online and in early years settings to both families and staff. Other activities include the "cook and eat" community classes which are being recommissioned for a further 2.5 years, starting from April 2023. These classes focus on developing cooking and nutrition skills among families. There are also ongoing initiatives to promote healthy food in schools,[152] to establish healthier practices in food businesses,[153] and to ensure sufficient outdoor play areas in new developments.[154]

The City and Hackney Neighbourhoods team have been facilitating joint working at a place-based level to understand childhood obesity barriers and opportunities for collaboration and intervention. For example, in Well Street Common primary care network (PCN), which has the highest levels of obesity at reception and year six, childhood obesity was identified as a priority. A series of meetings with a wide range of stakeholders was convened and a joint action plan has been established. The learning from this will be shared with other PCN/ Neighbourhood areas including Shoreditch and the City.

Future activities include a Healthy Weight Needs Assessment that is being developed to identify unmet needs, inequalities and areas of good practice in the delivery of services and wider system actions related to healthy weight in City and Hackney. There are also plans to appoint a Healthy Schools Coordinator, who can support schools to embed activities that improve the wellbeing of children, young people and their families.

<u>On ensuring access to Mental Health Support for Children and Young People</u>:

We are in year 3 of the delivery of the City and Hackney Integrated Emotional Health and Wellbeing Strategy 2020-2025, overseen by the Emotional Health and Wellbeing Partnership. Priorities include addressing the post-pandemic surge in crisis presentations, maintaining momentum around integration of the different Children and Adolescent Mental Health services and creating 'a single point of access'. Subgroups of the Partnership include families, neurodiverse/ learning disabilities, schools, education, training and employment. There are also a number of system wide Task and Finish Groups to address Crisis and Eating Disorders.

An update on implementation of the C&H Mental Health Strategy and a mental health needs assessment will be provided to the HWB during 2023. This will provide an opportunity to consider how any gaps in provision can be addressed.

3. Closing the gaps: Many impacts of the pandemic have worsened existing inequalities that were already on a poor trajectory - such as increasing child poverty. Partners in The City of London and Hackney must continue using evidence-based efforts to tackle poverty due to its far-reaching implications for children's health.

The London Borough of Hackney (LBH) has developed a Poverty Reduction Framework which sets out the Council's strategic approach to poverty reduction. It aims to meet the immediate needs of people already in poverty whilst working towards preventing poverty for future generations. While it was developed by LBH, it has wider applicability across the City and Hackney place-based partnership and many elements of it require a partnership approach.

LBH has established four workstreams to respond to the cost of living crisis, the first of which is providing support to residents. This includes establishing a "Money Hub" with a £800k package to support those who have no other source of monetary support, targeted support using the government's Household Support Fund (£2.8M), and embedding financial assistance into all aspects of the Children and Education directorate's work.

Co-locating welfare advice services within GP practices will be funded for an additional year and then evaluated to assess the impact and consider whether this service should be expanded to all primary care networks, including Shoreditch and the City.

Work being undertaken in the City of London to address poverty and the rising costs of living includes general communication activities to promote services such as access to energy advisors, access to warm places and support for accessing work through the **Connecting Communities** programme. Targeted financial assistance is also being provided through an Energy Grant Scheme for people on prepayment meters and through the government funded Housing Support Fund. On tackling food poverty, there are plans to commission the charity **Family Action** to deliver a food pantry service for City of London residents and those residing in bordering boroughs.

The impact of poverty and the cost of living crisis on children and families in City and Hackney is ongoing. Continued monitoring of this impact and ensuring that services are able to meet identified needs must continue.

Appendix 2.

A model of Sexual and Reproductive Health services

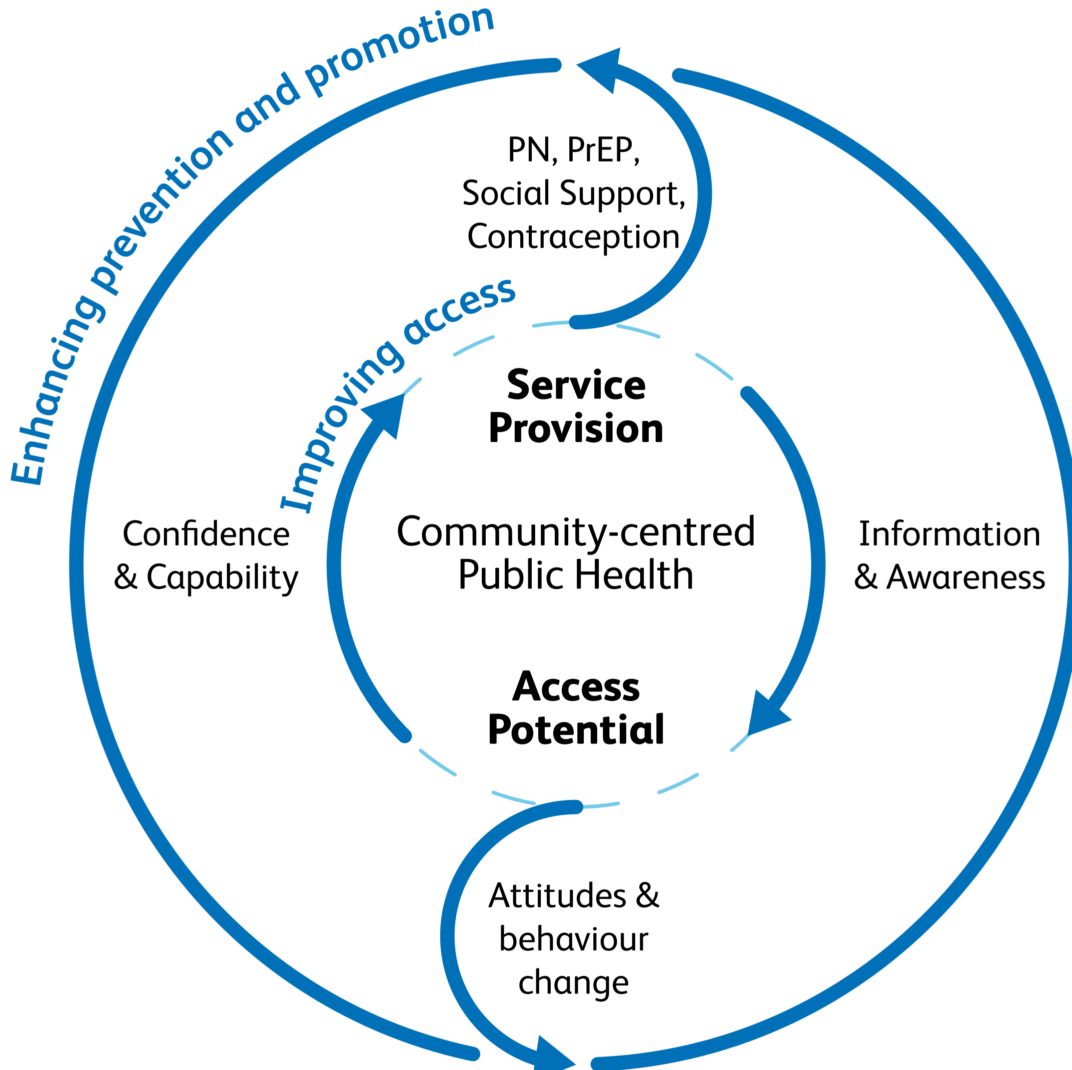
The model outlined here (see Figure 2) illustrates the linked nature of the recommendations made in this report, particularly recommendations 2 and 3 which relate to the design of services on the one hand and people's ability and willingness to access them on the other hand. The model demonstrates how initiatives taken in different areas are mutually supportive and the importance of keeping a focus on collaboration with communities at the centre of our work.

Many public health models look at the determinants of health, either from the perspective of the individual or the public, or they examine how best to implement and provide services to a population.[155] This model, however, aims to draw attention to the linked nature of service provision on the one hand and willingness, or ability, to access those services on the other hand. The issue of whether or not people have the potential, capability or willingness to access services is perhaps more relevant to sexual health than any other aspect of healthcare. It is in sexual health that, according to practitioners in the field, many of the barriers to access come from the individuals and communities themselves. This model, therefore, specifically applies to sexual health: where cultural and community norms are so paramount; and factors relating to personal choice, identity and individual circumstances are so significant. There are few fields of healthcare where the capacity to access services is so dependent upon issues that go beyond simply being aware that a service is available.

Applying this model to "young people" helps to illustrate that efforts to improve access must take into account many factors. The model can act, therefore, as a checklist when trying to address issues of access and, in turn, improve a population or community's sexual health generally.

For the model to be most useful, it would be best to apply it to a single community rather than "young people" in general. Stakeholders are encouraged to consider specific community-orientated approaches to designing, commissioning and implementing services - an approach which this model may help facilitate. For example, the model might be used to explore issues relating to Turkish-speaking communities, or to the Charedi community, or to other distinct communities.

Figure 2: a model of sexual and reproductive health services



Cycles of positive reinforcement

The outer circle: preventing ill health and other negative aspects while promoting enjoyment of sexual wellbeing, agency and freedom.

The inner circle: improving Access to services. This illustrates two aspects that need to be considered to improve access: the appropriateness of services provided (service provision) and the ability/willingness to access them (access potential).

As the inner circle spins, access improves which in turn helps widen the circle of prevention and health promotion at a population level.

Service provision: the right services, that are appropriate and sufficient, are available.

Information & Awareness: there is clear and accurate **information** available; and people are **aware** of that information and the services.

Access potential: an individual's willingness to access services, influenced by RSE, community & individual attitudes, religious and cultural contexts.

Confidence & Ability: people are **confident** to access services (not blocked by confidentiality, embarassment or stigma issues); and people are **capable** of accessing services (appropriate times and locations). As more people from a community access a service, word of mouth spreads and attitudes change.

Notes on terms used in the diagram

At the centre of the diagram

"Community-centred Public Health" is a community-centred approach to tackling public health issues which is increasingly being adopted "to enhance individual and community capabilities, create healthier places and reduce health inequalities" (PHE 2020[156]). It strongly advocates, among other things, a commitment to co-production and community-based participatory research.

The inner circle - improving Access

"Service provision": appropriate services, and arrangements, designed in collaboration with the community/ies of concern.

"Information & Awareness": appropriate services must be communicated to potential users of those services through high quality information (***better***, not more, information).

"Access potential": ensuring knowledge of services through, for example, public information campaigns, community champions, and relationships and sex education (RSE). Access potential can also be enhanced by addressing stigma and embarrassment and through mitigating any logistical or financial barriers that are identified (for example, some young people may not be able to cross gang lines).

"Confidence and capability": addressing issues around "access potential" should result in more willingness and ability to access the services available.

Ensuring appropriate "service provision" (for example, providing easily accessible comprehensive STI testing) while at the same time increasing the "access potential" among the population, will lead to benefits relating to the prevention of ill health and promotion of healthy sexuality. This will be self-reinforcing, with positive effects maximised by addressing as many aspects of the model as possible.

The outer circle - enhancing Prevention and Promotion

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

"Service provision" helps achieve population level health promotion through elements such as patient notification (***PN***);[157] provision of ***contraception*** services; ***social support*** (including psychosexual, high risk behaviour and trauma therapies); and ***PrEP*** (albeit this involves relatively small numbers).

"Access potential" helps achieve population level health promotion through helping to change attitudes and health behaviours. Shifting people's attitudes, including stigma or prejudice, as well as their health behaviours, can both have the potential for positive knock-on effects on people who are not directly addressed by the original interventions (for example, the effects on parents as a result of their children's attendance at RSE, or positive health behaviours modelled by some individuals being adopted by others in their peer groups).

Efforts made to enhance s***ervice provision*** and those made to increase ***access potential*** will both, together and separately, help support the prevention of ill health and the promotion of healthy and enriching relationships at a population level. Health promotion at the population level is fundamental to a community-centred public health approach. Focusing on prevention and promotion is about health ***care*** as opposed to a medical model of ***sick*** care. And not only is prevention better than cure for the individual, it is also cheaper for both the individual and the community.

Holding Hands, Hoxton Square, STIK 2020

Endnotes

1 Data is available from the Office for Health Improvement & Disparities (OHID) on their Fingertips platform (see **here**). The rate of "new STI diagnoses" excludes diagnoses of chlamydia in the under 25s because those numbers are so high it makes comparison between Local Authorities more difficult. However, even including all new STI diagnoses (see **here** for data), the rate in Hackney in 2022 was over four times higher than the England average, at 2,897 compared to 694 per 100,000. The value for the City of London was even higher, at 3,655 per 100,000 but it must be borne in mind that the absolute number of cases in the City of London is low (the total count was 315).

2 In 2021/22, approximately 10,000 STI screens were conducted across the sector, compared to over 23,000 in 2019/20 (Homerton Sexual Health Services, Sexual Health Equity Audit 2021/22).

3 "Sexual health-related issues are wide-ranging, and encompass sexual orientation and gender identity, sexual expression, relationships, and pleasure. They also include negative consequences or conditions such as: … sexually transmitted infections ... ; unintended pregnancy and abortion; sexual dysfunction; sexual violence; and harmful practices (such as female genital mutilation)." WHO website, Overview of "Sexual Health", available **here**.

4 Pound and Campbell (2017) **Policy Report** on the delivery of sex and relationship education, University of Bristol.

5 Hackney's population is estimated at 259,956, while the City's is 8,618. These figures are from the Office for National Statistics (ONS) mid-year 2021 population estimates, based on 2021 Census data (ONS **Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland**).

6 The 2021 ONS estimate, available **here**, suggests 65.5% of the population of the City of London and Hackney is 40 years old or under.

7 2021 Census data gives the following percentages for ethnic groups within the City of London and Hackney: white British 34.2%, black 20.5%, white other 19.46%, Asian 11%, other ethnic group 8.55%, mixed/multiple 6.71%,

8 **https://hackney.gov.uk/knowing-our-communities** accessed 25 January 2023.

9 **https://hackney.gov.uk/knowing-our-communities** accessed 25 January 2023.

10 2021 Census data on sexual orientation by sex available **here**. Data was released on 4 April 2023 and is for persons aged 16 and above.

11 This is particularly relevant to the provision of sexual health services because local data shows that men who have sex with men (MSM) are three and half times more likely to attend sexual health clinics than other men (HSHS Sexual Health Equity Audit 2021).

12 The "Index of Multiple Deprivation" combines several deprivation indicators relating to income, employment, crime, living environment, education, health, and barriers to housing and services, in various proportions to produce an overall figure which can be used to compare different regions.

13 The scores in London ranged from 9.4 for Richmond Upon Thames (the best) to 32.8 for Barking and Dagenham (see 2019 IMD scores on OHID Fingertips **here**).

14 It is important to note, when considering this contrast between the relative affluence of the City of London as opposed to Hackney, that the estimated residential population of the City of London is just 3.7% of the combined population of the City of London and Hackney. This means that more than 96% of the combined population of the City of London and Hackney live in the relatively deprived borough of Hackney.

15 "Strong links exist between deprivation and sexually transmitted infections (STIs), teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), trans community, teenagers, young adults and black and minority ethnic groups", DoH & PHE (2018) **Integrated Sexual Health Services: A suggested national service specification**, p.5.

16 PHE Guidance **Health matters: reproductive health and pregnancy planning**, 26 June 2018. Note that IUSs can, as well as being used for contraception, also be used as part of Hormone Replacement Therapy (HRT) to manage perimenopausal symptoms.

17 PHE Guidance **Health matters: reproductive health and pregnancy planning**, 26 June 2018.

18 These figures are for women aged 15-44 and exclude prescriptions for contraceptive injections.

19 From 2014 to 2021, Hackney was only below the London average in 2020.

20 See OHID Fingertips data available **here**. While increasing LARC provision through General Practice in Hackney may, therefore, represent an opportunity to enhance access to LARC for the local population, it is also possible that many people have historically simply preferred to access LARC through specialised sexual health clinics, and access to such clinics may be easier in Hackney and the City than in other parts of the country.

21 See 2021 data from OHID Fingertips, available **here**.

22 The provision of contraception, including LARC, is considered in more detail in the upcoming City and Hackney Sexual and Reproductive Health Five-Year Strategy.

23 Teenage mothers are less likely to finish education, more likely to bring up their child alone and in poverty, and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers (Office for Health Improvement and Disparities, available **here**).

24 See data available **here**. It must be noted that comparison with national averages is hampered by the relatively small absolute numbers involved. For 2020, the absolute number of conceptions in women under 18 years old in the City of London and Hackney was 44, indicating a rate of 10.1 per 1,000 women aged 15-17 living in the area.

25 Data for the City of London is not available.

26 In 2021, Hackney had the 3rd highest rate of abortions in women under 18 compared to its 15 nearest neighbours (UKHSA **Summary profile of local authority sexual health Hackney**, 1st Feb 2023).

27 UKHSA **Summary profile of local authority sexual health Hackney**, 1st Feb 2023.

28 Partner notification is the system by which sexual contacts of people diagnosed with an STI are informed that they should be tested and may require treatment. This can be done by the patient themselves but should also be available as an anonymous service through the healthcare provider. Effective partner notification systems are essential for timely treatment of those who may be infected but asymptomatic and to prevent further transmission. See further discussion of partner notification in the section on **testing for STIs** under **Recommendation 2** below.

29 OHID Fingertips, data available **here**. The value for the City of London was even higher, at 3,655 per 100,000 but it must be borne in mind that the absolute number of cases in the City of London was low (the total count was 315).

30 The City of London is the local authority with the second highest prevalence of HIV in England, while Hackney has the 13th highest prevalence. This is according to the most recent available data (**see here**) which is for 2022.

31 Data which includes primary care, secondary care and SHL, show that in the reporting year 2019/20 there were 23,568 STI screening tests performed compared to just 10,189 in the year 2021/22 (Homerton Sexual Health Services, Sexual Health Equity Audit 2021/22).

32 It must be borne in mind that not everyone can access SHL as it is only for people aged 16 and above and requires both access to online resources to book tests and an address where testing kits can be received.

33 The number of all new STI diagnoses in Hackney fell by 40% from 9,432 in 2019 to 5,614 in 2021 (UKHSA **Summary profile of local authority sexual health Hackney**, Feb 2023). However, the amount of testing across the sector dropped by 57% and at the same time the ratio of positive results to tests performed has increased slightly from 1:3.5 to 1:3.1 (HSHS, Sexual Health Equity Audit 2021).

34 Data for 2022 were released by OHID on 6 June 2023. These show that the number of new STI diagnoses in Hackney and the City of London increased in 2022 compared to the previous year. At the same time, the amount of STI testing (excluding chlamydia in the under 25s) also increased, albeit not by as much as the increase in new STI diagnoses. The inference that STI testing is still not matching the level of disease in the community is supported by the fact that the positivity rate for tests (again excluding chlamydia in the under 25s) for both Local Authorities is now slightly higher than before the pandemic (although this increase does not meet criteria for statistical significance). See **here** for OHID Fingertips Sexual Health data.

35 Examples of proactive engagement include teaching RSE in schools and the virtual engagement events organised by the Community Gynae pilot project commissioned by NHS England.

36 Indeed, there is debate in the field regarding the appropriate terminology to describe different services. Terms such as sexual health, reproductive health, women's health, gynaecology and maternity care all overlap with one another and can lead to confusion. The discussion around these, and other, terms is significant because of the implications for commissioning and determining where responsibility lies for funding. In this report, the term Sexual and Reproductive Health (SRH) has been adopted in order to mitigate some of these concerns and maintain a wide frame of focus on the issues.

37 The majority of STI-related care accessed by residents of the City of London and Hackney is provided by Homerton Sexual Health Services (HSHS). Between 2018 and 2020, 101,485 activity codes registered at the HSHS GUM service were for STI-related care (e.g. treatments prescribed and partner notification). During the same period,

7,560 SH patients were seen by GPs in the City of London and Hackney and only 9 appointments were provided by pharmacies in the City of London and Hackney for chlamydia treatment. This equates to HSHS providing 93.1 % of care, GPs providing 6.9 %, and pharmacies providing <0.1 % (GUMCAD, CCG GP data, Pharmoutcome), as per the draft SRH Needs Assessment, Hackney & City Public Health Intelligence Team 2022.

38 Local information on PrEP is available on the Homerton Healthcare NHS Foundation Trust website **here** and general information at the **Prepster** website.

39 See UKHSA **Information on HPV vaccination** (updated 10 Aug 2022) for background on the human papillomavirus (HPV) vaccination programme (accessed 10 Feb 2022).

40 Stakeholders are nevertheless concerned about potential gaps and these are discussed below in the section “groups requiring particular attention”.

41 For example, services available in evenings and weekends can reduce the cost of accessing services associated with lost earnings or facilitate access for those with caring responsibilities or in full-time education.

42 The Future Insight Partnership Project’s evaluation of SRH services describes considerable problems at specialist clinics with appointment booking systems and telephone access (Future Insight Partnership Projects report, **East London Mystery Shopping**, Dec 2022).

43 Several service providers consulted during the preparation of this report expressed frustration with long waiting times as a result of staffing capacity. Issues relating to staffing are well known and present across the system, including in the voluntary sector.

44 Future Insight Partnership Projects report, **East London Mystery Shopping**, Dec 2022.

45 While HSHS continues to offer walk-in appointments to children under 19, this is only at one clinic. There is a specific service for young people aged 11-19 (CHYPS Plus) but it has not been able to maintain its level of service due to staffing issues.

46 Between 2018 and 2021, Hackney residents recorded a 390.1 % increase in the number of tests completed through the sexual health e-service, while City residents recorded a 235.7 % increase.

47 HSHS Sexual Health Equality Audit 2022.

48 The increase in the use of online sexual health services is dramatic and likely to continue. Evolving AI technology, such as ChatGPT, may facilitate the provision of additional information and advice via online services.

49 In January 2020, there were a total of 6,331 attendances at HSHS compared with just 3,470 in January 2023 (HSHS Equity Audit 2022 and HSHS Activity Report, January 2023). Comparing attendances specifically for LARC, in January 2023, HSHS had 70 % of the attendances it had in January 2020 (297 as opposed to 425).

50 Although primary care stakeholders report a significant drop in face-to-face appointments, data from NHS NEL suggests that this has not been as dramatic as in secondary care. NHS NEL report that in February 2023, 76 % of GP appointments were face-to-face as compared to 82 % in February 2020 although they also note that the pre-pandemic data is not as reliable as they would like. It is important to bear in mind that a move to larger numbers of telephone consultations is welcomed by many patients and may represent improved efficiency. Nevertheless, there does appear to have been a significant reduction in the number of STI tests being carried out in primary care although again, stakeholders report considerable concerns regarding the reliability of the data.

51 The number of LARC prescriptions per 1,000 women in Hackney was 37.5 in 2021 after dropping to just 19.3 during 2020. In 2019, before the pandemic, the figure was 45.9 compared to a London average that year of 39.6 (OHID Fingertips data available **here**).

52 Staffing shortages have been described in almost all interviews conducted with stakeholders during the preparation of this report. In particular, nursing shortages, including school nurses, are impacting service provision. Staff shortages and high levels of turnover are reported in secondary care, general practice, pharmacies and the charity sector.

53 Some stakeholders felt that the impact of Brexit locally was to exacerbate staffing difficulties within healthcare.

54 “Self-reported measures of personal well-being dropped to record lows during the first and second waves, with some groups experiencing particularly poor or deteriorating mental health - including women, young people, disabled people, those in deprived neighbourhoods, certain ethnic minority groups and those who experienced local lockdowns” (quote from Living with COVID, referring to: Office for Health Improvement and Disparities, COVID-19: mental health and wellbeing surveillance report, 18 November 2021.

55 A Department of Education report notes that “pupils from disadvantaged backgrounds (primarily those eligible for free school meals at some point in the last six years) experienced greater learning losses than their more affluent peers as a result of

the pandemic." DfE **Understanding Progress in the 2020/21 Academic Year: Extension report covering the first half of the autumn term 2021/22**, March 2022. (p.8 accessed 20 Feb 2023).

56 For example, the proportion of men who have sex with men (MSM) accessing services at HSHS is higher than the proportion in the general population; and the number of white people accessing services at HSHS are lower (HSHS Sexual Health Equity Audit 2021).

57 Highlighting poverty as the overarching cause of inequalities in SRH does not undermine the importance of ongoing efforts to address racism, including structural racism. The UK Faculty of Public Health declared in 2020 that, "[n]ot enough is being done to rectify the inequalities experienced by Britain's minority ethnic population, as most recently demonstrated by **PHE's COVID-19 disparities review** and **stakeholder engagement**" (see Faculty of Public Health Statement on racism and inequalities, available **here**).

58 Office for Health Improvement & Disparities (2023) **Integrated sexual health service specification**.

59 2021 data on new STI diagnoses excluding chlamydia arranged by District and UA deprivation (IMD2019). Data source Fingertips accessed **here**. This trend is also seen in chlamydia detection rates in 15-24 year olds, see **here**.

60 This may partly be because financial issues act as a barrier, both directly and indirectly, to accessing services or continuing to engage with them. Service providers describe individuals who face financial difficulties losing touch with services because of their other concerns. This particularly affects people requiring longer term treatment or support.

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

62 The Homerton Sexual Health Services Equity Audit 2022 notes that 96% of PrEP prescriptions were for MSM. Furthermore, from July 2020 to March 2021, only 12% of individuals attending HSHS for initiation of PrEP were black, yet black people made up 33% of all clinic attendances suggesting that black communities are not accessing PrEP as might be expected. By contrast, during the same period, white people accounted for 63% of PrEP initiations but only 41% of patients seen at the clinic. It is important to bear in mind that the City of London is the local authority with the third highest prevalence of HIV in England, and Hackney has the twelfth highest prevalence (data available **here**).

63 Stakeholders in primary care report discussions with colleagues and reasling none of them have prescribed HRT for menopausal symptoms to Turkish-speaking patients. The Community Gynae Project Pilot has also recognised this potential gap and has plans to hold future events on menopause specifically for Turkish-speaking patients.

64 Late diagnosis is defined here as having a CD4 count <350 cells/mm3 within 91 days of first HIV diagnosis in the UK.

65 Data from the UKHSA Summary profile of local authority sexual health, Hackney, 1 Feb 2023. The report notes that data may refer either to Hackney or both Hackney and City of London combined.

66 In Hackney, 2019-2021, late diagnosis of HIV in heterosexual men occurred 53.3% of the time, similar to the 58.1% in England; in heterosexual women it was slightly higher than national average at 55.0% compared to 49.5% in England as a whole (UKHSA **Summary profile of local authority sexual health, Hackney**, 1 Feb 2023).

67 The NHS Talking Therapies programme was previously known as the Improving Access to Psychological Therapies (IAPT) programme and was developed as a way to improve access to evidence-based psychological therapies.

68 One clinician explained that, "splits in commissioning impact how we conceptualise and deliver care … in my experience, the commissioners don't talk to each other and it is beyond frustrating".

69 The **National LGBT Survey: Summary Report**, 2019 from the Government Equalities Office notes that "[o]f the 2,900 respondents who discussed gender transition and gender identity services … a picture was painted of hard-to-access services, a lack of knowledge among GPs about what services are available and how to access them, and the serious consequences of having to wait … trans people reported going abroad, using the internet to purchase hormones or turning to prostitution to raise the money needed to access private medical treatment" (accessed 26/1/2023). It further notes that trans people have high rates of self-harm, citing the **Trans Mental Health Study 2012**.

70 These figures are from the Office for National Statistics (ONS) mid-year 2021 population estimates, based on 2021 Census data (ONS **Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland**).

71 2021-2022 data from the Homerton Sexual Health Service (HSHS) show that 20-29 year old women are overrepresented in terms of accessing HSHS compared to the population as a whole.Similarly, 25-34 year old men are also overrepresented as users of HSHS services (Homerton Sexual Health Services, Sexual Health Equity Audit 2021/2022).

72 The peak age for men accessing services at HSHS is slightly higher than women. 38% of men accessing the services were under 30, but 62% of men were under the age of 35.

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

74 Different organisations adopt different cut-offs. The

HSHS, for example, defines young people as those aged 25 and below.

75 ONS 2021 mid-year population estimates, available **here**.

76 NICE guideline [NG221] **Reducing sexually transmitted infections** Published: 15 June 2022, p.8. The same guideline gives recommendations for possible topics for discussion when working with communities on reducing STIs. The pdf version of the guidelines is available **here**.

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

78 The final version of the charter was published in 2022 with the cooperation of the London Borough of Hackney, the City of London Corporation, Hackney CVS, Mind in the City, Hackney and Waltham Forest, East London NHS Foundation Trust, Homerton Healthcare NHS Foundation Trust and the North East London Clinical Commissioning Group (now NHS North East London Integrated Care Board).

79 Community-centred Public Health is an approach to tackling public health issues which is adopted "to enhance individual and community capabilities, create healthier places and reduce health inequalities" (PHE 2020 briefing, Community-centred public health: Taking a whole system approach available **here**). See further **Health Matters** (28 February 2018) and the PHE/NHS England **guide to community-centred approaches** (2015).

80 This may follow the model adopted by the Hackney Young Futures Commission for their 2019/20 consultation using peer researchers supported by a project team (see **Valuing the Future Through Young Voices**); or the model be adopted by the Community Gynae Pilot Project in which members of the public are invited via their GPs to participate in virtual meetings of up to 100 people.

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

82 The 20-24 year old age group has recorded the highest number of STI tests per 100,000 people in the City of London and Hackney over the last five years of available data (2016 to 2020). This data is from the GUMCAD STI Surveillance System, a mandatory surveillance system for STIs that collects information on STI tests, diagnoses and services from all commissioned sexual health services in England.

83 Reinfection rates refer to the likelihood of someone testing positive for an STI within one year of previously testing positive.

84 In Hackney, an estimated 10.9% of women and 16.4% of men presenting with a new STI from 2015 to 2019 became re-infected with a new STI within 12 months. Nationally, during the same period, 7.1% of women and 9.9% of men became re-infected (SPLASH supplementary reinfections report).

85 In the year 2019/20, 23,568 STI tests were performed across the system compared to just 10,189 in the year 2021/22. The ratio of positive diagnoses to tests performed is similar post-pandemic, at 1:3.1 as it was pre-pandemic (1:3.5) (HSHS Health Equity Audit 2022).

86 The source of this data is the HSHS Sexual Health Equity Audit 2022. According to this audit, in 2021/22, SHL performed 6054 STI screens, HSHS 2128 and primary care 2007. These figures have been discussed with the GP Confederation who noted that it is possible that some negative test results in primary care were not recorded.

87 In January 2020, there were a total of 6,331 attendances at HSHS compared with just 3,470 in January 2023 (HSHS Equity Audit 2022 and HSHS Activity Report, January 2023).

88 The reason given on the website for moving to appointment only clinics is the need to maintain social distancing. Staff report that they have not been restarted due to staffing issues and concerns that people can become frustrated with long waits. Walk-in appointments are still available to children under 19 but only at one clinic. The specific service for young people aged 11-19 (CHYPS Plus), which is also run by the Homerton Healthcare NHS Trust, has unfortunately struggled to maintain its level of service post-pandemic due to staffing issues.

89 This was one of the main findings of the "East London Mystery Shopping" report, December 2022, by Future Insight Partnership Projects. Mystery Shoppers contacted 13 different SRH services across North East London. Mystery Shoppers reported telephone numbers not working; a lack of queuing system; extremely long waits in excess of one hour; and the phone ringing off unexpectedly. Difficulties were also reported when trying to book online. In total, 33.9% (n=20) of "shoppers" were able to get an appointment on their first attempt, 28.8% (n=17) needed to make five or more attempts to book an appointment, and 37.3% (n=22) were unsuccessful in booking an appointment despite trying on multiple occasions.

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

91 This data is from Pharmoutcomes and only applies to the 44 Hackney and City pharmacies that recorded information using the Pharmoutcomes system. As noted previously, the absolute number of STI kits provided in pharmacies is relatively small, with 921 self-test kits distributed in the four year period 2018-2021.

92 It is worth noting that the use of secondary care SRH services provided by Homerton Sexual Health Services (HSHS) does not, according to 2016-2020

data, vary considerably by geography, at least not within Hackney, which suggests that variations between GP practices and pharmacies is unlikely to relate to differences in the level of local need. While it is the case that the lowest appointment rate at HSHS services was recorded for City of London residents, this is most likely because these residents are relatively far from HSHS services and are probably seeking care elsewhere (data source: SRHAD).

93 Stakeholders from primary care have noted that new patient checks have, in many practices, stopped altogether because they were time consuming and poorly remunerated. STI testing, including for HIV, was commonly offered at these checks and they offered a good opportunity for providing health promotion information.

94 The need to provide training and information to staff is highlighted by stakeholders who report that, in primary care "there is definitely a lot of residual belief that there are counselling barriers to wider testing [for HIV]"; and that in pharmacies, high staff turnover means that staff are sometimes unaware of services or do not have the skills to counsel patients effectively.

95 Young Hackney's Health and Wellbeing Team attend schools to support the delivery of the Relationship and Sex Education (RSE). A list of the RSE sessions they offer in schools and colleges can be seen **here**.

96 Positive East uses a community based testing model: going into a range of venues where people can test to increase access. They report that around 30% of the people they help to test are not in primary care, and 20-25% of people are first time testers.

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

98 The **British Association for Sexual Health and HIV** Standards for the management of sexually transmitted infections (STIs), (April 2019), states that "Commissioners should ensure that all providers of services commissioned to manage STIs: … instigate PN as a core requirement either by patient referral … or by provider referral …The form of PN utilised should be the choice of the person diagnosed with a STI" (p.37, available **here**).

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

100 The "status neutral" approach was first introduced in the US in relation to HIV prevention. It is described on the US CDC website (see **here**) as defining "the entry point to care as the time of an HIV test. At this entry point, clients' needs are assessed and they are engaged and linked to appropriate services based on these needs, regardless of whether their HIV test is positive or negative".

101 Residents aged 16+ can access contraception through SHL. This can be delivered to their home or collected from a pick-up point. 16-17 year-olds must collect their prescription from a pharmacy.

102 HSHS Equity Audit 2022 and HSHS Activity Report, January 2023.

103 City & Hackney GP Confederation data, 1 April 2021 to 1 January 2022.

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

105 Stakeholders suggest that if sufficient momentum could be established for training LARC fitters in primary care, individual practices would perhaps have less concern about the costs of establishing a service and the risk of staff leaving because they would be able to draw on a community of local fitters that could be employed on an ad-hoc basis to cover clinics when required.

106 The community gynae pilot project setting up a women's health hub stems from the government's **Women's Health Strategy for England** 2022. As well as LARC, it offers menopause services and organises virtual events, peer support networks and group consultations. For further information see the case study **Setting up a Women's Health Hub in Hackney** (May 2022) prepared by Primary Care Women's Health Forum.

107 Data from Pharmoutcomes, Pathway analytics, and Preventx.

108 Healthwatch Hackney, Mystery Shopping exercise of Access to Emergency Hormonal Contraception in Hackney, February 2023.

109 23 of the pharmacies confirmed that the service was free but three were unable to provide it for staffing or stock issues and five gave conflicting or confusing information.

110 One pharmacy that had offered free services on the phone, requested payment for the service during the visit.

111 Pharmacy data shows that EHC usage is highest among 15-24 year olds (Pharmoutcomes).

112 The Community African Network (CAN) is also commissioned to provide condoms to adults in The City of London and Hackney from black African and other ethnic minority groups.

113 Data from Pharmoutcomes and Therapy Audit Condom distribution data. In 2019 there were 60 registered outlets in The City of London and Hackney and 46 in 2020. The highest number of encounters was at the Clifden Centre (HSHS) followed by CHYPs Plus.

114 Homerton Sexual Health Services combined with CHYPS Plus accounted for 29.6% and Hackney's children and young people's services (Young Hackney) accounted for 15.2%.

115 Stakeholders report that condom distribution through primary care is, in contrast, largely ineffective because GP Practices are discouraged from participating in schemes because of requirements to be part of a pilot scheme and to record all distributions.

116 Homerton Sexual Health Services note on their website that walk-in appointments are still available at the Clifden Centre for people under 19 years old. However, this is only one out of their four centres and even there, only two clinics operate after 4pm: a GU evening clinic on Wednesdays 5-7pm and an MSM clinic 5-7pm on Thursdays. All other clinics finish at 4pm.

117 Some stakeholders have expressed concerns that youth hubs and clinics are not always universally accessible due to problems relating to gang lines. Also, young people have expressed concerns relating to risks to confidentiality when accessing some services: they are not always offered private consultation rooms in pharmacies, and the waiting room at the Clifden centre is currently shared with the hospital's general phlebotomy service.

118 Issues regarding booking systems and appointment availability were highlighted by the NEL Mystery Shopping exercise.

119 See **here** for the type of RSE support provided by Young Hackney's Health and Wellbeing Team.

120 Levels of LARC and STI testing vary considerably from GP practice to practice and between pharmacies; and specific concerns around provision of EHC in pharmacies have been identified.

121 Stakeholders in primary care report that partner notification systems are cumbersome and expensive, and consequently rarely being used. This creates the risk that people that may have been infected are not being notified which delays their treatment and increases the chance of onward transmission.

122 Primary care stakeholders report that negative STI tests are not routinely communicated to patients which is a missed opportunity for instigating behaviour change and making every contact count.

123 For example, HIV testing may be increased in primary care as part of new patient checks, where these are ongoing, or NHS health checks.

124 In 2018, Public Health England published **A consensus statement: reproductive health is a public health issue** which outlines six pillars of reproductive health. The "Knowledge and Resistance" pillar was described as having two elements, (1) to "[i]ncrease user awareness and knowledge about reproductive health over the life course, how to remain healthy, have positive fulfilling relationships and access care when needed." and (2) to "[f]acilitate access to sex and relationships education throughout the life-course, intergenerational learning and ensuring that reproductive health is part of wider public health messaging."

125 "Health promotion and education remain the cornerstones of STI prevention, through improving risk awareness and encouraging safer sexual behaviour." BASHH Standards for the management of sexually transmitted infections (STIs) in outreach settings, July 2016, p.4, available **here**.

126 NICE guidelines recommend that any interventions that are undertaken are delivered by people who share a culture or group background with the target group, and are "sex and identify positive", focusing on "self-worth and empowering people to have autonomy over their bodies and their sexual decision making" (see NICE Guidelines on **Reducing Sexual Transmitted Infections** [NG221] July 2022). The same guideline defines "sex-positive approaches" as being "non-judgemental, [and] openly communicating and reducing embarrassment around sex and sexuality. Recognising the diversity of sexual experiences that exists and that sex can be an important and pleasurable part of many people's lives." The full document is available **here**.

127 Stakeholders suggest that contraception, for example, could be better promoted throughout primary and secondary care. GPs were previously incentivised with Quality and Outcomes Framework (QOF) targets to provide advice to women whenever they had a contraceptive pill check or request a repeat prescription. This QOF target was not popular and has been removed but there are concerns that there may consequently be fewer conversations regarding LARC in primary care.

128 NICE defines sexual self-efficacy as a "person's sense of control over their sexual life and sexual health, and their ability as an individual to have safe, consensual and satisfying sex" (NICE guideline [NG221] **Reducing sexually transmitted infections** Published: 15 June 2022).

129 RSE became compulsory in all state-funded secondary schools in September 2020. The Sex Education Forum report, **RSE: The Evidence**, (Nov 2022) outlines evidence indicating that RSE can: reduce sexual violence; make children more likely to seek help; make them more likely to practise safe sex; make it more likely that 'first sex' is concensual; improve online literacy; and increase gender-equitable and inclusive attitudes.

130 Stakeholders have also emphasised the need to ensure that safeguarding is always considered when reviewing interventions, in particular issues of child sexual exploitation and possible problems relating to gangs.

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

132 The recent Mystery Shoppers report on Sexual Health Services in North East London (December 2022) notes that service users were surprised that there is no single telephone or website access point for North East London SH services.

133 Stakeholders report the effectiveness of the **Shout Textline** run by Young Minds to provide mental health support to young people. It may be possible to offer a similar service regarding SRH if this was determined, by young people themselves, to be a popular way to access information and support.

134 This may include ensuring compliance with standards such as the **You're Welcome** criteria for young person appropriate services; reiterating commitments to anti-racism; effectively communicating commitment to confidentiality; or providing peer navigators/youth workers to help guide people through the process. One specific area of concern that has been raised by stakeholders is the co-location of SRH services with other services. For example, the co-location of general hospital phlebotomy services at the Clifden Sexual Health Clinic means that waiting areas are shared between people waiting for the sexual health services and those waiting for general blood tests. This may make people accessing the sexual health clinic feel less comfortable.

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

136 Initiatives may involve schools, faith groups, Public Health Community Champions (now funded for a further 5 years), anchor institutions, youth hubs and VSOs. Public organisations in The City of London and Hackney may, for example, wish to engage with the Fast Track Cities **Anti Stigma HIV Charter**.

137 For a discussion of whole system commissioning and a useful set of key messages, see PHE **Making it Work: A guide to whole system commissioning for sexual health, reproductive health and HIV**, 2015. A whole system approach is also advocated in City and Hackney's integrated Children and Young People's Emotional Health and Wellbeing Strategy 2021-2026 available **here**.

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

139 While menopause services are primarily provided through primary care, it can be an area for fruitful collaboration between primary and secondary care, for example through the Community Gynae pilot project, and between public health and local employers through the City Corporation's Business Healthy network.

140 Some stakeholders interviewed for this report noted the need for commissioners to recognise the time commitment required by service providers to engage effectively not only with each other but also with the commissioners themselves. They also noted the importance of effective coordination between the various commissioning bodies whose work can impact the field of SRH.

141 Work is already being undertaken, for example, to enhance outreach from sexual health clinics providing LARC to postnatal wards and these efforts should be supported.

142 One stakeholder consulted in the preparation of this report gave the example that relative needs between different schools or colleges could be explored to determine whether STI infection rates or incidence of unplanned pregnancy is higher in some areas than others.

143 On the issue of PrEP, stakeholders discussed efforts to enhance collaboration between the charitable sector and secondary care, and to explore the possibility of PrEP being provided through primary care.

144 Proportionate universalism has been identified as one of the six pillars of reproductive health in a 2018 consensus statement from Public Health England (available **here**).

145 A Public Health Scotland 2014 briefing gives the following description: "Proportionate universalism aims to improve the health of the whole population, across the social gradient, while simultaneously improving the health of the most disadvantaged fastest. This approach recognises the continuum of need and addresses the possible disadvantage of a purely universal approach, which may result in disproportionate benefits for those groups most able to make use of services" (available **here**).

146 **BASHH Standards for the Management of STIs 2019**, at p.4.

Appendix Endnotes

147 See Appendix 2 for a model of sexual health services that illustrates the linked, and mutually supportive, nature of the recommendations made in this report.

148 Data provided **here** by the Office for Health Improvement and Disparities. The same trend is seen with routine vaccinations at five years old. The data from primary and secondary school aged children does not show such marked reductions.

149 Schools are following the approach outlined in the Education Endowment Foundation's **Guide to the Pupil Premium**.

150 The disadvantage gap index summarises the relative attainment gap between disadvantaged pupils and all other pupils. Pupils are defined as disadvantaged if they are known to have been eligible for free school meals at any point in the past six years (from year 6 to year 11), if they are recorded as having been looked after for at least one day or if they are recorded as having been adopted from care.

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

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

153 Public Health commissioned LBH's Environmental Health team to support Food Business Operators in Hackney to join the **Healthier Catering Commitment** and apply healthier cooking practices within their food businesses.

154 Hackney's Planning team has published '**Growing Up In Hackney: child-friendly places supplementary planning document**', which places a focus on outdoor play, and health and wellbeing within its design principles.

155 See for example, Figure 1 in PHE's 2020 briefing, Community-centred public health: Taking a whole system approach at p.6 available **here** (accessed 26 January 2023).

156 PHE's 2020 briefing, Community-centred public health: Taking a whole system approach available **here** accessed 26 January 2023. See also Public Health England and NHS England, A guide to community-centred approaches for health and wellbeing, Public Health England, Editor. 2015: London available **here**, which explains that community-centred approaches "are not just community-based, but about mobilising assets within communities, promoting equity, and increasing people's control over their health and lives." The February 2018 Edition of Health Matters, "community-centred approaches for health & wellbeing", available **here**, recommends commissioning across all four strands of the "family of community-centred approaches", which are summarised as: strengthening communities; volunteer and peer roles; collaborations and partnerships; and, access to community resources.

157 Patient notification refers here to both contact tracing and informing patients of test results. Note that, in primary care, negative STI tests are not routinely communicated to patients and there are reports of difficulties relating to contact tracing.

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

HDS17072

Title of Report	NEL ICB BIG CONVERSATION - What does good care look like to people in Hackney?
For Consideration By	Health and Wellbeing Board
Meeting Date	25/01/2024
Classification	Public
Ward(s) Affected	All
Report Author	Sally Beaven *Executive Director, Healthwatch Hackney*

Is this report for:

☑	Information
☑	Discussion
☐	Decision

Why is the report being brought to the board?

This in-depth engagement work gives a deep understanding of what matters to residents of Hackney when thinking about receiving or accessing care. The learning from this report is far reaching and we feel it may influence the way in which a wide range of services are delivered to local people.

We urge stakeholders to consider the full report and make use of the four pillars of good care to evaluate their services and identify any areas where improvements could be made, in response to what residents have told us matters to th

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

The Hackney specific report is being shared first with the Health and Wellbeing Board. We will share and showcase this work with a wide variety of Boards and forums between now and 1st April.

1. Background

Healthwatch Hackney, working in collaboration with the NHS, asked local people open-ended questions about what good health and care means to them. At community events and in focus groups we helped local people to draw out what their own vision of good care would look like.

The resulting framework, informed by what local people said, can be used by stakeholders to develop their own success measures and evaluation tools. We took what they told us and started to identify themes, these themes eventually developed into four pillars of good care, or four aspects of what makes the difference between good care and inadequate care. We also looked at the wider issues that impact good care at a society level - the wider determinants.

A) Drawing on what resident told us, the NEL Healthwatches (local Healthwatch groups working together) created a framework consisting of four pillars of good care:

- Accessible
- Competent
- Person-centred
- Trustworthy

B) This report considers these four pillars against the NEL ICS priority areas, which are as follows:

- Babies, children and young people
- Long-term conditions
- Mental Health
- Workforce

C) A brief overview of what residents told us good care looks like:

- Appointments for acute issues AND routine check-ups are available within a reasonable timeframe
- Health and care services both RESPOND TO and ANTICIPATE people’s needs
- Patients get REASSURANCE that they are well
- Health and care services are ACCOUNTABLE to patients and local people
- Patients’ WORRIES and CONCERNS are understood and addressed
- CULTURAL DIFFERENCES in expectations of what care should look like are taken into account

- Patients understand how care decisions are taken and believe professionals are providing good treatment
- There is CONSISTENCY of care, quality of care does not vary based on individuals and staff turnover.
- There is CONTINUITY OF CARE between services and within services
- Services work well with each other, at community level, beyond just health and care
- Patients get to make appointments and be seen in a way that works for them
- Services are interconnected around the patient, not just centred on a condition or specialism
- Barriers to accessing care are understood and addressed eg.disability (physical, sensory, or mental), language barriers, IT literacy, knowledge barriers, costs including hidden costs

D) Wider determinants

We feel of particular interest to the Health and Wellbeing Board are what residents told us about the wider determinants of health - and **what they told us they want:**

Accessible

- Affordable healthy choices
- Accessibility of professional, social, civic opportunities for everyone;
- Tackling barriers to access, for example those relating to disability, poverty of caring responsibilities

Trustworthy

- Accessing public spaces and activities feeling safe from harm - including crime, pollution, antisocial behaviour
- Having a say in how local communities are run

Competent

- Public and private sector service providers, employers, schools etc. understand the needs of local people
- Freedom from stigma and judgement over identity or needs
- Evidence-based technology and policy solutions for improving local people's lives.
- Local people have the information they need to improve their health and well-being

Person-centred

- Health improvement interventions take into account local people's specific needs and preferences, no one size fits all approach

- Opportunities for education, employment, community involvement and civic participation take into account different people's communication preferences, life circumstances etc

E) **The report gives a detailed understanding of:**

- What residents perceive as barriers to receiving good care (unblocking the pipeline),
- The importance of cultural competence
- How to measure the health of the local community
- What changes would have an immediate positive impact
- The importance of clear information
- The importance of being heard around services

We hope the findings in this report will be of value to all those that commision or deliver care and services to local people.

2. Policy Context:

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

☑	Improving mental health
☑	Increasing social connection
☑	Supporting greater financial security
☑	All of the above

Please detail which, if any, of the Health & Wellbeing Strategy '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 leve
☑	Making the best of community resources

☐	All of the above

2.1. Equality Impact Assessment (EIA)

Has an EIA been conducted for this work?

☐	Yes
☑	No

2.2. Consultation

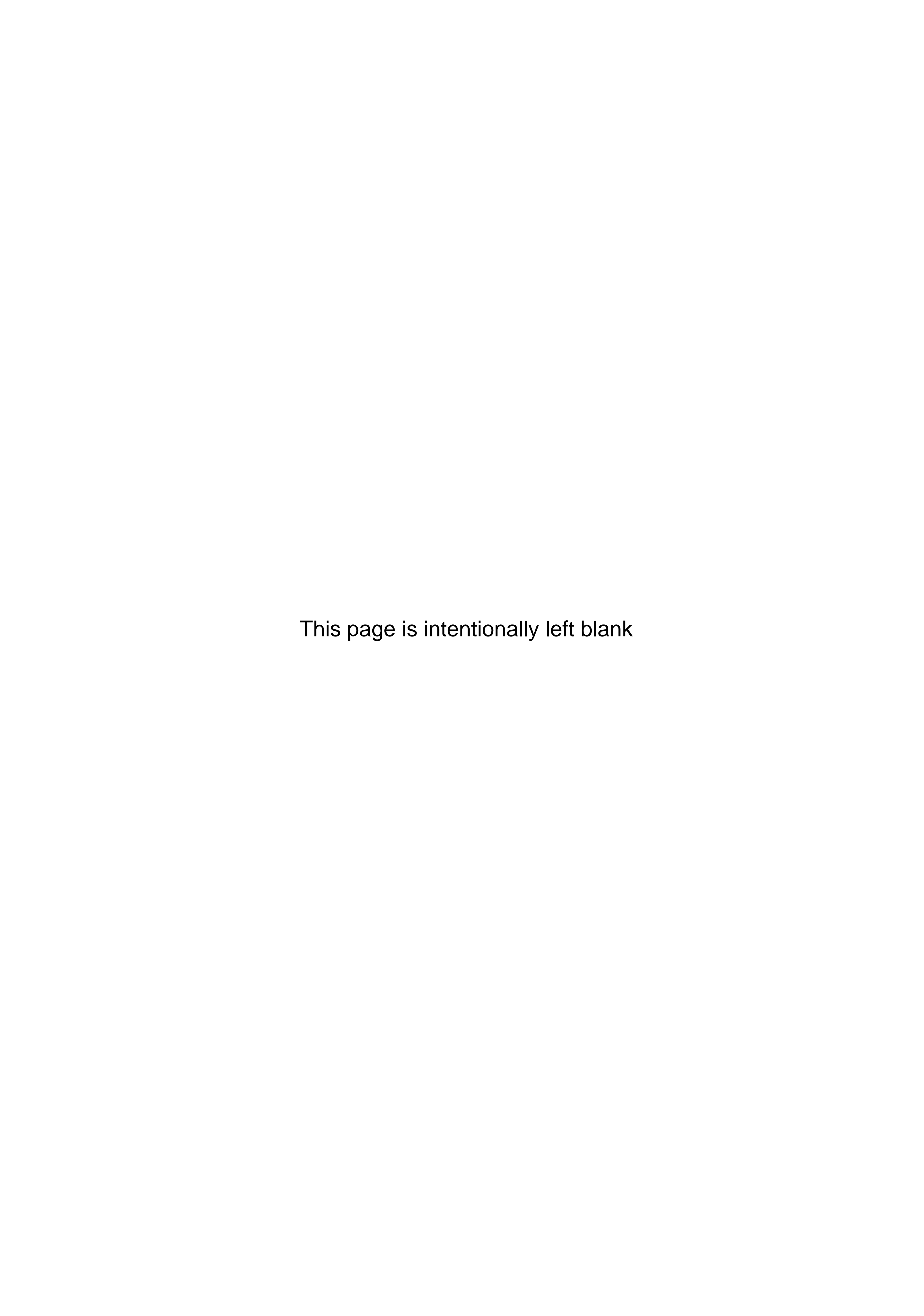
Has public, service user, patient feedback/consultation informed the recommendations of this report?

