Public Document Pack

Health and Wellbeing Board

Date: **MONDAY, 11 FEBRUARY 2019**

Time: **1.45 pm**

Venue: **COMMITTEE ROOMS**

Members:
Deputy Joyce Nash (Chairman)
Marianne Fredericks (Deputy Chairman)
Randall Anderson
Tom Anderson
Jon Averns
Matthew Bell
Dr Penny Bevan
Andrew Carter
Dr Gary Marlowe
Jeremy Simons
Gail Beer
David Maher
Kate Smith

Enquiries: **Julie Mayer – 0207 3321410**
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Lunch will be served in the Guildhall Club at 1pm

John Barradell
Town Clerk and Chief Executive

AGENDA

Part 1 - Public Reports

1. **APOLOGIES OF ABSENCE**

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

3. **MINUTES**
To agree the public minutes of the previous meeting.

For Decision
(Pages 1 - 10)

4. **ANNUAL REVIEW OF TERMS OF REFERENCE**
Report of the Town Clerk.

For Decision
(Pages 11 - 12)

5. **DEVELOPMENTS WITHIN THE PRIVATE SECTOR RE PROVISION OF CORPORATE AND INDIVIDUAL CARE PACKAGES IN A TECHNOLOGICAL AGE**
A presentation from PPP Taking Care.

For Information

6. **THE CITY AND HACKNEY SAFEGUARDING ADULTS BOARD (CHSAB) ANNUAL REPORT 2017/18**
Report of the Director of Community and Children's Services.

For Information
(Pages 13 - 16)

7. **INTEGRATED COMMISSIONING - PREVENTION WORKSTREAM UPDATE**
Report of the Director of Community and Children's Services.

For Information
(Pages 17 - 44)

8. **SYSTEM COMMISSIONING INTENTIONS 2019/20 AND FEEDBACK FROM ENGAGEMENT**
Report of the Integrated Commissioning Programme Director.

For Information
(Pages 45 - 70)

9. **SOCIAL WELLBEING STRATEGY ANNUAL UPDATE**
Report of the Director of Community and Children's Services.

For Information
(Pages 71 - 116)

10. **DRAFT CARERS STRATEGY**
Report of the Director of Community and Children's Services.

For Decision
(Pages 117 - 150)

11. **AUTOMATED EXTERNAL DEFIBRILATORS - FINDINGS FROM CORPORATE SURVEY**
Joint report of the Director of Community and Children's Services and the Director of Human Resources.

For Decision
(Pages 151 - 164)

12. **MENTAL HEALTH SERVICES FOR CHILDREN AND YOUNG PEOPLE**
Report of the Director of Community and Children's Services.

For Information
(Pages 165 - 174)

13. **HEALTH AND WELLBEING BOARD UPDATE REPORT**
Report of the Director of Community and Children's Services.

For Information
(Pages 175 - 192)

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

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

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

For Decision

Part 2 - Non-Public Reports

17. **NON-PUBLIC MINUTES**
To agree the non-public minutes of the previous meeting.

For Decision
(Pages 193 - 194)

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

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

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HEALTH AND WELLBEING BOARD

Friday, 23 November 2018

Minutes of the meeting of the Health and Wellbeing Board held at Committee Rooms - Committee Rooms on Friday, 23 November 2018 at 11.30 am

Present

Members:
Marianne Fredericks (Deputy Chairman, in the Chair)
Randall Anderson
Jon Averns
Dr Penny Bevan
Andrew Carter (Director, Community and Children's Services)
Dr Gary Marlowe
Jeremy Simons
David Maher
Gail Beer
Kate Smith

Officers:

Lorraine Brook	-	Town Clerk's Department
Chloe Rew	-	Town Clerk's Department
Chandni Tanna	-	Town Clerk's Department
Rosalind Ellis	-	City of London Police
John Peacock	-	City of London Police
Farrah Hart	-	Community and Children's Services Department
Adrian Kelly	-	Community and Children's Services Department
Xenia Koumi	-	Community and Children's Services Department
Chris Pelham	-	Community and Children's Services Department
Samantha Tharme	-	Department for Built Environment

1. **APOLOGIES OF ABSENCE**
   Apologies for absence were received from Deputy Joyce Nash and Matthew Bell.

2. **DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**
   A declaration was made by Dr Gary Marlowe in respect of Item 5 (City of London Health Protection) by virtue of being Chair of the London Regional Council of the British Medical Association (BMA).

3. **MINUTES**
   The Board considered the minutes of the last meeting held on 21st September 2018.

RESOLVED – That the minutes of the last meeting held on 21st September 2018 be approved as an accurate record, subject to the following amendments:-

(i) John Averns was not in attendance; and
(ii) Xenia Koumi, Project Lead – Business Healthy for Community and Children's Services and Nicole Klynman, Public Health Consultant for City and Hackney, were in attendance.

Matters Arising

1. ***Item 5: Health and Wellbeing Update Report***
   It was noted that a subsequent update on mental health services for young people would be provided at the next meeting of the Board.
2. ***Item 8: Health Care Provision for People Sleeping Rough in the City of London*** It was noted that there was currently no update.
3. ***Item 9: Voluntary Smoke Free Space in Finsbury Circus***
   Members were advised that a delay of nine months to Finsbury Circus being returned to the City was anticipated, with reinstatement expected in summer 2019.
4. ***Item 10: Developing a New Housing Strategy***
   In respect of the housing strategy, the Chairman of the Community and Children's Services Committee advised that an update would be provided at a future meeting.

4. **RIVER CAMERAS PROJECT - UPDATE**

The Board received a report of the Commissioner of the City of London Police relative to an update on the River Cameras Project which was considered by the Police Committee on 20th September 2018. In light of the work being undertaken by the City of London Police around suicide prevention and the protection of vulnerable people, both of which were relevant to the work of the Health and Wellbeing Board, the Committee had asked that the report be submitted to the Board for information.

Members were advised that due to funding issues, progress with the project had been slow. The Deputy Chairman expressed dissatisfaction with the lack of progress with the project which had now been incorporated within the broader Ring of Steel project, particularly as funding had already been identified through Bridge House Estate (BHE). A number of Members commented that they had previously been assured that the River Cameras project would proceed as a separate piece of work.

Members suggested that the project should be delivered in conjunction with the Bridge Illumination project and should include thermal imaging technology.

RESOLVED – That

(i) the report be noted; and
(ii) the Board's concerns in respect of delays to the River Cameras project be submitted to the Police Committee and an update in respect of progress with the project, submitted to the next meeting of the Board.

5. **CITY OF LONDON HEALTH PROTECTION**

The Board received a presentation from Dr Deborah Turbitt regarding Public Health Protection. The presentation addressed communicable disease and environmental hazards in the City, monitoring both residents and workers in the City. It was noted that the City generally had a low disease rate, but the following were present in the City:- food-borne illnesses, measles and scarlet fever.

Following the presentation, a number of queries were raised by members of the Board.

In respect of Measles and how those individuals who did not receive the Measles, Mumps and Rubella (MMR) vaccine as children could be vaccinated in order to prevent outbreak, it was suggested that, amongst other solutions, vaccinations could be offered to those entering university or graduate studies.

In respect of Tuberculosis (TB) it was suggested that, due to supply restrictions, only some boroughs had been offering TB vaccinations, which meant that the disease could potentially spread across boroughs. However, Dr Turbitt stated that the supply issue had now been resolved and all boroughs should be vaccinating against TB.

With reference to testing laboratories, some concern was expressed that there was no longer a 24-hour laboratory service in London. Dr Turbitt advised that many hospitals in London now had their own testing facilities and where samples were sent outside of London (i.e. to Birmingham or Cambridge) there continued to be an efficient service with only a 2-hour delay in returning results due to travel time. In light of the comments made by some Members, it was agreed that a further item about the City's position in respect of public health laboratories and vaccinations should be submitted to the Board's next meeting.

Following a query about how food hygiene could be improved in the City in order to reduce food-born illness, it was noted that the City venues were largely well-rated for hygiene. However, with a high number of catered venues in the City, it was important to have a cross-borough dialogue about contractors, to visit premises and establish what food hygiene practices were in place to reduce the risk of food poisoning. Those present were advised that the following food hygiene rating app could be accessed by consumers to check restaurant ratings: https://www.scoresonthedoors.org.uk/

RESOLVED – That:

(i) the presentation and the details presented in respect of Public Health Protection be noted; and

(ii) a further item about the City's position in respect of public health laboratories and vaccinations be submitted to the Board's next meeting.

6. **HEALTHWATCH CITY OF LONDON ANNUAL REPORT 2017/18 AND UPDATE**

The Board received a report from the Chair of Healthwatch City of London (HW CoL) relative to the Annual Report 2017/18 and an update in respect of Healthwatch City of London activity.

The Healthwatch Executive Director advised the Board that since 1 April 2018, when the Healthwatch City of London contract was awarded to Healthwatch Hackney, Healthwatch City of London board members who wished to continue with the organisation had been in discussion with their Healthwatch Hackney colleagues about the future governance arrangements. It was noted that it had not been an easy start to the new arrangements, with a restructure of staff and development of a delivery plan with the Commissioners. The Executive Director explained that it was important that HW CoL continued to remain a separate entity from Healthwatch Hackney so the City's priorities for the coming year were clear. There should also be a greater emphasis on focussed delivery over the coming months.

In respect of delivery, it was noted that HW CoL had been present at three community events since October. However, the HW CoL representatives only spoke to six people, thus highlighting the need for more effective public engagement. 42 people had attended the AGM on 4 October 2018, aiding development of the Healthwatch priorities. Following a staffing restructure and with key people now in place, as well as the appointment of two new Board Members, it was noted that HW CoL was developing its own identity and this would further develop with the appointment of Board Associates.

There was a brief discussion regarding the current and future budget position and reference was made to the GP/patient ratio with some concern expressed that people were struggling to get GP appointments. Whilst it was noted that there had been a deterioration in services provided by Healthwatch since the introduction of the new arrangements, it was important not to duplicate the work of the Commissioners, Members were keen to receive a future update report from Healthwatch setting out deliverables in the City and an overview of the new Communications Strategy which was expected to be in place by January.

RESOLVED – That:

(i) the Healthwatch City of London Annual report 2017/18 be noted;
(ii) the update on Healthwatch City of London activity be noted; and
(iii) an update report about Healthwatch City of London be submitted to the next meeting of the Board.

7. **BETTER CARE AND WELLBEING IN EAST LONDON**

The Board received a report from the East London Health & Care Partnership on better care and wellbeing in East London.

David Maher from the East London Health & Care Partnership advised the Board about the changing role of the Clinical Commissioning Group (CCG) and updated members on the work of the Partnership so far, as highlighted in the report before the Board.

The following issues were referenced:

1. Prevention – the focus was on preventative services in to reduce the need for long term care;
2. Urgent and emergency care – there was room for improvement to ensure that local people were properly linked to local services and resources were used in the most efficient way;
3. Mental health – there was scope for progressive changes in mental health services as highlighted by the triage scheme that had been developed in collaboration with the City of London Police.
4. NHS long-term plan – this was due to be released in December 2018 with a view to 1/4/10 year planning which would influence the report before Members. A further report would therefore be submitted to the Board once the NHS plans were clearer.

With reference to Diabetes, it was noted that this was a pressing problem and a focus for City and Hackney, particularly given the link to obesity. It was suggested that whilst a Diabetes nurse specialist service had been in operation for some time and been positive, the service should be reviewed with consideration given to how new technology could now be used. As a linked factor, it was also important to continue working with restaurants and food outlets to promote healthier eating. Members agreed that the prevention element of this work was vital, and it was important to recognise the complexities within boroughs by using a neighbourhood template to deliver effective prevention strategies that reflect local health issues and community factors. It was noted that the City, which had a low obesity rate and was generally healthy, had introduced a good prevention programme with exercise programmes in City schools, sugar tax, less advertising for fast food, and limited access to unhealthy fast food shops in the city.

A Board Member welcomed the report but queried what was being delivered and how, recognising the complexities of the healthcare environment. Further to this, a query was raised regarding the target audience and it was suggested that the current format might not be easy for the public (i.e. without health sector knowledge) to understand. It was therefore agreed that an update report would be submitted to the next meeting of the Board.

RESOLVED – That-

(i) the report and the update be noted; and
(ii) a further update report be submitted to the next meeting of the Board.

8. **ENDORSEMENT OF HIV STIGMA CAMPAIGN: "U=U"**

The Board considered a report of the Director Public Health relative to the on-going work being done to tackle sexually transmitted infections and their associated stigma. The Director of Public Health updated Members about the Prevention Access Campaign which seeks to tackle HIV stigma by asking organisations to endorse a consensus statement acknowledging that they recognise “Undetectable Equals Untransmittable” (U=U). It was noted that by endorsing the U=U consensus statement, and by encouraging City businesses to do the same, the Board would further demonstrate its support and leadership in championing the wellbeing of Londoners, as well as contributing to the City

Corporation's Responsible Business Strategy. It was noted that in 5-10 years, HIV could become an imported-only disease.

RESOLVED – That:

(i) the "Undetectable Equals Untransmittable" U=U consensus statement be endorsed; and

(ii) the City Corporation's Business Healthy Programme should encourage City employers to endorse the U=U consensus statement.

9. **THE PREVENTION CONCORDAT FOR BETTER MENTAL HEALTH PROGRAMME**

The Board considered a report of the Director of Community and Children's Services relative to the appointment of an elected Member to act as a Mental Health Champion for the City of London Corporation, as well as becoming a full signatory of Public Health England's Prevention Concordat for Better Mental Health.

Given their interest in mental health, it was proposed that both Matthew Bell and Tom Anderson jointly assume the role of Mental Health Champion for the City, subject to their consent.

RESOLVED – That:

(i) the City of London Corporation become a joint signatory to the Prevention Concordat with Hackney Council; and

(ii) Matthew Bell and Tom Anderson be nominated as Mental Health Champions for the City of London Corporation, subject to their consent.

10. **DEFIBRILLATORS - VERBAL UPDATE**

The HR Health and Safety Manager provided Members of the Board with an update following a recent survey which identified defibrillator locations in the City, including schools, markets, the Barbican and Guildhall and highlighted recent use of defibrillators in four locations, including Hampstead Heath and Smithfield Market.

Members emphasised the importance of ensuring that people were aware of defibrillator locations (i.e. within the City's housing stock) and appropriate arrangements were in place to ensure that the equipment was routinely checked and maintained. The Director of Community and Children's Services acknowledged the points raised by Members and commented that a more detailed report would be submitted to a future meeting of the Board.

RESOLVED – That:

(i) the update be noted; and

(ii) a further report be submitted to a future meeting of the Board outlining the location of defibrillators across the City's housing stock, the maintenance and monitoring processes in place and any aspects of good practice arising from the survey.

11. **DRAFT CITY OF LONDON TRANSPORT STRATEGY**

The Board received a report of the Director of the Department of the Built Environment (DBE) relative to the draft City of London Transport Strategy which was considered, as part of a widespread consultation exercise, by the Planning and Transportation Committee on 30th October 2018.

It was noted that the department had commenced consultation and engagement activities to gain an understanding of concerns regarding walking and transportation in the City. The aim was to make walking safer and more comfortable in order to encourage physical activity. The following outcomes were being considered: (i) increasing accessibility; (ii) implementation of a 15-mph speed limit to create a calmer and more comfortable environment; (iii) addressing the conflict between cyclists and pedestrians and encouraging more people to cycle; and (iv) improving air quality within the City given that the City is above the national guidelines for NO_2 and exploring the potential to introduce zero emission zones.

Whilst Members agreed that the Strategy provided a positive focus on health and wellbeing, some concern was expressed regarding the rationale for the introduction of a 15-mph speed limit as there was not a straight-line association between collisions and speed-limits. It was suggested that appropriate data and evidence should be provided to justify why such a limit would have a tangible impact. In noting that the Bank Junction Scheme had been successful in reducing traffic in that area, a query was raised regarding the impact on the London Ambulance Service and how road traffic delays impacted, in general, on their operation.

All those present were encouraged to review and comment on the draft City of London Transport Strategy on-line at www.citystreets.london .

RESOLVED – That the report be noted.

12. **HEALTH AND WELL BEING BOARD UPDATE**

The Board considered a report from the Director of Community and Children's Services which provided an overview of local developments and policy issues related to the work of the Board where a full report was not necessary. The report addressed the following topics:

- Business Health Challenge
- PHE Conference Paper
- Better Care Fund Performance
- Local Government Declaration on Sugar Reduction and Healthier Foods
- Community Safety Update
- Rough Sleepers Winter Campaign
- Social Wellbeing Strategy Update

Reference was made to the Local Government Declaration on Sugar Reduction which highlighted the City Corporation's commitment, through collaborative ways of working, to tackle obesity amongst those living, working and visiting the Square Mile. It was noted that an action plan setting out the various streams of

work being undertaken by the City Corporation would be considered by the Health and Wellbeing Advisory Board.

RESOLVED – That the report be noted.

13. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**
There were no questions.

14. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**
With the Board's consent, the following item of urgent business was considered:-

Dr Penny Bevan – Retirement
In light of Dr Penny Bevan's retirement at the end of the year, the Deputy Chairman thanked Dr Bevan for her contribution to the Health and Wellbeing Board, and her efforts to ensure that the City was on the right track to be a healthy place to live, work and visit. Members concurred that Dr Bevan had left a notable legacy for future members of the Board and the City of London Corporation. The Director commented that Dr Bevan had been an advocate for training and development for the next generation of health advisors and her work with the Board had brought many benefits to the City Corporation.

RESOLVED – That, upon her retirement from the Health and Wellbeing Board, the thanks of the Board and the City Corporation be extended to Dr Penny Bevan for her outstanding contribution to the work of the Board over the past five years and for the benefits brought to the City Corporation.

15. **EXCLUSION OF PUBLIC**
RESOLVED – That under Section 100(A) of the Local Government Act 1972, the public be excluded from the meeting for the following items on the grounds that they involve the likely disclosure if exempt information as defined in Paragraph 7 of Part 1 of Schedule 12A of the Local Government Act.

Item	Paragraph
16	7

16. **CITY OF LONDON DRUGS PROFILE AND RISK REDUCTION STRATEGY**
The Board considered a report of the City of London Police relative to the City of London Drugs Profile and Risk Reduction Strategy.

RESOLVED – That the report be agreed.

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

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

The meeting ended at 1.15 pm

Chairman

Contact Officer: Lorraine Brook
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Committee(s)	Dated:
Health & Wellbeing Board	11 February 2019
Subject: Terms of Reference	**Public**
Report of: Town Clerk	**For Decision**
Report author: Julie Mayer – Town Clerk's Department	

Summary

As part of the post-implementation review of the changes made to the City Corporation's governance arrangements in 2011, it was agreed that all Committees should review their terms of reference annually. This is to enable any proposed changes to be considered in time for the annual reappointment of Committees by the Court of Common Council.

The terms of reference of the Health & Wellbeing Board are attached at Appendix 1 to this report for Members' consideration.

Recommendations

It is recommended that:

- the terms of reference of the Board, subject to any comments, be approved for submission to the Court of Common Council in April, and that any further changes required in the lead up to the Court's appointment of Committees be delegated to the Town Clerk in consultation with the Chairman and Deputy Chairman; and

- Members consider whether any change is required to the frequency of the Committee's meetings.

Appendices

- Appendix 1 – Terms of Reference

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Appendix 1

HEALTH & WELLBEING BOARD

1. **Constitution**
A Non-Ward Committee consisting of,
- three Members elected by the Court of Common Council (who shall not be members of the Health and Social Care Scrutiny Sub-Committee)
- the Chairman of the Policy and Resources Committee (or his/her representative)
- the Chairman of Community and Children's Services Committee (or his/her representative)
- the Chairman of the Port Health & Environmental Services Committee (or his/her representative)
- the Director of Public Health or his/her representative
- the Director of the Community and Children's Services Department
- a representative of Healthwatch appointed by that agency
- a representative of the Clinical Commissioning Group (CCG) appointed by that agency
- a representative of the SaferCity Partnership Steering Group
- the Environmental Health and Public Protection Director
- a representative of the City of London Police appointed by the Commissioner

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

3. **Membership 2018/19**

2	(2)	Marianne Bernadette Fredericks, *for three years*
2	(2)	Thomas Alexander Anderson
5	(1)	Joyce Carruthers Nash, O.B.E., Deputy

Together with the Members referred to in paragraph 1 above.

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

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

a) carrying out all duties conferred by the Health and Social Care Act 2012 ("the HSCA 2012") on a Health and Wellbeing Board for the City of London area, among which:-

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

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

All of these duties should be carried out in accordance with the provisions of the HSCA 2012 concerning the requirement to consult the public and to have regard to guidance issued by the Secretary of State;

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

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

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

Committee(s):	Dated:
Safeguarding Sub Committee Community and Children Services Safer City Partnership Health and Wellbeing Board	19/09/2018 02/11/2018 23/11/2018 11/02/2019
Subject: The City and Hackney Safeguarding Adults Board (CHSAB) Annual Report 2017/18 Presented by Dr Adi Cooper Independent chair of the CHSAB and Melba Gomes, Interim CHSAB Manager	**Public**
Report of: Director of Community and Children's Services	**For Information**
Report author: Melba Gomes, City and Hackney Safeguarding Adults Board Manager	

Summary

The City and Hackney Safeguarding Adults Board (CHSAB) is a statutory Board and it is a statutory requirement to produce an annual.

In summary during 2017/18:

- City of London partnership concluded its financial abuse awareness event. The CHSAB has taken up the mantle and is planning a follow-up campaign in 2018/19 to raise awareness among residents about how to keep safe and avoid financial abuse.
- City of London continues to build on its work with people who are socially isolated. We are involved in an initiative to address social isolation and loneliness for residents, which has the potential to reduce the likelihood of people becoming the subject of an adult safeguarding concern.
- City of London ran successful 'Rough Sleeping' event, signposting rough sleepers to appropriate services.
- City of London staff from all partner agencies attended the 'Learning from Safeguarding Adults Reviews (SARs)' workshops and have taken the learning back into their organisations.
- The Assistant Director for People and Community Services is the chair of the SARs sub-group and has led the group towards an evaluation of learning that identifies key themes to address in the strategic plan.

Recommendation

Members are asked to:

- Note the report.

Main Report

Background

1. The London Borough of Hackney and the City of London have diverse, vibrant communities. Many organisations and individuals provide effective adult safeguarding, and are also committed to the Safeguarding Adults Board and the partnerships it represents. The CHSAB is a multi-agency partnership of statutory and non-statutory stakeholders. This report sets out an appraisal of the safeguarding adults activity of those agencies across the City of London and Hackney boroughs in 2017/18.

2. The Care Act 2014 sets out a clear statutory framework for how local authorities and other key partners – such as care providers, health services, housing providers and criminal justice agencies – should work together to protect an adult's right to live in safety, free from abuse and neglect. It introduces new safeguarding duties for local authorities including: leading a multi-agency local adult safeguarding system; making or causing enquiries to be made where there is a safeguarding concern; carrying out SARs; arranging for the provision of independent advocates; and hosting Safeguarding Adults Boards.

3. In setting out a statutory requirement for Safeguarding Adults Boards for the first time, the Care Act establishes three core duties for those Boards. The Board must:

    - publish a strategic plan for each financial year that sets out how it will meet its main objectives and how members will achieve this

    - conduct any SARs as required

    - publish an annual report detailing what the Safeguarding Adults Board has done during the year to achieve its main objectives and implement its strategic plan.

This annual report is provided in line with this requirement.

Key Achievements

4. In line with its strategy, key achievements for the Board in 2017/18 include:

- We trained Safeguarding Champions to promote the message to the community that safeguarding is everybody's business.
- The Chair of the Board and the Board Manager visited community groups to tell them about safeguarding and the work of the Board.
- We responded to the views of service users and set up a User/Carer/Patient sub-group of the Board to enable us to hear the views of users and carers.
- We reviewed our website with service users and amended the content to be clearer about safeguarding and service users' rights.

- We supported staff to develop their learning to be able to work effectively with people who use safeguarding services.
- We reviewed the information we received and sought improvements where required, for example, through audits or analysis.
- We met our legal duty to commission SARs and we considered referrals, one of which progressed to a SAR. We will report on this in the 2018/19 report.
- The City of London arranged an event on Financial Abuse which was very well received.
- We held a winter-long campaign to address the needs of rough sleepers.

5. What didn't we do so well?

- Although we have raised awareness of safeguarding adults far and wide, we have not reached all groups. It has not been easy or possible to reach all groups of people from different ethnic backgrounds and faiths.
- We started hearing from adult social care and health service users through the Safeguarding Champions and the user groups, but we have not heard from people who use Safeguarding Adults services.
- We laid the foundation for a prevention strategy, but we have not been able to put anything in place to enable people to ask for early help or intervention.

6. What we have yet to find out

- We have done much work to pass on the learning from the SARs and we heard from staff about what will help to improve services. However, we will not know until 2019 if this has made any difference to practice.
- City and Hackney are involved in a project on social isolation. We await its findings.
- We need to find out more about how we can work with other Boards in City and Hackney to prevent abuse and neglect.

Comments from Service Users and Residents on the Annual Report 2017/18

7. CHSAB website:
- "You heard us …we said we don't understand 'abuse', you used 'harm'. That's good."
- User feedback said that the website and safeguarding should be on the front page of the Council's website. Users said it is currently hard to find, except through Google search.

8. People told us that they want:
- regular communication from the Board, as there was much in the report that they could not relate to
- simple safeguarding information so they can be informal ambassadors in the community for safeguarding
- safeguarding information advertised across the boroughs
- an effective service user group to be 'critical friends' to the Board

- partners to have a better understanding of advocacy so as to improve its use in the Safeguarding Adults service.

2017/18 Data

9. Summary data

- 32 concerns were raised
- 22 led to Section 42 enquiry
- of the 19 concluded cases, 11 expressed their desired outcomes and all were fully or partially achieved (nine were fully achieved)
- there were five repeat concerns.

Priorities for 2018/19

10. We will:

- continue to raise awareness
- engage with service users to get feedback
- aim to make services personal
- meet our duties to commission SARs
- improve services in line with learning gained, including through commissioning relevant training
- evaluate improvements through multi-agency case file audits and self-audits
- promote advocacy to support people
- aim to devise a prevention and early intervention protocol
- gather appropriate data to provide reassurance and improve services.

Corporate & Strategic Implications

11. Safeguarding is a Corporate and Departmental priority.

Appendices

- None

Background Papers

CHSAB Annual Report 2017/18

Melba Gomes
City and Hackney Safeguarding Adults Board Manager
melba.gomes@hackney.gov.uk

Committee(s):	Date(s):
Health and Wellbeing Board	11.02.2019
Subject: Prevention Workstream Report	**Public**
Report of: City and Hackney Integrated Care System (Prevention Workstream)	**For Information**
Report author: Jayne Taylor, Prevention Workstream Director Farrah Hart, Consultant in Public Health	

Summary

This report provides an overview of recent work by the Prevention Workstream within the City and Hackney Integrated Care System, setting out achievements and challenges to date, as well as identifying areas for future work and joint working with other workstreams.

Recommendation(s)

Members are asked to:

- Note the report and comment on any issues of particular relevance to the City of London

Main Report

Background

Integrated commissioning arrangements between NHS City and Hackney Clinical Commissioning Group (CCG), Hackney Council (LBH) and City of London Corporation (COLC) started on 1 April 2017.

A City Integrated Commissioning Board has been set-up to agree joint decisions between the NHS and the City of London Corporation. An equivalent board has been set up for Hackney. Each board is made-up of local elected members and local CCG leaders. They meet monthly in public and the minutes are published on the City of London committee pages. All the main local health and care organisations come together on a Transformation Board where they discuss how to improve services.

Four care workstreams look to join up services in the area to better meet local need.

The care workstreams are:

- Unplanned care,
- Planned care,

- Prevention, and
- Children and young people and maternity.

This paper presents the achievements and challenges to date for the Prevention Workstream, which is also the workstream that has the highest proportion of aligned funding from local authority budgets (in particular, Public Health) (89%) compared with CCG financial input (11%).

Appendices

- Appendix 1 – Prevention Workstream Report

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Prevention Workstream Report

City of London Health and Wellbeing Board
11 February 2019

CITY OF LONDON

Hackney

NHS
City and Hackney
Clinical Commissioning Group

Prevention – overview of the ask

Support all care workstreams to embed prevention principles in their plans to achieve a system shift towards prevention and early intervention

Reduce exposure to the main preventable risk factors for health inequalities, poor health and premature mortality

Enable people to live healthy lives and manage their own health

Early identification (of risk factors)
Early diagnosis (of long-term conditions)
Early intervention

Advocacy and partnership to improve the social, economic and environmental drivers of health and health inequalities ('Marmot principles')

Summary – successes & challenges to date

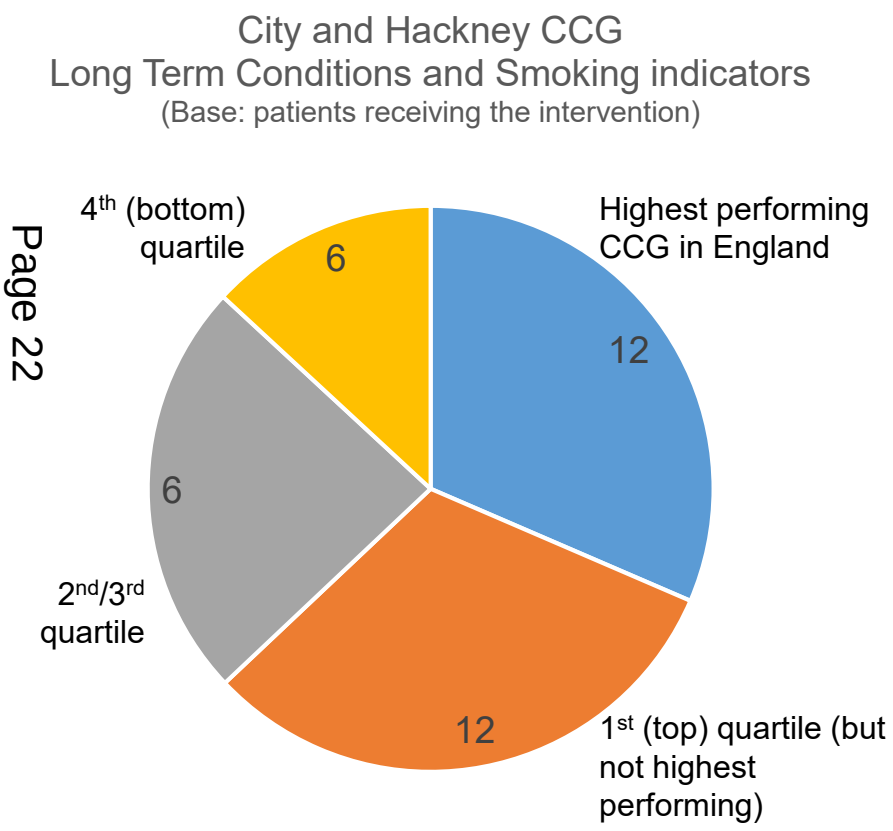
Successes

- **Management of Long Term Condition in primary care**: City and Hackney top performer on many clinical outcomes (out of 194 CCGs in England)
- High/increasing number **referrals to preventative services**: 2,000 to National Diabetes Prevention Programme and 1,200 to Social Prescribing so far; 3,500 annual referrals to weight management/exercise of referral; almost 3,000 smokers accessing support to quit each year
- **Good progress with tobacco control plans**: NHS smokefree pledge signed by Homerton (Barts since 2015), ELFT, CCG, GP Confed; smoking in pregnancy pathways established
- **High levels of sexual health screening**: high chlamydia detection rate; comparatively high HIV testing rates (=relatively low late diagnosis rates)
- Significant **improvement in alcohol treatment completions**
- 300+ people trained in Mental Health First Aid

Challenges

- **Sexual health**: increasing and changing demand; service fragmentation
- **Child obesity** remains stubbornly high (limited data for the City)
- Ongoing (local and national) challenge of **access to mental health services for people with substance misuse**
- **Low employment rates** among adults with learning disability and severe mental illness

Quality and Outcomes Framework performance 2017/18



Top performing CCG on 12/38 measures:

- Managing blood pressure in people with: high blood pressure; peripheral arterial disease; stroke; coronary heart disease and diabetes (2 measures)
- People with asthma and Chronic Obstructive Pulmonary Disease (COPD) who have had a review and been monitored with a recognised clinical measure (3 measures)
- People with COPD who have been diagnosed using the correct assessment (spirometry)
- People with long term conditions who smoke being offered support and treatment to stop smoking
- People with diabetes who have had a foot check in the last year

Summary – opportunities & risks

Opportunities

- Neighbourhoods – prevention focus
- Collaboration with other care workstreams to embed prevention in their plans
- Embedding treatment of tobacco dependency in NHS care pathways (in line with recent Royal College of Physicians report, '"Hiding in plan sight")
- Sexual health e-service: improving access and addressing cost pressures
- Mental health: mental health and substance misuse joint re-commissioning; NHS England funding for supported employment
- Alcohol Very Brief Advice –potential to increase screening in primary care?

Risks

- Ongoing rise in numbers of people with obesity and diabetes - service capacity to cope
- Funding not identified for a number of priorities identified through RightCare process (funding bids unsuccessful), including:
  - pulmonary rehabilitation
  - stroke vocational rehabilitation
- Spirometry accreditation: risk to future provision of service in primary care

Summary – transformation plans

- **Making Every Contact Count**
  - Final tranche of funding for training delivery confirmed (from Community Education Provider Network)
  - Programme manager appointed, recruitment of digital/comms lead underway
- **Care navigation** and supporting **self-management**
  - 2 joint Prevention/Neighbourhood projects underway/planned:
    a) care navigation (provider led working group) – mapping and strengthening the local offer
    b) community asset mapping – improving access to information about local resources that support positive health and wellbeing
  - Relevant ICT enabler funded projects:
    - Social Prescribing digital pilot
    - Directory of services
  - Opportunities to align Social Prescribing and Health Coach services through re-commissioning plans during 2019
  - Roll-out of group consultations
  - Learning from peer support pilots

Workstream asks 2017/18 and 2018/19
TACKLING PREVENTABLE RISK FACTORS FOR POOR HEALTH

Tobacco	**In the City, action on tobacco control is led by the Healthy Behaviours Steering Group.** 'Whole system' CLeaR peer assessment planned for early 2019.
Obesity	**Hackney Obesity Strategic Partnership** – multi-disciplinary partnership taking whole system action to tackle obesity. Strategic priorities: (1) working with local businesses to improve access to healthy, affordable food; (2) community insight and engagement; (3) getting people active as part of their daily lives; (4) workplace heath; (5) identifying and supporting people at increased risk of obesity-related harm; (6) school-based interventions. Learning from this whole system approach being shared with the City.
Alcohol & drugs	**In the City, oversight of substance misuse services is provided by the Healthy Behaviours Steering Group and Health & Wellbeing Advisory Group.** **Alcohol strategy** to be published in the City of London in 2019. **Substance misuse services**: joint re-commissioning of substance misuse services in the City and Hackney to commence shortly (new services in place by October 2020); currently working with ELFT and Greenhouse practice to identify mental illness earlier and develop a trauma informed model of treatment.

Workstream asks 2017/18 and 2018/19
LONG-TERM CONDITIONS – EARLY INTERVENTION

NHS Health Check	Cardiovascular disease risk assessment and prevention programme for people age 40-74. Managed through primary care. Good uptake in both the City and Hackney – performance has improved in recent years and compares favourably with other similar areas (see page 18). 2019/20 commissioning intention – integrate NHS Health Check within Long-term conditions contract (see below).
Long-term conditions contract	Incentivises early detection and effective management of long-term conditions in primary care. Includes 'Time to Talk' – extended consultations for patients with multiple Long Term Conditions. Continues to produce positive results on key metrics when compared with other areas – blood pressure control, Chronic Obstructive Pulmonary Disease management, support to smokers. Long Term Conditions contract incentives have supported significant improvement in performance in diabetes treatment.
RightCare	Respiratory and stroke reviews completed and recommendations for new/enhanced service pathways are being progressed – in partnership with Planned Care workstream.
Diabetes Prevention	National Diabetes Prevention Programme - new local (NEL) provider in place since May 2018. Approx 2,000 referrals to date. Homerton structured education programme for people at high risk of diabetes (XPERT Prevention of Diabetes programme - XPOD).

Workstream asks 2017/18 and 2018/19
MENTAL HEALTH

Integrated Public Mental Health/5 to Thrive Steering Group	Delivering Public Mental Health Action Plan and embedding 5 to Thrive. Public Mental Health Action Plan priorities: (1) Promote good mental health and mental health self-help, and support prevention and early identification of mental health problems through mental health services, healthcare pathways and our work with the community; (2) Design and deliver services that are tailored to meet individual needs and offer people the greatest possible choice and control over their lives; (3) Provide support that is focused on recovery and self-management; (4) Commit to delivering effective Mental Health services and respond effectively to people in crisis
Suicide prevention	Multi-agency suicide prevention groups established in City and Hackney.
Mental Health First Aid	Programme re-commissioned in Hackney and being rolled out in the City.
Wellbeing Network	Service designed to build resilience to prevent onset of mental health problems and alleviate issues such as stress, anxiety, low mood. Evaluation underway. Service redesign and re-commissioning to commence 2019/20.
Improving access to mental health services for people with substance misuse	Service User Network (SUN) group run by ELFT located in Hackney Recovery Service. PIC funding being used to develop a local approach to address this local/national issue – to inform substance misuse re-commissioning.
Supported employment	Provider-led Supported Employment Network established.
LTC IAPT service	Service based at Homerton, designed to increase referrals to IAPT (psychological therapy) for patients with physical long-term conditions.

Workstream asks 2017/18 and 2018/19
SEXUAL HEALTH

City and Hackney Sexual Health Forum	Chaired by Homerton clinician. Membership includes: Voluntary and Community Sector (Brook, Positive East), CCG, GP Confederation, Homerton sexual health services (representing Leadenhall Clinic in City), Homerton children & young people's health services (CHYPS Plus), pharmacies and Public Health.
Sexual health services	Sexual health services re-commissioned in 2017 on basis of Integrated Sexual Health Tariff for London and standard specification – cost efficiencies and consistency of service. New City clinic at 80 Leadenhall opened April 2018. Sexual Health London e-healthcare service launched - residents can now register online for an STI test kit to be sent to them in the post. Draft specification for a new primary care sexual health service has been developed with the GP Confederation. Service fragmentation remains, linked to separate commissioning responsibilities (e.g. community gynae, psychosexual services, support for people living with HIV).

Workstream asks 2017/18 and 2018/19
STAFF HEALTH & WELLBEING

London Healthy Workplace Charter accreditation	City of London Corporation (Achievement) City & Hackney CCG (Commitment) Homerton (Excellence) LB Hackney (Excellence)
City of London Business Healthy network	Provides support to improve the health and wellbeing of City workers through a dedicated website (c800 organisations subscribed) plus events/workshops focused on different aspects of workplace health and wellbeing. Research underway to better understand the health and wellbeing needs of City workers to support service development.
Hackney staff health and wellbeing partnership group	LB Hackney, Homerton and the CCG meet on a regular basis to share good practice and deliver joint activity where relevant/appropriate. Close links with City's Business Healthy team.
City of London Corporation mental health and wellbeing programme	HR Transformation Board provides oversight and leadership. A network of wellbeing ambassadors and mental health first aiders support delivery.

Workstream asks 2017/18 and 2018/19
IDENTIFICATION & SUPPORT FOR VULNERABLE GROUPS

Carers	City of London in process of drafting a new strategy for carers. Strong co-production focus - carers network and City Healthwatch are shaping the development of the strategy.
Recently bereaved	Service provided by St Joseph's. Non-recurrent funding secured to expand age eligibility criteria. Options for sustainable funding under review.
Socially isolated	Social Prescribing and other care navigation services relevant here. City of London Social Wellbeing Action Plan to tackle social isolation. The 2019/20 Healthier City & Hackney Fund includes a 'tackling loneliness in under 50s' strand – learning from awarded projects will inform future service plans.
Rough sleepers	Recent review of the healthcare needs of rough sleepers in the City identified a number of key priorities which are being taken forward by the Corporation, in partnership with the Prevention workstream and Mental Health Coordinating Committee.
'Complex' needs	Multiple Needs Service continues to produce excellent outcomes – both for service users and in reducing utilisation/cost of crisis services. Other services providing a similar 'case worker' model of care for people with complex/chaotic needs includes PAUSE, Open Doors, HIV Clinical Nurse Specialists.

Supporting a system shift to prevention
Joint projects with other workstreams

Children, Young People & Maternity	• Integrated child obesity pathway • Maternal obesity pathway • Smoking in pregnancy • Teenage pregnancy self-assessment
Mental Health Coordinating Committee	• Substance misuse and mental health joint re-commissioning • City rough sleepers care pathway • (Supported employment) Individual Placement and Support (IPS) NHSE wave 2 funding bid
Planned Care	• Refresh of diabetes centre support to primary care • Integrated adult obesity pathway • Review/recommissioning of post-stroke community rehab pathway • Collaborative approach to commissioning women's community health services (including gynae and contraception services)
Unplanned Care	• Neighbourhoods projects – care navigation, community asset mapping • Falls prevention pathway • Frequent attenders (TBC)

Local alignment and progress towards STP plan

STP Prevention priorities

- Diabetes prevention and self-management – for local plans and progress see pages 8 and 16
  - 2 NHSE funding bids secured: City & Hackney structured education; NEL wide support for achievement of “triple treatment” target
- Smoking & tobacco control – for local plans and progress, see pages 7 and 18
  - Focus on smokefree NHS estate, smoking in pregnancy pathways, embedding treatment of tobacco dependency in care pathways
  - NB: City & Hackney Prevention Workstream Director is STP smoking/tobacco control lead
- Workplace health - for local plans and progress, see pages 11 and 22

Relevant STP Mental Health priorities

- Supported employment (Individual Placement and Support) – see pages 9 and 20
- Mental Health First Aid – see page 9

Prevention commissioning intentions

Incorporate NHS Health Checks (commissioned by Public Health) into the single GP Confed contract - alignment with LTC contract
Update KPIs and targets within LTC contract (business as usual)
Re-commission Social Prescribing service to better integrate with other care navigation services in City and Hackney, including Health Coaches (commissioned by LBH Public Health)
Embed the following CQUIN targets (acute & mental health) as service KPIs: preventing ill health by risky behaviours – alcohol and tobacco (screening advice / support & referral) *Proposed as a NEL commissioning intention*
Work with the Planned Care and CYPM Workstreams to develop and implement an obesity pathway for City and Hackney
Support the Planned Care Workstream to review the post stroke rehabilitation pathway to ensure patients are effectively supported in the community after having a stroke
Support the Planned Care Workstream to implement recommendations from the Type 2 Diabetes Healthcare Needs Assessment to ensure services are aligned with models of best practice and are providing optimal care for people living with type 2 diabetes in City and Hackney
Better support patients with psychosis to stop smoking and lose weight through the introduction of specific targets in our contract with ELFT (embedding 2018/19 CQUIN targets as service KPIs)
Complete a review of City and Hackney substance misuse services to inform re-commissioning plans for 2020/21 – including options to improve access to mental health support for clients with substance misuse
Progress work to develop the local Individual Placement & Support (IPS) offer in accordance with strategic work at an STP level

Improvement and Assessment Framework (IAF)

2017/18 CCG IAF Assessment Diabetes – 'good' performance
This is an **improvement** on 2016/17 (assessed as requiring improvement

IAF indicator: **103a Diabetes patients that achieved all NICE recommended treatment targets**

Latest outturn (2017/18): *Data not available at time of writing*

Actions and plans:

- Ongoing target within the LTC contract with the GP Confederation to call in and treat patients who are currently not meeting the NICE treatment targets.
- NHSE funded nurse (via STP) focusing on Type 1 patients.
- Work in progress to align local reporting to better reflect national data

IAF indicator: **103b People with diabetes diagnosed <1 year who attend structured education**

Latest outturn (2017/18): *Data not available at time of writing*

Actions and plans:

- Diabetes specialist nursing team now directly coding attendance into EMIS records
- Successfully applied for NHS England funding, which is being used to (a) increase the number and accessibility of structured education courses available locally (584 additional places funded so far) and (b) employ a psychology assistant to call non-attenders to ascertain reasons and encourage future attendance.

Improvement and Assessment Framework (IAF)

IAF indicator: **102a % Year 6 children (age 10-11) who are overweight or obese**
Latest outturn (2017/18): 40.2% Performance in lowest quartile for England, relatively stable since measures began (2006/7)
Actions and plans: • Whole system action to tackle obesity being led Hackney Obesity Strategic Partnership – see page 7 • Child obesity services re-commissioned in **2017**; re-procurement of physical activity services underway • Healthy Weight Strategy will be refreshed in 2019, taking a co-production approach (series of engagement events plus design workshop planned)
IAF indicator: **108a Proportion of carers with a LTC who feel supported to manage their condition**
Latest outturn (2017): 59.6% Performance in lowest quartile for England and 2nd quartile of peer group. New indicator – no trend data.
Actions and plans: • Re-commissioning of carer support services underway in Hackney (see page 12) • Long-term conditions contract supports early detection and effective management of long-term conditions in primary care

Other key indicators (1)

Indicator	Latest outturn	Actions and plans
Smoking prevalence	**Hackney** Latest outturn (2017): 21.4% Significantly above England average (14.9%), comparable to most 'similar' areas No data available for the City	Comprehensive tobacco control plan in place – see page 7
Uptake of NHS Health Check (PHOF 2.22V)	**Hackney** Latest outturn (2013/14-2017/18): 60.2% of eligible population received Health Check **City of London** Latest outturn: 56.5% Significantly above London average (49.3%)	City of London and LB Hackney contracts continue to incentivise uptake and reduce variation Opportunity to better align with Long Term Conditions contract
Sexual health – chlamydia detection rate age 16-24 (PHOF 3.02)	**Hackney** Latest outturn (2017): 4,463 per 100,000 pop **City of London** Latest outturn: 1,183 per 100,000 pop (*NB: based on very small numbers)* London average: 2,199 per 100,000 (Higher detection rate assessed as 'better' on PHOF)	Service re-commissioning supports continued high performance on these metrics – see page 10

Other key indicators (2)

Indicator	Latest outturn	Actions and plans
Alcohol and substance misuse (PHOF 2.15i & 2.15iii)	**City & Hackney** Significant improvements in successful **alcohol** treatment completions in recent years. Latest outturn (2017): 39.5% Slightly above England average (38.5%) Successful treatment completions for **opiate users** also in line with England average. Latest outturn (2017): 7.1% Slightly above England average (6.5%)	Planned re-commissioning will support continued improvement on these metrics – see page 7
People with a Long Term Condition feeling supported to manage their condition (NHSOF 2.1)	**City & Hackney** Latest outturn (2016/17): 60% Very similar to London average (59%), slightly below England average (64%)	Various initiatives to improve support for self-care - see page 6 +Other services led by Planned Care (e.g. rehab programmes, embedded psychologists in diabetes/COPD/sickle cell community services, IAPT for people with LTCs).

Other key indicators (3)

Indicator	Latest outturn	Actions and plans
Proportion of adults with a learning disability in paid employment (ASCOF 1E)	**Hackney** Latest outturn (2017/18): 3.7% (zero return for City of London – very low numbers) This compares with a London average of 7.5%	A new in-house service has been commissioned for LBH via Hackney Works with targets that would bring Hackney in line with the London average. Supported Employment Network – see page 9
Proportion of adults in contact with secondary mental health services in paid employment (ASCOF 1F)	**Hackney** Latest outturn (**2017/18**): 3.0% (zero return for City of London – very low numbers) This compares with a London average of 6.0%.	A new in-house service has been commissioned for LBH via Hackney Works with targets that would bring Hackney in line with the London average. Supported Employment Network – see page 9 Preparing bid for Individual Placement and Support (IPS) NHSE wave 2 funding

Quality Premium

Metric: **number of successful smoking quitters**

- 2017/18 target: 1398
- 2017/18 outturn: 1402 (exceeded)

- 2018/19 target: 1350
- Activity to achieve 2018/19 target: Stop Smoking Service KPIs

CQUINs

	2017/18 targets	2017/18 achievement
Staff health & wellbeing	• 5 percentage point improvement in selected staff survey questions	Partially achieved (ELFT) Not achieved (Homerton)
Healthy food for NHS staff, visitors and patients	• 70% drinks sugar free • 60% confectionary <250kcal • 60% pre-packed meals <400kcal/<5g sat fat per 100g	Achieved (Homerton) *N/A ELFT*
Flu vaccination uptake for frontline clinical staff	• 70%	Achieved (ELFT & Homerton)
Risky behaviours – tobacco & alcohol screening, brief advice, referral	• Tobacco screening – 90% • Tobacco very brief advice – 90% • Tobacco referrals/medication offer – 30% • Alcohol screening – 50% • Alcohol brief advice & referrals – 80%	ELFT: • Partially achieved • Achieved • Partially achieved • Achieved • Achieved *N/A Homerton – introduced in 2018/19*
Personalise care & support planning	• Systems in place • Patient cohort identified • Staff trained	Achieved (Homerton) *N/A ELFT*

Prevention budget – overview (month 8 position)

Fund type: Pooled vs Aligned	CCG £'000	LBH £'000	CoLC £'000	TOTAL £'000
Pooled Budgets				
Pooled - Prevention	50			
'Aligned' Budgets				
Aligned - Prevention	3,386	24,492	2,349	30,227
Total Contribution into **'Aligned'** budgets	**3,436**	**24,492**	**2,349**	**30,277**
Total Annual Budget	**3,436**	**24,492**	**2,349**	**30,277**
Forecast Actual	**3,436**	**24,491**	**2,546**	**30,472**
Forecast Variance	**0**	**1**	**(197)**	**(195)**

Co-production and resident engagement

Our approach

- 2x resident representatives as full workstream members (in process of replacing one of these)
- User engagement plan template developed for use in planning relevant projects
- Ad-hoc engagement with existing patient/public groups as appropriate
- Seeking to recruit a cohort of 'champions' to call on for specific engagement activity/shape specific projects

A few examples

- Patient engagement on group consultations
- Sexual health re-commissioning - waiting room survey and focus groups with local service users
- Carers network and City Healthwatch are shaping the development of the carers strategy
- Making Every Contact Count – co-production approach to business case development, to continue as programme evolves
- Advice sought from Patient User Experience Group on appropriate targeted engagement activity to improve hypertension outcomes
- Public engagement on commissioning intentions at Staying Healthy event (Nov 2018)

Questions, comments?

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Committee(s):	**Date(s):**
ICB – For Noting CCG Governing Body - For Noting City Health and Wellbeing Board – For Noting Hackney Health and Wellbeing Board - For Noting	17 January 2019 25 January 2019 11 February 2019 Date tbc
Subject: System Commissioning Intentions 2019/20 and feedback from engagement	**Public**
Report of: Devora Wolfson – Integrated Commissioning Programme Director	**For Information**
Report author: Olivia Katis - Integrated Commissioning Programme Manager	

Summary

During 2019/20 the Integrated Commissioning Programme care workstreams will be the main vehicle for the delivery of commissioning activities and system savings. Appendix A of this paper summarises the systems commissioning intentions across the four care workstream portfolio areas:

- Children Young People and Maternity (CYPM)
- Unplanned Care
- Planned Care
- Prevention

Our commissioning intentions are informed by a programme of consultation from residents, patients and clinicians. The paper summarises feedback on resident, patient and clinician engagement on the commissioning intentions at a workstream and system level and from the series of resident events held over autumn 2018.

Recommendation(s)

Members are asked to:
To **NOTE** the 19/20 systems commissioning intentions

Main Report

Background

Each year City and Hackney CCG is required to develop a set of commissioning intentions detailing their ambitions for the next financial year and contracting round;

this year we have taken a systems approach to the commissioning intentions in line with our IC ambitions, detailed in Appendix A.

We have also submitted items which could be commissioned at an STP level that could be considered for inclusion in the North East London (STP) Commissioning Strategy, a summary of which are in Appendix B.

Current Position

The draft 2019/20 system commissioning intentions have been discussed at a variety of system and CCG meetings [further details of which meetings are summarised in Appendix C]. These include the Integrated Commissioning Board and Transformation Board. The Intentions were also subject to a round of consultation by patients and service users, further details of which are below.

Between September and November 2018, consultation on 2019/20 system commissioning intentions was carried out via a series of resident engagement 'Let's Talk' events which had the following objectives:

- Make residents aware of the plans and offer them an opportunity to feed back
- Offer residents an opportunity to identify anything we were missing
- Offer residents an opportunity to identify anything we could consider doing differently

Hosting several events marked a change from previous years, where only one commissioning intention consultation event was run; it was felt that hosting a number of different events in different locations would broaden the number and range of residents able to participate.

The events themselves were co-produced working with workstream leads and public / service user representatives and included a mix of focused discussions on key areas, and more general feedback session on our broader plans. A summary of the events and attendees at each event is below:

Over 200 City and Hackney residents participated attending:

- 30 October 2018, Young Parents Advisory Panel, 4 residents
- 31 October 2018, Neighbourhoods focus group in South West A: 15 residents
- 15 November 2018, Staying healthy drop-in with information stalls: 120 residents
- 21 November 2018, Outpatients workshop, 28 residents
- 24 November 2018, Ridley Road market stall, 60 residents
- 26 November 2018, session at the end of Integrated Discharge Co-production workshop, 4 residents

An evaluation was carried out of the engagement events and we received positive feedback from residents. For example, at the Outpatients and Staying Healthy events, attendees were asked whether the events had helped them feel more informed about health and care services with over 80% answering yes; and whether,

as a result of attending these events they felt they had a better understanding of how to help shape services with over 70% answering yes.

Commissioning intentions were discussed at the CCG's Annual General Meeting in September 2018 which was attended by partners and the public.

Clinicians and practitioners represented in the workstreams were fully involved in the development of the draft commissioning intentions. Each workstream also attended a focussed Clinical Commissioning Forum in October or November 2018, where their commissioning intentions were discussed by primary care clinicians.

Options

N/A

Proposals

This paper is for noting and does not present recommendations or proposals to the City Health and Wellbeing Board

Corporate & Strategic Implications

19/20 commissioning intentions relate to a number of the strategic priorities of the City and Hackney health and social care system including:

- The Integrated Commissioning Programme
- The Neighbourhoods Programme
- The Neighbourhoods Health and Social Care Services [re-commissioning of the Community Health Services contract]
- Making Every Contact Count
- Provision of a high quality CAMHS Service for children and young people
- Provision of high quality Maternity Services
- Providing high quality end of life care services
- Improving our offer to patients with Dementia
- Development of outpatients transformation
- Delivering high quality services to patients with cancer and improving our performance against cancer targets

Resource Implications

All of the commissioning intentions will be funded from existing workstream budgets.

Conclusion

This report is to provide the City Health and Wellbeing Board with a summary of the 19/20 system commissioning intentions and work to date – the Health and Wellbeing Board are invited to make comment as suggestion on the information presented.

Appendices

Appendix A – Summary of 19/20 System Commissioning Intentions
Appendix B - Feedback from 'Let's Talk' Events which straddle a number of care workstream areas
Appendix C – Summary of consultation undertaken during autumn 2018

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Appendix A – Summary of 19/20 System Commissioning Intentions

Unplanned Care Workstream

Transformation Area	Commissioning Intention 19/20	Provider	Expected outcomes, including patient and cost savings	Patient, resident and clinical feedback and engagement
Discharge	Deliver the Discharge to Assess (D2A) Pilot Recommission the Integrated Independence Team (IIT) contract, including sourcing suitable space for 4 Intermediate care beds Work with Age UK to expand the Take Home and Settle service	HUH, LBH, Age UK	• Reduction of DToCs (Delayed Transfers of Care) across the system • Reduction in excess bed days • Better quality of assessment and improved patient access • Savings related to hospital bed usage (£) • Patients will benefit from an intermediate bed service closer to home and which suits local need • The Take Home and Settle Service assists patients who have just been discharged form hospital - patients will have a smoother transition from hospital 'back home' • Savings related to reduced hospital bed usage (£)	Service user representatives are part of the Discharge Steering Group A discharge co-production event took place in October 2018 *Direct feedback from patients:* 'Cross borough hospital discharge needs to be better coordinated' 'Hospital discharge plans need to be made in partnership with the person from the start' 'Need step-down and step-up beds in Hackney'

Urgent Care	Deliver a new, more integrated GP Out of Hours service which integrates our current OoH service with the Primary Urgent Care Centre (PUCC) Improve our falls response and prevention services	HUH, GPC, CHUHSE, OTAGO	• Improved working between primary and secondary care, • Reduce % of London Ambulance Service calls resulting in a conveyance • Improve % A&E attendances diverted into PUCC • Residents vulnerable to falling can access a range of services and can access a less fragmented offer • Reduce overall costs to the system from falls (£) • Support managing demand on City and Hackney emergency services (£)	Integrated GP out of hours service user engagement event held in May – 32 residents attended. A service user representative is part of the Urgent Care Reference Group The Falls Prevention Service was taken to our Patient User Experience Group in with July 2018 *Direct feedback from patients:* '111 call handlers need to be trained and able to identify when someone has urgent need. City residents shouldn't be automatically sent to the Homerton when other hospitals are closer' Feedback from our Clinicians: Queries around what the GP Out of Hours service was likely to look like Feedback around the type of patients being treated by the

				Ambulatory Medical Unit (HAMU) for which we are being charged tariff costs (e.g. vitamin B12 injection)
Neighbourhoods	Continue to progress the development and delivery of the City and Hackney Neighbourhoods Model	GP Confed Hackney CVS Homerton ELFT	• Reduction in duplication of effort/resources/time • Reducing emergency attendances and admissions • Improved patient reported measures • Improvement in recruitment and retention • Support system sustainability (£) • Make services more responsive, accessible, and joined up for residents	Neighbourhood patient panel convened, large-scale engagement underway in one of the neighbourhoods *Direct feedback from patients:* 'Personalisation is essential in the new Neighbourhoods care model'
End of Life Care	Commission a City and Hackney Hospice at Home service as a one year pilot	St Joseph's Hospice	• Patients will be able to access a person centred and sensitive service, which will specialise in a range of areas specific to end of life care including pain management and family/carer support • We expect the service to lead to a reduction in hospital admissions	The proposed model has been discussed with service user representatives at the Unplanned Care Board Further work is planned to involve service user representative in the model
Mental Health	Improve our offer for patients with Dementia including: The Dementia Memory Clinic (ELFT) and Dementia Navigation and Support Service (Alzheimer's Society)	ELFT Alzheimer's Society HUHFT	• Greater integrated alignment in Mental Health • Dementia Navigation and Support Service: expanded • Savings related to a reduction in hospital admissions inc. bed usage and A&E attendances (£)	We have involved users in the design of the Dementia Memory Clinic model through the psychological therapies alliance and

	Pilot a single integrated pathway for frequent attenders including those patients who use A&E, 111 and London Ambulance Service (LAS) frequently Use the outcomes of the Health Based Places of Safety (HBPOoS) options appraisal to devise a new staffing model for ELFTs HBPoS sites Review inpatient usage against recent increased investment into crisis services to explore optimum number and location of beds Pilot a Mental Health Neighbourhood Blueprint in 2019/20		• Meeting NHSE Dementia Diagnosis targets and centralised dementia register • Better sharing and co-ordination of care plans across organisations • Reduction in frequent attendance 6 months prior to & 6 months after for A&E, 111 and LAS and reduction in costs associated with frequent attending • Better quality built environments in terms of patient safety, privacy and dignity • Better trained staff with a broader range of skills • Improved understand of system requirements	the mental health voices advocacy project.

Planned Care Workstream

Transformation Area	Commissioning Intention 19/20	Provider	Expected outcomes, including patient and cost savings	Patient and resident feedback
Outpatients Transformation	Continue our Outpatients Transformation Programme [until March 2020]	HUHFT	• Better local support to allow patients to manage their own care • Services that can be accessed locally • Reviewing specialty pathways with secondary care for more mental health support • Reduce the number of multiple appointments spread over different days to avoid wasting time • Improve listening to patient and support • Improve equity of access • Preventing unwarranted first attendance	Local Healthwatch organisations are engaging patients on outpatient service and specialty reviews will include an ongoing dialogue with any proposed changes and what specific patients' needs must be addressed. *Direct feedback from patients:* 'Patient choice is essential. Outpatients appointments structure and communications need to be individualised and personalised' 'Electronic and text options should be available for appointment confirmations and results but with a choice to receive letters'
Learning Disability Transformation	Ensure that the whole population of people with Learning Disabilities have access to the same opportunities as the rest of the population	Various	• Strategy for people with Learning Disabilities across the borough identifying approach to universal and specialist services	Quarterly partnership forum with service users

	Continue to develop and deliver the Integrated Learning Disabilities Service (ILDS) model of integrated working		• Service specification with identified outcomes for ILDS specialist service • New integrated ILDS with clear pathways in place including: better accommodation, local understanding of the health needs for people with LD, reduction in health inequalities, better day services, smoother transitions, improved crisis support, improved support for those receiving long term care • Efficiencies will be delivered through integrated working (£)	Annual 'Big Do' for service users – with a range of workshops to input into service design *Direct feedback from patients:* 'Need better support for adults with learning disabilities in hospital – should always be given advocate'
Continuing Healthcare (CHC)	Extend our CHC domiciliary care and nursing home providers with a 2-year extension We are also considering whether to join the Domiciliary Care AQP contract for 2019/20 We are reviewing the options for - Provision of a CHC brokerage function to support the Homerton CHC team	Dom Care and Nursing Home Providers, HUHFT and LBH	• Improvements to the CHC domiciliary care and nursing home contact through reviewing the service specification and the KPIs in the contract • Reduction in individual procurement costs • Capitalise on synergies to work together around contracts, quality monitoring, service user safety, punctuality of care and also brokerage of packages of care • Creation of a more responsive, flexible and cost effective service • CHC bed base will help ensure that patients can be discharged from hospital more quickly once medical needs have been met	Intent to recruit service user and family/carer representatives to adopt a coproduction approach to CHC services

	- Delivery of care within people's homes overnight to residents with CHC and fast track requirements Residential Placement Options – as part of our work on pooled budgets we intend to review commissioning arrangements for local care homes bed		• Will allow greater flexibility for placements	
Cancer	Continue to deliver cancer targets with our providers Recognise living with cancer as a long term condition Better recognition of those requiring 2 week colorectal cancer referral Commission PSA monitoring for patients with stable prostate cancer in primary care	HUHFT, Barts Health, UCLH, Primary Care	• Work towards meeting the following targets: specialist within 7 days, referral-to-treatment in 62 day target and ITT to be completed in 38 days • Provide more ongoing support to patients and families • The service change will deliver shared care arrangements that ensure the patient receives holistic care closer to home at their local GP Practice. It will release capacity in secondary care and will generate a financial saving.	Patient representative sits on the Planned Care Workstream

Service Development	Develop an online tool for patients which will enable them to self-refer directly to the Physiotherapy Service	Community locomotor Service and GP Primary Care	• Patients will be able to self-refer and use an online service to receive advice and guidance	Utility in signposting patients who call surgeries to leaflets and YouTube links to support them – and the Physio-self referral service
	Commission the current Minor Eye Condition service to provide: a specialist referral review, advice on GP treatment, and referrals to the Minor Eye Condition service and to secondary care	MEH & HUHFT, HUHFT, Community Pharmacists		
	Work with colleagues at LBH and CoLC to create a Women's Health Community Service		• Service to encompass: Gynae, Pelvic Floor Continence, Linked Sexual health, Fertility, Contraception, Breast and Menopause leading to more integrated working arrangements between professionals	Feedback from our Clinicians: Query around Womens Pathways – potential for the Community Health Services to be the enabler
	Upskill practices nurses so they can better support parents of children with eczema		• Reduction in time spent by clinicians managing low level eczema management.	
	Undertake review of the Teledermatology Service, due to			

	start in 2018/19 and its impact on community services Work with the Prevention Workstream to develop and implement an Obesity Pathway for City and Hackney Work with the Prevention Workstream to review the post stroke rehabilitation pathway and implement recommendations from the Type 2 Diabetes Healthcare Needs Assessment Develop a local a Discharge to Pharmacy service where a discharged patient cohort are referred to a pharmacist in primary care to support medicines use.		• Patients are effectively supported in the community after having a stroke • Services are aligned with models of best practice and are providing optimal care for people living with type 2 diabetes in City and Hackney • Improve the discharge process in secondary care • Reduce delayed discharge by enabling pharmaceutical input • Patients receive the correct medicines on discharge and are able to use their medicines (e.g. inhalers), after discharge • Reduce hospital admissions and readmissions • Minimise risk of errors [e.g. patients being supplied medicines which were stopped during their inpatient stay]	Patient Representative (a member of the HUHFT Patient Safety Committee) is a member of the local discharge to Pharmacy steering group
Personal Health Budgets	We will extend our PHB offer to all CHC eligible patients receiving care at home The psychological Therapy and Wellbeing Alliance will pilot PHBs	Network VSOs, ELFT HUHFT	• PHB give service users greater control and choice over the care they receive. Care and support plans are more person centred and clearly outline costs of care.	Through Service User Mental Health Coordinating Committee reps

	for patients frequently attending A&E due to Mental Health concerns The Homerton Hospital Wheelchair service will pilot a PHB offer in quarter 4 of 2018-19 with a full rollout by 2019		• Plans to work with mental health service users – which will provide greater support for people with more severe mental health problems.	Mental Health Voice Service User group consulted
Mental Health	Develop more integrated pathways across HUH psychological therapies to link together IAPT interventions and HMP Create a secondary care psychological therapies offer	IAPT (HUH main provider), ELFT, Network VSOs	• Greater integrated alignment in Mental Health • Addressing the current unmet MH needs for people with LTCs in line with national strategy. • Improved contractual performance in relation to the delivery of recovery and clinical improvement • Improving the breadth of offer to patients • Increase cost / effectiveness (£) • Elimination of backlog waiting lists • Regular reporting of activity and outcomes • Greater availability of open access psychological support for crisis • Clear structures and pathways that support local integrated care strategies • A joined up health and local authority approach to mental health	Through Service User Mental Health Coordinating Committee reps Mental Health Voice Service User group

	Review existing mental health accommodation contracts Develop a Primary Care Liaison Service that links with emerging structures such as Primary care Neighbourhoods and population mental health issues		accommodation inc. increased use of floating support • Improved value for money (£) • Improved primary care integration in Neighbourhoods	
Prescribing	Continue to deliver a programme of Prescribing activities covering: • Clinical / Prescribing audits • Medication reviews • Quality improvement • Safety Antimicrobial Stewardship Biosimilar medicine optimisation	GPC, GP Practices , HUHFT	• Support safer prescribing and use of medication • Support a reduction in medicines wastage • Improve patients' understanding of their medication • Improve communication, relating to medicines & prescribing, across the interface and between professionals • Share learning & good practice Continue with activities including training and auditing – to ensure City & Hackney CCG continues to reduce inappropriate prescribing and use of antibiotics • Increase the uptake of biosimilar medicines by HUHFT in line with NHSE's prioritisation of	This has been consulted on at various patient and service user events; consistent feedback from patients around greater education on their medication to provide them with imported insight Prescribing Committee has a patient and public representative on the committee; all work plans have been reviewed by this group.