☑	Yes
☐	No

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

☐	Yes
☐	No

Report Author	Cover report - Sally Beaven *Executive Director, Healthwatch Hackney* Main report - Raluca Enescu *Head of Insights & Intelligence, Little Voice*
Contact details	sally@healthwatchhackney.co.uk raluca.enescu@localvoice.org.uk
Appendices	Draft Hackney Community Conversations Report 2023


This page is intentionally left blank

What does good care look like to people in Hackney?

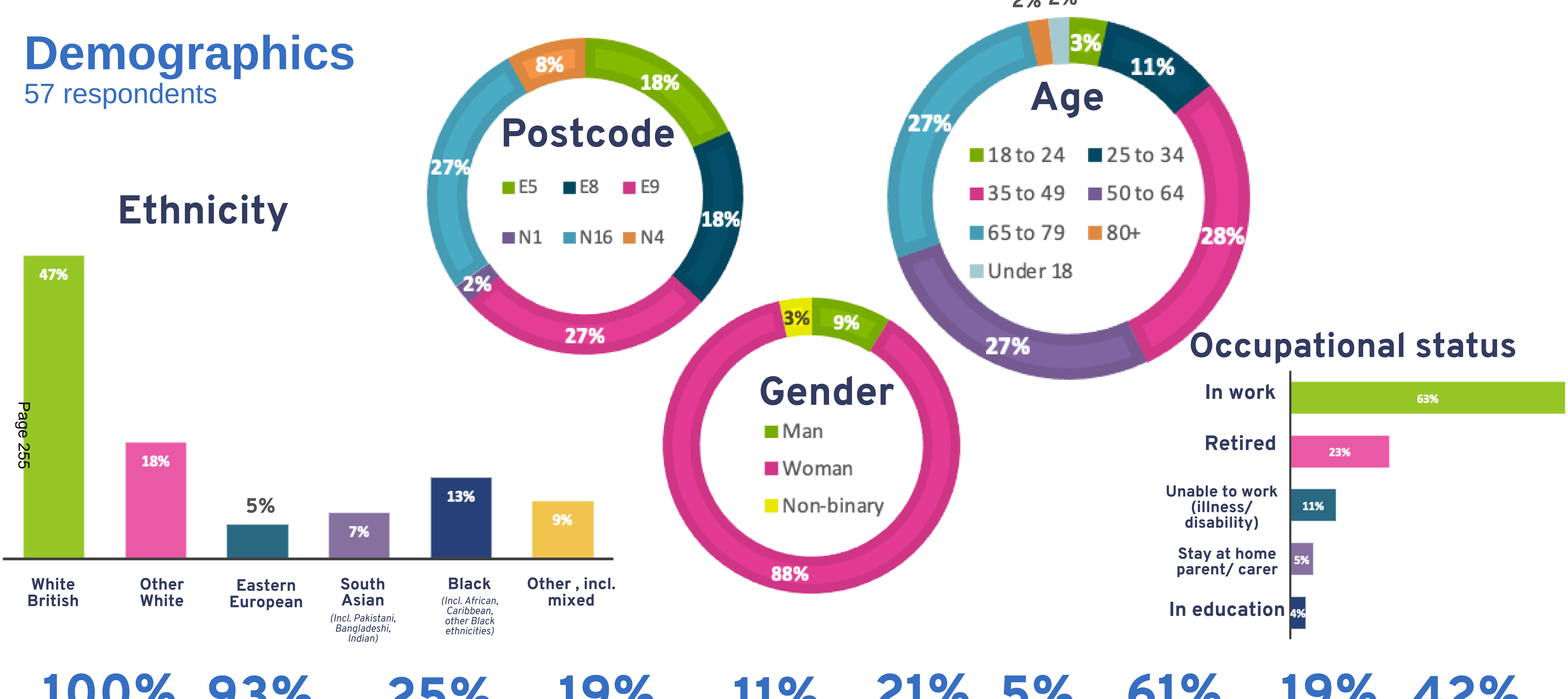
DRAFT Community Conversation Findings December 2023

Hackney Community Conversation

We asked local people open-ended questions about what good health and care means to them. At community events and in focus groups we helped local people to draw out what their own vision of good care would look like.

We took what they told us and and started to identify themes, these themes eventually developed into four pillars of good care, or four aspects of what makes the difference between good care and inadequate care. We also looked at the wider issues that impact good care at a society level- the wider determinants

The resulting framework, informed by what local people said, can be used by stakeholders to develop their own success measures and evaluation tools.



100% were registered with a GP

93% had used health or care services in the last 12 months

25% were parents of a child/ children aged under 18

19% were carers for an adult loved one or family member

11% were digitally excluded

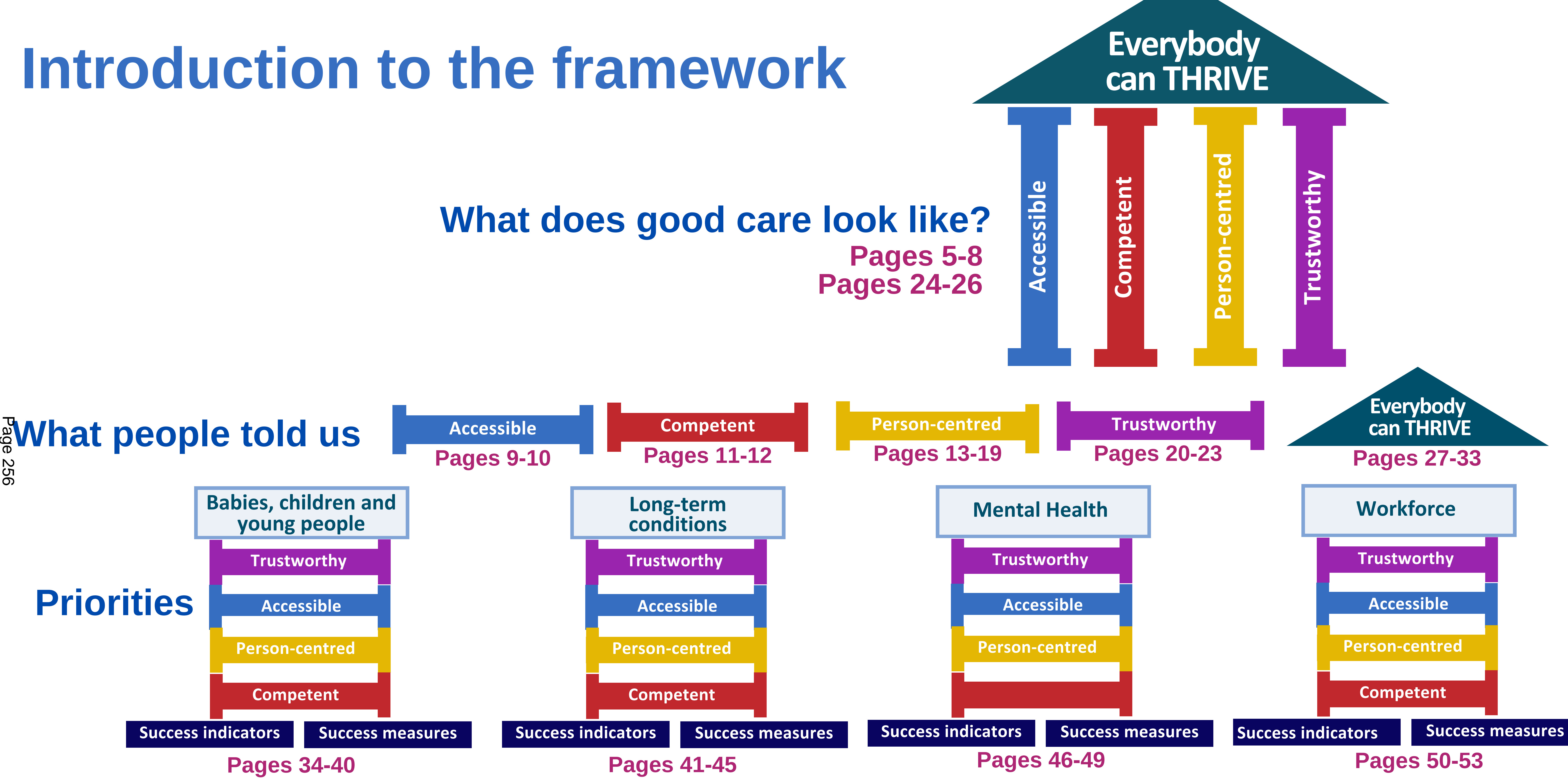
21% were disabled

5% were neuro-divergent

61% had a long-term condition

19% were LGBT

42% were struggling financially or just getting by



We hope to make this report and the dataset as adaptable as possible; different sections of it can be used either separately, in conjunction with each other or with additional data. The aim is to use it as a framework from which people led success indicators and measures can be developed. There is still a lot of work to do.

What does good care look like?

GOOD CARE IS

Trustworthy

Accessible

Competent

Person-centered

Appointments for acute issues AND routine check-ups are available within a reasonable timeframe

Health and care services both RESPOND TO and ANTICIPATE people's needs

Patients get REASSURANCE that they are well

Health and care services are ACCOUNTABLE to patients and local people

Patients' WORRIES and CONCERNS are understood and addressed.

CULTURAL DIFFERENCES in expectations of what care should look like are taken into account.

Patients understand how care decisions are taken and believe professionals are providing good treatment

There is CONSISTENCY of care, quality of care does not vary based on individuals and staff turnover.

There is CONTINUITY OF CARE between services and within services

Services work well with each other, at community level/ beyond just health and care

Services are inter-connected around the patient, not just centred on a condition or specialism

Patients get to make appointments and be seen in a way that works for them

Barriers to accessing care are understood and addressed:

- Disability (physical, sensory, or mental)
- Language barriers
- IT literacy
- Knowledge barriers
- Costs, including hidden costs

What does good care look like?

Everybody can THRIVE

Trustworthy Accessible Person-centred Competent

Good care is: trustworthy

What does enabling everyone to thrive look like?

The wider determinats of heatlh

Accessing public spaces and activities feeling safe from harm- including crime, pollution, antisocial behaviour.

Having a say in how local communities are run.

Freedom from stigma and judgement over identity or needs.

Affordable healthy choices

Accessibility of professional, social, civic opportunities for everyone; tackling barriers to access- for example those relating to disability, poverty of caring responsibilities.

Trustworthy

Accessible

GOOD CARE

Competent

Person-centered

Public and private sector service providers, employers, schools etc. understand the needs of local people.

Evidence-based technology and policy solutions for improving local people's lives.

Local people have the information they need to improve their health and well-being.

Health improvement interventions take into account local people's specific needs and preferences, no one size fits all approach.

Opportunities for education, employment, community involvement and civic participation take into account different people's communication preferences, life circumstances etc.

The four pillars interconnect and impact each other.

Accessible care

not being seen as gatekeeping

Trustworthy care

Problem-solve promptly

Adequate staffing, funding, resourcing

Pluralistic model of access to care

regular check-ups

expectations management

Reassurance, explaining,

Cultural competence,

Listen to patients

Competent care

Be aware of specific needs

medical, social and cultural

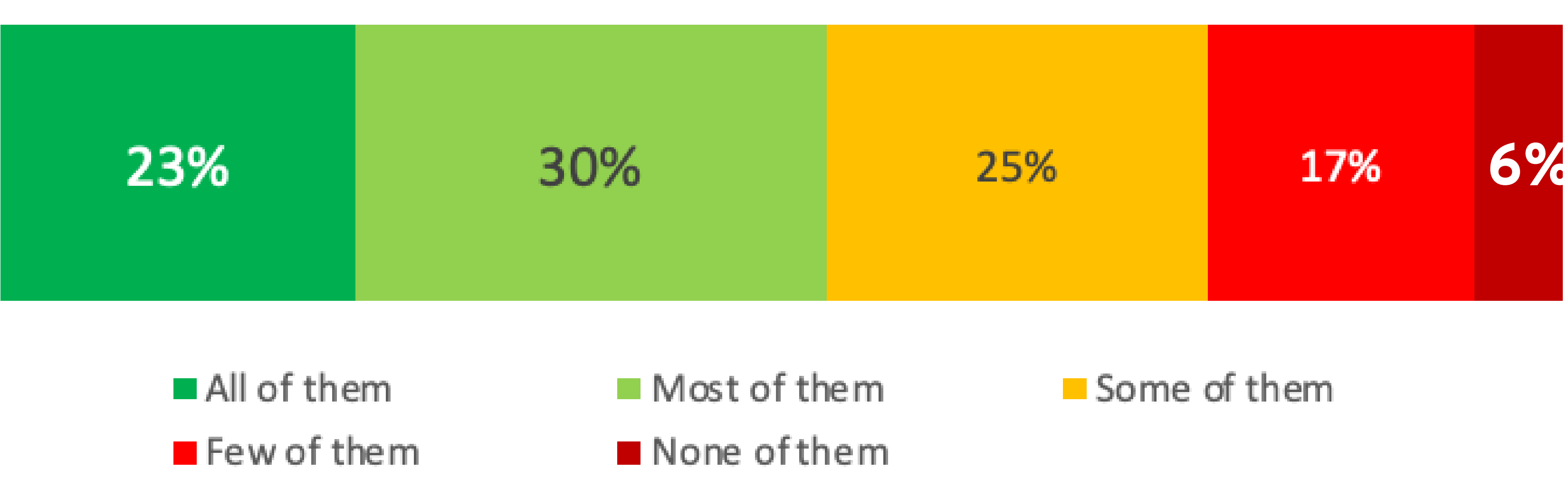
Person-centered care

Accessible

117 mentions from 81 respondents

How important is it for you:
Getting the care you need when you need it?

Professionals looking after me: are available to provide the care I need when I need it



Compared with North East London total, Tower Hamlets respondents were somewhat more likely to find they can access the care they need, when they need it.

What would indicate accessible care?

Patients can reliably access both routine and urgent care within a reasonable time frame, commensurate with their clinical urgency.

There are multiple equally reliable ways of booking appointments, taking into account both the needs of those who are most comfortable using online services and of those who are digitally excluded.

Services are available locally or within reasonably commuting distance; the needs of patients who don't drive are taken into account; and at different times, to meet the needs of patients who work full-time, as well as those who work irregular shifts/ non-standard hours and those with caring responsibilities.

All health and care services that patients need are free or affordable; no one has to go without necessary care because of the cost. Hidden costs of care are taken into account and minimised (for example: the cost of transport to healthcare facilities or of accessibility equipment).

Services understand and accommodate the needs of disabled patients; including awareness of mental health-related disability, and of complex needs arising from multiple forms of disability; as well as understanding and taking steps to mitigate any other forms of barriers to accessing care (language barrier, digital exclusion, general literacy, knowledge of the system, cultural issues, domestic violence).

Making healthy lifestyle choices is realistic for all; for example, people on low incomes and those who cannot cook for themselves still can have a healthy diet; exercise classes are available for those with limited mobility who can only handle gentle physical activity etc.

Accessible

> *Good care means having access to a GP appointment when you want one, being listened to with respect and having confidence that follow up care will be available without too much delay.*

What would NOT happen?

Patients going to A&E for issues that could have been dealt with by a GP or walk-in centre.

Over-stretched telephone lines, associated with a one size fits all booking system.

Patients paying for private healthcare they struggle to afford, because NHS care is too difficult to access.

Patients going without the care they need (dental treatments, domiciliary care, etc.) because they cannot afford it, or because they struggle with the process of accessing it.

People feeling that their personal circumstances (income, daily schedule, working conditions. physical limitations) force them to make unhealthy choices instead of healthier ones (for example making unhealthy diet choices because they can't afford healthier ones).

Competent

27 mentions from 23 respondents

Compared with North East London total, Hackney respondents were more likely to find they are looked after by professionals who understand their specific needs.

What would indicate competent care?

Competent

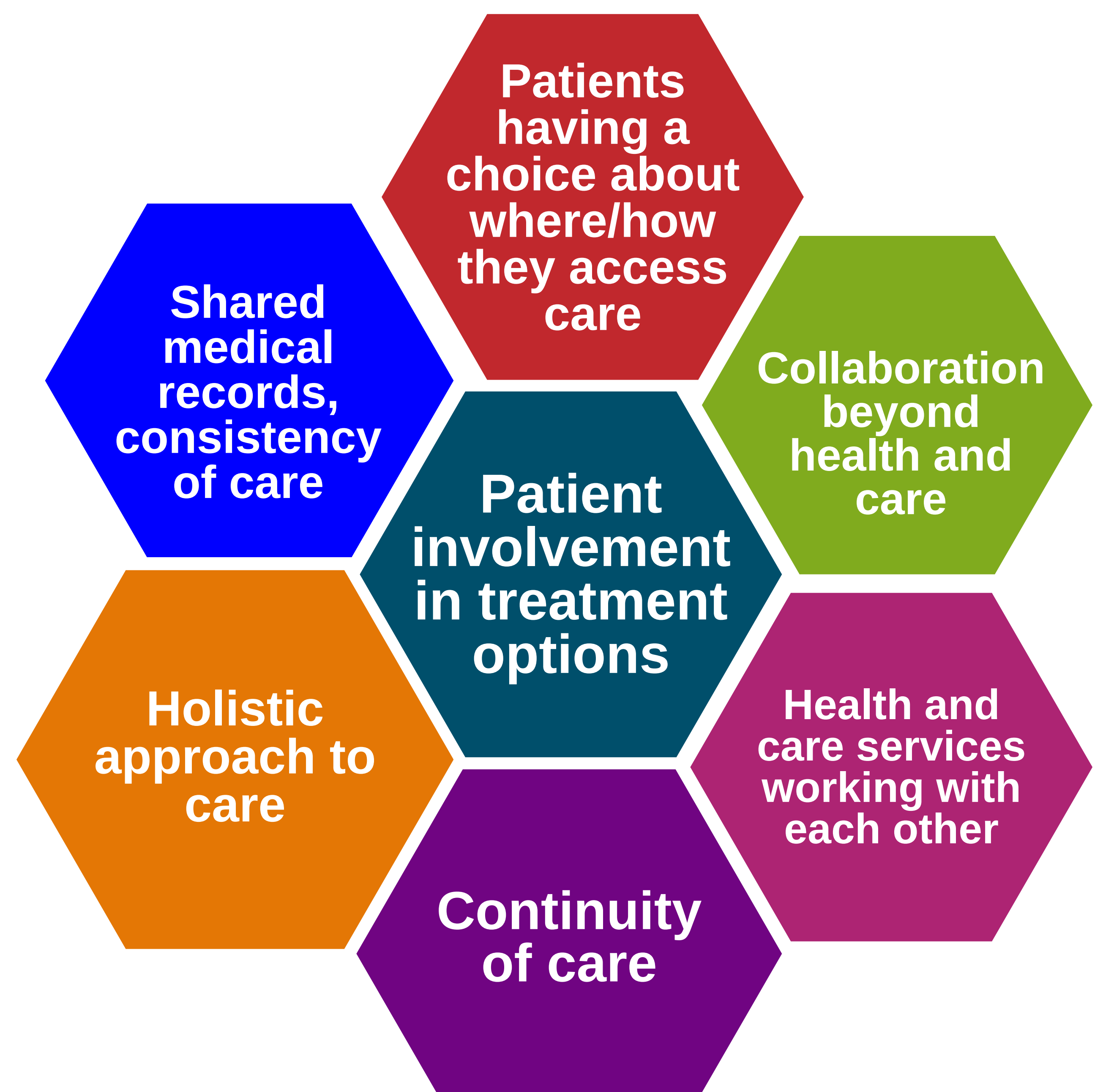
We need to see health care professionals having the time, knowledge and experience to delve into a problem and try to fix it. For the most part you feel like an inconvenience when trying to seek help. I've pretty much given up with GP's.

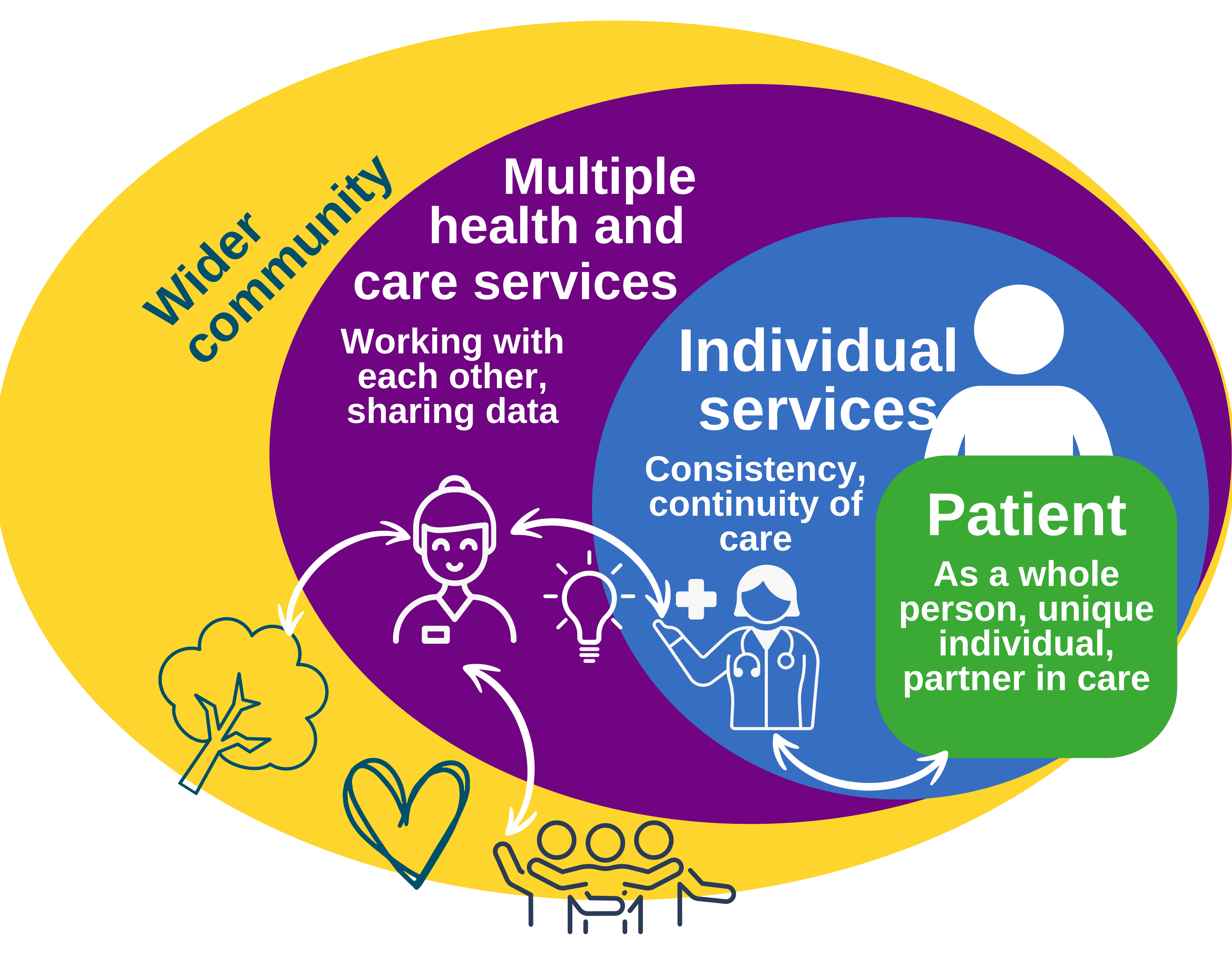
- Professionals providing health and care services have up-to-date, in-depth knowledge of the conditions they are treating.
- Professionals providing health and care services have a good working knowledge of patients' conditions, even outside their area of specialty, to the extent they impact patients' access to care, care needs and general wellbeing.
- Professionals providing health and care services have a good working knowledge of health inequalities, social inequalities and cultural issues that may influence patients' access to care.
- Patients are diagnosed accurately and within a reasonable timeframe; necessary investigations are available to ensure the accuracy of the diagnosis process.
- Patients receiving treatment informed by the NICE guidelines, and by the latest evidence-based developments in medical science.
- Local people having a good level of knowledge about keeping themselves healthy and well.
- Employers, schools, public services and local businesses knowing how to ensure they provide a healthy environment.

What would NOT happen?

- Excessively long waiting times for diagnosis/ investigations.
- Admin issues affecting the diagnosis process, e.g.: lost test results.
- Misdiagnosis as a result of superficial consultations/ poor knowledge.
- Lack of support with symptoms during an ongoing/ potentially long diagnosis process.
- Clinical decisions being taken based on factors such as budget constraints or professionals' own cultural biases, rather than clinical need and scientific evidence.
- Ineffective public health/ prevention interventions at a wider social level.
- Local people making decisions about their own health based on incorrect information or pseudoscience.

Person-centred

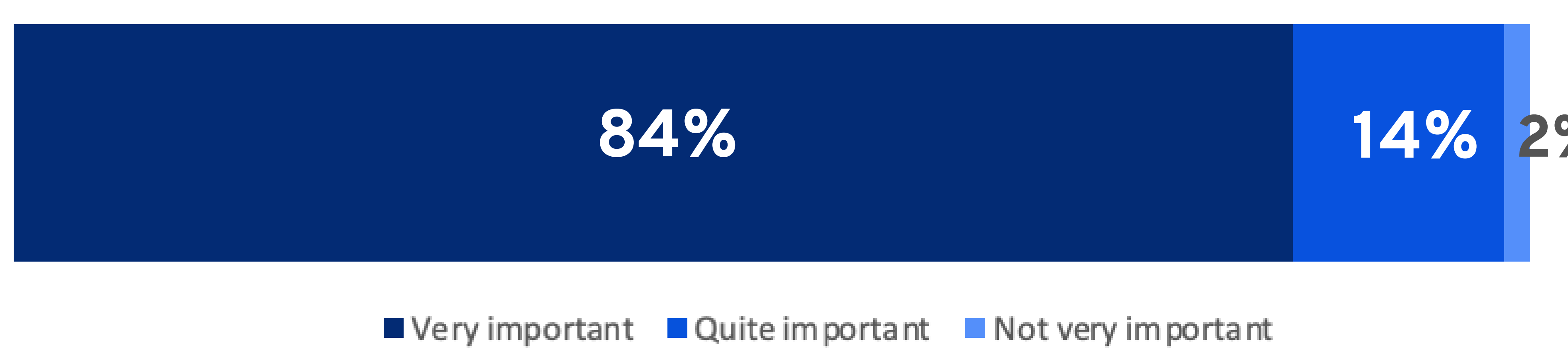




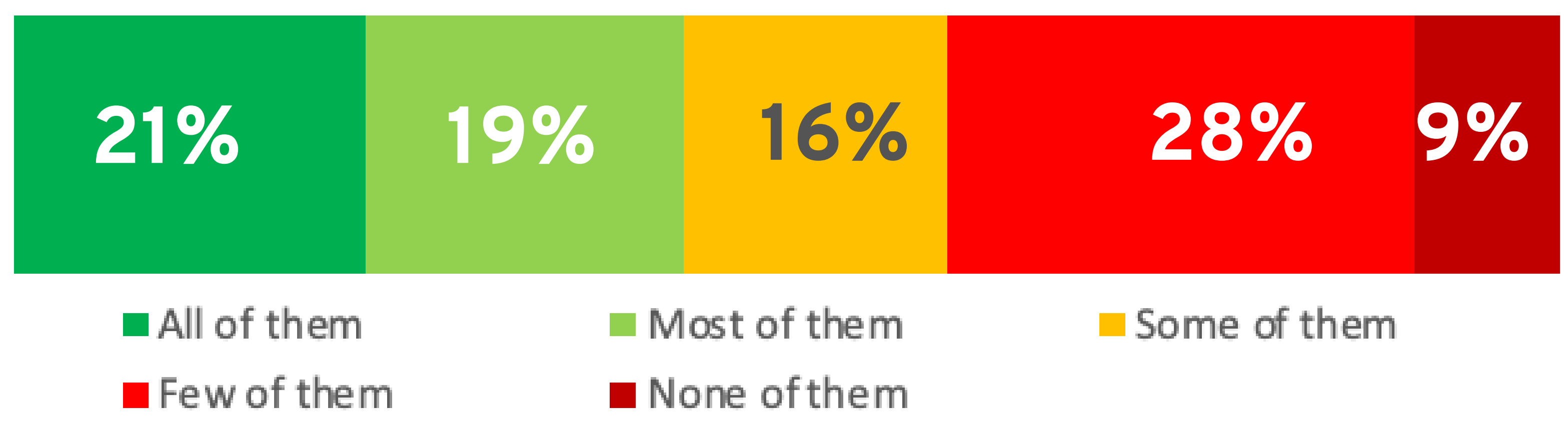
Person-centred

Knowing that different services supporting you work well together

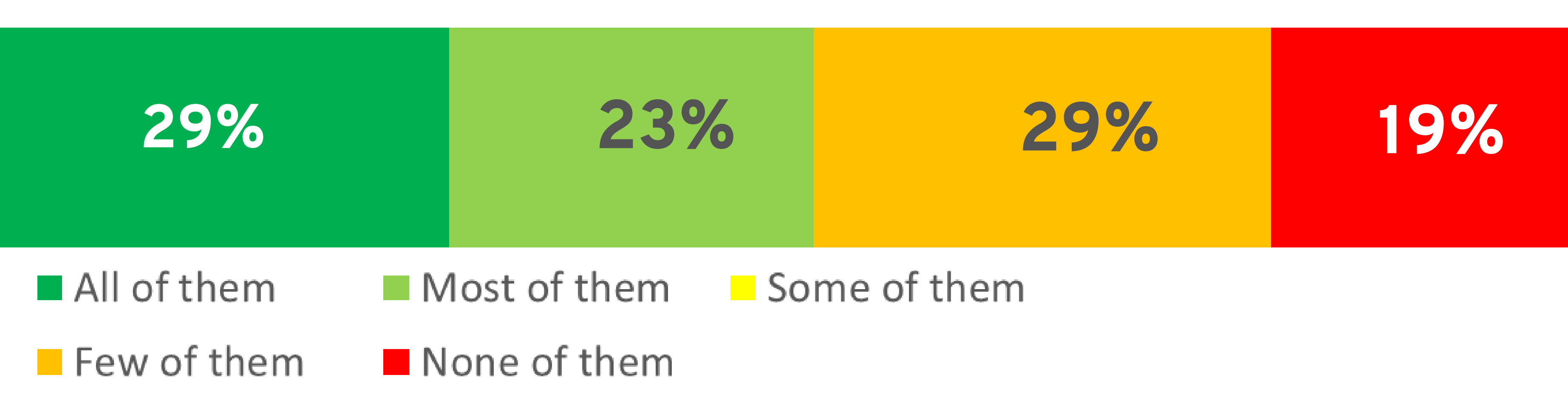
Being involved in decisions about your own care



Professionals looking after me: Work well together



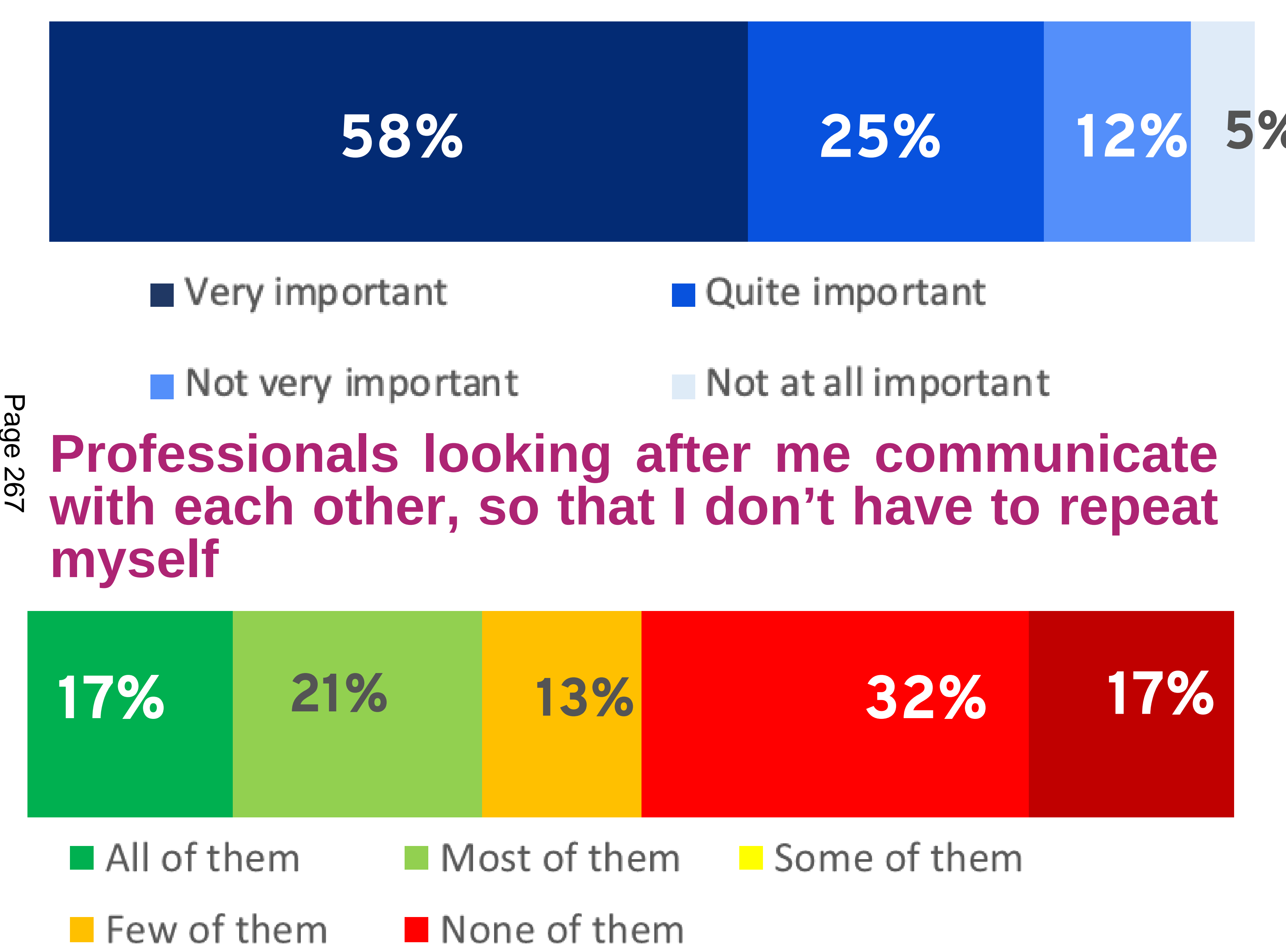
Professionals looking after me: Involve me in decisions about my own care



Compared with North East London total, Hackney respondents were slightly more likely to find that professionals looking after them work well together.

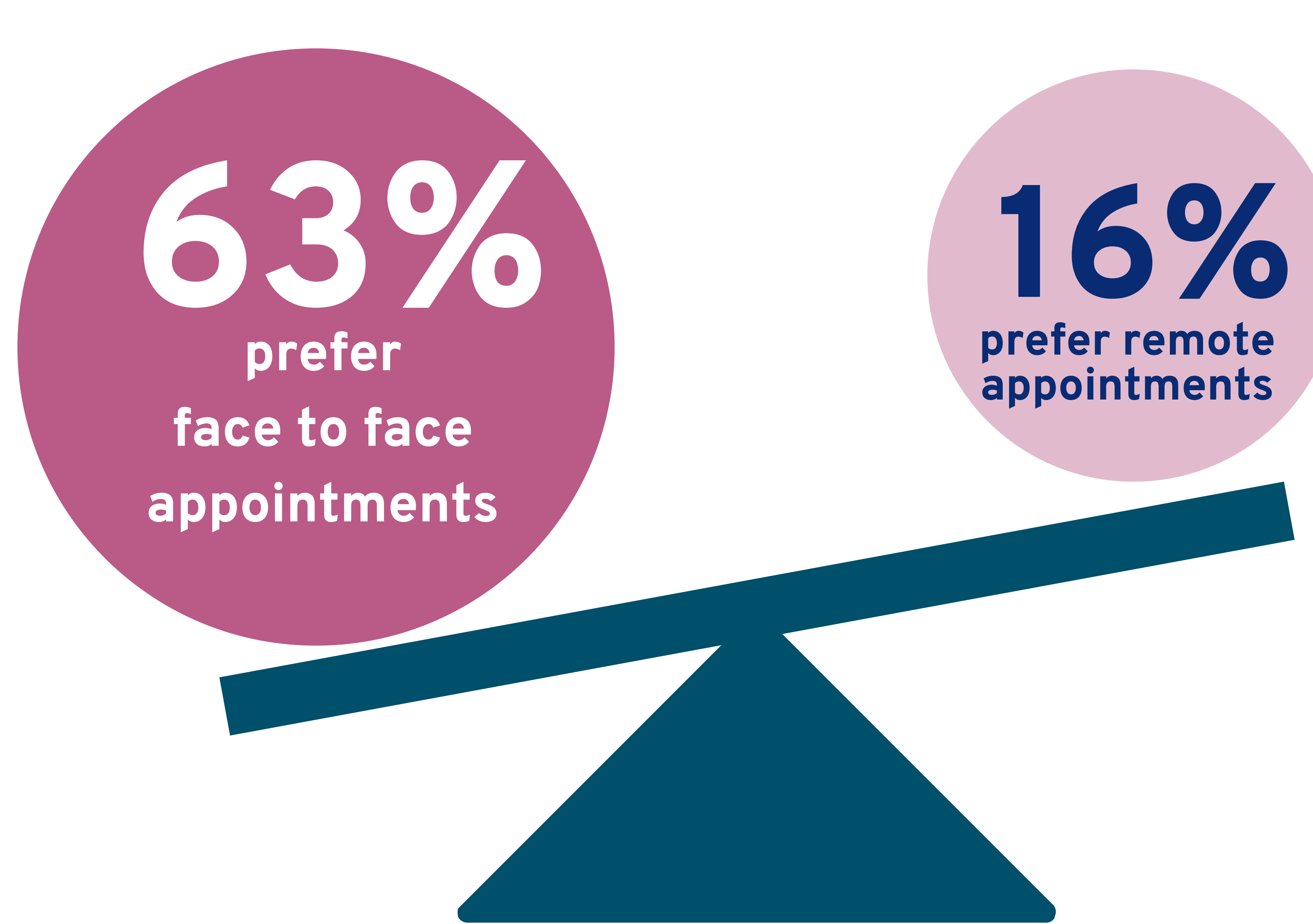
Compared with North East London total, Hackney respondents were about as likely to find that professionals looking after them involve them in decisions about their own care.

How important is it for you:



Compared with North East London total, Hackney respondents were **somewhat more likely** to find that they can avoid repeating themselves.

Previously, in the GP Extended Hours Survey, we asked Tower Hamlets residents if they preferred face-to-face or remote appointments.



Person-centred

We have previously analysed data on where and how patients want to access GP appointments. Findings are consistent with the findings of this survey.

Patient Profiles

Prefers to be seen in person

Only willing to travel up to 30 min

Willing to travel 30+ min

Prefers being seen remotely or doesn't mind

Least flexible

Specifically needs in-person appointment within their local area

43% of respondents

The in-person patient

Highly values in person appointments and is willing to travel for them

26% of respondents

The virtual patient

Seeks to avoid travelling to see a GP, but willing to have remote appts

18% of respondents

Most flexible

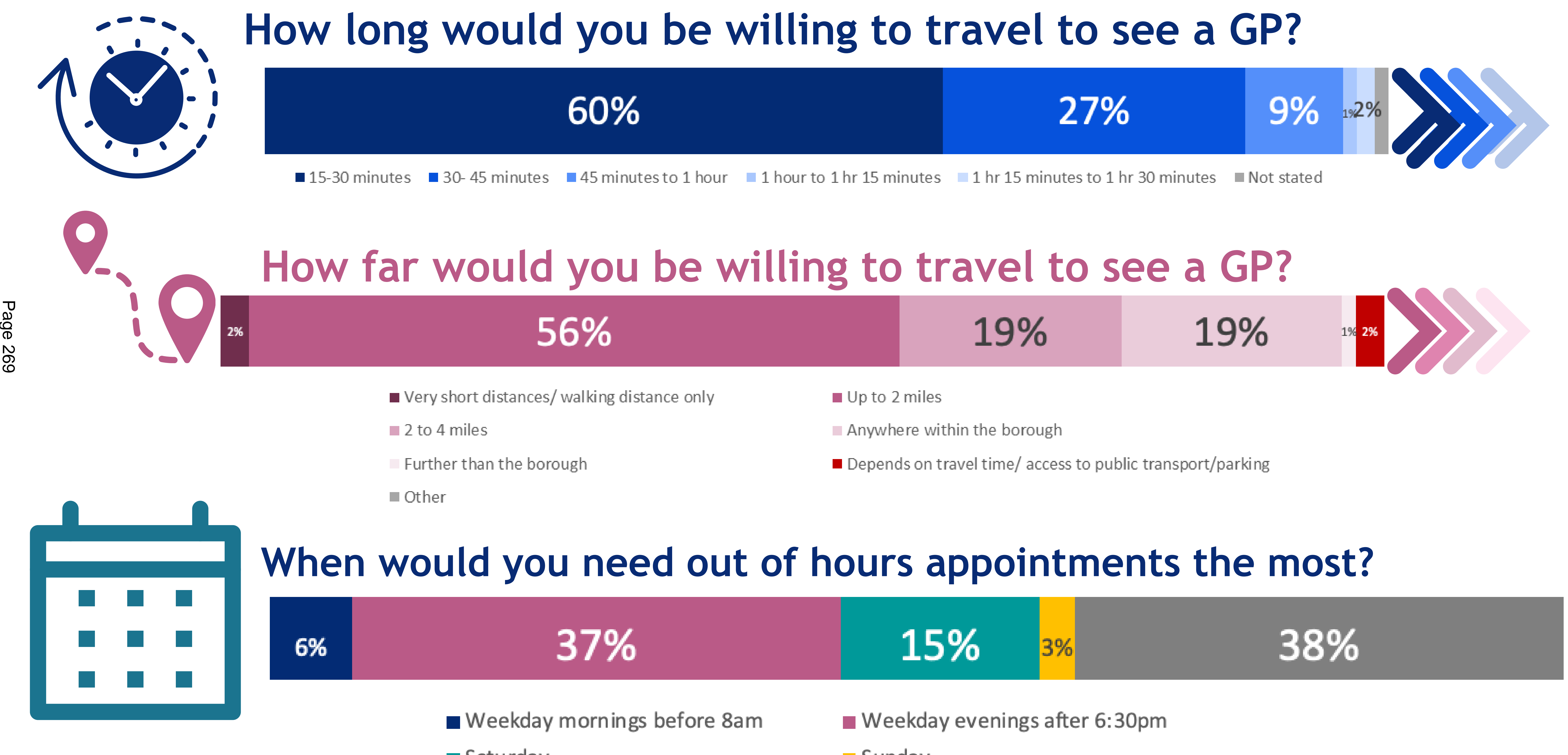
Happy to have virtual appointments or to travel to a GP appointment

14% of respondents

In this respect, Hackney respondents are slightly more likely than North East London total to be open to having remore consultations.

Extended hours survey

Person-centred



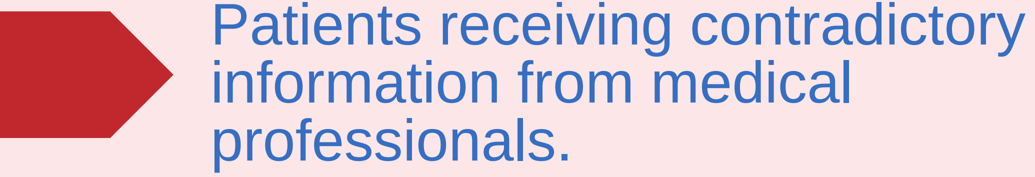
What would indicate person-centred care?

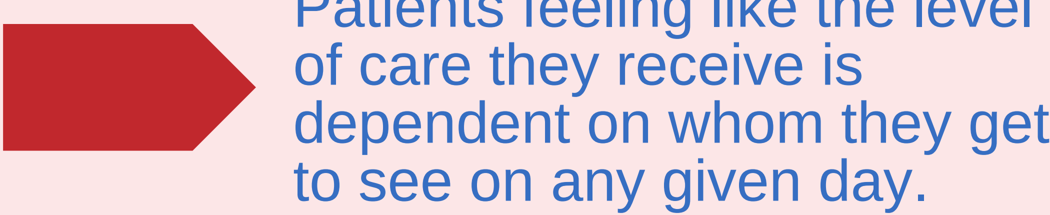
Person-centred

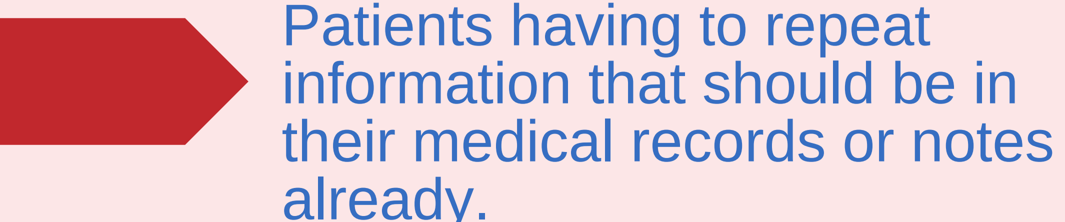
> *Holistic connection of various things wrong not isolated 4 minute appointments. Easy access to appointments*

- Patients get to see the same medical professional consistently (for example the same doctor or midwife), as much as it is practical. Otherwise, when patients see different medical professionals within the same service or there is a staff turnover, notes and patient records are passed down and read. Quality of care remains constant regardless of who is delivering the care.
- Referrals between different services are issued as needed and processed promptly; services share medical records and information seamlessly.
- Health and care services are actively working with the wider community to promote holistic patient health - social prescribers, the voluntary sector etc.
- Health and care professionals give patients clear options for treatment or care, presented objectively with pros and cons; empowering them to make informed decisions. Patients feel treated as a partners in their own care; and like medical professionals are interested in their own desired health outcomes.
- Health and care professionals take a holistic approach to patients' health rather than examining conditions and symptoms in isolation.
- Patients get a choice about where and how they access care or public services (using online services, having remote consultations or doing everything in person).
- Information is available in a variety of formats and outreach channels
- Employers, recruiters and schools consider work-life balance and fitting around workers' and students' lives; processes for workforce recruitment and career development look at the worker holistically.

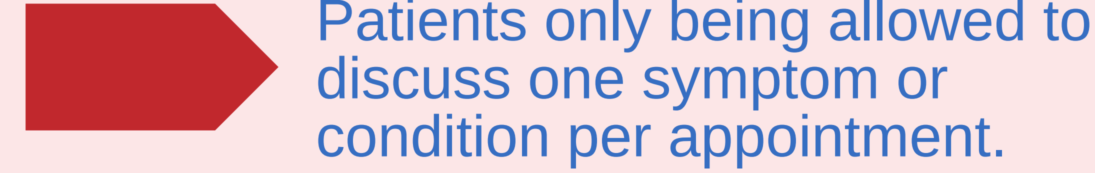
What would NOT happen?


Patients receiving contradictory information from medical professionals.


Patients feeling like the level of care they receive is dependent on whom they get to see on any given day.


Patients having to repeat information that should be in their medical records or notes already.

Patients feeling like they are passed around between services with no actual help.


Patients only being allowed to discuss one symptom or condition per appointment.