	Anticoagulation		implementing best value biological medicines. • Increase the number of patients able to access anticoagulants in primary care • Work to review adherence to newer anticoagulation medicines	

Prevention Care Workstream

Transformation Area	Commissioning Intention 19/20	Provider	Expected outcomes, including patient and cost savings	Patient and resident feedback
Support early identification (of risk factors) and early diagnosis of Long term Conditions	Update the Long Term Conditions (LTC) contract, including updating contract KPIs, and integrating the NHS Health Check into the LTC contract Embed the following 2018/19 (acute) CQUIN targets as service KPIs: preventing ill health by risky behaviours– alcohol and tobacco (screening advice / support & referral)	GP Confed, HUHFT	• Better incentivise early detection of conditions and support the effective management of long-term conditions in primary care • More patients assessed for risk of CVD • Increase in number of people receiving preventative advice/ services • Increase in number of patients receiving evidence-based support to manage their health • Patients supported to quit smoking and/or access support to reduce harmful levels of drinking. • Reduce the health harms from both of these risky behaviours	Patient Public Involvement (PPI) Committee Co-production events planned for the Making Every Contact Count Programme *Direct feedback from patients*: 'Need more information on COPD including in other languages'

				'Need community space in the City where can run peer group activities e.g. for those with type 2 diabetes offering drop-in, cooking/diet advice'
Enable people to live healthy lives and manage their own health	Re-commission Social Prescribing service to better integrate with other care navigation services in City and Hackney, including Health Coaches (commissioned by LBH Public Health)	Family Action	• Residents have access to information, advice and support to help them live healthier lives • Patients are better-equipped to manage their own health	Commissioning intentions engagement event *Direct feedback from patients*: 'Need access to affordable exercise like yoga, and healthy eating information and advice' 'Air pollution is a problem. People should be encouraged to use electrical cars and children in the City should be given pollution masks' 'Neaman Practice should offer social prescribing but needs to be community/voluntary activities in the City'
Mental Health	Embed the following 2017-19 (mental health) CQUIN targets as service KPIs: • Cardio metabolic assessment and treatment for patients with psychoses	ELFT, WDP	• Patients with psychoses will be supported to lose weight and quit smoking – with significant long-term health benefits • More mental health inpatients will be supported to quit smoking and/or	Mental Health Advocacy Group (via the Mental Health Coordination Committee)

	(EIP BMI outcome indicator and EIP smoking cessation outcome indicator) • Preventing ill health by risky behaviours– alcohol and tobacco (screening advice / support & referral) Improve access to mental health support services for people with substance misuse [part of a broader strategy to review substance misuse service] Develop an integrated approach to employment support for people with mental health problems		access support to reduce harmful levels of drinking; this will reduce the health harms from both of these risky behaviours • Reduced dosage of anti-psychotic drugs (e.g. clozapine) in smokers who quit • Improved recovery rates and mental health outcomes for people with substance misuse problems • Improved access to employment, with significant associated benefits for health and wellbeing and supporting recovery.	Hackney's Supported Employment Network

Children, Young People and Maternity (CYPM) Care Workstream

Transformation Area	Commissioning Intention 19/20	Provider	Expected outcomes, including patient and cost savings	Patient and resident feedback
Maternity Services	Deliver improvements to work towards an 'Outstanding' CQC rating (now 'Good')	HUHFT	• Improve the overall governance and safety of the service • Ensure the women accessing services at the Homerton are receiving optimal safe and quality care	*Direct feedback from patients:* 'More health and mental health support for mothers after giving birth'

	Reduce infant mortality and avoidable admissions to NICU Explore carrying out clinical audits into deliveries with complications and emergency caesareans Continue to promote the offer of the flu vaccination and pertussis to expectant mothers Increase continuity of care in line with NHSE recommendations Continue to deliver a robust perinatal mental health offer Continue to support women with Long Term Conditions (LTC) to		• All maternity and neonatal services to work together to identify babies whose admission to a neonatal unit could be avoided and to promote understanding of the importance of keeping mother and baby together when safe to do so. • Ensure that maternity risks are identified and actioned early • Increased numbers of women with flu and pertussis vaccinations • 20% of City and Hackney women delivering at HUH will have continuity of carer • Women planning a pregnancy including those with LTC are informed of ways to improve their	Feedback from our Clinicians: Query around the Homerton Maternity unit staffing – confirmed that service is currently at full capacity

	have safer healthier pregnancies and deliveries		health and that of their baby during pregnancy • There is support available with clear pathways for women with LTC during pregnancy	
Children, Young People and Maternity	Develop a high quality acute and community paediatric services including new baby clinics and la health offer for Looked After Children Agree tariffs and explore improving pathways for critical care To develop a clear offer for children in need of continuing healthcare and personal health budgets Develop a specialist epilepsy nurse offer, alongside a new respiratory specialist nurse offer, embedded across A&E and Primary Care	Range of providers including: HUFT, VCS, GP Confed, Primary care , Whittington Health, LBH CYPS	• More effective pathways for LAC through health, particularly for those CYP with complex health needs, mental health needs and challenging behaviour needs • Improved LAC service including monitoring of LAC performance and staffing issues • Enhance joint working between community paeds and primary care, recognising the trainee resource that can support capacity issues in primary care and offer optimised training opportunities. • Support reductions in unplanned asthma attendances • Clarify service provision and funding arrangements for SEND children and their families	A full engagement plan is being rolled out as part of the design of the new LAC health service. A SEND A co-production and engagement plan is being developed currently with our parent representatives *Direct feedback from patients:* 'Better assessment and support for young children with autism'

	Improve local pathways for children with Special Educational Needs and Disabilities Design and implement a new tier 2 and 3 audiology service Improve care pathways and information sharing across primary care to improve diabetes care Improve uptake of immunisations		• Increased access to early health support for children with SEND	
Mental Health	Continue to ensure we have a system that meets the needs of every child in City and Hackney Increase CAMHS access rates: we expect access rates to increase 35% by 2020/21 (an extra 70,000 children and young people nationally)	HUHFT, ELFT	• CAMHS support in all schools by 2020 • Assessment target of 2,068 in 2019/20 • Meeting the national target of increasing CAMHS access rates • Increased diagnosis (linked to increased investment) • Clearer pathways for residents and non-residents • Improved access to support for crisis • Improved outcomes for those transitioning to adult mental health services	Young Hackney has delivered a children and Young Peoples consultation to inform direction and development of the CAMHS transformation plans. *Direct feedback from patients:* 'Improve mental health not just for children with serious need but overall'

	Support the development of the Phase 3 CAMHS Transformation Plan focussing on schools, transition, parenting and crisis		• Reduced waiting times to entering treatment within 6 weeks by Q3, 18/19 • Extended hours of Paediatric Psychiatric liaison in A&E to 10pm • Enhanced eating disorders service • Improved neurodevelopmental pathways including increase funding for Autism diagnosis and aftercare	'Need more information in schools around mental health, young carers and what is inappropriate caring, sexual assault and safe relationships, healthy eating and cooking, general health, smoking, how to protect yourself, dental care' 'Need to fund mental health therapists in City schools'

Appendix B – Feedback from 'Let's Talk' Events which straddle a number of care workstream areas

Crosscutting Themes form 'Let's Talk' Events, including Primary Care
Below are items which were mentioned on frequently during our Let's Talk events: - 'Concern about hospital appointments being cancelled' - 'Carers are afraid of assessments' - 'Mental health is important not just for serious conditions but for in-betweens who are 20-50. Need to improve access to talking therapies' - 'Loneliness is a problem and brings depression– need buddying, companionship, befriending' - 'Problems getting GP appointments – need to be more readily available and needs to be more face-to-face time' - 'Health and care staff need to listen more' - 'Need more help for elderly and disabled' - 'Technology should be used where appropriate to release staff capacity' - 'Services are not speaking to each other. People are being bounced around the system and asked the same questions twice' - 'Need more consultation when changing and improving services' - 'Need more health and care services in the City itself including another GP practice'

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Appendix C - Summary of consultation on 19/20 commissioning intentions undertaken during autumn 2018

The draft 19/20 commissioning intentions was discussed at the following Board meetings between August – October 2018:

29th August 2018: City and Hackney Transformation Board

5th September: CCG Annual General Meeting including resident/patient input

12th September 2018: CCG Clinical Executive Committee

14th September 2018: City and Hackney Integrated Commissioning Boards

17th September 2018: CCG Governing Body

19th September 2018: CCG Finance and Performance Committee

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Committee	Dated:
Health and Wellbeing Board	11/02/2019
Subject: Social Wellbeing Strategy – Annual Update	**Public**
Report of: Andrew Carter, Director of Community and Children's Services	**For information**
Report author: Claire Giraud, Strategy Officer, Department of Community and Children's Services	

Summary

In 2017 the City of London Corporation published the Social Wellbeing Strategy, aimed at reducing loneliness and building communities. The strategy set out different approaches to tackling loneliness and social isolation in the Square Mile. This report and the attached Social Wellbeing Action Plan provide an update on the implementation of the strategy to date. The plan has moved forward since the last update and the majority of actions are now in progress.

Recommendations

Members of the Health and Wellbeing are asked to:

- Note the update on the Social Wellbeing Strategy.

Main Report

Background

1. Reducing social isolation has been identified as a priority in the DCCS Business Plan, in the City Corporation's Joint Health and Wellbeing Strategy, in the Mental Health Strategy and by the Adult Advisory Group.

2. Reducing social isolation supports Principle 2, Priority 6, Action 1 of the CHSAB Strategic Plan 2017-18. This is:

   > 'Develop a local "Early Help" protocol and overview of services to support socially isolated individuals who lack support and may be at risk of safeguarding concerns.'

3. The Social Wellbeing Strategy has been developed to reduce social isolation and loneliness in the City, based on the evidence provided by Dr Roger Green of Goldsmiths, University of London, and by the Social Wellbeing Panel.

4. The attached Social Wellbeing Action Plan has been developed to guide the implementation of the strategy. Progress on the Action Plan will be monitored by ASMT and regularly reported to AWP.

Action Plan Summary

5. Overall, 30 actions have now commenced and 5 have not yet started. Of those commenced, 14 have been completed (an increase of 13), 15 are in progress and 1 is experiencing minor problems.

6. Significant developments include the completion of the first pilot group of "Community Builders" in the Golden Lane Estate, the successful running of inclusion groups such as "Out and About in the Barbican", "the Mansell Street Women's Group" and the creation of a City Guide.

7. The action encountering minor problems is being managed:

    a. The creation of a community noticeboard in the Barbican Waitrose store was unfortunately not possible thus placing one in the Tesco Express on Chiswell Street is currently being investigated.

Theme One: Asset-Based Community Development

8. This theme aims to encourage community based responses to loneliness, drawing upon and enhancing the assets, strengths and skills already present within the City of London community.

9. Phase 2 of Community Builders is underway in other City estates and a sustainable model of delivery and training that incorporates the different local contexts but keeps the ethos of Community Builders is being developed.

10. Remembering Yesterday, Celebrating Today was incorporated into the Avondale Community Events Big Picnic on September 1st. The Community Engagement team have been supporting their Poppy Artwork Programme and liaised with the Royal British Legion for fundraising.

11. Aldgate Community Events were a key partner in the delivery of the Aldgate Square Festival. A very thorough outreach programme for the event was implemented, from initial consultation right through to an open call for performances.

Theme Two: Shared Spaces

12. The actions in this theme aim to create and enhance shared spaces where people naturally come together, either through chance encounters or organised community activities.

13. An evaluation of the Dragon Cafe in the City Pilot, which is hosted in Shoe Lane Library on a fortnightly basis found that three quarters of visitors (76%) agreed or

strongly agreed that attending helped to improve their mental wellbeing. The Café is a welcoming space to engage in creative activities to support mental and physical wellbeing.

14. Refurbishment of Golden Lane Community Centre was completed and handed over in July.

15. The Aldgate Square Scheme has seen the combining of the City Play project with the Community Fair in June 2018.

Theme Three: Early Intervention

16. This theme looks at how contact can be made with lonely people sooner, through sustained and consistent communication and by carrying out outreach work using a wider network of partners.

17. A reference guide to resources in the City has been created for City and Hackney's social prescribers.

18. The Over 50s City Guide was distributed in March 2018 with coordinated listings from around 50 groups in and around the City.

19. The FYi directory has been updated.

20. The new carer's assessment in place on Mosaic now has greater emphasis on the needs of the carer (including social and community needs) rather than the person cared for.

Theme Four: Building Skills

21. The actions in this theme aim to develop skills that will enable individuals to form new connections and enhance existing relationships.

22. Currently nine learners are attending English ESOL Conversation class since September 2017.

23. Digital inclusion project commissioned by *Age UK: Only Connect* launched the week commencing 1st October 2018.

24. A shopping service to support food access for residents with limited mobility started for one year on 1st April 2018.

Conclusion

25. The plan has moved forward since the last update in February 2018 and many of the actions are either complete or in progress. A further progress report will be presented to the Board at a future date.

Appendices

- Appendix A – Social Wellbeing Strategy
- Appendix B – Social Wellbeing Action Plan January 2019 Update

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Social Wellbeing Strategy 2017

Reducing loneliness and building communities

Contents

1. Vision and objectives

The City of London Corporation's Adult Wellbeing Principles includes a commitment that people are not socially isolated and that they have the relationships and support they need. The objective of this strategy is to realise this commitment in practice.

2. Background

2.1 The extent of loneliness

Loneliness is a national issue. A report from Age UK found that 7 per cent of people aged 65 or over in England said they always or often felt lonely. Including those who say they are sometimes lonely, the figure rises to 33 per cent.[1] There are reasons to believe that the City may be particularly affected, due to its older population and the prevalence of single person households. Greater London has an average of 11 per cent of residents over 65, while the City has 14 per cent, and 51 per cent of these older people live alone, compared to a national average of 33 per cent.

While loneliness can affect anyone, certain groups have been found to be more at risk. Older people are significantly more likely to be at risk, especially when coupled with a loss of income or existing relationships, living alone or in residential care. Being single, widowed, divorced or never married increases the risk of loneliness, as does having a partner or child but not feeling close to them.[2] A range of personal characteristics make loneliness more likely, such as entering later old age (75 years and over), being from an ethnic minority community, being gay or lesbian or having a mobility, cognitive or sensory impairment.[3]

While social isolation is mostly viewed an issue for older people, it can be an issue at any stage of life. A survey conducted on behalf of Family Action found that one in five new mothers lack support networks to help them through pregnancy. Among mothers living in low income households or from certain ethnic minorities, the figure rises substantially.[4] Research by the New Economics Foundation estimated around 1 million workers in the UK experience loneliness, with a total cost to employers of £2.5 billion per year.[5]

Policy makers are concerned about loneliness for three reasons. Firstly, because dissatisfaction with one's level of social contact leads to lower personal wellbeing. Secondly, being lonely has a significant impact on an individual's physical and mental health, which in turn leads to earlier than expected support needs and requires the provision of health and social care services.[6] Finally, social isolation can mean that someone is more at risk of abuse or neglect.

A survey by the Campaign to End Loneliness found that 16 per cent of over 60s would not know where to go for help if they were feeling lonely, while many more people are unwilling to seek help or identify as lonely because of the stigma associated with the issue. This is therefore not an issue which all individuals will have the capacity to solve for themselves and intervention from the statutory, voluntary and community sectors is required.

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[1] Susan Davidson and Phil Rossall (2014), 'Age UK Evidence Review: Loneliness in Later Life.'

[2] Panayotes Demakakos, Susan Nunn and James Nazroo (2006), 'Loneliness, relative deprivation and life satisfaction', Retirement, health and relationships of the older population in England

[3] Campaign to End Loneliness 'Risk Factors: Factsheet', http://campaigntoendloneliness.org/guidance/wpcontent/uploads/2015/06/Risk-factorsGFLA.pdf

[4] Janaki Mahadevan (2012) 'New mums lack support to cope with isolation and depression', Children and Young People Now.

[5] New Economics Foundation and the Co-op (2017), 'The Cost of Loneliness to UK Employers'

[6] The costs of an individual being chronically lonely are estimated at £12k per year in additional GP and A&E visits and social care costs.

2.2 Social isolation and loneliness

While isolation and loneliness are closely linked, they are two distinct concepts. Isolation is an objective term to describe a person with limited social connections. Loneliness is a subjective measure of a person's feelings about their social relationships. It is a deeply personal state and a level of social contact that may satisfy one person may leave another feeling profoundly alone.

While the two states are related, one does not imply the other. It is possible to be isolated but not lonely. A person may prefer solitude and find that this has no impact on their quality of life. It is also possible to be lonely in a crowd. Older people in large households and care homes are more likely to feel lonely.[7] Both isolation and loneliness are recognised as issues that should be addressed to improve wellbeing, although it is uncertain whether they have independent effects or whether isolation only impacts on health through loneliness. There are therefore three groups to consider when working to improve social wellbeing:

- the socially isolated and lonely – the most obvious target of any intervention, whose loneliness may be reduced by reducing their level of social isolation;
- the socially connected but lonely – interventions targeting this group may concentrate more on improving the quality of existing relationships, providing opportunities for specific interactions or reframing attitudes to the time they are alone;
- the socially isolated but satisfied – although happy with their limited social relationships, this group could be at risk if their personal circumstances change.

The importance of preventative work with this third group is highlighted by a recent investigation by the British Red Cross and the Co-op.[8] Their research identified that life transitions, when an individual's relationships or role in society suddenly and substantially changed, were common triggers for loneliness. An example of such a transition could be retirement, becoming a parent or experiencing bereavement. While offering support after the event is important, the effect can be more effectively mitigated by ensuring the individual has adequate social connections prior to the transition point being reached.

2.3 Policy context

The 2010 Marmot Review sought to identify the most effective evidence based strategies for reducing health inequalities. These included:

- putting empowerment of individuals and communities and reducing social isolation at the heart of action on health inequalities;
- paying attention to the importance of stress and mental health in shaping physical health and life chances, and the importance of personal and community resilience;
- concentrate on the 'causes of the causes' – that is, invest more in the material and psychosocial determinants of health.

The Care Act 2014 creates a clear imperative for a range of partners to take action on loneliness. It states that a local authority must promote wellbeing when carrying out its support duties. The wellbeing principle includes; personal dignity, physical and mental health and emotional wellbeing, protection from abuse and neglect, control by an individual over day to day life, participation in work, education and leisure activities, social and economic wellbeing, maintaining personal relationships and the individual's contribution to society. Loneliness and social isolation present substantial barriers to a number of these principles.

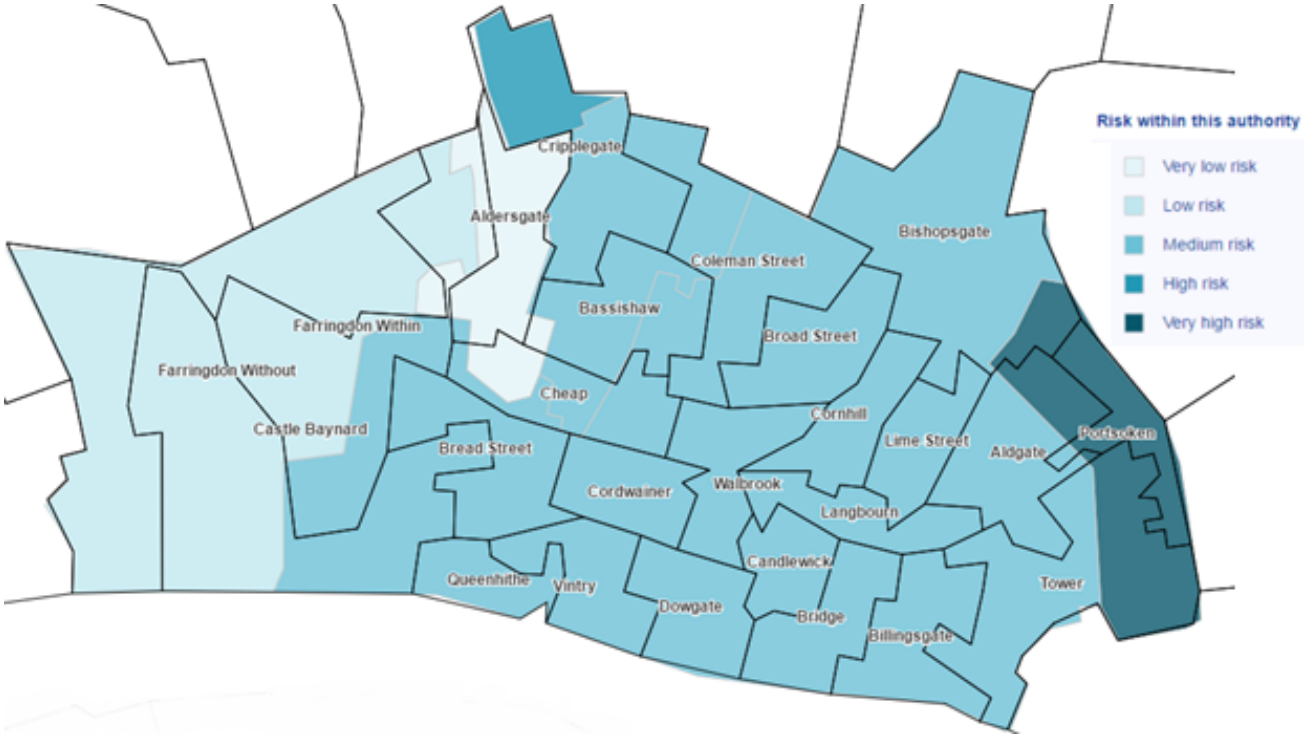
[7] Susan Davidson and Phil Rossall (2014), 'Age UK Evidence Review: Loneliness in Later Life.'
[8] Co-op and British Red Cross (2016) 'Trapped in a bubble: An investigation into triggers for loneliness in the UK'

3 Loneliness in the City

3.1 Older people

In the City 14 per cent of residents are aged 65 and over, higher than the Greater London average of 11 per cent. The City also has a higher proportion of people in later old age with 4 per cent of the population over 75 years of age, compared to a Greater London figure of 3 per cent. The City has a large number single person households and around a fifth of these are home to a person over 65. In the City, 34 per cent of people live alone; 31 per cent of people aged under 65 and 51 per cent of people aged 65 years or over.[9]

The majority of these people will not be lonely. However, as older age and living alone are strong risk factors, they can be used as a starting point to estimate the likely level of need. Age UK have analysed data from the English Longitudinal Study of Aging (ELSA) and the Office for National Statistics to predict the risk of loneliness in the older population. The darker areas of the map (below) show the areas with the greatest predicted prevalence of loneliness. The prediction is based age, marital status, household size and self-reported health. The darker the map, the greater the probability of loneliness predicted by the model.



This indicates that older people in two areas, Golden Lane and Portsoken, home to large concentrations of the City's population, stand out as being high risk and very high risk areas.

That the City's other main population centre, the Barbican, appears to be relatively low risk is likely due to the map's focus on poor physical health as a cause of, and thereby proxy for, loneliness. While older residents living in the Barbican may be less likely to report poor health than their counterparts living elsewhere in London, other sources of local evidence suggest that it would be a mistake to assume there is no problem with social isolation here.

The City Corporation and Healthwatch hosted a series of 'Ageing Well in the City' workshops to learn about people's needs as they grew older. A particular theme raised during the events was a need to do more to tackle social isolation and loneliness.

[9] Census 2011 / ONS

3.2 Working age people

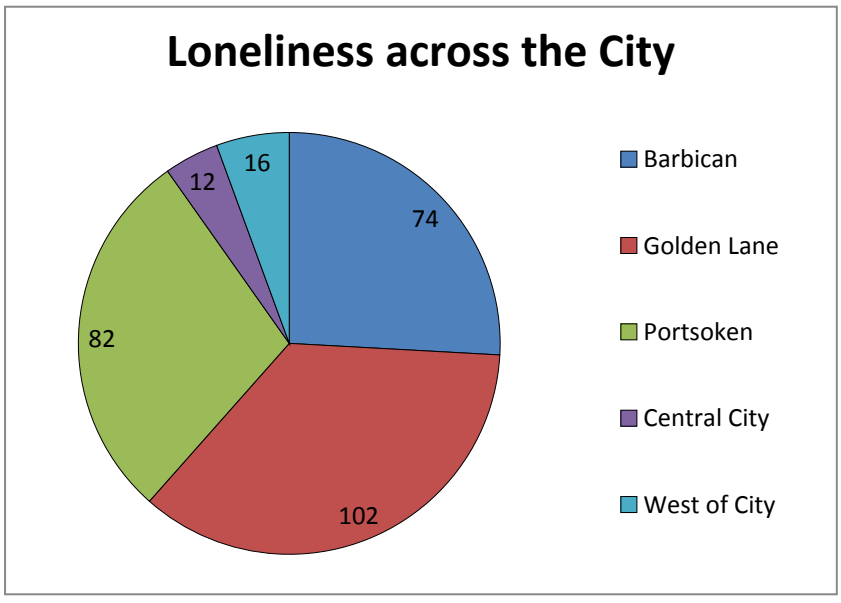
The Age UK and ELSA data only provides part of the picture, as loneliness can be an issue for people of any age. People with physical or mental health problems, caring or parental responsibilities, the long term unemployed and refugees and asylum seekers are all known to be at greater risk of loneliness. Other sources of data are needed to produce a more comprehensive picture.

In the City 42.5 per cent of Adult Social Care service users say they had as much social contact as they would like, similar to the average for Greater London of 41.8 per cent. Many carers are also both socially isolated and lonely as they can find their caring role leaves them with precious little free time to engage in social activity. Of City carers, 46.4 per cent are satisfied with their level of social contact compared to 35.5 per cent across Greater London. While the City compares favourably to the regional average, it still shows a majority experiencing loneliness.

Anecdotal evidence from Early Years Practitioners also suggests a considerable number of new City parents experience loneliness. This problem appears to cut across demographic groups. Nationally parents on low incomes or from BAME (Black and Minority Ethnic) groups are more affected by isolation. In the City these longer term residents tend to have enough of a social network to mitigate at least some of the problem. In contrast, high income professionals who move in to the City can become isolated from family and friends in other parts of the country and may be just as at risk.

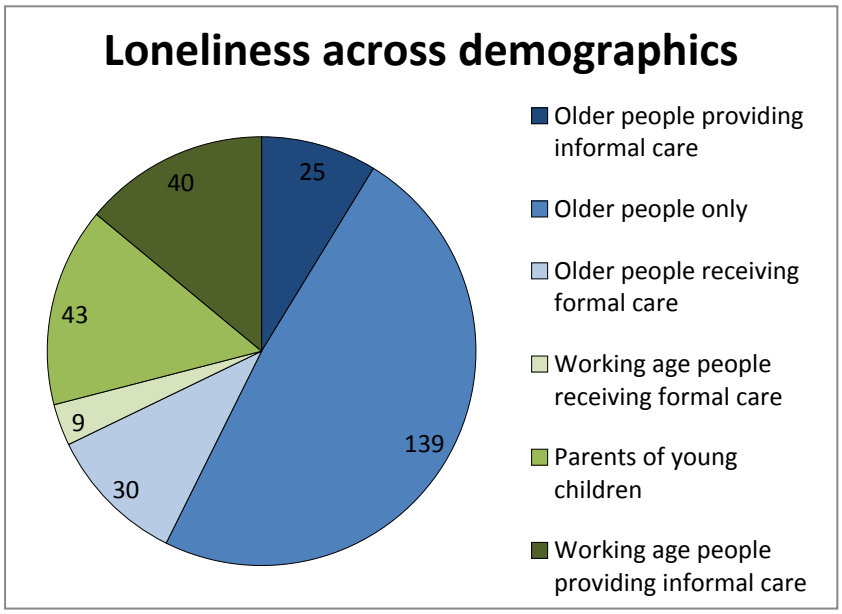
3.3 A Combined estimate

Combining these data sets to give a more complete overview of loneliness in the City replicates the geogrpahic spread seen on the Age UK map on page 6. The Golden Lane and Portsoken areas are still home to the majority of individuals at risk of loneliness, the Barbican has a slightly stronger presence, accounting for just over a quarter of the total at risk population. Only a small number of people thought to be at risk of loneliness live outside these main residential areas.



The data can also be used to produce an estimate of who is most at risk of loneliness in the City. The 'loneliness across demographics' chart on page 8 provides an at a glance breakdown between older (blue) and working age (green) groups, as well as all those

providing informal care (by viewing the dark blue and dark green sections together) and all those receiving formal care (by viewing the light blue and light green sections together).



This suggests that around two thirds of lonely individuals in the City are over 65. Around half of the total is made up of older people who neither provide nor receive care, and as such they are unlikely to already be known to Adult Social Care services.

A quarter of lonely individuals are estimated to be informal carers and around two-thirds of these are of working age. Some, but by no means all, of these people will be known to Adult Social Care. In the 2011 Census, 121 people said they provided at least 20 hours of unpaid care per week. However, only 60 carers are known to Adult Social Care and only 22 per quarter engaged with the City Carers Service in 2015-16.

An estimated one in seven lonely City residents receives care from Adult Social Care. The majority of these are older people. A similar number of working age parents are thought to experience loneliness. These will all receive personal contact from a Health Visitor and an information pack from the FYi service, but those who become isolated are unlikely to have yet taken up the offer of the play groups and early help services that the City Corporation provides. Finding the isolated parents, informal carers and older people without care needs will be a crucial challenge in tackling loneliness in the City.

Many people who experience severe loneliness will not fall into any of the groups listed above. Again it must be recognised that loneliness is an experience unique to each individual and factors that may leave one person lonely, another would take in their stride. The estimates made above should be seen as a minimum, acknowledging that the figures for the Barbican based on ELSA data may be an underestimate and recognising that loneliness does not just affect older people, carers, new parents and people with disabilities. While it is helpful for services to target these groups, they should also be open to all and look to tackle loneliness wherever they encounter it.

3.4 Community research

In order to better understand personal experiences of loneliness the City Corporation commissioned Dr Roger Green, from the Centre for Community Engagement Research at Goldsmiths, University of London, to explore the level and nature of need in the local older population. The study used a qualitative ethnographic approach to gain older residents'

views. While living in the City of London was experienced by older residents in a number of different ways, the experience of being socially isolated or lonely was voiced by many residents. A number of themes emerged from this:

- Many residents chose to live in the City because of the anonymity that comes from living in the centre of a large conurbation. This solitude can turn to isolation and become problematic following a major change such as retirement or bereavement.

- Other residents spoke of feeling separated from friends and relatives living elsewhere in the UK or abroad. While many maintained regular phone contact, they still complained of feeling isolated from family.

- Some minority groups appeared to be underrepresented in existing community networks. This was evident with LGBT* (lesbian, gay, bisexual and transgender) and BAME older people.

- Some residents felt isolated by the extremely urban built environment and those in later old age or with physical disabilities found the physical layout of their estates difficult.[10]

3.5 Local profiles

By combining the analysis of the ELSA, social care and early years data with Dr Green's research, local estimates of loneliness can be produced for each area of the City.

Loneliness in the Barbican

Anecdotal evidence suggests that the socially isolated here are 'asset rich and income poor' older people. Our model suggests that around two thirds of those at risk of loneliness in the area are over 65. Around 1 in 5 provide unpaid care and around 1 in 6 receive formal care.

Of the working age people thought to be at risk of loneliness, 1 in 3 are informal carers and 2 in 3 are new parents. Very few working age people receive formal care in the Barbican.

Dr Green's study observed that isolation was also a particular issue for older LGBT people in the Barbican area, with limited engagement with community activities or good neighbour schemes.

Loneliness in Golden Lane

Our estimate suggests that loneliness in Golden Lane is overwhelmingly an older people's issue, with 80 per cent of those thought to be affected over 65. While the proportion providing informal care is in line with the City average and a slightly higher number receive formal care, the vast majority have no known care needs.

Income may be a factor restricting social activities for some older people on Golden Lane. Of the City's 130 Pension Credit claimants in August 2015, 50 lived on Golden Lane. Claimants tended to share several of the risk factors associated with loneliness, such as living alone and being in later old age.

[10] Roger Green and Tim Stacey (2015), 'The Voices of Older People: Exploring Social Isolation and Loneliness in the City of London.'

Of the working age people thought to be at risk of experiencing loneliness on Golden Lane, half are informal carers and half are parents of young children. Again, few working age people receive formal care here.

Loneliness in Portsoken

Our loneliness estimate in Portsoken produces a more even split between age groups, with working age people accounting for 40 per cent of the total. Around half of these are providing informal care, a third are new parents and 1 in 5 are recipients of social care.

Three quarters of the older people thought to be at risk of loneliness in Portsoken neither provide informal care nor receive formal care. Very few older people here provide informal care, while 1 in 5 receives a care package from Adult Social Care. Portsoken has a higher number of Pension Credit claimants (60) than Golden Lane, despite having fewer people of pension age overall, indicating that income is likely to be an even larger barrier to socialising here.

Dr Green's study found that ethnicity was associated with loneliness on the Mansell Street Estate, with one resident saying said she felt that there was 'no bridge' between the different communities. This research, along with national data and the relative youth of Portsoken's BAME population, indicates that problems with loneliness are likely to be especially prevalent.

Loneliness in the West and Central areas of the City

Our estimate suggests there is less loneliness in the West and Central areas of the City. These non-residential areas are home to 32 per cent of the population but only 10 per cent of the people thought to be at risk of loneliness.

The picture of who is lonely is also very different here, with primarily working age people thought to be affected. In the centre of the City, loneliness is primarily thought to affect parents of young children. In the West of the City unpaid carers stand out as making up almost half of the total. Housing tenure is likely to restrict the population in both of these areas to affluent individuals. Targeted interventions aimed at busy professionals juggling work with parenting or caring responsibilities should be considered here.

4 Current provision

The estimates of loneliness given in section 3 do not take into account the positive impact made by current efforts to reduce isolation. A wide range of activities are already on offer in the City that provide opportunities for social interaction.

4.1 City Corporation provision

The City Corporation aims to reduce loneliness though the Reach Out Network of support groups for older people, carers and people with memory problems or a diagnosis of dementia.

Age Concern are commissioned to provide a volunteer befriending and shopping service for older people or people with mild to moderate mental health problems. This includes telephone and e-befriending for those with limited mobility.

Many classes and groups are also available in City libraries, through the Adult Skills and Education Service and as part of the Young at Heart programme run from the Golden Lane Leisure Centre.

4.2 Neighbourhood development

The City Corporation's Neighbourhood Development Team aims to build and support strong and inclusive groups that enable people to feel more connected to their community and happier in their homes.

Their work includes supporting residents associations to develop and grow, running one-off events on estates and longer term projects such as the CityPlay East and Remembering Yesterday, Celebrating Today, and supporting the Neighbour Networks that provide an easy way for neighbours to volunteer in their local communities.

Spice Time Credits are a crucial part of the City Corporation's neighbourhood development work. Time Credits encourage people to volunteer or form their own groups. Spice's 2015 evaluation found that 60 per cent of volunteers said their level of social contact had increased as a result of Time Credits and 32 per cent said they felt less socially isolated.

4.3 Community activity

A wide range of community groups operate in the City, many of them using the Spice framework. Gardening is hugely popular in the City, with groups operating on most estates and Friends of City Gardens working throughout the City. Each estate also has an older people's group and residents' association. Ward members in Portsoken put on a busy programme of events and social activities.

St Luke's community centre in Islington and St Hilda's community centre in Tower Hamlets have busy schedules of classes and events, including regular older people's lunch clubs. Specific provision for the Bangladeshi community is available in the form of lunch clubs at Toynbee Hall and Sonali Gardens as well as the Mohila Women's and Girl's Spice Time Credits groups that meet at the Portsoken Health and Community Centre.

As well as running the City Corporation's befriending service, Age Concern City of London run a range of other projects promoting social and digital inclusion. These include busy Walking for Health groups, regular trips, Techy Tea Parties and targeted work with the most disadvantaged communities in the Square Mile.

4.4 Health related provision

The City and Hackney Clinical Commissioning Group (CHCCG) has commissioned Family Action to run a social prescribing pilot project. If a person's GP thinks they might benefit from taking part in activities or joining social groups, they will refer them to the scheme. The surgery's Wellbeing Coordinator will then meet with the person to talk through the options available and work with them to find local activities, services or advice that suit their needs and interests.

One Hackney and City provide a similar service for the most vulnerable patients as well as those with serious physical and mental health problems.

The City and Hackney Wellbeing Network helps people to build resilience and to alleviate issues such as stress, anxiety and low mood. As well as offering a large number of arts and activity based groups, courses developing emotional resilience, managing difficult emotions and building self-confidence are very relevant in the context of reducing loneliness.

4.5 Provision for new parents

The City has one Children's Centre within its borders, the Cass Child and Family Centre in Aldgate. City parents can also access the Golden Lane Children's Centre nearby in Islington. A range of drop in Stay & Play sessions and bookable advice, support and educational activities are on offer. Three community libraries offer a weekly schedule of parent and child activities such as Storytime, Rhymetime and Stay & Play.

The Adult Skills and Education Service offers a range of courses intended for parents to take with their children, such as Family Arts and Crafts and Learning Through Play. Courses are also available to address the practical issues that may be contributing to parental isolation, such as English for Speakers of Other Languages (ESOL), CV writing and interview skills. Little Outdoor Explorers, developed by the Family and Young People's Information Service, is an occasional six-week course designed to build confidence in parents with children under five, by helping them to venture out into the urban environment.

Targeted City parents will receive two additional Health Visitor assessments (supplementing the mandatory five) in their home with a focus on maternal mental health, maintaining infant health, promoting development and keeping safe. The targeted offer is aimed at first time parents and families identified as having needs such as physical or mental health problems, substance misuse issues and safeguarding or domestic abuse concerns.

The Hackney WellFamily Service is a primary care service commissioned by the CCG and provided by Family Action, aimed at addressing complex psychosocial needs. The service provides recovery-focused and holistic interventions including a mix of individually targeted and flexible practical and emotional support.

5 Evidence on interventions

5.1 Literature Review

There is limited evidence on what makes an intervention to reduce loneliness effective. A systematic review by Cattan and White was able to draw some limited conclusions about what showed the most promise.[11] Another evidence review compiled for the National Institute for Health Research made similar recommendations.[12]

The researchers concluded that group based interventions showed promise in reducing loneliness, especially when targeted at a specific group and with a specific activity in mind. Long-term effectiveness was improved by providing activities that enhance self-esteem and personal control. Where groups have a support purpose, such as post-bereavement, attendance needs to be over a period of five months or more to be of benefit.

One on one contact from health or social care workers may be successful at achieving other objectives, but has no impact on loneliness. One on one contact from a volunteer appears to be of limited impact, with the majority of studies failing to find a statistically significant impact.

While this indicates a preference for group based interventions, many group based interventions already exist and yet loneliness persists. This is because groups are only accessible for those who already possess the social skills to participate. The one on one interventions that have shown promise are those that aim to find and work with individuals at the stage before they can begin access group activities.

The outcome of technology-assisted interventions depends on whether existing relationships are being developed or new ones are being sought. There is some limited evidence that loneliness can be reduced by training older people to communicate online with friends and family. However, three systematic reviews of telephone-based interventions looking to match people with new contacts showed no decrease in loneliness.

Evidence also suggests that an asset based approach is likely to be effective in tackling loneliness. This means involving participants in the design and delivery of services in order to harness the skills, knowledge and connections already present within a community. Working in an asset based way is more likely to be successful as it is better able to deliver services that the intended beneficiaries want, to genuinely involve people as co-producers and to be sustainable in the long term.[13]

5.2 The Social Wellbeing Panel

The City Corporation established the Social Wellbeing Panel to gather further evidence on successful interventions implemented elsewhere and to learn more about how to reduce loneliness in the City.

Based on community research and feedback from residents, the Panel chose to hear from experts on isolation amongst new parents, Black and Minority Ethnic older people, those living in the commercial areas of the City and people with physical and mental health issues. Despite these groups having different circumstances, shared themes emerged from each evidence session.[14] These themes, discussed in the next four sections, will be the building blocks of any attempt to reduce loneliness.

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[11] Cattan, M. White, J. Bond and A. Learmouth (2005) 'Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions' Ageing and Society 25:1. p.41-67.
[12] Interventions for loneliness and social isolation; The University of York Centre for Reviews and Dissemination (2014)
[13] Jane Foot (2010) 'A glass half-full: how an asset approach can improve community health and well-being'
[14] Improving Social Wellbeing in the City of London: Reducing loneliness and building communities (2017)

5.2.1 Asset Based Community Development

In every evidence session witnesses spoke of the strength of volunteers, the effectiveness of peer support and the benefits of placing trust in communities. Local people are experts in their own lives and know what community assets they value and what further support they need to thrive. Local people already have the trust of their neighbours, the networks to reach people seen as 'hard to reach' by public services and the life experiences and language necessary to build relationships.

As well as providing valued support to others, volunteering can be transformative for the volunteer, building skills, confidence and social capital, instilling a sense of purpose and having a significant impact on personal wellbeing. Witnesses from a maternity support project spoke of their volunteers going on to train as midwives and doulas, while a community research project saw their interviewers grow in confidence and independence during the life of the project, becoming agents of change in their own communities.

Taken together, these principles lead to an asset based approach. This moves from seeing communities as repositories of need, such as loneliness and isolation, to being the source of opportunities and strengths, like volunteers and neighbours with lived experience. Instead of seeing people as clients receiving a service, commissioners should move to viewing people as citizens, each with something to offer and with the capacity to develop their own potential.

A word of caution was sounded that an asset based approach can take time to show results. Some communities will need an initial investment to strengthen and support local associations and it will take time to build up confidence and a sense of empowerment, as well as to build trust and assure local people that there is a genuine intention to share power with them. Finding enough suitable volunteers who can commit sufficient time to a project and sustain their involvement in the long term can also be a challenge.

In the City of London, this approach is most developed in the Portsoken Ward on the City's eastern edge. Here the ward's elected Members act as facilitators for community activity, securing funding and asking local people to decide what is most needed. While residents have the final say, Members have a preference for activity with a clear purpose, such as gardening or social trips, as this has proven to be most effective at bringing people together.

Regular and keen attendees are seen to be the most effective means of promoting events. They are asked to reach out to friends and neighbours who may be more isolated and to bring them along. This kind of low commitment activity may also be a good way of recruiting new volunteers and act as a catalyst for more involvement.

5.2.2 Shared Spaces

Another common theme to emerge was the need for shared spaces where relationships can develop naturally and where community building can take place. This can include some public sector places such as libraries, other inclusive spaces like cafes or venues run by community groups or simply areas of the streetscape that are welcoming, safe and encourage people to socialise.

To be effective assets for enhancing social wellbeing, shared spaces must be welcoming and informal. They must not appear to be, and should not be, the front door of statutory services. Many people will be unwilling to engage in venues where they fear judgement or where they may be given more help than they are ready to receive. Trust must be built up gradually on neutral ground, with contact moving at a pace set by each individual. Referrals to formal support, while important, can only be made once relationships are established and myths are dispelled.

Shared spaces should also have a broad appeal, offering activities and events that a wide variety of people want to participate in. Not only will a wide appeal enable more relationships to form, it is also an essential part of engaging with isolated people, as it prevents an intervention from becoming stigmatised.

While venues are important, those delivering loneliness interventions should not feel tied to their own bricks and mortar. Taking opportunities to engage with people in the informal spaces where they normally are is equally important. Venues such as housing estates, supermarkets and faith buildings should not be ignored.

5.2.3 Early Intervention

All of the speakers at the Social Wellbeing Panel stressed the importance, but also the challenge, of early intervention. If loneliness leads to lower personal wellbeing and risks to physical and mental health, providing support sooner is clearly preferable. It is also easier to deal with problems at an earlier stage, before the psychosocial effects of loneliness, such as lower confidence and a reluctance to engage with others, become entrenched.

The shared spaces discussed above play a crucial role in early intervention. People may not be comfortable approaching statutory services for help, but important issues can come out in informal and comfortable spaces once trusted relationships have been built up. Food or entertainment can draw people into venues and often more serious issues are raised. Other people participate when they realise there are people willing to listen and help is available.

There is also a need to work hard to let people know support is available. Poorly advertised support will only be accessed by those who would have found it anyway, those who are already well connected or who have the skills required to easily find and access help. Providing written information, in the right places and in the right format, as well as keeping health and community professionals briefed on the support available is a starting point. However, the best method of reaching the most isolated is to have advocates within the community who will vouch for services and actively promote them to a wide network.

A culture change across services can also play a part in early intervention and every service provider should be encouraged to ask themselves what they can do to improve social wellbeing. GP practices have developed this approach well, with social prescribing schemes enabling doctors to refer patients at risk of loneliness to social support.

5.2.4 Building Skills

A final theme to emerge was the potential to reduce people's risk of loneliness by building their skills. This could be about enabling people to have more ways to communicate, either through learning a shared language or by getting online and learning how to make new connections and keep in touch with friends and family on social media and Skype.

It could also look to the Recovery College Model and involve increasing people's ability to manage their own health conditions, thereby being better able to focus on other aspects of life such as social wellbeing. This is relevant beyond mental health, and includes helping everyone to develop the skills needed to make new connections and ensure their current relationships are healthy and mutually beneficial.

The effectiveness of skills development interventions can be enhanced by using asset based approaches and shared spaces. Recovery colleges use a co-production approach between a professional tutor and a peer supporter who is an 'expert by experience'. Languages and IT classes will have the best reach with their target audiences if they are supported by volunteers from those communities and if they are delivered in a local and welcoming venue.

6 Approach One: Asset Based Community Development

The evidence from the literature review and the Social Wellbeing Panel points to Asset Based Community Development as an effective way to tackle loneliness. Community based responses have the potential to reach isolated individuals that officials ones could never hope to connect with, to be sustainable in the long term and to maximise opportunities for social contact and personal growth by involving local people in their design and delivery.

The City Corporation has a role to play in creating the conditions necessary for community groups to thrive and in supporting vulnerable members of the community to feel able to take part and contribute their personal assets. However, the City Corporation should not seek to define community for residents and should recognise that many different understandings of this concept exist. Communities of interest, place and circumstance all enable people to connect to others and the most suitable approach will vary from person to person.

6.1 Communities of interest - Community Connectors

Throughout Dr Green's research, City residents report being lonely but also feeling that something is holding them back from engaging in the community life they know exists on their doorstep. He found that many lonely people were waiting for a helping hand to take the first step and approach these groups, either because they were unaware of what was available, because of a lack of confidence and a fear of rejection or simply because long established habits can take some encouragement to break.

Instead of waiting for lonely individuals to ask for help, there is a need for a more nuanced befriending approach that reaches into communities directly and pro-actively. Community Connector volunteers would help people to reconnect with their community using the individual's interests and skills. They would offer positive encouragement and emotional support, as well as practical help to identify activities that align with the person's passions and abilities. At first the volunteer may accompany the person to a new activity, or it may be enough to buddy them up with other new attendees. Ultimately the aim is to help build each person's confidence so they are able to take part independently.

Volunteers would be the face of the project and would use their existing social networks to contact people at risk of loneliness, making their approach more likely to be trusted and accepted and giving the project a wide reach into local communities. Referrals would also be sought from concerned family members or neighbours, frontline City Corporation staff who notice something amiss, and self-referrals from people who realise they need some additional support. Partnering with the Fire Service's Home Fire Safety Visits could give the Community Connectors direct access to some of the most isolated people in the City. Where a similar partnership was trialled in Cheshire, an Age UK advocate was invited into 98% of visited homes, resulting in the provision of further support in 36% of cases.

This quote from a worker in Gloucester shows how the project would work in practice:

> *"I received a call about a lady in her 70s living alone. I made contact and after discussing her interests I put her in touch with people attending her local chapel. She also enjoyed scrabble but had recently lost her fellow players due to illness. I was aware of another single lady living close by, who also enjoyed scrabble. With permission I passed on their contact numbers. Soon afterwards they arranged to meet and enjoy playing regularly. She says she is now much happier."*[15]

[15] Campaign to End Loneliness, Promising approaches to reducing loneliness and isolation in later life, http://www.campaigntoendloneliness.org/wp-content/uploads/Promising-approaches-to-reducing-loneliness-and-isolation-in-later-life.pdf

6.2 Communities of place – Neighbourhood Development

Neighbourhood development interventions may not be recognised as being intended to reduce loneliness by the communities they serve. Instead, they are focused on creating communities of place with shared activities bringing people together in a natural way.

As explored in 4.2, the City Corporation already has a successful Neighbourhood Development Team, which works to develop residents' groups and one-off events as well as promoting volunteering through Spice Time Credits and the Neighbour Networks.

The Volunteering Review found residents thought that more local and community based volunteering options would break down barriers between neighbours. In particular, there was a call for more housing estate based volunteering projects. This work will improve social wellbeing directly as people take part in activities, and indirectly, as when the community builds, people are more likely to look out for their neighbours.

Our approach to community development is to work with what is already there and keep momentum going, rather than continually changing our approach or suggesting new projects when development is slow-moving, but building. True community development means working with residents to assist them to develop and undertake activities that are inclusive and enjoyable for all, leading to long-term, workable community groups. We can do this by:

- continuing to support the 'Remembering Yesterday, Celebrating Today' programme of events which enables integration and intergenerational relationships to thrive;
- building the capacity of residents groups, using those at the Avondale Square estate as a benchmark and providing additional training and support where required;
- expanding our existing Neighbour Networks, providing support where necessary to foster these growing communities;
- offering clarity on where safeguarding procedures such as DBS checks are required and where they are not, and providing support for their administration;
- developing Time Credits as an empowerment tool for both estate staff and residents, encouraging a variety of new community groups to meet and develop;
- using mediation to improve communications with both newly-established and existing groups, to secure on-going relationships;
- building officer confidence to work with communities and to support resident led activity in its vital early stages;
- encouraging resident groups to cross estate boundaries and share what they do with others, working towards a City of London community;
- supporting Members and business organisations in the commercial areas of the City to better engage with their local resident populations.

6.3 Communities of circumstance

6.3.1 Perinatal support

All four witnesses speaking at the Social Wellbeing Panel's new parents evidence session agreed on the importance of providing support to new parents in both the periods before and after the birth of their baby. They also all spoke about the power of peer support and that using volunteers, rather than paid workers, would give a service the trust of the community, access to a greater number of isolated parents and the lived experience necessary to provide the right support to parents who are struggling.

The current offer to new parents is based around support provided by paid workers or informal group activities for parents and children in the libraries and Children's Centres. In

our consultation many parents told us that these groups were good for getting out and making acquaintances, but were not ideal venues for building deeper friendships.

This highlights a gap for a voluntary befriending service, supporting isolated parents from three months before birth up until their child's first birthday. A new perinatal support service would aim to develop a trained group of volunteers who were able to identify isolated new parents, encouraging them to form social groups with each other and provide mutual support, as well as signposting them to other services as trust is built up.

Our evidence on best practice told us that the most effective interventions started working with mothers from three months before birth. However, we recognise that this may present difficulties for working women. Consideration will need to be given to this when planning the work of the service. There should also be flexibility about what support means and it may be that these mothers would find it easier to engage online before their maternity leave begins.

6.3.2 Out and About at the Barbican

Dr Green's research noted a greater level of isolation was experienced by the Barbican's LGBT* community. In response, the City Corporation has commissioned Opening Doors London (ODL) to provide a pilot project working with this community.

ODL will establish a local, informal and supportive social group for LGBT* City residents aged 50 and over called 'Out and About at the Barbican'. Activities will be determined by attendees' interests and there will be opportunities to connect with ODL's London wide programme of events and befriending. The Barbican Centre has agreed to provide a regular meeting space and there is potential to work with the centre on a cross art project that will culminate in an installation in the Barbican foyers.

Initially the group will be supported by a small number of volunteers to act as 'buddies' for those less confident about coming along. Over the course of a nine month pilot, a small group of volunteers from within the City of London group will be recruited and trained to deliver monthly sessions and buddying themselves. The Sessional Worker will also identify additional support needs among more vulnerable members and offer advice, signposting and referrals to other support services as required.

6.3.3 The Mansell Street Women's Group

Dr Green's research also noted that ethnicity was a driving factor of loneliness for some residents of the Mansell Street estate. The City Corporation has commissioned Age Concern City of London to provide a pilot project working with women, primarily of Bangladeshi origin, aged 45 and over.

Age Concern will establish a bilingual social group based locally to Mansell Street at the Portsoken Health and Community Centre. Activities will be determined by attendees' interests and there will be opportunities to connect with Age Concern's local programme of events. The City Corporation will also run a Speaking English with Confidence class through the group, available free of charge to any member interested in improving their spoken English. Age Concern are also exploring the possibility of offering IT classes, either with the City Corporation or in partnership with Queen Mary, University of London.

Initially the group will be supported by bilingual (Sylheti and English) Engagement Workers. Over the course of the pilot, they will identify and support members of the community to take on volunteering and coordinating roles to enable the group to move towards self-sufficiency. The Engagement Workers will also identify additional support needs among more vulnerable members and offer advice, signposting and referrals to other support services as required.

7 Approach Two: Shared Spaces

Certain spaces in any area become locations where people not only 'meet and greet' each other but also where social and community capital emerges and where friendships and social networks can develop.

The Social Wellbeing Panel heard that to be at their most effective, these shared spaces should be separate from statutory services, be welcoming and offer activities with a wide appeal. Services should also move beyond their own spaces and seek to work with people in the places where they already go and naturally feel comfortable.

7.1 Libraries first

Public libraries provide a shared space where people feel they belong and which people feel comfortable visiting on their own. This provides an accessible, safe and relaxed space where people can access help at their own pace – as shown by the success of offering light-touch support at informal sessions in the libraries, such as the parent and child groups and Read and Relax group.

Efforts to improve social wellbeing should therefore take a 'libraries first' approach. Libraries are a place where many people naturally go, making them an ideal venue for outreach work. They are places where people feel at home, enabling trusting relationships to be built up. They are also an existing asset, reducing costs and offering value for money.

Some concerns have been raised that reduced library opening hours may limit their potential as community venues. However, the more libraries are used and the greater the number of services delivered through them, the better the budgetary pressures that have limited opening hours can be resisted.

7.2 Providing community space in City libraries

More can be done to fully utilise the City's lending libraries as focal points for the community. The Barbican area lacks a suitable community venue and this shortage of suitable local venues can make it difficult for residents to organise their own group activities.

The library is already a well-used community hub, but it lacks a separate, multi-use, low-cost space, bookable by groups where social activities can be run.

By repurposing some of the space within the existing footprint of the library, such a space can be provided. This space can then enable a variety of community activity to take place in a local and accessible setting, as already takes place at the Artizan Library and the Portsoken Health and Community Centre.

Shoe Lane Library in the West of the City has recently been refurbished to host a new wellbeing area, a cosy seating space, iPads for reading e-magazines and a coffee machine, all of which should encourage social interaction.

7.3 Improving City Corporation community spaces

Of the City's existing community spaces, two were identified in Dr Green's research as not effectively facilitating informal relationship building. There were the Golden Lane Estate Community Centre and the Portsoken Health and Community Centre, known locally as the Green Box. Current projects offer an opportunity to these spaces.

The proposal to refurbish the Golden Lane Estate Community Centre, and locate the City of London Community Education Centre (COLCEC) and the Estate Office on the same site would allow the Centre to remain open for longer by sharing reception staff. The Golden Lane Residents Association are carrying out a feasibility study into a community-led management model. Whichever option is chosen, it must overcome the issues with access arrangements and opening hours which have contributed to making Centre an underused space. An access agreement should also be arranged with the City of London Primary Academy Islington (COLPAI) to enable this to be used as an additional community venue.

The freeholders of the Mansell Street Estate are exploring completely redeveloping the estate to increase the density of homes. The proposal includes the provision of a ground floor public Community Centre to replace the Portsoken Health and Community Centre, as well as a community rooftop top space for Guinness residents. This should provide a more effective and inviting community space for the area.

The management model used for these community spaces matters as much as the design. Residents should feel a sense of ownership, spaces should be inviting and easily adapted to a range of purposes, and booking should be accessible. Again, the Artizan Centre provides an example to follow. Residents can book space and party pay in Time Credits, achieving the dual aims of increasing the amount of activity and making the space more available to people on lower incomes.

The Aldgate Square scheme will also create a new public space conducive to relationship building, providing the Portsoken area with a pleasant, central, open space by the end of 2017. The Aldgate gyratory it replaces was a traffic dominated system that was difficult for all road users to navigate. Instead, the new scheme will be centred upon a large green space available for events, leisure and play. This will host will CityPlay East as well as City Café, a new community venue equidistant between the areas two housing estates.

7.4 Using other community spaces

It is also important to think outside the spaces managed by the City Corporation and to offer support to people in the venues they naturally frequent. This will enable interventions to take place earlier and increase the chances of reaching those who are most isolated.

Potential venues could include the GPs' surgery, pharmacies, supermarkets, housing estate offices, pubs, cafés, places of worship and local cultural venues. For example, volunteers with the proposed perinatal support project could attend the Neaman Practice when the baby clinic is running and talk to new parents, offering further support if it is needed.

Local pharmacists are keen to be more involved with public health work and as 76 per cent of Neaman Practice patients have their prescriptions dispensed at either Portman's Pharmacy on Cherry Tree Walk or Chauhan's Chemist on Goswell Road, these venues provides a means to reach a large proportion of City residents.[16]

A recent study by the University of Hertfordshire highlighted the social benefits many older people gain from a trip to the shops and suggested that this could be enhanced by using slower checkout lanes to improve the social aspect of shopping or using special offers to encourage older people to shop at quieter times of the week, making the supermarket a less stressful and more enjoyable environment.[17] Dr Green's study found that the Waitrose on Cherry Tree Walk was a crucial 'bumping space' for Barbican residents and these ideas should be explored with store managers.

[16] City and Hackney Joint Strategic Needs Assessment City Supplement (2014)

[17] Wendy Wills, University of Hertfordshire (2016) http://www.foodprovisioninlaterlife.com

8 Approach Three: Early Intervention

Given the risks to health posed by loneliness, and the cumulative impact over time, it is clearly preferable to offer support as soon as possible. Sustained and consistent communication is needed to reach the most isolated – with the most effective forms of communication being service users and volunteers who will champion services to others. There is also a role for all service providers to play in reducing social isolation, from GPs surgeries to libraries and leisure centres.

8.1 Social prescribing

The City already has a pilot social prescribing service, commissioned from Family Action by the CHCCG. This allows GPs to refer patients with social and emotional needs to a Wellbeing Co-ordinator to receive tailored support. This will typically take place over two or three sessions and might result in referrals to welfare advice, walking clubs, art clubs, exercise groups or further support from the community or voluntary sector. Referrals to mental health support or CBT (cognitive behavioural therapy) are also available. If helpful, volunteers with the service can accompany people to the first sessions of a new activity.

The Neaman Practice has improved from being a low referrer of patients into the scheme to an average one, but a number of actions could be taken to ensure social prescribing is fully utilised as a means to support isolated people:

- Raising awareness of social prescribing amongst patients and the public, so if people feel they would benefit from the service they can ask for it, and do not need to wait for their GP to offer;
- Enhancing the social prescribing offer to carers. For most patients, GPs will make a referral to social prescribing if issues of isolation become evident during a consultation. Given the likelihood of carers both experiencing loneliness and attending the GPs' surgery, GPs could pro-actively discuss social wellbeing with all carers and consider referrals to social prescribing;
- Building links with other City services. A referral agreement between Social Prescribing and Fusion Leisure is being piloted and an agreement with Spice Time Credits is being explored;
- Working with Tower Hamlets CCG and ensuring that their new social prescribing service has the information and capacity to effectively support people living in the East of the City;
- Making more use of One Hackney and City for patients with serious physical and mental health problems and those who have previously been reluctant to engage with support;
- The actions listed in improving information below will also help the Wellbeing Coordinators to better tailor their support to a patient's needs and interests. Wellbeing Coordinators work mostly with Hackney or Tower Hamlets patients, and there is a need to make it easy for them to know what is available in the City.

8.2 Improving information

There is already a large amount of community and voluntary activity in the City of London, but barriers can make it difficult for socially isolated people to get involved. Some of these barriers will take considerable effort to overcome while some may be dealt with more simply. Improving communication offers a way a relatively large number of people with low level needs can be supported to engage with the community.

Dr Green's research found that information about current activities had considerable room for improvement and speakers at the Social Wellbeing Panel stressed the need for sustained

and consistent communication reiterating that support is available, in order to intervene as early as possible and reach those most in need.

Communications about the social activity available in the City could be improved by:

- Providing a one-stop website listing community groups and social activities in the City of London;
- Producing a City Over 50s Guide listing the most popular community groups and services working to improve social wellbeing;
- Ensuring full use is made of existing publications such as City Resident and the Barbican Broadcasts to raise awareness of community activity;
- Making more use of new technology such as Meetup and interests.me to enable people to find out about activities and make new connections.

8.3 Assertive outreach

A range of City Corporation services, such as the Fusion Young at Heart Over 50s Group or the reading groups in the libraries provide opportunities for social contact and companionship. Looking at those who have recently dropped out of attending may help identify those affected by social isolation.

Initially staff from the service should contact the resident. They may have an unrelated issue for non-attendance, such as having moved out of the area, or they may have comments relevant to the service. However, staff should also be alert to any social issues that may arise and should either seek to deal with these themselves or seek permission to make a referral to the Community Connectors or other services as appropriate.

Training may be required to enable staff to make the calls confidently and effectively. Targeting people who have recently dropped out of attendance at a group may find people who have experienced a significant life event, such as bereavement. These conversations and subsequent referrals will need to be handled sensitively. The calls may raise a number of issues, for example a fall in income may have caused a resident to stop going to a sports club, and officers will need to access to a wide variety of service to meet this range of needs.

Social Workers should ensure that their work with carers promotes having a life outside of their caring role, making use of referrals to the Reach Out Network, Community Connectors and other sources of support as appropriate. The Carer's Strategy also commits to developing a carer's buddying system to provide additional one to one peer support.

8.4 Financial safeguarding

The City of London Adult Safeguarding Board Sub Group has identified preventing financial abuse as a priority for the City, as this accounts for the second highest number of adult safeguarding alerts in the Square Mile.

Financial abuse has a complex relationship with social wellbeing. Those who are already isolated are more likely to become victims of financial abuse, while those who are targeted are at risk of experiencing a significant emotional impact, increased stress and anxiety, reduced self-esteem and family relationship breakdown.

To tackle financial abuse, a Task and Finish Group with representatives from the City Corporation, City Police and voluntary sector has been established. An awareness raising leaflet will be included alongside every 2017-18 Council Tax Bill and the participating organisations will explore how data sharing between them may enable those at risk of financial abuse to be identified and supported.

9 Approach Four: Building Skills

Developing skills can improve an individual's social wellbeing by enabling them to have more ways to communicate, make new connections and keep in better touch with friends and family. Improvements can also be made by learning to value existing personal relationships as wellbeing assets and by achieving personal development goals to build self-confidence or reframe an individual's attitude to the time they are alone.

9.1 Language skills

Improving the English language skills of those City residents who are not yet fluent will enhance their ability to make new friends outside of their own linguistic community. Chance encounters with neighbours or at the school gates will become more likely to lead to developing friendships, while gaining employment or joining a community group will be made easier. ESOL (English for Speakers of Other Languages) classes have an important role in promoting social integration and community cohesion.

In the 2011 Census, 101 residents said they could not speak English well or at all. These were mainly (80) working age people concentrated in the East of the City. In Portsoken 18 per cent of households contain no-one who speaks English as a main language, 4 per cent of households do not contain an adult who speaks English as a main language and 11 per cent of households contain some adults who do speak English as a main language and some who do not. This means 33 per cent of households in the area could benefit from additional English language education.

Offering additional pre-entry and entry level ESOL classes at Sir John Cass's Foundation Primary School in Aldgate or the Green Box on the Mansell Street Estate would make the classes more accessible to local people in Portsoken. Linking the classes to other community groups, such as the Mansell Street Women's Group with its bilingual outreach workers and community volunteers will extend the reach of the classes into the harder to reach sections of the community.

9.2: Technology tuition

Dr Green's research found that a large number of older people in the City had only very basic computer skills. This was particularly evident in discussing how residents became both physically and visually separated from their families who might live in another part of the UK or abroad, and felt very isolated from them despite regularly speaking to a child or grandchild over the phone. Many people were unaware of the social benefits of using Skype with a camera to keep in closer contact with family or friends.

Providing IT training would enable more people to get online and connect with friends and family or new people who share their interests. Age Concern City of London have previously run a training scheme, cITy Smart, at the Artizan Library and COLCEC (which also runs its own computer classes). Whilst this was successful at promoting digital inclusion amongst those who are moderately active and engaged, IT training in community venues misses those who are most isolated and unable to travel.

The training should follow the principles laid out by the Good Things Foundation, which found that using peer support, from trained volunteers who have experienced similar challenges to their trainees, and lending people devices to use in their homes was particularly effective. The training should be responsive to the person's needs and interests, but with a focus on establishing social networks both on and offline. This could include closed Facebook and WhatsApp groups for participants, linking them in to special interest groups and forums online and using Skype to keep in touch with family and friends.

The training should also be supplemented by offline events, as it is a lot easier for people to chat to one another online if they have met in person first. Regular drop in IT sessions at a local venue should be available for those who can get there, while occasional social meetings with transport provided for everyone will enable digital relationships to flourish.

An intergenerational aspect to technology training should also be explored. This is something that was piloted previously as part of cITy Smart and St Paul's Girls School in the Barbican area have expressed an interest in playing a role.

9.3 Signposting to relationship advice

Research by Relate found that around one in five couple relationships are distressed to the point where the problems are having a clinically significant impact on one or both partners' wellbeing. There are also clear links between relationship distress and depression, anxiety, increased blood pressure and heightened risk of heart attacks.

Several life events older people are likely to experience, such as retirement, children leaving the home or becoming a carer can put relationships under considerable strain. However, only 4 per cent of Relate clients are over 60. Becoming a parent, particularly for the first time, also puts people at risk of experiencing personal and relationship distress. It is estimated that 40 to 70 per cent of couples experience a decline in relationship quality in their first year of parenthood.

Providers of counselling and support services typically operate a pay-what-you-can-afford model to ensure services are as accessible as possible. However, cultural attitudes often delay people seeking support and research indicates that most people who access relationship counselling believe they left it too late. Personal relationships are widely held to be a private matter and people often feel obliged to address any issues themselves without outside help. Similarly relationship support is often perceived as a specialist activity – the preserve of specific provider organisations. Frontline practitioners may need support to identify relationship distress, value relationships as an asset, and make appropriate referrals.

City Corporation officers and partner agencies should be offered training to help them identify relationship difficulties, respond using active listening and solution-focused techniques, and make appropriate referrals to further support. Embedding relationship support in services which are already accessed and trusted by people, such as GPs, health visitors, social workers and housing officers, can achieve more widespread take up.

Greater use should also be made of the social and emotional wellbeing courses offered by the City and Hackney Wellbeing Network. Courses are available at no charge to City residents and can help individuals to change how they respond to difficult emotions and situations, build self-confidence, develop emotional resilience and take part in arts and other activities in a relaxed and therapeutic setting.

10 Evaluating the impact

Evaluating the impact of any intervention to improve social wellbeing presents a number of difficulties. The stigma associated with loneliness can lead to significant levels of under-reporting. Loneliness is a fluid and subjective state, with vastly different experiences felt between individuals and by the same individual at different times. There will also always be considerable uncertainty as to whether the most vulnerable have been reached, as the most isolated are by definition not known to services and not easily found.

10.1 Public Health Outcomes Framework

The Public Health Outcomes Framework can provide one indicator. This asks Adult Social Care service users and informal carers whether they are satisfied with their current level of social contact. Improving these scores would be an encouraging sign. However, the confidence intervals attached to the data for the City of London are high, making any change unlikely to be statistically significant. The indicator also does not attempt to measure reductions in loneliness in the general population at a stage before they begin to require care, although the Department of Health has said that it will introduce such a measure.

10.2 Quantitative scales

Individual interventions should be evaluated using a quantitative scale to numerically measure participants' feelings about their own level of social contact. A number of different scales are available, with varying degrees of academic rigour, sensitivity and clarity between different types of loneliness.

The Campaign to End Loneliness Measurement Tool has undergone academic tests to ensure it produces valid and reliable results, it is short enough to be used routinely be service providers and it contains positive, sensitive, non-stigmatising language. Participants are asked to answer the following three questions on a scale of strongly disagree to strongly agree:

- I am content with my friendships and relationships
- I have enough people I feel comfortable asking for help at any time
- My relationships are as satisfying as I would want them to be.

Answers are combined to place each individual on a twelve point scale, ranging from lowest social wellbeing to highest.

This can be used to evaluate a service in two stages. All new participants should be asked to answer the questions at an early stage. This will provide a baseline and will also allow the service to check whether it is engaging with participants who truly need help to improve their social wellbeing. This is not intended filter out individual participants, as the scale has explicitly not been designed or tested to work as a screening tool. However, it may provide an indication that a service needs to refocus its outreach work.

After a period of six to twelve months all participants should be asked to answer the questions again. The focus will now be on how people's scores have changed over time. If someone scores '9' at one point, and then '7' three months later (after having been matched with a befriender, for example) it is reasonable to assume that their experience of loneliness has decreased.[18]

[18] Campaign to End Loneliness 'Measuring your impact on loneliness in later life', http://www.campaigntoendloneliness.org/wp-content/uploads/Loneliness-Measurement-Guidance1.pdf

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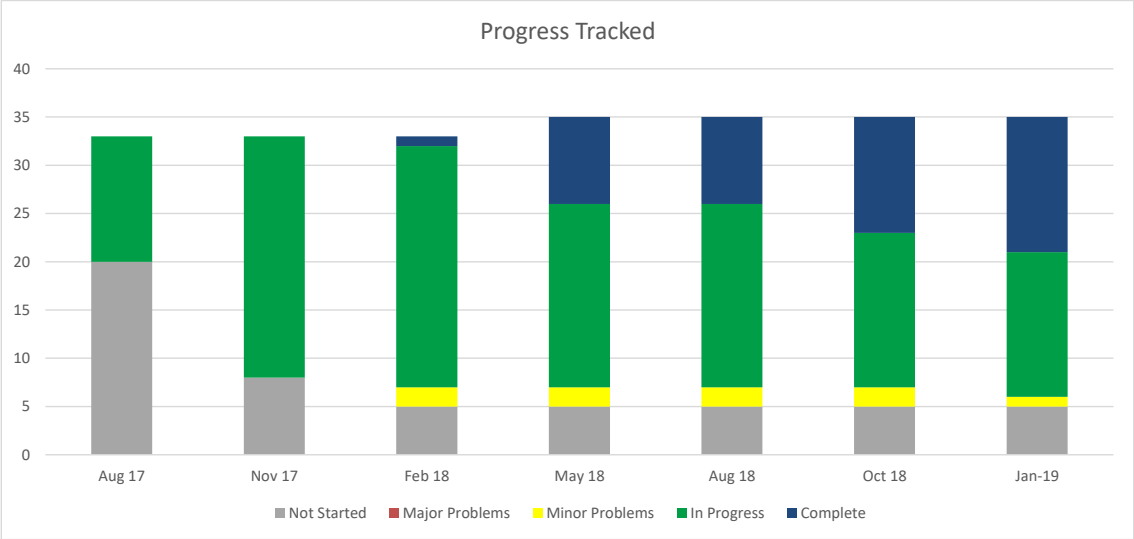
Name:		Social Wellbeing Strategy Action Plan	
Duration:		2017-2020	
Relevant Strategies:		Joint Health and Wellbeing, Resident Communications & Engagement, Mental Health	
Board responsible for monitoring plan:		AWP / ASMT	
Owner:		Claire Giraud	
Implementation date:	Jul-17	**Review date:**	Jan-19

RAG Status Key and Summary	
Not Started	5 (-3)
Major Problems	0
Minor Problems	1 (-1)
In Progress	15(-9)
Complete	14 (+11)



Approach:	Asset Based Community Development						
Objective:	Encourage community based responses to loneliness, drawing upon and enhancing the assets, strengths and skills already present within the City of London community.						
Ref:	**Action:**	**Start:**	**End:**	**Measure/outcome:**	**Lead officer:**	**RAG Status:**	**Comment:**
1.1	**Communities of interest**						
1.1.1	Pilot a Community Builders project	Aug-17	Mar-18	i) Increase in social wellbeing of participants (CTEL measurement)	Neighbourhood Development and Engagement Manager	Complete	The first pilot group of Community Builders on Golden Lane is complete. Jade Ibegbuna has been evaluating outcomes using the star evaluation method. The community builders on Golden Lane organise community coffees and weekly chats. A wellbeing event was held in the community centre on 19 November 2018.
1.1.2	Roll out of Community Builders project	May-18	Sep-18	i) Increase in social wellbeing of participants (CTEL measurement)	Neighbourhood Development and Engagement Manager	In Progress	Phase 2 of the Community Builders project is underway. Jade Ibegbuna has begun visiting other City estates to engage with residents. We are developing a sustainable model of delivery and training that incorporates the different local contexts of each estate, but that keeps the ethos of Community Builders. Recruitment and training for new community builders from other estates is being facilitated and supported by a Peer Research project addressing social isolation, which is being developed by Dr Roger Green of Goldsmith University with Strengthening Communities funding. Peer researchers will be encouraged to become 'Community Builders'.
1.2	**Communities of place**						
1.2.1	Develop and expand our existing Neighbour Networks	Aug-17	Jul-20	i)Proportion of City estate residents satisfied with their neighbourhood as a place to live ii) Percentage of participants involved in community activities iii) Proportion of residents involved in community activities who are new to volunteering and volunteering reporting an improved quality of life	Neighbourhood Development and Engagement Manager	Complete	Volunteers supported a Community Arts Project on the Golden Lane Estate. We are awaiting an evaluation report.
						In Progress	Research by Roger Green is underway, with Roger visiting various out of City estates. Training for the first 8 community researchers has taken place on 13 December 2018, 6 estates have been chosen for interviews, the pilot estate will be Southwark collington house, the interviews are to be conducted in January, the interviews and their results to be reported on by Easter 2019. 18/1/19 The first interviews are taking place on Monday Jan. 21st at Collinson Court, Southwark.