Unblocking the pipeline

Person-centred

Borough-wide GP service, near good transport links

Emergency appointments, routine screening, able to refer to other services

A radical new approach may be the answer

OWN GP

Provide reassurance

Online services (booking, repeat prescriptions, etc)

Remote appointments, GP at Hand model

Better info on accessing the right GP service

In-person appointments -prioritising long term conditions and the most vulnerable

Social prescribing

Wider integration

Wider community

Health checks

Support groups

NHS 111 and other centralised services

Extend 111 remit with better skilled call handlers

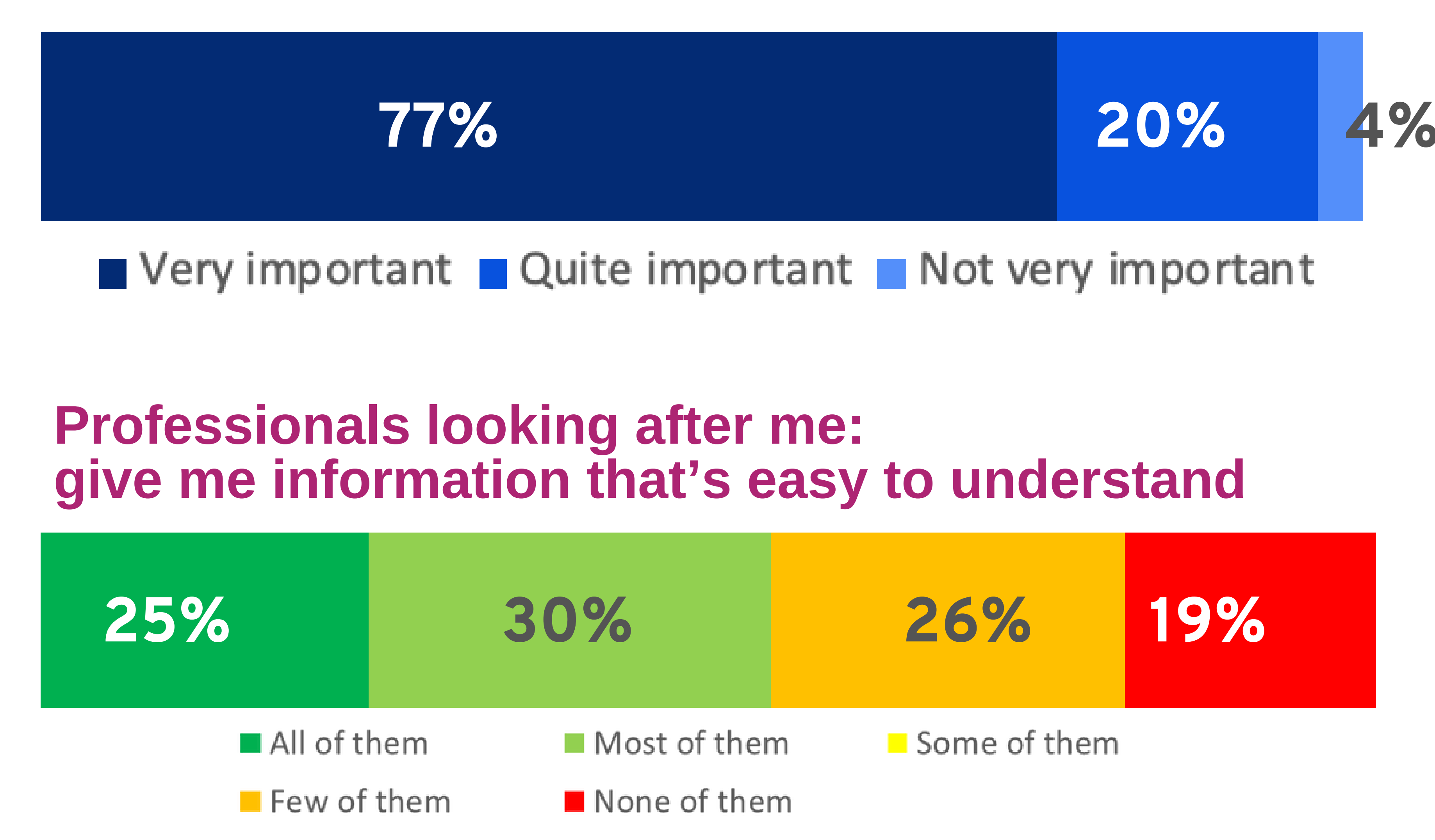
Repeat prescriptions, specialist advice for long term conditions

AI and digital information

Advanced algorithms for diagnosis and reassurance, linking up to relevant services if needed

Info on prevalent conditions(Strep-A, Covid, flu) in multiple formats: written, audio, phone line etc.

Trustworthy

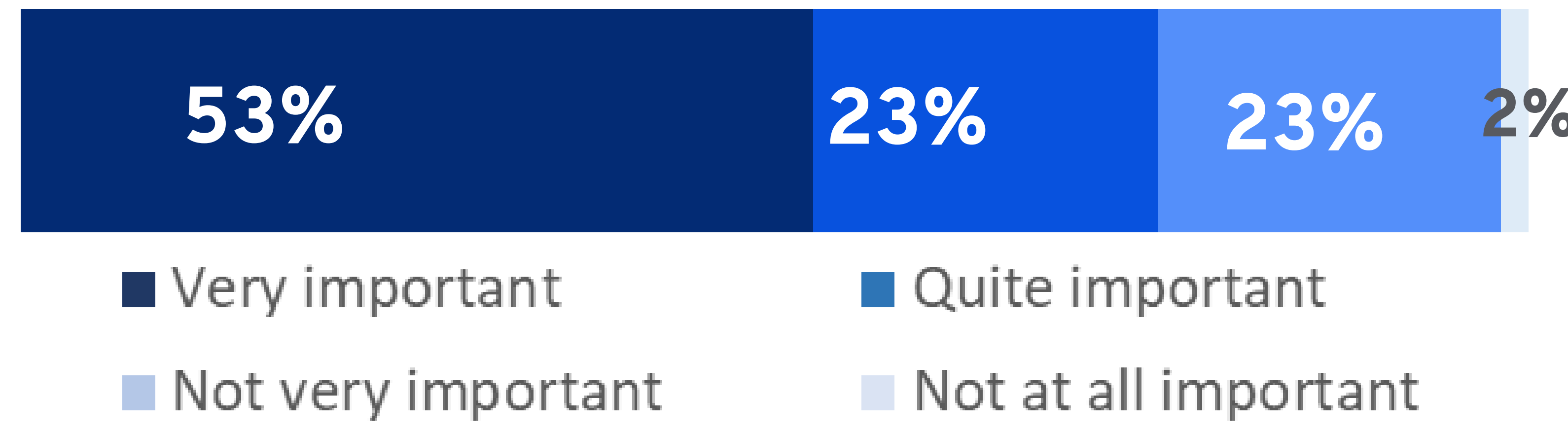


Compared with North East London total, Tower Hamlets respondents were about as likely to find that they receive information that's easy to understand.

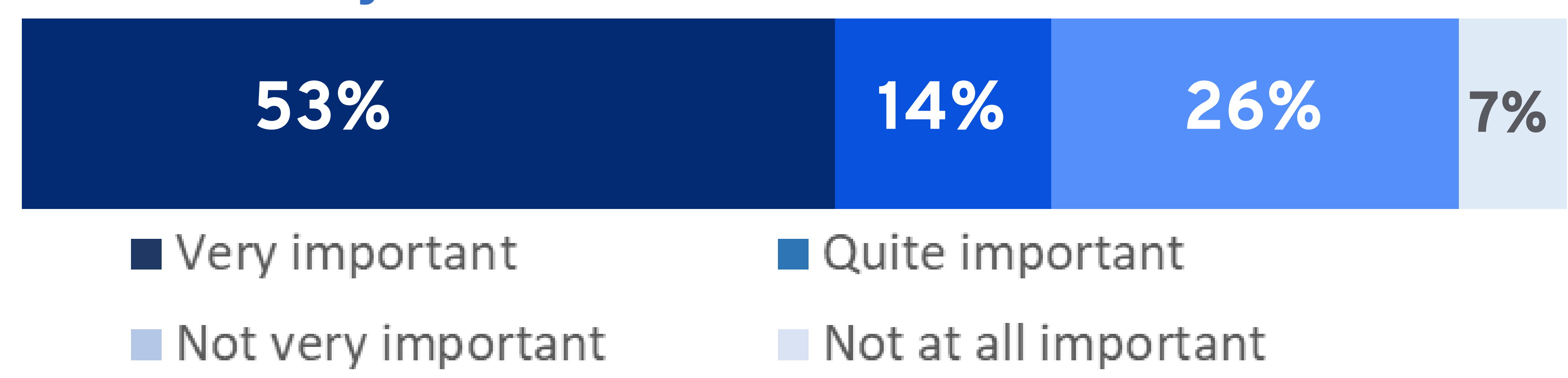
How important is it for you

Trustworthy

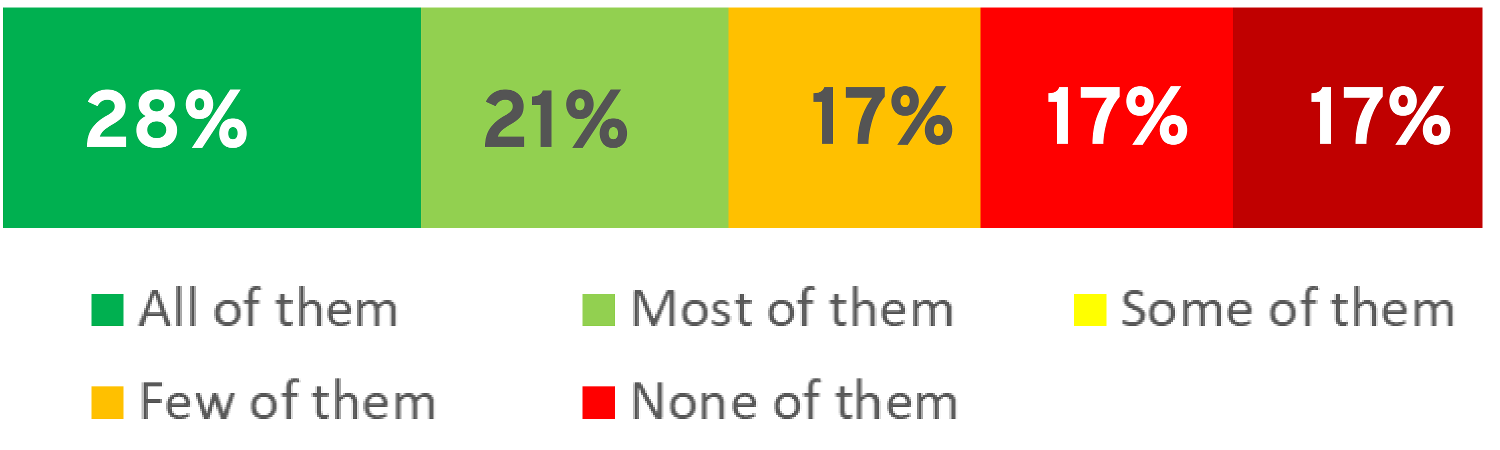
Being looked after by people who understand your beliefs and values.



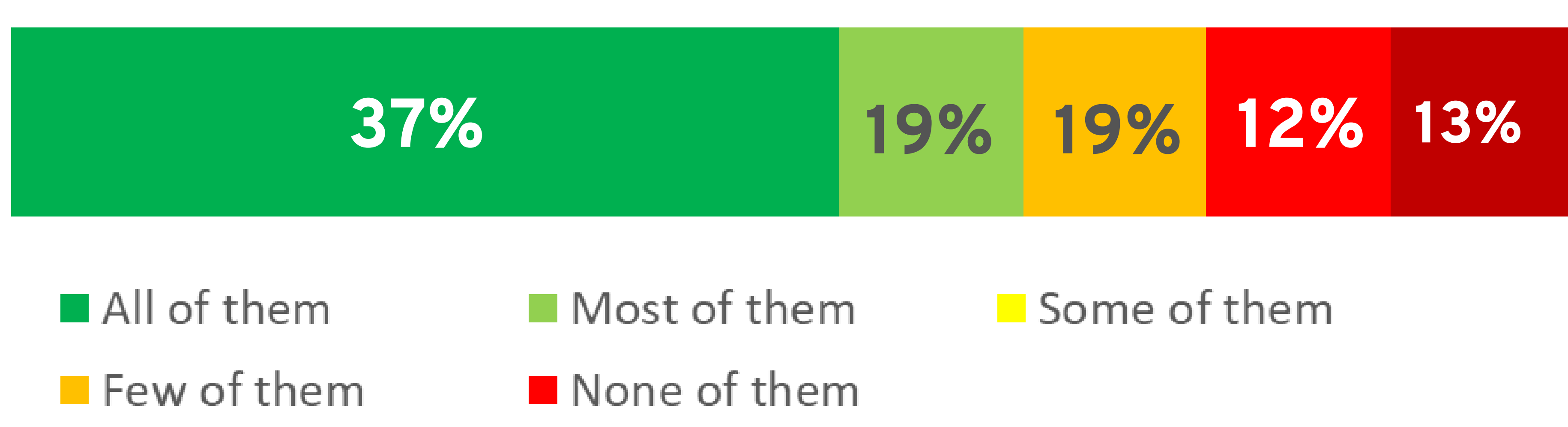
Being looked after by people who understand your culture.



Professionals looking after me: understand my beliefs and values



Professionals looking after me: understand my culture



Compared with North East London total, Hackney respondents were slightly more likely to find that professionals looking after them understand their beliefs and values,

Compared with North East London total, Hackney respondents were somewhat more likely to find that professionals looking after them understand their culture.

What would indicate trustworthy care?

- Patients feel listened to and reassured that their problems are taken seriously by care professionals; they feel that they are given adequate time .
- Health and care services proactively engage with patients and ask about what is important to them.
- Patients communicate with professionals about their care, in a honest, straightforward manner; understanding why they are offered a certain course of action.
- Patients have someone they can turn to for competent advice, reassurance and prevention; they know whom they can turn to if they are worried about specific aspects of their health.
- There is a straightforward and transparent process for accessing care.
- Patients have access to routine check-ups in order to feel fully reassured that their health is good.
- Services demonstrate accountability and act upon feedback received from patients.
- In the family, workplace and community, local people feel comfortable talking about their health needs with no fear of judgement or stigma.
- Local people feel safe from harm in their local community; they are comfortable using local amenities/facilities and engaging with their neighbours.

Trustworthy

"Having access to a GP appointment when you want one, being listened to with respect and having confidence that follow up care will be available without too much delay.

What would NOT happen?

- Patients feeling like they are fobbed off or their concerns are dismissed.
- Patients feeling that they are treated like a burden; feeling discouraged from seeking care or asking questions.
- Consultations feeling more like a tick-box exercise than a consultation.
- Patients perceiving admin staff as gatekeepers or relating to them in an adversarial way.
- Workers feeling reluctant to ask for sick leave or necessary adaptations at work, fearing discrimination or judgement.

What about cultural competence?

A note on engaging with local people on their beliefs and values

In some situations, rather than asking local people about their culture, beliefs and values in relation to health and care services, an alternative way of framing the question would be to address their **expectations in relation to the care they receive.** This could in turn inform culturally competent care.

What does good care look like?

Good care has good consequences

- Local people feel **empowered** to live full healthy lives, to look after themselves and families. They feel **heard** and **reassured**. They worry less about their own health.
- **Children and young people** have a good start in life.
- People with **long-term conditions** manage them well. They are able to work and/or contribute to society in other ways. They are able to engage with others and do things they enjoy.
- **Older people** stay healthy and active for longer. They maintain a goo level of independence.

What does good care look like?

Bad care has bad consequences

Trustworthy care

Accessible care

Competent care

Person-centered care

- People **worry about their health,** as they don‘t have the knowledge to assess their own level of health or deal with specific symptoms; and they don’t have a reliable source of advice.
- People **distrust** doctors and the treatments they prescribe; they may see the health and care system as defined by **gatekeeping** and doing the bare minimum. As a result, they may turn to alternative sources of care and/or reassurance, including those which may be pseudoscientific or harmful.
- Conditions that **would have been more easily treated** or controlled at an early stage worsen.
- People with **long-term conditions**, especially as they age, leave the workforce earlier and experience highter risks of social isolation.

What could make care accessible, competent, person-centred, trustworthy in Hackney

- Improve telephone and online booking in GP surgeries.
- Improve availability of GP and specialist appointments, including tests and investigations; improve referral mechanisms and integrations of services.
- Improve continuity of care and record-sharing in GP surgeries; improve data sharing within the same organisation and between organisations in a healthcare setting.
- Streamline appointments; address multiple issue within the same appointment.
- Improve access to healthcare for mental health.
- Improve provision of social prescribers and links between GPs and community/ advice/ voluntary resources.
- Provide local residents with the opportunity to receive health checks and bring up questions and concerns about their health. These could be geared towards the general population or specific groups (older people, small children, long-term conditions etc.) and take place in GP surgeries or in a community-based setting.

What does a healthy community look like?

How to measure the health of the wider community based on what matters to local people

- Improved affordability of public transport
- Improved accessibility of public transport
- Reduction in traffic congestion
- Safer roads for pedestrians and cyclists
- Improvement in air quality
- Increased availability of inclusive exercising classes for all abilities at times suitable for all
- Increased availability of free or affordable exercising facilities
- Increased % of local residents who are physically active
- Decrease of amount of rubbish in public spaces/ green spaces
- Improved diet for residents on low incomes
- Decrease in substance misuse

My neighbourhood is a place where I can live a healthy life- *survey respondents*

100 Very good

0 Very poor

61

60

SCALE

NEL

Hack-
ney

N16

E5

E9

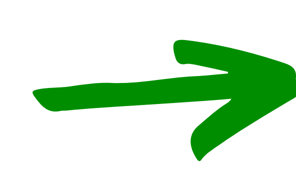
E8

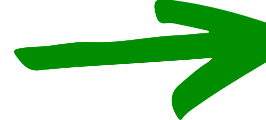
N1

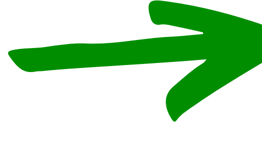
What could create healthier communities in Hackney

Improve the safety of public spaces; in particular, crack down on drug dealing and using.

Improve smoking cessation and substance misuse services.

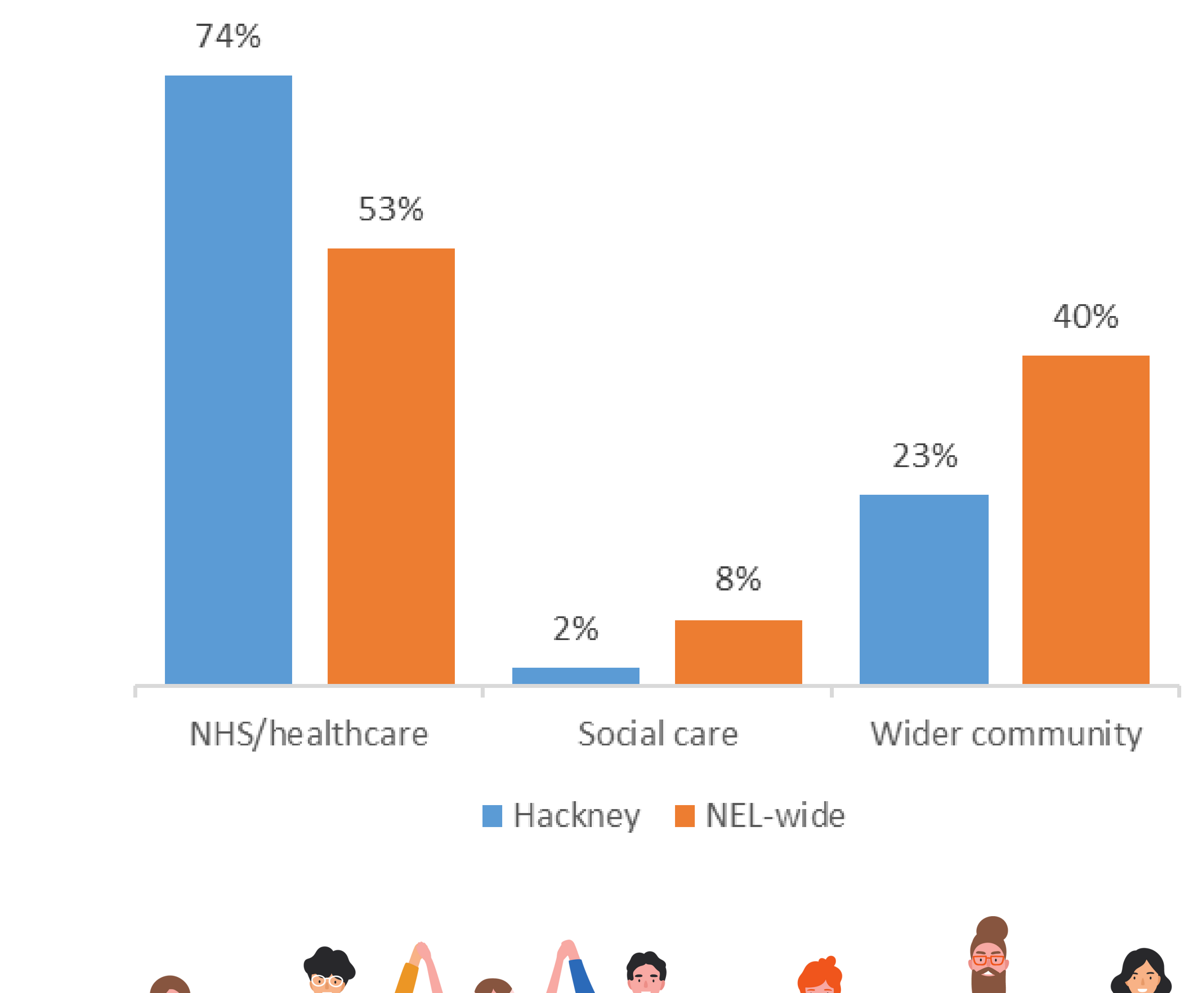

Make use of public spaces, especially outdoor/ green spaces for engaging local people in community-building and health promotion activities; organise events including the entire community.

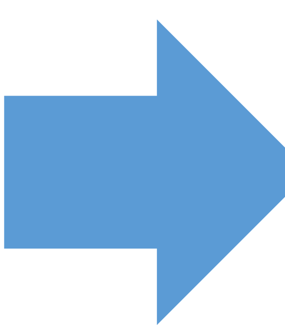

Improve traffic and reduce car use.


Improve provision of social housing; including accessibility for disabled council/ housing association renters. Improve services aimed at supporting homeless residents or those at risk of homelessness.

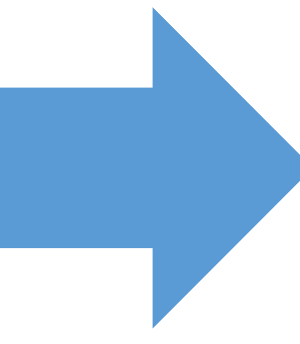
Improve safety and cleanliness of parks; crack down on antisocial behaviour in public spaces.

What changes would make an immediate positive difference to people's lives?



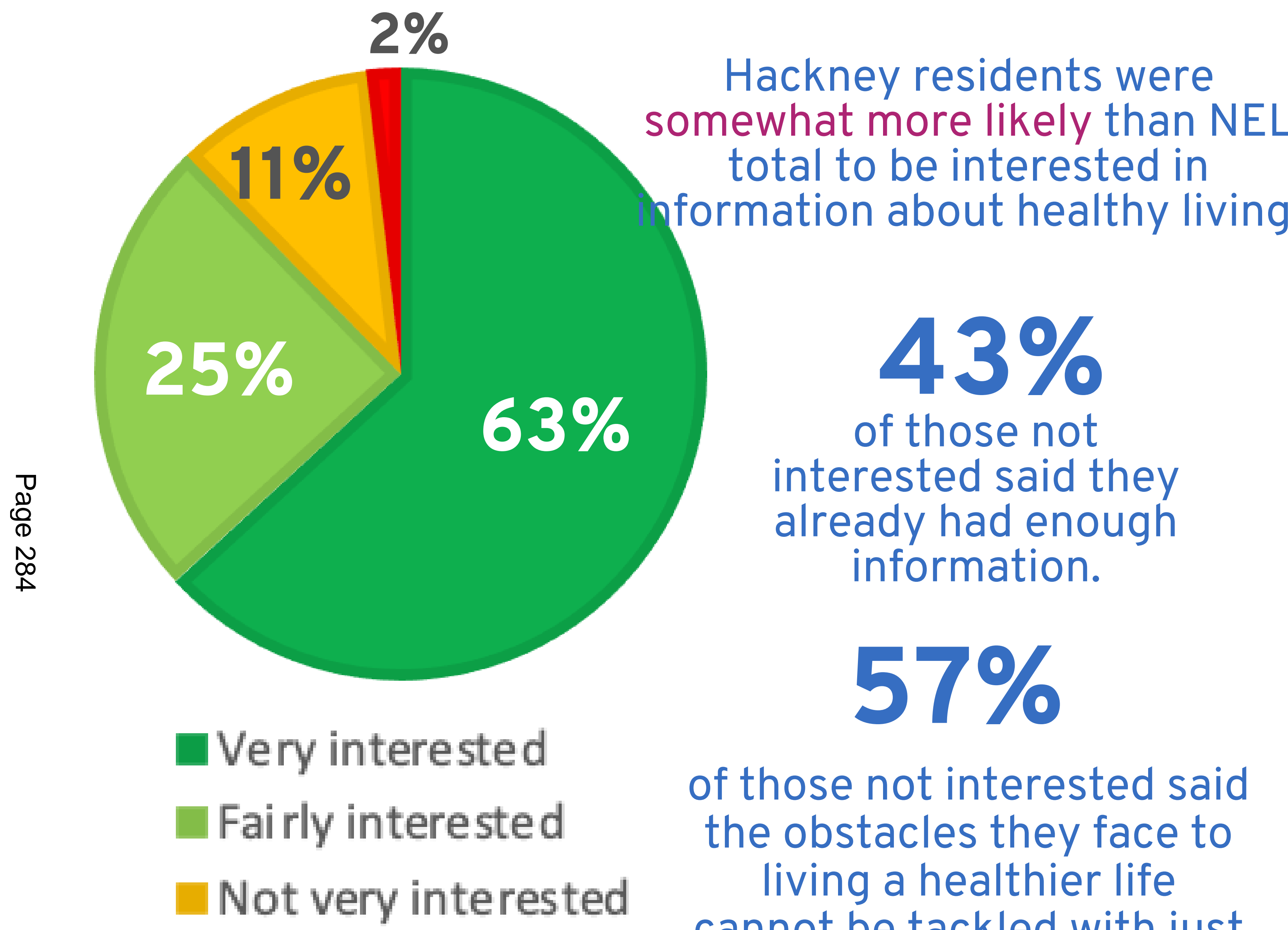


Most mentioned healthcare change: improve access to primary care, especially to GP appointments.



Most mentioned wider community change: tackle drug use in public spaces.

How interested would you be about having information available where you live about living a healthy life? - *survey respondents*



Hackney residents were somewhat more likely than NEL total to be interested in information about healthy living.

43%

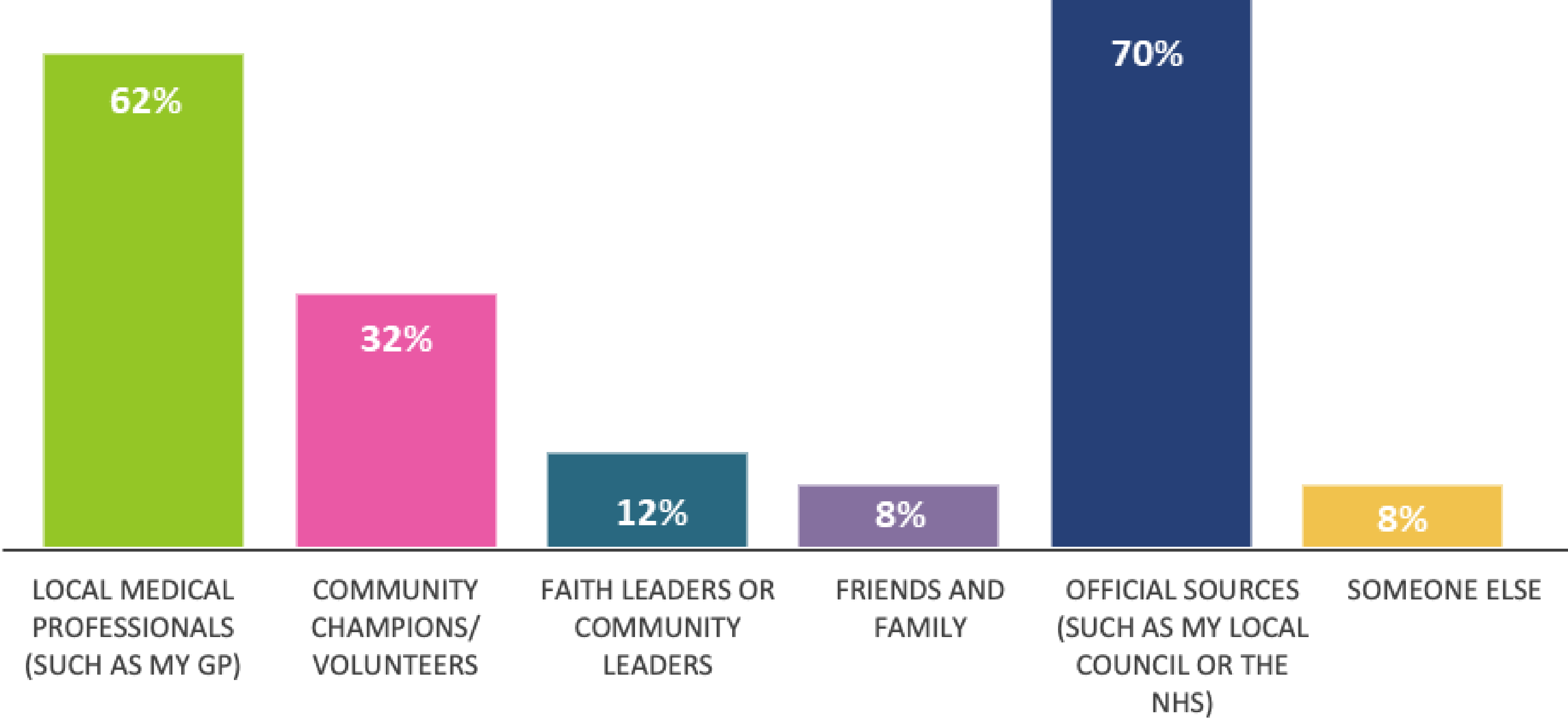
of those not interested said they already had enough information.

57%

of those not interested said the obstacles they face to living a healthier life cannot be tackled with just information.

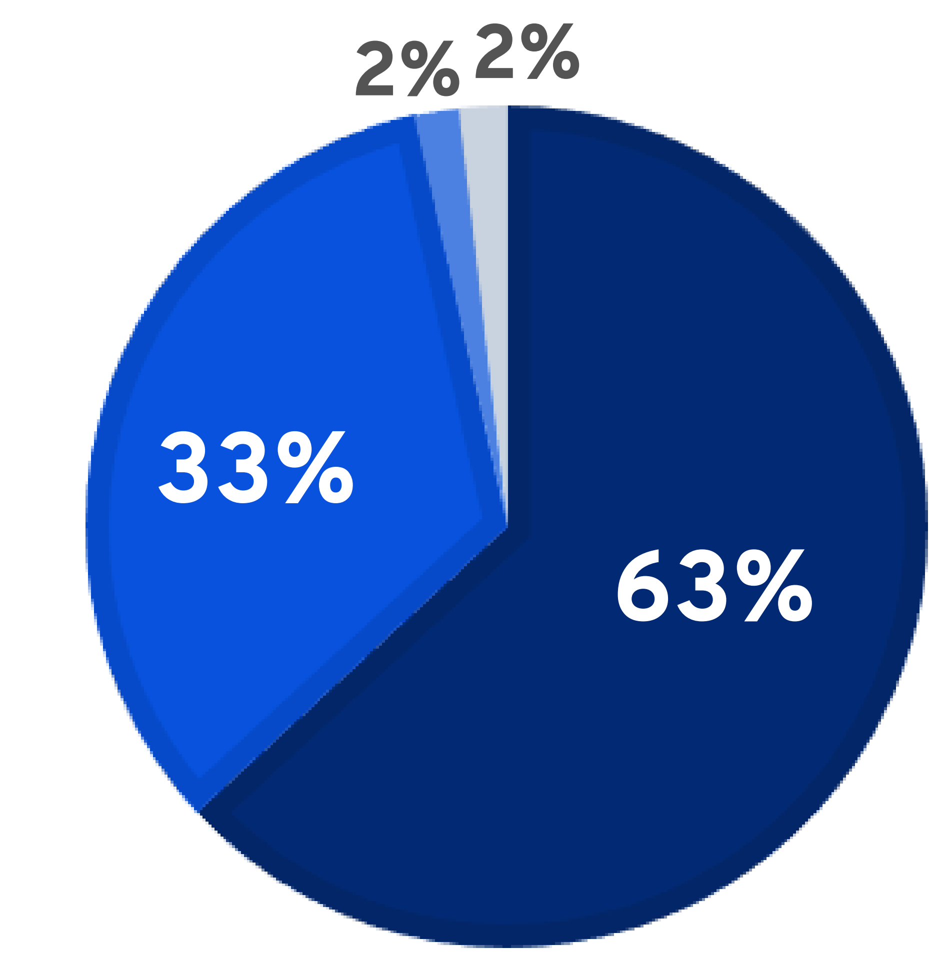
Whom information should come from

according to those who would like to receive info



Hackney residents were less likely than NEL total to want information coming from friends and family and more likely to want information from community champions or volunteers.

How important is it for you to have a say about how local health and social care services are run? - *survey respondents*



Compared with North East London total, Hackney respondents were slightly less likely to believe it is important to have a say.

What would help local people be more involved in shaping health and care services:

Inform local people about involvement opportunities

Be flexible in terms of dates/time and medium; consider accessibility
Accommodate those who prefer to take part in meetings and those who prefer to give feedback in writing; those who are digitally excluded and those who prefer online communication; those who work full-time and those with limited ability to travel.

Consider the specific expertise individuals can bring
Professional experience, lived experience, transferrable skills.

Consider financial incentives/ paying for expertise

Show local people how their involvement is making a difference
Offer clarity on how their data will be used; demonstrate accountability; publicise "You Said/We Did" results

Priority: babies, children and young people

	Young people NEL wide	Young people Hackney
Health and care providers understand the needs of young people like me	55	31
I believe I am getting a good start in life in my local area	60	38
I feel optimistic about my future	64	52

	Parents NEL-wide	Parents Hackney
Health and care providers understand the needs of my children	60	55
I believe my children are getting a good start in life in our local area	56	57

SCALE: 100 Very good – 0 Very poor

Priority: babies, children and young people

What young people want from health and care services

- Trustworthy sources of information about healthy lifestyles
- Routine check-ups/ screenings/ blood tests
- Mental health and wellbeing support; faster access to mental health services; holistic mental health support
- Awareness of mental health-related disability; signposting and integration
- Services that are easy to use (streamlined admin), with reasonable waiting lists; simplified access/paperwork
- Non-judgemental, empathetic professionals you can be open with; communicating sensitively
- Younger social workers and friendly space them can put them at ease
- Medical professionals that speak to them in an age apropriate way from as early as possible, not just to their parents
- Respect for their confidentiality and privacy
- Health professionals that do not dismiss young people's concerns and symptoms, especially those that make them stressed or self-conscious; not having their concerns dismissed because of age.
- Social prescribing; working within the community
- Continuity and integration of care when transitioning from child/adolescent to adult health services; without a need for restarting the referral process.
- They place a high importance on health and care workers being fairly paid and having a good work environment

Priority: babies, children and young people

What young people want from schools

- Holistic/ interdisciplinary teaching
- Better security/ protection/ safe environment.
- School-based mental health support.
- Opportunities to learn about different career paths, including for those who are not academic over-achievers.
- Work experience. Opportunities to build employablity skills.

What young people want from their local communities

- A strategy to address poverty, especially food poverty and housing poverty/homelessness;
- Better awareness of the different types of abuse and support for abuse victims.
- More after-school clubs particularly aimed at young men, as a violence prevention strategy.
- Work experience. opportunities to build employable skills.
- Better promotion of community organisations/ charities offering relevant services.
- Safety from bullying, harassment, robberies and gangs.
- Connection, motivational community; encouragement to pursue dreams
- Open green spaces, spaces for physical activity and sports
- Disability inclusion

Priority: babies, children and young people

What parents want from health and care services

- Easily accessible/ availabilty of appointments
- Quick access to urgent primary care (same day or walk-in); a dedicated helpline for paediatrics advice/
- Single point of access for children's services
- Local children's hub providing health checks; for older ages (from primary school onwards) continue to provide routine health checks and health information in a regular basis, possibly in a different setting.
- Better continuity/ consistency of care in the provision of postnatal health visitors, especially for vulnerable families and those with mental health issues; better non-judgemental breastfeeding support; continuity of care/ support from birth to school age. Extend Home Start to older ages
- Nutrition, mental health and family education for parents and children; access to antenatal/ parenting classes, including for those on low incomes.
- Multicultural staff reflecting the diversity of local areas
- Signposting service connecting to community resources
- Holistic/ community-connected support for families with special needs or vulnerabilities.
- Better support for children with special educational needs in schools.
- Better, more accessible child and adolescent mental health services
- Mental health support and health education in schools.

57%

of parents didn't have anyone to turn to for advice on supporting their children to grow healthy and well.

Hackney parents were just as likely as NEL total to have someone.

Priority: babies, children and young people
The good care model

Accessible

Babies and children can get same-day GP appointments or be seen on a walk-in basis.

There is a single point of access for children's health services.

Health and care services for children and young people take into account school schedules when offering appointments.

Children's centres, family hubs and youth clubs are in every neighbourhood.

Mental health support and interventions/ activities to improve mental well-being are available in a school and community setting.

Parenting classes, activities for children, families and young people are free or affordable.

Healthy food options are convenient and affordable including for those who can't cook (children at school, students living in halls etc.)

Competent

Young people and new parents have access to impartial, evidence-based advice on living a healthy lifestyle.

All services working with new parents, babies, children and young people, including schools, nurseries, health and social care services, have a good awareness of mental health in the context of parenthood, childhood and youth; as well as of learning disabilities and neurodivergence.

Professionals don't assume young people's symptoms are less serious or that they can't have chronic conditions.

Person-centred

Transition between child and adult services is straightforward and happens without disrupting access to care for young adults; patients are not required to undergo complex bureaucratic processes or tell their story from the beginning all over.

Health services, social care, schools and community organisations work together and signpost to each other. Support for special needs/ vulnerable families (poverty, domestic violence etc.) is holistic and inter-connected.

Schools, universities and training providers work with employers to build skills and recruit young workers.

Teaching in schools is holistic/ interdisciplinary.

Trustworthy

Routine health checks for babies and children are available in hubs, children's centres or GP surgeries, providing reassurance to parents.

Young people get to access care and speak about their concerns to professionals that take them seriously, respect their dignity and their confidentiality; they get to ask about sensitive topics such as mental health or sexual health without fear of being judged.

Young people's health concerns are taken seriously, not dismissed.

Younger social workers and friendly spaces put vulnerable children at ease.

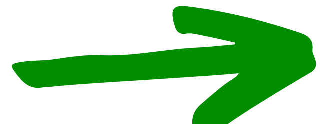
Children, young people and parents feel safe from harm in their local area and at school.

Community offers safe spaces for self-expression.

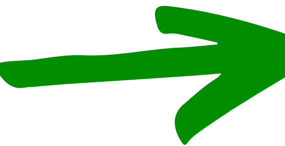
How to measure success for babies, children and young people based on what matters to local people

Pillar	Success indicator	How it could be measured
Accessible	Decrease in waiting times for GP appointments for babies and young children. Decrease in waiting times for children and young people accessing mental health/ neurodivergence services. Improved ease of accessing health services for children and young people- in terms of booking processes and flexibility. Improved provision of resources for promoting physical and mental health in schools and the wider community. Improved access to community resources for children and families on low incomes Improved access to affordable healthy food in schools; improved affordability of healthy food options that don't require cooking at home. Decrease in demand for food banks. Improved access to jobs with a career progression for young people, including for those from working class backgrounds and those who are not high academic achievers.	Data generated by health and social services providers: waiting times for appointments by age; % of patients who unsuccessfully try to make appointments by age; mapping booking and referral processes. Engaging with parents and young people on how easy or hard they find accessing services. Engaging with young people on their lifestyles and the incentives/ obstacles the experience for healthy or unhealthy behaviour; taking into account physical and mental health. % of parents on low incomes accessing parenting classes % of children and young people on low incomes taking part in extracurricular activities and youth clubs.
Competent	Improved knowledge of health lifestyles among parents, children and young people. Improved knowledge of mental health and of neurodivergence among health professionals working with children and young people, including those not specialised in neurodivergence or mental health. Improved knowledge of the wider determinants of health among professionals working with children; decrease in poverty-related preventable illness in children and young people. Presence of evidence-based, effective interventions and initiatives on public health (smoking/vaping cessation, healthy eating, physical activity, reduction of substance misuse) and wider determinants (crime reduction, violence prevention)	Monitoring and evaluation- success rate of public health and related initiatives (for example % of young people who give up smoking, reduction in of young people who take up vaping, reduction in violent crime locally, reduction in substance misuse) Measures of general well-being among children and young people. Engaging with young people on their lifestyles and knowledge levels, including ability to identify impartial vs biased advice, and evidence-based vs pseudoscientific Engaging with health and care professionals about their knowledge of mental health/ neurodivergence in young people/ wider dererminants of health and their training needs Engaging with young people who are experiencing mental health issues and/or are nurodivergent on the extent the feel understood,
Person-centred	Improved continuity of care for young people with long-term conditions (including mental health conditions) aging out of children's services Simplified/ single point of access health, care and social services for babies/ new parents/ vulnerable families Improved links between schools/ universities/ training providers and employers; including for those who are not high academic achievers.	Mapping referral and transition processes for young people with long-term conditions (for example, between CAMHS and a CMHT); engaging with patients to understand their experience. Mapping journeys of new parents or vulnerable families accessing care, with a focus on points of access/ how often do they have to tell their stories. Mapping journeys of young people into employment, in combination with anaysing statistics about education and employment (for example: what % of graduates have a job within a year/ within five years? Are the jobs they are getting in the field they trained for? Do they have career progression? How do they find out about jobs/ how are they recruited?
Trustworthy	Increased availability of health checks for young children; parents receiving reassurance and learning how to tell whether their children are well; decrease in rates of unnecessary children's A&E visits Young people feeling comfortable talking about mental health with health professionals; at school; and in community settings. Young people feeling safe at school and in communities.	% of children attending A&E not receiving treatment; % of children receiving health checks; mapping patient journeys. In-depth interviews with young people about worries, trust and emotions in various contexts.

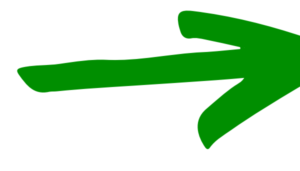
Recommendations for babies, children and young people in Hackney

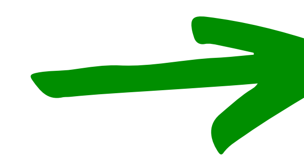
 Improve access to mental health and wellbeing services, both for children/ young people and for new parents.

Improve availability and affordability of early years education; bring back Sure Start.

 Monitor the quality of schools and education providers; track children's educational progress and identify those in need of educational support.

Involve young people in informal educational activities - including on healthy living topics, such as sex education, substance misuse and mental wellbeing.

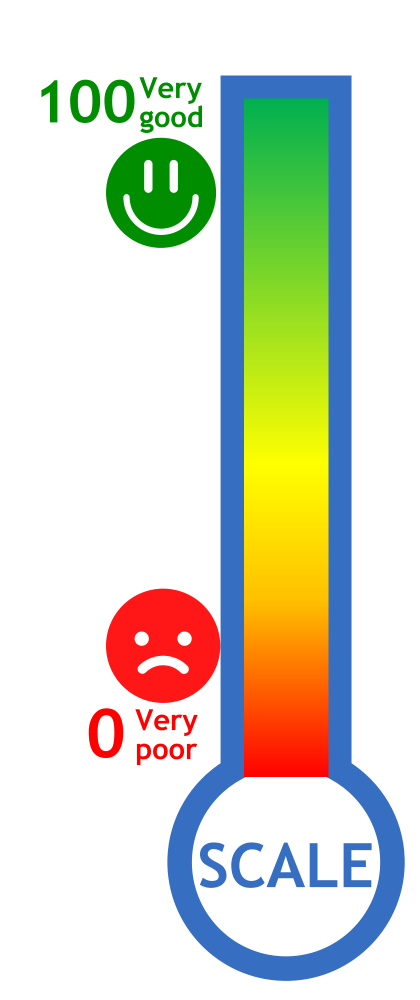
 Encourage children and young people to take part in team sports and other forms of physical activity at school; organise sports competitions and fun activities with a physical exercise element in the community.

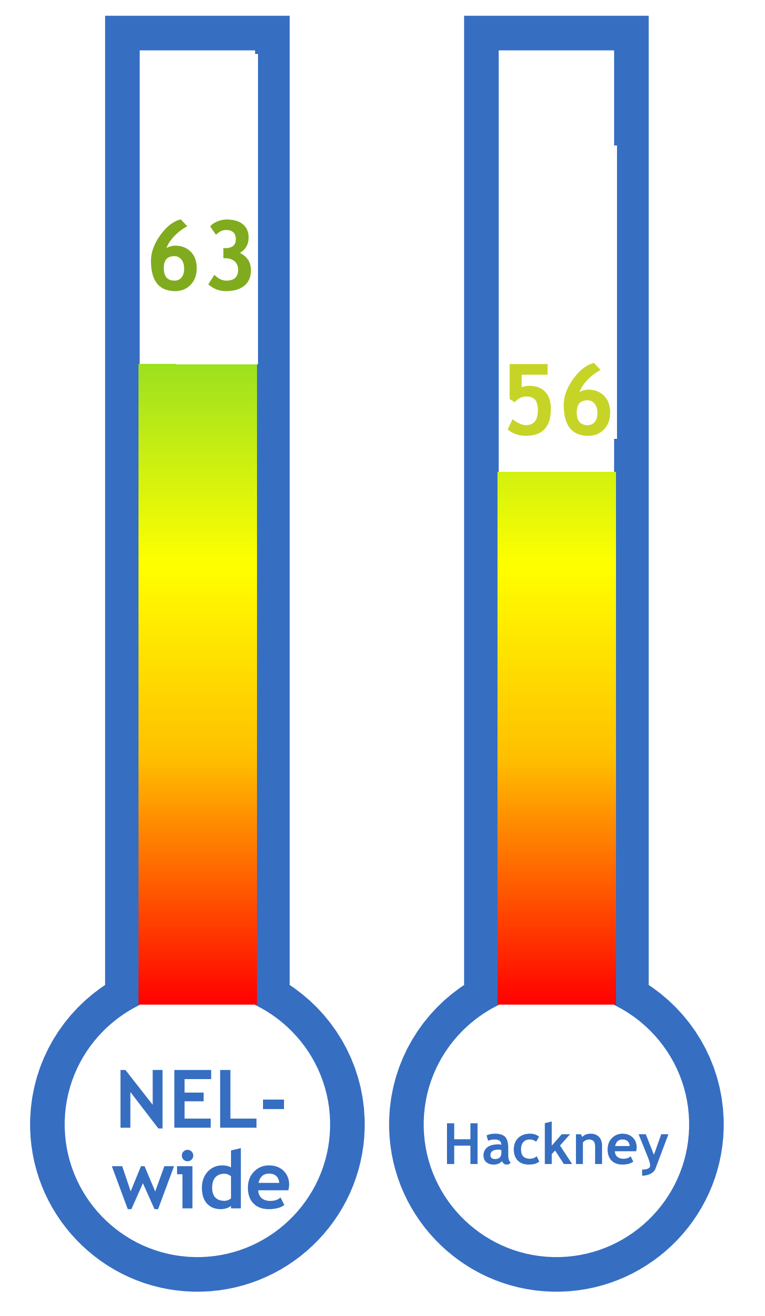
 Provide free school meals for all children; ensure school meals are healthy and nutritious.

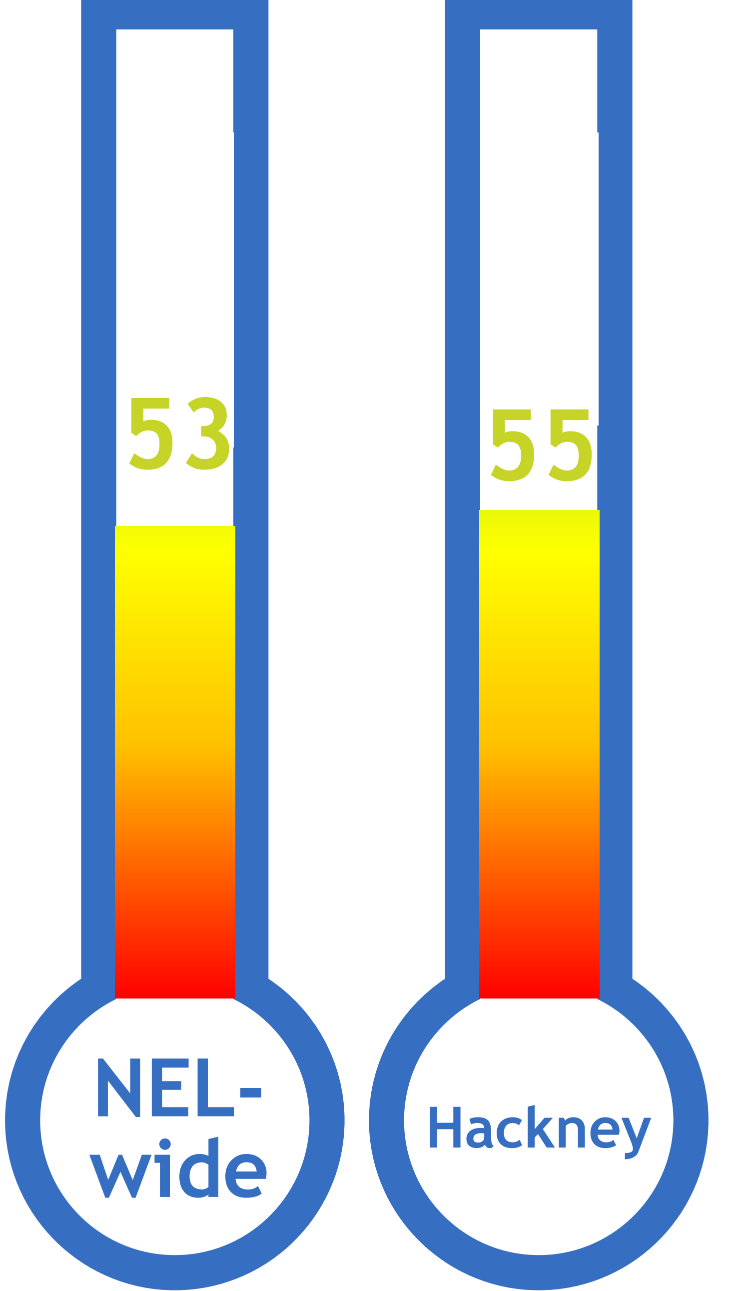
Priority: long-term conditions

Survey respondents with long-term conditions

I am able to manage my long-term condition well







Priority: long-term conditions
The good care model

Accessible

GP routine appointments are scheduled ahead of time and available.

Practical help solutions to empower people with long-term conditions to manage their lives and live well are available, including to those on low incomes.

People with long-term conditions have a reliable way of getting specialist advice when needed (for example: a helpline dedicated to their specific condition)

Exercising classes and physical activity are accessible for all levels, including those who need gentle exercise.

Workers with long-term conditions have the flexibility and accommodations the need to stay in work.

Competent

Health and care providers understand long-term conditions; including how different conditions and co-morbidities may impact each other.

Impartial, evidence-based advice on self-care and managing long-term conditions is available in the community.

Patients experiencing new symptoms are diagnosed promptly and reliably.

Person-centred

Primary care, specialist health services and wider community support are connected with each other.

Patient records are shared between services; referrals are processed smoothly and efficiently.

There is a single point of access for patients with a long-term condition (could be GP surgery, care navigator or community hub).

Patients are treated holistically, not each condition in isolation (especially for those with multiple conditions)

Trustworthy

Patients have access to routine check-ups and reviews, in order to understand the progress of their condition, make sure they are well and improve self-care ability.

Patients in the process of being diagnosed or those experiencing new symptoms are taken seriously, listened to and supported to manage in the meantime.

Workers feel safe disclosing their condition at work, taking sick leave or asking for accommodations.