1.2.2	Continue to support the 'Remembering Yesterday, Celebrating Today' programme of events	On-going	Dec-18		Neighbourhood Development and Engagement Manager	Complete	Remembering Yesterday, Celebrating Today was incorporated into the Avondale Community Events Big Picnic on 1st September. The Community Engagement team have been Supporting their poppy artwork programme and linked in with Royal British Legion for fundraising etc. This project has come to close now as we reach the end of the Centenary year marking the end of WW1. Avondale Community Events held an auction of their collaborative art works based on the poppy emblem, in partnership with the Royal British Legion on the 25th October which raised money for the Legion. The project included a piece from Mark Anthony Taylor.
1.2.3	Work with residents to assist them to develop activities that are inclusive and enjoyable for all, using those at Avondale Square as a benchmark	On-going	Jul-20		Neighbourhood Development and Engagement Manager	Complete	Aldgate Community Events were a key partner in the delivery of the Aldgate Square Festival. CE Team worked extensively with ACE to ensure a very thorough outreach programme for the event, from initial consultation right through to an open call for performances. The Aldgate Square Festival took place in June as the community launch of the new public square after an extensive community engagement and outreach programme involving consultation and workshops to help design the festival. Over the three days we had over 1500 people attend the event from all across the community. We had performances from local residents, community groups and artists, as well as collaborating with local arts organisations to pull together a diverse programme that reflected the community of Aldgate.
1.3	**Communities of circumstance**						
1.3.1	Commission a pilot Perinatal Support Project	Aug-17	Aug-18	Increase in social wellbeing of participants (CTEL measurement)	Strategy Officer (Housing and Adults) Commissioning Manager (Housing and Adults)	Not started	Action on hold - Initially we considered creating a Maternity strand within the Community Connectors instead of commissioning a group but for now this is already addressed with the CCG numerous ante natal classes.
1.3.2	Monitor and support the ongoing pilot project 'Out and About at the Barbican'	On-going	Dec-17	Increase in social wellbeing of participants (CTEL measurement)	Strategy Officer (Housing and Adults) Commissioning Manager (Housing and Adults)	In Progress	Spoke with the provider re attempts to increase City attendances - speaking with JI in order to ensure the community builders are aware of this service. 13 November 18 the project manager reported: "We have recorded 6 LGBT individuals from the City who have attended the group and associated activities in the last six months. We're still struggling to reach residents but have had some engagement via Barbican Talks online" and that they will not be seeking funding for 2019
1.3.3	Monitor and support the ongoing pilot of the Mansell Street Women's Group	On-going	Apr-18	Increase in social wellbeing of participants (CTEL measurement)	Strategy Officer (Housing and Adults)		MSWG continues to meet monthly and has built up a regular group of attendees. Funding, to continue throughout 2018-19, has been received from the Stronger

								Commissioning Manager (Housing and Adults)	In Progress	Communities Grant Fund. Baseline CTEL evaluation surveys have been completed. Will need to look ahead for longer term commissioning of this service. MSWG has reapplied for funding in December 2018.

Approach:	Shared Spaces						
Objective:	Create and enhance shared spaces where people naturally come together, either through chance encounters or organised community activities.						
Ref:	Action:	Start:	End:	Measure/outcome:	Lead officer:	RAG Status:	Comment:
2.1	Libraries First						
2.1.1	Adopt a 'Libraries First' approach when delivering community activity	Jul-17	On-going	Promote libraries to all both as a venue for community activity and as an opportunity for outreach	Head of Barbican and Community Libraries	In Progress	Shoe Lane Library has been awarded funding for a project called "Release the Pressure". The project is now three quarters of the way through, and is now called "The Dragon Café in the City" (DCC). We have had 10 sessions so far with a wide mix of activities, such as storytelling, mindfulness, lunch & learn workshops, yoga, pickling workshops, hoola-hooping and chess. We have about 240 people registered with DCC, many of whom have attended multiple times, and we have on average a 76% increase in library visitors on the days we are hosting the café. We are currently working with Deloitte to evaluate the impact of the project, with a view to seeking further funding to continue it in the autumn/winter. 4 January 19 - Following the success of the dragon cafe funding for a new sustainable model is in the process of being agreed. in the meantime monthly one off sessions have organised in order not to lose the interest and momentum gained by this project.
2.2	Providing community space in City libraries						
2.2.1	Investigate the potential to repurpose an area of Barbican Library to create a separate, multi-use, low-cost community use space	Jul-17	Jul-18	I) The possibility of providing a community space has been investigated ii) If agreed, a bid for CIL funding is submitted	Head of Barbican and Community Libraries Assistant Director Barbican & Property Services	In Progress	framework produced using ASC, Police and City Advice datasets. Surveys will be designed for event participants and residents (ASCOF & STAR) to further gauge impact. Letter sent to all ASC ser 4 January 19 - A further set of options for a space with reduced soundproofing and possible alternative access points are currently being considered. Conversations with the barbican centre regarding out of hours access have taken place and are in the process of being costed. A further report will come to committee when the findings are complete
2.3							
2.3.1	Refurbish the Golden Lane Community Centre and reopen with a management model to maximise community use	Oct-17	Apr-18	I) Refurbishment completed ii) Management model chosen to maximise community use	Head of New Developments & Major Projects Head of Estates	Complete	Refurbishment of Golden Lane Community Centre was completed and handed over in July.
2.3.2	Seek an access agreement with the City of London Primary Academy Islington	Aug-17	Jul-19	Access agreement in place	Assistant Director, Commissioning & Partnerships	Not started	Action not yet required as this is not built yet

2.3.3	Ensure redevelopment of Mansell Street includes provision of a Community Centre as well as a community space for Guinness residents	On-going	On-going	I) Community Centre provided ii) Community space provided for Guinness residents	Principal Planning Officer	In Progress	The planning application for the Mansell Street development was submitted in September 2016 incorporates a Community Centre and community space for estate residents. The application is still pending while the applicants review aspects of the scheme. The proposed community provision would not be affected by these. 28/01/19 still working on a revised design but the amended scheme would still include a community centre and community space, the project is on hold for the next few months.
2.3.4	Complete the Aldgate Square scheme to create a public space that includes community use opportunities	On-going	Jun-18	I) Scheme completed	City Surveyor Engineer/ Project Manager	Complete	Scheme has been delayed but planned to complete in mid-June 2018.
				ii) Aldgate Play performed	Assistant Director, Housing & Neighbourhoods		We are combining the City Play project with the Community Fair, which is happening in June in Aldgate Square. Plans are developing and the community is engaged.
				iii) 25 per cent of Aldgate Pavilion Café employees from the local community	Assistant Director, Commissioning & Partnerships		Café will commence operation June 2018, commissioning manager (Lorna Corbin and then maternity cover) will monitor achievement of target.

2.4	**Using other community spaces**						
2.4.1	Social wellbeing services will deliver outreach work by visiting the places City residents already naturally go	Aug-17	On-going	Outreach in spaces such as housing estates, the GP surgery, supermarkets and places of worship	Strategy Officer (Housing and Adults)	Not started	Action first requires 1.2.1 (Neighbour Networks) to go live. Contract ends in April 2019 it will all be under one contractor after.
2.4.2	Explore the suggestions in the Food Provision in Later Life study with Waitrose at the Barbican	Aug-17	Dec-18	Discussions held with Waitrose to determine their level of interest	Strategy Officer (Housing and Adults) Raj Singh - Business administration apprentice	Minor Problem	Waitrose has been unable to commit to supporting the study, or allowing a Community Builder to spend a period of time in the store each week. However, a short list of shops that act as informal community spaces are being drawn up and contacted.

Approach:	Early Intervention						
Objective:	Reach lonely people sooner, through sustained and consistent communication and by carrying out outreach work using a wider network of partners.						
Ref:	**Action:**	**Start:**	**End:**	**Measure/outcome:**	**Lead officer:**	**RAG Status:**	**Comment:**
3.1	**Social prescribing**						
3.1.1	Raise awareness of social prescribing	Jul-17	On-going	Increase in participation in social prescribing	Wellbeing Coordinator	In Progress	Wellbeing Coordinator continues to promote service in North of the City. Item to appear in Square Mile Health leaflet.
3.1.2	GPs to pro-actively discuss social wellbeing with all carers and consider referrals	Aug-17	On-going	Increase in participation in social prescribing	Adult Social Care Service Manager	In Progress	Although outside of our direct control ASC service manager the issue is discussed at the strategic quarterly meetings with the Neaman practice, who report this as going well from their perspective. Zoe Dahmi (strategy officer) has met with the Neaman Practice on 18th July 2018. ZD is working on a wider integration programme, in particular the neighbourhood model for CoL - this will link in to how GP's refer people to other services. Evaluations and Q2 figures for social prescribing in London and hackney provided by Charlotte Painter from the NHS in January 2019.
3.1.3	Build links between social prescribing and other City services - Fusion and Tempo (previously Spice).	Jul-17	Aug-18	Improved health and wellbeing outcomes for social prescribing patients (measured by EQ5D)	Strategy Officer (Housing and Adults)	In Progress	An agreement is in place with Fusion to enable easier access for social prescribing clients. Discussions are underway about making Tempo Time Credits (previously Spice) available on social prescription. We are currently organising a meeting between Family Action and Spice Time Credits to create implementation plan.
3.1.4	Ensure new Tower Hamlets social prescribing service can effectively support people living in the East of the City	Jul-17	On-going	Improved health and wellbeing outcomes for social prescribing patients in Portsoken	Strategy Officer (Housing and Adults)	In Progress	AJ met with Jon Owens, Transformation Manager at Tower Hamlets CCG to discuss how their service can support our residents. Information on City services / groups provided to be passed to prescribers at Spitalfields and Whitechapel. Zoe Dahmi (strategy officer) to meet with Jon Owens again in regard to neighbourhood plan, which will ensure better outcomes for CoL residents.
3.1.5	Improve the information available to Wellbeing Co-ordinators about activities and services in the City	Jul-17	On-going	Improved health and wellbeing outcomes for social prescribing patients (measured by EQ5D)	Strategy Officer (Housing and Adults)	Complete	A quick reference guide to resources in the City has been prepared for CHCCG social prescribers.
3.2	**Improving information**						
3.2.1	Provide a one-stop website listing community groups and social activities in the City of London	Oct-17	Sep-18	I) Website developed and promoted across the City ii) Website is receiving a substantial number of page views	Strategic Communications and Engagement Manager Strategy Officer (Housing and Adults) Adult Social Care Service Manager	Complete	The FYi directory has been updated.

					Family & Young People's Information Service Manager		
3.2.2	Identity funding for and produce a City Over 50s Guide listing the most popular community groups and social activities	Aug-17	Sep-17	I) Guide produced and available in venues across the City of London ii) Distribution venues report members of the public are taking copies of the guide	Strategic Communications and Engagement Manager Strategy Officer (Housing and Adults)	Complete	The Guide is in production and the Community Engagement Team are coordinating listings with around 50 groups in and around the City. Aiming to design, print and distribute by the end of March.
3.2.3	Ensuring full use is made of existing publications	Jul-17	On-going	Relevant news stories are used to promote new and existing groups	Strategic Communications and Engagement Manager Strategy Officer (Housing and Adults)	Complete	Ongoing work using appropriate corporate and departmental channels such as quarterly City Resident publication.
3.2.4	Making more use of new technology such as Meetup and interests.me to enable people to find out about activities and make new connections	Jul-17	On-going	I) Interests.me site is developed as/alongside 3.2.1 ii) Meetup is promoted within other actions in 3.2 and in 1.1 and 3.1	Strategy Officer (Housing and Adults)	Not started	At present this has been put on hold. The information currently sits on the FYi directory. In the future it may be decided that the information is pulled over on to one of these formats, however, it would need someone being responsible for keeping it updated.

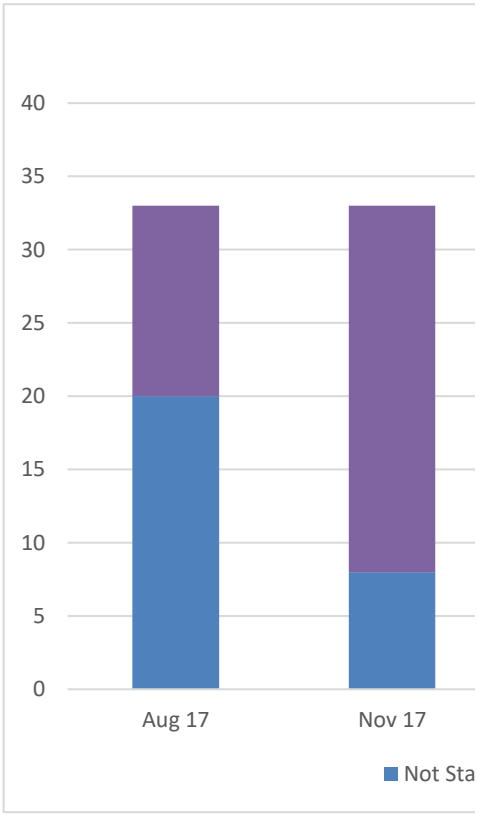
3.3	**Assertive Outreach**						
3.3.1	Officers and commissioned providers from services that have a social element to proactively contact residents who stop attending	Jul-17	On-going	Number of residents referred to Community Connectors, City Advice, Social Care or other sources of support	Strategy Officer (Housing and Adults)	In Progress	A training course to support officers in this role is currently being delivered. Engagement has been good from libraries, adult education and some commissioned providers. Community Builders have completed their training (pilot), and this is being progressed to social prescribers.
3.3.2	Social Workers to ensure that their work with carers promotes having a life outside of their caring role	Jul-17	Jul-18	Increase in social wellbeing of carers (measured in ASCOF)	Adult Social Care Service Manager	Complete	New carers assessment in place on Mosaic. This has a much greater emphasis on the needs of the carer (including social and community needs) rather than the person cared for.
3.3.3	Develop a carer's buddying system to provide additional one-to-one peer support	Jul-17	Jul-18	Increase in social wellbeing of carers (measured in ASCOF)	Adult Social Care Service Manager	In Progress	The idea of a buddying system is on hold awaiting the new carers strategy. Carers Network have advised they have tried this before with very mixed results.
3.4	**Financial Safeguarding**						
3.4.1	Reduce the prevalence of financial abuse in the City by raising public awareness and undertaking preventative work with vulnerable groups	On-going	Jan-18	I) Performance framework produced to give a profile of financial abuse across the City ii) Top 100 vulnerable people in CoL at risk of financial abuse identified and information session in their own home offered iii) Partnership Event held to raise awareness of financial abuse amongst officers, partners and residents iv) Increase in queries about financial abuse received by CoL and relevant partners v) Incidences of financial abuse avoided or intervention provided at an earlier stage	Assistant Director - People	In Progress	A framework was produced using ASC, Police and City Advice datasets. Surveys will be designed for event participants and residents (ASCOF & STAR) to further gauge impact. A letter was sent to all ASC service users offering preventative visits from Trading Standards, which Social Workers followed up on over the next 3 months. An awareness raising event, aimed at officers, partners and community figures, took place on 4 December 2018 and received positive feedback. Work is ongoing and the future direction / resourcing of the group will be decided at CHSAB City Sub Committee on 28/02/18. A service User Event for both City and Hackney residents on Financial Abuse Awareness Planning took place on 4/10/18. At the CHSAB in February , it was agreed that this specific workstream had achieved what it set out to do and future work in this area would be addressed by the CHSAB as a whole and not solely the City. To that end, there was a campaign in November 18 across CHSAB raising awareness of financial abuse. This was reported by the CHSAB to our Members. There is also a bigger strategic discussion taking place with ourselves in DCCS, Trading Standards, City Bridge Trust and Members to explore how the City can support regional and national initiative to help the banking sector improve its safeguarding practices in terms of preventing investment fraud. These conversations are at an early stage.

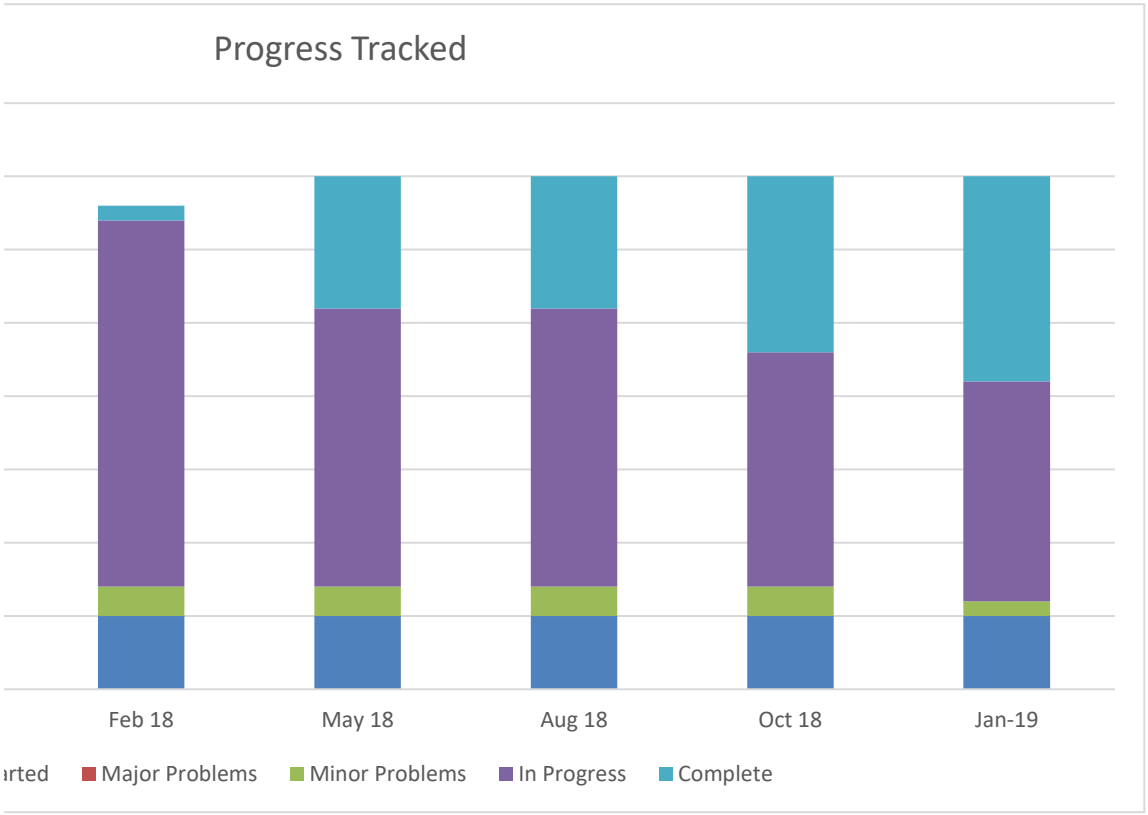
3.4.2	Participate in the national safeguarding research project run by Nottingham City Council	Aug-17	On-going	I) Research proposal submitted ii) Data collected and analysed	Adult Social Care Service Manager	In Progress	the research proposal has been submitted and accepted. A meeting was held with external evaluators and the requested logic model of links between social isolation work and safeguarding was provided. Part of the SAB 2018/19 plan, is to be followed by an analysis of returns/data including of cases that haven't proceeded to Section 42 investigation. 04/12/18 Research project updates sent to Nottingham as follows: As part of this work the community builders' pilot's first phase is complete, with community builders for one of our estates trained and running regular workshops and coffee catch up with their community; work is underway to 'recruit' community builders in the other estates. The learning from the CoL Financial Abuse awareness raising resulted in the City and Hackney Safeguarding Adults Board rolling out a similar campaign across whole of Hackney and City. At a macro level, conversations are progressing with Members of the CoL, Academics and CoL Officers to improve current safeguarding arrangements in banks linked to scams. Within the context of the City's small numbers , we have identified 1 potential case of financial abuse linked to social isolation. We are carrying out internal review and may be able to use as a case study for wider learning.

Approach:	Building Skills						
Objective:	Develop skills that will enable individuals to form new connections and enhance existing relationships.						
Ref:	**Action:**	**Start:**	**End:**	**Measure/outcome:**	**Lead officer:**	**RAG Status:**	**Comment:**
4.1	**Language Skills**						
4.1.1	Offer additional ESOL classes to residents who do not speak English fluently, at a time, place and cost they find accessible	On-going	Mar-18	I) Classes organised and attended by City residents ii) Number of ESOL qualifications achieved by City residents iii) Increase in social wellbeing of participants (CTEL measurement compared for MSWG members who attend and those who do not)	Quality & Performance Lead	Complete	Currently nine learners are attending English ESOL Conversation class and has been running since September. The session is delivered Monday morning 10:00-12:00 and proposal is to continue in the spring term and summer terms. Will continue to be delivered in summer term.
4.2	**Technology Tuition**						
4.2.1	Commission a digital inclusion project targeted at the most isolated and unable to travel, aiming to help participants have more contact with friends and family	Oct-17	Sep-18	I) Peer-to-peer training programme in place with participants and volunteers drawn from City population ii) Increase in social wellbeing of participants (CTEL measurement)	Strategy Officer (Housing and Adults) Lydia Dye-Stonebridge Executive Support Officer Commissioning Manager (Housing and Adults)	Complete	The specification for hybrid internal/external partnership is developed; Libraries will steer and host, volunteer management and programme coordination are handled by an external provider. RFQs sent 30.5; the selection is to take place in early July. Only Connect launches the week commencing 1st October 2018, Age UK has been commissioned. Update to follow as the new project manager from the City is put in place. There are only connect sessions on Wednesdays at the golden lane community centre. Age UK purchased in January 2019 a bank of devices (tablets etc) for the project.
4.2.2	Commission a shopping service to support food access for residents with limited mobility	Oct-17	Sep-18	I) Shopping service in place to support food access for residents with limited mobility ii) Number of clients who say confident using online shopping iii) Number of clients referred to 4.2.1 for further technology tuition	Commissioning Manager (Housing and Adults)	Complete	Started for one year on 1st April 2018. will then be part of the much wider Early Intervention and Ongoing Support Service.
4.3	**Relationship Skills**						
4.3.1	Identify funding for and offer training to resident-facing officers and partners, to enable them to identify signs of relationship distress and offer timely and appropriate support and referrals	Sep-17	Aug-18	I) Number of officers and partners received Brief Encounters training ii) Officers and partners report that the training has improved their practice engaging with residents experiencing relationship distress	Strategy Officer (Housing and Adults)	Not started	In conversation with providers to identify a course that meets the City's budget and training requirements. Awaiting update from Zak Darkwood

Progress Tracker

	Aug 17	Nov 17	Feb 18	May 18	Aug 18	Oct 18	Jan-19
Not Started	20	8	5	5	5	5	5
Major Problems	0	0	0	0	0	0	0
Minor Problems	0	0	2	2	2	2	1
In Progress	13	25	25	19	19	16	15
Complete	0	0	1	9	9	12	14




Progress Tracked
Feb 18
May 18
Aug 18
Oct 18
Jan-19
Major Problems
Minor Problems
In Progress
Complete

Committee	Dated:
Health & Wellbeing Board	11/02/2019
Subject: Draft Carers Strategy 2019-23	**Public**
Report of: Andrew Carter, Director of Community and Children's Services	**For Decision**
Report author: Zoe Dhami, Strategy Officer, Department of Community and Children's Services	

Summary

This report presents the City Corporation's draft Carers Strategy 2019-23 for endorsement.

The Carers Strategy will guide the design and development of services, support and activities for those caring for someone within the Square Mile and for carers working for the City Corporation. The new strategy covers support for young carers, which was previously dealt with in a separate document. This report outlines the main points of the Carers Strategy and summarises how it will be delivered and governed.

Recommendations

Members are asked to:

- endorse the draft Carers Strategy 2019-23 set out in Appendix 1.

Main Report

Background

1. The Carers Strategy is the overarching strategic document that will guide the design and development of services and activities for those caring for someone within the Square Mile and for carers working for the City Corporation. It sets out the values and principles that will guide our work, our vision and aims for carers, and how we intend to achieve them.

Current Position

2. The Carers Strategy explains:
    - what the issues are for our carers,
    - how we plan to address them, and
    - what we hope to achieve.

3. City of London carers were interviewed to understand current challenges, and this was conducted through the Carers Forum and the City Corporation Carers

and Support Network. We used this local intelligence, together with national data, to determine the plan's vision, aim and outcomes. Carers were then engaged throughout the drafting process for feedback.

4. To develop this draft strategy we engaged with internal and external stakeholders. The City Corporation's Adult Social Care team, Families and Children team and commissioned services were interviewed and advised throughout the drafting of the strategy. The Corporate Strategy and Performance Team were also consulted throughout the drafting process.

5. The draft strategy went out for a nine-week public consultation from 12 November 2018 until 14 January 2019. Healthwatch developed a web page which included a link to the draft strategy and a method for providing feedback. Healthwatch shared the draft strategy across social media, the Golden Lane Residents Association website and the Healthwatch City of London e-newsletter. The consultation also included: the Reach Out Network Carers Forum, Parent Carer Forum and the Barbican Estate Bulletin.

6. The majority of respondents agreed with the three outcomes of the strategy. Appendix 2, Carers Strategy Supplement, summarises the engagement and consultation process.

7. An Equality Impact Assessment has been drafted and is awaiting sign off.

Carers Strategy 2019 - 2023

8. The strategy sets out the City's Corporation's vision for carers, our overarching aim and the three outcomes that we will focus on.

9. **The Vision is that:**
   The City of London Corporation fosters a community that supports and values carers, recognising their economic and societal contributions.

10. **The Aim is that:**
    To ensure that there is real integration of health, social, community and voluntary services that understand and support our carers to thrive, both in their individual ambitions and in their caring role.

11. **The three outcomes that the strategy will deliver on are**:

    1. The Square Mile is a carer friendly community.
    2. Carers enjoy good physical, mental and economic wellbeing.
    3. Children and young people will be protected from inappropriate caring and have the support they need.

12. **Delivery**

    This strategy will be supported by a detailed delivery plan with clear and measurable actions and indicators for each outcome.

Next Steps

13. The strategy will be sent for approval to the Community and Children's Services Committee on 8 March 2019.

14. The implementation of the plan will be overseen by the Department of Community and Children's Services (DCCS). The Adults Senior Management Team will receive regular update reports to monitor progress and assess impact.

Corporate Implications

11. The Carers Strategy will directly support the achievement of the following outcomes set out the City Corporation's Corporate Plan 2018-23:

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

12. This plan sits below the DCCS business plan. It contributes to the plan's delivery by mirroring its five priorities and applying them to the specific needs of our population of carers.

13. This strategy also supports the delivery of a number of other strategies:
    - The Skills Strategy
    - The Education Strategy
    - The Housing Strategy
    - The Social Wellbeing Strategy
    - The Responsible Business Strategy
    - The Social Mobility Strategy.

Conclusion

14. The Carers Strategy 2019 - 23 is the overarching strategic document that guides services and activities for carers in the City of London. It outlines the values and principles that guide our work, our vision for carers, and how we intend to achieve it. This report asks members to endorse the Carers Strategy 2019 - 23.

Appendices

- Appendix 1 – draft Carers Strategy 2019- 23
- Appendix 2 – Carers Strategy Supplement

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CARERS STRATEGY 2019-23

Carers Strategy 2019-23

FOREWORD

<TO BE ADDED>

Chairman, CCS Grand Committee

Town Clerk

Contents

Carers Strategy 2019-23 Executive Summary

Vision: The City of London Corporation fosters a community that supports and values carers, recognising their economic and societal contributions.

Aim: To ensure there is real integration of health, social, community and voluntary services that understand and support our carers to thrive, both in their individual ambitions and in their caring role.

Carer Strategy 2019-23 outcomes		
Outcome 1: The Square Mile is a carer friendly community.	Outcome 2: Carers enjoy good physical, mental and economic wellbeing.	Outcome 3: Children and young people are protected from inappropriate caring and have the support they need.
Corporate Plan 2018-23 links		
Outcome 4: Communities are cohesive and have the facilities they need	Outcome 2: People enjoy good health and wellbeing.	Outcome 3: People have equal opportunities to enrich their lives and reach their full potential.
The Carer Strategy outcomes will indirectly support: Outcome 1: People are safe and feel safe. Outcome 5: Businesses are trusted and socially and environmentally responsible.		
Key outcomes of success		
• Carer identification is embedded across all services that have regular contact with people and families. • The community and voluntary sector are able to identify carer needs, and support them. • City of London Corporation carers are supported. • City of London businesses engage with the City of London Corporation's Business Healthy initiatives promoting Carer awareness.	• Services are accessible and personalised. • Carers are involved in the planning and design of local services. • Carers can access support to enable them to fulfil educational and employment potential. • Carers are provided with the information and support needed to stay healthy and make positive life choices. • Carers have support when their caring role ends.	• Young carers and parent carers are prepared for the transition into adult carers' support services and supported through the process. • There is multi-agency working and information sharing to help identify young carers. • Carers can access support to enable them to fulfil educational and employment potential.

Delivering this strategy

Communication

- The action plan that sits beneath this strategy will ensure that communication is incorporated into each of the relevant actions with steps taken to develop the form of communication that is most appropriate for each stakeholder group.

Technology

- Making the most of new developments in data sharing and connection through the wider City and Hackney Neighbourhood Programme work.
- Piloting new ways to share data and connect people will be central to improving the services for carers and helping our workers achieve more.

Working together

- Improving the lives of carers does not stop at health and social care. It is a 'golden thread' that should run beyond the health and social care system, to other organisations and employers in the public, private and voluntary sector who all potentially have a role to play.
- Commissioning and reviewing services will include the service users, officers, agents across City of London Corporation departments and partner organisations.

1. **BACKGROUND & CONTEXT**

1.1 **The purpose of this strategy**

The City of London Corporation (City Corporation) recognises the vital role that carers play both for the community and the economy. This strategy acknowledges that more can be done to support both our known and unknown[1] carers, the impact that caring can have on their health and wellbeing, and how our services work with them.

This Carers Strategy sets out our priorities through to 2023. Further, it explains how we intend to work with carers, including those carers working for the City Corporation, throughout the length of this four-year strategy.

This strategy should not be considered in isolation, as achieving the stated outcomes will be dependent on support from national, regional and City Corporation strategies. This includes the Government *National Carers Strategy*, the *Carers Action Plan 2018-2020*, *A Connected Society: a strategy to tackle loneliness* and the upcoming *Social Care Green Paper.* The delivery of the Carers Strategy will also be supported by the following City Corporation strategies: the *Skills Strategy*, the *Education Strategy*, the *Housing Strategy*, the *Social Wellbeing Strategy,* the *Responsible Business Strategy* and the *Social Mobility Strategy*.

In developing the Carers Strategy, the City Corporation has considered how it can support the priorities, listed below, published by Department of Health and Social Care through the *Carers Action Plan 2018-2020:*

1. Services and systems that work for carers.
2. Employment and financial wellbeing.
3. Supporting young carers.
4. Recognising and supporting carers in the wider community and society.
5. Building research and evidence to improve outcomes for carers.

1.2 **Our Carers**

The legislative changes through the Care Act 2014 and the Children and Families Act 2014[2] are crucial in acknowledging and supporting carers. However, there are still ample opportunities available to improve carers lives within the definition of the 2014 Acts and in the broader sense. Thinking too narrowly risks people not getting the recognition and support they need. For the purposes of this strategy, a carer is **anyone who spends time looking after or helping a friend, family member or neighbour who, because of their health and care needs, would find it difficult to cope without this help regardless of age or whether they identify as a carer.** This definition includes City Corporation employees with carer responsibilities, young carers and parent carers of children with disabilities or additional needs (parents or carers of a child with a disability or additional needs are often called parent carers).

[1] Unknown carers are those not registered with Adult or Children's Social Care

[2] Future reference to the Care Act 2014 and the Children and Families Act 2014 will be as 'the 2014 Acts'.

In drafting the 2019-23 Carers Strategy, City of London carers were engaged and consulted with through the Carers Forum and City Healthwatch[3].

National

The majority of care provided does not come from the NHS or care homes, but unpaid family members, neighbours and friends. Nationally, about 1 in 10 of the population are carers[4]. The value and importance of carers to health and social care and broader society is ever increasing with our ageing population. The unpaid carer population is estimated to be worth £132 billion per year[5].

Life as a carer can be hard work and whilst those in this role certainly need support it can also be an extremely rewarding role. People are able to give back to their loved ones and spend quality time with them. Being a young carer can provide a range of positive benefits. Young carers can be highly self-motivated multi-taskers, coping with and achieving at school while undertaking a caring role[6]. Many transfer caring experiences into career choices, having developed the key skills and competencies needed for their families to function. Young carers are often noted for their communication and management capabilities[7].

The Square Mile

There were 576 self-identified carers in the Square Mile at the time of the 2011 Census, out of a resident population of 7,400 at that time. At the start of 2018 there were 55 carers on the register[8]. Those carers registered have been assessed by the City Corporation's Adult Social Care team[9] and have been found eligible for assistance. The Care Act 2014 introduced important new rights for carers, giving them similar entitlements to the people for whom they care. Carers now have legal rights to an assessment of their needs, and support where eligible. The criteria used for determining who is eligible to access care and support is set out in the Care Act 2014[10].

All carers' assessments in the City of London are carried out by social workers in the team and they work with the carer to develop a support plan, with a personal budget to give the carer more control. The amount of the budget depends on the individual, and not all will be entitled to a budget. Some people will need signposting and advice. During 17/18 45 carers received an assessment with 40 receiving a carers payment.

Of the 576 self-identified carers identified through the 2011 census, some may not be eligible for support and some may not know they could receive support. Those known to the City Corporation will be caring for people who live within the Square Mile but they, as carers, may live outside.

Young Carers

The current exact number of young carers (aged 18 years or under who help to look after a relative) in England and Wales is not known. Although, the 2011 Census identified 177,918 young unpaid carers (5-17 year olds) in England and Wales. In 2011 the census had 33 people in the Square Mile,

[3] For more information please refer to the Carers Strategy Supplement, section 1, 'Listening to City Carers'.
[4] Census, 2011
[5] Carers UK, University of Sheffield, University of Leeds (2015) Valuing Carers 2015 – the rising value of cares support
6 http://www.glosyoungcarers.org.uk/wp-content/uploads/2013/06/Action-for-children-new.pdf
7 Ibid
[8] The list of individuals that have been assessed by the ASC team as a carer.
[9] The Adult Social Care Team is part of People's Services under the Community and Children's Services department.
[10] Please refer to glossary.

aged 0-24 self-identify as a carer, but the exact total of young carers now in the Square Mile is not known. It is known that the number is small and not likely to grow due to the Square Mile's small resident population of approximately 8,000. However, it is still important to ensure we are identifying and supporting these young carers.

The Children and Families Act 2014 extended the right to a needs assessment to all young carers, regardless of who they care for or the type of care they provide. When a child is identified as a young carer, the needs of everyone in the family will be assessed, triggering the involvement of both children's and adult's support services.

A social worker from the City Corporation's Children and Families Team will visit and assess if a young carer needs any help, if they, or their parent request this. This is done through a Young Carers Needs Assessment. Anyone who has concerns about a child's welfare can make a referral to a local authority children's social care service. Referrals can come from the child themselves, professionals such as teachers, the police, GPs and health visitors as well as family members and members of the public.

Parent Carers

A parent carer is someone over 18 who provides care to a disabled child for whom they have parental responsibility. The Children and Families Act 2014 amends the Children Act 1989 requiring local councils to assess parent carers on the appearance of need or where an assessment is requested by the parent. This is called a parent carer needs assessment. This assessment can be combined with one for the disabled child and could be carried out by the same person, at the same time.

The local council must also be satisfied that the child and their family come within the scope of the Children's Act, i.e. that the child is a child in need[11].

The City Corporation's Community and Children Services support 14 children and young people (0-24 years) with complex special educational needs and disabilities within the Square Mile. The needs of these children and young people include: autistic spectrum disorders/Asperger Syndrome, profound and multiple learning difficulties, speech, language and commotion needs, social, emotional and mental health and sensory impairment.

As a parent carer of a disabled child providing substantial and regular care beyond what is usually expected for a child of a similar age, can have a considerable impact on the parent carer, siblings and the wider family. This can include emotional, financial, relationship pressures and risk of isolation. Some families will have more than one child with a disability or a learning difficulty.

Short breaks provision is used to give parent carers a break from their caring responsibilities. In the City of London, siblings with a caring responsibility have also benefited from this provision.

Transition to adulthood

When young carers and disabled children are approaching 18 there are different 'in transition' assessments undertaken[12]. These assessments must be carried out by the local council where it considers that the young carer, disabled child or carer of a disabled child is:

- likely to have care and support needs after the child becomes 18, and

[11] Please refer to Glossary

[12] Please refer to Glossary

- there is 'significant benefit' to the young carer, disabled child or adult carer if an assessment is carried out.

1.3 **Addressing challenges and recognising opportunities**

A challenge for the City Corporation is sharing the understanding that there is not a generic type of carer, and therefore when it comes to services there is not a one size fits all approach. Carers often go through a journey, starting with small acts of help through to complete dependency from their loved ones. The support offered to carers does not end when their caring role ends, and the City Corporation needs to ensure there are adequate support for bereaved carers as well current carers.

We have a role to play in ensuring that caring is everybody's business. At the root of this is the need to raise the profile of carers and caring – so that all of us recognise and value the contribution carers make within our families, communities, workplaces and society.

With 576 self-identified carers in the City of London as of the 2011 census, the challenge for City Corporation is to ensure that each of these carers, whether providing full time care or not, are receiving the support that is right for them.

Work at both a national and local level can be used to support the priority outcomes of the Carers Strategy. These include:

- The increased prominence of carers through national publications (the social care green paper and the loneliness strategy);
- The integration programme whereby City Corporation is reviewing its health, social and community service offering to ensure that pathways are person centred rather than organisation centred;
- The Early Intervention and Prevention Project aims, via an outcomes-led approach, to address service gaps which were identified during consultation and engagement processes by improving coordination, communications, connections and community support activities within the City of London. The services will include identification and support for carers and young carers; and
- The commitment of the Department of Community and Children's Services to co-produce our offering with the people who are going to use it.

2. **OUR CARERS STRATEGY**

2.1 **Vision & Aims**

Our **vision** for the Carers Strategy is that:

The City of London Corporation fosters a community that supports and values carers, recognising their economic and societal contributions.

To deliver this vision our **aim** is:

To ensure that there is real integration of health, social, community and voluntary services that understand and support our carers to thrive, both in their individual ambitions and in their caring role.

The Carers Strategy sets out the three key outcomes that will inform the carers action plan:

1. The Square Mile is a carer friendly community.
2. Carers enjoy good physical, mental and economic wellbeing.
3. Children and young people will be protected from inappropriate caring and have the support they need.

2.2 **Carers and our corporate plan**

The Carers Strategy will directly support the achievement of the following outcomes set out in the *City Corporation's Corporate Plan 2018-23*:

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

It will also indirectly support the following outcomes set out in the Corporate Plan:

1. People are safe and feel safe.
5. Businesses are trusted and socially and environmentally responsible.

It will also contribute to the five priorities set out in the Department of Community and Children's Services *Business Plan 2017-22*.

3. **DELIVERING OUTCOMES**

3.1 **The Square Mile is a carer friendly community**

Why this outcome

The 2011 census data indicates that there are many carers within the Square Mile that have little to no contact with services for carers and are not receiving formal support in their caring role. Many of the people who self-identified as a carer could be referring to the standard caring role within a family, such as a mother or father caring for their children. However, the City Corporation needs to consider that of the 576 self-identified carers there are those that need and may be unaware of:

- Support from the Adult Social Care Team,
- Support from the Children and Families Team,
- Financial support, and
- Community and volunteer services.

Identification of carers should be happening within primary and secondary care. However, carers at the Carers Network described the need for community and volunteer services to better understand the role of a carer. Carers pointed to the need for services that value and involve carers, because feeling respected and listened to is important to them.

Involving carers extends to those working within the City Corporation, which offers the Carers Network. However, the City Corporation's employees struggle with the same challenges as other carers, notably a lack of time to get everything done. This is having an impact on the network's ability to support carers, as a lot of time is taken trying to find people to help organise the sessions.

Our City Corporation carers also stressed the importance of line manager support, and that when this was done well it helped them balance work and caring responsibilities.

Delivering the strategy

Awareness raising and training for health and social care professionals is of particular importance, as they can help identify carers and be proactive in providing information and support. However, national and local engagement has emphasised the importance of working with the voluntary and community sector. It is therefore vital that work is done with partners beyond formal health and care pathways to build a carer friendly community.

Awareness raising must also extend to the business community within the Square Mile. The City Corporation already provides a workplace health initiative, Business Healthy, that has over 800 business members. Through this vehicle the City Corporation can share best practice with businesses and raise awareness of their working carers.

We will:

- Develop opportunities to contact carers that are not registered.
- Improve the way communities understand and support carers to improve carers' experiences.
- Develop social action and volunteering that can support the work of carers.
- Seek to raise awareness, identification and engagement with carers so that carers feel they are properly listened to and that their lives are appropriately considered.
- Use the work and learning of national regulators, such as NHS England, to understand how to develop a carer friendly GP practice and to best identify older carers.

- Make use of national funding such as the Carer Innovations Fund to identify and promote creative and cost-effective models that look beyond statutory services to develop carer friendly communities.
- Undertake trials of technological solutions with small cohorts of carers.
- Make best use of national campaigns and research with the City of London carer population.
- Align the Carers Action Plan with the Responsible Business Strategy and the actions that are being developed through this.
- Help those new to caring identify themselves in their carer role through information, such as leaflets or posters, in communal areas of City Corporation workplaces.
- Review the current Carers Network format and create ways to support the group, and ensure it provides value to City Corporation carers.
- New guidance for carers, and for employers in relation to carers, to be shared on the Business Healthy website.
- Talks and events held through Business Healthy to help raise awareness on working carers and how carers can be supported with businesses in the square mile.

Monitoring progress

Specific targets will be developed and included as part of the Carers Strategy Action Plan.

High level measures of success	Key Corporate Plan Outcomes	Links to City Corporation workstreams
• Carer identification is embedded across all services that have regular contact with people and families. • The community and voluntary sector are able to identify carer needs and support them. • City Corporation carers are supported. • City of London businesses engage with the City of London Corporation's Business Healthy initiatives promoting Carer awareness.	**Directly** Outcome 4: Communities are cohesive and have the facilities they need **In addition** Outcome 5: Businesses are trusted and socially and environmentally responsible.	Early intervention and prevention project Integration, new model of care SEND Joint strategy 2017-20 Responsible Business Strategy Business Healthy Equality and Inclusion Action Plan

3.2 **Carers enjoy good physical, mental and economic wellbeing.**

Why this outcome

Feedback from the Carers Network shows that access to health and social care services for both themselves and the ones they are caring for can frequently be a problem.

2011 Census data reports that 21.0% of City of London carers provide unpaid care for 20 or more hours a week and 12.2% of carers provide care for 50 or more hours a week. A lot of time is spent making sense of pathways that span several organisations and physical locations. Further, feedback from the Carers Forum stressed the need for health and social care services to "speak" with one another and share data. Carers said they spent a lot of time retelling their story.

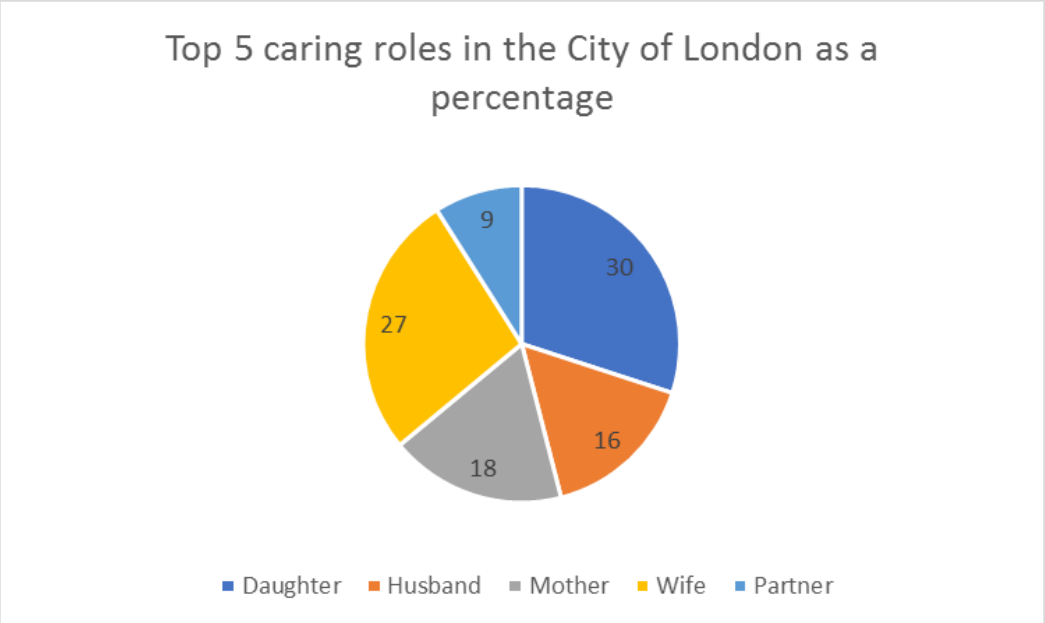
Through their role carers often acquire expert knowledge. Carers highlighted the importance of having this knowledge understood and respected by health and social care professionals when providing care for the cared for.

Through the *Call for Evidence* carers reported difficulties in balancing work, looking after their health and wellbeing and performing a carer role. In some cases, people had to give up their work altogether. In the 2017 SACE Survey, 46% of carers in the City of London reported not being able to look after themselves as much as they should. Carers also reported stress, depression and problems with sleep as the most common issues affecting their health.

Delivering the strategy

The City Corporation, as part of the wider City and Hackney Neighbourhood Programme, is reviewing its current model of services for City residents. The intention is to ensure that pathways are developed around the user. Whilst the improvement of pathways for those that are cared for may not fall directly within the Carers Strategy, they do have an impact on carers. Further, it is important that when a carer accesses services for their own needs that their role as a carer is known and considered.

Proper segmentation of carers will also help to target interventions, as their motivations for caring will be different, and they may perceive their role differently. E.g. a person looking after their parent may not consider themselves as a carer. Of those carers registered with social care there is a wide



typology. The top 5 relationships are shown in the chart, but there are also friends, neighbours, fathers, nephews, sisters, granddaughters and sons undertaking caring roles.

We will:

- Seek to ensure that individuals can access health and social care services in a way that is personal to them through support planning and use of community services.
- Ensure that Adult Social Care explains the support available for carers at the start of the caring journey to help prepare for the worst.
- Ensure that carers are clear on what support can be provided by the City Corporation and how this is linked to both their ability to pay for services and what support is needed for their loved one.
- Consider further training and education on how social care workers can fulfil their duties under The Care Act 2014.
- Make use of the Department of Health and Social Care funded project to support parent carers to navigate the transition from child to adult services as their child approaches the age of 18.

- Ensure that commissioned services are fulfilling the needs of carers through their offering, e.g. support during bereavement.
- Encourage innovation among partners in the voluntary and community sector to find creative ways to support carers through the Early Intervention and Prevention project.

- Raise discussion on individual carers in multi-disciplinary team meetings to ensure that health professionals are aware of carer involvement and need.
- Utilise current roles and systems to target support for carers at the right time, e.g. hospital discharge of their cared for.
- Make use of government challenges and funding to support society to age better, including looking at innovations which can support people to have happier, healthier and independent lives.

- Develop a database of carers through Mosaic by asking carers to note their consent to be consulted in commissioning of new services and reviews of current services.
- Develop a method for carers, City Corporation officers, providers and health professionals to work together.
- Ensure involvement of ex-carers who may have more time to support work and have valuable knowledge of the system.

- Learn and make use of National pilots[13] and campaigns[14] to raise awareness of the technology that can support carers.
- Explore the use of technology to help people live more independently in the future. Improved use of assistive technology will have benefits for those who are providing care.

[13] From 2018-2020, every person accessing Adult Social Care in these three areas will be given a joint health and social care assessment – including a needs assessment, and subsequently a single, joint plan that will meet the bespoke needs of the individual. All assessment and plans will consider the role, health and wellbeing of their carers as a fundamental part of the process.

[14] The Department of Health and Social Care have funded work in partnership with Carers UK and Digital Health and Care Alliance on a project to support greater awareness (of the availability of technology, products to support carers) among carers, support groups, commissioners, health professionals, local authorities, service providers and potential developers of technologies.

- Explore healthcare education and training needs for unpaid carers to ensure they have the skills they need through Health Education England and Carers UK.
- Make use of the Department of Health and Social Care funded project on actions to promote best practice for local authorities, clinical commissioning groups, and other service providers and commissioners on carer breaks and care replacement.
- Ensure carers are aware of longer-term mental health therapies available through the City of London Mental Health Centre, opening in the Summer 2019.
- Make use of national campaigns to help people be better informed about mental health.
- Incorporate actions from the City Corporation Social Wellbeing strategy and make use of the national cross-government loneliness strategy.

- Promote services such as the Timewise Carers Hub, which provides support, advice and flexible job opportunities to help carers balance their responsibilities with fulfilling careers.
- Provide support and training to carers to help them return to work, and to do so at a level that is commensurate with their skills and experience.
- Share online resources to help carers recognise the skills they have developed through caring and how they can use these skills.
- Use national research by the Department of Work and Pensions to improve signposting and advice on benefits for carers.

Monitoring progress

Specific targets will be developed and included as part of the Carers Strategy Action Plan.

High level measures of success	Key Corporate Plan Outcomes	Links to City Corporation workstreams
• Services are accessible and personalised. • Parent carers are prepared for the transition of their child into adult support services and supported through the process. • Carers are involved in the planning and design of local services. • Carers can access support to enable them to fulfil educational and employment potential. • Carers are provided with the information and support needed to stay healthy and make positive life choices. • Carers have support when their caring role ends.	**Directly** Outcome 2: People enjoy good health and wellbeing. **In addition** Outcome 3: People have equal opportunities to enrich their lives and reach their full potential.	Early intervention and prevention project Integration, new model of care SEND Joint Strategy 2017-20 Social Wellbeing Strategy Social Mobility Strategy

3.3 **Children and young people are protected from inappropriate caring and enjoy positive childhoods.**

Why this outcome

While some caring can be rewarding for young carers this should not inadvertently encourage the continuation of inappropriate care. Equally, young carers' abilities to cope and achieve should not be allowed to mask their need for support[15]. Most young carers look after a family member and, as they can start caring at a very young age, do not realise they are 'carers' who are entitled to support. The exact number of young carers in the UK is not known. Many caring roles are hidden and not known until a young person or their family identify as being in need or identify themselves to services.

Delivering the strategy

Whilst the City of London is unlikely to have many young carers, due to the low number of residents, the need for accessible and comprehensive support does not diminish. There are likely to be children and young people providing care that we are not yet aware of. This includes the siblings of children who are currently receiving care and those who attend the City of London family of schools.

We will:

- Seek to improve identification of young carers to enable them to get early access to support services and enable safeguarding arrangements to be put in place quickly where necessary.
- Make use of national projects, such as 'train the trainer', a young carers identification project being developed by the Department for Health and Social Care and the Carers Trust.
- Implement learning from reviews of best practice in identification of young carers and access to support.
- Ensure commissioning considers how services need to be tailored to young carers.
- Enable stronger multi-agency working between practitioners and enable better assessments and decision making within children's social care through improved information sharing by the Department for Education.
- Seek to improve young carers' educational opportunities and outcomes to enable them to achieve their full potential.
- Make use of the Department for Education review of Children in Need, which includes young carers, to understand the challenges pupils face and the support that best improves their educational outcomes, both in and out of school.
- Seek to improve young carers' access to support services to make sure they are properly supported at an early stage and interventions are put in place promptly where necessary.
- Provide a holistic approach through a standard referral into children's social care, that considers the whole family, local support and environment.
- Seek to improve the support young adult carers receive to enable them to make positive transitions between the ages of 16-24.

15 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/498115/DFE-RR499_The_lives_of_young_carers_in_England.pdf

Monitoring progress

Specific targets will be developed and included as part of the Carers Strategy Action Plan.

High level measures of success	Key Corporate Plan Outcomes	Links to City Corporation workstreams
• Young carers are prepared for the transition into adult carers' support services and supported through the process. • There is multi-agency working and information sharing to help identify young carers. • Carers can access support to enable them to fulfil educational and employment potential.	**Directly** Outcome 3: People have equal opportunities to enrich their lives and reach their full potential. **In addition** Outcome 1: People are safe and feel safe.	SEND local offer Early Help local offer Social Mobility Strategy Early intervention and prevention project Integration, new model of care

4. ENABLERS

Underlying the strategy and informing the action plan will be three enablers:

1. ***Communication***
    - ***a.*** The action plan that sits beneath this strategy will ensure that communication is incorporated into each of the relevant actions with steps taken to develop the form of communication that is most appropriate for each stakeholder group.
2. ***Technology***
    - ***a.*** Making the most of new developments in data sharing and connection through the wider City and Hackney Neighbourhood Programme work.
    - ***b.*** Piloting new ways to share data and connect people will be central to improving the services for carers and helping our workers achieve more.
3. ***Working together***
    - ***a.*** Improving the lives of carers does not stop at health and social care. It is a 'golden thread' that should run beyond the health and social care system, to other organisations and employers in the public, private and voluntary sector who all potentially have a role to play.
    - ***b.*** Commissioning and reviewing services will include the service users, officers, agents across City Corporation departments and partner organisations.

5. OVERSIGHT AND ACCOUNTABILITY

We will monitor and regularly report on our progress in delivering the City Corporation's Carers Strategy. This will be done through annual surveys of carers and through performance data of our services.

Further, the action plan that will be developed to deliver the strategy will outline the accountable officers for each area of work. Progress in delivering the strategy will be overseen by the City

Corporation's Community and Children's Services Grand Committee, to which the accountable officers will report and provide updates. There will also be regular reports to the Health and Wellbeing Board, recognising the impact caring has on health and wellbeing priorities.

6. **GLOSSARY**

Care Act 2014, eligibility criteria

There are three conditions that must be considered:

1. The carer's needs for support arise because they are providing necessary care to an adult.
2. Because of their caring responsibilities, the carer's physical or mental health is either deteriorating or is at risk of doing so or the carer is unable to achieve any of the outcomes as specified in the regulations and as summarised in the section 'Eligibility outcomes for carers with support needs'.
3. As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the carer's wellbeing.

Child in need

- This is defined as:
  - A child who is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a local council.
  - A child whose health or development is likely to be significantly impaired, or further impaired, without the provision of services.
  - A child who is disabled.

Transition assessment

- The term 'transition assessment' describes 3 different types of assessments. The type of transition assessment that must be completed depends on who needs the assessment.
  - Child's Need Assessment - A person aged under the age of 18 who is preparing for adulthood and has a likely need for care and support (not just Care Act eligible needs) regardless of whether-or-not they currently receive care under Children's legislation.
  - Young Carer Assessment - A young person preparing for adulthood who is also a carer and has a likely need for support (not just Care Act eligible needs), regardless of whether-or-not they currently receive care under Children's legislation.
  - Child Carer' Assessment - The adult carer of a young person preparing for adulthood, who has a likely need for support (not just Care Act eligible needs).

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CARERS STRATEGY 2019-23 SUPPLEMENT

Contents

1. **LISTENING TO CITY CARERS**

1.1 **Background**

In 2015 Carers UK were commissioned by the City of London to develop the 2015-18 Carers Strategy. The organisation undertook extensive and in-depth engagement, ultimately writing a comprehensive and well-targeted strategy. Due to the thorough evidence base developed by Carers UK, the engagement for the 2019-23 strategy built on this to 'refresh' the strategy. To ensure that the outcomes for the 2019-23 strategy are fulfilled, the focus will be on working with carers throughout the lifespan of the action plan and ensuring City of London Corporation accountability. The action plan is the vehicle for the strategy.

1.2 **Work undertaken by Carers UK in 2015**

- A survey of key professional stakeholders followed by a stakeholder focus group
- Telephone interviews with professionals
- A survey of carers in the City of London followed by a focus group

1.3 **Work undertaken by DCCS in 2018**

The main themes from the stakeholder survey of 2015 were used in 1-2-1 interviews with officers/staff of:

- Adult Social Care Team
- The Children and Families Team
- Commissioned providers

Through this engagement with professionals it confirmed that the evidence from Carers UK work is still relevant and necessary for the 2019-23 strategy. The themes include: carer identification, barriers and challenges around this, the gaps in services, how carers can be better supported, the strengths of certain services in place and potential solutions.

The key themes of the survey and focus group were pulled out of the Carers UK research and compared against recent engagement with carers through:

- Healthwatch engagement notes from the Carers Forum, May 2018
- Officer engagement with the Carers Forum and Carers Support Group held by the Carers Network 2018.

The above engagement reaffirmed that the work by Carers UK is still valid, with the headline issues still including: understanding the caring role, the impact of caring on health and wellbeing, contingency and emergency planning, identification and support from GPs, support for carers from local services and organisations, the extent to which support meets carers needs, what could be done differently to better support carers, the different types of caring role, those not identifying as carers and respite need.

1.4 **National evidence informing and confirming local engagement**

Survey of Adult Carers in England
In 2016/17, the City of London Corporation participated in the biennial Survey of Adult Carers in England. This mandatory survey captures carers' thoughts and opinions on a variety of topics that are considered to be indicative of a balanced life alongside their caring role. Results are used to inform national policy.
Questionnaires were sent to all carers aged 18 or over who were helping or looking after someone aged 18 or over and had been assessed or reviewed in the previous 12 months.

Data from the survey feeds into the Adult Social Care Outcomes Framework and populates the following outcome measures:

- 1D: Carer reported quality of life
- 1I: Proportion of people who use services and carers, who reported that they had as much social contact as they would like
- 3B: Overall satisfaction of carers with social services
- 3C: The proportion of carers who report they have been included or consulted in discussions about the person they care for
- 3D: The proportion of people who use services and carers who find it easy to find information about services

In the City of London, 20 questionnaires were completed out of an eligible population of 51 (39.2%). As the eligible population and number of respondents was below the recommended level needed to produce statistically robust results (at least 150 carers), results of the survey are viewed with caution.

2018 Carers Action Plan
Central Government has made a commitment to work across government and with partners outside of government to support carers, which has been set out in the 2018 Carer Action Plan. Ministers from the Government Equalities Office, the Department for Digital, Culture, Media and Sport, the Department for Business, Energy and Industrial Strategy, the Department for Work and Pensions and the Department for Education have all contributed to and are investing in the action plan. The plan has been signed alongside the Department for Health and Social Care. The action plan will deliver improvements for carers alongside the social care green paper, due later 2018.

In 2016 the government launched a carers' Call for Evidence consultation which received 6,802 responses. In developing the action plan the responses were drawn on to outline five primary themes. The City of London Corporation Carers Strategy 2019-23 also takes into consideration this large piece of research in forming the outcomes for the strategy.

Caring for carers, Social Market Foundation 2018
The paper was researched using the British Household Panel Survey and the more recent Understanding Society and is based on data collected between 2015-2017. The report highlights the important role that family carers fulfil and the negative impact it can have on individuals. The report seeks to influence policy makers, and specifically around the role of care navigators.

State of Caring 2018, Carers UK
This report references the Carers UK (2016) State of Caring survey, papers from outside organisations researched with and without Carers UK. The paper sets out 5 aims for national and local government, the NHS and employers. This report emphasises that it is the actions that count.

1.5 Consultation with carers and key stakeholders in the City of London

Consultation for this strategy includes the following stakeholders:

- Adult Social Care Team
- The Children and Families Team
- Corporation Strategy & Performance Team
- Carers Network
- Carers of the City of London through Carers Network
- Residents of the City of London through Healthwatch
- Residents of the City of London through the Barbican Bulletin
- City and Hackney Older Peoples Reference Group
- Parent Carer Forum
- Members

Healthwatch consultation break down:

A. Healthwatch City of London social media

Facebook

- 1,200 people reached, 22 'shares', 58 post engagements (likes and clicks), 2 comments, 22 shares.
- 1 posted comment
- 3 Facebook Messenger exchanges with comments

Twitter

- Tweet 1: 784 impressions/ reach /1.3% engagement rate – no comments
- Tweet 2: 4,520 impressions/ 0.2% engagement rate – no comments

B. Golden Lane Residents Association website

- 1 detailed 'case study' response

C. Healthwatch City of London e-newsletter Story inviting feedback on draft strategy sent out in our Newsletter to 512 recipients (members and supporters).

- 10 recipients clicked through to the carers' strategy news item
- 3 email comments received

2. **How we will work with our carers**

The City of London Corporation will develop the action plan associated with this strategy in conjunction with carers. The dialogue will be structured around an oversight group (following the delivery model of the Leeds *Commitment to Carers)* and adopt joint decision-making amongst its collaborators. Additional focus groups may be set up, to ensure that all types of carers are represented during the process. The development of the action plan is the first step towards establishing a long-term collaborative model between carers, project officers and healthcare professionals.

3. **Demographics**

There were 576 carers in the City of London at the time of the 2011 Census, making up 7.8% of the total population, compared to 8.4% of the population in London and 10.2% across England.

3.1 **Resident Zones**

The table below shows the carer population by Census Resident Zone. The percentage of carers in the population varies from 2.2% in Queenhithe to 11.7% in the Mansell Street Estate area. In terms of actual numbers, the most significant carer populations are in Barbican (281) and Golden Lane (101). The overall number of carers in some areas is small so this analysis should be viewed with caution. The table also shows that 21.0% of carers provide unpaid care for 20 or more hours a week. This is lower than London (36.9%) and England (36.4%). 12.2% of carers provide care for 50 or more hours a week. This is also lower than London (21.6%) and England (23.1%).

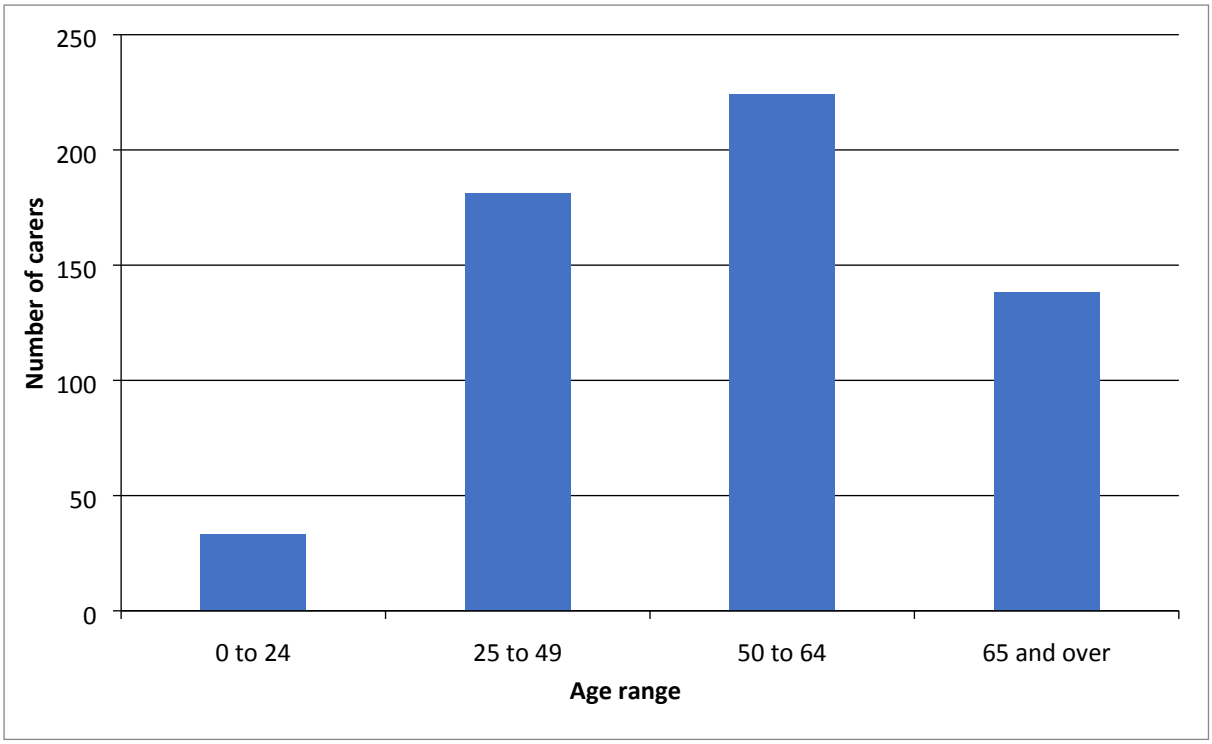
Area	**1-19 hours**	**20-49 hours**	**50+ hours**	**Total carers**	**Total pop.**	**% carers**
Barbican	244	14	23	281	2,994	9.4%
Bishopsgate	9	2	0	11	222	5.0%
Botolph	11	1	0	12	227	5.3%
Carter Lane	8	0	1	9	276	3.3%
City West	6	1	2	9	151	6.0%
Golden Lane	68	12	21	101	1,130	8.9%
Little Britain	4	0	0	4	123	3.3%
Mansell Street Estate	25	9	9	43	369	11.7%
Middlesex Street Estate	20	4	8	32	391	8.2%
Minories	7	2	1	10	225	4.4%
Queenhithe	7	0	0	7	319	2.2%
Smithfield	20	4	2	26	628	4.1%
Temples	26	2	3	31	320	9.7%
City of London	**455**	**51**	**70**	**576**	**7,375**	**7.8%**

London	**435,278**	**105,399**	**149,296**	**689,973**	**8,173,941**	**8.4%**
England	**3,452,636**	**721,143**	**1,256,237**	**5,430,016**	**53,012,456**	**10.2%**

Provision of unpaid care in the City of London by hours of care provided a week: Census (2011)

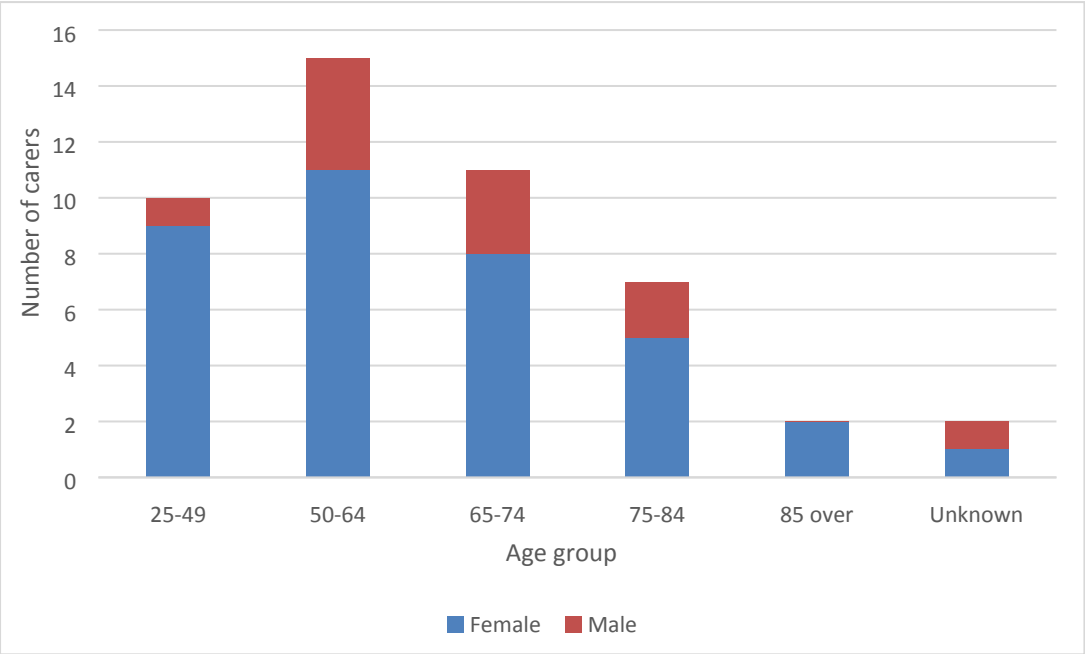
3.2 **Age and gender of carers**

The Census shows that 5 in 10 carers in the City of London are male (49.9%), compared to 4 in 10 carers in London (42.5%) and England (42.2%); however, 6 in 10 carers (61.4%) in the City providing care for 50 or more hours a week are female. The figure below shows that the age profile of carers in the City of London peaks between 50 and 64; 38.9% of carers are in that age group and 15.9% of people aged 50 to 64 are carers. 17.1% of carers aged under 65 are providing 20 or more hours of care a week; for carers aged 65 and over, this jumps to a third (33.3%).



Distribution of City of London carer population by age; Source: Census (2011)

The figure below shows the age and gender breakdown of 48 carers known to the City of London Corporation in 2017/18. Known carers are predominantly female (75%), whereas males are underrepresented if the data is compared to the 2011 Census.



Age and gender of carers known to social care; Source: City of London Corporation

3.3 **Carer ethnicity**

In the City of London, 29.2% of the carer population are from BME groups (all communities that are non-white British) compared to 42% of the general population in the Square Mile. 5.4% of the BME population in the City of London provide unpaid care, compared to 9.6% of the White British population. The table below shows that this ranges from 3.1% of the Black/African/Caribbean/ Black British population, to 7.6% of the Asian/Asian British population.