Priority: long-term conditions

What makes the difference between those who manage there long-term condition well and those who manage them badly?

Individual level:

- Knowledge about self-care
- Healthy lifestyle

Care level

- Availability of a point of contact for specialist advice
- Availability of regular check-ups and reviews
- Professionals understanding your condition(s), including how co-morbidities impact each other.

Society level

- Affordability of help with things you struggle with because of your condition (technology, a cleaning service, transport etc.)
- Flexibility, accommodations and understanding at work.

NHS has been efficient with appointments and investigations. I have had to to wait long up until this year. I am now waiting on elective surgery (which should remove the long term condition), which was supposed to be with 2-3 months of agreeing to it in January, however I appreciate that the strike action within the NHS has delayed everything.

My doctor keeps changing my pills, and the amount taken

I have not been given enough timely information. I have not been able to access certain providers, like physio / dermatology as they are perennially engaged or don't have appointments available

I feel misunderstood by my psychiatrist and have zero support for my degenerative disc disease and arthritis

The individual issues are cared for well - BSO and mammograms, waiting list for preventative mastectomy etc, but each condition is siloed and I could do with someone other than me alone co-ordinating things and self-advocating.

How to measure success for people with long-term conditions based on what matters to local people

Pillar	Success indicator	How it could be measured
Accessible	Increased availability of on-demand specialist advice for managing long-term conditions. Increased availability of routine check-ups for managing long-term conditions. Decrease in number of people accessing private services because of NHS waiting lists. Decrease in number of people leaving the workforce or limiting their career prospects because of long-term conditions. Decrease in number of people limiting their social lives because of long-term conditions. Increased uptake of physical activity among people with long-term conditions.	Audit of available resources (medical, patient and community) and mapping patient journeys in terms of accessing them. Engaging with patients about where they turn to for advice and care; and what obstacles they experience. Analysis of statistics about the employment status of people diagnosed with long-term conditions, in terms of type of jobs held, numbers of hours worked, career progression, rates of leaving the workforce before retirement age. In-depth interviews both with professionally successful people living with long-term conditions; and with people who have left jobs/ left the workforce entirely because of their long-term condition
Competent	Decrease in the amount of time it takes to get a diagnosis and receive appropriate treatment. Increased knowledge of co-morbidities and of how different long-term conditions impact each other among health and care professionals.	Mapping patients journeys; time passed from first symptoms to diagnosis and treatment. Engaging with health and care professionals about their knowledge of long-term conditions and their training needs.
Person-centred	Availability of specialist advice for managing long-term conditions in a variety of formats and settings (for example: phone helplines, online resources, community-based peer support groups etc. Decrease in the amount of time it takes to get a referral. Improvement in the sharing of data and records between services.	Mapping patients journeys; referral rate, time passed from first GP appointment to first specialist appointment, sharing of patients record and data Engaging with patients on whom they turn to for advice and their experience doing so.
Trustworthy	Increased availability of health checks; people with long-term conditions receiving reassurance and learning how to tell when they are well and when they need to be seen; decrease in rates of unnecessary A&E visits Workers feeling comfortable disclosing their long-term condition as work; asking for sick leave or adaptations as needed, with no fear of discrimination.	Audit of available resources in terms of routine checks and patient education. Monitoring of A&E attendance by patients with long-term conditions.

How care could be improved for people with long-term conditions in Hackney

- Improve access to GP appointments in person, including more frequent routine checkups. Improve continuity of care by assigning care for long-term conditions to named clinical staff.
- Improve access to interventions that can prevent conditions from getting worse proactively; including physiotherapy and other allied health disciplines.
- Improve cooperation between medical, social and community services in order to provide patients with necessary adaptations and other forms of support. Engage with patients on the specifics of what they need; work with employers, local business and public services for accessibility and inclusivity. Take a holistic approach- treat the person not the disease.
- Provide better self-management advice, on an ongoing/ as needed basis, including information on interpreting test results. This could include specialist helplines and peer support groups.
- Streamline repeat prescriptions; simplify the process of requesting them.
- Identify and proactively support vulnerable patients at risk of social isolation and loneliness.
- Ensure local people living with long-term conditions are empowered to live healthy lives; ensure they have access to adequate housing, including dealing with damp and insulation.

Priority: mental health and well-being

	I have a good level of happiness and mental well-being *All survey respondents*	I have a good level of happiness and mental well-being *Survey respondents with mental health conditions*	I am comfortable talking about my mental health	I am receiving good care for my mental health *Survey respondents with mental health conditions*
NEL-wide	67	40	73	34
Hackney	45	39	53	29

SCALE: 100 Very good – 0 Very poor

Priority: mental health and well-being
The good care model

Accessible

People can access therapy, specialist services (such as an ADHD diagnosis) or other forms of support (such as emotional support groups for mothers or grief counselling) within a reasonable time frame.

Health and care services understand stigma around mental health and difficulties some people may have in seeking help.

Therapy and counselling are available in a variety of community languages.

Mental health-related disability is taken into account when considering accessibility in healthcare, social care, community and workplace settings.

Competent

Health and care providers, including those not working directly in mental health, understand various mental health conditions and how they can impact access to care.

Health and care providers understand the link between physical and mental health.

Employers, school and community stakeholders have knowledge of how to promote well-being for all at a wider social level.

Person-centred

A variety of evidence-based treatment options are available (for example: multiple types of therapy rather than just CBT)

Health and care services work closely with the wider community to tackle issues such as poverty and social isolation, both for people experiencing mental health issues and for the wider community, as a prevention strategy.

Mental health is understood in a wider social context, not only from a strictly clinical point of view.

Trustworthy

Patients accessing services for mental health are supported ling-term in a proactive way; follow-on support is available and routinely offered.

Patients can talk to health and care professionals about their mental health needs without fear of stigma or being dismissed.

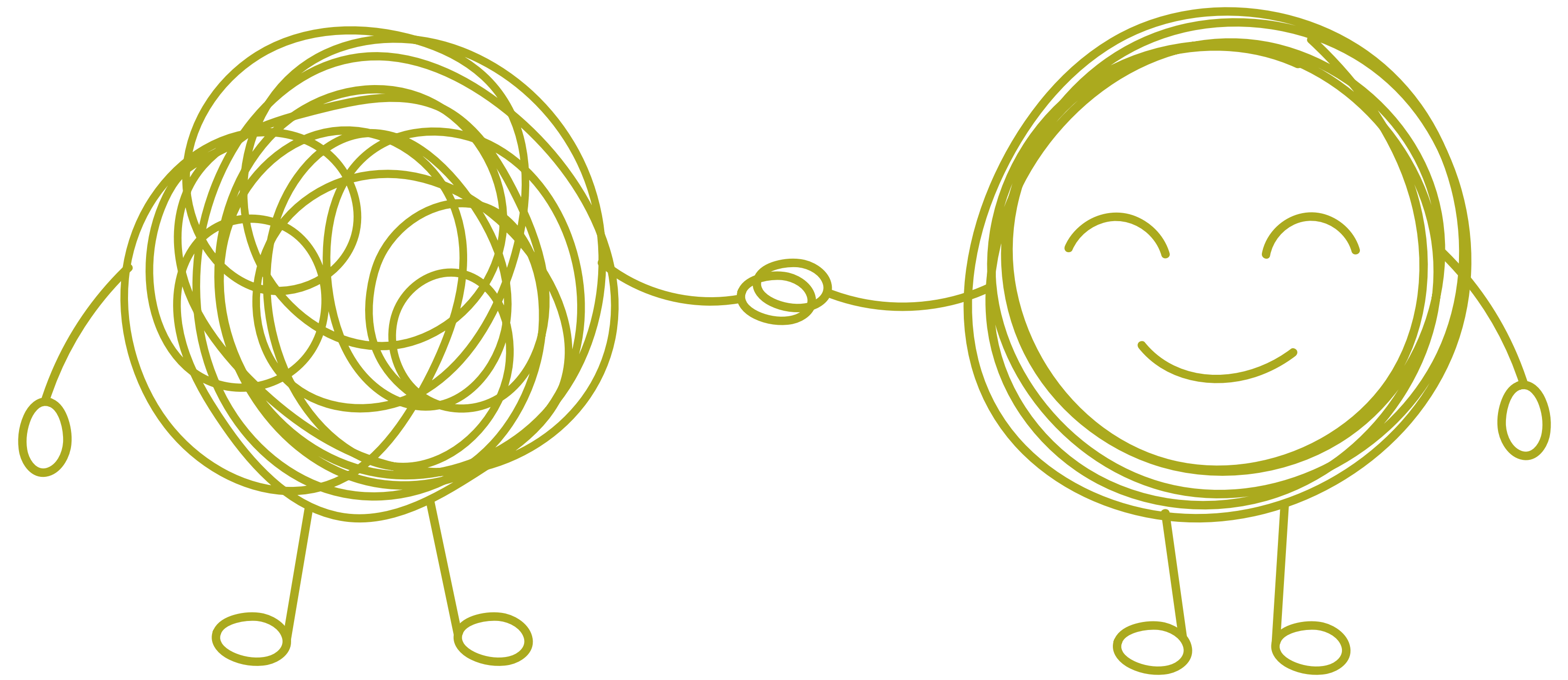
Routine health check-ups (for example: for new parents, for people with long-term conditions, for the elderly) include questions on mental health and well-being.

How to measure success for mental heath and well-being support based on what matters to local people

Pillar	Success indicator	How it could be measured
Accessible	Decrease in waiting times for services such as IAPT, CMHT, CAMHS, autism/ADHD assessments etc. Simplification of the process by which people access care for their mental health- improvement in user experience Decrease in social isolation among people living with mental health issues	Data generated by services- "hard data" on waiting times. Engagement with service users; specific questions about user experience when trying to access care, and to take part in the life of their community.
Competent	Improved understanding, among health and care professionals, of the link between physical and mental health; improved understanding on mental health among professionals not specialised in mental health (such as GPs or occupational therapists). Improved understanding among managers of HR professionals of how to support health and wellbeing in the workplace, and how to accommodate workers experiencing poor mental health. Increase in number of people who report having a good work-life balance.	Engagement with professionals; data on training available and undertaken. Engagement with service users to assess the extent the feel professionals treating them are aware of mental health issues. Engagement with workers on their experience of mental wellbeing at work.
Person-centred	Increased integration between primary care, specialist mental health services, social care services and the voluntary/ community service, Increased availability and awareness of community services supporting local people, including but not limited to those affected by mental health issues, with topics such as access to benefits, employment rights/ employability, tackling social isolation etc.	Data generated by services- mapping of referral systems and patient journeys. Audit/ stock-take of available community resources. Engagement with service users on their experience. Engagement with local people who may need support but are currently not accessing it
Trustworthy	Increased availability of follow-on appointments and routine check-ups for patients receiving mental health care. Patients feeling comfortable talking t about their mental health- to health and care professionals; to friends and family; in the workplace. Decrease in number of people who report feeling worried about issues such as poverty, housing or safety locally.	Data generated by services- availability and uptake of follow-on. Engagement with local people on their experience of communicating about mental health in various situations Hard data/ statistics: relation between mental health diagnosis and poverty/ deprivation; elation between mental health diagnosis and unemployment and/or leaving the workforce before retirement age

How care for mental health and well-being could be improved in Hackney

- Improve GPs awareness of mental health issues and the referral pathway; improve knowledge of mental health issues among medical professionals not specialised in it.
- Improve access to therapy and counselling.
- Improve access to community social and leisure activities for people on low incomes and other excluded or disadvantaged groups; tackle loneliness and isolation.
- De-stigmatise mental health and neurodivergence at a society level; provide holistic social support to people experiencing mental health issues, especially those on low incomes.
- Offer mental health support in the workplace/ through employers; EAPs. Improve work-life balance and ensure work stress doesn‘t negatively impact workers‘ mental well-being.
- Provide support to trauma and abuse survivors.



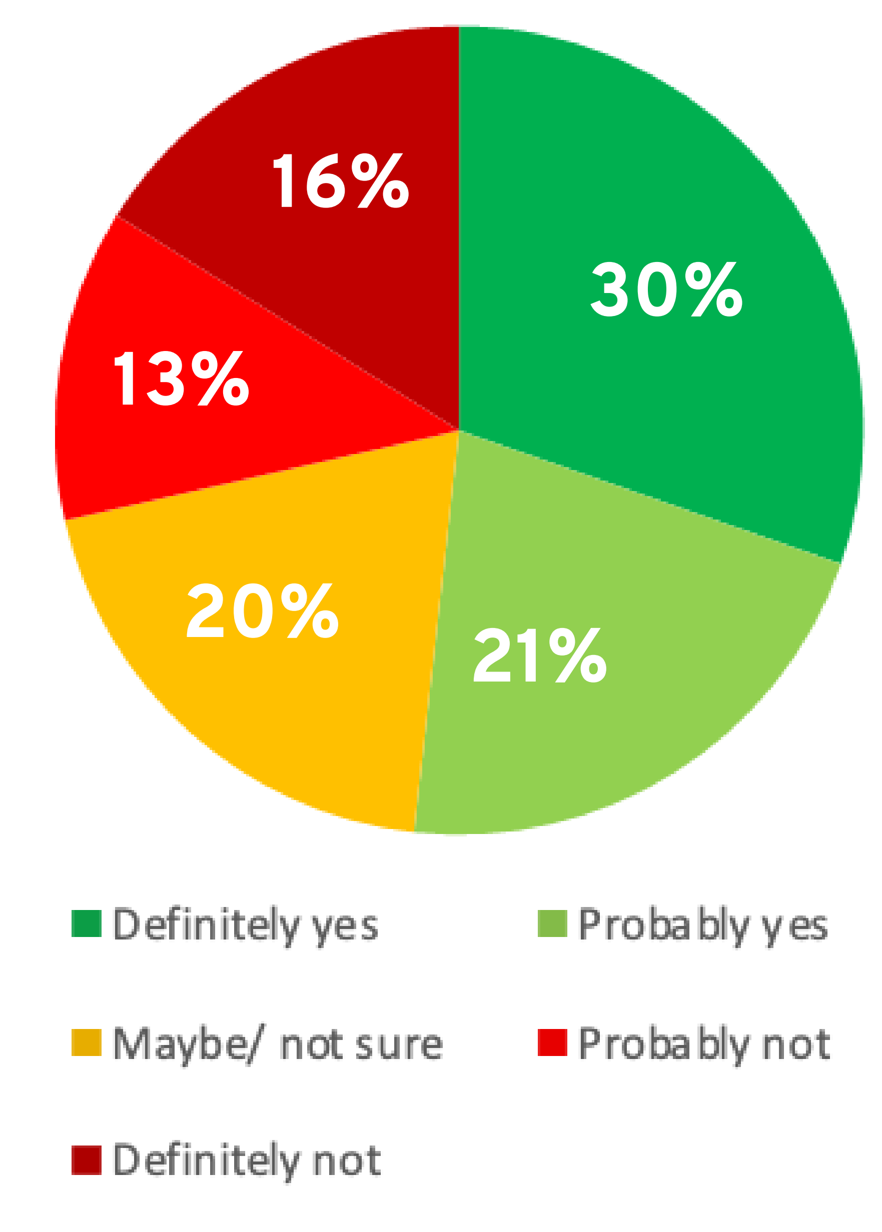
Priority: workforce and employment

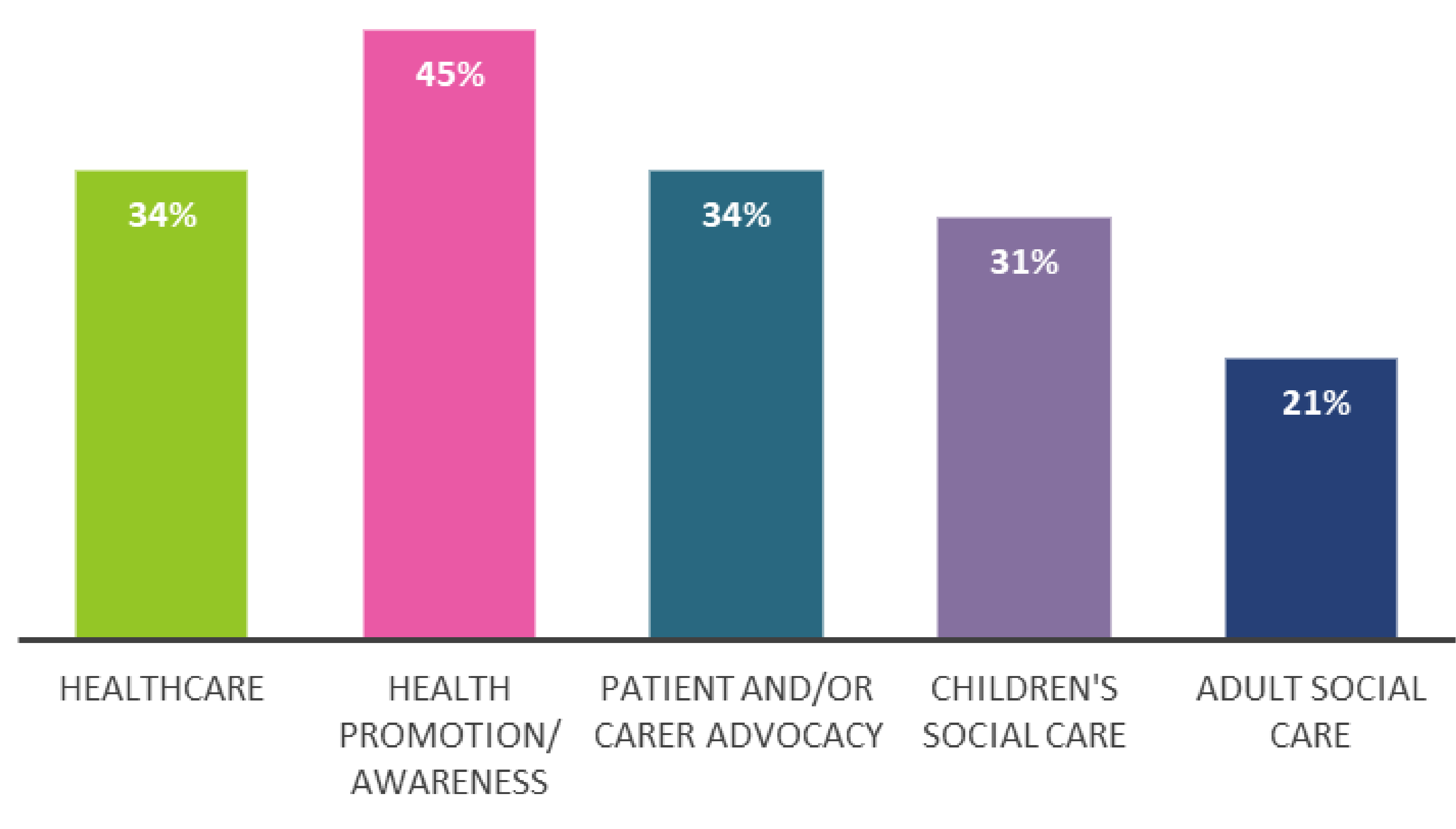
What kind of support would people need for a health or social care career?

- Pathways to training while getting paid (such as apprenticeships); availability of free training; less reliance on volunteering/ unpaid work for gaining experience.
- Mentoring and shadowing opportunities from people with experience in the field; information on qualifications needed for specific jobs; support in matching existing or transferrable skills with job opportunities. Job cafes and open days.
- Work experience in partnership with schools; career advice in schools not exclusively focused on high academic achievers.
- A clear and realistic career progression path; a living wage at entry level.
- Workers having a say in how their workplace is run/' management accountability to workers.
- Better connections with the local community (shops, community centres, faith groups) for advertising jobs, training opportunities and mentoring.
- ESOL training for immigrants with health and care experience in their countries of origin.
- Disability-friendly workplaces, including for those with mental health related disabilities.
- Accomodations for working parents and carers, especially single parents.

Priority: workforce and employment
Volunteering

About half of survey respondents would potentially be interested in volunteering locally.





Priority: workforce
The good care model

Accessible

People can train/qualify professionally and earn at the same time; entry-level jobs pay a living wage.

Workplaces offer flexibility and adaptations for those who need it (disabled, parents, carers etc.); including those with mental health related disabilities.

ESOL classes are available for those with employable skills from abroad.

The job advertisement and recruitment process is designed with diversity in mind, tackling obstacles faced by under-represented groups.

Competent

Understanding of health inequalities/holistic approaches to health is built into training for all health and care professionals.

Health and care professionals feel supported and empowered to do their jobs to the highest possible standard of quality.

Knowledge is shared through mentoring and shadowing; ; support in matching existing or transferrable skills with job opportunities.

There are comprehensive guidelines about how to qualify for specific professions.

Person-centred

There is a good level of flexibility and work-life balance, to the full extent of what the nature of the job allows.

Schools, universities and training providers work together with employers to train local people in the right skills and connect skilled workers with relevant jobs.

Career advice in schools doesn't focus exclusively on academic high achievers.

Workplaces establish connections with the local community (shops, community centres, faith groups) for advertising jobs, training opportunities and mentoring; jobs are advertised where the community is rather than expecting jobseekers to know where jobs are.

Trustworthy

Workers have a good level of job stability.

There is a clear and realistic career progression path.

People can talk about their needs in the workplace, including their metal health needs, and ask for flexibility or adaptations without fear of discrimination or judgement.

Workers feel appreciated and believe the are making a difference

How to measure success for work force development based on what matters to local people

Pillar	Success indicator	How it could be measured
Accessible	Increase in opportunities to access health and care jobs among groups who would otherwise struggle to access this career path. Increase in workplace flexibility	% of workers who are from disadvantaged backgrounds/ have caring responsibilities/ are from any other under-represented groups, in junior and senior positions. Engagement with jobseekers and workers, to understand their career progression and experience.
Competent	Improved knowledge of issues such as health/ social inequalities and mental health among health and care professionals; and among managers in various fields. Increased number of professionals who feel confident and empowered to do their jobs well.	Engagement with health and care professionals; data on training available and undertaken. Assessment of training needs, monitoring of how they are being met. In-depth interviews on mentoing and knowledge-sharing.
Person-centred	Improved collaboration/ continuity between education/training and work; improved collaboration between workplaces and key community stakeholders. Culture of workplace flexibility, in which workers can have work-life balance and align their career goals with otherr aspects of their lives.	Mapping career journeys. Audit/ stock-take of available community resources in terms of education, training and employability advice. Engagement with workers on carreer rprogrression and work-life balance.
Trustworthy	Increased rate of success/ positive outcomes for working requesting flexibility or adaptations in the workplace (for example, as new parents or to accommodate a disability). Workers feeling comfortable talking about their mental health and well-being at work. Workers feeling optimistic about their career progression and job stability.	% of new parents, people with long-term conditions etc. continuing to work vs. leaving the workforce; Mapping/ monitoring career progression, including for groups such as parents and people with long-term conditions. Engagement with workers on communication and trust in the workplace.

This page is intentionally left blank

Title of Report	City & Hackney Sexual and Reproductive Health Strategy, Action Plan and Consultation Report
For Consideration By	Health and Wellbeing Board
Meeting Date	25 January 2024
Classification	Open
Ward(s) Affected	All
Report Author	Froeks Kamminga, *Senior Public Health Specialist* Chris Lovitt, *Deputy Director of Public Health*

Is this report for:

☐	Information
☐	Discussion
☑	Decision

Why is the report being brought to the board?

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

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

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

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

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

Public Health Senior Management Team

1. **Background**

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

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

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

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

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

Issues and topics that were suggested or expanded on include:

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

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

2. Current Position

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

- Co-production is a central part of the strategy but is an approach that requires time and resources
- Relationship and sex education elements of the action plan are still being confirmed as an approach with Young Hackney
- Lack of engagement from NHS place on wider commissioning and alignment of services
- London SH and HIV programmes not delivering on wider commissioning alignments
- Other NEL LAs taking a different approach to commissioning of specialist clinical services using the newly approved Provider Selection regime (PSR)
- Increased “ambition” against a backdrop of Public Health savings and inflationary increases not reflected in the PH grant allocation to Local Authorities

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

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

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

3. **Recommendations**

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

4. **Policy Context:**

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

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

Please detail which, if any, of the Health & Wellbeing Strategy ‘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

4.1. **Equality Impact Assessment (EIA)**

Has an EIA been conducted for this work?

☐	Yes
☑	No

4.2. **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

4.3. **Risk Assessment**

Risks have been addressed in the body of the text.

4.4. **Sustainability**

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

Report Author	Froeks Kamminga *Senior Public Health Specialist*
Contact details	froeks.kamminga@hackney.gov.uk
Appendices	Consultation overview (Presentation) Consultation report Strategy Action Plan

City & Hackney
Sexual and Reproductive Health Strategy

Overview and consultation presentation

Froeks Kamminga
City & Hackney Public Health

Overview

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

Themes

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

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

Process and timeline for strategy and consultation

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

Consultation promotion

Channels (online/social media)

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

Consultation promotion

Email

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

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

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

Consultation

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

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

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

Consultation

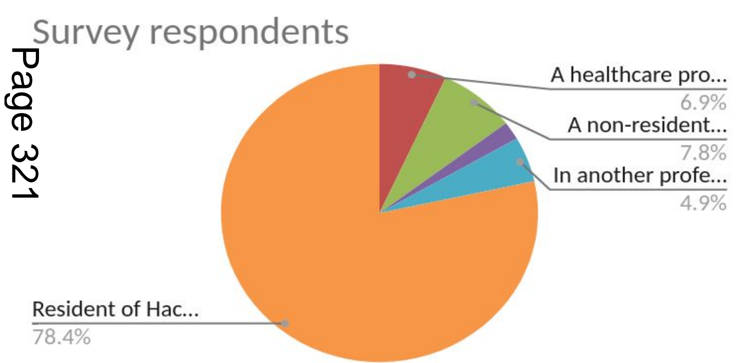
- Face to face focus group discussions/informal engagement
  - Barbican Library, CoL residents/service users
  - Hackney People First (adults with learning disabilities)
  - STEPS brunch drop-in (service users)
  - Young People

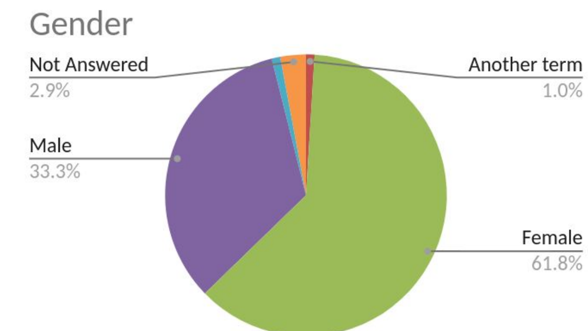
- Workshops with commissioned services and key partners with thematic focus (hybrid of in person and online)
  - Young people and sexual health
  - Contraception and reproductive health

- NEL strategy workshops

Consultation survey

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

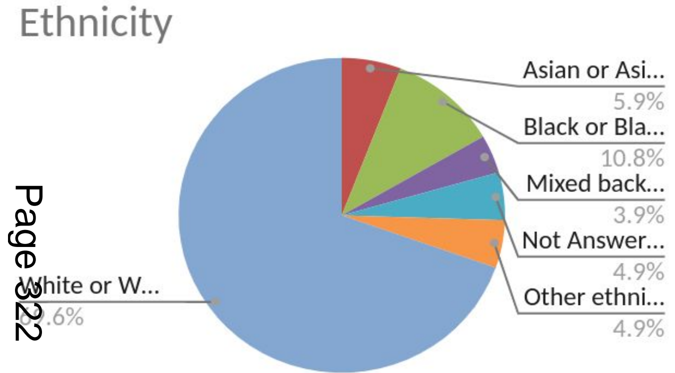


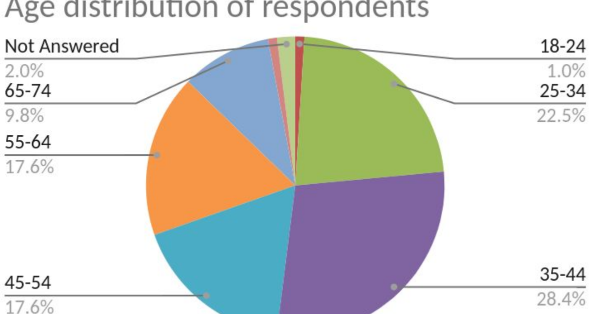


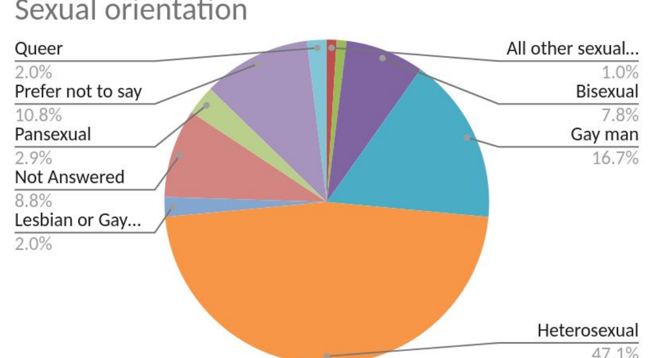
A healthcare provider or health related professional: 7
A non-resident of City or Hackney who uses local C&H services: 8
A representative of a community or voluntary service organisation (CVS): 2
In another professional capacity: 5
Resident of Hackney or City of London: 80

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

Survey: respondent information





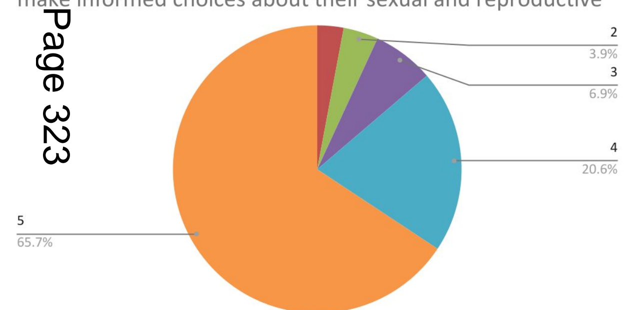


Survey: views on priorities

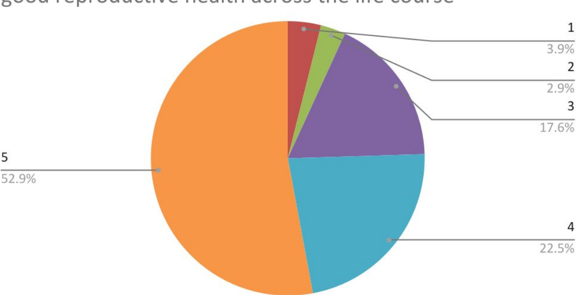
Overall: majority approval of selected themes and priority areas

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

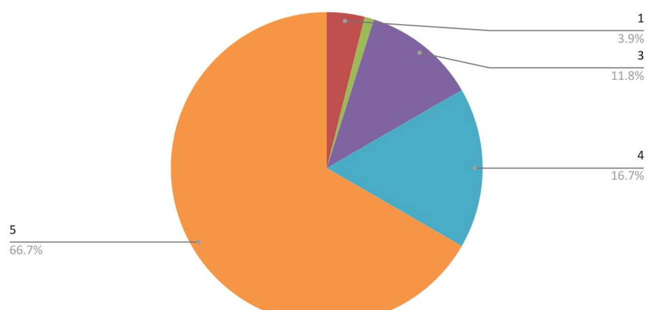
Priority 1: Residents in City of London & Hackney are able to make informed choices about their sexual and reproductive



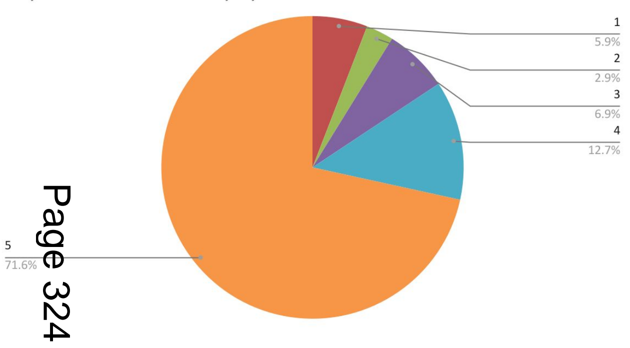
Priority 2: Residents of City of London & Hackney have good reproductive health across the life course

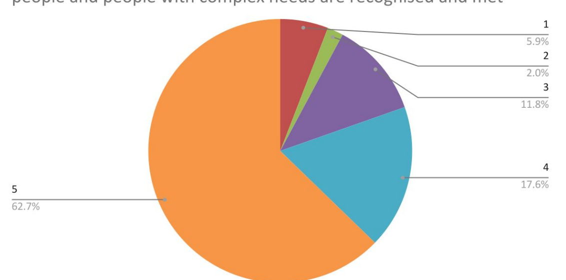


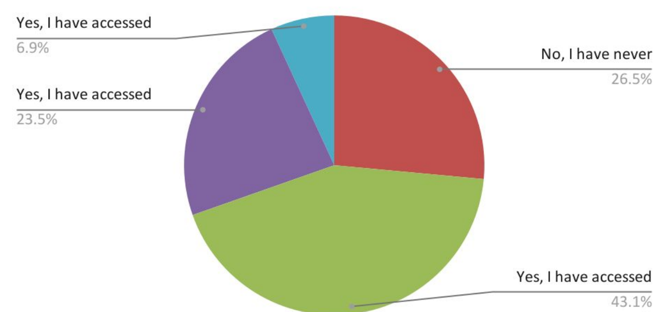
Priority 3: Residents of City of London & Hackney have access to high quality and innovative testing and treatment for Sexually Transmitted



Survey: views on priorities



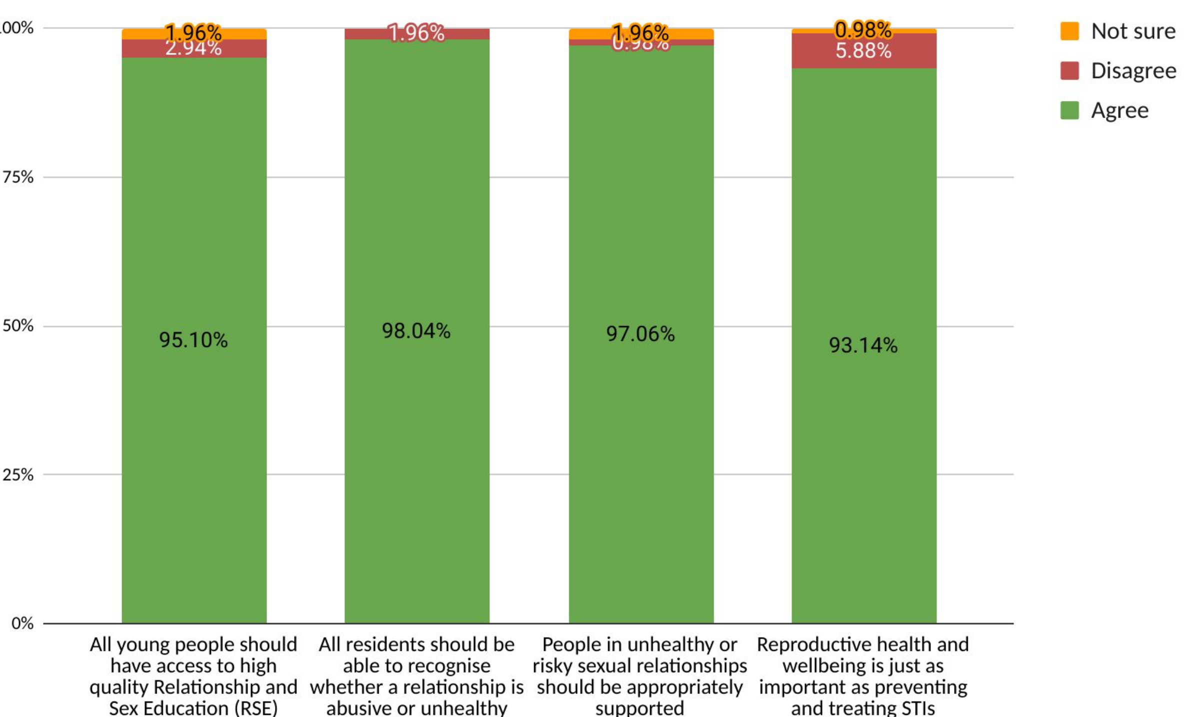




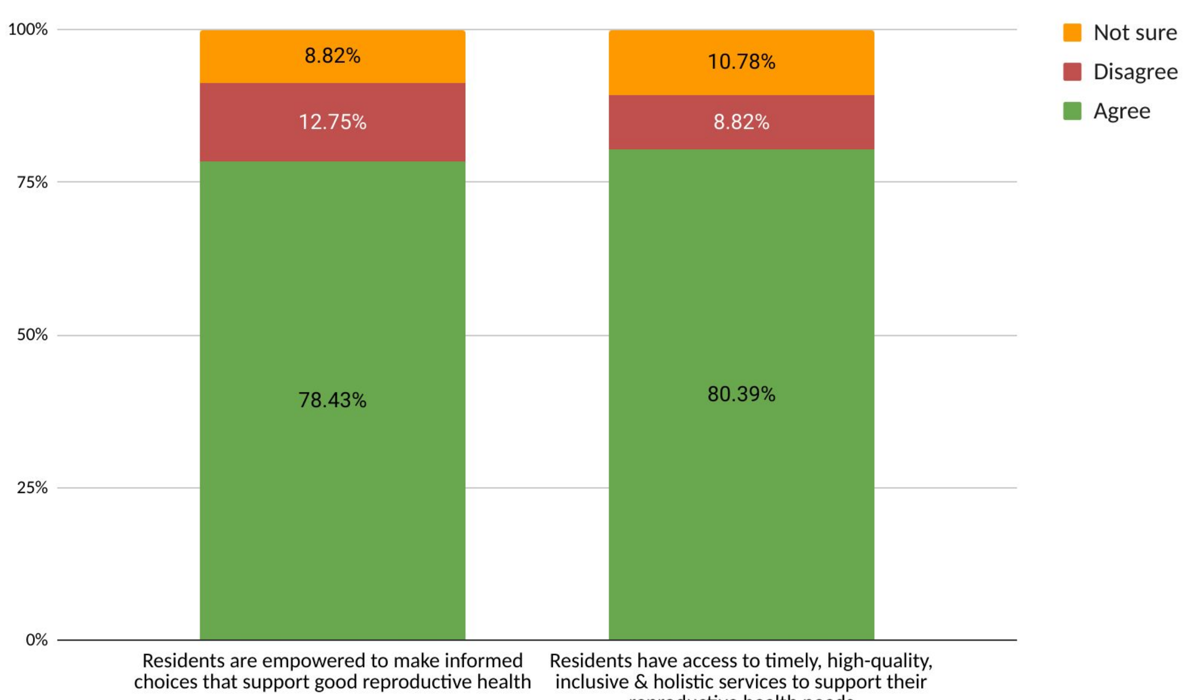
Red=never
Green=in C&H
Purple=elsewhere
Blue= NEL

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

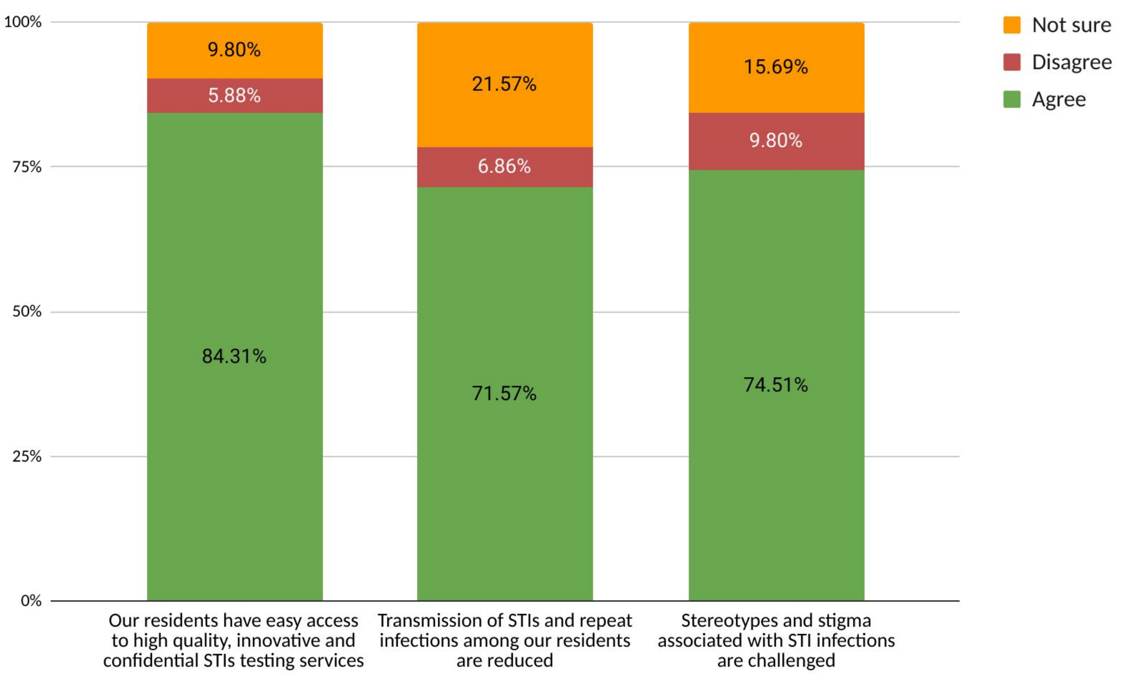
Priority 1: Residents in the City of London & Hackney are able to make informed choices about their sexual and reproductive health



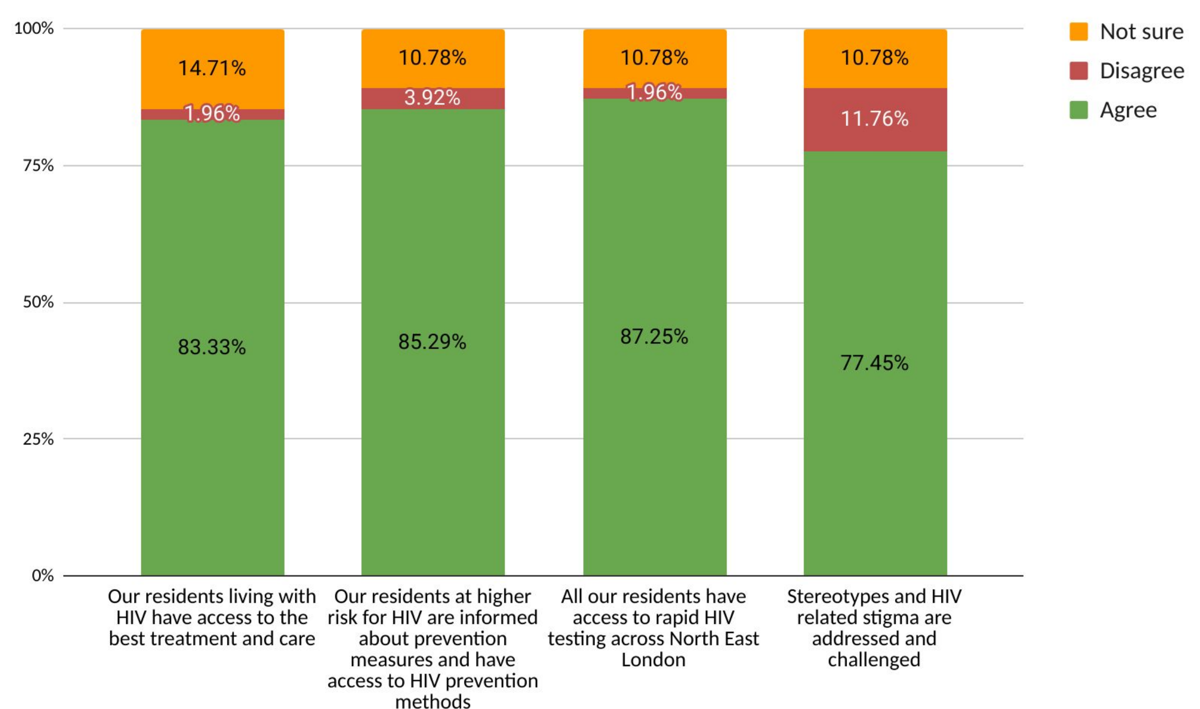
Priority 2: Residents of City of London & Hackney have good reproductive health across the life course.