Ethnic Group	Population	Provides care	% provides care
White: English/Welsh/ Scottish/Northern Irish/British	4243	408	9.6%
White Irish/Gypsy or Irish Traveller/Other White	1556	71	4.6%
Black/African/Caribbean/Black British	193	6	3.1%
Asian/Asian British	940	71	7.6%
Mixed/multiple ethnic group	289	11	3.8%
Other ethnic group	154	9	5.8%

Percentage of the population who provide unpaid care in the City of London, ethnic group: Census (2011)

3.4 **The impacts of caring**

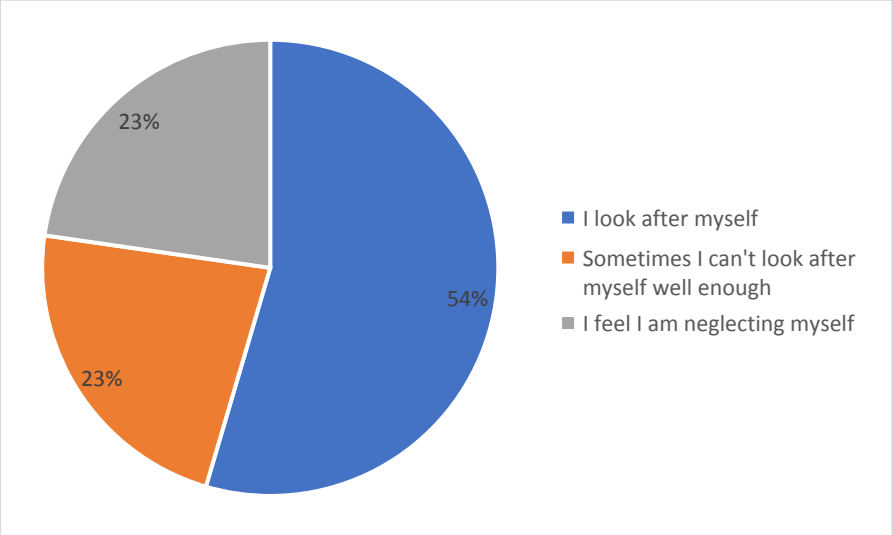
Caring for others can adversely affect your health and wellbeing and research has consistently shown this.[1] Census data shows that carers are significantly more likely to be in poor physical and emotional health than those without caring responsibilities.

[1] In Sickness and in Health (Carers Week, 2013); State of Caring report (Carers UK, 2015)

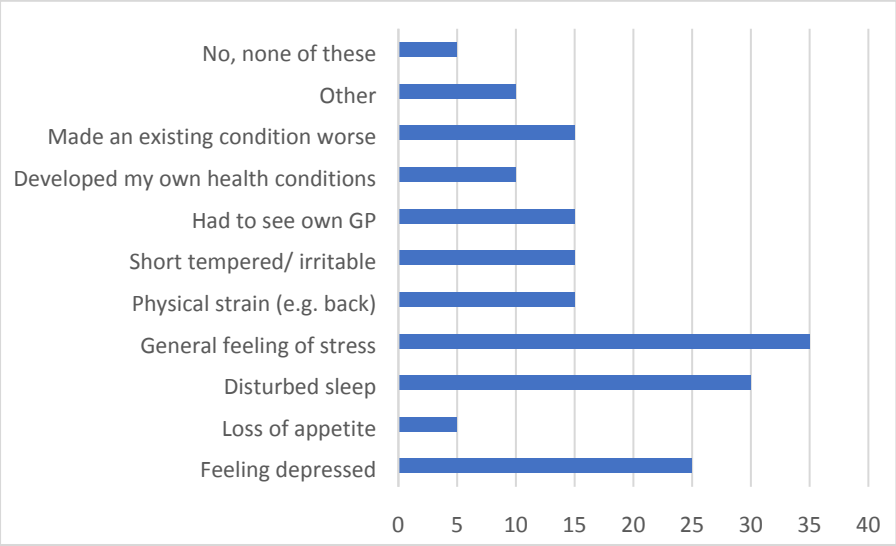
Carer health

In the 2017 SACE Survey 2 in 10 carers (19.9%) in the City of London report being in 'not good' health, compared to 1 in 10 non-carers (11.5%). 4 in 10 people (38.8%) providing 20 or more hours of unpaid care a week report being in 'not good' health; this increases to 6 in 10 carers (58.7%) aged 65 and over.[2] More than 110 carers in the City (including more than 50 aged 65 and over) declare their health to be 'not good'. This includes around 30 who declare their health to be 'bad or very bad'.

In the 2017 SACE Survey, 46% carers in the City of London reported not being able to look after themselves as much as they should (20 respondents from City of London). Carers also reported feelings for stress, depression and problems with sleep as the most common issues affecting their health (55 respondents from City of London).



'Thinking about how much time you have to look after yourself - in terms of getting enough sleep or eating well - which statement best describes your current situation?' (SACE Report, 2017)



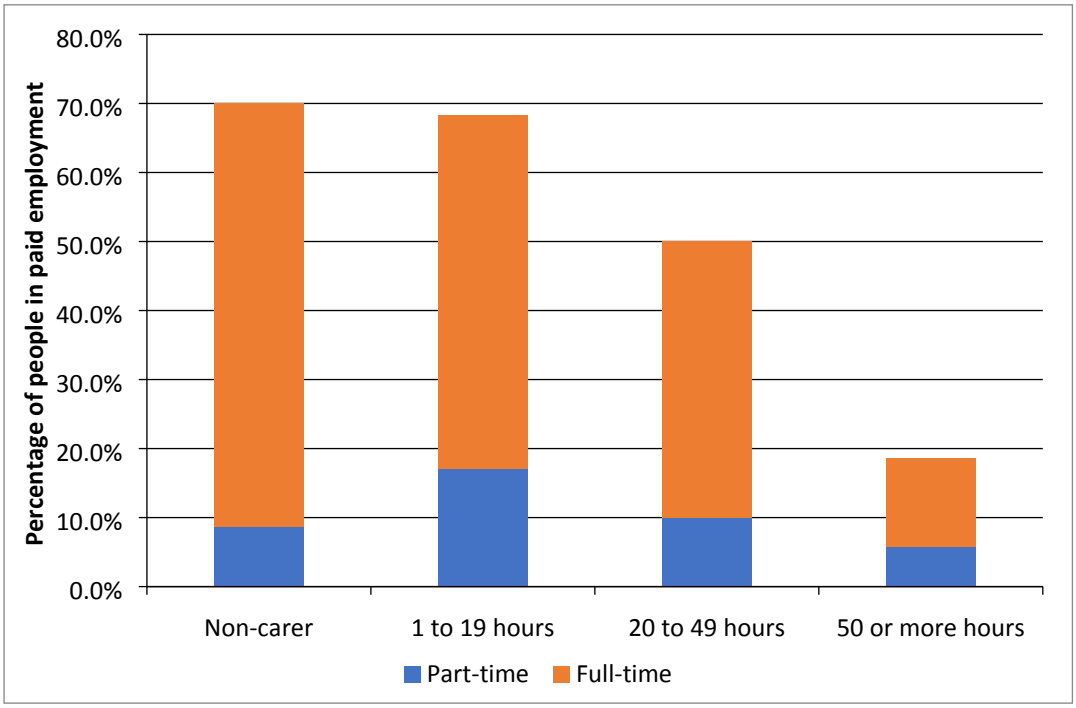
[2] Responses of 'fair', 'bad' and 'very bad' represent 'not good' health

'In the last 12 months, has your health been affected by your caring role in any of the ways listed below?' (SACE Report, 2017)

Economic activity

In the City of London, the proportion of carers aged 16 and over in full-time employment is 45.5%, lower than the 61.4% of non-carers aged 16 and over. Carers are more likely to be in part-time employment; 15.0% of carers are in part-time work against 8.7% of non-carers.

The figure below shows that the proportion of carers in employment differs significantly depending on the intensity of their caring role. 7 in 10 people (68.2%) providing unpaid care for 1 to 19 hours a week are in some type of employment, against less than 2 in 10 (18.6%) who provide care for 50 or more hours a week.



People aged 16 and over in paid employment in the City of London by hours of care provided a week; Source: Census (2011)

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Committee(s)	Dated:
Health and Wellbeing Board	11.02.2018
Subject: Automated External Defibrillators – Findings from Corporate Survey	**Public**
Report of: Chrissie Morgan, Director of Human Resources Andrew Carter, Director of Community and Children's Services	**For Decision**
Report author: Justin Tyas, Health Safety and Wellbeing Manager Claire Giraud, Strategy Officer	

Summary

This report provides an overview of the provision of Automated External Defibrillators (AEDs) from a self-reported corporate survey (excluding the City of London Police) following the publication of internal AED (Best Practice) Guidance in September 2018.

Under the Health and Safety (First-Aid) Regulations 1981, there is no legal duty to provide first aid for non-employees but the Health and Safety Executive (HSE) strongly recommends that they are included. This is the policy of the City of London Corporation. However, the provision of public access AEDs should not be conflicted with the provision of AEDs provided for the purposes of first-aid at work.

Central London, including the City of London, already has an extremely high density of defibrillators, many of which are public access. Additionally, the City of London Police carry portable defibrillators in most of their patrol and tactical vehicles. The responsibility for maintenance and governance of these AEDs lies outside of the City Corporation's remit, and it would not be appropriate for the City of London Corporation to assume any form of liability for these.

Recommendation(s)

Members are asked to:

- Support the continued development of a corporate AED policy and action plan building on the lessons learned from the defibrillator survey and good practice guidance, which will ensure that installation of corporate AEDs is based on first aid needs assessment principles.
- Support that the Corporation takes further action itself regarding the installation or promotion of additional public access defibrillators in the City

where there is no identified first aid need, but instead encourages specialist organisations to take this forward locally as they are better placed to address this issue.

- Support that the Corporation explores further the London Ambulance Service (LAS) accreditation and whether there would be an appetite for engaging with City organisations that have their own AEDs on this issue.

Main Report

Background – Defibrillators in the Workplace

1. An Automated External Defibrillator (AED) is a machine used to give an electric shock when a person is in cardiac arrest.

2. Modern AEDs are very reliable and will not allow a shock to be given unless it is needed. They are extremely unlikely to do any harm to a person who has collapsed in suspected sudden cardiac arrest. They are safe to use and present minimal risk to the rescuer.

3. In recent years, AEDs have been installed in many busy public places such as train stations[1], shopping centres or schools. Many workplaces also have an AED to ensure they are prepared for a first aid emergency. The installation of a defibrillator involves purchasing and locating a site for it, training volunteers to use it and maintaining and governing it; full records of the defibrillator, its installation and the history of checks and use must be maintained.

4. The London Ambulance Service (LAS) encourages the deployment of AEDs and run an accreditation scheme for publicly accessible defibrillation. To become accredited, organisations need to meet strict criteria. Accreditation is on an annual basis. Such accreditation necessitates a governance and maintenance model which can be resource and time consuming.

5. During a first aid emergency, HSE guidance (*ibid*) states that *'there is no requirement for the assessment of first-aid needs to be formal or written down,'* However, documenting is a good way of demonstrating how first aid provision was determined. The City Corporation's First Aid Guidance provides advice about how to undertake first aid needs assessment and is now supplemented by specific Defibrillators (Best Practice) Guidance.

Background – Public Access Defibrillators

6. Public access defibrillator initiatives make AEDs available to the public. This should facilitate earlier defibrillation of cardiac arrest victims and could save lives.

[1] According to a question to the Mayor of London in July 2018 there were 214 defibrillators situated across 150 London Underground stations including Aldgate, Aldgate East, Bank/Monument (8 AEDs), Barbican, Farringdon, Liverpool Street (6), London Bridge (5), Mansion House, Moorgate, St Pauls and Tower Hill.

7. The Defibrillators Availability Bill 2017 – 2019 is a private member '*Bill to require the provision of defibrillators in education establishments, and in leisure, sports and certain other public facilities; to make provision for training persons to operate defibrillators; to make provision for funding the acquisition, installation, use and maintenance of defibrillators; and for connected purposes.'*
   It is unclear if / when the Bill will become law. The second reading of the Bill is scheduled for 25.01.2019.

Current Position – Public Access Defibrillators

8. Mapped AED data shows that, in terms of defibrillator density, central London is the '*safest*' place in the UK to suffer an out-of-hospital cardiac arrest, with readily available AED units positioned in key areas. Outside of central London, AED provision is less dense. Additionally, many City businesses have defibrillators installed for their staff, although these are not accessible for the public. However, there is no evidence of disproportionately high numbers of cardiac arrests in the Square Mile

9. It is understood that the City of London Police (CoLP) operational sites have AEDs and that portable defibrillators are carried in most area patrol and tactical vehicles.

10. The responsibility for maintenance and governance of these AEDs lies with their providers – for example, TfL has many AEDs installed in tube stations in the Square Mile and are therefore responsible for managing these devices.

11. These AEDs are outside of the City Corporation's remit, and it would not be appropriate for the City of London Corporation to assume any form of liability for these.

12. If the City Corporation were to produce a map which advertised the locations of the "fixed point" AEDs (bearing in mind that many more AEDs are mobile), onus would fall to the City Corporation to regularly check with each and every responsible provider as to whether they still had the correct governance and maintenance processes in place for each device that they were responsible for. This would represent a huge amount of officer time, for which there is currently no capacity.

13. The City Corporation has previously approached voluntary sector providers The British Heart Foundation and The Community Heartbeat Trust to ask if either would be interested in establishing an AED scheme for the City. It is clear that specialist organisations like this would be most appropriate to take this forward locally as they are better placed to address this issue. However, we have not yet seen any interest on this issue from the voluntary sector (possibly because of the density of AEDs in the Square Mile).

14. There is potential for the City Corporation to work with businesses to encourage those that have AEDs on their premises to be part of the London Ambulance service's accreditation scheme. This would ensure that the AEDs in the Square

Mile were being appropriately managed and maintained, without the City Corporation assuming responsibility for this process.

Current Position – City Corporation Defibrillators

15. The City Corporation is supportive of the provision of AEDs where this is justified by robust (First Aid) needs assessment. Departments / services are currently responsible for the local management and funding of AED provision.

16. All corporate First Aid training: First Aid at Work (FAW), Emergency FAW, Refresher/requalification include the management of a casualty requiring CPR and use of AEDs as per the Resuscitation UK Guidelines.

17. At the end of 2018, a self-reported survey of AED provision across the City Corporation was undertaken (**Appendix 2**).
    - Thirty-nine defibrillators were identified by respondents across twelve departments, including educational establishments, leisure, sports and other public facilities. A defective AED was also identified at Artizan Street (DCCS).
    - All three of the City Corporations Independent Schools have defibrillators.
    - Defibrillators have reportedly been used at six locations (Guildhall, Smithfield Market, Mansion House, Parliament Hill Lido, Kenwood Ladies Pond and Hampstead Health); sometimes on more than one occasion per site.
    - The survey suggests that there appears to be reasonably good coverage of corporate AEDs based on the first aid *needs assessment* type of criteria (**Appendix 1**).

Proposals

18. There should be a clearly defined policy for corporate AED provision based on first aid needs assessment principles, based upon need and exploiting local intelligence.

19. The corporate AED policy should build upon our internal Defibrillators (Best Practice) Guidance and the results of the survey.

20. The provision of public access AEDs should not be conflicted with the provision of AEDs provided for the purposes of first-aid at work.

21. The Corporation is not responsible for installing and managing additional AEDs where there is no identified first aid need.

Corporate & Strategic Implications

22. Liability of both individuals and the Corporation, along with reputational risk, may influence the installation of AEDs.

23. The use of AEDs by individuals, whether they are trained or untrained, can be a cause for concern as they may feel at risk of having a claim brought against them if that casualty suffers harm as a result of their intervention.

24. Potential liability can arise at common law although there have been no reported cases at all where a casualty has successfully sued someone who came to their aid in an emergency. In theory, a claim might be brought against an individual in either:

- the law trespass, on the grounds that an intervention constituted an assault on the casualty
- the law of negligence for a breach of duty of care towards the casualty

25. Using an AED cannot make a victim's condition worse since the device will only discharge its shock if the victim has a heart rhythm that will lead to death if they do not receive a shock.

26. However, where an AED is provided, it could be seen that the organisation has a duty to ensure the AED is available for use and is well-maintained.

Conclusion

The City Corporation will continue to develop its corporate AED policy and develop an appropriate action plan for implementation. It is not recommended that the City Corporation install additional AEDs where there is no identified first aid need or promote existing ones that are not under its management or guardianship.

Appendices

- Appendix 1 – First Aid Needs Assessment for Defibrillators (Adapted from the Resuscitation Council UK)
- Appendix 2 – Corporate AED Provision
- Appendix 3 – AEDs in the City of London

Background Papers

i. City of London Corporation:
   - First Aid Policy
   - First Aid Guidance
   - Guidance on Defibrillators

ii. A Guide to External Automated Defibrillators (April 2017), Resuscitation Council UK

iii. London Ambulance Service Defibrillator Accreditation Scheme

iv. Smith, M J et al., (2017). Barriers and facilitators to public access defibrillation in out-of-hospital cardiac arrest: a systematic review. *European Heart Journal*

- *Quality of Care and Clinical Outcomes*, Volume 3, Issue 4, 1 October 2017, Pages 264–273, https://doi.org/10.1093/ehjqcco/qcx023

v. British Heart Foundation National Defibrillator Network

vi. HeartSafe® UK (AED locator): http://www.heartsafe.org.uk/

vii. Defibrillators in London Underground Stations. MQT on 2018-07-19. July 19, 2018. Question of the Mayor of London.

viii. People are Reluctant to use Public Defibrillators to Treat Cardiac Arrests (Warwick University), https://warwick.ac.uk/newsandevents/pressreleases/people_are_reluctant/

ix. Defibrillators (Availability) Bill 2017-19 (Private Members Bill): https://services.parliament.uk/bills/2017-19/defibrillatorsavailability.html

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Appendix 1: First Aid Needs Assessment for Automated External Defibrillators

[Adapted from the Resuscitation Council UK – *do I need and AED?]*

In terms of AEDs, the RC(UK) states that "completing a first aid needs assessment entails making an estimate of the risk of a cardiac arrest (CA) occurring at a location and considering the potential consequences if it were to occur".

In doing so, the RC(UK) suggests that the likelihood of a sudden CA (SCA) occurring will be influenced by the:

- number of people using a facility (including the public if first-aid treatment is offered to them)
- risk of cardiac arrest occurring at the site due to the profile of users (e.g. predominantly middle-aged males or older persons)
- type of work activities or premises (e.g. physical exertion or stressful environments).

Generally, cardiac arrest is more common with increasing age and, clearly, the more persons present the more the likelihood of an arrest occurs. Therefore, the person completing the assessment will need to determine the number of persons for whom first aid will be provided (including the public, visitors, contractors, etc).

The RC(UK) then suggests applying a 1–5 scale with 1 being a rare occurrence of SCA and 5 being almost certain of occurring. Of note, the guidance to this states that "at present there is insufficient published evidence to give precise or dogmatic advice for an individual location and the rating score applied has to be a 'best-guess' or estimate".

The 1–5 scale is also applied to consequence but RC(UK) highlights that "cardiac arrest is uniformly fatal (unless treated), so the score will always be 5" and that "even if resuscitation is successful, the impact on the individual will be significant, so the score will remain the same at 5".

The scores are then combined in a 5x5 matrix to give a determination of need, details of which can be found on the RC(UK) website.

Of interest, international resuscitation guidelines advise that evidence supports the establishment of public access defibrillation programmes when the:

- frequency of cardiac arrest is such that there is a reasonable probability of the use of an AED at least once in two years
- time from call out of the conventional ambulance service to delivery of a shock cannot reliably be achieved within five minutes
- time from collapse of a victim until the on-site AED can be brought into use is less than five minutes.

This last factor, in particular, suggests that the needs assessment should be taking into consideration of the location and use of an AED.

Appendix 1: First Aid Needs Assessment for Automated External Defibrillators

[Adapted from the Resuscitation Council UK – *do I need and AED?]*

Worked examples – for illustrative purposes only:

To help attach a numerical value to **the likelihood of cardiac** arrest occurring, the descriptions in the following Table 1 can be used.

Table 1

Probability	Score	Probability of risk being realised	Description
Almost certain	5	76 - 100%	Risk has high likelihood of occurring despite precautions **GUILDHALL – has happened before**
Likely	4	51 - 75%	Risk has high likelihood of occurring **BARBICAN CENTRE**
Moderate	3	26 - 50%	Risk has a moderate likelihood of occurring
Unlikely	2	11 - 25%	Risk is considered unlikely to occur **KEATS HOUSE**
Rare	1	0 - 10%	Risk will occur in rare circumstances

In the case of cardiac arrest, the likelihood of the event occurring in most public places and workplaces will be low with a score of 1 or 2. Examples might include a small shop, garage or workshop. Some higher risk sites like busy transport hubs and sports centres will justify a score of 3, possibly even 4. Higher scores are unlikely outside a specialist healthcare setting.

The consequences (severity) of cardiac arrest occurring

In a typical risk assessment, a score of 1 - 5 will be allocated based on the consequences of the event occurring. Table 2 shows a convenient grid that might be used.

Table 2

Score	Consequences	Description
1	Negligible	Minimal or no effects if event occurs
2	Minor	Consequences very minor, no lasting effects
3	Moderate	Important consequences
4	Major	Significant impact / injury on anyone affected
5	Extreme	Death or serious injury

However, cardiac arrest is uniformly fatal (unless treated), so **the score will always be 5.** Even if resuscitation is successful, the impact on the individual will be significant, for example they will be in hospital for some time and probably require additional clinical interventions, so the score will remain the same at 5.

Risk rating score

Risk = Severity (5) x Likelihood

By multiplying the scores for the severity and likelihood, the risk is given a numerical value ranging from 1 (unlikely to happen and with minimal consequences even if it does occur) to 25 (highly likely to happen with disastrous consequences). Given the severe consequences of cardiac arrest in the present example the minimum score will be 5. **Table 3** shows a convenient way to plan a response depending on the score calculated.

Appendix 1: First Aid Needs Assessment for Automated External Defibrillators

[Adapted from the Resuscitation Council UK – *do I need and AED?]*

Table 3

Rating Score	Action
1 - 4*	Broadly acceptable - No action required
5-9	Moderate - reduce risks if reasonably practicable
10 - 15	High Risk - priory action to be undertaken
16-25	Unacceptable -action must be taken IMMEDIATELY

* This score will not be possible in the case of cardiac arrest because of the severe consequences necessitating a minimum score of 5.

Example scores:

Guildhall 5 * 5 = 25 "*Unacceptable"* – has provision of 2 AEDs

Barbican 5 * 4 = 20 "*Unacceptable"* - has provision of 2 AEDs

Keats House 5 * 2 = 5 "*High Risk"* – has provision of 1 AED

NOTE: from RC (UK):

At present there is insufficient published evidence to give precise or dogmatic advice for an individual location and the rating score applied has to be a 'best-guess' or estimate. More accurate information will be available with increasing experience and we encourage research in this area.

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Appendix 2: Summary of City Corporation External Automated Defibrillator (EAD) Provision from Survey

Note: Excludes City of London Police. Self-reply survey results (December 2018).

Department / Location	Persons responsible for AED	Numbers of AED	Use of defibrillator?	Comments
Barbican Centre	Audience Experience department [Named manager]	2	No	
City Surveyors	Security team (Guildhall); Premises Controller / Building Manager (W Wharf)	2 - Guildhall 1 – W Wharf	Yes (at Guildhall)	See also provision at W Wharf under Town Clerks (Occupational Health)
City of London School (Boys)	Named persons	2 (school / sports ground)	No	
City of London School (Girls)	Named person	1	No	
City of London Freemens School	Medical team	5	No	
Built Environment (West Smithfield)	Drainage Inspectors	3 (2 mobile / 1 office)	No	Provision based on work environment / tasks undertaken
Children's and Community Services	All staff / Named manager	1 – Golden Lane Estate Office 1 – Lauderdale Tower lobby	No	Artizan Street AED (*1) had dead battery. Reportedly old unit and replacement batter could not be sourced.
Guildhall School	Facilities department	3	No	
Markets & Consumer Protection	Named persons	2 – Smithfield Market 3 – New Spitalfields 1 – Port Health 1 - Billingsgate	Yes (at Smithfield and Billingsgate)	Billingsgate are seeking to update / augment provision.

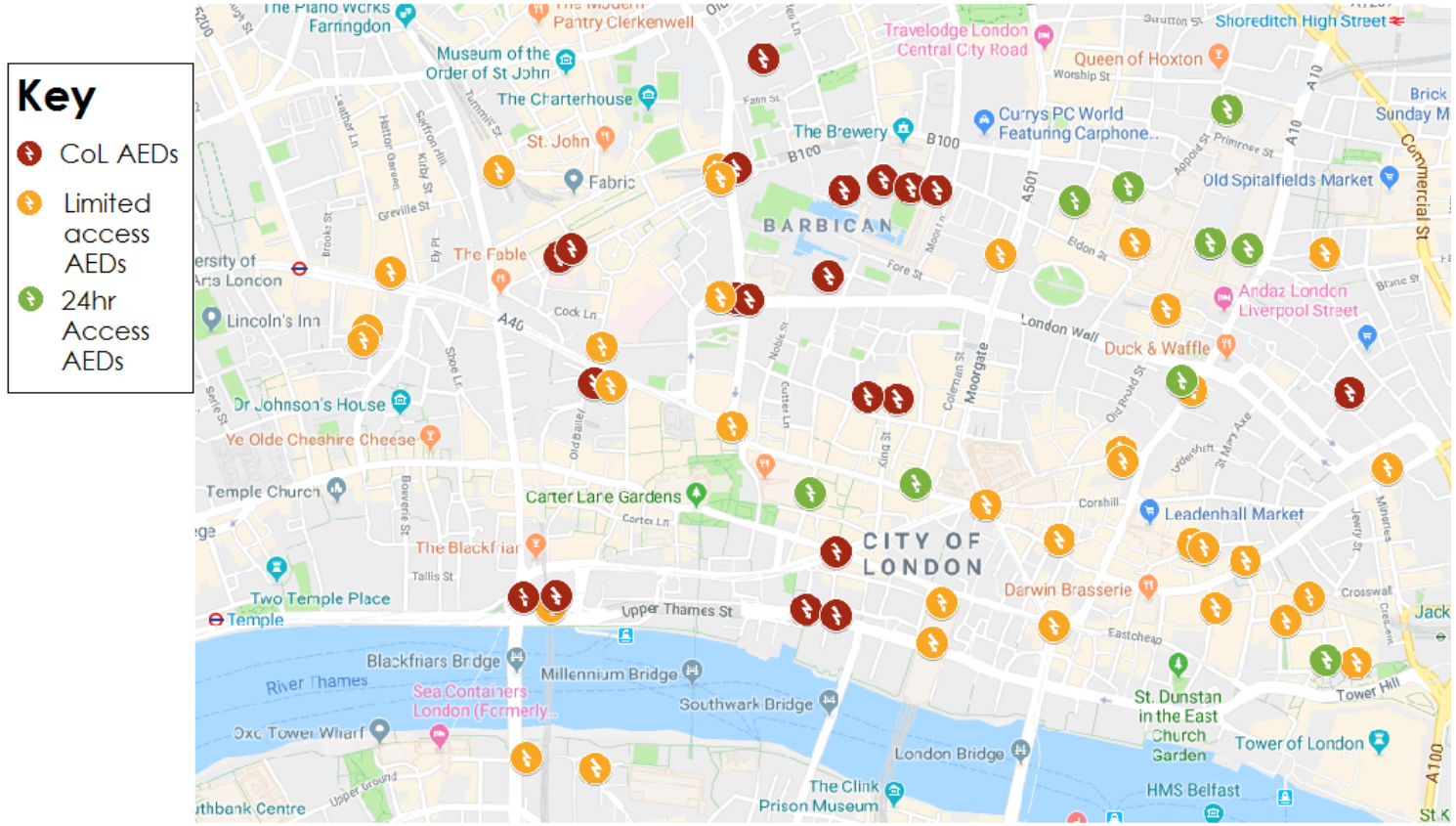
Appendix 2: Summary of City Corporation External Automated Defibrillator (EAD) Provision from Survey

Note: Excludes City of London Police. Self-reply survey results (December 2018).

Department / Location	Persons responsible for AED	Numbers of AED	Use of defibrillator?	Comments
Mansion House and Central Criminal Court	Named person (MH) / Security Team (CCC)	1 – Central Criminal Court 1 – Mansion House	Yes (at Mansion House)	
Open Spaces	Named persons	5 – Hampstead Heath (ponds / lido plus heath constabulary) 1 – Keats House 1 – Tower Bridge	Yes (at Parliament Hill Lido; Kenwood Ladies pond; on the Heath)	Swimming is a 'higher risk' activity The Commons have an AED manged by third party at Burnham Beeches
Town Clerks	Named persons	1 – London Metropolitan Archive 1 – W Wharf	No	1 W Wharf defibrillator is under control of Occupational Health the other under City Surveyors (see above)
Confirmed totals / further comments	**Most sites report to have staff specifically trained to use the AED.** Both RC(UK) and HSE guidance recommend that *"it is essential to have people on site who are willing to be trained to use the AED" but that "it is the view of the Resuscitation Council (UK) that the use of AEDs should not be restricted to trained personnel".*	**39** *Mixture of makes and models from different suppliers. For example, Hampstead Heath (OS) have 5 HeartStart FRx AEDs which are robust and suitable for external locations and can be 'switched' with a key for treating children < 8 years old.*	Reported use at 'higher risk' sites: • Large number of persons using facility; • risk of cardiac arrest occurring at the site due to the profile of users (e.g. older); • type of work activities or premises (e.g. swimming)	See **Appendix 1** – ***First Aid Needs Assessment for AEDs***

Appendix 3 - AEDs in the City of London

Defibrillators (AEDs) in the City of London



AEDs at key City of London buildings: CoL Boys' and Girls' Schools, Walbrook Wharf, Guildhall, Barbican Estate, Lauderdale Tower, Barbican Centre, Guildhall School, Smithfield Market, Central Criminal Court, Mansion House, Tower Bridge, Golden Lane and London Metropolitan Archives. Drainage engineers in Department of Built Environment house three AEDs (two in engineer's vans).
(The map represents 19 of the City of London Corporation's 39 AEDs)

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Committee	Dated:
Health and Wellbeing Board	11/02/2019
Subject: Mental Health Services for Children and Young People	**Public**
Report of: Andrew Carter, Director of Community and Children's Services	**For Information**
Report author: Claire Giraud, Strategy Officer, Department of Community and Children's Services	

Summary

This report provides a comprehensive overview of mental health provision available for children and young people in the Square Mile, as requested by members.

Recommendations

Members of the Health and Wellbeing Board are asked to:

- Note the content of this report.

Main Report

Background

1. Good mental health has been identified as a priority in the City of London Corporate Plan; in the City Corporation's Joint Health and Wellbeing Strategy; in the Mental Health Strategy; in the Children and Young People's Plan; and by the Adult Advisory Group.

2. At the Health and Wellbeing Board in September 2018, members requested a report that provided an overview of mental health provision for children and young people in the Square Mile, including both residents and non-residents.

A. CCG Funded Services – open to residents

A.1 Community Child Psychology Services (First Steps)

3. Provided by the Homerton, First Steps Early Intervention Community Psychology Service provides a service for children and young people aged 0-18 and their families, who have mild to moderate mental health problems and who are likely to be helped by a brief psychological intervention.

A.2 Child and Adolescent Mental Health Service (CAMHS) Disability Team

4. The CAMHS Disabilities Service is provided by the Hackney Ark Children & Young People's Centre for Development & Disability by Homerton Hospital and East London NHS Foundation Trust (ELFT).
    - A specialist, tier 3 service for children and young people aged 0-19 who have dual difficulties; mental health or emotional needs, which occur alongside a disability.
    - A joint multidisciplinary team provided by Homerton Hospital and ELFT, which consists of clinical psychologists, consultant child and adolescent psychiatrist, play specialist, systemic family therapist, child psychotherapist and specialist autism clinicians.
    - The service provides diagnosis e.g. ASD, ADHD, psycho-pharmacological intervention (medication), therapeutic/behavioural support and interventions and support with emotional response to diagnosis. It also delivers group work around parenting, siblings support groups, Next Steps intervention (MDT) for under 5s, Teen Troubles (ASD), ASD parent support group.

A.3 Specialist Child and Adolescent Mental Health Services (CAMHS)

5. Core specialist CAMHS services are provided by ELFT at Homerton Row. Specialist CAMHS offers assessment and help to children, young people and their families with significant emotional, behavioural and mental health difficulties. The suspected mental health difficulties are urgent, persistent, complex or severe.

A.4 Adolescent Mental Health Team (Specifically targeted work with psychosis)

6. Adolescent Mental Health Team provides an early intervention in psychosis service to offer quick identification of the first onset of a psychotic disorder and appropriate treatment including intensive support, crisis intervention, assertive outreach and home treatment in the early phase.

7. The service also provides assessment and treatment of mental health problems of an acute and severe nature for young people including complex eating disorders, OCD, ASD, Anxiety and Depression.

A.5 Parent Infant Psychotherapy Service (PIP)

8. The PIP Service, provided by ELFT, works with women who have moderate to severe mental health difficulties in pregnancy or within the first year after child birth. These may be pre-existing illnesses or have their onset in the perinatal period.

B. NHS England Funded Services (Specialist Commissioning) – for residents

B.1 The Mother and Baby Unit

9. ELFT provide a family centred mother and baby unit for mother's experiencing mental health problems before and after pregnancy.

B.2 Youth Justice Liaison and Diversion

10. ELFT have historically hosted this post. However, subsequent to CAMHS Transformation Phase one, work is currently underway to collaboratively commission this with City and Hackney CCG.

B3. CYP Improving Access to Psychological Therapies (IAPT)

11. City & Hackney was a wave two CYP IAPT site and the City & Hackney CYP IAPT partnership was set up in late 2012. The original partnership consisted of ELFT specialist CAMHS, Homerton CAMHS and the London Borough of Hackney's Young Hackney service. City & Hackney is part of the London and South East Collaborative linked to University College London and Kings College London. The CYP IAPT programme has also enabled greater participation by children, young people and parents/carers in service design and delivery.

C. City of London Services

C1. Enhanced CAMHS – for children who are looked after by the City of London

12. The City of London Corporation public health and children's social care teams have commissioned an enhanced CAMHS scheme for the looked after children under the care of the Corporation. Under this service, all looked after children and care leavers receive a CAMHS assessment. These are undertaken in the placement and include the mental state of the child or young person. All relationships are assessed. All assessments include diagnosis of common conditions such as ADHD, and Autistic Spectrum Conditions can be screened for and diagnosed if appropriate. Support is also given to foster parents and carers for crisis management on a case by case basis, as is teaching and training to foster parents and carers.

C2. Prospects – for all children

13. Prospects is commissioned to run IAG and Youth Participation.

C.3 City of London Schools Services – for all children

14. City and Hackney are part of the Anna Freud CAMHS School link programme and we are currently undergoing a CAMHS transformation to embed an integrated school model into our maintained school. Staff have received mental health training as part of the transformation and will now have a CAMHS link worker based at the school for a proportion of the week. They are also embedding a wellbeing support framework (Wellbeing and Mental Health in Schools) and have completed a survey of emotional wellbeing and mental health as part of this work. This work is overseen by the CAMHS alliance schools steering group which the City Corporation sits on. In addition, the school has:
    - Counselling services by psychotherapist
    - First Steps programme for parents in children centre
    - First steps work with whole school including visits to staff meetings to discuss individual cases

15. Young Hackney is commissioned to deliver sessions in schools or community centre, for 5 to 13 years old and 9 to 19 years old, one of which is called Emotional Wellbeing. The session equips young people with the necessary skills to manage their emotional responses, cope with stress in a healthy way and maintain a sense of perspective when under pressure.

16. The maintained and private schools within the City provide a huge number of services and interventions for pupils attending, regardless of whether they are resident or non-resident in the City. See appendix 1 for the full list.

D. Voluntary Sector Provision

D.1 Family Action – Well Family Plus

17. Family Action provides the 'Well Family Plus' service, which supports primary care by seeing cohorts of patients, who may experience unexplained symptoms and / or frequent attenders thus relieving some of these known pressures on primary care.

D.2 Off-Centre at Family Action

18. Off Centre provides therapeutic services to children and young people experiencing difficulties such as bereavement, substance misuse, abuse, unstable accommodation in a young person friendly setting. Off-Centre have recently been commissioned to provide the 16-25 transition service as part of CAMHS Transformation.

E. Other mental health services not specifically directed at children and young people:

19. The City has a pilot social prescribing service commissioned from Family Action by the City and Hackney CCG which allows GPs to refer patients with social and emotional needs to a wellbeing co-ordinator.

20. *Fusion* provides subsidised leisure facilities and classes in the City, including Golden Lane Sport & Fitness which offers a wide range of indoor and outdoor sports and activities.

21. ELFT runs a number of health services for City residents including the 24-hour mental health crisis helpline.

F. Upcoming services

22. A Mental Health centre for over 18 years old is estimated to open summer 2019 on Middlesex Street and offer long term mental health therapies that are not widely offered through the NHS for people living and working in the Square Mile. There will be subsidised treatment for those who are not able to pay the full cost for sessions.

23. Mental Health first aid training (MHFA) for City schools is being organised with Mental Health First Aid England.

24. An awareness raising campaign for safeguarding children and young people in schools and education settings in the academic year 2018/2019 is currently being developed. It will focus on raising awareness on a range of the identified needs in the context of safeguarding, particularly focusing on those more vulnerable pupils with mental health and wellbeing concerns.
    - The campaign will include a full training programme around the identified topics that will be available to all staff in the City Education settings, including those independent and sponsored Schools.
    - A conference is also being planned, primarily for schools, early years and other education settings and staff.

Corporate & Strategic Implications

1. The Mental Health Strategy supports the City of London Corporate Plan's aim to provide modern, efficient and high quality local services within the Square Mile for workers, residents and visitors and to provide valued services, such as education, employment, culture and leisure, to London and the nation.

2. It also supports the following priority from the Department of Community and Children's Services Business Plan: Priority Two – Health and Wellbeing: Promoting the health and well-being of all City residents and workers and improving access to health services in the Square Mile.

Conclusion

25. There is good provision of Mental Health Services for Children and Young people in the Square Mile, both for residents and children who attend schools in the City. The provision is constantly being reviewed by officers, the commissioning team, through the CAMHS transformation plan, the Children Partnership Board and the Joint Mental Health Strategy with the London Borough of Hackney and the CCG.

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Appendix 1 - Schools provision

1. The following table shows the schools in the City and the range of mental health services on offer to their pupils.

School	Mental health services
City of London School for Girls	- two school counsellors - the sixth form run a mental health committee which works on friendships and relationships in Year 8, for example, which includes a session with the school counsellor about grief and loss, and helping a friend in need. Most year groups do something about body image and also social media. Year 7 have a session on transitions and where to go to ask for help. - school nurse. - Mental health programmes such as mindfulness covered in PSHCE and assemblies. - run a wide range of clubs, sports and societies.
City of London School	-2 counsellors – both psychotherapeutic; one of our counsellors is a child and adolescent psychotherapist -Pastoral and well being advisor – this is a person who is a senior social worker and her work with young people is informed by social work models of working (e.g. motivational interviewing, systemic practice, solution-focused questioning, etc.) 30+ members of teaching staff are mental health first aid trained -A SEND department which intersects with mental health provision in as far as being able to do initial assessments for some learning issues such as ADHD. The department does a huge variety of work with pupils with ASD, ADHD etc. including social communication workshops -Weekly pastoral case meetings with DSL, nurse, counsellors and other key pastoral staff to review cases and reflect on best practice

	-Regular training for all staff about mental health issues, including depression, anxiety, eating disorders, stress etc. -all key pastoral staff have undergone Suicide Prevention Training with Papyrus -Network of professionals in the mental health field – private, hospital based and CAMHS -Relevant case meetings with external agencies and pastoral staff at CLS to support pupils with mental health issues -A number of key pastoral staff are Tavistock trained in a variety of different areas of counselling and psychotherapy (specifically in adolescents)
Charterhouse Square School	-one teacher trained in Drawing and Talking -one teacher training in counselling.
St Paul's Cathedral School	-endeavour to support pupils though their form teachers, the school nurse and the school Chaplain. -work closely with CAHMS for early intervention. -one pupil who currently meets with a private counsellor who comes in for the meeting to take place at school.
Sir John Cass Primary School	- First Steps in fortnightly to meet with parents. - Play therapist 1 day per week - Counsellor 1 day per week - CAMHS support half a day per fortnight (this academic year, whilst we undertake a pilot project) - Some of the other provisions include: ongoing training for staff - ACES, trauma sensitivity Developing children's Growth Mindset Training in Philosophy for Children Broad and balanced curriculum

	- currently undertaking/developing a wellbeing and mental health in schools project (WAMHS) that lasts for 1 year and will possibly extend to 2 years. Wellbeing and Mental Health in Schools (WAMHS) is a project which seeks to improve access to the appropriate mental health support for all CYP in City & Hackney. This involves improving early identification of possible mental health problems by supporting and equipping schools to confidently identify and intervene early in emerging mental health problems and to upskill school staff to be able to successfully promote and support their student's wellbeing, thus off-loading pressure created by later intervention of more severe problems. The project also seeks to ensure that all children receive the right intervention. The transformation project ultimately seeks to increase the number of CYP with diagnosable mental health conditions accessing services, by ensuring that they are identified and correctly signposted to the appropriate CAMHS service. In the same way, the project seeks to reduce the current inequalities in accessing mental health services, as well as in exclusion rates by taking into consideration the cultural diversity and specific needs of the population in City & Hackney. To achieve this, the Schools workstream has developed 3 interlinked strands of intervention brought together under the name of Wellbeing and Mental Health in Schools (WAMHS) Project: a) Anna Freud Schools and Mental Health Link Project b) Wellbeing Framework Support in 50% of schools in City & Hackney: c) Deployment of CAMHS clinicians in 50% of schools in City & Hackney

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Committee:	Date:
Health and Wellbeing Board	11.02.2019
Subject: Health and Wellbeing Board update report	**Public**
Report of: Director of Community and Children's Services	**For Information**
Report Author: Farrah Hart, Consultant in Public Health	

Summary

This report is intended to give Health and Wellbeing Board Members an overview of local developments and policy issues related to the work of the Board where a full report is not necessary. Details of where Members can find further information or contact details for the relevant officer are set out within each section. Updates included are:

- TB immunity and access to labs for testing
- Healthwatch City of London update
- Drugs and the City Working Group
- Health care for people sleeping rough
- Sexual Health E-service
- East London Health and Care Partnership update
- Childhood obesity services
- London Food Strategy update
- The NHS Long Term Plan
- Public health grant to local authorities 2019/20

Recommendation

Members are asked to:

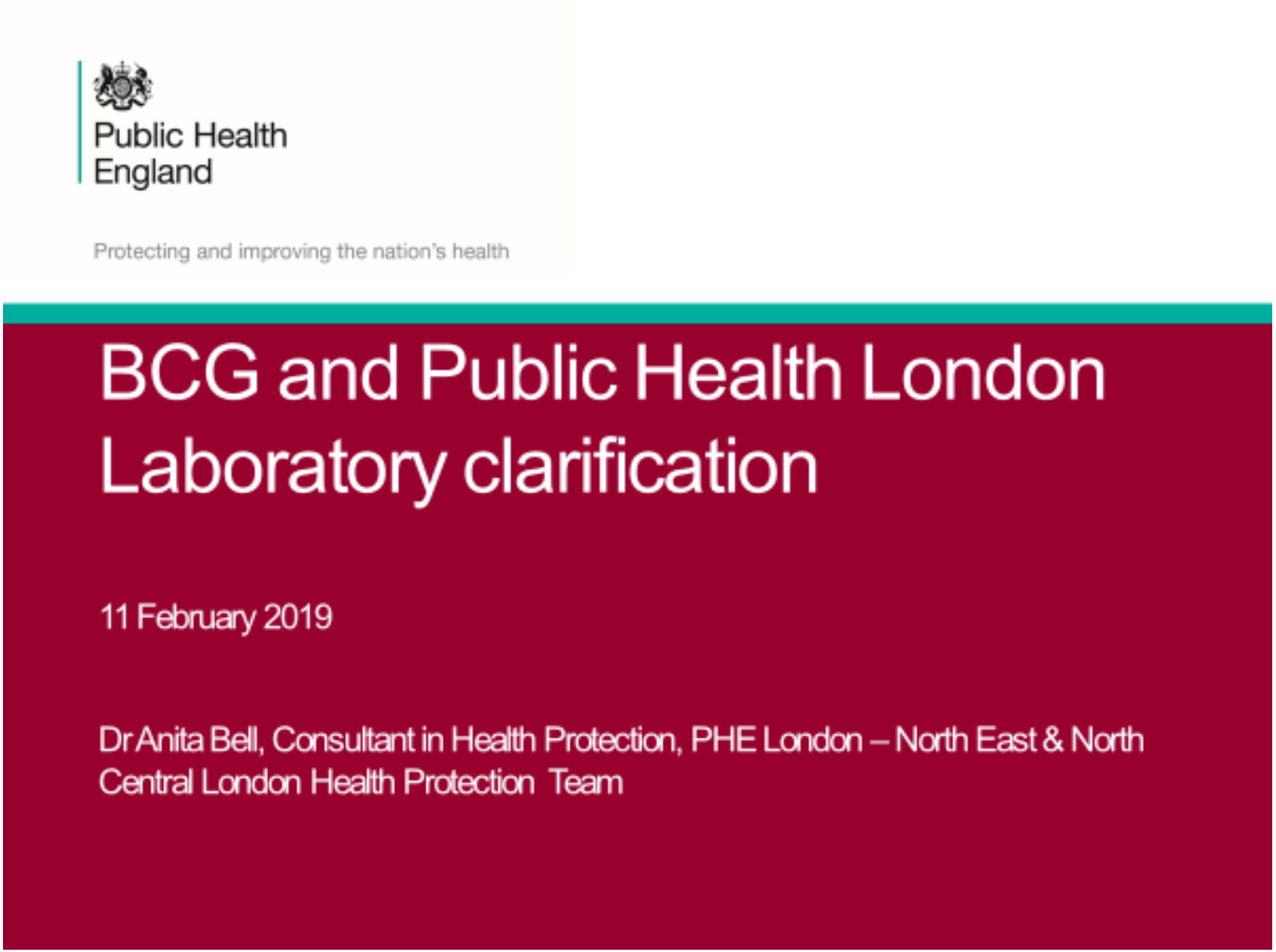
- Note the report

Main Report

TB immunity and access to labs for testing

1. At the November Health and Wellbeing Board, Dr Deborah Turbitt of Public Health England presented an overview of health protection arrangements for the City.
   Members requested further clarification about tuberculosis (TB) vaccine supply restrictions, with concern that the disease could potentially spread across boroughs. Additional concerns were raised in relation to the movement of testing laboratories away from London. Dr Anita Bell has provided the following presentation to address the concerns raised by the Board.

2.


Public Health England
Protecting and improving the nation's health
BCG and Public Health London Laboratory clarification
11 February 2019
Dr Anita Bell, Consultant in Health Protection, PHE London – North East & North Central London Health Protection Team

BCG criteria since 2016

BCG vaccine is available at present:

For all babies at birth or within 28 days at maternity units in London.

For those who miss this universal offer at birth or who move into a London borough, the following infants will be eligible for referral via maternity, GP, health visitors etc to a LA community service for BCG up to 12 months of age:

- living in a London borough where the TB incidence rate is 40 cases per 100,000 or higher[1].
- living in a household with parents or grandparents from countries where the TB incidence rate is 40 cases per 100,000 or higher.
  - link for finding countries with rates of >40/100,000. https://www.gov.uk/government/publications/tuberculosis-tb-by-country-rates-per-100000-people

1. London boroughs with an incidence of TB >40 per 100,000 population are: Newham, Brent, Ealing, Hounslow, and Redbridge.

BCG vaccine

https://www.gov.uk/government/publications/vaccine-update-issue-283-august-2018-bcg-special-edition

- Supplied by PHE to NHSE for those at high risk of TB exposure
- In 2015 BCG supply was interrupted
- From July 2016 alternative BCG supply used criteria developed by NHSE– restricted availability and thus delivery by maternity and named LA community providers (provision in all LAs).
  - Universal to those under 31 days and to high risk for those aged over 31 days to 1 year.
- Since mid year 2018, old vaccine now available again using PHE high risk eligibility guidance.
- As NHSE contracts covers under 1 year for BCG (section 7A) then work required regarding delivery to for those high risk aged 1-5 years across England and London,
  - In London at present for those parents enquiring re child in a high risk group aged 1-5 then can be referred to the LA BCG community providers (NHSE contract).

Public Health Laboratory (PHL) -London

No change in testing. Only change is that the PHL London has moved from London to Cambridge.

The same service is provided to HPTs and urgent/routine tests – as required are couriered/sent to the PHL lab in Cambridge

The lab is used by the HPTs for certain urgent or routine testing as agreed. This includes measles, whooping cough, influenza, faecal specimens for clearance of cases and contacts etc.

Local labs carry out their own testing and thus this should not impact on them.

Healthwatch City of London update

3. This update is to inform the Board on work of Healthwatch City of London since the last Health and Wellbeing Board meeting on the 28 November 2018.

4. In April 2018, Healthwatch Hackney became the provider of the Healthwatch City of London contract for the City of London Corporation. In September, City Commissioners were concerned at delivery of the contract. As a result, there have been meetings to resolve issues of concern and put the contract back on track.

5. Since the last meeting the focus has been on the processes of the Healthwatch, so it is better able to deliver on this contract. In terms of resolving issues of concern, the following actions have been taken:

   a. A Governance document, setting out the relations between the two Healthwatch Boards, has been agreed.

   b. A schedule of Healthwatch City of London Board meetings has been agreed along with an Annual General Meeting. Board meetings are set for:
      i. 3pm to 5pm Monday 28 January 2019
      ii. 6pm to 8pm Thursday, 4 April 2019
      iii. 6pm to 8pm Thursday 11 July 2019
      iv. 2pm to 4pm Friday 29 November 2019

      The Annual General Meeting is set for Thursday 3 October 2019. It will be in two parts, an afternoon session and an evening session to encourage both City resident and worker attendance.

   c. Internal staff issues have been resolved and Healthwatch Hackney has instituted a Staff Governance Committee to provide the Hackney Board with improved oversight of staff matters. The Committee has agreed to institute an organisational development review to ensure the organisation is able to carry out all its functions out effectively.

   d. Two staff left the organisation and one went on maternity leave; recruitment to these posts is under way. An update on progress will be given at this meeting.

   e. In December, Healthwatch moved offices to St Leonard's Hospital and is now closer to the City. Previously the organisation was based in Dalston.

   f. A process for signing off Healthwatch City of London Newsletter has been agreed. A Healthwatch City of London Board member now works with the Communications and Intelligence Manager to develop the newsletter. There will be a bi-monthly newsletter and, if necessary, email bulletins will be sent out for urgent matters, which cannot be deferred for the regular newsletter.

   g. A draft Communications and Engagement Plan has been finalised for review by the Healthwatch City of London Board.

h. An external meetings calendar is being developed so Healthwatch City of London can manage its involvement with local partners; these include meetings run by City of London Corporation, local hospitals, City and Hackney Clinical Commissioning Group and local Integrated Commissioning groups. This is to be reviewed by the Healthwatch City of London Board once complete.

i. A proposal to update the Healthwatch City of London website has been presented to City Commissioners.

j. In agreement with the City of London Corporation, Healthwatch City of London will absorb the work of the Corporation's Adults Advisory Group. This Group had its last meeting in December 2018. Healthwatch City of London Board and Executive Director to discuss how to take this work forward.

6. In terms of external activity Healthwatch City of London has:

k. Trained 3 City residents to carry out Enter and View Visits of local health and care services.

l. Possible new board member: City worker interview in March.

m. Liaised with City and Hackney Clinical Commissioning Group (CCG) on issues raised at the Neaman GP Practice Patient Participation Group. This related to reductions in the drugs budget, which the CCG is investigating further, and how Consultant letters are referred to the right clinician at the practice.

n. A Healthwatch Board member successfully extended the deadline to responses to the Corporation's Carers Strategy to allow for more time to respond to this consultation.

7. For more information, please contact Jon Williams, Healthwatch Executive Director, T: 020 7923 8351, E: jon@healthwatchhackney.co.uk

Drugs and the City Working Group

8. This report provides an update on the work to date of the Drug and the City Working Group, which met for the first time in December 2018. Three areas of planned activity have been agreed for the year ahead. These are:
   a) improve understanding and responses to dependent and problematic drug use within the City;
   b) Support venues operating within the Night Time Economy to reduce drug related harms;
   c) work with employers to promote advice and understanding as well as highlight the consequences of criminal convictions.

9. The Working Group will also help improve understanding of the drug issues in the City by pulling together different sources and building on the City of London Police's drug profile (presented to the Health and Wellbeing Board in November).

10. This work is at an early stage, but members will be kept informed of progress as it develops. The Working Group intends to progress these work strands over the coming year. In December 2019 the utility and benefits of the group will be reviewed. The Group will report regularly to this group, the Safer City Partnership, the Licensing Committee and Police Committee.

11. For more information, please contact David Mackintosh, Head of Community Safety, T: 020 7332 3084, E: David.MackIntosh@cityoflondon.gov.uk

Health care for people sleeping rough

12. At the November 2018 meeting of the Health and Wellbeing Board, members requested an update on how the findings from the report on rough sleeper health were being taking forward.

13. City & Hackney CCG has awarded the tender for the provision of the Greenhouse, which is a specialist primary care service that delivers for clients who are homeless. City officers are discussing with the CCG how the mobilisation of that contract will respond to the needs of City rough sleepers for whom the location of the Greenhouse is too far to travel.

14. Officers have met with the Accountable Officer of the East London Health and Care Partnership (the STP of which City and Hackney are part). Discussions included the potential for health interventions for rough sleepers to be commissioned across a wider geography, given the highly transient nature of the client group. A follow-up discussion will be held in March.

15. "Navigating health and social care for rough sleepers and homeless people" was one of the priorities for this year's Healthy City and Hackney Fund, and some promising bids for the City of London have progressed to the second stage of the application process.

16. Officers have agreed an allocation of Section 256 funding to resource the development of health proposals identified in the review commissioned by the City in order to progress their implementation.

17. For further information, please contact Simon Cribbens, simon.cribbens@cityoflondon.gov.uk

Sexual Health E-service

18. The sexual health e-service now covers residents of 28 authorities after Barking and Dagenham joined on December the 1st 2018. At this point we also introduced a new category of pick-up points for “smart kits”; at a community service in Bromley, and we are exploring more opportunities to widen access to smart kits through outreach and community services in other boroughs.

19. Test kit volumes have continued to build steadily, we have dispatched almost 140,000 kits and tested over 103,000 returned kits. These tests have revealed over 6,000 infections although some of these will be historic latent infections as is the case with syphilis. Service users continue to respond positively with 98-99% approval and recommendation scores. This has been further evidenced by continued endorsement by service users on social media.

20. For more information, please contact Adrian Kelly, Lead Commissioner – Sexual Health E-Service – Adrian.kelly@cityoflondon.gov.uk

East London Health and Care Partnership update

21. At the Health and Wellbeing Board meeting on the 28 November 2018, members requested further information from East London Health and Care Partnership on their intended action plans for East London.

22. The publication of the NHS Long Term Plan (LTP) on 7 January 2019 gives us an opportunity to refresh our local East London Health and Care Partnership, reflecting our local changes since 2016 and the new national priorities for health and care. Key pledges in the plan include saving almost half a million more lives with practical action on major killer conditions and investment in world class, cutting edge treatments including genomic tests for every child with cancer. There are also pledges around the use of the latest technology, such as digital GP consultations for all those who want them, coupled with early detection and a renewed focus on prevention to stop an estimated 85,000 premature deaths each year. Another focus of the LTP is on the prevention of 150,000 heart attacks, strokes and dementia cases nationally while more than three million people will benefit from new and improved stroke, respiratory and cardiac services over the next decade. Patients will benefit from services ranging from improved neonatal care for new parents and babies to life-changing stroke therapy and integrated support to keep older people out of hospital, living longer and more independent lives.

23. The LTP also outlines a new guarantee that investment in primary, community and mental health care will grow faster than the growing overall NHS budget. This will fund a £4.5 billion new service model for the 21st century across England, where health bodies come together to provide better, joined up care

in partnership with local government. This will be the major focus for us as a Partnership in refreshing our local Plans, as we will be expected to ensure our plans fulfil this aspiration in order to secure these resources.

24. The commitment to tackle major physical conditions comes alongside the biggest ever investment in mental health services rising to at least £2.3 billion a year by 2023/24. Building on significant expansion in recent years, the long-term plan will see around two million more people who suffer anxiety, depression or other problems receive help over the next decade including new dads as well as mums, and 24-hour access to crisis care via NHS 111.

25. The NHS long term plan also gives pledges to:
    - Open a digital 'front door' to the health service, allowing patients to be able to access health care at the touch of a button
    - Provide genetic testing for a quarter of people with dangerously high inherited cholesterol, reaching around 30,000 people
    - Give mental health help to 345,000 more children and young people through the expansion of community-based services, including in schools
    - Use cutting edge scans and technology, including the potential use of artificial intelligence, to help provide the best stroke care in Europe with over 100,000 more people each year accessing new, better services
    - Invest in earlier detection and better treatment of respiratory conditions to prevent 80,000 hospital admissions and smart inhalers will be piloted so patients can easily monitor their condition, regardless of where they are
    - Ensure every hospital with a major A&E department has 'same day emergency care' in place so that patients can be treated and discharged with the right package of support, without needing an overnight stay.
    - Further improve cancer care, including the development of Rapid Access Diagnostic Centres and the introduction of shorter target times from presentation to treatment.
    - Responding to the challenges of workforce development (more detail expected shortly), including new community roles in GP surgeries and across networks of practices

26. For more information, please contact Simon Hall, Director of Transformation, ELHCP – simonhall2@nhs.net

Childhood obesity services

27. This update provides an overview of services available to tackle childhood obesity within the Square Mile, as requested by members at a previous meeting of the Health and Wellbeing Board.

28. The London Borough of Hackney has commissioned two new healthy eating and obesity services for children and young people in City and Hackney.

29. From 1 April 2018, the *Best Start with HENRY* service supported all City and Hackney families with children aged 0-5 to provide the best and healthiest start in life for their children.

30. With a specific focus on healthy eating and healthy weight the service offers:
    - Healthy eating workshops for families on starting solids, and healthy eating in the early years;
    - Targeted *Healthy Families* programmes for families of children who have been identified as requiring additional support;
    - A broad training programme for all education, health professionals and community and voluntary organisations who work with families of children aged 0-5, including raising the issue of weight;
    - Supporting the Eat Better Start Better programme in early years settings;
    - Promotion and delivery of Healthy Start Vitamins;
    - General health promotion of healthy, active lifestyles including healthy eating and early nutrition across services, and to health and education professionals who work with 0-5-year olds within the City and Hackney.

31. From 1 April 2018, the 5-19's healthy eating and obesity service has supported all City and Hackney families with children aged 5-19 (and up to the age of 25 for those with a special educational need or disability (SEND)) to achieve healthier lifestyle habits, including healthy eating, physical activity, and providing support to achieve a healthy weight.
    The service delivers a range of evidence-based interventions including:
    - A family-based child weight management programme
    - Engaging and non-judgemental follow up with families of children and young people who are identified as being above a healthy weight in the National Child Measurement Programme (NCMP);
    - Training on raising the issue of weight to front line professionals from health, education, youth services, and community and voluntary services;
    - Providing nutritional support and expertise to primary schools and youth hub settings.

32. In addition to these two main services, the promotion of healthy eating and healthy weight is embedded within all early years and young people's service provision

33. Healthy weight is a high impact area in the health visiting service and early intervention work, including breastfeeding which contributes to the childhood obesity strategy.

34. **Health Visiting and midwifery Services** monitor maternal weight, offer brief advice and can make referrals for weight and healthy lifestyle issues
35. The **Family Nursing Programme** (**FNP)** closely aligned to health visiting has a stated aim to tackle childhood obesity in working with vulnerable young pregnant women and their children aged under two. At age two, the family is transferred into the heath visiting service.

36. **Young Hackney Health and Wellbeing Service** delivers a range of PSHE/SRE Session Topics to ages 5 -19 mainly within the maintained City school in but also to youth clubs, uniformed groups (Scouts, Guides etc.) and other youth provision in City and Hackney. Topics includes sessions on weight and body image and the importance of health, exercise and wellbeing.

The team also runs drop in sessions where young people can get advice on a range of issues including healthy weight.

37. **CHYPS Plus** provides a clinical service including sexual health and smoking cessation, but also advise on healthy weight, emotional wellbeing etc. All young people have an initial holistic assessment which includes weight and the team give brief advice around this and can refer to other services where needed.

38. **School Based Health Services** provide preventative health support within maintained schools to maximise the health and wellbeing of children. In addition to delivering the National Child Measurement Programme (NCMP) and supporting schools in meeting the needs of children with special education needs and disabilities (SEND), they provide exercise and healthy eating sessions to pupils and early year's settings staff. When necessary, they can refer children in need of more support to specialist clinical services such as dietetics

39. These services can refer eligible residents into the 0- 5 and 5-19 commissioned services. Staff can also access the training opportunities and resources to ensure they continue to deliver consistent and up to date, evidence-based messages and interventions that effectively, support children, young people and their families, to adopt healthier lifestyles and help reduce childhood obesity.

40. The coming months will see the creation of a Healthy Eating and Physical Activity Alliance, provider-led forum to further strengthen collaborative service delivery.

41. Hip hop dance classes are running at the Golden Lane community centre on Wednesday evenings as part of the youth club nights.

42. Pupils at local schools, including the City of London School and City of London School for Girls are now benefiting from a recently refreshed offering within their canteens after City of London Corporation signed the Local Government Declaration on Sugar Reduction and Healthier Food.

Upcoming services

43. Fusion, the sports centre in Golden Lane is planning to establish a boxing club. It is also investigating funding from London Sport to establish a "young gym".

44. Healthy eating classes have been recently recommissioned and some of the sessions will be targeted at children and young people.

45. Young Hackney has developed several PSHE education sessions on healthy living. The commissioning team is hoping to have these delivered in City schools and community centres by the end of the school year:
    - For 9 to 15 year olds

- Body Image - addresses increasing concerns around weight and body image and the impact that celebrity and Instagram culture have on young people's self-esteem and emotional wellbeing.
- Healthy Living – an introductory session looking at the importance of health, exercise and wellbeing for growth and development in all parts of an individual's life.

- For 5 to 13 year olds
  - Healthy Eating – keeping a well-balanced and varied diet and how it contributes to mental and physical wellbeing.

46. The Access to Sports Project delivered a 5-week school holiday programme of free, inclusive activities at Finsbury Leisure Centre for young people aged 8-16 years old. The commissioning team is investigating whether to renew this over the summer of 2019:
    - Football – 16 sessions held
    - Badminton – 12 sessions held
    - Multi-Sports – 12 sessions held
    - Table Tennis – 8 sessions held
    - Basketball – 8 sessions held

47. Eat Club delivered a cooking club in the Golden Lane Community Centre over the summer of 2018. The commissioning team is assessing whether to renew this contract as take up was low and there is another ongoing healthy cooking classes project starting soon.

48. For further information, please contact Claire Giraud, T: 020 7332 1503, E: claire.giraud@cityoflondon.gov.uk

London Food Strategy update

49. The London Food Strategy was published by the Mayor of London in December 2018, with the aim of improving the food landscape in London and tackling a range of issues, such as food inequality and poverty, food waste and empowering people and communities to make changes to their relationship with the food that they buy, grow and eat. The strategy covers six key areas:
    i. Good food at home, and reducing food insecurity
    ii. Good food economy, shopping and eating out
    iii. Good food in community settings and public institutions
    iv. Good food for pregnancy and childhood
    v. Good food growing, community gardening and urban farming
    vi. Good food for the environment

50. The strategy is accompanied by an implementation plan, which proposes actions to support the delivery of the strategy. It includes specific recommendations for local authorities, to work in partnership with each other

and also with other stakeholders, such as local VCSE sector organisations and businesses:

51. Good food at home, and reducing food insecurity

- To supporting residents to eat more healthily, London boroughs should develop Good Food Retail Plans, sign up to the Local Government Declaration on Sugar Reduction and Healthier Food and lead a SUGAR SMART campaign.
- Every London borough should support its residents to learn more about healthy food and how to cook it, particularly focusing on key within areas of deprivation.

52. Good food economy, shopping and eating out

- Deliver the Healthier Catering Commitment within local authority areas, which supports hot food takeaways to make simple, healthy improvements to their food.
- Support local authorities and businesses to help staff eat healthy, sustainable food in the workplace. They will be encouraged to consider Public Health England guidance on catering standards for employers, adopt and promote the Healthy Workplace Charter and Food for Life Served Here accreditation.
- Local authorities should form local food partnerships and join the Sustainable Food Cities network to share best practice with other UK cities.

53. Good food in community settings and public institutions

- Use improved public food procurement to increase the provision of fresh, healthy meals across public sector settings by promoting and joining collaborative tendering contracts, such as Procurement Across London.
- Local authorities should combat social isolation by working with third sector organisations to offer communal eating opportunities to vulnerable groups.

54. Good food for pregnancy and childhood

- Help early years providers meet the Voluntary Food and Drink Guidelines for Early Years Settings in England, and to work towards a Healthy Early Years London award.
- Help school leadership teams adopt whole-school food policies to improve food culture, by working towards a Healthy Schools London Award and/or a Food for Life Schools Award.
- Protect and make better use of children’s centres to help address food insecurity and healthy eating including through promoting Healthy Start voucher uptake, providing good food education, and income maximisation, debt and employment advice.
- Support the London Health and Social Care Devolution Agreement to create health super zones around schools.

55. Good food growing, community gardening and urban farming

- Local authorities and partners should continue to promote planting of fruit and nut trees in parks, green spaces and institutional grounds, inspired by the Regent's Park Allotment, Growing Communities' Dagenham Farm and others across London.
- Local authorities should support and encourage food growing projects within London's Green Belt, where appropriate.
- Local authorities should ensure that information on the availability of allotment spaces in their borough is on their websites, to ensure all vacant spaces are allocated.

56. Good food for the environment

- Local authorities and businesses should work with the London Waste and Recycling Board (LWARB), Resource London, waste authorities and others to support programmes including Love Food Hate Waste and TRiFOCAL.
- Local authorities and businesses should use food's role as a key part of the circular economy to increase the value of food waste and food surplus through new technology, to improve redistribution to those in need, recognising that redistribution is not a long-term solution to food insecurity.
- Businesses, local authorities and other public sector bodies should increase the amount of local, seasonal and sustainable food they buy, and measure their progress at providing a better balance of plant-based food compared to meat and dairy.

57. Many of the London Food Strategy's recommendations for local authorities are already being delivered by the City of London Corporation and its partners across a range of strategies and action plans, including the Responsible Business Strategy, the Local Government Declaration on Sugar Reduction and Healthier Food, the Joint Health and Wellbeing Strategy, the Corporate Catering Contract and the Waste Strategy. This will help to ensure that the City Corporation is supporting the efforts of the Mayor of London and other partners in improving the food landscape across the capital.

58. For further information, please contact Ryan Jones, Public Health Support Officer (Apprentice) – ryan.jones@cityoflondon.gov.uk

NHS Long Term Plan

59. The NHS Long-Term Plan was launched in early January. The full plan (120 pages) and summary are available at: https://www.longtermplan.nhs.uk/

60. The plan is very much focussed on the NHS and clinical solutions. The LGA notes that the plan does not acknowledge the relationships between social care and the NHS, and how pressures in social care will impact upon the NHS in coming years. Similarly, Association of Directors of Public Health (ADPH) note that the plan is undeliverable without an increase in local authority public health funding, which will be needed to bring about some of the plan's health improvement aims.

61. A longer and more detailed briefing is available at: https://www.kingsfund.org.uk/publications/nhs-long-term-plan-explained

62. The LGA response is available at: https://www.local.gov.uk/about/news/lga-responds-nhs-long-term-plan

63. The ADPH response is available at: http://www.adph.org.uk/wp-content/uploads/2019/01/ADPH-statement_NHS-Long-Term-Plan-1.pdf

64. Below is a very brief overview of some of the key ambitions for the plan.

65. Improving Quality and Outcomes

- Waiting time targets and access standards for emergency mental health services from 2020 (including CYP)
- Greater CQC emphasis on system-wide quality
- New cancer Rapid Diagnostic Centres from 2019

66. New service models

- New primary care network contracts to extend the scope of primary and community services
- 2.5 million people to benefit from social prescribing, a personal health budget and support for managing their own health
- Same Day Emergency Care model across all acute hospitals – increasing same day discharges from 1/5 to 1/3
- Clinical assessment service to be a single point of access for patients, carers and health professionals
- Reforms to diagnostic services, with new investment in CT and MRI scanners

67. Prevention

- Funding for evidence-based prevention programmes, including smoking cessation, T2 Diabetes, limit alcohol-related admissions and lower air pollution
- Local health systems to reduce inequalities over the next decade

68. Digital care

- Patients will be able to switch from their GP to a digital first provider – everyone in England will have access to digital first by 2022/23
- More online consultations in secondary care to reduce 1/3 of outpatient appointments within 5 years
- All trusts must move to full digitalisation by 2024
- By 2021/22, all Integrated Care Systems to have a chief clinical information officer and a chief information officer
- Introduction of a new digital front door

69. Workforce

- Potential introduction of formal regulation of senior NHS managers
- Introduction of an NHS leadership code
- More doctors encouraged to train as generalists
- Mandatory flexible rostering across all trusts
- Apprenticeships, nursing associates, online qualifications and “earn and learn” schemes
- £2.3m investment in volunteers

70. Finance

- 3.4% funding growth over next 5 years
- 4.5b funding for primary and community care; 2.3b funding for mental health
- NHS Improvement led accelerated turnaround process for poor performing trusts
- Finance recovery fund to be set up
- £700m savings in admin costs in the next 5 years (£290m from commissioners; £400m from providers)

71. Structure

- England covered by integrated care systems (ICS) in two years – involving a single CCG for each ICS
- ICSs supported by legal shared duties and ability to create joint committees between CCGs and providers
- Legislative change requested to free commissioners from procurement rules and remove the role of the competition and markets authority in NHS mergers and acquisitions
- Exploration of opportunities to fund public health services through the NHS budget
- NHS England and NHS Improvement empowered to establish joint committees

Public health grant to local authorities 2019/20

72. The Government has published the public health allocations to local authorities in England for 2019/20, confirming there will be an £85 million reduction to public health budgets in 2019/20. For the City of London, this represents a reduction from £1,614,000 in 2017/18 to £1,571,000 in 2019/20 – a reduction of £43,000.

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