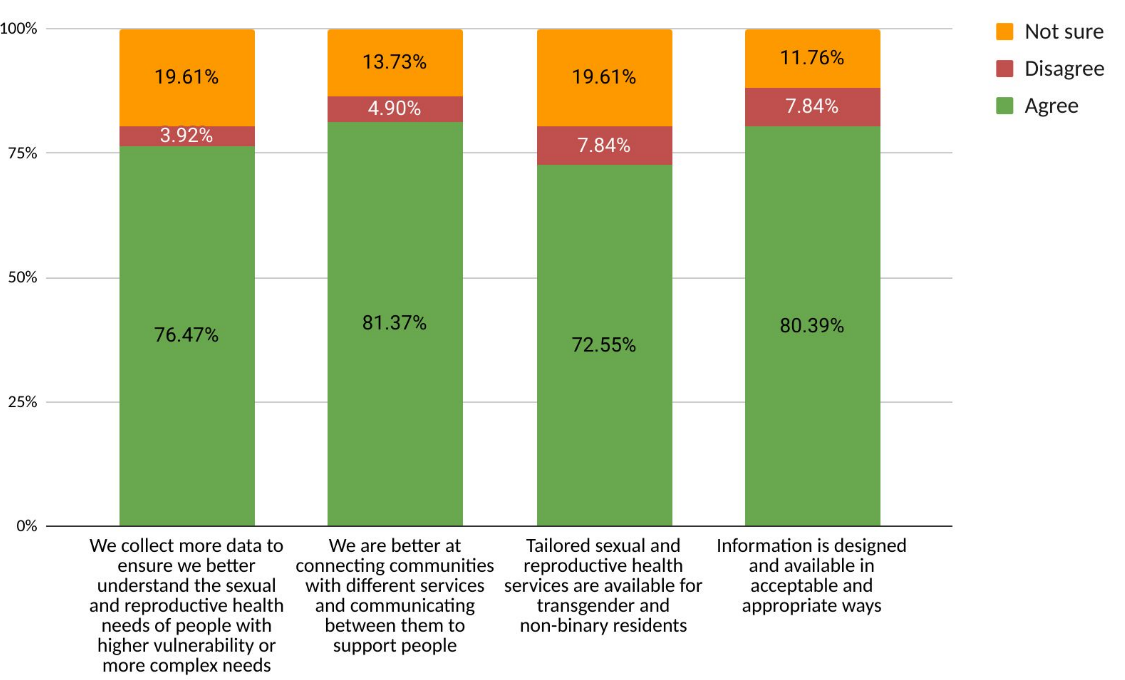
Priority 3: Residents of City of London & Hackney have access to high quality and innovative testing and treatment for Sexually Transmitted Infections (STIs)



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

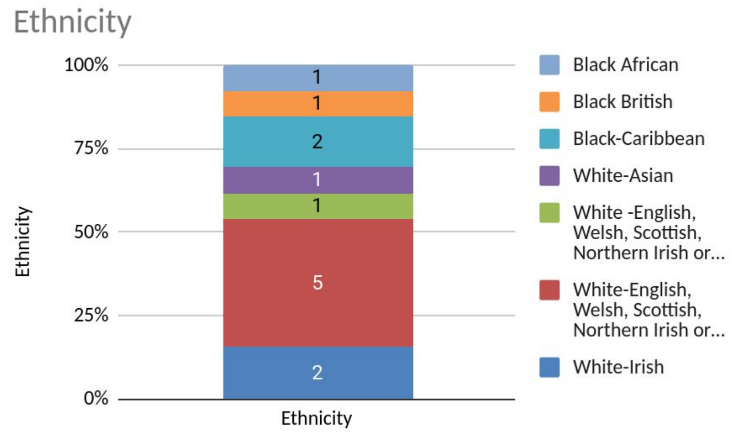


Priority 5: The sexual and reproductive health needs of vulnerable people and people with complex needs are recognised and met within the overall service provision



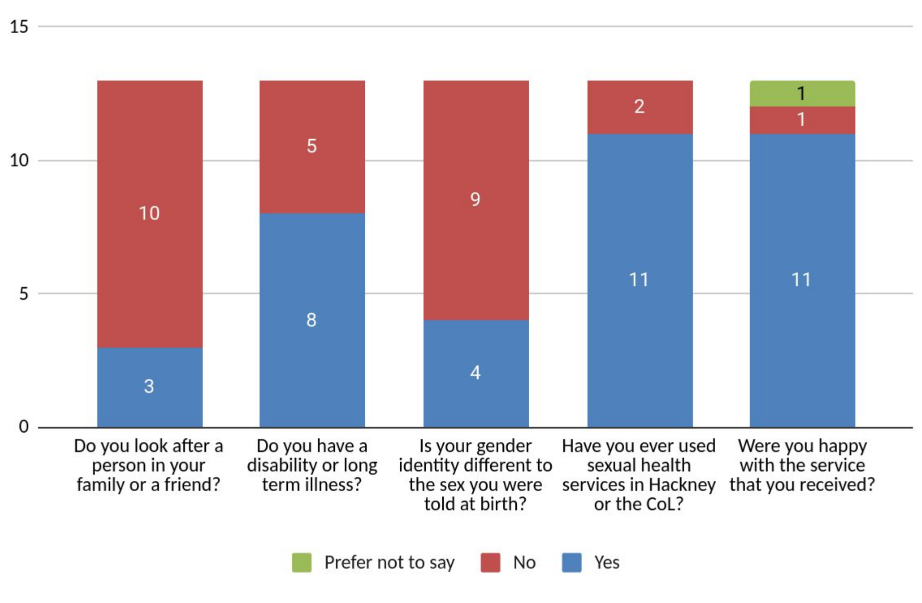
Easy Read survey - demographics (*small sample*)

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

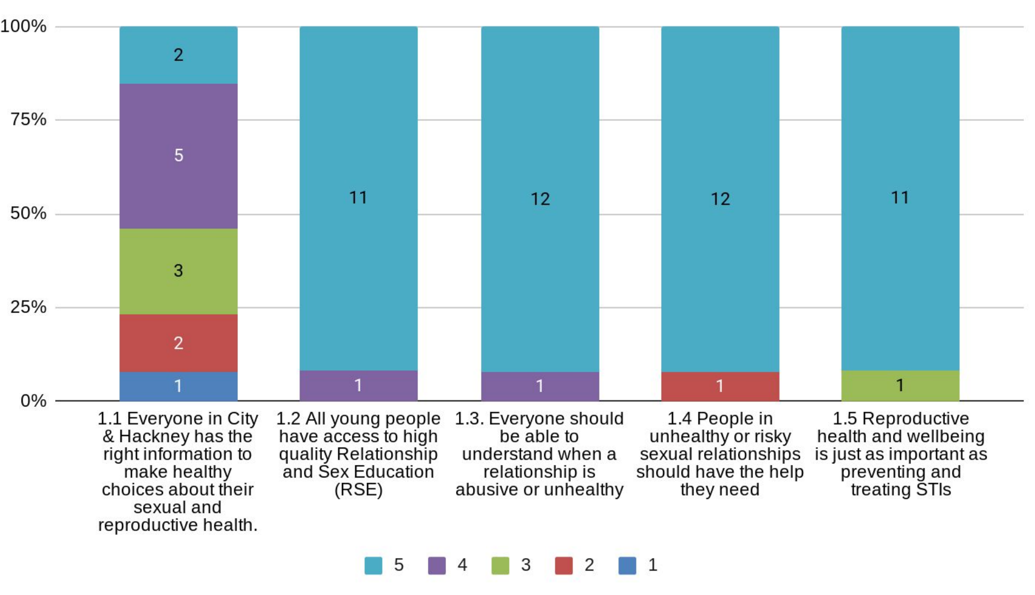


Easy Read survey - demographics

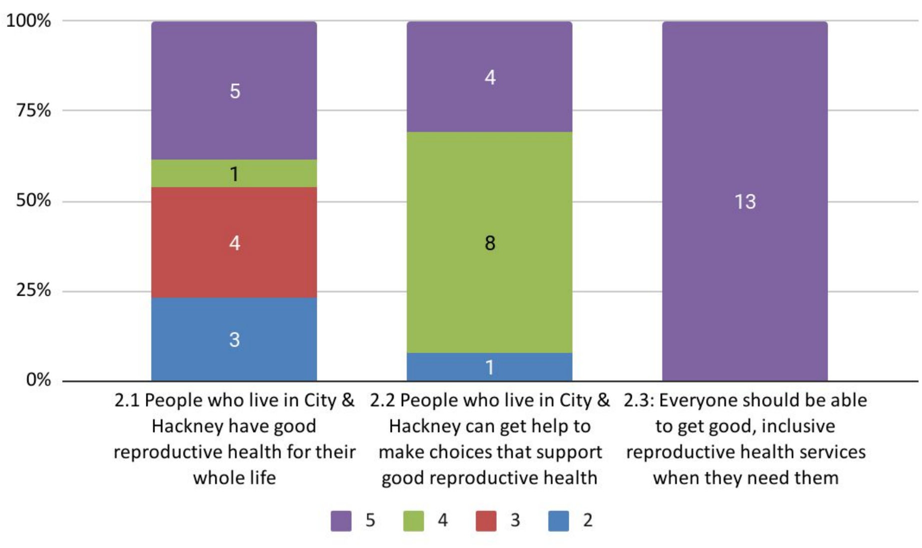
- Majority of respondents had used sexual health services and were happy with services received
- Majority stated to have a disability or long term condition
- Three out of 13 had a caring responsibility



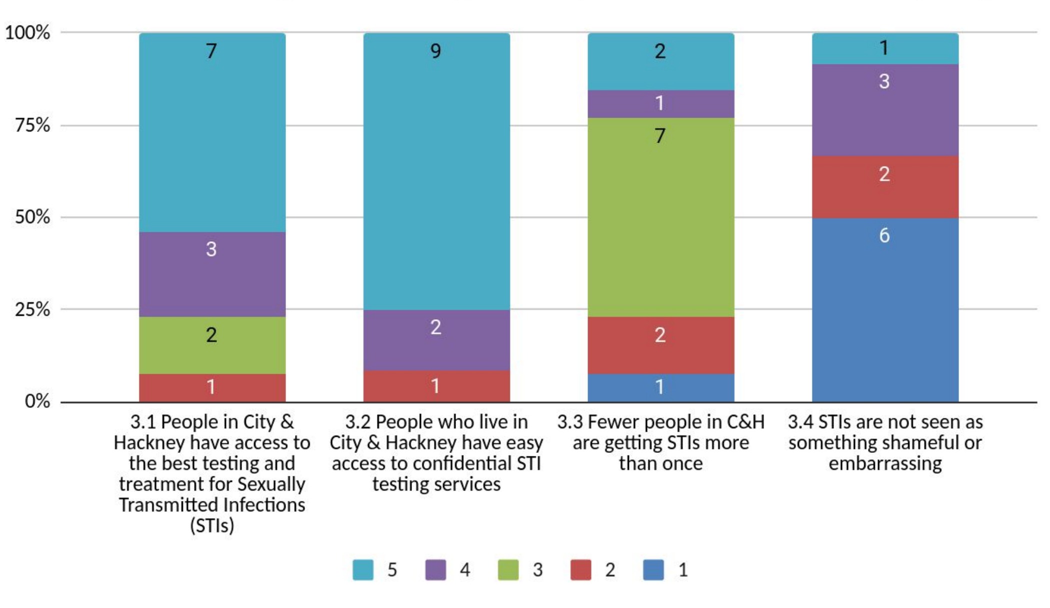
Easy Read survey feedback, Theme 1



Easy Read survey feedback, Theme 2

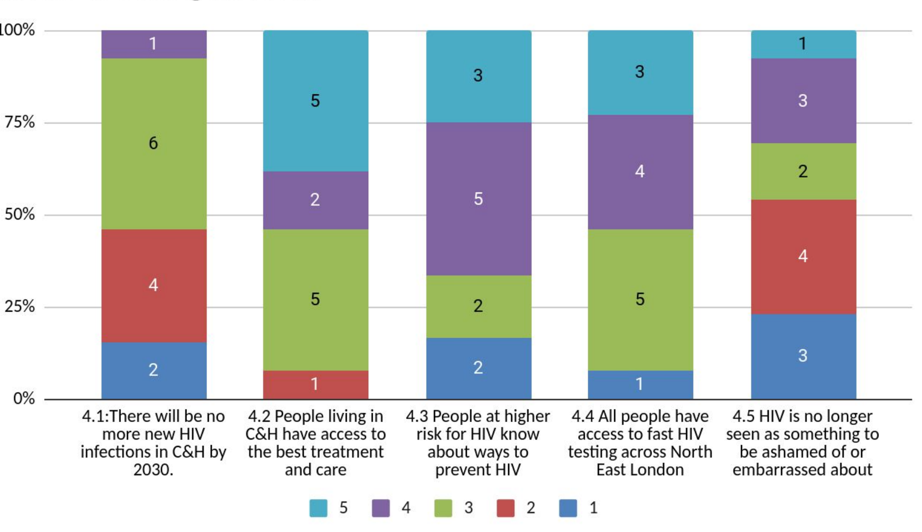


Easy Read survey feedback, Theme 3

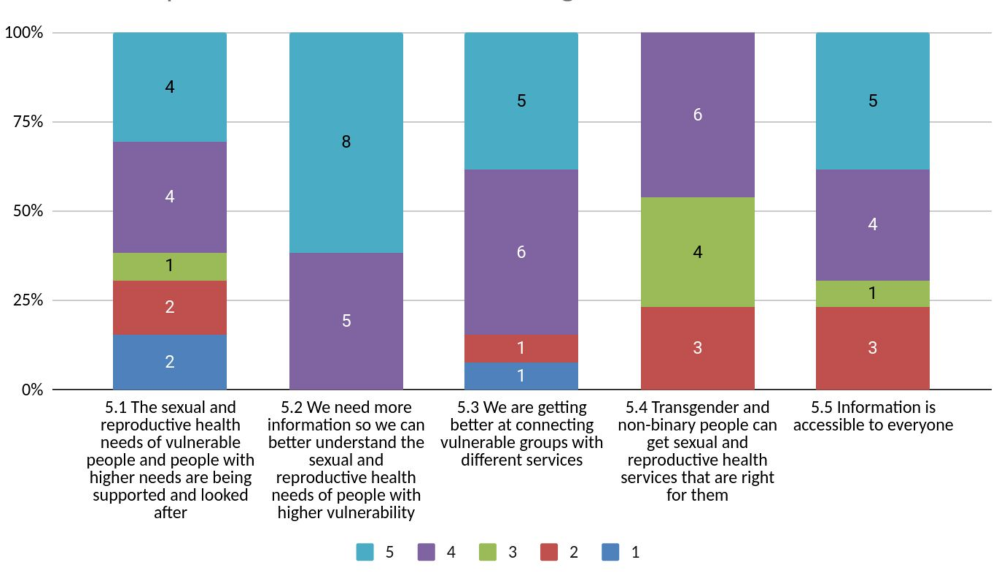


Page 334

Easy Read survey feedback, Theme 4



Easy Read survey feedback, Theme 5



Key observations from overall engagement

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

Action Plan

The action planning process was informed by

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

Action planning format:

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

Themes

1 - Healthy and fulfilling sexual relationships

2 - Good reproductive health across the life course

3 - STI prevention and treatment

4 - Getting to Zero new HIV transmissions

5 - Vulnerable populations and those with complex needs

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

Process

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

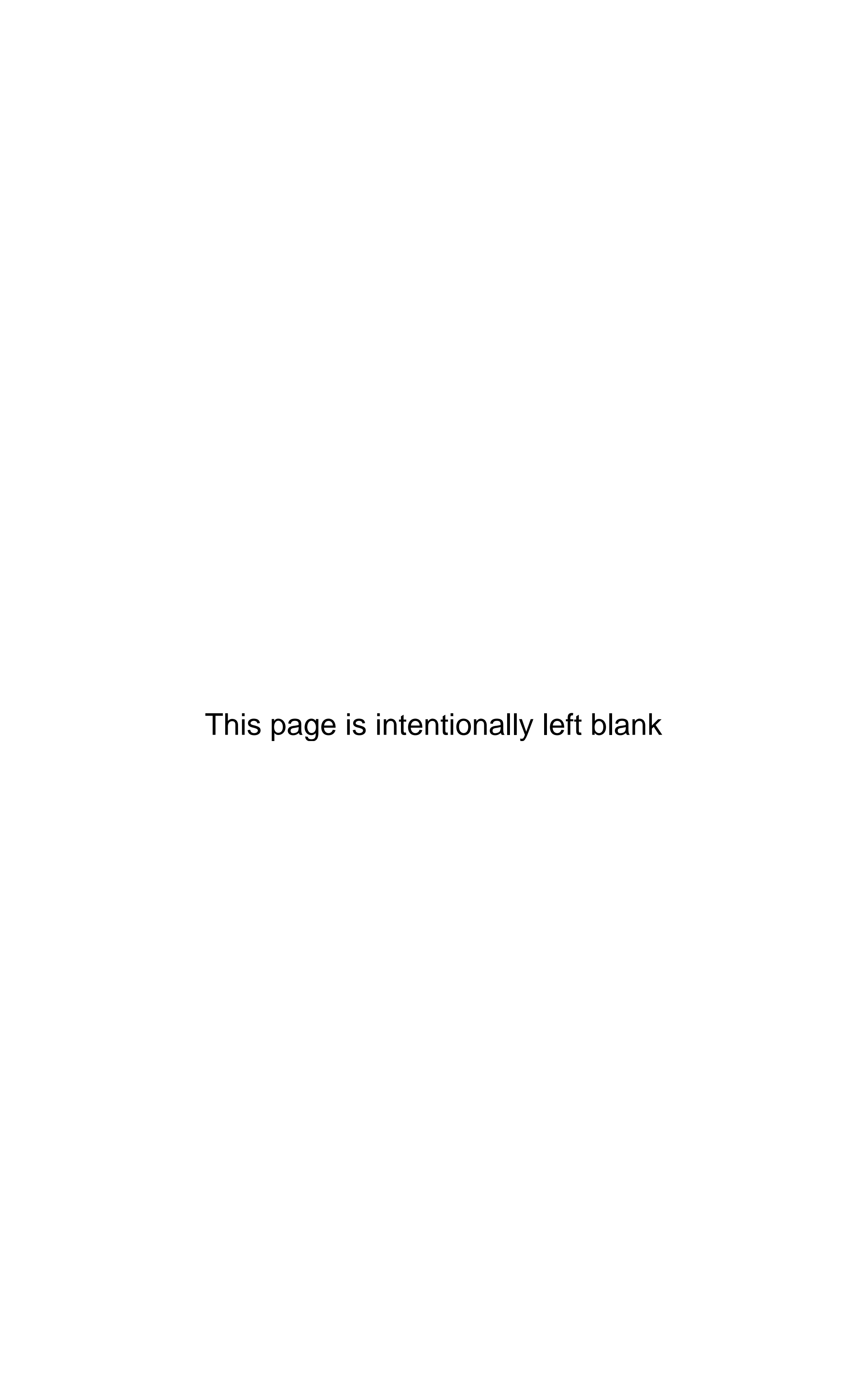
Governance

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

Implementation and oversight

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

Hackney
CITY OF LONDON


This page is intentionally left blank

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

Report Date: January 2024

Report authors:

Froeks Kamminga
Senior Public Health Specialist

Patience Quarcoo
Consultation & Engagement Officer

Introduction 4
Background 4
Rationale for consultation 4
Promoting the survey 5
Easy Read survey 6
Consultation events 6
Online and in person engagement 6
Executive summary 8
Overview of findings 10
Question 1: I am answering this survey as a... (Base 102) 10
Question 2: (Priority 1) Residents in the City of London & Hackney are able to make informed choices about their sexual and reproductive health. (Base 102) 11
2.1 All young people should have access to high quality Relationship and Sex Education (RSE) 12
2.2 All residents should be able to recognise whether a relationship is abusive or unhealthy 12
2.3 People in unhealthy or risky sexual relationships should be appropriately supported 13
2.4 Reproductive health and wellbeing is just as important as preventing and treating STIs 13
Question 3: (Priority 2) Residents of City of London & Hackney have good reproductive health across the life course. (Base 102) 13
3.1 Residents are empowered to make informed choices that support good reproductive health 14
3.2 Residents have access to timely, high-quality, inclusive & holistic services to support their reproductive health needs 14
Question 4: (Priority 3): Residents of City of London & Hackney have access to high quality and innovative testing and treatment for Sexually Transmitted Infections (STIs). (Base 102) 15
4.1 Our residents have easy access to high quality, innovative and confidential STIs testing services 16
4.2 Transmission of STIs and repeat infections among our residents are reduced 16
4.3 Stereotypes and stigma associated with STI infections are challenged 16
Question 5 (Priority 4): Towards Zero - there will be no new HIV infections in the City of London & Hackney by 2030 (Base 102) 17
5.1 Our residents living with HIV have access to the best treatment and care 18
5.2 Our residents at higher risk for HIV are informed about prevention measures and have access to HIV prevention methods 18
5.3 All our residents have access to rapid HIV testing across North East

London 18
5.4 Stereotypes and HIV related stigma are addressed and challenged 19
Question 6: (Priority 5): The sexual and reproductive health needs of vulnerable people and people with complex needs are recognised and met within the overall service provision 19
6.1 We collect more data to ensure we better understand the sexual and reproductive health needs of people with higher vulnerability or more complex needs 20
6.2 We are better at connecting communities with different services and communicating between them to support people 20
6.3 Tailored sexual and reproductive health services are available for transgender and non-binary residents 20
6.4 Information is designed and available in acceptable and appropriate ways 20
Qualitative insights 21
Question 7.1: Have we missed anything? Please outline in the text box below any additional priorities you think we should consider for the sexual and reproductive health strategy. 21
Question 7.2: Have you ever accessed Sexual Health Services? 24
Question 7.3 What do you think works well in the Sexual and Reproductive Health Service Provision that you received? 24
Question 7.4 Is there anything that could be improved in the Sexual and Reproductive Health Service Provision that you received? 26
Question 7.5 What stopped you from accessing Sexual Health Services? 27
Demographic information (online survey respondents) 28
Gender 29
Age group: Are you... (Base 100) 29
Disability 30
Caring responsibilities 31
Ethnicity 31
Religion 32
Sexual orientation 33
Housing Tenure 34
Easy Read survey 34
Theme 1: Healthy and fulfilling sexual relationships 35
1.1 Everyone in City & Hackney has the right information to make healthy choices about their sexual and reproductive health. 35
1.2 All young people have access to high quality Relationship and Sex Education (RSE) 36
1.3. Everyone should be able to understand when a relationship is abusive or unhealthy 36
1.4 People in unhealthy or risky sexual relationships should have the help they need 36
1.5 Reproductive health and wellbeing is just as important as preventing

and treating STIs 36
Theme 2: Good reproductive health for your whole life 37
2.1 People who live in City & Hackney have good reproductive health for their whole life 37
2.2 People who live in City & Hackney can get help to make choices that support good reproductive health 37
2.3: Everyone should be able to get good, inclusive reproductive health services when they need them 38
Theme 3: Preventing and treating sexually transmitted infections (STIs) 38
3.1 People in City & Hackney have access to the best testing and treatment for Sexually Transmitted Infections (STIs) 38
3.2 People who live in City & Hackney have easy access to confidential STI testing services 38
3.3 Fewer people in City & Hackney are getting STIs more than once 39
3.4 STIs are not seen as something shameful or embarrassing 39
Theme 4: Getting rid of HIV 39
4.1 There will be no more new HIV infections in C&H by 2030 39
4.2 People living in City & Hackney have access to the best treatment and care 40
4.3 People at higher risk for HIV know about ways to prevent HIV 40
4.4 All people have access to fast HIV testing across North East London 40
4.5 HIV is no longer seen as something to be ashamed of or embarrassed about 40
Theme 5: People who are vulnerable or have higher needs 40
5.1 The sexual and reproductive health needs of vulnerable people and people with higher needs are being supported and looked after 41
5.2 We need more information so we can better understand the sexual and reproductive health needs of people with higher vulnerability 41
5.3 We are getting better at connecting vulnerable groups with different services 41
5.4 Transgender and non-binary people can get sexual and reproductive health services that are right for them 41
5.5 Information is accessible to everyone 42
Demographic information 42
Appendix: summary of written feedback in the online survey 46

Introduction

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

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

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

Background

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

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

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

Rationale for consultation

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

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

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

Promoting the survey

Channels (online/social media)

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

Email

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

Meetings

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

  - Health Inequalities Steering Group

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

Easy Read survey

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

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

Consultation events

Online and in person engagement

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

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

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

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

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

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

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

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

Executive summary

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

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

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

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

Below is a summary of the findings.

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

- ○ The majority of respondents stated that they were a Resident of Hackney or City of London (80, **78.43%**)

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

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

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

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

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

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

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

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

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

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

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

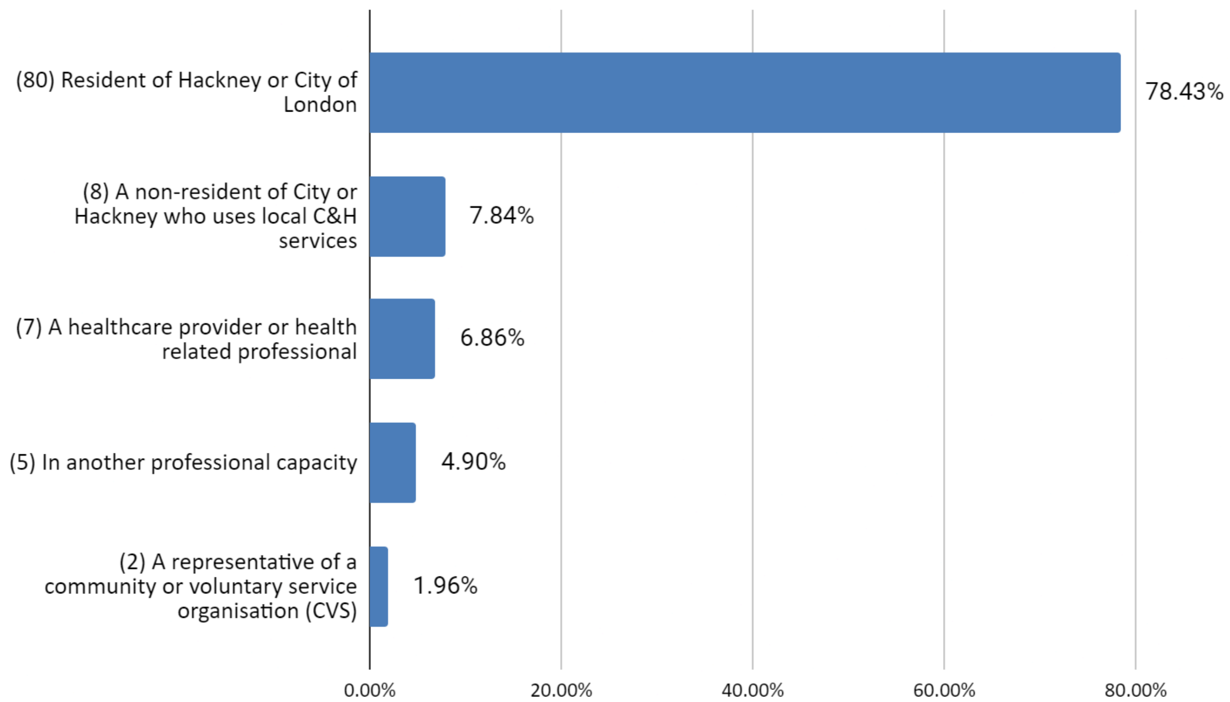
Overview of findings

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

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

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

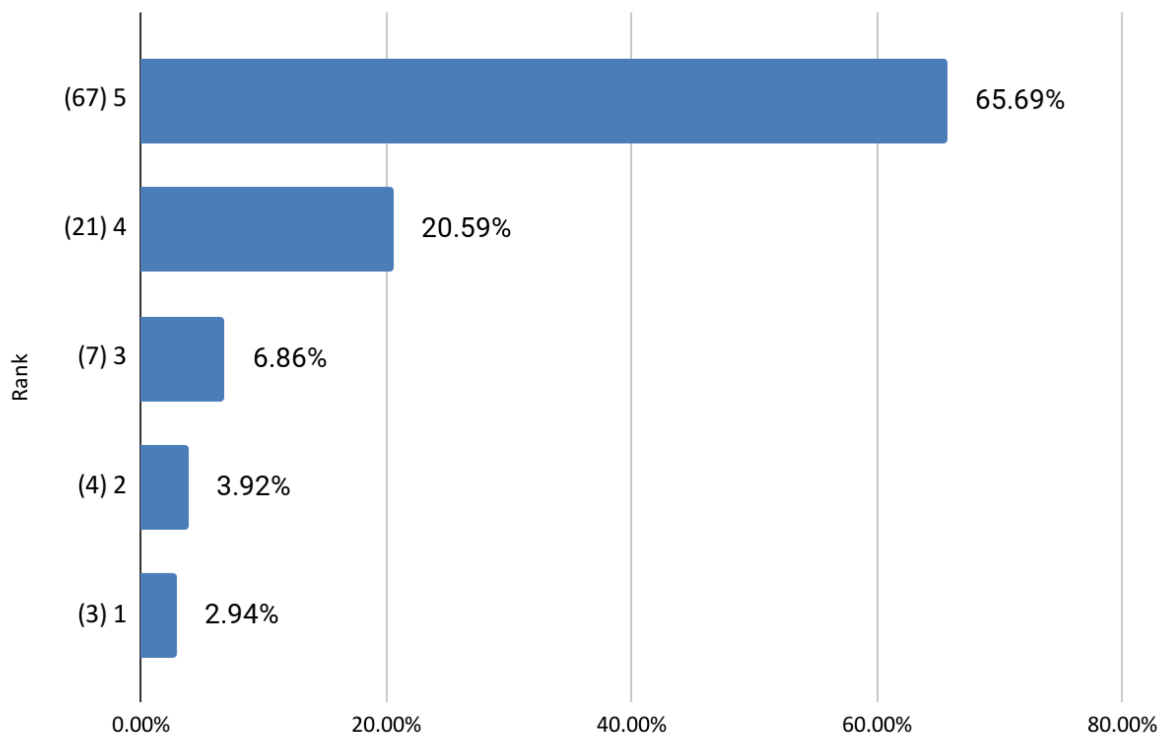
The majority of survey respondents (78%) were City and Hackney residents, with a smaller number identifying as service users or healthcare professionals. No postcode data was requested so it is not feasible to filter out whether someone was a City of Hackney based resident.



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

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

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

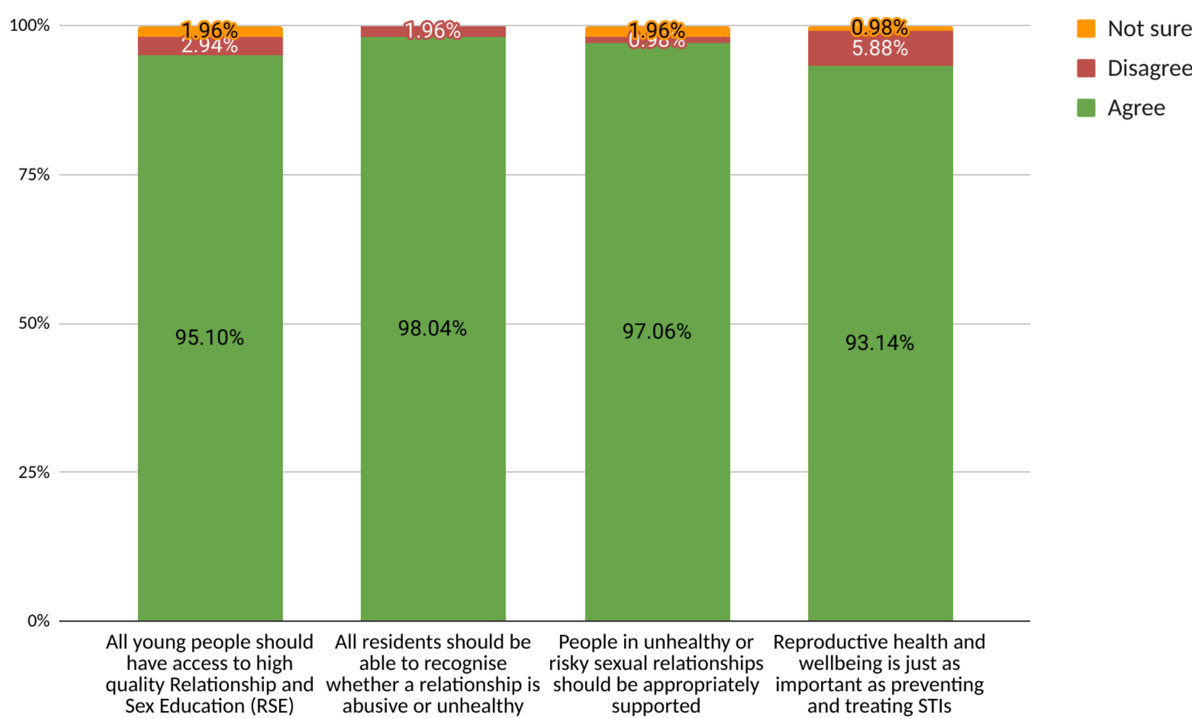


The survey presented five priorities. For each of the priorities respondents were asked to rate them from 1 to 5, with 1 being lowest importance to five being highest importance.

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

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

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



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

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

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

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

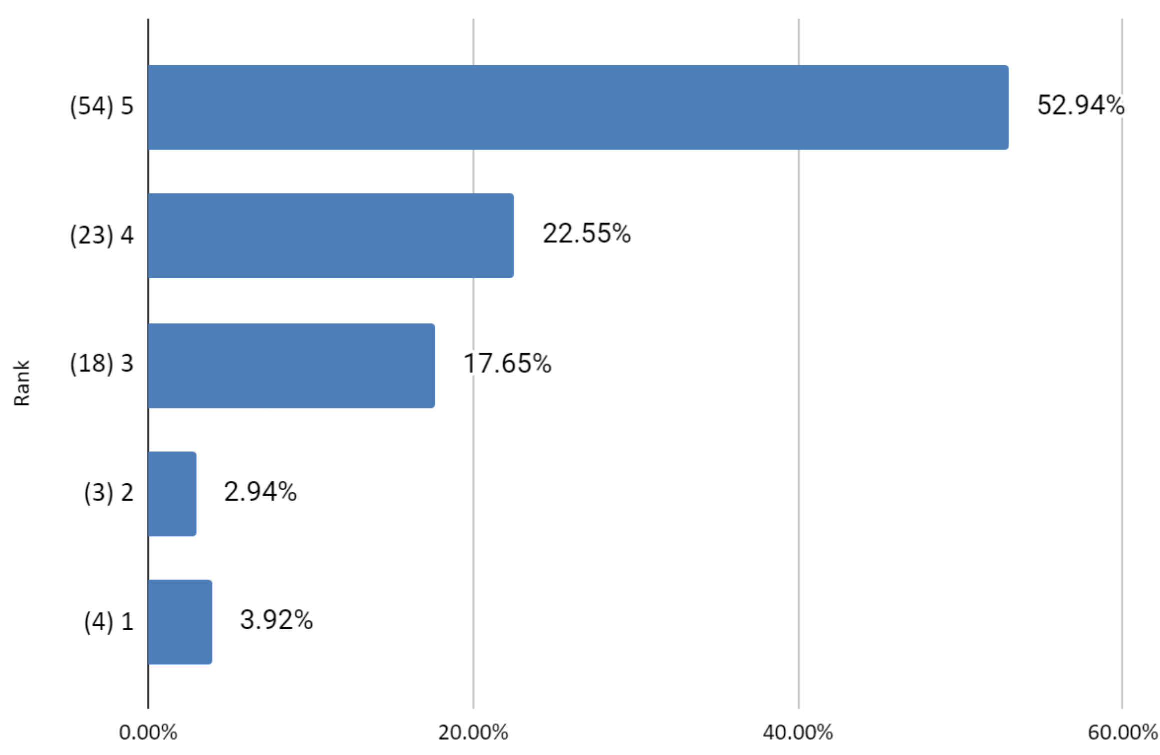
2.3 People in unhealthy or risky sexual relationships should be appropriately supported

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

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

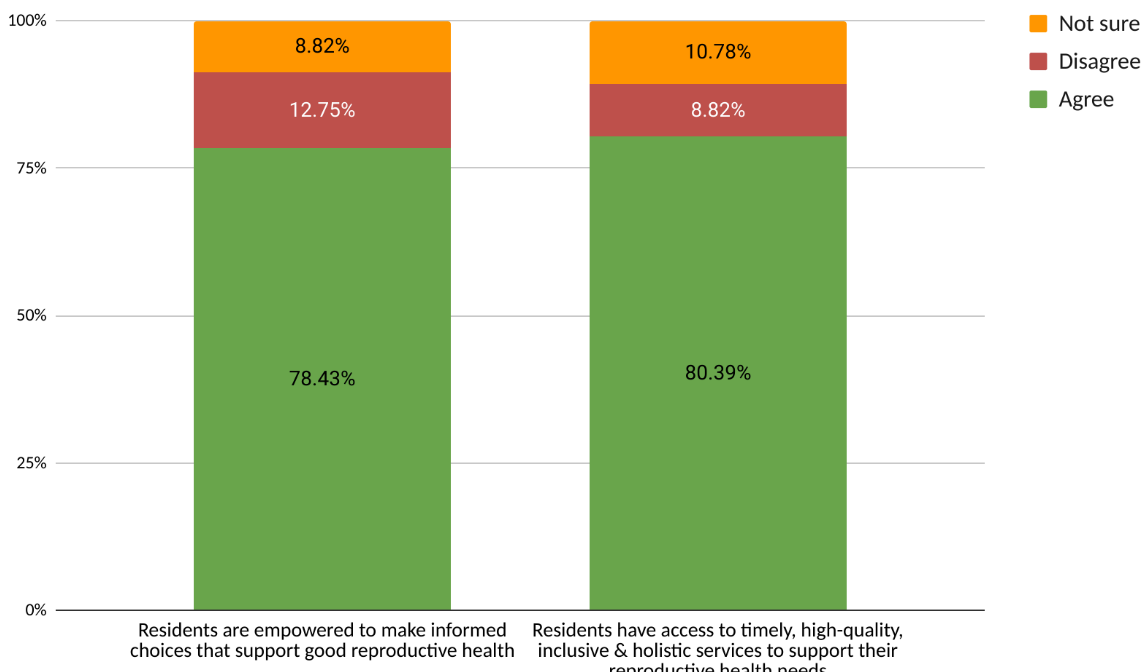
This aim also had strong agreement from 95 (93.14%) respondents, with 6 (95.88%) not agreeing.

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



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

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



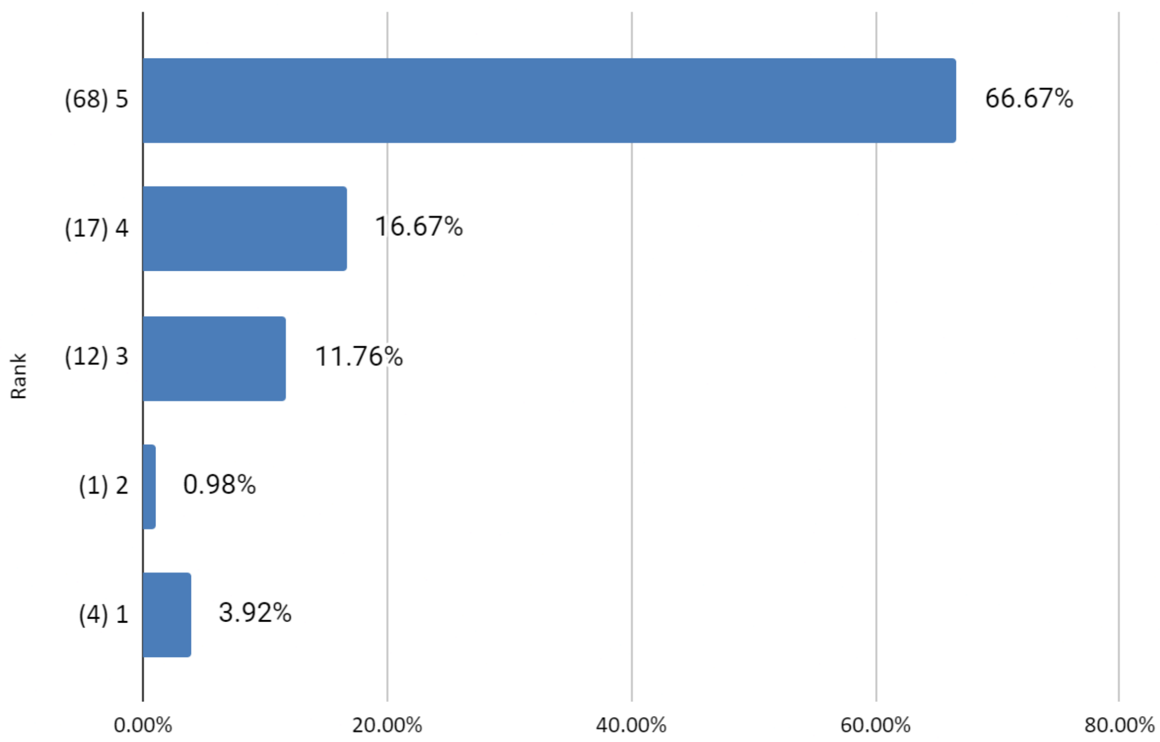
3.1 Residents are empowered to make informed choices that support good reproductive health

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

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

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

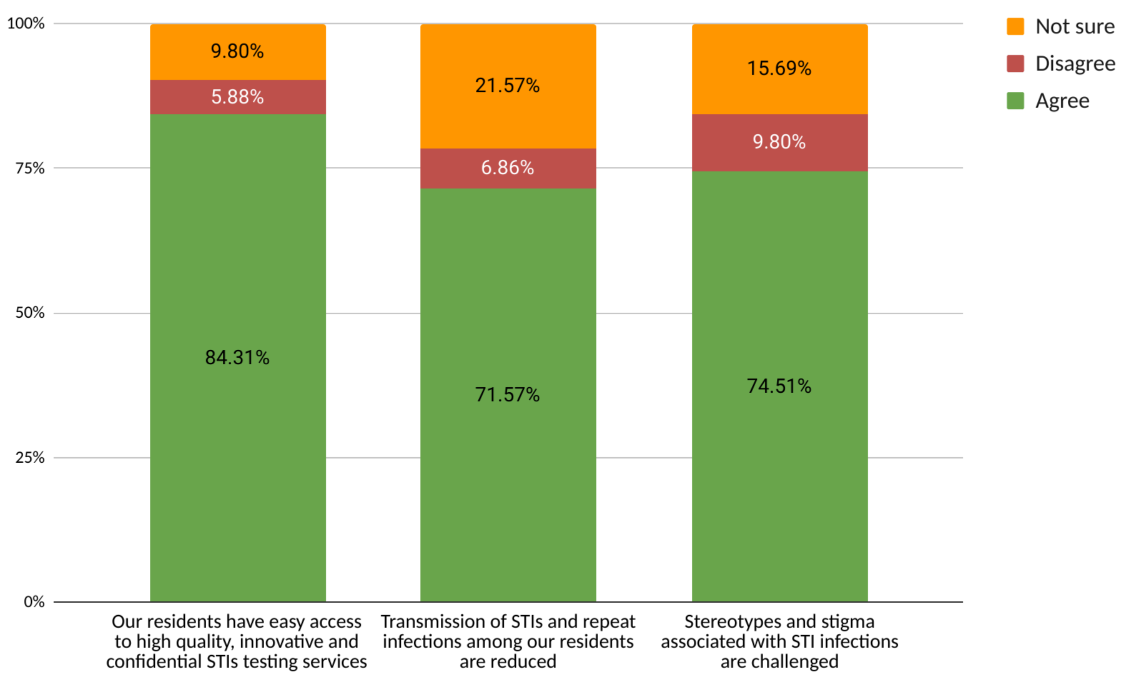
Question 4: (Priority 3): Residents of City of London & Hackney have access to high quality and innovative testing and treatment for Sexually Transmitted Infections (STIs). (Base 102)



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

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

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



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

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

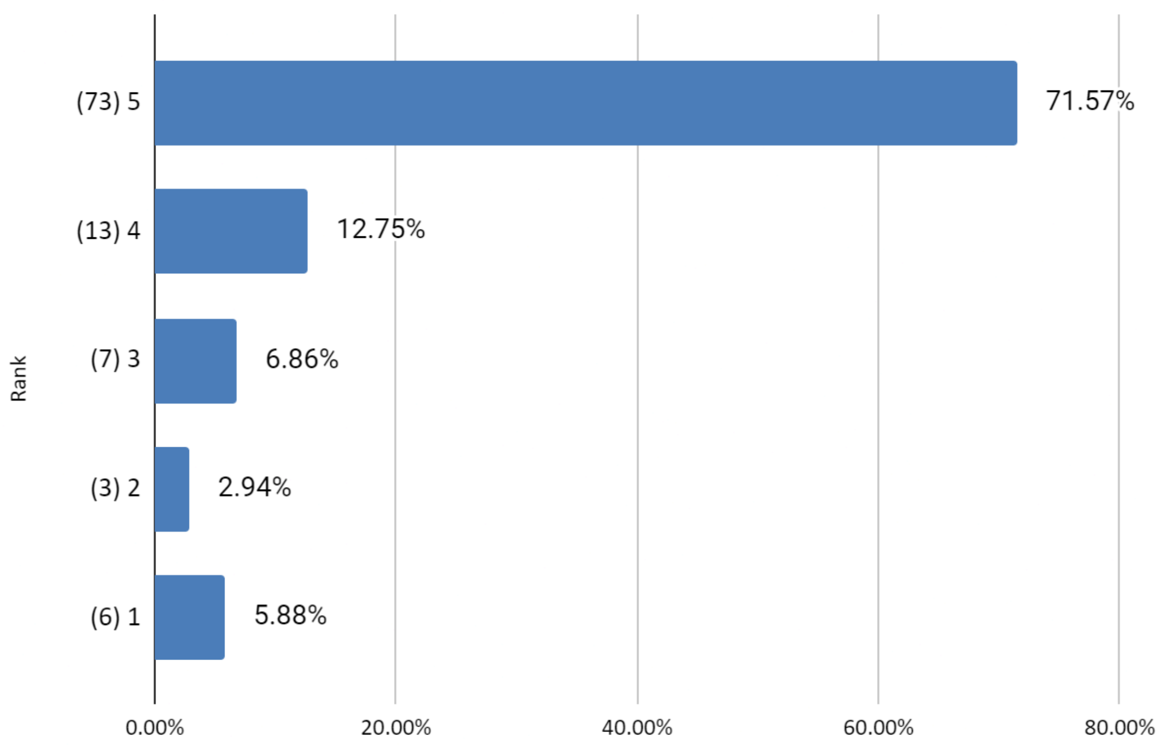
4.2 Transmission of STIs and repeat infections among our residents are reduced

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

4.3 Stereotypes and stigma associated with STI infections are challenged

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

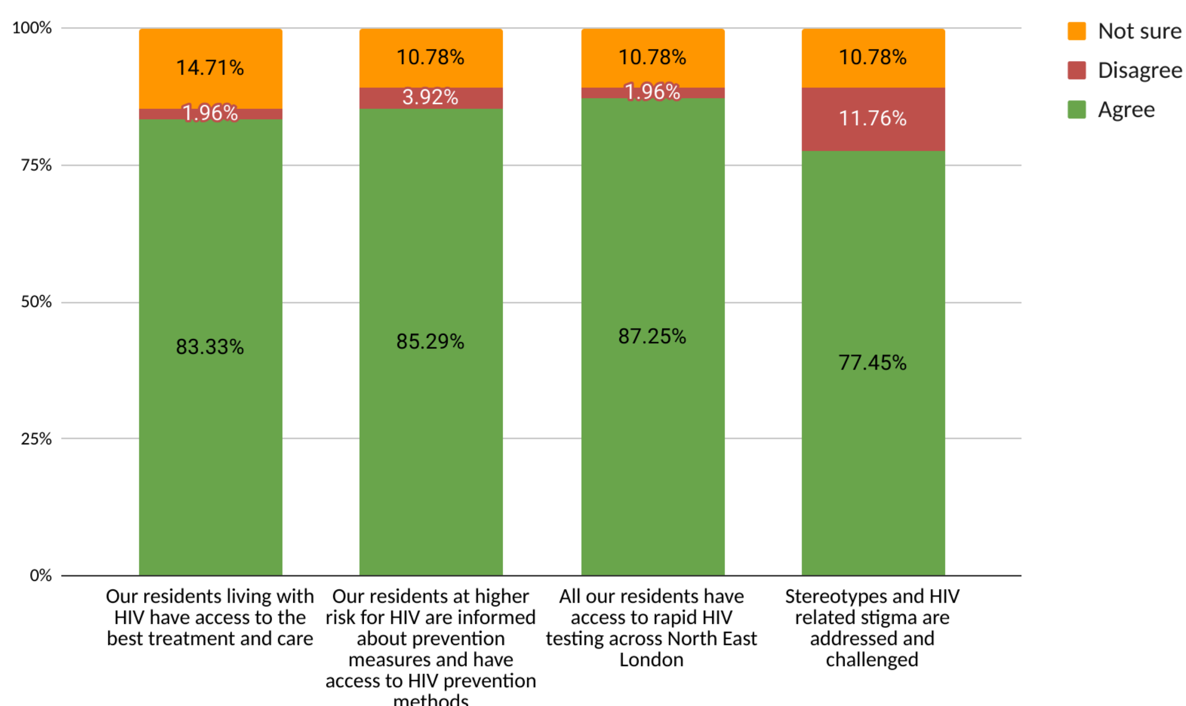
Question 5 (Priority 4): Towards Zero - there will be no new HIV infections in the City of London & Hackney by 2030 (Base 102)



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

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

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



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

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

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

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

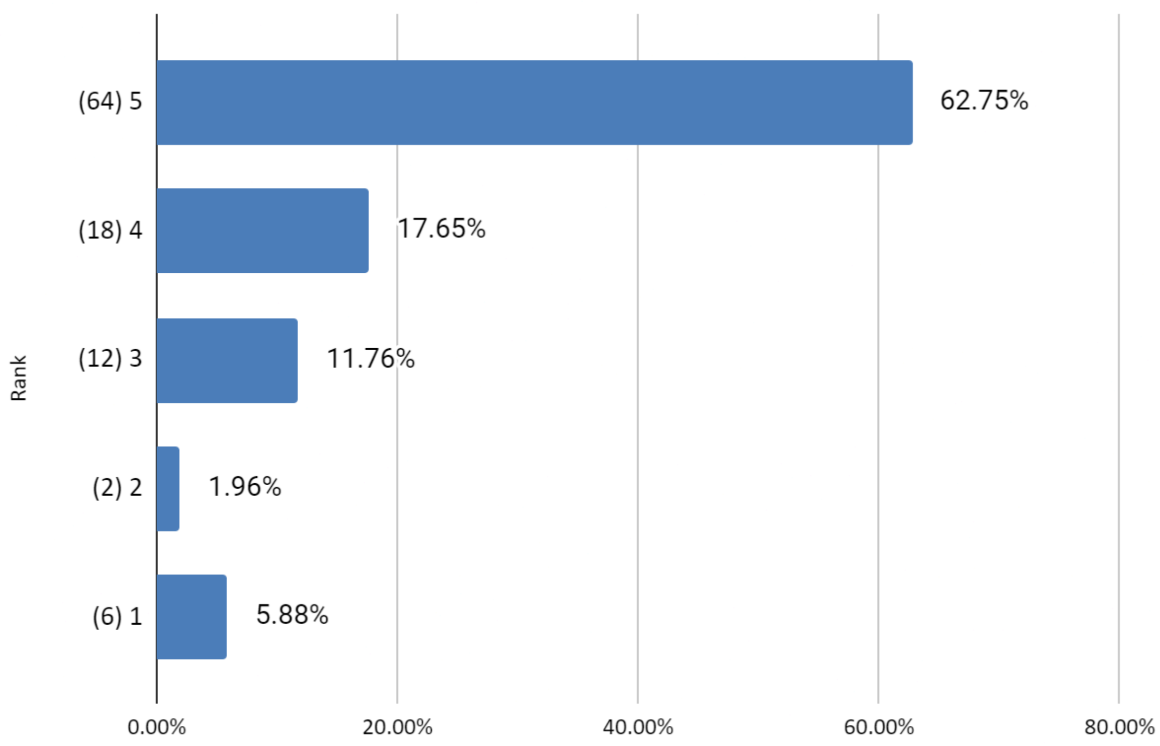
5.3 All our residents have access to rapid HIV testing across North East London

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

5.4 Stereotypes and HIV related stigma are addressed and challenged

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

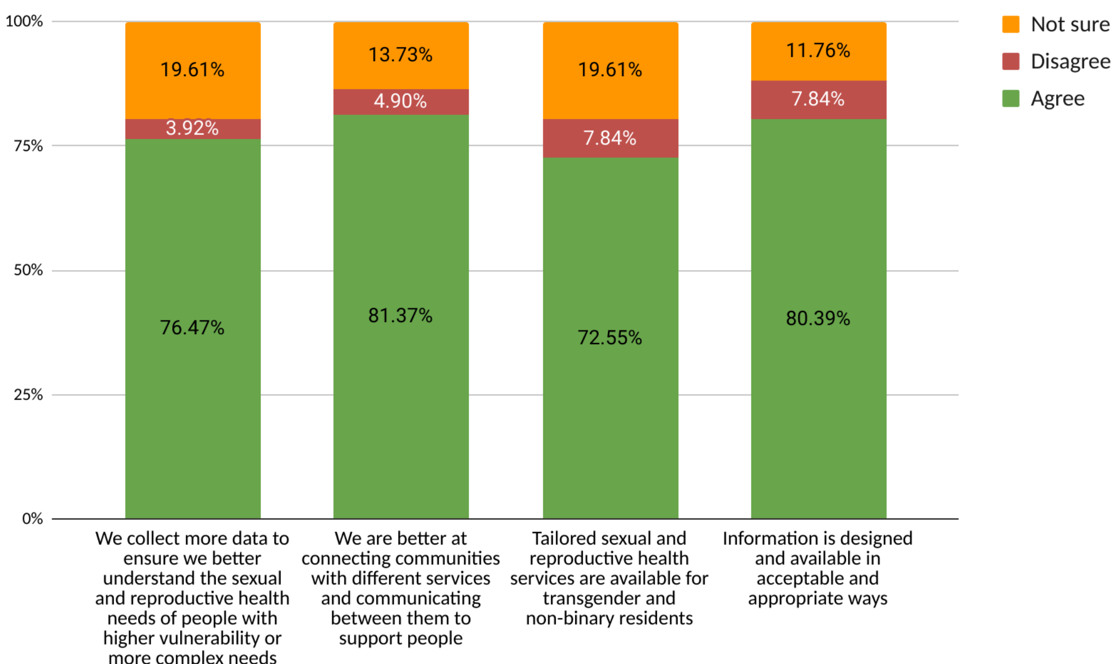
Question 6: (Priority 5): The sexual and reproductive health needs of vulnerable people and people with complex needs are recognised and met within the overall service provision



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

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

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



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

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

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

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

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

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

6.4 Information is designed and available in acceptable and appropriate ways

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

Qualitative insights

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

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

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

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

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

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

Verbatim comments question 7.1

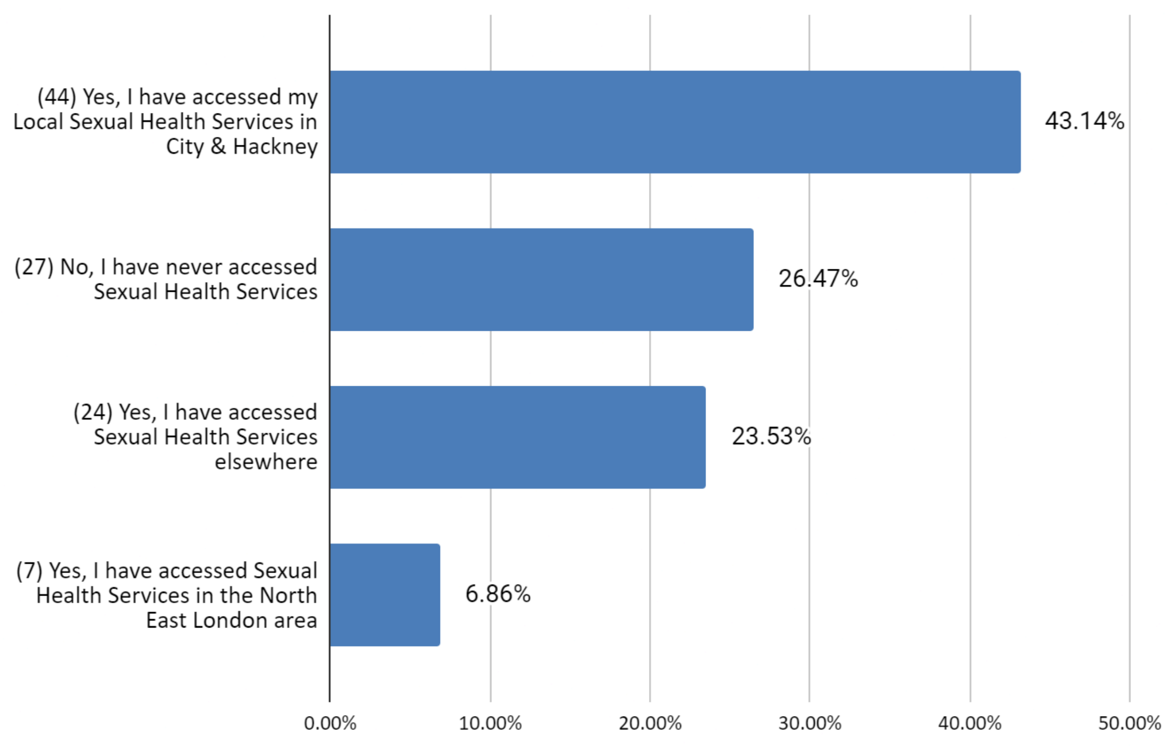
All residents need to be able to access appropriate, free, reproductive health services regardless of immigration status. This must include access to fertility, abortion and maternity services. Sex and relationship education in schools needs to be reflective of the range of different family models and sexualities within Hackney's population. Young people should be given information about a range of services, including sexual health and abortion services. Helping rape / sexual abused victims appropriately. Please ensure that men who have sex with men and who engage in Chemsex have access to high quality help and support Crucial to put the strategy in the context of the importance of good stable relationships particularly marriage and family. Crucial also not to encourage children in any way to be sexually active or expose children to unhelpfully sexualised material. Education at school- sexual education in all its diversity esp in LBH where STI's amongst 18-25 yo are very high! I know this will have been considered already, but the vital importance of ensuring that age-appropriate sex and sexual health education happens in all schools and colleges across City & Hackney cannot be stressed enough. I hope this will play a large part in your strategy. There needs also to be consideration given to how to reassure those parents who resist this to understand, overcome their reservations and fears and see the benefits. Many children are excluded from sex education classes because their parents don't want them to take part. We need to respect parental wishes, of course - but it is nevertheless worrying that a whole section of our young population may never hear factual information that they need. How can the new strategy address this?	
"I'm extremely concerned about aspects of the sexual health and relationships advice being delivered in many Hackney schools at all levels. The notion that 'gender identity' is real and is more significant than biological sex is a travesty. Teaching that sex is 'assigned at birth' rather than a biological reality is actively lying to children and the notion that they may decide they are really the	I am concerned about the misinformation and prejudice spread about non-binary and transgender issues on social media. I think it has become a kind of cyber war of misinformation where otherwise usually discerning and intelligent [people] are groomed to believe that transgenderism is the new thing to fight against, despite the consequences of their actions

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

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

Question 7.2: Have you ever accessed Sexual Health Services?

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



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

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

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

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

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

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

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

Verbatim comments question 7.3

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Verbatim comments question 7.4

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

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

Question 7.5 What stopped you from accessing Sexual Health Services?

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

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

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

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

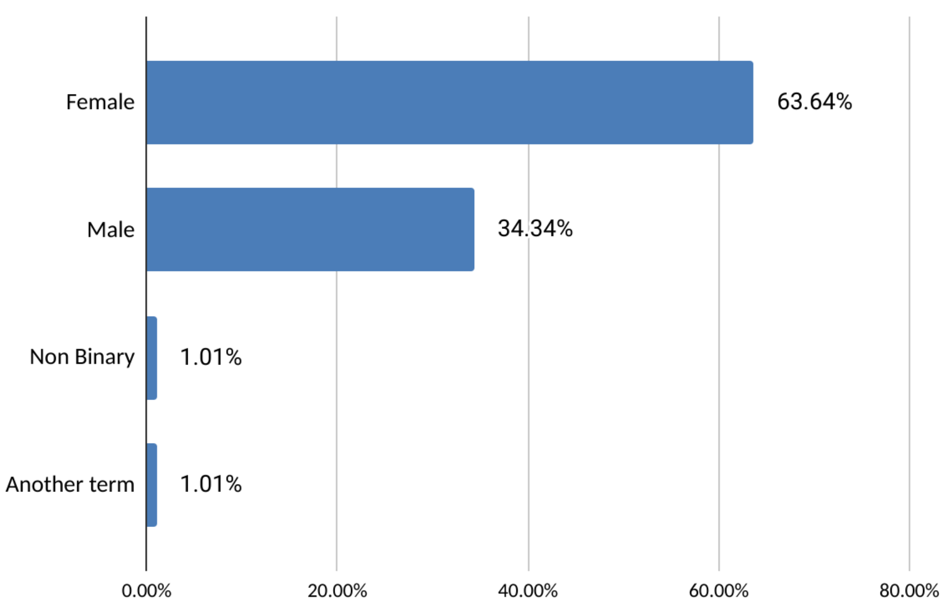
Verbatim comments question 7.5

Lack of appointment availability Age restrictions on clinics, clinics far-away or no appointments. I have not yet had any issue in relation to sexual health Having to wait too long Not knowing it's there I didn't have because I was always careful But I scared for my children because Now life is very hard And very sensitive I don't want nothing happen to my children I try to teach them every day But I don't trust strangers ore who is behind the corner Lack of confidence about how I would be treated. I got over it and used them but I did find it hard and I worried a lot.

Demographic information (online survey respondents)

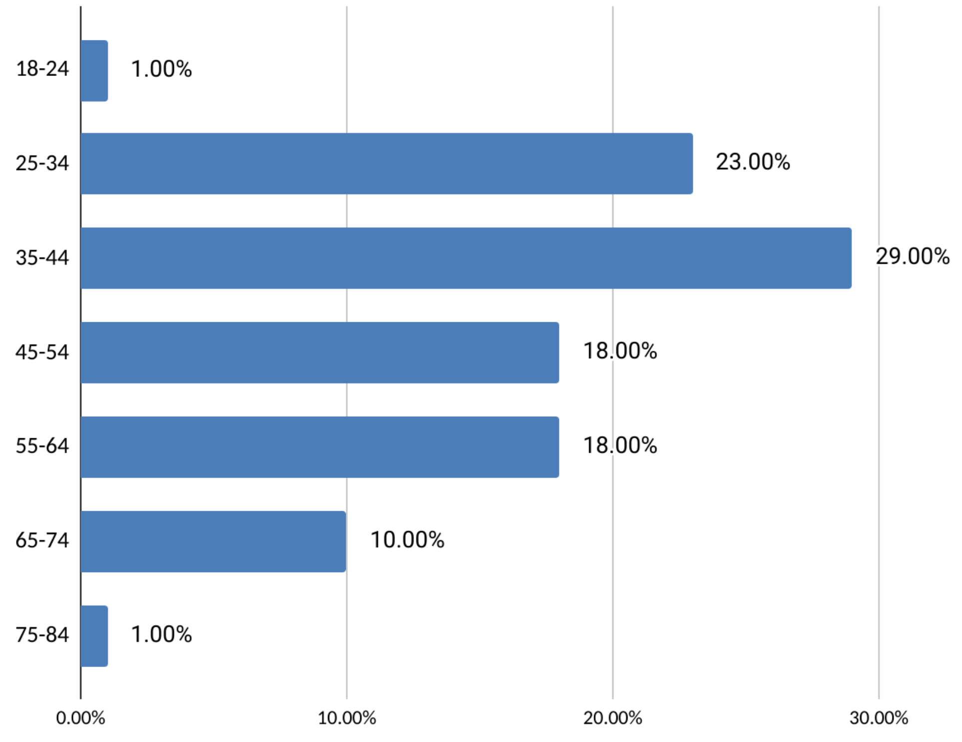
Demographic information on the online survey respondents (102).

Gender



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

Age group: Are you… (Base 100)



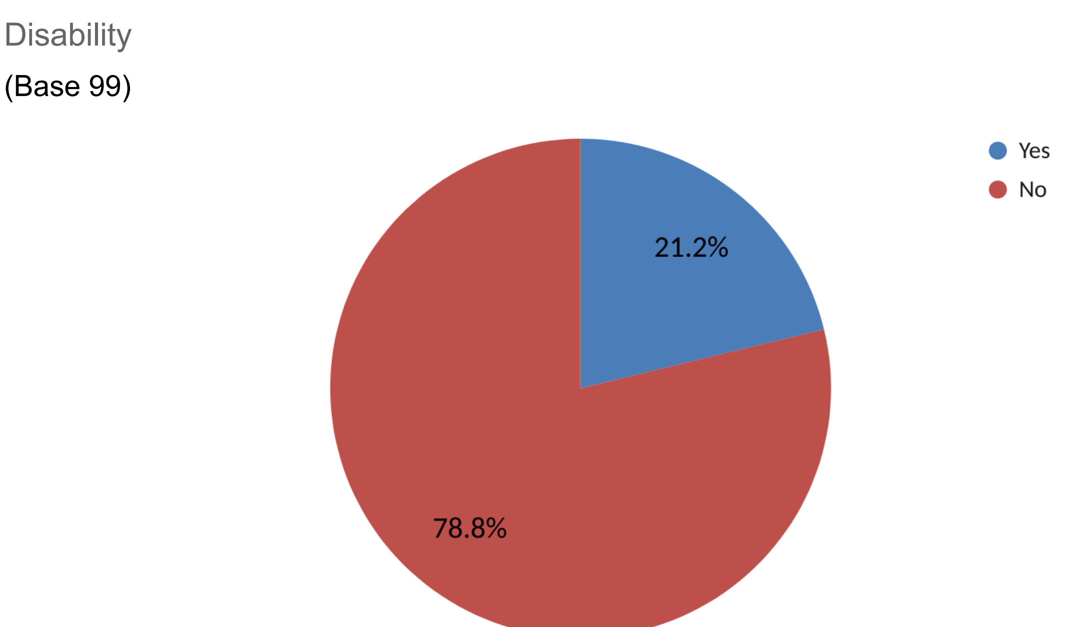
The age group with the highest number of respondents was 35-44 (29), closely

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

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

Disability

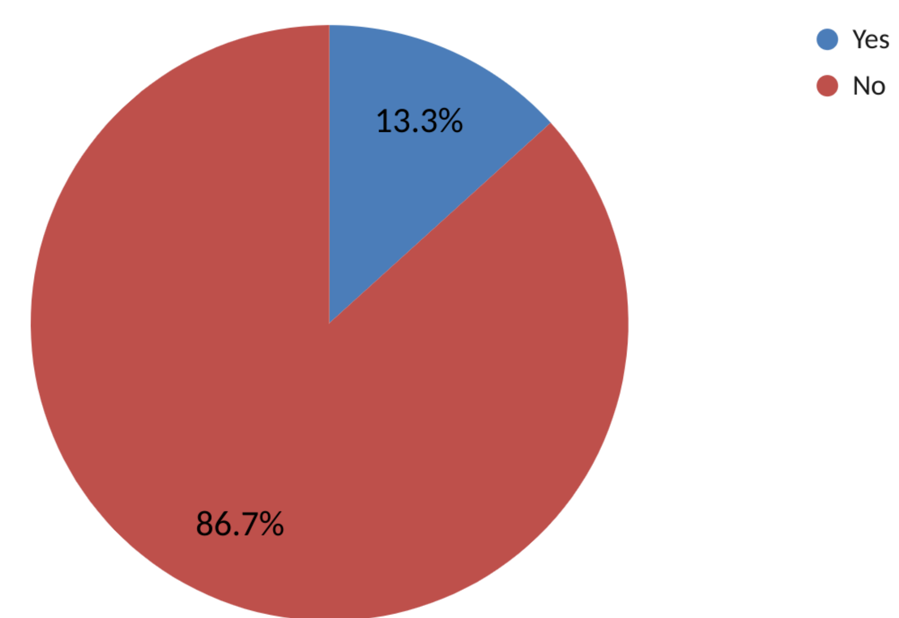
(Base 99)



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

Caring responsibilities

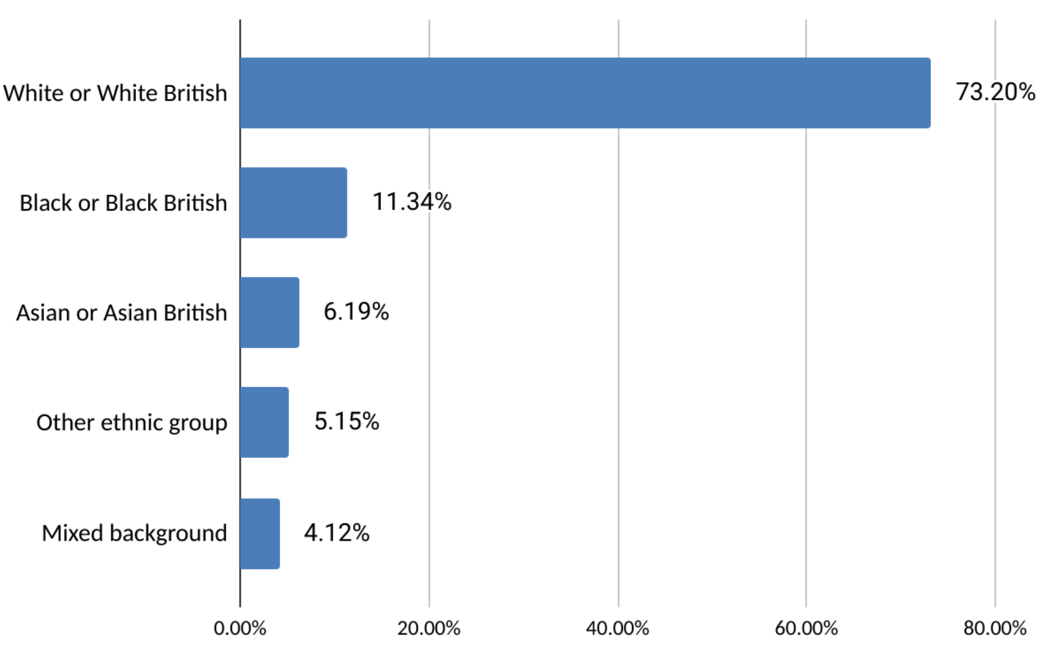
(Base 98)



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

Ethnicity

(Base 97)



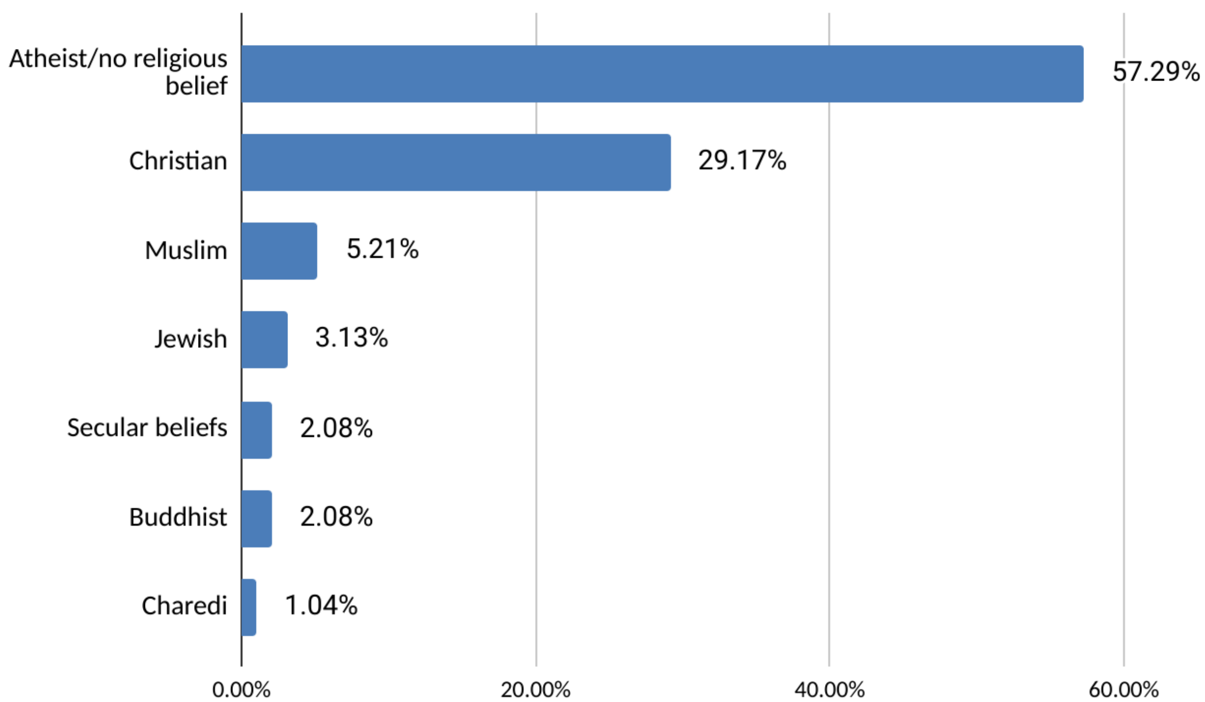
The majority of respondents stated that they were white or white British (71

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

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

Religion

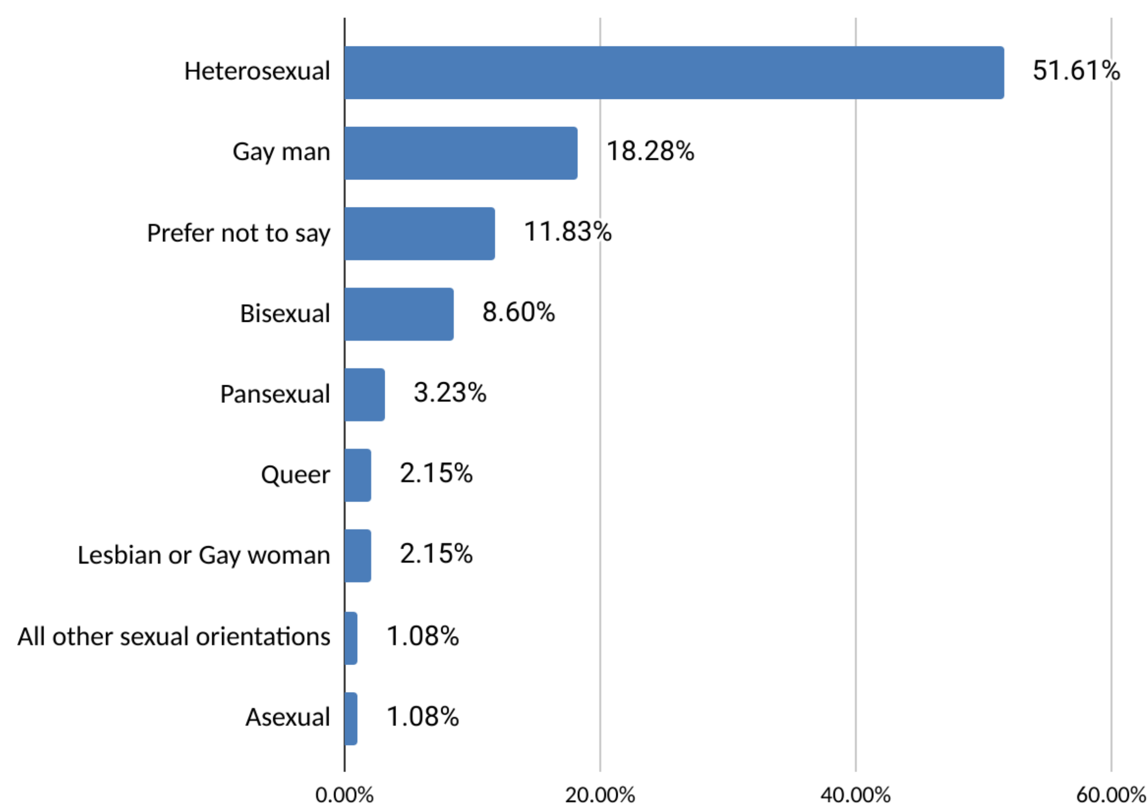
(Base 96)



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

Sexual orientation

(Base 102)



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

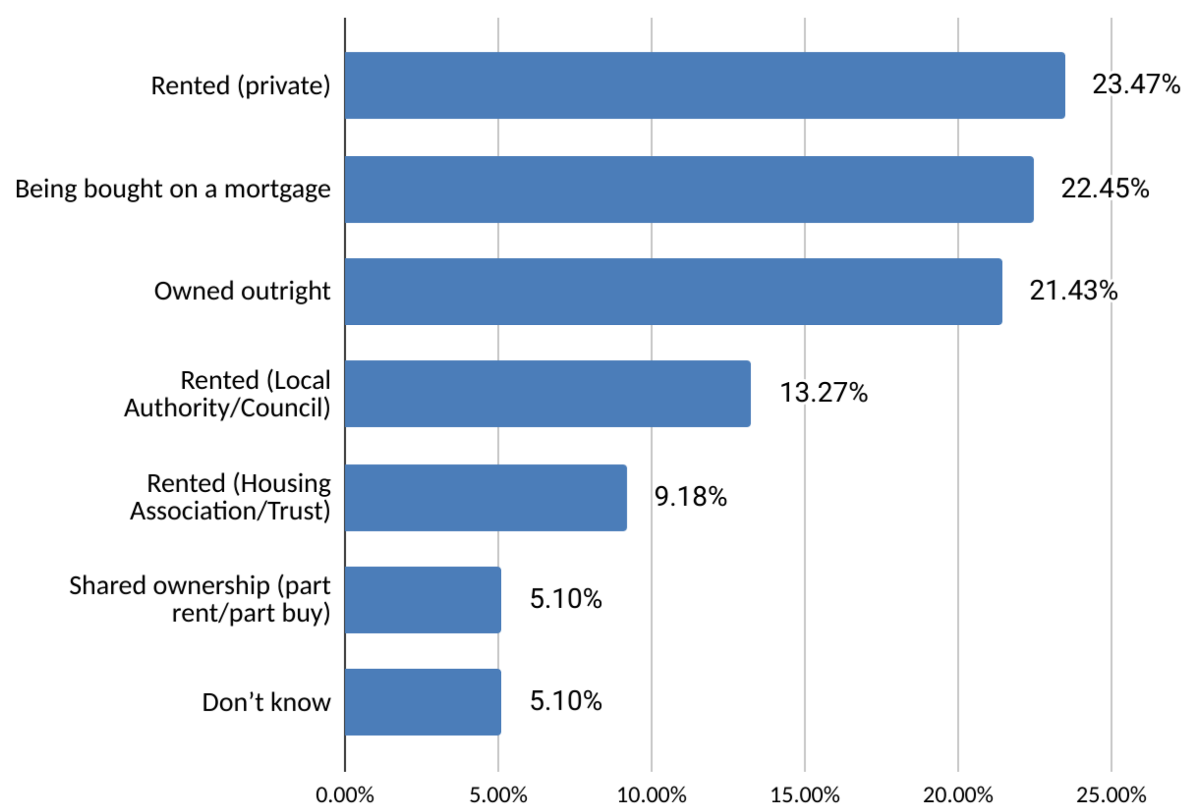
Even though the majority described themselves as heterosexual, this was less than 50% of all respondents, with gay men making up 16.7% of respondents and 7.8% bisexual. This means together, LGBTQ+ representation made up 33.3% of respondents.

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

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

Housing Tenure

(Base 98)



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

Easy Read survey

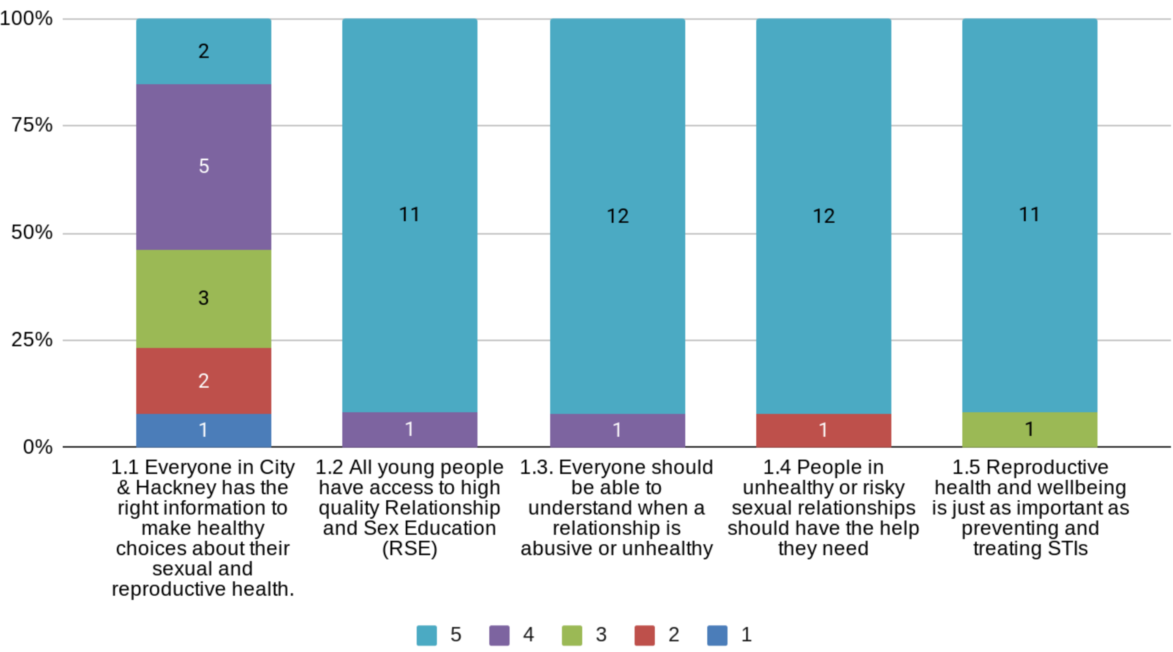
An image-based Easy Read survey was made available for people with learning disabilities or others who preferred this over a fully word-based survey. A total of 13 responses were collected. The findings are reflected in this section. The questions were in essence the same as in the online survey but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

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

Theme 1: Healthy and fulfilling sexual relationships

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

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



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

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

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

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

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

This was deemed very important by most.

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

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

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

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

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

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

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

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

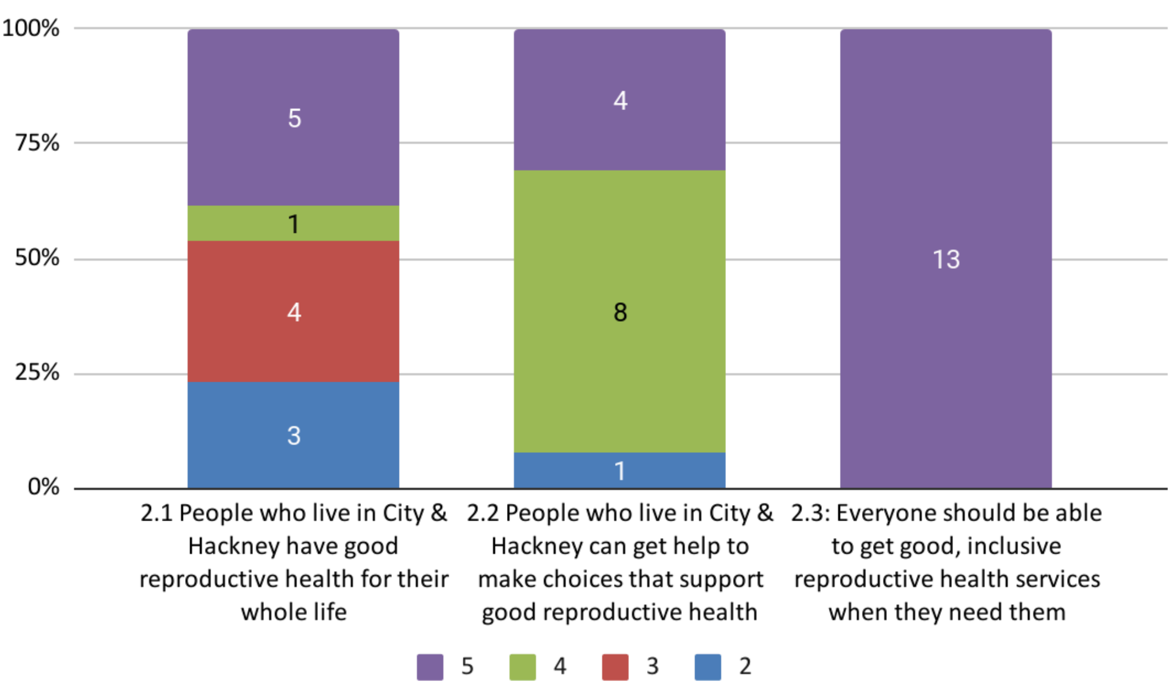
This aim also had strong agreement from respondents.

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

Theme 2: Good reproductive health for your whole life

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

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



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

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

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

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

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

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

This was strongly agreed on by all.

- Especially to prevent pregnancys
- Absolutely

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

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

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

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

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

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

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

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

3.4 STIs are not seen as something shameful or embarrassing

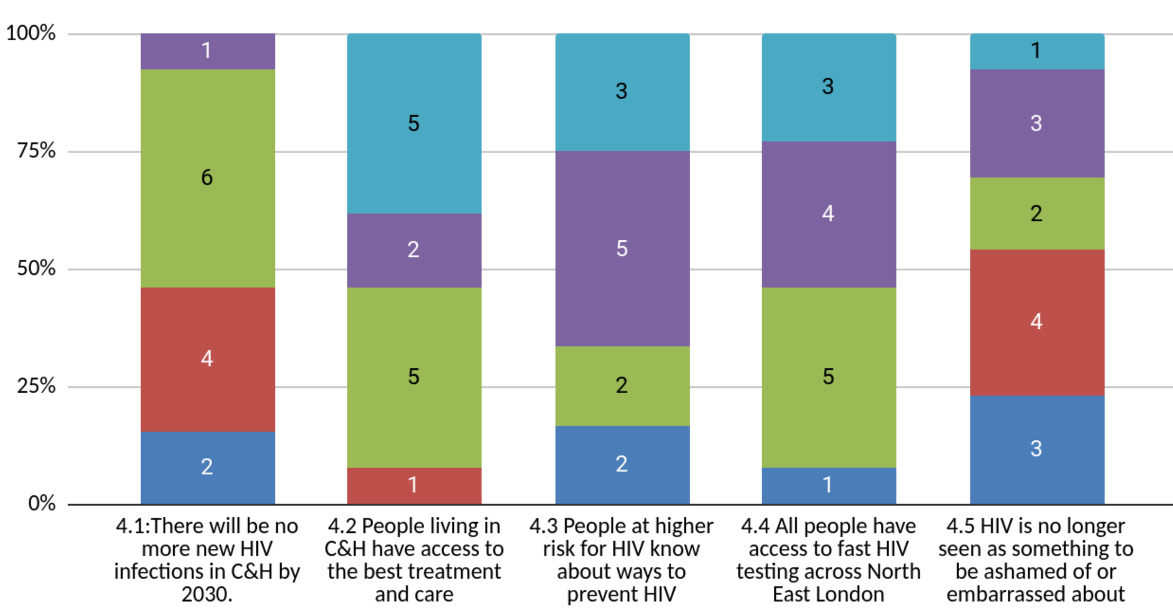
The feedback indicates there is still a lot of work to do around normalising conversations about sexual health and reducing the stigma attached to STIs.

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

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

Theme 4: Getting rid of HIV

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



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

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

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

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

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

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

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

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

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

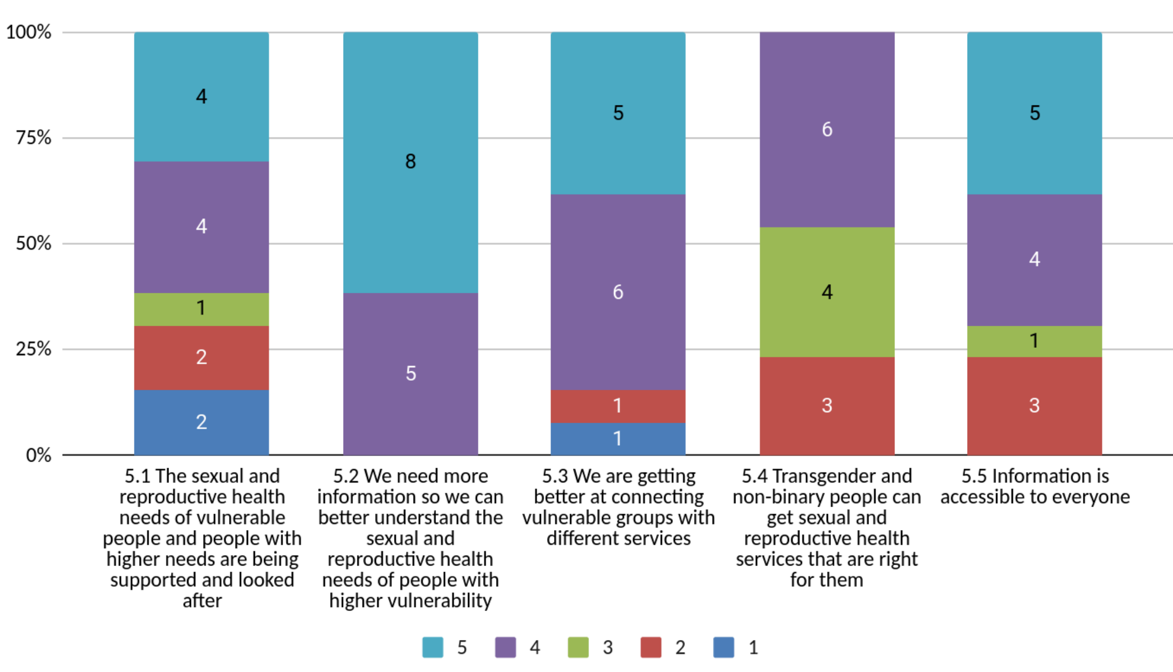
- There's still a stigma around HIV
- Quite a stigma about it
- If you get it you get it, don't get bitten on the arse

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

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

Theme 5: People who are vulnerable or have higher needs

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



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

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

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

- That's true

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

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

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

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

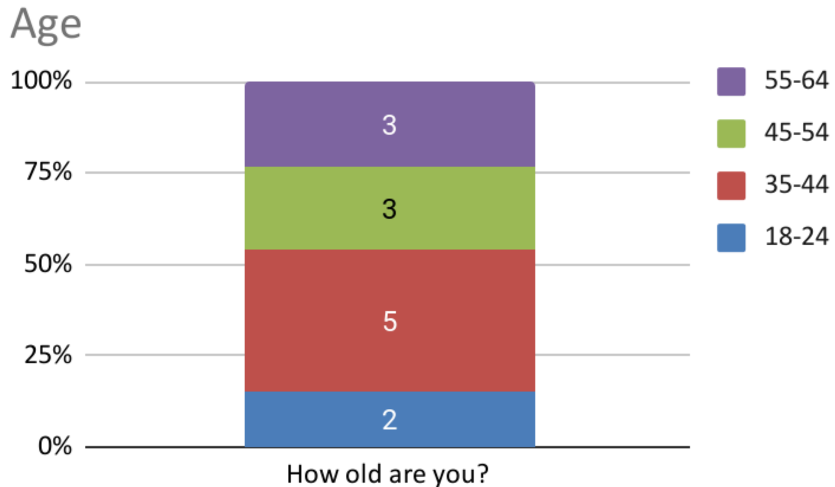
5.5 Information is accessible to everyone

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

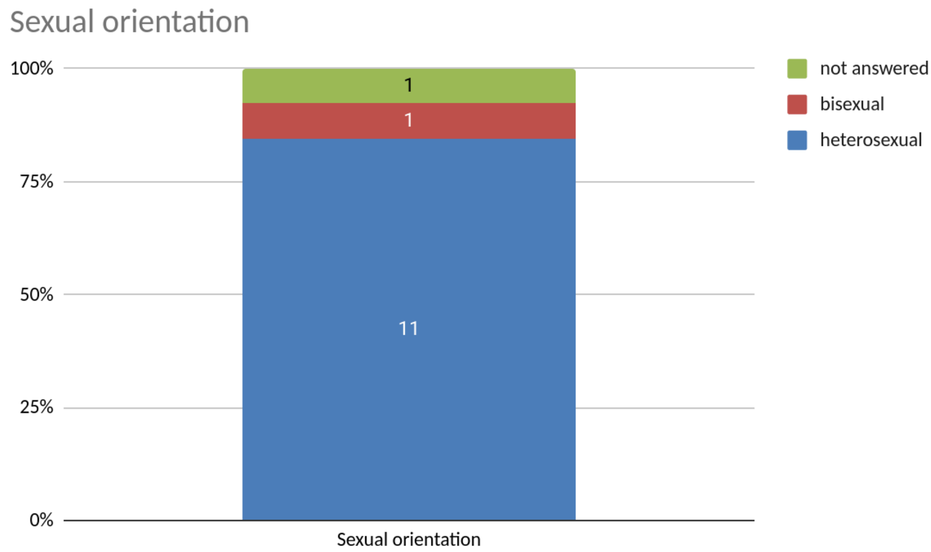
Demographic information

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

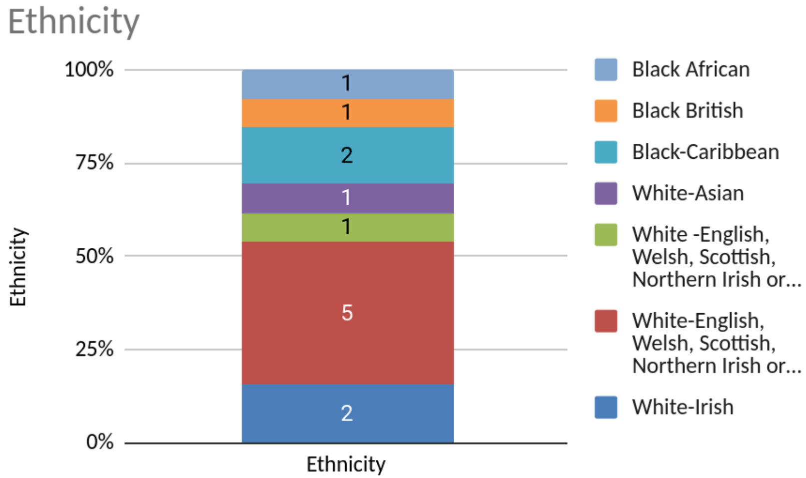
For the Easy Read survey, all 13 respondents were or identified as women, most of whom were in the 35-44 age range, or over 45. There were only two younger respondents. For 12 respondent 5s, a partial postcode was provided which indicated they lived in Hackney.

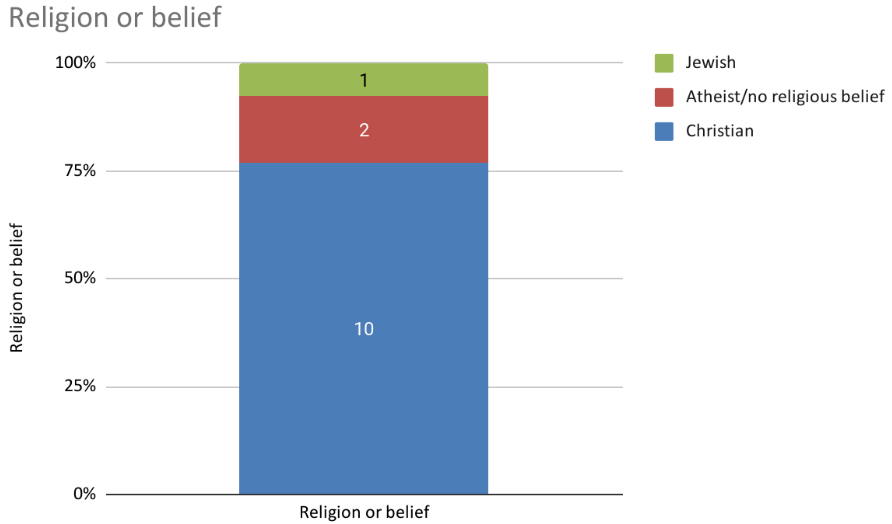


In terms of sexual orientation, the majority identified as heterosexual, with one person stating bisexual and one person not answering the question.



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

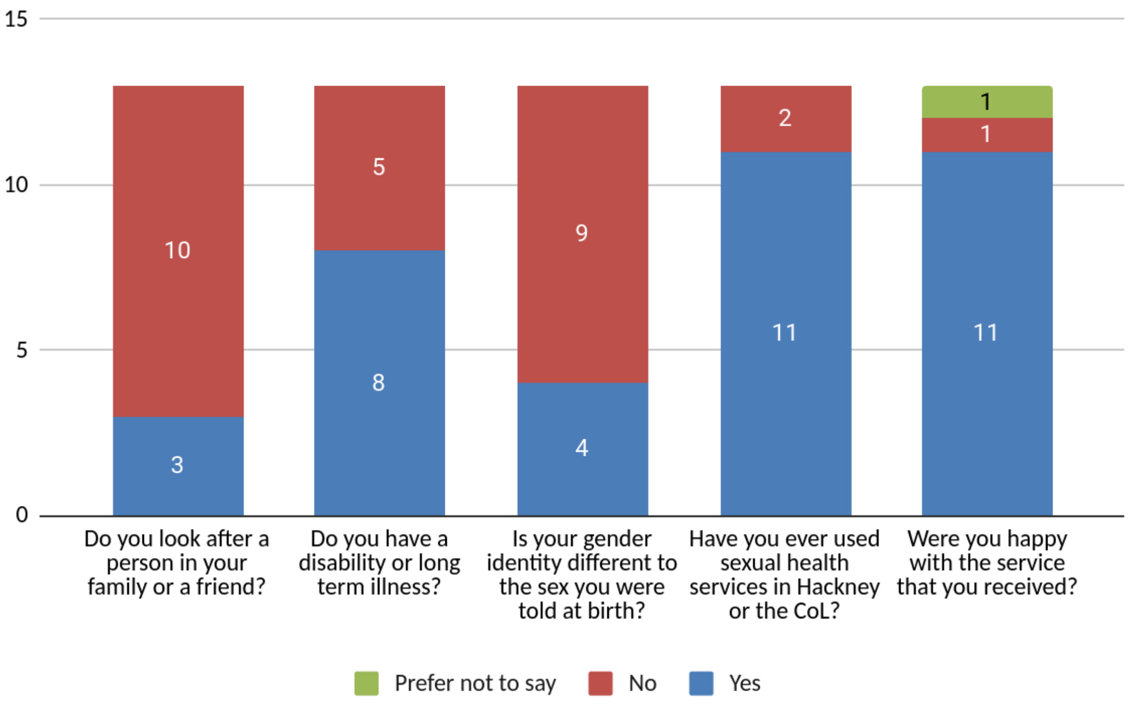




When asked if people had caring responsibilities, three answered they did, while eight respondents said they had a disability or long term illness. This represents 61.5% of a small sample, but is an indication that the Easy Read survey did provide a platform for people with potentially more complex needs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

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

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



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

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

Appendix: summary of written feedback in the online survey

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

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

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

- Good service
- Walk-in/drop in service

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

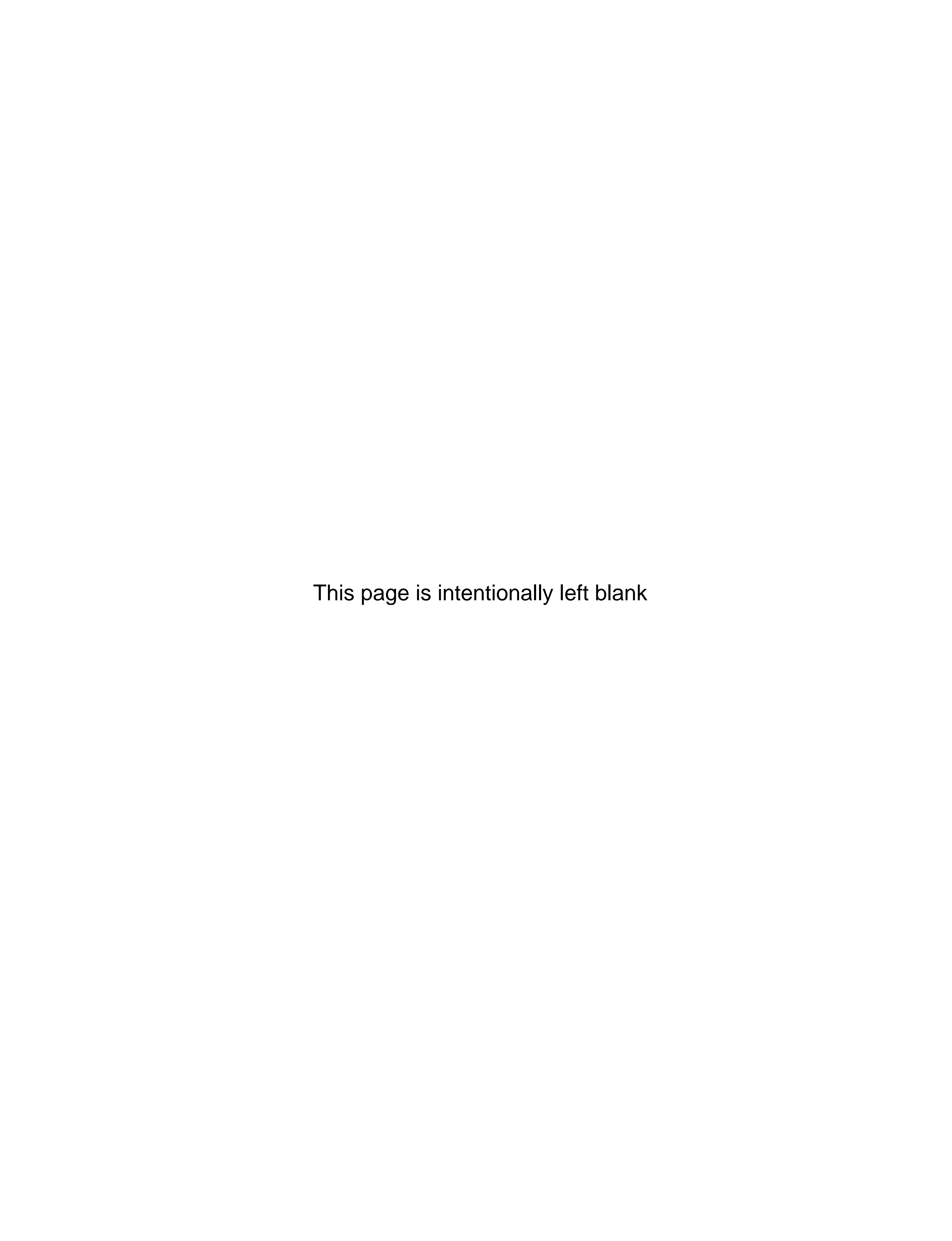
Q: Is there anything that could be improved in the Sexual and Reproductive Health Service Provision that you received?

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

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

Q: What stopped you from accessing Sexual Health Services?

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


This page is intentionally left blank

City and Hackney Sexual and Reproductive Health Strategy

2024 - 2029

Executive Summary **3**
1 - Introduction **8**
1.1 Vision 10
1.2 Core principles 10
1.3 Scope 11
1.4 Strategic priorities 12
2 - Healthy and fulfilling sexual relationships **13**
2.1 Importance to public health 13
2.2 Local need and inequalities 14
2.3 Aims and outcomes for healthy and fulfilling sexual relationships 14
3 - Good reproductive health across the lifecourse **17**
3.1 Importance to Public Health 17
3.2 Local need and inequalities 18
3.2.1 Long Acting Reversible Contraception (LARC) 19
3.2.2 Fertility and assisted conception services 19
3.3 Aims and outcomes for reproductive health across the life course 20
4 - STI prevention and treatment: access to high quality and innovative testing and treatment services **21**
4.1 Importance to Public Health 21
4.2 Local need and inequalities 22
4.2.1 Testing 22
4.2.2 Infections 23
4.2.3 Reinfection 23
4.2.4 Treatment and partner notification (PN) 24
4.3 Aims and outcomes for STI prevention and treatment 24
4.3.1 Young people 24
4.3.2 General population 25
5 - Living well with HIV and zero new HIV infections **26**
5.1 Importance to Public Health 26
5.2 Local need and inequalities 26
5.2.1 Prevention 27
5.2.2 Diagnosis, treatment and virological suppression 27
5.3 Aims and outcomes for HIV prevention, access to care and treatment 28
6 - Inclusion communities and those with complex needs **29**
6.1 Importance to Public Health 29
6.2 Local need and inequalities 30
6.2.1 LGBTQI+ 30
6.2.2 Chemsex and substance users 31
6.2.3 Homeless people and rough sleepers, asylum seekers and migrants 32

6.2.4 Commercial sex workers 32
6.2.5 People with disabilities (learning and physical) 33
6.2.6 PAUSE and STEPS service users 33
6.2.7 Young people: Social Care and Youth Justice 34
6.3 Aims and outcomes for inclusion communities and those with complex needs 34
7 - Way forward **35**
7.1 Strategy status and updates 36
7.2 Monitoring 36
Appendix 1: Overview of commissioned services **37**

Executive Summary

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

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

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

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

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

The five overarching themes are:

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

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

a) Healthy and fulfilling sexual relationships

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b) Good reproductive health across the life course

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

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

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

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

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

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

> *Outcome 1: Reproductive health services consider the life course from adolescence to the post-menopausal stage*
>
> *Outcome 2: Reproductive health services are cognisant of inequalities in service provision and uptake in different ethnic population groups and work to ensure anyone can access services in their preferred setting and equally, to address those inequalities*
>
> *Outcome 3: The role of all services in providing comprehensive reproductive care and services to residents is clear, promoted and optimised while pathways into and out of non-LA-commissioned services are optimised and integrated, including: fertility services, period poverty; perimenopause/ menopause; community gynaecology; termination of pregnancy; maternity and post-partum care and complications; cervical screening; endometriosis, genital dermatology, incontinence, heavy menstrual bleeding, Female Genital Mutilation (FGM), and sexual assault services*
>
> *Outcome 4: Inequalities in access and uptake of services have decreased over time and are not a reflection of socio-economic background*
>
> *Outcome 5: Assisted fertility services review and reduce barriers to access (‘fertility friendly City & Hackney’).*

c) STI prevention and treatment

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

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

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

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

Young people

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

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

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

General population

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

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

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

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

Outcome 8: Vaccination coverage has improved

d) Living well with HIV and zero new HIV infections

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

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

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

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

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

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

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

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

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

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

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

e) Inclusion communities and those with complex needs

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

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

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

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

Outcome 2: Improved data collection to inform service delivery

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

Outcome 4: Information is designed in acceptable and appropriate forms

Implementation

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

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

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

[Placeholder for oversight mechanism that is to be agreed]

1 - Introduction

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

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

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

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

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

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

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

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

---

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

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

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

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

1.1 Vision

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

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

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

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

1.2 Core principles

This strategy is underpinned by the following core principles:

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

1.3 Scope

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

The local authorities are responsible for:

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

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

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

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

Out of scope are:

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

1.4 Strategic priorities

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

1) **Healthy and fulfilling sexual relationships**
   People are empowered to have healthy and fulfilling sexual relations:
   - People make informed choices about their sexual and reproductive health
   - People in unhealthy, risky sexual relationships or victims of sexual assault, rape or abuse are supported appropriately

2) **Good reproductive health across the life course**
   People effectively manage their fertility and contraceptive choices, understand what impacts on it and have knowledge of and access to contraceptives:
   - Reproductive health inequalities are reduced
   - Unwanted pregnancies are reduced
   - Knowledge and understanding of contraceptive choices and preconception health are increased
   - Barriers to accessing assisted conception are reduced

3) **High quality STI testing and treatment**
   The local burden of STIs is reduced, in particular among those who are disproportionately affected:
   - There is equitable, accessible, high-quality testing, treatment, vaccination and partner notification that is appropriate to need
   - Transmission of STIs and repeat infections are reduced

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

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

The following considerations underpin the themes:

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

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

2 - Healthy and fulfilling sexual relationships

2.1 Importance to public health

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

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

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

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

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

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

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

---

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

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

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

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

2.2 Local need and inequalities

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

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

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

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

2.3 Aims and outcomes for healthy and fulfilling sexual relationships

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

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

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

Aims

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

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

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

Aims

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

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

Aims

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

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

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

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

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

Aims

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

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

Aim

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

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

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

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

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

Aim

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

3 - Good reproductive health across the lifecourse

3.1 Importance to Public Health

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

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

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

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

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

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

---

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

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

3.2 Local need and inequalities

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

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

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

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

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

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

[7] 2022 HSHS Equity Audit, Dr Sarah Creighton

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

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

3.2.1 Long Acting Reversible Contraception (LARC)

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

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

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

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

3.2.2 Fertility and assisted conception services

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

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

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

3.3 Aims and outcomes for reproductive health across the life course

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

Aims:

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

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

Aims:

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

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

Aims:

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

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

Aims:

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

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

Aims:

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

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

4.1 Importance to Public Health

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

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

4.2 Local need and inequalities [9]

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

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

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

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

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

4.2.1 Testing

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

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

---

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

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

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

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

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

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

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

4.2.2 Infections

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

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

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

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

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

4.2.3 Reinfection

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

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

---

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

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

4.2.4 Treatment and partner notification (PN)

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

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

4.3 Aims and outcomes for STI prevention and treatment

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

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

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

4.3.1 Young people

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

Aims:

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

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

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

Aims:

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

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

Aims:

1. HSHS clinics are welcoming to young people and offer no appointment, face-to-face walk-in services
2. Chlamydia treatment can be accessed at selected community pharmacies and SHL
3. Dedicated young people's services such as youth hubs and/or the 'super youth hub' offer safe spaces for sexual health advice and treatment through inreach sexual health clinics

4.3.2 General population

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

Aims:

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

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

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

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

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

Aims:

1. Increase effectiveness and outcomes of partner notification

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

Aims:

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

Outcome 8: Vaccination coverage has improved

1. Residents are protected from vaccine preventable diseases

5 - Living well with HIV and zero new HIV infections

5.1 Importance to Public Health

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

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

5.2 Local need and inequalities

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

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

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

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

5.2.1 Prevention

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

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

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

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

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

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

5.2.2 Diagnosis, treatment and virological suppression

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

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

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

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

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

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

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

Aims:

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

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

Aims:

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

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

Aims:

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

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

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

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

Aims:

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

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

Aims:

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

6 - Inclusion communities and those with complex needs

6.1 Importance to Public Health

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

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

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

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

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

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

6.2 Local need and inequalities

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

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

6.2.1 LGBTQI+

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

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

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

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

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

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

6.2.2 Chemsex and substance users

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

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

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

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

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

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

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

6.2.3 Homeless people and rough sleepers, asylum seekers and migrants

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

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

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

6.2.4 Commercial sex workers

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

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

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

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

6.2.5 People with disabilities (learning and physical)

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

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

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

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

6.2.6 PAUSE and STEPS service users

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

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

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

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

6.2.7 Young people: Social Care and Youth Justice

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

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

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

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

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

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

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

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

Aims:

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

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

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

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

---

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

5 - Encourage GP registration

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

Outcome 2: Improved data collection to inform service delivery

Aims:

1 - Explore alternative ways of data collection

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

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

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

Aims:

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

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

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

Outcome 4: Information is designed in acceptable and appropriate forms

Aim:

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

7 - Way forward

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

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

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

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

7.1 Strategy status and updates

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

7.2 Monitoring

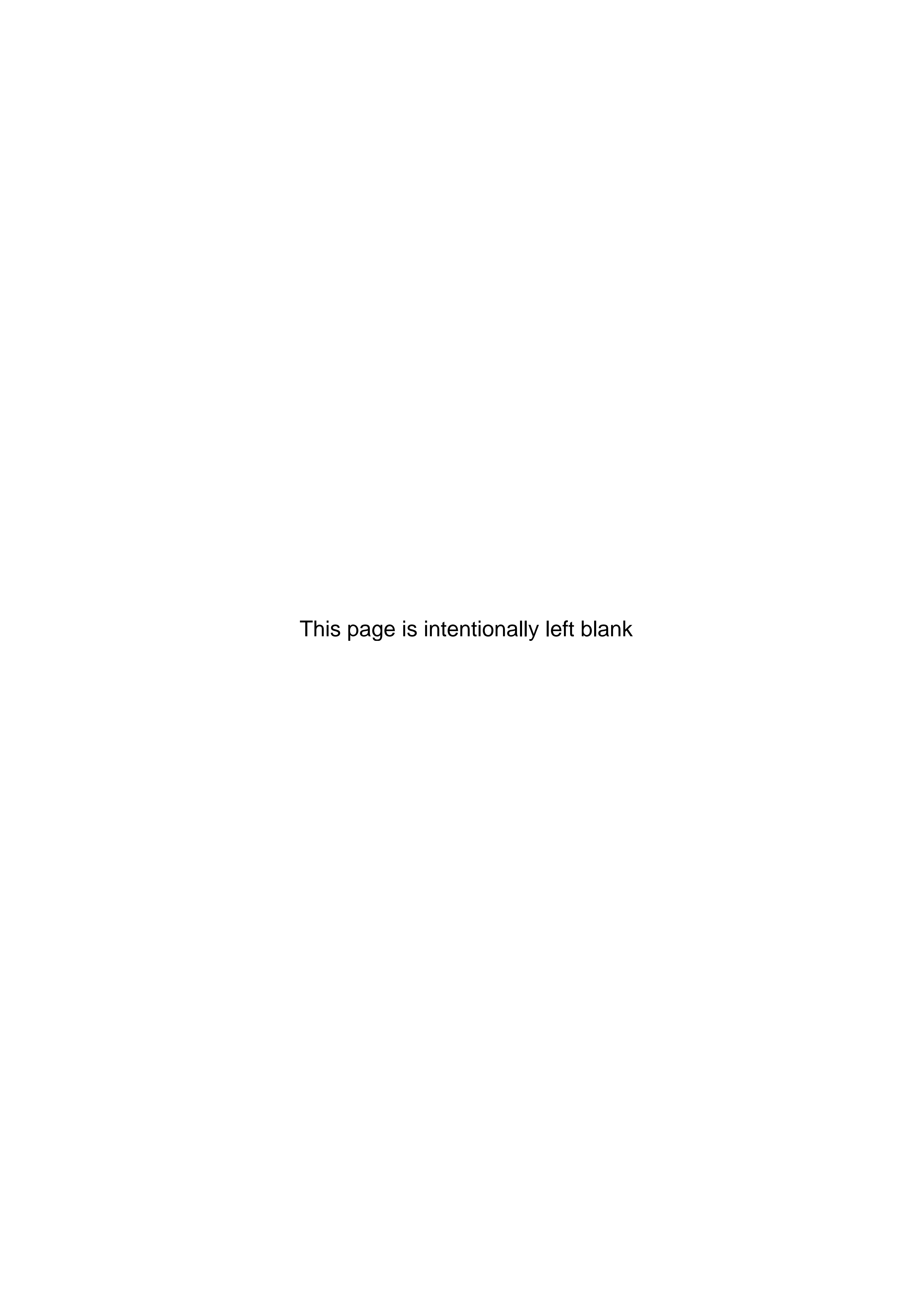
In the first year of the strategy a **sexual health dashboard** will be developed to help with monitoring progress over time and identifying where gaps or inequalities are present.

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

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

Appendix 1: Overview of commissioned services

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


This page is intentionally left blank

Title of Report	Combating Drugs Partnership and Substance Use Support Update
For Consideration By	Health and Wellbeing Board
Meeting Date	25th January 2024
Classification	Public
Ward(s) Affected	All
Report Author	Simon Young *Principal Public Health Specialist* Andrew Trathen *Consultant in Public Health*

Is this report for:

☑	Information
☐	Discussion
☐	Decision

Why is the report being brought to the board?

To provide an update on current government policy on drugs, our local Combating Drugs Partnership, and progress against a range of metrics for substance use support.

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

No

Summary

This paper provides an update on current government policy on drugs, our local Combating Drugs Partnership, and progress against a range of metrics for substance use support.

The Board are asked to:

- **Note the contents of the report**

1. Introduction

1.1. Since 2021 there has been a significant increase of focus on Substance use support nationally.

1.2. Following on from Dame Carole Black's independent review of drugs[1] in 2021, the government responded with an increase in funding for Local Authorities to help support service and system development for people with problematic drug and alcohol use.

1.3. Alongside increased funding, Central Government has also released a ten year drug strategy, titled 'from harm to hope'[2], outlining its ambitions to reduce the harms of illegal drug use.

1.4. The strategy aims are:

- Reducing drug use
- Reducing drug-related crime
- Improving recovery outcomes

1.5. These aims are further supported by more immediate outcomes:

- Reducing drug supply
- Increasing engagement in treatment
- Improving recovery outcomes

1.6. All local authorities have been tasked to support in delivering these aims.

1.7. To monitor success against these aims, Central Government has laid out 11 headline and 22 subsidiary metrics which all Local Authorities are measured against.

1.8. These metrics include:

- Increasing numbers of individuals engaging in substance use treatment ('tier 3')
- Increasing the percentage of individuals leaving prison with a drug treatment need entering community provision
- Increasing the number of young people entering treatment
- Increasing the number of individuals engaging in residential placement for detoxification and rehabilitation

[1] https://www.gov.uk/government/collections/independent-review-of-drugs-by-professor-dame-carol-black
[2] https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives

- Increase in the number of individuals showing ‘substantial progress’ whilst engaging with treatment

1.9. Central Government has instructed that areas form local ‘Combating Drugs Partnerships’ (CDP) to help monitor and drive success against these measures.

2. The City and Hackney Combating Drugs Partnership

2.1. The City of London (CoL) and London Borough of Hackney (LBH) formed their CDP in late 2022. The CDP is responsible for delivering against the national strategy, setting local objectives, and overseeing the use of funds from the government’s Supplementary Substance Misuse Treatment and Recovery Grant (SSMTR).

2.2. Dr Sandra Husbands, the Director Public Health for both authority areas, was named as the senior responsible officer. Other members of the Public Health team have key roles in coordinating and developing the CDP.

2.3. The public health team commissions local substance use services, and our lead provider is currently Turning Point. Following a period of service improvement, a recent CQC inspection rated the service as ‘Good’ across all domains. The public health team also provides intelligence functions to monitor outcomes at the service and population levels.

2.4. As such, the public health team has been well positioned to initiate the CDP and support joint decision making around local priorities. It is also able to ensure close liaison with the Office for Health Improvement and Disparities, which oversees the additional funding being made available to LBH and ensures continued adherence to the World Health Organisation’s international directive to take a health-led approach to drug-related harms.

2.5. The CDP is a broad partnership, with members including but not limited to:

- Adult Social Care
- Children’s Social Care
- Community Safety
- Drug treatment provider
- Integrated Care Board
- Local metropolitan police
- Young person’s services
- Other local third sector organisations

2.6. Governance and delivery within the CDP is overseen by a Strategy Group (CDPSG) of senior leaders that meets quarterly and a series of working groups that meet as required, focusing on specific topics.

2.7. The CDPSG has defined strategic outcomes for the overall CDP. These outcomes take into account both the key aims of Central Government as well as both LBH and CoL’s vision for reducing drug related harms.

2.8. The top level strategic aims are:

- Reducing the premature deaths of people who use drugs
- Reducing the impacts of drugs on our communities
- Improving the wellbeing of people exposed to the harms of drugs
- Reducing inequalities in substance use support

2.9. In order to help meet these aims working groups currently focus on substance use and:

- Mental Health
- Equalities in access and treatment
- Social care needs, including homelessness
- Physical Health
- Premature death, and end of life care
- The City of London
- Criminal Justice

2.10. Although the main focus of the drug strategy and funding has been towards drugs other than alcohol, Turning Point continues to work with the Alcohol Care Team at Homerton hospital, to provide support for those with problematic alcohol use. We will shortly commence an Alcohol Working Group and ensure it is well connected to the broader CDP.

3. Current Position

3.1. Delivery against aims so far has been positive, particularly when compared to other London Authorities. Across London and the country we are seeing many metrics decline, and in several areas we are experiencing the same locally. However, we are also seeing major improvements in several key areas and outperforming peer LAs.

3.2. Whilst most London Authorities have seen decreases in their numbers in treatment, LBH has seen a small increase against its baseline of 2,014, with 2,024 individuals having received support for substance use between October 2022 and September 2023.

3.3. In comparison Tower Hamlets reduced from 2,166 to 1,891 and Islington reduced from 1,707 to 1,658 individuals in the same reporting period/same baseline period. London as a whole saw reduction in numbers in treatment , from 40,229 to 39,687 for the same period.

3.4. Continuity of Care (CoC), the percentage of individuals accessing community treatment following prison discharge, has seen a significant increase in LBH.

3.5. The CoC baseline for the authority area is 18%. From July 2022 to June 2023 the CoC has risen to 43%. This compares to 29% for London as whole and 45% nationally. Looking at rolling three month figures (Jun 23 to Aug 23) suggests further improvements are being made, as LBH currently sits at 59%, which is above the national figure of 48%.

3.6. The percentage of individuals engaged in treatment showing substantial progress has declined slightly, from 34% in March 2022 to 30% in September

2023. This is a national trend, with the national figure falling from 40% to 38% for the same period.

3.7. Successful treatment completions have also slightly declined, from 17% in March 2022 to 15% in September 2023. Again, this echoes the national trend which has seen a slight decline from 21% to 20%.

3.8. Although there are clear targets for further improvements, our successes have been recognised by OHID, and they have confirmed that Public Health will receive the full £2.9 Million of additional substance misuse grant funding in 24/25, to further enhance and develop the substance use system. Other authorities who have not performed as well face a 10% reduction in the overall envelope allocated to them.

4. Next Steps

4.1. Planning for the use of further SSMTR funding in 24/25 is currently underway.

4.2. All workstreams delivered as part of the funding received in 23/24 are likely to continue, this includes:

- Increased numbers of frontline practitioners in our core treatment service
- The provision of culturally sensitive support for individuals identifying as Black
- Complex employment and developmental support for individuals furthest from the employment market
- Enhanced local authority oversight and coordination
- Prison outreach services

4.3. As the funding is increasing significantly for the authority area there will be further workstreams brought online in 24/25.

4.4. In consultation with the CDPSG and working groups, as well as with OHID, we will likely focus on:

- Developing access to and provision of mental health support for individuals using substances
- Increasing the availability of inpatient detox and rehabilitation
- Further developing mobile, outreaching approaches to support to engage underserved populations
- Developing and working with local, grass roots organisations working with individuals who face significant barriers to substance use treatment
- Increasing the clinical capacity, and oversight, of our core treatment provider
- Develop further work to focus on drug use amongst LGBTQ+ populations, including our work to support individuals engaged in chemsex

4.5. Focusing on these areas will help us to continue to deliver increases in numbers in treatment, as well as help support us in developing more meaningful engagement with our treatment services and meet the holistic needs of people using substances.

4.6. The initial submission for the award is to be made at the end of January, with OHID confirmation of the final award expected soon after. The CDPSG will ratify the submission before it is made in order to ensure that all partners are supportive of the plan.

5. Conclusion

5.1. There has been a significant increase in focus on reducing drug related harms nationally, accompanied by a 10-year strategy and increased local funding.

5.2. The formation of the local Combating Drugs Partnership, and its associated governance structures has helped develop a set of locally relevant strategic aims to reduce drug related harms.

5.3. Work to deliver against these aims continues at pace, with clear success across key metrics, notably Numbers in Treatment and Continuity of Care.

5.4. Some areas of delivery require further improvement, particularly treatment progress and successful completions of treatment.

5.5. Our successes and strong performance relative to other LAs has secured our full grant allocation for LBH in 24/25.

5.6. This grant funding will be used to continue work already delivered, as well as make improvements across the system in key areas identified by the CDP.

5.7. Confirmation of the specific work in scope of the grant will be made by OHID following LBH submission to be made in late January.

Appendices

No appendices

Title of Report	North East London Integrated Care Board: Forward Plan Refresh 2024/2025
For Consideration By	Health and Wellbeing Board
Meeting Date	25 January 2024
Classification	Public or Non-Public (delete as applicable)
Ward(s) Affected	All
Report Author	Amy Wilkinson *Director of Partnerships, Impact and Delivery (City and Hackney Place Based Partnership)*

Is this report for:

☐	Information
☑	Discussion
☐	Decision

Why is the report being brought to the board?

To inform the Health and Wellbeing Board of the intended process for refreshing the NHS NEL Joint Forward plan for 2024/25, and to discuss the contents of the plan.

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

NO. A paper outlining the intended process for place input into the Joint Forward plan has been discussed at the City and Hackney Health and Care Board.

1. Background

1.1. The NEL Joint Forward Plan (NEL JFP) 2024-2025 Refresh draft document, attached, follows on from the first JFP 23/24 submitted in June last year. The expectation is that our system's five-year plan is refreshed yearly and submitted to NHSE by the end of March each year. It will therefore continue to describe how we will, as a system, deliver our Integrated Care Partnership Strategy as well as core NHS services.

1.2. As a partnership, we continue to work towards developing a cohesive and comprehensive delivery plan for meeting all the challenges we face. As part of these annual refreshes going forward we will work with local people, partners and stakeholders to iterate and improve the plan as we develop our partnership, to ensure it stays relevant and useful to partners across the system.

1.3. For next year's 2024/2025 refresh we have maintained much of the core information and headlines that are in the current iteration. Updating and amending statistics and information where relevant.

1.4. Key additions that will be made for next year's NEL JFP include dedicated slides for our Place-based Partnerships and the identified cross-cutting themes within our interim strategy, as well as all our system improvement portfolios.

1.5. At this stage it must be emphasised that this version of the JFP is draft with refinements taking place until 23rd February.

2. Report Overview

2.1. NEL ICB was formed on 1 July 2022 following the Health and Care Act 2022, and we published our interim Integrated Care Strategy in January 2023. This was followed by the Joint Forward Plan 2023/24, our first five-year plan.

2.2. We are required to refresh the Joint Forward Plan (JFP) yearly, to reflect what we set out to deliver in the coming years.

2.3. We heard from our partners last year that they would like us to engage with them earlier in the process. These slides outline how we have structured our system planning process for 24/25 and where the JFP fits in, the steps we are taking to refresh the JFP for 24/25 as well as the main changes from the previous year.

2.4. Our Place-based Partnerships have been developing their plans for 2024/25, of which an overview is included in the JFP 24/25. To note, the City and Hackney Place slide on on slide 52.

2.5. We have included an unedited first DRAFT of the JFP 24/25 as an appendix, to indicate the direction of travel. A further draft will be available by the end of January 2024, with a final draft by the end of February. The ICB Board will be asked to approve the JFP 24/25 in March 2024.

3. Overview of system planning approach:

3.1. The NEL system planning cycle has been divided into three steps:

1) integrated care strategy,

2) delivery plan, and

3) operational planning.

These are outlined in the paper with related deliverables included below each step. These are not comprehensive but indicate some of the key activities underpinning each stage.

3.2. Joint Forward Plan (JFP) Refresh for 24/ 25 next steps:

Based on feedback and lessons learnt from this year's JFP development, we are now engaging with NEL System stakeholders earlier within the system planning cycle in order to ensure improved awareness and input to the 24/25 JFP.

There will be annual refreshes of the JFP going forward in order to ensure that the document remains current. This JFP refresh continues to describe the challenges that we face as a system in meeting the health and care needs of our local people, but also the assets we hold within our partnership.

Full timescales are outlined in the report.

4. Recommendations

It is recommended that the HWBB:

- note why the JFP refresh is being undertaken and the approach being followed in order to deliver a refreshed NEL 24/25 JFP by March 2024.
- note the amended content proposed
- review and comment on the first JFP 24/25 draft document (Appendix 1- Draft JFP 24/25

5. Policy Context:

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

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

Please detail which, if any, of the Health & Wellbeing Strategy '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 leve
☐	Making the best of community resources
☑	All of the above

5.1. **Equality Impact Assessment (EIA)**

Has an EIA been conducted for this work?

☐	Yes
☐	No

5.2. **Consultation**

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

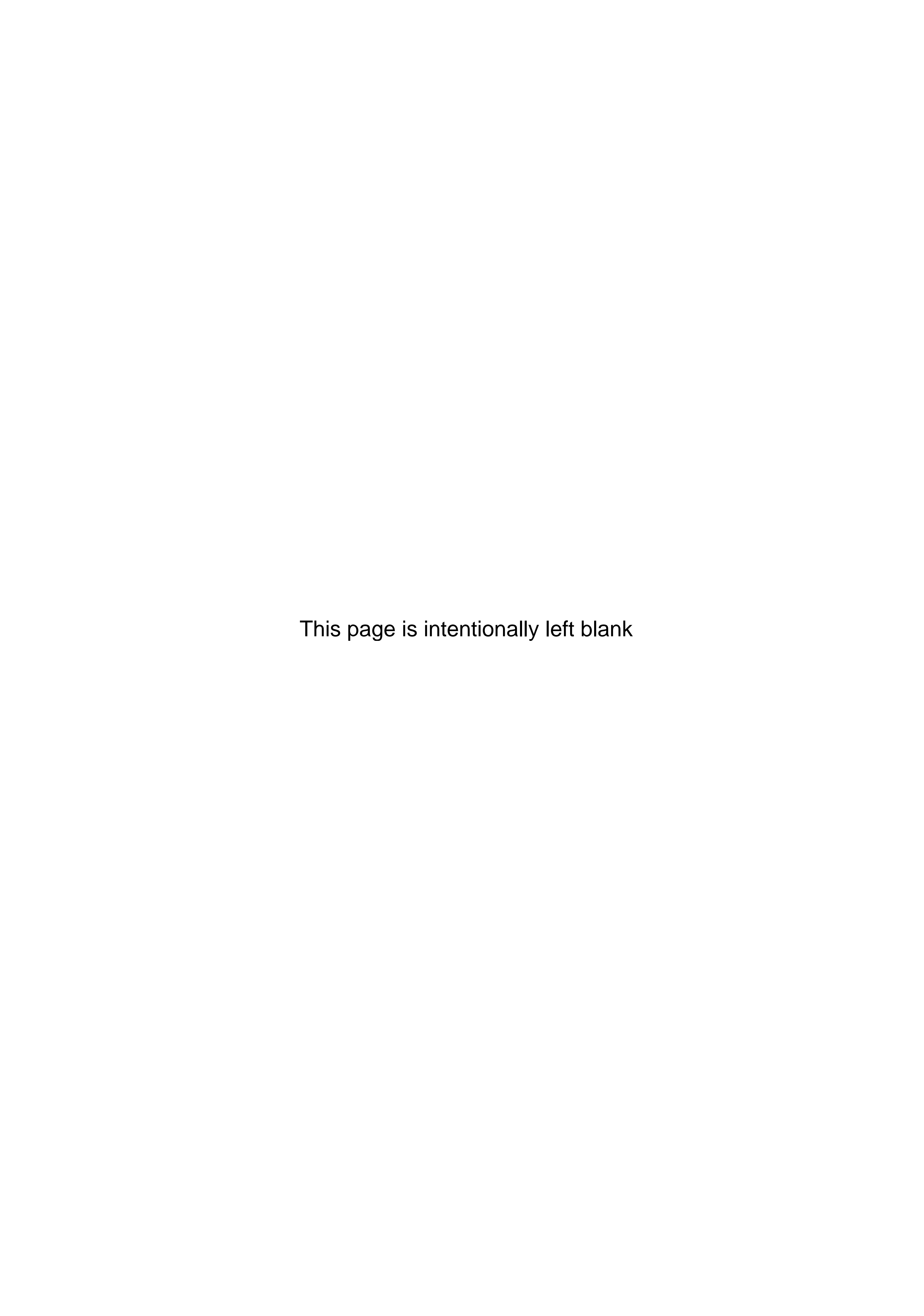
☑	Yes
☐	No

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

☑	Yes
☐	No

Report Author	Anna Carratt *Deputy Director of Strategic Development NHS NEL* Amy Wilkinson

	Director Partnerships, Impact and Delivery, City and Hackney Place Based Partnership
Contact details	amy.wilkinson@hackney.gov.uk / amy.wilkinson32@nhs.net
Appendices	Appendix 1: Joint Forward Plan 24-25 - INITIAL DRAFT v1.0 The NEL Joint Forward Plan 2023/ 2024: https://www.northeastlondonhcp.nhs.uk/ourplans/north-east-london-nel-joint-forward-plan/



This page is intentionally left blank

North East London (NEL) Joint Forward Plan

June 2023

FINAL

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 in this plan 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 together. We will work with local people, partners and stakeholders to update 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 increasingly affecting our ability to improve population health and inequalities, and to sustain core services and our system over the coming years.

- **Poverty and deprivation** – which is more severe and widely spread compared with other parts of London and England, and further exacerbated by the pandemic and cost of living which have disproportionately impacted communities in north east London
- **Population growth** – significantly greater compared with London and England as well as being concentrated in some of our most deprived and 'underserved' areas
- **Inadequate investment** available for the growth needed in both clinical and care capacity and capital development to meet the needs of our growing population

In January 2023, our integrated care partnership published our first strategy, setting the overall direction for our Joint Forward Plan

Partners in NEL have agreed a **collective ambition** underpinned by a set of **design principles** for improving health, wellbeing and equity.

To achieve our ambition, partners are clear that a radical new approach to how we work as a system is needed. Through broad engagement, including with our health and wellbeing boards, place based partnerships and provider collaboratives we have identified **six cross-cutting themes** which will be key to developing innovative and sustainable services with a greater focus upstream on population health and tackling inequalities.

We know that our people are key to delivering these new ways of working and the success of all aspects of this strategy. This is why supporting, developing and retaining our workforce, as well as increasing local employment opportunities, is one of our four system priorities identified for this strategy.

Stakeholders across the partnership have agreed to focus together on **four priorities as a system.** There are, of course, a range of other areas that we will continue to collaborate on, however, we will ensure there is a particular focus on our system priorities. We have been working with partners to consider how all parts of our system can support improvements in quality and outcomes and reduce health inequalities in these areas.

We recognise that a **well-functioning system** that is able to meet the challenges of today and of future years is built on **sound foundations.** Our strategy therefore also includes an outline of our plans for how we will transform our enabling infrastructure to support better outcomes and a more sustainable system. This includes some of the elements of our new financial strategy which will be fundamental to the delivery of greater value as well as a shift in focus 'upstream'.

Critically we are committed to a relentless focus on equity as a system, embedding it in all that we do.

Both the strategy and this Joint Forward Plan build upon the principles that we have agreed as London ICBs with the Mayor of London

Page 446

Our integrated care partnership's ambition is to
"Work with and for all the people of north east London
to create meaningful improvements in health, wellbeing and equity."

Improve quality and outcomes	Deepen collaboration	Create value	Secure greater equity

6 Crosscutting Themes underpinning our new ICS approach

- Tackling **Health Inequalities**
- Greater focus on **Prevention**
- Holistic and **Personalised** Care
- **Co-production** with local people
- Creating a **High Trust Environment** that supports integration and collaboration
- Operating as a **Learning System** driven by research and innovation

4 System Priorities for improving quality and outcomes, and tackling health inequalities

- Babies, Children & Young People
- Long Term Conditions
- Mental Health
- Local employment and workforce

Securing the foundations of our system

Improving our **physical** and **digital infrastructure**
Maximising **value** through collective financial stewardship, investing in prevention and innovation, and improving sustainability
Embedding **equity**

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

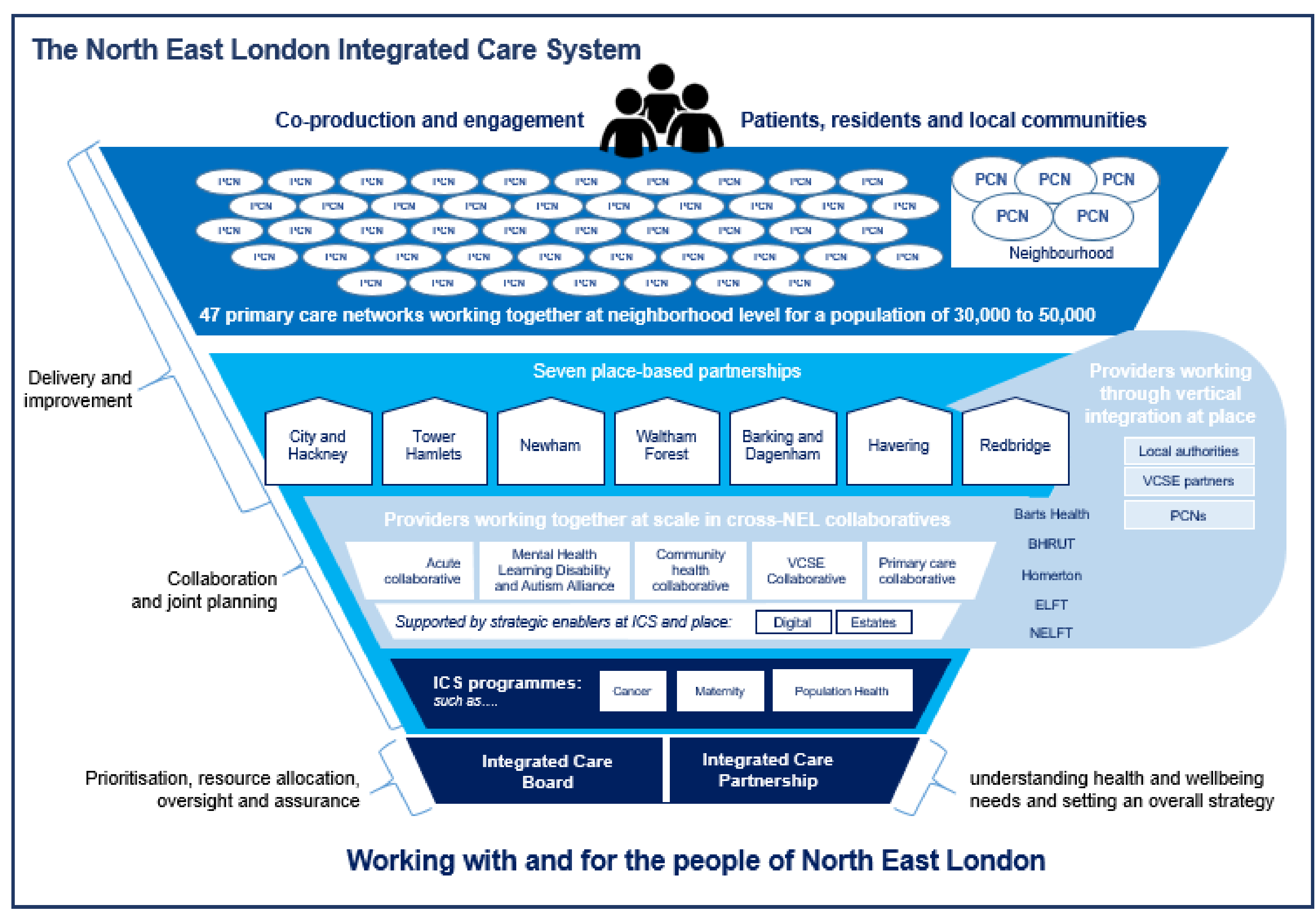
We are a broad partnership, brought together by a single purpose: to improve health and wellbeing outcomes for the people of north east London.

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 and community sector, is uniquely positioned to improve all aspects of health and care including the wider determinants.

With hundreds of health and care organisations serving more than two million local people, we have to make sure that we are utilising each to the fullest and ensure that work is done, and decisions are made, at the most appropriate level.

Groups of partners coming together within partnerships are crucial building blocks for how we will deliver. Together they play critical roles in driving the improvement of health, wellbeing, and equality for all people living in north east London.



2. Our unique population

Understanding our unique population is key to addressing our challenges and capitalising on opportunities

NEL is a diverse, vibrant and thriving part of London with a rapidly growing population of over two million people, living across seven boroughs and the City of London. It is rich in history, culture and deep-rooted connections with huge community assets, resilience and strengths. Despite this, local people experience significant health inequalities. An understanding of our population is a key part of addressing this.

Rich diversity

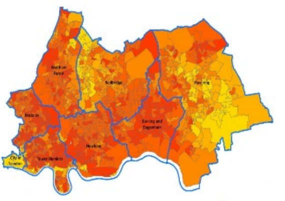
NEL is made up of many different communities and cultures. Just over half (53%) of our population are from ethnic minority backgrounds.

Our diversity means a 'one size fits all' approach will not work for local people and communities, but there is a huge opportunity to draw on a diverse range of community assets and strengths.

Young, densely populated and growing rapidly

There are currently just over two million residents in NEL and an additional 300,000 will be living here by 2040.

We currently have a large working age population, with high rates of unemployment and self-employment. A third of our population has a long term condition. Growth projections suggest our population is changing, with large increases in older people over the coming decades.



Poverty, deprivation and the wider determinants of health

Nearly a quarter of NEL people live in one of the most deprived 20% of areas in England. Many children in NEL are growing up in low income households (up to a quarter in several of our places).

Poverty and deprivation are key determinants of health and the current cost of living pressures are increasing the urgency of the challenge.

Stark health inequalities

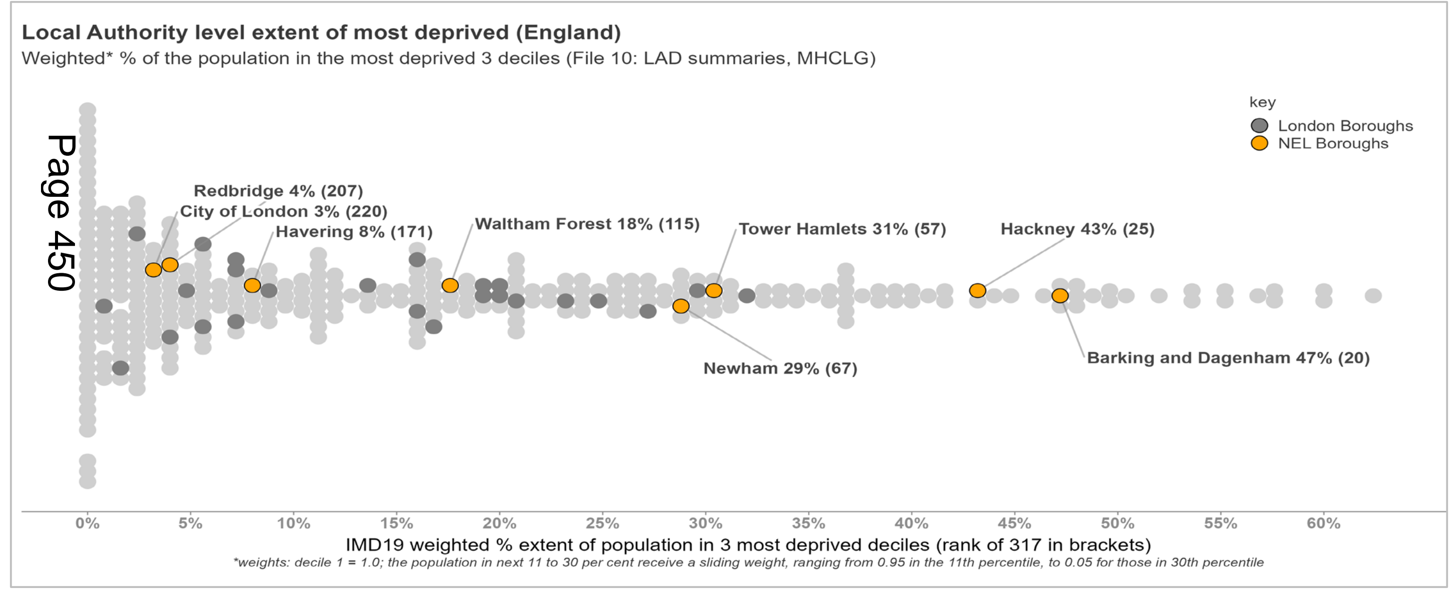
There are significant inequalities within and between our communities in NEL. Our population has worse health outcomes than the rest of the country across many key indicators. Health inequalities are linked to wider social and economic inequalities, including poverty and ethnicity.

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

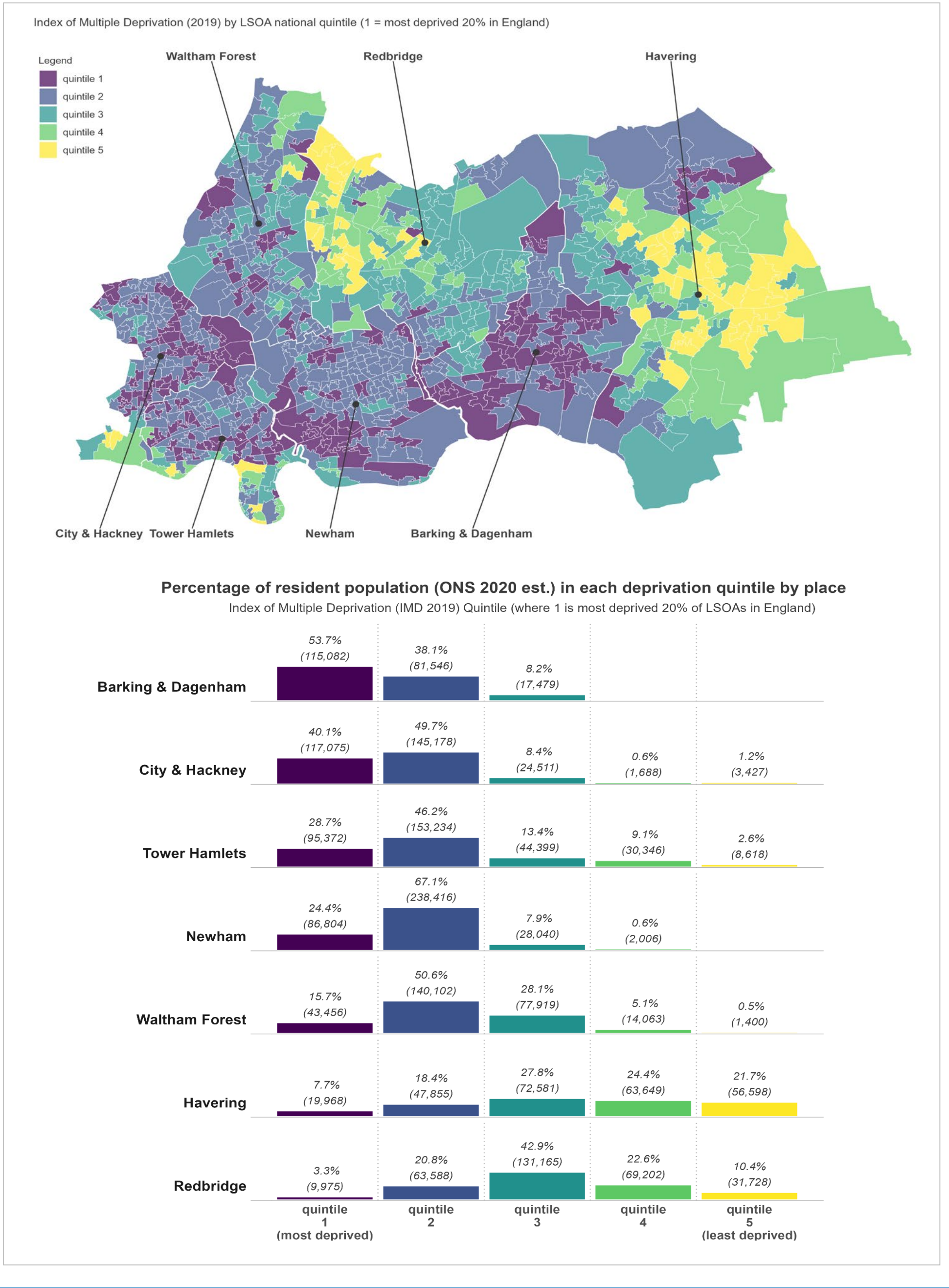
Key factors affecting the health of our population and driving inequalities - poverty, deprivation and ethnicity

Large proportions of our population live in some of the most deprived areas nationally. NEL has four of the top six most deprived Borough populations in London, and some of the highest in the country, with Hackney and Baking and Dagenham in the top twenty-five of 377 local authorities (chart below).

By deprivation quintile, Barking and Dagenham (54%), City and Hackney (40%), Newham (25%) and Tower Hamlets (29%), have between a quarter and more than half of their population living in the most deprived 20% of areas in England (map and chart right).



People living in deprived neighbourhoods, and from certain ethnic backgrounds, are more likely to have a long term condition and to suffer more severe symptoms. For example, the poorest people in our communities have a 60% higher prevalence of long term conditions than the wealthiest along with 30% higher severity of disease. People of South Asian ethnic origin are at greater risk of developing Type 2 Diabetes and cardiovascular disease, and people with an African or Caribbean family background are at greater risk of sickle cell disease.



To meet the needs of our population we need a much greater focus on prevention, addressing unmet need and tackling health inequalities

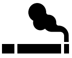
Child Obesity

Nearly 10% of year 6 children in Barking and Dagenham are severely obese. Nearly are third of children are obese (the highest prevalence rate in London).

NEL also has a higher proportion of adults who are physically inactive compared to London and England.

Mental Health

It is estimated that nearly a quarter of adults in NEL suffer with depression or anxiety, yet QOF diagnosed prevalence is around 9%. Whilst the number of MH related attendances has decreased in 22/23, the number of A&E attendances with MH presentation waiting over 12 hours shows an increasing trend, increasing pressure on UEC services.



Tobacco

One in 20 pregnant women smokes at time of delivery. Smoking prevalence, as identified by the GP survey, is higher than the England average in most NEL places. In the same survey, NEL has the lowest ‘quit smoking’ levels in England.

Premature CVD mortality

In NEL there is a very clear association between premature mortality from CVD and levels of deprivation. The most deprived areas have more than twice the rate of premature deaths compared to the least deprived areas. 2021/22 figures showed for every 1 unit increase in deprivation, the premature mortality rate increases by approximately 11 deaths per 100,000 population.

Vulnerable housing

NEL has higher numbers of vulnerably housed and homeless people, including refugee and asylum seekers, compared to both London and England. At the end of September 2022, 11,741 households in NEL were in council arranged temporary accommodation. This is a rate of 23 households per thousand compared to 16 per thousand in London and 4 per thousand in England as a whole.

Homelessness

Shelter estimates in 2022 there were 42,399 homeless individuals in NEL inc. those in temp accommodation, hostels, rough sleeping and in social services accommodation. That’s 1 in 47 people, compared to 1 in 208 people across England and 1 in 58 in London. People experiencing homeless have worse health outcomes & face extremely elevated disease and mortality risks which are eight to twelve times higher than the general population.

Childhood Poverty

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

Childhood Vaccinations

The NEL average rate of uptake for ALL infant and early years vaccinations is lower than both the London and the England rates

There are particular challenges in some communities/parts within Hackney, Redbridge, Newham and B&D, where rates are very low with some small areas where coverage is less than 20% of the eligible population.

There is clear indication of unmet need across our communities in NEL

- For many conditions there are low recorded prevalence rates, while at the same time most NEL places have a higher Standardised Mortality Ratio for those under 75 (SMR<75) – a measure of premature deaths in a population – compared to the England average. Whilst some of this may be due to the age profile of our population, there may be significant unmet health and care need in our communities that is not being identified, or effectively met, by our current service offers.
- Analysis of DNAs (people not attending a booked health appointment) in NEL has shown these are more common among particular groups. For example, at Whipps Cross Hospital, DNAs are highest among people living in deprived areas and among young black men. Further work is now happening to understand how we can better support these groups and understand the barriers to people attending appointments across the system.

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

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

The majority of NEL's population growth during 2023-2040 will occur within three boroughs: Barking and Dagenham (27%), Newham (26.3%) and Tower Hamlets (20.3%), all of which are currently home to some of the most deprived communities in London/England.

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

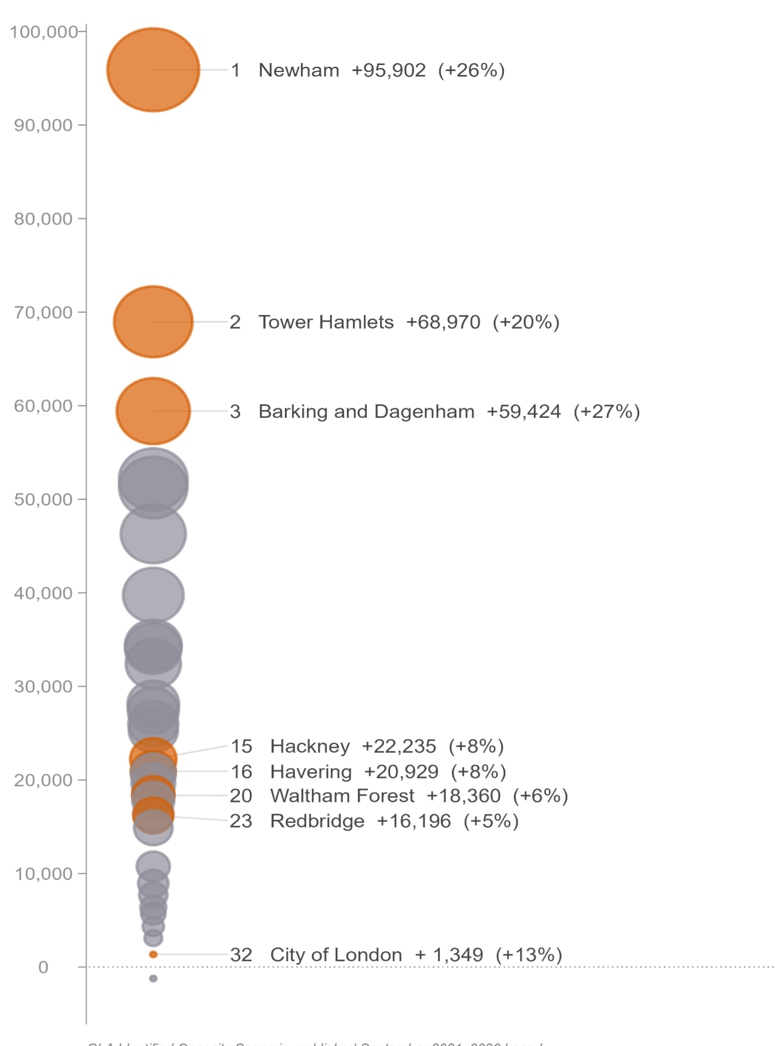
In addition, the age profile of our population is set to change in the coming years. Our population now is relatively young, however, some of our boroughs will see high increases in the number of older people as well as increasing complexity in overall health and care needs.

London borough all age population increase 2023-2040

Labelled circles = NEL Boroughs rank out of 33 in London

20
23
16
15
3
1
2
Key
-
NEL

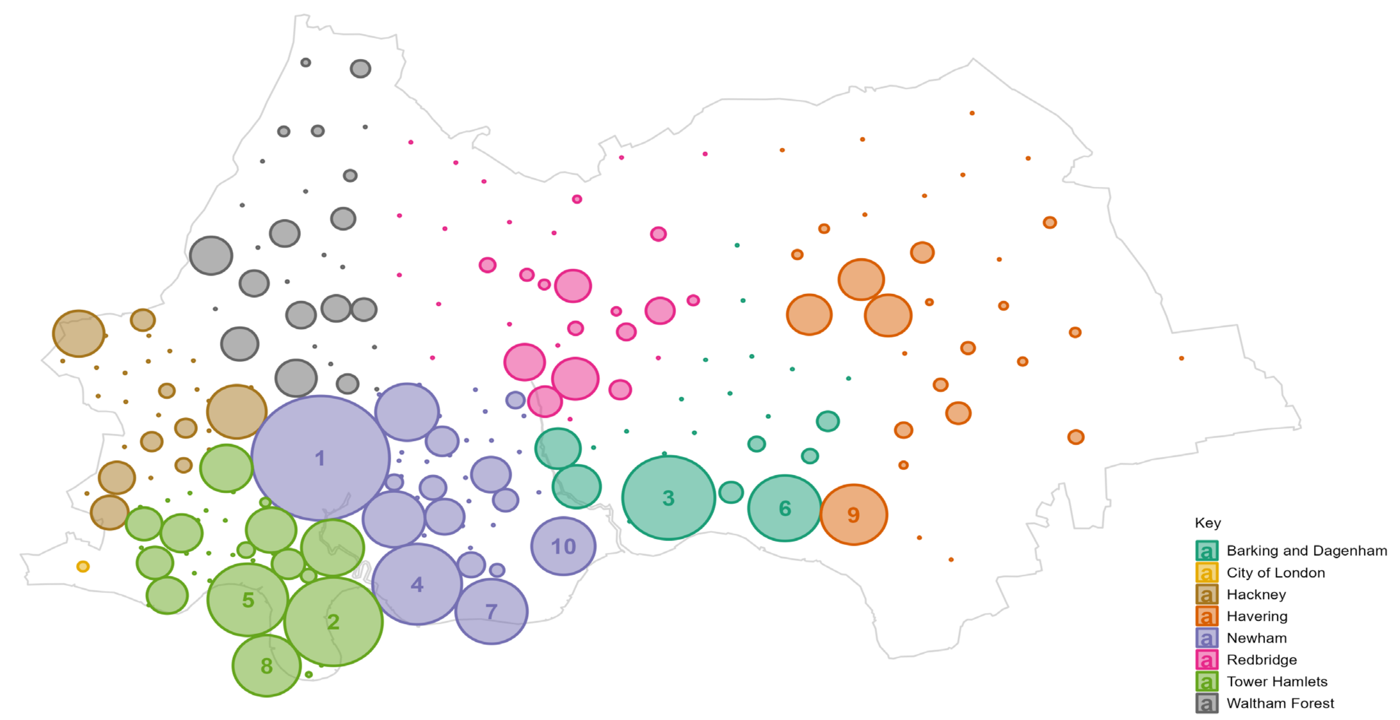
GLA Identified Capacity Scenario, published September 2021, 2020 based

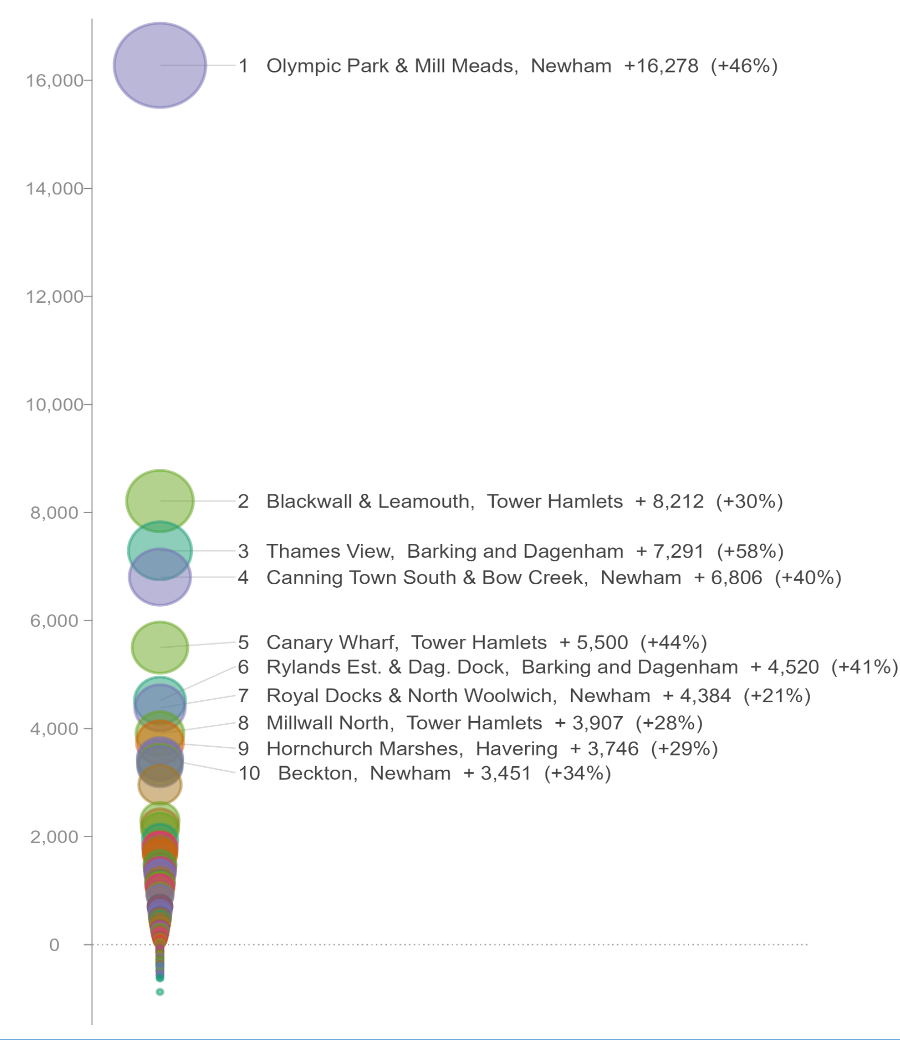


We need to act urgently to improve population health and address the impact of population growth

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 and Dagenham.

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





3. Our assets

We have significant assets to draw on

North east London (NEL) has a growing population of over two million people and is a vibrant, diverse and distinctive area of London, steeped in history and culture. The 2012 Olympics were a catalyst for regeneration across Stratford and the surrounding area, bringing a new lease of life and enhancing the reputation of this exciting part of London. This has brought with it an increase in new housing developments and improved transport infrastructure and amenities. Additionally, the area is benefiting from investment in health and care facilities with a world class life sciences centre in development at Whitechapel. There are also plans for the Whipps Cross Hospital redevelopment and for a new health and wellbeing hub on the site of St George's Hospital in Havering, making it an exciting time to live and work in north east London.

Our assets

- **The people of north east London** – bring vibrancy and diversity, form the bedrock of our partnership, participating in our decisions and co-producing our work. They are also our workforce, provide billions of hours of care and support to each other and know best how to deliver services in ways which work for them.

- **Research and innovation** – continuously improving, learning from international best practice and undertaking from our own research and pilots, and our work with higher education and academia partners, to evidence what works for our diverse communities/groups. We want to build on this work, strengthen what we have learnt, to provide world-class services that will enhance our communities for the future.

- **Leadership** – our system benefits from a diverse and talented group of clinical and professional leaders who ensure we learn from, and implement, the best examples of how to do things, and innovate, using data and evidence in order to continually improve. Strong clinical leadership is essential to lead communities, to support us in considering the difficult decisions we need to make about how we use our limited resources, and help set priorities that everyone in NEL is aligned to. Overall our ICS will benefit from integrated leadership, spanning senior leaders to front line staff, who know how to make things happen, the CVS who bring invaluable perspectives from ground level, and local people who know best how to do things in a way which will have real impact on people.

- **Financial resources** – we spend nearly £4bn on health services in NEL. Across our public sector partners in north east London, including local authorities, schools and the police, there is around £3bn more. By thinking about how we use these resources together, in ways which most effectively support the objectives we want to achieve at all levels of the system, we can ensure they are spent more effectively, and in particular, in ways which improve outcomes and reduce inequality in a sustainable way.

- **Primary care** - is the bedrock of our health system and we will support primary care leaders to ensure we have a multi-disciplinary workforce, which is responsive and proactive to local population needs and focused on increasing quality, as well as supported by our partners to improve outcomes for local people.

Our health and care workforce is our greatest asset

Our health and care workforce is the linchpin of our system and central to every aspect of our new Integrated Care Strategy and Joint Forward Plan. We want staff to work more closely across organisations, collaborating and learning from each other, so that all of our practice can meet the standards of the best. By working in multi-disciplinary teams, the needs of local people, not the way organisations work, will be key. Where necessary, our workforce will step outside organisational boundaries to deliver services closer to communities.

Our staff will be able to serve the population of NEL most effectively if they are treated fairly, and are representative of our local communities at all levels in our organisations. Many of our staff come from our places already and we want to increase this further.

Our workforce is critical to transforming and delivering the new models of care we will need to meet rising demand from a population that is growing rapidly, with ever more complex health and care needs. We must ensure that our workforce has access to the right support to develop the skills needed to deliver the health and care services of the future, and to adapt to new ways of working, and, potentially, new roles.

Our ICS People and Workforce Strategy will ensure there is a system wide plan to underpin the delivery of our new Integrated Care Strategy and Joint Forward Plan, through adopting a joined up 'One Workforce' across the system that will work in new ways and be seamlessly deployed for the delivery of health and care priorities. The strategy will focus on increasing support for our current workforce through the implementation of inclusive retention and health and well-being strategies, and creating innovative, flexible and redesigned heath and care careers.

It will ensure right enablers at System, Place, Neighbourhood and in our provider collaboratives, to strengthen the behaviours and values that support greater integration, and collaboration across teams, organisations and sectors. It will contribute to the social and economic development of our local population through upskilling and employing under-represented groups from our local people, through creating innovative new roles, values-based recruitment and locally-tailored, inclusive supply and attraction strategies in collaboration with education providers.

There are almost one hundred thousand people working in health and care in NEL, and our employed workforce is growing every year.

Our workforce includes:

- Over 4,000 people working in general practice with 3.7% growth in our workforce in 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 to supporting a greater shift towards prevention and self-care. They work closely with local communities and are key system transformation, innovation and integration partners.

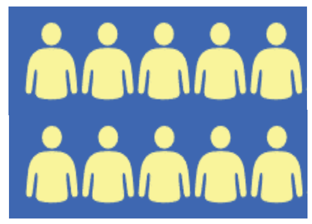
In NEL we are supporting the development of a VCSE Collaborative to create the enabling infrastructure and support sustainability of our rich and diverse VCSE in NEL, also ensuring that the contribution of the VCSE is valued equally.

Social care plays a crucial role in improving the overall health and well-being of local people including those who are service users and patients in north east London. Social care promotes people's wellbeing and supports them to live independently, staying well and safe, and it includes the provision of support and assistance to individuals who have difficulty carrying out their day-to-day activities due to physical, mental, or social limitations. It can therefore help to prevent hospital admissions and reduce the length of hospital stays. This is particularly important for elderly patients and those with chronic conditions, who may require long-term social care support to maintain their independence and quality of life.

In north east London 75% of elective patients discharged to a care home have a length of stay that is over 20 days (this compares to 33% for the median London ICS).

The **work of local authorities more broadly, including their public health teams,** as well as education, housing and economic development, work to address the wider determinants of health such as poverty, social isolation and poor housing conditions. As described above, these are significant challenges in north east London, critical to addressing health and wellbeing outcomes and inequalities.

In our strategy engagement we heard of the desire to accelerate integration across all parts of our system to support better access, experience and outcomes for local people. We heard about the opportunities to support greater multidisciplinary working and training, the practical arrangements that need to be in place to support greater integration, including access to shared data, and the importance of creating a high trust and value-based environment which encourages and supports collaboration and integration.



There are **more than 1,300 charities operating across north east London**, many either directly involved in health and care or in areas we know have a significant impact on the health and wellbeing of our local people, such as reducing social isolation and loneliness, which is particularly important for people who are vulnerable and/or elderly.

Thousands of informal carers play a pivotal role in our communities across NEL, supporting family and friends in their care, including enabling them to live independently.

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 face today as well as securing our sustainability for the future. Our Integrated Care Strategy highlights that a shift in focus upstream will be critical for improving the health of our population and tackling inequalities. The health of our population is at risk of worsening over time without more effective **prevention** and **closer working with partners** who directly or indirectly have a significant impact on healthcare and the health and wellbeing of local people, such as local authority partners and VCSE organisations.

Two of the most pressing and visible challenges our system faces today, which we must continue to focus on, are the long waits for accessing **same day urgent care;** and a large backlog of patients waiting for **planned care**. Provision of urgent care in NEL is more resource intensive and expensive than it needs to be and the backlog for planned care, which grew substantially during Covid, is not yet coming down, as productivity levels are only just returning to pre-pandemic levels. Both areas reflect pressures in other parts of the system, and have knock-on impacts.

The wider determinants of health are also key challenges that contribute to challenges. Most of our places we have seen unemployment rise during the pandemic, although this number is dropping, and we still have populations who remain unemployed or inactive.

We currently have a **blend of health and care provision for our population that is unaffordable**, with a significant underlying deficit across health and care providers (in excess of £100m going into 23/24). If we simply do more of the same, as our population grows, our financial position will worsen further and we will not be able to invest in the prevention we need to support sustainability of our system.

To address these challenges and enable a greater focus upstream, it is necessary to focus on **improving primary and community care services**, as these are the first points of contact for patients and can help to prevent hospital admissions and reduce the burden on acute care services. This means investing in resources and infrastructure to support primary care providers, including better technology, training and development for healthcare professionals, and better integration of primary care with community services. In addition, there is a need for better management and **support for those with long-term conditions** (almost a third of our population in NEL). People with LTCs are often high users of healthcare services and may require complex and ongoing care. This can include initiatives such as care coordination, case management, and self-management support, which can help to improve the quality of care, prevent acute exacerbation of a condition and reduce costs.

Achieving this will require our workforce to grow. This is a key challenge, with high numbers of vacancies across NEL, staff turnover of around 23% and staff reporting burnout, particularly since the COVID-19 pandemic.

The following slides describe these core challenges and potential opportunities in more detail. Where possible we have taken a population health approach, considering how our population uses the many different parts of our health and care system and why. More work is required to build this fuller picture (including through a linked dataset) and this forms part of our development work as a system.

We face substantial pressures on same day urgent care

Key messages	*Detail*
Demand for same day urgent care is growing rapidly as NEL's population grows	• Demographic and non-demographic changes to the NEL population are projected to increase demand for A&E attendance and unplanned admissions by 15-16% over the next 5 years
The status quo isn't viable. Doing more of the same will exacerbate existing pressures	• We have significant performance challenges across all three acute Trusts (e.g. average 60% on 4 hour A&E target) • Growing demand for unplanned care within acute settings risks undermining efforts to reduce backlog of patients waiting for planned care
Improvements in care pathways, including a shift of system resource to out of hospital services (primary and community care), could help reduce demand for expensive unplanned acute care for some patients	• Rates of avoidable admissions (for conditions that ought to be manageable through better primary care) are high at a large number of primary care practices within NEL (between 37 and 46 depending on the type of avoidable admission) • Mental Health patients are facing long waits in A&E (4,440 waited more than 12 hours during 22/23) • Non-conveyance from ambulance calls to care homes vary considerably and represent a higher proportion than the London average • Around 13% of A&E attendances leave without any significant investigation or treatment, suggesting they could have been better managed elsewhere in the system
Patients on waiting lists are causing pressures across other parts of the system	• A snapshot of the current elective waiting list indicates that 14% of the patients waiting for elective care have been responsible for 47,000 A&E attendances during their wait
There is an opportunity for improving UEC by better system working	• An analysis of NEL against other London ICSs indicates that moving to the median ICS performance for non-elective admissions would see a reduction of around 10%. This would be a substantial contribution to closing the projected gap created by growing demand and equates to around £65m per year

We have a large backlog of people waiting for planned care

Key messages	*Detail*
Demand for elective care is growing, adding to a large existing backlog	• Demand for planned care is expected to grow by 19.7% between 2022/23 and 2027/28, or by around 4% per year. • There are currently around 174,000 people waiting for elective care As of December 2022, 18 people had been waiting longer than 104 weeks, 843 longer than 78 weeks and 8,646 longer than 52 weeks.
Activity levels vary week on week for many reasons and we haven't yet seen consistent week on week improvements in the total waiting list size	• The 'breakeven' point for NEL's waiting list (neither increasing nor decreasing) requires an activity level of 4,281 per week*. This breakeven point is expected to increase by around 4% per year due to projected increases in demand. • Activity levels vary throughout the year. For instance, in Sept-Dec 2022 trusts in NEL were reducing the overall number of waiters by 391 per week, whereas since then the overall number waiting has increased.
There are financial implications from over/under performance on elective care	• We have an opportunity to earn more income (from NHSE) by outperforming activity targets, thereby bringing more money into north east London. If the additional cost of performing that extra activity is below NHSPS unit prices then this also supports our overall financial position.
Tackling the elective backlog is a long-term goal and will require continuous improvements to be made	• A reasonably crude analysis of our elective activity suggests that delivering elective care at the rate of our peak system performance for last year (Sept-Dec 2022) would lead to no one waiting over 18 weeks by September 2027. This timescale would require an uplift in care delivery each year equivalent to expected demand increases (4% per year).
There may be opportunities for improvements in elective care, particularly around LOS	• An analysis of NEL against other London ICSs indicates that moving to the median LOS for elective admissions would reduce bed days by 13% and moving to the England median would reduce bed days by 31% (comparison excludes day cases).

* Activity calculations are based on assessment of those on waiting list for more than 18 weeks, at end of Feb 2023

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

- North-east London currently has fewer GP appointments per 100,000 weighted population than other ICSs in England. The national median is around 8% greater than in NEL, suggesting part of the cause of pressure on other parts of the system, including greater than expected non-elective admissions at the acute providers, may be due to insufficient primary care capacity.
- Across NEL there is wide variation in the number of delivered appointments or average clinical care encounters per week. For 2022/23 this ranges from 93.56 per 1000 (weighted registered) patients in Tower Hamlets, to 68.01 per 1000 (weighted registered) patients in Havering. The NEL average is 77.78 per 1000 (weighted registered) patients.**
- Between March 2022 and March 2023, booked general practice appointments across NEL increased by around 32% to 11 million appointments. 56% of appointments were delivered by other professionals such as nurses and 43% of all appointments were seen on the same day as they were booked*. This figure includes both planned and reactive care. 57% of appointments were patient-initiated contacts, booked and seen on the same day.***
- We are developing a set of principles to streamline patient access to the most appropriate type of appointment and advice, with clear signposting, for health care professionals and local people to ensure they are directed to the full range of services available at Practice and Place, in and out of general practice hours.
- Without substantial increases in primary care staffing the GP to patient ratio will worsen as demand for primary care increases in line with projected population growth. There are pockets of workforce shortages with significant variation in approaches to training, education and recruitment. We are committed to focusing upon retention initiatives such as mentoring and portfolio careers having developed SPIN (specialised Portfolio innovation) which is the basis for the national fellowship programme which we are offering to GPs and other professional groups.
- Community care in north east London is currently fragmented, with around 65 providers offering an array of community services. More work is required to understand the impact this has on patient outcomes and variability across NEL's places, but we know that for pulmonary rehab, for example, there is variation in service inclusion criteria and the staffing models used, and that waiting times vary between 35 and 172 days, with completion rates between 36% and 72% across our places and services.
- More children and young people are on community waiting lists in NEL than any other ICS (NEL is about average, across England, for the number of people on adult community waiting lists).
- There are opportunities to build on our best practice to further develop integrated neighbourhood teams, based on MDTs, social prescribing and use of community pharmacy consultation services, which will strengthen both our continuity of care of long term conditions and our ability to work preventatively.

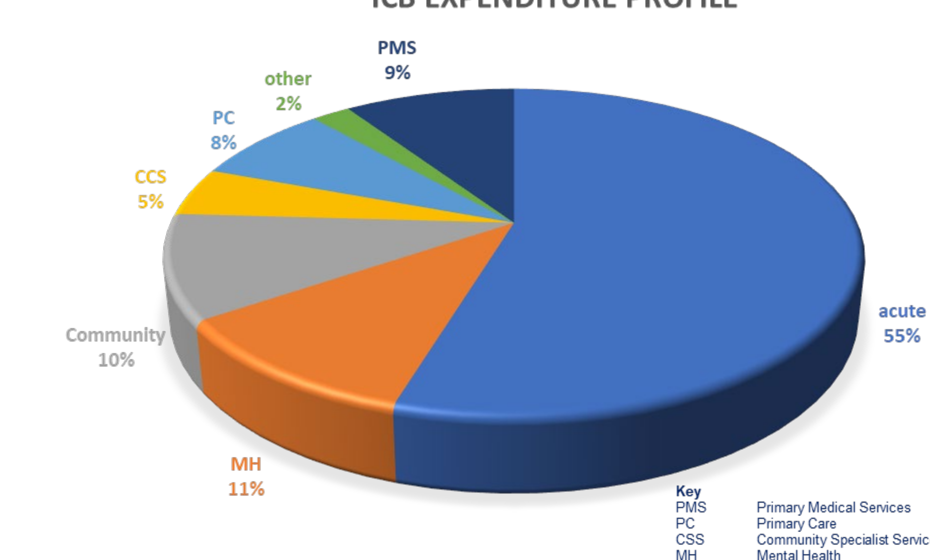
Long term conditions

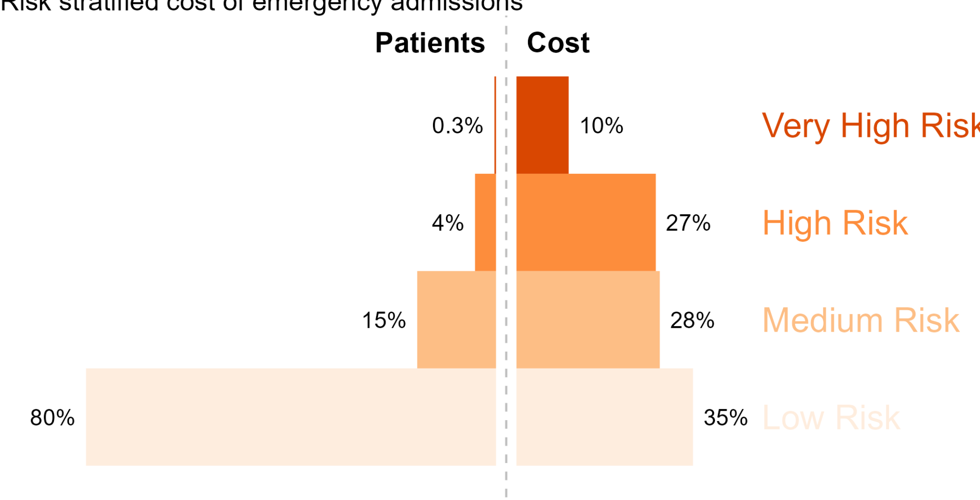
- Across north east London, one in four (over 600 thousand people) have at least one long term condition, with significant variation between our places (in Havering the figure is 33%, vs 23% in Newham and Tower Hamlets).
- Age and deprivation are strong predictors of long term conditions, so while north east London has a relatively young population, significant areas of deprivation drive our numbers up (those in the poorest areas, the bottom deprivation quintile, can on average expect to get a long term condition around 10 years earlier than those in the best off, the top deprivation quintile)
- In 21/22 those with long term conditions accounted for 139,213 A&E attendances; 53,676 emergency admissions and 488,057 bed days.

Source(s): *GPAD, **Discovery, ***Edenbridge APEX

We need to move away from the current blend of care provision which is unaffordable

- The system has a significant underlying financial deficit, held within the Trusts and the ICB. Going into 2023/24 this is estimated to be in excess of £100m. This is due to a number of issues, including unfunded cost pressures.
- 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 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 (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. The variation is at odds with the government's intended formula (which is based on SMR<75) and is the result of grants largely being based on historical public health spend. This impacts on our ability to invest upstream in preventative services.
- As a system the majority of our spend is on more acute care and we know that this is driven by particular populations (0.3% of the population account for 10% of costs associated with emergency admissions; just under 20% account for 65%).





Percentage of emergency admission cost and patients attributable to risk bands for expected risk of admission for patients registered with a NEL GP in February 2023. Combined Predictive Model run on NEL SUS data estimates risk of admission. Cost of all emergency admissions to patients in each risk band in FY22/23 to January 2023 extracted from SUS. Patients with no risk score have been excluded from the analysis but follow a similar pattern to the low risk group. Data from NEL data warehouse.

* Capital figures are based on 2022/23. Norfolk and Waveney ICB received £98.5m capital in 22/23 and has a population of 1.1m people

5. How we are transforming the way we work

Across the system we are transforming how we work, enhancing productivity and shifting to a greater focus on prevention and earlier intervention

- The previous section set out the challenges that the north east London health and care system needs to address to succeed in its mission to create meaningful improvements in health and wellbeing for all local people
- North east London's portfolio of transformation programmes has evolved organically over many years: rooted in the legacy CCGs and sub-systems, then across the system through the North East London Commissioning Alliance and the single CCG, and now supplemented by programmes being led by our place partnerships, provider collaboratives, and NHS NEL.
- It has never previously been shaped or managed as a single portfolio, aligned to a single system integrated care strategy.
- As part of moving to this position, this section of the plan baselines the system portfolio with programmes set out according to common descriptors – providing a single view never previously available across the system, with the scale of the investment of money and staff time in transformation clearer than ever before.
- This section sets out how partners across north east London are responding to the challenges described in the previous section. It describes how they are contributing to our system priorities by considering five categories of improvement

1. Our core objectives of high-quality care and a sustainable system

2. Our NEL strategic priorities

3. Our cross-cutting programmes

4. Our supporting infrastructure

5. Local priorities within NEL

Urgent and emergency care

The benefits that north east London's local people 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
  - Consistently meeting 70% + UCR target NEL target is 90% meet trajectory count of 9995 local people 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 i.e. 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 local people 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 local people 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 local people supported by the end of 23/24 in accordance with trajectory for the service
- Electronic Single Point of access pull Pilot to increase number of local people 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

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 to deliver the full programme of work, ICB prioritisation may be required
- Variation of the way service is configured across NEL
- 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 local people 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 local people 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 local people
  - 2,000 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 local people 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 engagement and co-production with local people
- 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 local people 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 local people 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 local people 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 and 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 local people 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 local people
- By April 2024 we will have reduced the variation in community/out of hospital service access across NEL specifically in ENT, MSK, dermatology, gynaecology and ophthalmology
- By April 2024 local people and communities able to access community diagnostic services in Barking and Mile End.

Key programme features and milestones:

The Planned Care Recovery and Transformation portfolio is designed to meet national requirements for recovering and transformation of 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 and Mile End
- Ophthalmic outpatient/diagnostic/surgical centre-Stratford
- Additional theatre capacity in Newham, Ilford and Hackney.

Further transformation to be planned in this area:

- Over the next two years
  - Development of referral optimisation tools across NEL
  - Review of 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 and revenue funds

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

- Workforce – ability to recruit workforce to fill vacancies, creation of CDCs and 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 local people 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 local people 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 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 conditions

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 co-produced 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 have 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 local people will experience by April 2024 and April 2026:

- April 2024:
  - ➢ All women experiencing urinary incontinence to be able to access postnatal physiotherapy up to 1 year post delivery
  - ➢ Reduced unwanted variation in the delivery of care (through the regional service specification)
  - ➢ Increased breastfeeding rates, especially amongst babies born to women from black and minority ethnic groups or those living in the most deprived areas
- April 2026:
  - ➢ The majority of women are offered Midwifery Continuity Care, prioritising the provision to women from Black and minority ethnic (BAME) groups who will benefit from enhanced models of 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 local people and communities:

- By reducing stillbirth, maternal mortality, neonatal mortality, and serious brain injury in women and babies from BAME groups and women from deprived areas. National ambition to reduce by 50% by 2025
- By closely aligning maternity and neonatal care to deliver the best outcomes for women and their babies who need specialised care
- By improving personalised care for women with heightened risk of pre-term birth, including for younger mothers and those from BAME groups and deprived backgrounds
- By ensuring that all providers have full baby-friendly accreditation and that support is available to those who are from BAME groups and/or living in deprived areas who wish to breastfeed their babies

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
- Implementing the NEL equity and equality action strategy and action plan
- Implementation of the Senior Maternity and neonatal advocate role across NEL

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	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

Babies, children, and young people

The benefits that north east London local people 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 children's 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 local people and communities:

- 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 children's 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 and 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 local people will experience by April 2024 and April 2026:

April 2024:
- By 2024 all eligible local people 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 local people who achieve T2 diabetes remission,
- Increased personalised care plans through population Health Management and co-production
- 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 local people 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 local people. By **2024 virtual CKD Clinics** will be available across NEL
- Early and 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 local people and communities:

- 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 local people with TIA which currently ranges between 40% for BHR local people to 92% for City and Hackney local people
- 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 and 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)
- Co-produce 7 day TIA service with local people so that 90% of people with TIA will have access 7 days a week to a stroke professionals who can provide specialist assessment and treatment within 24 hours of symptom onset thus preventing long term disability
- 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

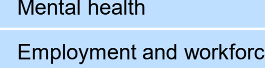
Programme funding:
- See reference pack for details
- SDF funding
- IHIP funding
- Pooled resources
- Health inequality funding
- NHSE funding

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 affecting delivery of NEL wide plans to address regional, national and local ambitions.
- Financial reduction in NHS SDF funding in 23/24 affecting 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 local people will experience by April 2024 and April 2026:

April 2024:

- A common personalised care planning tool focused on what matters most to service users (DIALOG) will be in place across all of north east London by the end of 2023/24
- Personal development and support will be available through our Lived Experience Leadership Programme for children, young people and adults with lived experience of mental health, which will enable service users and carers to co-produce/co-deliver improvements across the system, and work towards paid employment, if that is their aim
- Additional adult mental health hospital beds to ensure people do not experience long waits in emergency departments, coupled with improved crisis support services in the community

April 2026:

- Increased numbers of peer support workers across all-age mental health services, with a coordinated approach to training, recruitment, support and retention across the system
- Improved equity of access, outcomes and experience of NHS Talking Therapies for minoritised communities and other under-served populations (e.g. people with long term health conditions and older adults)
- Equity of access to physical health checks for people with severe and enduring mental illness, in particular for people from minoritised communities and people living in the most deprived communities
- Working towards an equitable offer of support to children and young people in 100% of secondary schools

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

- The partners of the Mental Health, Learning Disability and Autism Collaborative have commissioned a system diagnostic to help us understand the outcomes, experience, equity and value that patients receive for the money we spend on mental health services across the system. The outputs of this work will help to shine a light on the inequities between boroughs, but also between communities and groups with protected characteristics. It will pave the way for a more equitable approach to resource allocation in the future
- Using Quality Improvement tools and techniques we are developing a number of improvement networks to lead the programmes of work that are best delivered at scale, led by clinicians and service users. Improvement networks focus on sharing learning, reducing unwarranted variation, and tackling health inequalities within and between borough populations
- For example, through our Crisis Improvement Network and service user 'Think Tank' we are committed to developing and testing plans to address the over-representation of black men being detained in hospital for treatment
- The Mental Health, Learning Disability and Autism Collaborative is committed to developing and implementing anti-racist commissioning practices which aim to build trust between the NHS and VCSE organisations, deliver more equitable and sustainable funding to the sector and improve the health and wellbeing of minoritised communities

Key programme features and milestones:

- By the end of summer 2023 we will have recruited to our dedicated People Participation Lead and People Participation Worker to develop our Lived Experience Leadership Programme for adults with mental health needs
- By September 2023 we expect to have finalised the outputs of the system diagnostic
- By November 2023 we will have opened additional acute bed capacity at Goodmayes Hospital
- By January 2024 we will have completed our business case for Lived Experience Leadership resource for children and young people

Further transformation to be planned in this area:

Over the next two years:

- We will roll-out NHS 111 press 2 for mental health and improve our existing mental health crisis lines and crisis alternatives
- We will expand NHS Talking Therapies to include 16 and 17 year olds

Over years three to five:

- We expect our Lived Experience Leadership Programme to enable service users and carers to initiate transformation and improvement projects themselves, supported by our programme team and the networks

Programme funding:

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

Leadership and governance arrangements:

- Mental Health Learning Disability Autism Collaborative Committee (we are expecting this to become a joint committee of the ICB, ELFT and NELFT Boards from July 2023 onwards)
- Programme boards
- Improvement networks
- NEL ICS Place-based partnership boards and local governance arrangements

Key delivery risks currently being mitigated:

- In some boroughs, reduced access to some mental health services (e.g. NHS Talking Therapies, Children's Eating Disorder Services) has been caused by high numbers of staff vacancies. These will be mitigated through focused efforts to improve recruitment and retention in our Improvement Networks
- Some programme areas / improvement networks sit across multiple portfolios (e.g. paediatrics, long term conditions, primary care, frailty, end of life, planned care, social care, acute) which means there can be a lack of clarity across places and the system on leadership and improvement goals. This risk could be mitigated through the support of the NEL Senior Improvement Advisers to coordinate across collaboratives and pathways of care

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

Employment and workforce

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

- April 2024:
  - ➢ By April 2024 we will deliver 900 jobs in health and care across 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:
  - ➢ Establish a permanent hub for local population to access job opportunities in health and care
  - ➢ Methodology for planning and introducing new roles building on the learning from collaboratives and development of new services and approaches (St George's health hub)

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

- By providing employment opportunities to our local people in our health and care organisations providing employment to ensure social mobility
- By ensuring opportunity and development to our local people to reduce deprivation and health opportunities
- By providing career pathways for our staff to develop skills that deliver effective health and care to our population
- 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 delivery of activity and finance requirements from 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
  - ➢ Build and grow out of hospital workforce with focus on development on GP and Primary Care workforce to deliver services at Neighbourhoods
  - ➢ 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
  - ➢ To explore feasibility of training academies to support pipeline

Programme funding:

- Currently non recurrent, Funding from NHSE and GLA against long NEL priorities
- Funding redistribution to NEL strategic priorities 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

Health inequalities

The benefits that north east London local people will experience by April 2026:

- Reduced differences in health care access, experience and outcomes between communities within north east London, particularly for people from ethnic minority communities, people with learning disabilities and autism, people who are homeless, people living in poverty or deprivation, and for carers.
- Improved healthy life expectancy for all communities across north east London, irrespective of who you are or where you live.
- Our population receives more inclusive, culturally competent and trusted services, underpinned by robust equity data.

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

Reducing health inequalities is a cross-cutting theme embedded within all of our transformation programmes within places and across NEL. Improving health equity and population health is a core focus for our place-based partnerships and neighbourhoods. For example, dedicated health inequalities funding has been provided to each place to lead locally determined programmes to reduce health inequalities within their local communities.
Taking a population health management (PHM) approach, led by places and neighbourhoods, will support frontline teams to identify high risk groups and address unmet health need. A PHM Roadmap has been developed for NEL.

To support opportunities across NEL, some specific targeted inequalities programmes have been developed including for Refugees and Asylum Seekers, Homelessness, Tobacco dependence treatment services, Developing a NEL anchor system and Net Zero and implementing the Green Plan (see related JFP reference pack for details). We have also established enabler programmes to support system-wide work on health equity:

- Establishing a NEL Health Equity Academy will support people and organisations working in health and care in north east London to be equipped with the knowledge, confidence and skills to reduce health inequalities.
- Agreeing a shared ambition to reduce health inequalities, and funding local action towards achieving this ambition over three years.

All programmes and services will support the Core20Plus5 and the ICP Strategy:

- Applying a poverty lens to all our work. This includes paying particular attention to the health and social needs of people living in poverty, reviewing their access to, and usage of, services, tackling unmet need, and addressing the wider determinants of health through making every contact count and through our role as anchors.
- Ensure we are measuring and addressing ethnic disparities, including in our waiting lists, a strong focus also on cultural competency, building trust and tackling racism.
- Support for carers running through all our priorities and wider transformation programmes.
- Ensure all services are accessible, appropriate and effective for people with learning disabilities and autism, increase the number and quality of annual health checks and vaccinations for Covid-19 and flu, reviewing deaths to ensure we have up to date data and action plans to address health inequalities and safeguarding.
- Collaborate to improve the quality of health and care services for people experiencing homelessness and reduce the mortality gap between people who are homeless and the rest of the population.
- We are committed to being an intentionally anti-racist system where we prioritise anti-racism, understand lived experience of staff and local people, grow inclusive leaders, act to tackle inequalities and review progress regularly.
- Build our understanding and recognition of intersectionality.
- Review the impact of local place based partnerships in reducing health inequalities and accelerate and invest in scaling up good practice.

Key programme features and milestones:

- Launch NEL Health Equity Academy, September 2023
- Establish the Shared System Ambition, Summer 2023
- Evaluations of place health inequalities projects (22/23 funding), September 2023
- Mobilisation of 3 year place health inequalities plans, Summer 2023

Further transformation to be planned in this area:

- Development of an anti-racism plan.
- Development of a health inequalities outcomes framework.
- Revise and update the NEL population health profile.
- Development of a QI approach for health equity.

Programme funding:

- £6.6m per year for health inequalities funds at place, health equity academy and shared ambition.
- ~£1m per year for tobacco (in baselines from 24/25).

Leadership and governance arrangements:

- Place Based Partnerships
- NEL Population Health & Integration Committee
- NEL Population Health & Health Inequalities Steering Group

Key delivery risks currently being mitigated:

- Financial risk –lack of recurrent investment combined with high inflation affecting sustainability of current provision in some areas e.g. tobacco
- Workforce – capacity, skills and expertise to do everything we can across the system to improve health equity

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

Fuller

The benefits that North East London local people will experience by April 2024 and April 2026:

April 2024:
- Improve same day access through better sign posting and cloud telephony, which enables local people to access different types of health and care professionals in their neighbourhood without having to access specialist services
- Developing a community of practice for Places with regards to enabling local people to access different types of health and care professionals in their neighbourhood without having to access specialist services
- Continue to increase the utilisation of Additional Roles Reimbursement Scheme roles
- Review the requirements at Place and NEL

April 2026
- Local people to be able to access integrated same day services with clear access points and integrated routes between primary and secondary care provision
- Increased population health-based personalisation of people's care at neighbourhood level through wrapping integrated neighbourhood teams around our local people and enabling neighbourhood teams to deliver the majority of care to the population,
- Improve the patient experience through a stable workforce with good retention and staff attendance through a systematic focus on all elements of the NHS People Promise
- Provide seamless care to local people by giving staff access to all the information they need in one place and enable them to share this information safely
- Put in place the appropriate infrastructure and support for all neighbourhood teams
- Reduced health inequalities

How this transformation programme reduces inequalities between north east London's local people and communities:
- This programme works to
  - Shift the culture change needed within our different providers (PC/acute/community/MH) to work as Integrated Neighbourhood Teams around the patient to deliver personalised care
  - Support PCNs and Places to develop and drive the Integrated Neighbourhood Teams implementation and Increased co-location of services and community teams, bringing holistic care closer to home
  - A streamlined integrated approach to managing same day care to ensure local people receive the same level of care regardless of where they live in north east London

Key programme features and milestones:

Same day Access
- Develop better signposting for health care professionals (Q4)
- Pilot, within multiple PCNs, the use of cloud based telephony (Q4)
- Review the interoperability of appointments between primary and urgent care (Q3)
- Develop a contracting framework of in-hours and out-of-hours services (Q3)

Continuity of care
- Establishing a Community of Practice forum (Q2)
- Arrange NEL wide workshop to review current practice (Q1)

People
- Embed the Fuller appraoch of Integrated Neighbourhood teams (Q4)
- Support PCN development and establish a community of practice for ARRS roles (Q3)

Infrastructure
- Deliver Digital First programme (Q4)
- Work with the Local Infrastructure Forum to define estate needs (Q4)

Further transformation to be planned in this area:
- Baselining of the work currently progressing at Place regarding Continuity of Care
- Deliver a NEL workshop bringing together Places to review and share learning of local programmes of work
- Further work regarding recruitment and retention of staff across NEL, particularly focusing on the Additional Roles Reimbursement Scheme
- Establishment of working and task and finish groups to support delivery

Programme funding:
- Currently no programme funding aligned to this programme
- Funding for the programme is proposed to come from existing transformation funding

Leadership and governance arrangements:
- SROs have been confirmed for the four Fuller workstreams, Chief strategy and transformation officer, Medical Director, Chief place and participation officer and MD of Primary Care
- A Fuller Steering Group established with an Oversight Board also proposed
- Currently working to set up workstream Working groups and subsequent task and finish groups will report into the Steering Group

Key delivery risks currently being mitigated:
- Lack of programme funding may limit scope of deliverables
- Lack of programme management to coordinate and drive delivery
- Lack of engagement

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

Physical infrastructure

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

- Across NEL ICS organisations, there are 332 estates projects in our pipeline over the next 5 /10 years, with a total value of c. £2.9 billion
- These include the redevelopment of Whipps Cross hospital and a new centre on the site of St George's, Hornchurch
- Formal opening of new St George Health and Wellbeing Hub – **Spring 2024**

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

- Infrastructure transformation is clinically led across the footprint whilst also achieving the infrastructure based targets set by NHSE.
- Our vision is to drive and support the provision of fit for purpose estate, acting as an enabler to deliver transformed services for the local population. This is driven through robust system wide Infrastructure planning aligned to clinical strategies, which is providing the overarching vision of a fit for purpose, sustainable and affordable estate.

Key programme features and milestones:

- Acute reconfiguration £1.2bn (includes estimated total for Whipps Cross Redevelopment of c. £755m)
- Mental Health, £110m
- Primary and Community Care, £250m
- IT systems and connectivity, £623m (inc. NEL Strategic digital investment framework c.£360m)
- Medical Devices replacement, £256m
- Backlog Maintenance, £315m
- Routine Maintenance inc PFI, £160m

Further transformation to be planned in this area:

- Construction will be undertaken where possible using modern methods in order to reduce time and cost and will be net carbon zero.
- Consider use of void spaces and transferred ownership of leases to optimise opportunity to meet demand and contain costs.
- Support back-office consolidation

Programme funding:

- Over the next 10 years there is expected to be a c£2.9bn capital ask from programmes across NEL

Leadership and governance arrangements:

- System-wide estates strategy and centralised capital pipeline
- Capital overseen by Finance, Performance and Investment Committee of NHS NEL.

Key delivery risks currently being mitigated:

- Recent hyperinflation has pushed up the cost of many schemes by as much as 30%. Currently exploring how to mitigate this risk, including reprioritisation
- Exploring opportunities for investment and development with One Public Estate, with potential shared premises with Councils

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 local people will experience by April 2024 and April 2026:

- Improve accuracy of record keeping and recall within the Trusts, enabling patients to 'tell their story once', enabling 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 local people 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 NHS App as the 'front door' to NHS services, including Patients Know Best (PKB), primary care record, Online Consultations and ordering of repeat prescriptions
- Maternity service digitisation Expanding the Electronic Prescription Service to outpatient services
- Significant investment in facilitators has been made by Digital First to support practice staff to utilise new digital products
- Specific programmes such as PKB include investment in change management and clinical leadership to embed new ways of working

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	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

Finance

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

- Improving quality and outcomes for local people of north east London
- Securing greater equity for our residents
- Maximising value for money
- Deepening collaboration between partners

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

- Incentivising transformation and innovation in clinical practice and the delivery of services to improve the outcomes of local people
- Supporting delivery of care closer to patients' homes, including investing in programmes that take place outside the hospital environment
- Refocus how the money is spent to focus on population health, including proactive measures that keep people healthier and to level up investment to address historical anomalies of funding
- Increasing investment in prevention, primary care, earlier intervention and the wider determinants of health, including environmental sustainability

Key programme features and milestones:

- Supporting our providers to reduce transactional costs, improve efficiency and reduce waste and duplication
- Support the financial stability of our system providers and underpinning a medium to long term trajectory to financial balance for all partners
- Recognising existing challenges, including that NEL is, as a SOF 3 ICS, financially challenged with a growing population and an acute provider (BHRUT) in SOF 4 for financial performance.
- Ensuring we do not create unnecessary additional financial risk, especially in the acute sector
- ICS investment pool to fund programs designed to reduce acute demand
- Finance development programme to agree overall budgets and develop place based budgets and budgetary delegation to place
- Effective integration of specialised commissioning, community pharmacy, dental and primary care ophthalmology services

Further transformation to be planned in this area:

- Supporting the integration of health and social care for people living with long term conditions who currently receive care from multiple agencies
- Ensuring that all partners are able to understand and influence the total amount of ICB resources being invested in the care of local people.

Programme funding:

- ICB plan submitted with a total budget of £4,218m
- Specific transformation budgets, including health inequalities, virtual wards, physical, demand and capacity funding

Leadership and governance arrangements:

- Reporting to the ICB Board and Place Partnership Boards
- Finance, Performance and Investment Committee
- Audit and Risk Committee
- CFO lead monitoring of monthly and forecast performance

Key delivery risks currently being mitigated:

- Risk to delivery of a balanced financial position. Mitigated by delivery of efficiencies, delay of planned investments

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

Further programmes

Across our partnership there are many further programmes, beyond those described above, 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.

Further local priorities

Led by	Programme
Acute provider collaborative	Critical care
	Research and clinical trials
	Specialist services (also see p53 to 58)
Mental health, learning disabilities, and autism collaborative	Lived experience leadership programme
	Learning disabilities and autism improvement programme
Barking and Dagenham place partnership	Ageing well
	Healthier weight
	Stop smoking
	Estates
City and Hackney place partnership	Supporting with the cost of living
	Population health
	Neighbourhoods programme
Havering place partnership	Infrastructure and enablers
	Building community resilience
	St George's health and wellbeing hub
	Living well
	Ageing well
Newham	Neighbourhood model
	Population growth
	Learning disabilities and autism

Further local priorities

Led by	Programme
Newham	Ageing well
	Primary care
	Newham Proactive Care Model
Redbridge place partnership	Health inequalities
	Accelerator priorities
	Development of the Ilford Exchange
Tower Hamlets place partnership	Living well
	Promoting independence
Waltham Forest place partnership	Centre of excellence
	Care closer to home
	Home first
	Learning disabilities and autism
	Wellbeing
NHS North East London	Tobacco dependence programme
	NEL homelessness programme
	Anchors programme
	Net zero (ICS Green Plan)
	Refugees and asylum seekers
	Discharge pathways programme
	Pharmacy and Medicine Optimisation/ NEL
	Fuller implementation

Strategic alignment with local health and wellbeing priorities

Hackney

- Improving mental health
- Increasing social connection
- Supporting greater financial security

Waltham Forest

- The best start in life to develop, thrive and achieve
- Healthy, longer, happy lives prosperous, active and sustainable
- Thriving maturity and protected community: safe, supported and independent

Redbridge

- Achieving the best start in life
- Diabetes prevention and management
- Mental wellbeing
- Cancer survival
- Living well in a decent home you can afford
- End of life care

Havering

- Assisting people with health problems (back) into work
- Further developing the Council / NHS Trusts as 'anchor institutions'
- Provide strategic leadership for collective efforts to prevent homelessness and the harm caused
- Realising the benefits of regeneration for health and social care services
- Improve support to residents whose life experiences drive frequent calls on health and social care services
- Obesity
- Reducing tobacco harm
- Early years providers, schools / colleges as health improvement settings
- Development of integrated health and social care services for CYP and adult s at locality level

City of London

- Good mental health for all
- A healthy urban environment
- Effective health and social care integration

Page 482

Waltham Forest
Redbridge
Havering
City and Hackney
Barking and Dagenham
Newham
Tower Hamlets

Tower Hamlets

- We can all access safe, social spaces near our homes, so that we can live active, healthy lives as a community
- Children and families are healthy, happy, and confident
- Young adults have the opportunities, connections and local support they need to live mentally and physically healthy lives
- Middle-aged and older people are enabled to live healthy lives and get support early if they need it – whether it is for their mental or physical health
- Anyone needing help knows where to get it, and is supported to find the right help

Newham

- Enabling the best start through pregnancy and early years
- Supporting our young people to be healthy and ready for adult life
- Supporting people around the determinants of their health
- Developing high quality inclusive services, ensuring equity and reducing variation
- Meeting the needs of those most vulnerable to the worst health outcomes
- Creating a healthier food environment
- Supporting active travel and improved air quality
- Creating an active borough
- Supporting a Newham of communities where people are better connected and supported
- Working towards a smoke free Newham
- Building a borough of health promoting housing
- Building an inclusive economy and tackling poverty

Barking and Dagenham

- Best Start in Life
- Early Diagnosis and Intervention
- Building individual and community strength

*Note these are joint health and wellbeing priorities which may evolve as place based partnerships become more established

What engagement we have done so far

- We have engaged with various partners across NEL, these include Health and Wellbeing Boards, Place-based Partnerships, Provider Collaborative groups and Care Providers, as well as internal staff lunch and learn sessions.
- Acknowledgment that a lot of work has gone into the JFP, further work to be done on looking ahead in the future
- We have received **support of the NEL JFP direction of travel** and appreciation of seeing all the transformation plans in one place.
- Further work is needed to ensure that places and collaboratives can fully see their priorities reflected in the NEL wide plan.
- We are now looking to establish an on-going dialogue with our local people and wider partners to reflect their needs and priorities.
- We have created a summary version of our JFP which is more accessible to the general public.

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 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 tells us we need to:
  - better understand and explain the specific beneficial impact of each programme for local people 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;
  - ensure we have a consistent way of prioritising across north east London's transformation portfolio;
  - 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 on as we update the plans and programmes described over the coming months.

Next steps for our transformation programmes

- As the early analysis shows, all programmes within the portfolio can demonstrate alignment with elements of the integrated care strategy and operating plan requirements. The extent to which the portfolio responds to the more specific challenges described in the first half of this plan is more variable.
- Our shared task now is to prioritise (and therefore deprioritise) work within the current portfolio according to alignment with the integrated care strategy, operating plan requirements, and additional specific local challenges.
- This task is especially urgent in light of the highly constrained financial environment that the system faces, along with the upcoming significant reduction in the workforce within NHS North East London available to deliver transformation.
- The work required to achieve this is two-fold – part technical and part engagement – and will be carried out in parallel, with the technical work providing a progressively richer basis for engagement across all system partners and with local people.

Technical work

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

- the **quantifiable beneficial impact** on local people, beyond the broad increases or decreases in certain measures currently signalled;
- the definition of **firm milestones** on the way to delivering these benefits;
- the **financial investment** in each programme and the anticipated returns on this investment; and
- quantifying the **staff resource** going into all programmes, and from all system partners.

Engagement

There is an important cross-system conversation needed, that enables us to create a portfolio calibrated to the competing pressures on it. Principle pressures to explore through engagement include:

- achieving early results that relieve current system pressures *and* creating the resources to focus on achieving longevity of impact from transformation around prevention;
- implementing transformation with a wide range of benefits across access, experience, and outcomes *and* ensuring, in the current financial climate, that we achieve the necessary short-term financial benefits;
- focussing on north east London's own local priorities *and* being open to additional regional or national opportunities, especially where new funding is attached;
- focussing on fewer large-impact transformation programmes *and* achieving a breadth that reflects the diversity of need and plurality of ambition across north east London; and
- ensuring that benefits are realised from transformation work already in train *and* pivoting to implementing programmes explicitly in line with current priorities.

We will continue to evolve as a system

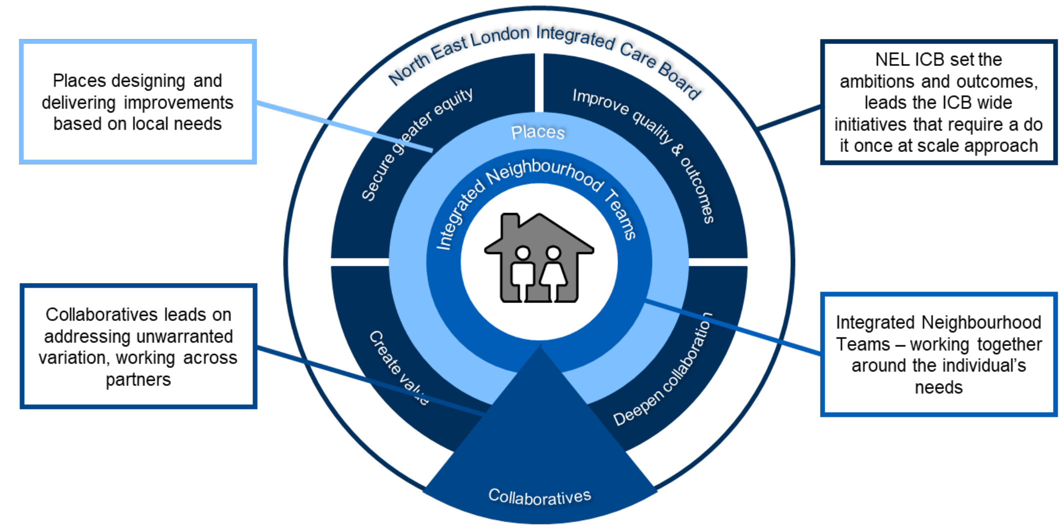
Our system has been changing rapidly over recent years, including the inception of provider collaboratives, the launch of seven place based partnerships, the merger of seven CCGs followed by the creation of the statutory integrated care board and integrated care partnership in July 2022.

Since becoming an ICS we have designed our way of working around teams operating:

- At **Place** delivering services and improvement for Neighbourhoods and Place;
- In **Collaboratives** reducing unwarranted variation, driving efficiency and building greater equity;
- For **NEL** sharing best practice, implementing NEL solutions for NEL work, providing programmatic support and oversight, and delivering enabling functions to our organisation and ICS through a business partner model.

Coordination between our Places, Collaboratives and NEL wide programmes is critical so that we:

- Operate as a learning system and spread best practice
- Ensure that activity, transformation and engagement happens at the most appropriate level, duplication is reduced and tensions are identified and resolved
- Identify where there is NEL work which should be done once for NEL
- Deliver value for money
- Deliver beneficial and sustained impact for the health and wellbeing of local people.



We are now looking to work with our partners to further develop how we work together, underpinned by our ambition to create a **High Trust Environment** that supports integration and collaboration and to operate as a **Learning System** driven by research and innovation.

Designing together *how* we want to work will be as critical as agreeing *what* we want to deliver.

This will help us get greater clarity on the responsibilities of different parts of the system, and critically how we want each part of the system to interact with another to enable integration and continuous improvement.